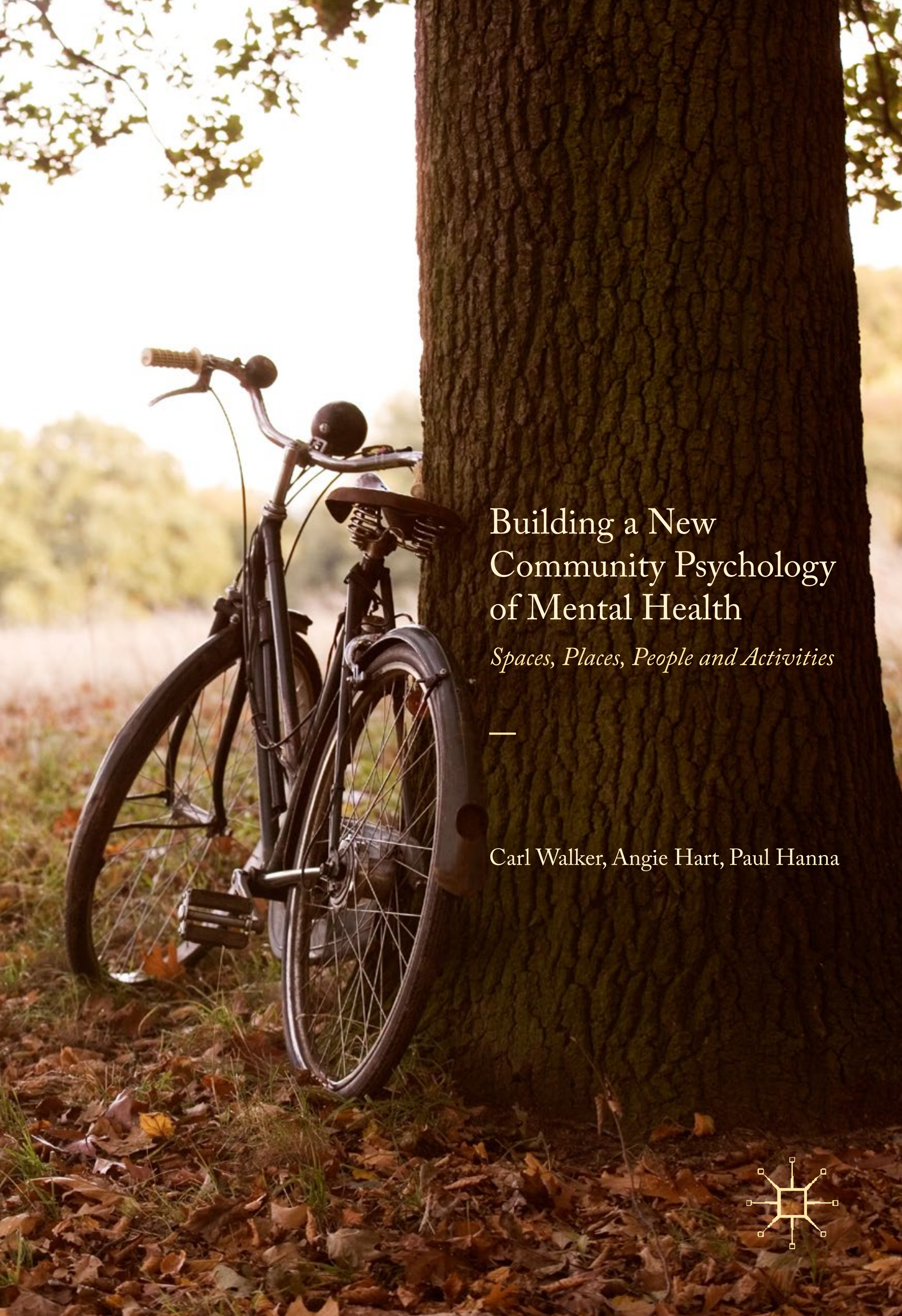

Building a New Community Psychology of Mental Health

Spaces, Places, People and Activities

Carl Walker, Angie Hart, Paul Hanna

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To those lost to, or experiencing, distress

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Contents

1

Introduction: Conceptualising Mental Health in the Twenty-First Century

2016, Beachy Head, East Sussex, England. James, stinking to high heaven, stands on the cliff edge, his eyes fixed on a boat far out to sea. He's about to step out. He can see a bridge that leads to his personal pirate ship. He shouts back to a woman begging him to stay put. 'Don't worry, it's all going to be okay, Mum.'

Just down the road, Louise sits in the pub with a shandy to her left, her daughter Jessica to the right. It had been a mistake to bring mum out thinks Jessica. She just can't stop crying.

Polegate, not far away at all. The child is in school this time. At the back of the classroom this 12-year-old is not listening to the art teacher tell them about using a colour wheel. She's digging a pencil deep into her arm. Her bag's on the table so nobody else can see.

Dealing with mental distress often provokes anxiety. Little wonder, the stakes can be high, as the authors of this book know only too well from personal experience. We are all trained in the psych disciplines, and one of us is a practising mental health worker. In our personal lives, we've had more than our fair share of psychiatrists, psychologists and the kind of severe distress with which we began this book. We've sobbed down the phone, begging for psychiatrists to turn up so that people who were a danger to themselves and others could be taken to a place of relative

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safety. We've demanded psychiatric medication on behalf of loved ones, knowing that it can have brutal side effects and that the evidence base for many of the medications is weak. We've lain awake at night hoping that people we cared for hadn't killed themselves. We also understand why many people are scared of other human beings who struggle to be in control of themselves and who want definitive action, even though a great deal of ambiguity and uncertainty surrounds us when we think about mental distress.

We understand all of this. But we also hold out for different ways of dealing with distress that are more humane than some of the ways that mental health is currently 'treated'—ways that aren't tied up with professional aggrandisement and the bolstering of practitioner identities, which go beyond conventional psychiatric and psychological responses. Even pausing for a moment to think about some of the history of such responses here, we are struck by the scale of the inhumane drama involved in the history of treating mental distress, and how in many ways, things don't seem to be changing all that much for the better.

And yet, in the last 100 years or so the disciplines of psychiatry and psychology have seen radical change. In only 100 years we have seen institutions characterised by the most profound and disturbing male-dominated incarcerations, where husbands had the abilities to admit wives into asylums that doubled as freak shows for paying customers. Such incarcerations could result from such gross indecencies as suggesting that human beings are not born evil, or because husbands wanted a quick divorce, or because wives protested over a husband's affair with another woman. Reasons for incarceration included infidelity, postnatal depression and being generally disobedient.[1]

We have lived through the 'science' of eugenics where Darwinian thinking was taken to the extreme in the form of many thousands of forced sterilisations to ensure that those considered to be of mentally unsound mind were not able to propagate their 'defective genes'. We have seen the popularity of trans-orbital lobotomies win Nobel prizes—a practice that involved jamming ice picks into the corner of each eye socket and moving it backward and forward to sever connections to the prefrontal cortex. This practice became so mainstream that Walter Freeman could drive around America in his 'lobotomobile' performing lobotomies for $25 a pop (and performing as many as 3439 lobotomy surgeries in 23 states, of which 2500 were his ice-pick procedure, despite the fact that he had no formal surgical training). Indeed, Freeman even lobotomised 19 minors, including a four-year-old child, before it was decided that perhaps ice-pick lobotomies were not all that they were cracked up to be.[2]

In the mid-1950s electroconvulsive therapy (ECT) became popular. Formerly known as electroshock, it exists to this day as an inpatient psychiatric treatment in which seizures are electrically induced in patients to provide relief from psychiatric illnesses. Its mechanism of action remains unknown and the guidelines of the National Institute of Clinical Excellence (NICE), the body that regulates what constitutes good medical practice, report that it is beneficial and life-saving for some, and terrorising, shameful and barbaric for others. The antidepressant era began in the 1950s where the predominance of the psychoanalytic model was challenged by the development of a range of new medications, still popular today, which were thought to work on various neurotransmitter pathways in the brain to provide relief from mental distress.

We have also witnessed the growth of the cognitive (behavioural) era, the development of both the antipsychiatry movements and the service user movements as a response to what for many still continue to be disempowering, disengaged and deeply problematic methods of social control dressed up as ‘medicine’. At the close of the eighteenth century there were 40 asylums in England and Wales; 60 years later there were over 400. In 1940 there was no ‘psychiatrists’ bible’; in 2014 we have been through five separate versions of the Diagnostic and Statistical Manual of Mental Disorders (DSMs) with a growth from 16 mental disorders to over 300, spread over 947 pages.

In this book we are going to argue that this field of inquiry is ripe yet again for a radical shift, and show what this new shift might look like. In doing so, we are going to commit the same error that all speculators of the future before us have willingly committed. We’re going to ask the reader to suspend their disbelief (a lot) while we posit a version of the UK moving on from 2016 to the year 2050. We’re going to do this to provide a framework for new forms of understanding, institutions and practices that could govern how we might look at mental distress after this much-needed shift.

An (Admittedly Shaky) Version of the UK in 2050

Okay, so it's the UK in 2050. And it has to be hot. You can't talk about a future without assuming that global warming is going to continue. We are going to need a few of your standard sci-fi tropes; otherwise before we know it, we're visiting Aunt Mavis after work and the only difference is that we're wearing T-shirts. It's so hot that humans are restricted to leaving the house between 6:00 and 9:30ish at the latest in the morning and then after 5:00 in the evening. The hours of 10:00–5:00 are out of bounds for most people unless you are very wealthy and can afford a solar suit. See what we did there? Boom, a standard sci-fi trope, the solar suits. And of course there is an aging population. The average age of retirement in the UK is now 80 with most of the older workers filling low-paid, service-sector jobs.

And we have personal hovercrafts too. Or at least those who can afford them have personal hovercrafts. So what else is different in this world of 2050? The reader at this point is probably thinking 'where are the robots?' We certainly would be. That's the first thing we'd be thinking and we'd be feeling pretty short-changed without them. Surely there are lots of them, shiny and metal and doing things that we ourselves take for granted? Nope, there are some pretty cool techno gadgets and transport devices, but other than that we still brush our teeth using our hands and a small vibrating plastic brush, still do our own cleaning and still cook our own food. Okay this wasn't the only reason. Since the banning of invisibility cloaks in 2041 (bank robberies soared by 250 % in their first year of public sale), there was a bit of a moratorium on the use of technology, social, medical and otherwise, especially when the online organ gambling craze of the late 20s started to put an almost intolerable strain on local hospitals.

The Retirement of 'Mental Health'

Other than the hovercrafts and T-shirts, things look pretty much as they do now, with alarming inequalities in health and the ever present threat of war and migration crises. However, a few things have changed, and most specifically, some of the issues that concern us in this book. A social democratic government had been in power for 15 years, and proportional representation is now the order of the day. What in 2016 was once quaintly referred to as 'mental health' is no more in 2050. Indeed, the term has as much relevance as other strange describers of distress from bygone ages like 'hysteria' and 'schizophrenia'. Misery, which had previously been the remit of health professionals like GPs, psychiatrists and psychologists, was completely deinstitutionalised. The seeds were sown by some academic psychiatrists themselves. Arthur Kleinman in 2012[3] said that for all the efforts in neuroscience, genetic research and neuroimaging, there was no better understanding of what was still referred to as 'mental illnesses' and that academic psychiatry still acted like the breakthrough was just round the corner. This failure had already clearly been apprehended by the pharmaceutical industry which had begun to move away from mental disorders, towards treatments for the neurodegenerative diseases so prevalent in an aging population.[3]

Kleinman was a key figure and many listened when he said that 'if by 2030 we still have no useful biological test for mental disorders and little in way of new therapeutic agents, academic psychiatry will be consigned to irrelevancy'. It turned out that many absorbed this prescient warning. When a year later the National Survivor User Network[4] noted that 'nearly all of the members who responded to their survey said that the governments' mental health strategy was failing', there appeared to develop a small but significant movement towards questioning the psy disciplines (psychiatry and psychology) and how useful they really were. Soon everyone had something to say on the matter.

Clinical psychologists like Colin Feltham[5] openly noted that 'Counsellors cannot do much directly about the upstream causes of mental health problems', and Pat Bracken et al[6] in 2012 warned that psychiatry faced challenges it couldn't ignore—a need to move beyond its own paradigm and more importantly, the growing evidence of the primary importance of 'nontechnical aspects of mental healthcare'. There was a growing acceptance that improvements in people's misery could come from simple human interactions, very often with people who had no training or expertise. These notions gradually gained momentum and a consensus slowly formed, albeit one that many service users had known for many years—that people were entrained to see themselves as 'mentally ill'.

That's not to say that they did not suffer horresdously- it simply meant that understanding this suffering as a biological illness was no longer good enough. Moreover, the consensus grew that receiving alienating 'treatments' from remote professionals paid many times their own salaries in environments that were lifeless and completely removed from their own families, friends and communities was not perhaps the best way to address misery. The pain of stigma didn't come from ignorance or a lack of education in the public but from the diagnostic labours of the psy institutions who had inadvertently worked so hard on a social segregation that enforced 'mental health' identity niches that almost demanded that people were stigmatised.[7]

And those were seeds. But they were seeds that soon flourished into discussions about values-based commissioning of services[8] that was underpinned by the realisation that the values and experiences of everyday people could be put at the forefront of helping rather than a reliance on problematic evidence-based medicine (EBM).[9] EBM was an enticing idea in name but one where the technicality of knowledge was irrevocably tied up with professionals' claims to autonomy and status. EBM had more value in strengthening the authoritative voices of clinical experts than in helping people with their misery. There was a growing acceptance that there needed to be a more nuanced awareness of humanity, one where people were understood not as fixed carriers of disorders but as fluid and plural subjects that couldn't simply be captured by scientific rational and objective forms of knowledge. That was best left to the physicists working on the memory machines and the invisibility cloaks.

At its worst, at the turn of the century nearly 20 % of British people had consulted a counsellor as counselling had come to be the answer for all manner of personal and social problems[10] —boredom, loneliness, overexcitement, rejection, unattractiveness, workplace change and marital infidelity. There was a growing understanding that antidepressants didn't treat, they sedated (although such sedation was certainly useful for some in the throes of suffering), and that the evidence base for trials of medications and psychological therapies was so flawed as to leave little but placebo. And there was a growing acceptance from within the discipline that psychiatry was scientifically bankrupt—it was a collusion of good will, self-interest, inappropriate understanding of people and complex social environments,[10] and more importantly that suffering was social, not personal. The World Health Organization[11] released a report that said as much, stating that what was really needed for mental health was an increase in the number of people with a living wage; that what was needed more than anything was government action on the social determinants of mental health in order to achieve advances in health equity.

The Mental Health Foundation[12] reported that psychiatry needed to be moved into the community for fresh ways of working in mental health. When in 2013 Whitely[13] called the publication of DSM-V, previously understood as the 'psychiatric bible', an exercise in blatant disease-mongering where normal human behaviours were pathologised and medicalised, even he could little have known DSM-IX would, in 2029, contain 'leaving your house without locking the door syndrome' and 'Bad hovercraft use disorder'. Social prescribing, that is, the prescribing of non-medical community-oriented services for immiserated people visiting their GPs, began to take off under the early century neoliberal governments that saw in this model a way to promote 'patient choice' and cut state medical costs in one fell swoop. A financially besieged community and voluntary sector was increasingly ready to be recognised for much of the work that it was already doing.

And so things changed—not overnight but slowly and irrevocably. The National Service User Movement's 'It's often bollocks' campaign drew more and more supporters through the ever-developing social media. That campaign morphed into the 'Community Options' movement. It was clumsy at first. Well-being shops opened up on high streets around the country but were often backed by private equity firms. These largely virtual environments scored a bit of an own goal. But eventually and slowly they got there. 'Options in the Community' programmes developed around the country to help support people who were experiencing what was no longer referred to as mental health problems. Psychologists and psychotherapists who had always been keen to differentiate themselves from the biomedical psychiatrists, yet often who had reproduced and benefitted from the conceptual tools of psychiatry (DSM, disorders, illnesses, treatments), were quick to respond and rebrand themselves as 'community psych workers' and then eventually 'community supporters'.

People like James and company, introduced at the beginning of this chapter, who were experiencing embodied suffering, and often as very clear and understandable responses to life histories, losses, abuses, dislocations, humiliations and pressures, were no longer seen as 'abnormal' or 'different'. They were just people going through a period of change (albeit a period which felt excruciating) much like other periods of life change. Many people continued to experience distress as a result of coming to terms with difficult things that they had experienced, such as housing, benefits and legal issues, with work difficulties and debt. These people were no longer automatically sucked into the institutions of medicine to be sedated or inappropriately counselled when in many cases they just needed help with the specific life circumstances that were causing their distress. Instead, an 'Options in the Community' programme, staffed by volunteers who did a fixed term in the programme to avoid the building of professional enclaves and interests, pointed them to a vastly expanded array of networks of community organisations whose incredible distress work, often carried out by non-trained staff and volunteers, was finally recognised with funding by parliament of the Community Options Programme nationwide in 2050. People still had facility to talk to the rebranded psychologists who had become 'community friends', many of whom had come through the volunteer ranks and had never had any psychological or medical training. However, that wasn't deemed important.

For some of those whose acute distress took the form of hearing voices, a vastly expanded series of Soteria houses were integrated with the 'Community Options Programme' and served as community spaces for people experiencing mental distress or crisis. The Soteria approach included non-medical staffing and worked by preserving residents' personal power, social networks and communal responsibilities; finding meaning in the subjective experience of hearing voices by 'being with' clients; and involving no or very little use of antipsychotic medication. Staff members at the house were encouraged to treat residents as peers and to share household chores. The programme was designed to create a quiet, calming environment that respected and tolerated individual differences and autonomy. They were initially heavily criticised as irresponsible or ineffective by what had become the Nike College of Psychiatrists, but came to be widely established across the country.

And for those whose period of acute crisis meant that they were considered to be in danger of taking their own lives or harming others, the institutional baby wasn't completely thrown out with the psy bathwater. Safe zones, shorn of the biomedical and diagnostic pretensions that had engulfed the old inpatient hospitals, were used to hold people in these forms of crisis. As with Soteria houses, non-medical staffing and a focus on preserving residents' personal power, social networks and communal responsibilities were emphasised. The sedatives that had previously laboured under the guise of treatments were sometimes used here. And as with the old inpatient hospitals, they failed in the eyes of many to hold the uneasy tension between crisis and liberty.

Back to 2016: This Book

The world outlined above may look naive/silly/hideous/odd/irresponsible depending on your positioning, but you don't have to buy into the notion of hovercrafts to know that there is, and always has been, something quite fundamentally wrong with the institutions that have coalesced around people's misery over the years. This book won't chart a path to some form of mental distress utopia, but what it will provide is an unashamed and much-needed celebration of the precious and often invisible non-professional, non-technical mental distress work happening in communities up and down the country on any given day. We want to tease out, and articulate in some detail, the very texture of the kinds of things that are happening in this arena.

We will get to that in due course. But first we will provide an account of some of the fundamental misunderstandings which underpin much of the theory and practice of mainstream psychiatry and psychology, outline some of the implicit and explicit problems with any institution that has an impulse to reward professional expertise and in so doing highlight the profound need for a banality of misery, not one which privileges the notion that misery is somehow exotic, distant and irrelevant to most people's lives. Psychological misery is largely a social phenomenon and its potential lies within every single living person. Moreover, despite esoteric enclaves of expertise often anointing themselves as the only sources of authority on misery, there is a perfectly good lay vocabulary on misery that is reproduced all over the country by people with no mental health training and in all manner of institutions and settlings around the country. And it's often happening with barely a psy person in sight. It works because people and distress are fundamentally social in nature.

After outlining some of the difficulties with psych institutions and the social character of misery, this book will set out case studies that show what is already happening for many people experiencing misery, albeit sidelined and marginalised in the dominant story of biomedicine. There are 161,000 active voluntary organisations in the UK, 2.5 voluntary organisations for every 1000 people doing immensely valuable work.[14] This book is a celebration of the non-technical, but it is far from a celebration of anti-intellectualism and the two should not be conflated. It marks a movement from one set of dominant conceptual and institutionalised ideas of biomedicine, to one which explores the knowledge and capabilities inherent in many of the informal community settings and spaces around the country. We hope to reinforce the understanding that important mental distress work occurs in a great variety of lay social settings: in arts centres, schools and libraries; along river paths; and in sports clubs, community groups and support groups.

The Chapters in This Book

Chapter 2 in this book takes some of our critical thinking highlighted in this chapter and provides a theoretical framing for this. We utilise a Martian friend to explore the ways in which we might think differently about mental health and indeed models of the 'self'. Towards the end of the chapter we start to suggest that the self can be seen as a social, rather than individual, being. While in itself this argument has been made in a variety of places, it enables this book to move on to Chap. 3 in which we explore some of the implications for mental health practice if this alternative understanding of the self and mental health is adopted.

The book then moves on to our research-based chapters. From Chaps. 5 to 9, we draw on a range of empirical material (interviews, focus groups, participant observation) we have collected over the past four years in a range of settings. Such settings include community singing groups, an unemployed family centre project, a fishing project, a support group for parents of children with disabilities and complex needs, a cycling group for people with mental health problems, and organisations taking a positive view on the practice of sex. Whilst all of these settings are clearly very different, and as you will see, our accounts of them are also very different; we hope these empirical chapters will offer an assemblage of the core social fabric that underlies each setting and which we feel can deeply benefit the individuals that use them.

Finally, our conclusion chapter attempts to offer a summary of the data we offer up in this book to provide some hint at the ways in which we feel mental health practice might be more usefully understood in the future.

Firstly, let's get to our Martian friend…

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2

The Flawed Assumptions of Psychology and Psychiatry: A Martian Analysis

After what seemed like an eternity of watching David's moods shifting to such radical extremes, it had become more difficult to recognize him than it was to recognize his mood state. He had levelled out for a while. He had been profoundly low, desperate, demented and crawling with the agony of an ever present anxiety for too many months to remember. He was now back on the up. Nobody knows why. He didn't know why. From experience I gave him about 2 or 3 weeks before the mania really took hold. Before the abuse, the anger, the incoherence, the wild spending, the voices, the discussions about how to counter the people who were following him in order to train him into the secret services, the newly discovered superpowers, the false texts telling me our dad had died, and the repeated threats of suicide. Then the promises that all of these would stop. Then more abuse, anger, rogue secret service agents and dead dads. Our dad must have died more times than Freddy Krueger over the years. Sure enough it was about 2 or 3 weeks. I got a call to tell me that he had gone AWOL leaving a message that he was going to drown himself in the sea. After driving around for 2 hours looking for David I finally found him on the beach staring at the sea. He said he wanted to be left alone so that he could throw himself in. I told him that as he wasn't on a platform it would probably be easier to walk in. If he threw himself, he'd bang his face on the

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shingle. This raised a smile. The momentary thrill of levity are pretty much all you have in these circumstances. We talked for a while. He said that he couldn't control the buzzing in his head. Everything was happening so fast inside his head that he couldn't control it. I said that it might be useful if he talked to a doctor. He thought the same and we walked back from the beach. One day the sea might get its man but not this time.

It is generally understood that when we start talking about things like 'minds' and 'mental health', those of us who populate the psy institutions, that is, psychiatrists, psychologists, psychoanalysts, psychotherapists and counsellors, are the people to listen to. Or if they are not the people to listen to, then at the very least, they are worth listening to. Through decades of hard-won empirical research and therapeutic practice, these professionals have, through their institutions, built up a corpus of knowledge upon which rests our best understanding of human beings and the psychological distress that they experience. This chapter will suggest, however, that some of the key assumptions that much of these professional understandings are based on is flawed, and in many cases problematic.

There are a number of ways in which people can come into contact with the professionals whose job it is to treat distress. Let us, for example, take a person meeting with a GP, who in the UK at least, is generally the first medical doctor one would see when ill, and the gatekeeper to other health services. If a person walks into a consultation with a medical professional, there may well be a number of unspoken assumptions about the person walking in. And these assumptions are profoundly important because on these assumptions rest a whole range of practices, therapies, medications, conversations and approaches. For instance, the fact that many people who go to their GPs in 2016 experiencing what they understand to be depression, feeling down, sadness, anxiety or worry will find themselves treated with cognitive behavioural therapy (CBT), or some close approximation, and/or psychotropic medication, suggests a number of things. The first is that the person is a *patient*. Once the person steps through the GP's door to talk about the misery, fear or confusion that he or she is experiencing, the person changes from a citizen to a citizen/patient. As we'll see later this can have some profound consequences for the people experiencing distress.

So the newly anointed 'patient' will probably have conversations with their GP, and this will broadly take the form of responding to a number of questions about how they are feeling and what their thoughts are like, and possibly they will be asked about recent events in their life. Experiences vary widely depending on a number of factors, not least the person and the doctor. A number of assumptions underpin this line of questioning. The first one is that the key area of focus should be the newly anointed patient's mind. There will be questions about sleeping, eating and physical agitation, but questions on thoughts and feelings will likely predominate.

Now forgive us for appearing flippant, but we're going to use an example of a Martian here; let's call her Martha, not because we like being self-consciously zany but because it offers the reader a perspective shorn of the many cultural social assumptions that govern mental distress treatment that are so commonly mobilised that they become invisible. So, were our Martha (who is visiting Earth for the first time; a Martian who has been resident on Earth for a couple of years is no good here) to watch this consultation, she might feel bold enough to make one or two statements. She might observe that there is an unusually regimented formality between the professional and the 'patient' that isn't generally there between people during most other social transactions. She might note its brevity—seven minutes—wondering if this is long enough to learn anything significant about the 'patient' while being impressed with just how many 'patients' the man in the small room with astonishing bladder control encounters that morning.

She might also guess that whatever is wrong with the person is in some sense a predominantly cognitive process. She might assume that there is some sense of constancy both in the experience of the person's distress and in the person's thinking on a daily basis more generally. Moreover, she might conclude that people are generally taken to be capable of accurately reporting their distress and using a series of concepts that both the 'patient' and the doctor share (like depression, anxiety, esteem, misery, pain, suicidal thoughts, sadness). Martha might watch the patient be told that the most up-to-date evidence base suggests that certain treatments are appropriate for them. The GP rattles off that NICE, the National Institute for Clinical Evidence, is the respected authority on what constitutes depression and its associated treatments and that NICE has isolated the most effective treatments for the patient. At this point, Martha might note down 'NICE' on her Martian Ipad.

The 'patient' might then be prescribed an antidepressant to address levels of specific neurotransmitters in the brain, and so our Martian friend might assume that whatever is troubling our patient has a biological basis and can be treated by this medication. Depending on the patient's reaction, Martha might conclude that these treatments are either controversial or uncontroversial. Or she might not, because she is picking up on a power dynamic where the patient person defers to the doctor person and so it might be hard to tell whether they are agreeing on the things that they say they are agreeing on (or indeed whether that is important).

If the patient is prescribed CBT, then he or she might assume that the key to addressing misery is conscious, guided reflection and action on thoughts, feelings and behaviours by a skilled professional person, and that if you teach a person how to think and feel and indeed act differently, his or her misery will recede. This seems to be based on the premise that human beings are essentially rational creatures. This hasn't been Martha's experience up until now but she is willing to have an open mind. If they are not thinking rationally, then they need a little guidance so that this unitary, rational-thinking self can once again assume control of their steering wheel because misery is irrational and needs to be corrected so that people 'think straight'.

This all might strike Martha as odd. First, a little picture of what Mars might look like to help contrast human with Martian misery. On Mars there is a general acceptance that Martians are not essentially rational. Martians don't think that they have a unitary self; instead they see themselves as sites of interplay between their histories, their social environments and their nervous systems.[1] Martians don't believe that their memories are fixed concepts stored in a computer that can be accessed and changed via a skilled professional through rational exercises. Instead, they barely trust their memories since Martians are notorious for changing them to justify their actions. Unlike human beings, Martians don't see themselves as their own bosses but instead see themselves as an assemblage of changing voices, some talking about things that happened a long time ago, some about yesterday. And the voices change with context.

Interestingly the Martians appreciate that while they have access to these different voices, they don't necessarily control them and only partially understand them. For them, individuals exist, but all of their experiences are thoroughly and completely social at the same time as being singular and personal.[2] The idea of a social versus individual dichotomy, which our little Martian heard talk of in the UK (and Martians haven't yet visited places in the world where there are more people who see things a bit more like they do), doesn't make sense. For Martians, what people call 'cognitions', that is, the mechanics of thinking, are secondary to the social relationships and shared social understandings that make the cognitions possible and that shape them. The Martians have nervous systems but they don't cause things any more than the nerves in their legs cause them pain after they take a painful kick playing Martian football (played with three balls, one for each leg). They simply enable relationships between what happens outside the body and what they come to experience as misery, joy, happiness and so on.

The Martians don't really buy into an idea of subjective experience that fragments into something mental and something physical and which you can then train specialised Martians to work on this newly fragmented mental bit. Misery for them is all too often beyond the reach of words or transient rational exercises, so nobody bothers trying.

And then of course there is evidence. Martians worry about evidence. They worry about it a lot, about what constitutes evidence and how it is used, probably a lot more than we do. Sometimes they worry about it so much that they can't sleep. For them, all knowledge claims are provisional and tentative; some are incredibly useful but they appreciate that the way that they saw Mars 100 years ago is quite different from now so they are confused that humans don't seem to take much heed of this. They think that evidence is never neutral or objective[3] and that anything that someone says, whether through the tools of science or not, is tied up with the specific claims of autonomy and status of any given Martian.

It is confusing for Martians that what NICE talks about as 'evidence-based medicine' serves the political purpose of strengthening the authority of presently dominant clinical experts, and yet few humans seem to talk about this. As a result, NICE only seems to include some ways of collecting and recognising what evidence is. When they look at how we 'do' evidence-based practice, they see bureaucracies of health policy makers, professionals and academics who together collect certain forms of evidence in order to make multiple recommendations that promote evidence-based treatment practices and evidence-based prevention strategies.[4] This model of public health sees mental health and mental disorder in a very specific way, and a culture of efficiency and efficacy is generated so that policy makers can get the maximum return from the modest investment.

The Martian sees a couple of problems with this approach. The first is that it tends to privilege forms of evidence that are produced by professionals, big pharma and professional academics. Lay people and community organisations (and publishers of accessible psychology books) also participate in this process of generating authoritative forms of knowledge on what misery is and how it can be assuaged. However, the Martian has observed that these forms of knowledge aren't really important unless they agree with the beliefs and practices of professional experts. Another problem that Martians have is that it seems to them that what is being called 'evidence-based medicine' only concerns interventions that are focused on individual people and not the social contexts that govern much of their health experiences.[4] A visiting Martian may claim Robert McNamara, the former United States Secretary of Defense from 1961 to 1968, as one of their own based on his thoughts on making decisions based solely on quantitative observations and ignoring all others. McNamara was talking about what led to quantifications of 'success in the Vietnam war (e.g. enemy body count)' and ignoring other variables:

> The first step is to measure whatever can be easily measured. This is OK as far as it goes. The second step is to disregard that which can't be easily measured or to give it an arbitrary quantitative value. This is artificial and misleading. The third step is to presume that what can't be measured easily really isn't important. This is blindness. The fourth step is to say that what can't be easily measured really doesn't exist. This is suicide.[5]

This perfectly sums up the Martian belief on the limits of the scientific rational and quantitative objective forms of knowledge that humans seem to love, yet that seem so antithetical to what human beings actually are. It frustrates Martians because different ways of generating knowledge that aren't based on science and on quantification become completely invisible.

The Martians think that humans are like them—essentially plural beings, fluid, changeable and open to being articulated and rearticulated in different contexts and places—but most humans themselves don't seem to be interested in this. Much of the evidence on mental health converts mental experiences into numbers with little questioning on whether the attribute in question is quantifiable.[6] The Martians don't use questionnaires to measure mental states because evidence shows that during the rating process, respondents are mistakenly assumed to have direct access to their personal and stable meanings of the given scale attribute; they can't accept the assumption that complex attributes can be understood by a continuous measure between two points. Martians don't assume that all respondents understand the scale questions and answers the same way.[6]

Trying to get into a Martian's headspace, let's take, for example, The Beck Depression Inventory (BDI), a standardised and popular measure of 'depression'. Let's say we have a single parent who works an 80-hour week and who lives in a damp flat that means their daughter's asthma requires regular hospital treatment. Despite the hours of work, she might be in debt and receiving letters through the door telling her she will lose her belongings. And she is in conflict with her neighbours because their dog barks at night when she's trying to sleep. As these things have happened for a while, she is miserable and goes to see her GP who may give her the BDI. This confirms that she has the thing called 'depression'. According to many professionals and academics, this is an illness that seems to be related to neurotransmitter activity, and thinking/feeling patterns. And she will probably receive an antidepressant and/or be put on a waiting list to talk to a well-paid professional who will help her to change the way she thinks and feels. These things have happened because the questionnaire designated her as depressed. Now imagine the questionnaire asked the following:

1. Is your damp housing, that is making your daughter ill, making you feel miserable, guilty and anxious?
2. Do you think you would sleep better and feel better if it wasn't for that bloody dog?
3. Does working 80 hours a week, and not being able to see your kids much, make you miserable?

She might well have answered yes to these questions and that might have produced another person, a different picture. But it didn't because these questions won't be relevant to many people who are miserable/distressed/troubled, so they can't be put on a general questionnaire. And so on the general questionnaire we put general things that have been completely disembodied from the things that might have caused them. And then we're back to McNamara's first step—we measure that which is easy to measure. And we don't measure the other things that are not easy to measure. And if we keep giving the BDI out again and again to many people over many years, the results that it produces will be important and the things that it doesn't produce won't be important. And so on and so on.

Our Martian is frustrated. She is frustrated because to understand misery and human experience requires more than the process of asking people to complete a questionnaire that strips the person from their social world, history and culture, generates a number or series of numbers for that person depending on their answers to a group of disembodied questions on a given day, and then puts those numbers in with a batch of thousands of other numbers and makes statements based on the outcome. The Martian is frustrated because any kind of opposition to evidence-based practice and the randomised control trials that serve as the gold standard is understood and constituted as irrational or less valid.[6] What it doesn't do is recognise that if people give the same responses to a questionnaire on misery, it does not mean that their experiences are standardised or similar, that people's reactions to a single factor in an experiment tell us little about how they react in contexts where other things aren't controlled and that a science carried out by humans on humans has a variety of failings and there is a scope for oversimplifying causal relationships that don't take so many other things into account.[6] And the reason that Martians ditched their evidence-based preoccupation phase thousands of years ago was that they saw the impacts of a narrow, means-end rationality imposed by Martian public service agreements at the time. They helped contribute to a performance/audit culture which had a really bad impact both on the Martians using services and on those delivering them.[7] And because they got Martians completely wrong.

The Martian might scoot off back to Mars and report on the results of her mission to understand sad and suffering human beings quite confident that she can say a number of worthwhile and interesting facts about what misery, and indeed people who are miserable, are on Earth.

Now the more eagle-eyed among you will of course have spotted that, through this laboured analogy of little green people on Mars (we didn't mention the colour but they are of course green), we are actually suggesting that all of those attributes that we are attributing to Martians and that may seem unusual or foreign to many people, are of course a more useful way of also describing humans and their distress. And that all of the assumptions that the little Martian took from the GP consultation are in fact a range of fallacies reproduced and disseminated, often with the best will in the world, through the machinery of the psy institutions. Many of the assumptions that we hold about human beings and the way that they relate to other human beings are very limited ways of tuning into human experiences and particularly misery. At their core are a range of ways of thinking about people that bear only a passing resemblance to our everyday experiences. That many of them have a widely shared popularity in western society in 2016 does not make them any more useful, although they are certainly seductive. They are simply ways of thinking about people and their misery that have been talked into being or 'reified'.

This is not an antipsychiatry/antipsychology book. Well it is a just a little bit, but there is no desperate urge to throw the baby out with the bathwater. Psy professionals, institutions, manuals of disorder and treatments may produce a range of misunderstandings about human beings and their forms of misery, but that is not to say that they have no value to people. In fact, often the opposite can be true. They can and often do have value to people. However, the understanding that advances in medical treatment have had little discernible impact in improving longer-term rates of recovery[7] and the knowledge that there is no consistent evidence for biological causes for the overwhelming majority of the things that we understand to be 'mental disorders'[8] need to be addressed. Despite the tendency of contemporary psy logic and naming to suggest otherwise, intrapsychic and interpersonal distress and misery are likely to have a fundamentally social context. This is something only fleetingly and tangentially appreciated by the mental health industries that have formed around the forms of knowledge produced by the psy institutions.

Surely Everyone Already Knows that Distress Is Social?

For all of the efforts in neuroscience, genetic research and neuroimaging (and the efforts have been quite considerable over the years), we still don't understand the pathophysiology of what are commonly referred to as 'mental illnesses'. This is despite the ratio of biological to psychosocial aetiology (cause) studies being 16:1.[9] Indeed, the mass of research into genetic predispositions for schizophrenia has been described as one of the 'costliest blind alleys in scientific history'.[9] There has been a failure of decades of science to find any biological or psychological marker identifying a psychiatric diagnosis, a failure to link psychiatric processes to diagnoses, and molecular research is failing to uncover any specific genetic profile of any disorder.[10] This failure has now been understood by the pharmaceutical industry where, after more than 60 years, the focus is beginning to shift from mental disorders to neurodegenerative diseases like Alzheimer's.[11] However, despite evidence to the contrary, many in academic psychiatry and mainstream psychology continue to behave as though the big breakthrough is just around the corner.[10] It is not and can never be.

The principal reason for this is that misery and suffering result from complex and embodied arrays of social experiences that are embedded within specific historical, cultural, political and economic settings. These complex and embodied arrays of social experiences that are embedded within political and economic settings do things to people, sometimes that can be experienced positively, sometimes negatively and other times with indifference. Trying to create artificial boundaries between the intrapsychic and the socio-economic works really well if you're in the business of treating individual people for individual problems. But if your business is trying to understand the complex nature of distressing experiences, it makes little sense, not least because much routinised misery is invisible[12] both to the sufferer and to the professional who has placed the sufferer within their, vacuum-sealed analytic chamber with a view to devising a cure.

All manner of large-scale social forces and discreet local social experiences can come to be translated into personal distress and misery.[13] Life choices and ways of knowing the world are structured through experiences of social class, abuse, gender, race, sexuality, disability, exclusion and grinding poverty. To explain suffering, you need to embed individual biographies in the larger matrix of culture, history and political economy which, when understood through the intrapsychic biomedical lens of the psy institutions, are often rendered invisible. The psy institutions, the socially approved authorities in personal misery, have understood and actively reproduced these as organic illness and disorders of thinking and feeling. However, these are actually how most of us would respond to periods of intense pressure, loneliness, despair, deprivation and/or mistreatment. And what have been discussed as 'symptoms' that need treatment can be better understood as the attempts of everyday people to control, deflect or ignore the pain that accompanies these.[1] That these attempts can destroy lives, make carers and distressed people themselves endure untold misery, and that they may often make no rational sense, does not make them any likelier to be disorders.

What has been made knowable as symptomatic behaviour can often be better or just as convincingly explained by forms of social deprivation.[14] Sixty to seventy per cent of people experiencing visual or auditory hallucinations have been subject to physical or sexual abuse as a child, and distress is consistently associated with markers of social inequality such as unemployment, low income and impoverished education.[2,15] People abused as children are 9.3 times more likely to hear voices, and people who have endured three types of abuse, sexual, physical and bullying, have an 18-fold higher risk of hearing voices and the link is causal. Social exclusion and relationship breakdowns can cause neurological changes that are experienced as real pain.[16] The long-term impact of racism, bullying, poverty, inequality and the corrosive effects of dysfunctional families, social worlds and political regimes are reasons why people become distressed.[17]

There is consistent evidence that the daily occurrences and fabric of people's lives play a major role in creating different forms of emotional distress and behavioural problems, including psychosis; and the many different forms of evidence, taken together, are compelling.[18] Distress is an acquired and embodied way of being in the world. Distress is not an idea that someone holds but a legacy of encounters with a social world that can manifest in misery and confusion that leave ‘crazy’ or disordered people isolated, vulnerable, disliked and unreachable.[19] Our current responses to this are health care systems that in one sense provide forms of support for some people, some of the time, but that also fundamentally disguise the realities of social distress. In so doing, such systems can protect and make invisible many of the institutions and factors in society that are central to creating distressed lives.

If we dispense with the popular western fallacy that we are rational, unitary people whose normal response to challenging social encounters and social worlds is to keep being rational unitary people, then it’s easier to accept change, low mood, misery, suicidal thoughts and hearing voices as a fundamental part of the human experience rather than illnesses or symptoms that require treatment. The misery of mental health is a misery of, for and between individuals, families, carers, friends, communities and societies.[20]

One problem is that when we understand distress as having a social dimension, it makes an awful lot of things difficult. If you understand distress as a discrete biological and/or cognitive experience situated in an individual unit that you can standardise into an illness, then it can be meaningfully talked about, researched and treated. It can be understood by employers, teachers and government departments, and it can be understood by distressed people and their families. This is workable—well, to a point it is. But the idea of embodied, socially and culturally mediated experiences that are made manifest and knowable through recent and distant social experiences and that can be facilitated and contextualised by social, political and economic institutions, and where those who are distressed may have as little idea about the precursors of their distress, is much more difficult. How we know distress, what we call it, how we experience it and what causes it are socially mediated. However, in the techniques of naming distress and treating it, the psy institutions have not sufficiently paid attention to this. And as a result, their techniques of naming and treating it are profoundly problematic.

What the Misunderstandings Look Like When Distress Is Treated Asocially: The DSM

The Social Perspectives Network (SPN) is a UK-based coalition of mental health service users/survivors, carers, policy makers, academics, students and practitioners who are interested in how social factors both contribute to people becoming distressed and play a crucial part in promoting people's recovery. In their Spring 2013 newsletter, the SPN[21] launched a 'no more psychiatric labels' campaign which joined the International Critical Psychiatry Network in calling for an abolition of psychiatric diagnoses. They suggested that psychiatric diagnoses are not valid. That is, they don't actually represent coherent, discernible disorders. The SPN say that the use of such labels increases stigma for those who are experiencing misery and that they don't actually help with decisions over treatment. So the question is, are they right?

The first psychiatric taxonomies were developed by Kraepelin and Salmon in 1893,[22] and if the reader in 2016 were to glance at what these looked like, they might be quite interested to see what were, at that time, considered to be psychological illnesses. For instance, just over 100 years ago medics may well have referred to such disorders as 'masturbatory insanity'. Kellogg, a zealous medical advocate of abstaining from masturbation, warned of masturbation-related deaths that could cause cancer of the womb, urinary diseases, nocturnal emissions, impotence, epilepsy, insanity, and mental and physical debility.[23] Aside from the obvious observation that few adolescents would live through their teens were such a diagnoses to carry any medical weight, a key thing to note is that this is not, in 2016, accepted as a psychological disorder. Nor indeed is hysteria, the third most common diagnosis in 1975 but which had fallen into obscurity by the mid-1980s.[20] Or indeed homosexuality, a mental disorder until 1973, or Drapetomania, a mental illness proposed by the physician Samuel A. Cartwright in 1851 that caused black slaves to flee captivity and which is now understood as little more than pseudoscientific racism.

The point being made here about diagnoses is not to mock previous generations in their attempts to map out historically contingent ways of understanding distressed people, but to make the point that any attempts to transform human distress into psychiatric illnesses will entail a process of disease mongering. It is axiomatic that viewing complex attempts to maintain personal survival and integrity in the face of current or past trauma are understood, using the conceptual apparatus that is popular at the time, as symptoms of underlying illnesses, is critically problematic. This is why you can almost guarantee that those with an interest in misery in 100 years' time will look back on what we called schizophrenia, depression, personality disorders and the like, with a bemused fascination for the quaint, unusual and laughable conceptual apparatuses that we use.

The point here is that over the years the profession of psychiatry has developed categories that have come to define thoughts, deeds and indeed whole people as in some sense deviant.[24] But what counts as deviant thoughts, deeds and people changes over time. And the radical nature of this change over the last 100 years is perhaps the most profound challenge to advocates of the biomedical disease model of mental distress. What goes missing in the diagnostic process of eliciting symptoms is the biographically situated meaning of what the person is experiencing, and it is quite possible for two patients with no first-rank 'symptoms' in common to receive the same diagnosis.[25]

It might be helpful to understand suffering less as a condition and more as an event within the context of a larger surrounding plot.[26] This plot is both unique to individual people, and in many senses shared with others, as the outcome of preceding acts. If we think like this, it is difficult to avoid understanding acts of diagnoses as little more than professionally legitimised social fictions (albeit quite convincing ones). Suffering and misery are incredibly difficult things to grasp, often idiosyncratic to individual people with very particular life histories and given expression through whatever ideas and discourses are popular at a given time in history. This is why we do such a bad job of it when we try. Suffering and misery are not natural biological entities but types of social status that we extend or withhold depending on what is popular at a given time.[26] In one generation this might include such channels for suffering as masturbatory psychosis and hysteria; in another it may be oppositional defiant disorder of narcissistic personality disorder. And while the organised attempts to give validity to these rituals of language through generations of psy professionals reinforce the status of their institutions in society at a given time, it is difficult to avoid the conclusion that they very rarely provide value for 'patients' or 'clients' who experience forms of pathologisation and infantilisation.[27]

With this in mind, it is perhaps not surprising that these acts of diagnoses are plagued by problems of reliability over time, validity and prognostic value.[28] The DSMs, in their various incarnations, are collections of often overlapping symptoms that each exist in their own conceptual vacuums. This book, often termed the 'psychiatric bible',[29] offers no attempts to explain *why* people experience the misery that they do. For those who adhere to an understanding of 'misery as social response', this is deeply problematic. This is not to say that these forms of misery are not real, or painful or utterly destructive to people's quality of life. Nor is it to say that professionals who engage in these systems of naming and treating misery do so through a series of intentional practices that harm people and control people. Indeed, they very often provide experiences of amelioration, comfort and beneficence to those with whom they come into contact. Rather it is simply to say that the conceptual frameworks through which they name and make sense of misery are redundant.

DSM-V, published in 2013, is perhaps the greatest example of what Whitely[30] calls 'disease mongering'—where normal human behaviours are conceptualised as diseased or deviant, where the strategies that people use to survive, resist and make sense of their world are increasingly formulated as symptoms of illness and pathology.[31] The example of the broadening of the ADHD criteria as contrary to the process of defining legitimate diseases has resulted in children who are too active, not active enough or inattentive being rendered neurobiologically deficient;[31] between 1994 and 2003, stimulant prescriptions rose from 6000 to 345,000 cases.[24]

The DSM is a deeply entrenched enterprise where the professionals whose role it is to construct these categories are frequently funded by the pharmaceutical industry.[32] Fifty-six per cent of DSM panel members who decide what is, and is not, a mental disorder have one or more financial associations with companies in the pharmaceutical industry.[32] And 100 % of the members of the panels on 'Mood Disorders' and 'Schizophrenia and Other Psychotic Disorders' had financial ties to drug companies. The DSM enterprise is profitable to the tune of $5bn a year.[33] This raises pertinent questions as to the degree to which the process is potentially compromised.

An idea that is commonly found traversing the machinery of academic and practitioner psychiatry and psychology is the need to increase the mental health awareness of the public. It is perhaps time to ask whether it is those mental health professionals, who have strict adherence to meaningless and problematic disorder criteria and who are institutionalised into wholly reductionist models of human experience, who need further educating.[34] Rather than allow diagnostic techniques to continue to maul the fragile core of misery, some[35] have suggested a need to nourish ambiguity, whether or not we like that ambiguity. To peel back the layers of bureaucratic talk which has muffled the voices of people in pain rather. Diagnoses are not facts but networks of simplistic assumptions that fail to do justice to complex realities.[1]

The Self-fulfilling Prophecy of Diagnoses

Bearing in mind some of the key issues mentioned above, it is perhaps not surprising that psychiatrists frequently disagree about what constitutes a correct diagnosis.[2,10,18,25,36] Moreover, as well as questionable validity, it raises potential problems of stigmatising those given abstract biomedical labels that other them.[25] A considerable number of studies have found that attributing mental health problems to biology is associated with negative public attitudes, such as the belief that people are dangerous or unpredictable and, through fear, keep their distance.[10] Mental illness is frequently felt to be a shameful or dirty word with a stigma that is all-pervasive and hard to challenge. People come to be aware of the label and the need to have strategies to fight or resist it and to counter the ways in which some people's reactions to them change once they become a 'disordered' person.[37]

Psychiatric labels can give people identities. They artificially separate them from other people and, rather than have them understood as people reacting in meaningful ways to life histories and challenging circumstances, both recent and distant, labels separate them as sufferers of a biological illness. They are different, deviant and defunct. They often enter a world of labels, pills, 'shrinks' and powerlessness becoming what Ridgway has described as a 'nothing in a no-world', and for some this is like entering a world of suspended animation where their access to the normal rhythms of community life lies in the hands of a group of professionals and their invalid diagnoses.[38]

Moreover diagnoses, as well as being subject to professional disagreement often on a case-by-case basis and rendering people subject to stigmatised suspended animation, can also lead to a self-fulfilling prophecy. Here, miserable people, through their contact with powerful and publicly legitimised mental health professionals, become entrained into careers or chronicity,[38] inducted and supported into the entrapping niches of the status of chronically ill mental patients and party to the social segregations that accompany this. In such cases, as we know only too well from our personal and professional experiences, struggling people and their families learn how to perform the roles of mental patient and carer, and come to know what performances are required to gain certain privileges.[39]

Indeed, people come to interpret their experiences as symptoms, as illnesses, and to do so can bring currency and value in certain settings. This can absolve people from blame and responsibility,[16] provide access to time off work, financial benefits, space and sympathy. Moreover it can give people a framework to make sense of the maelstrom of pain, confusion and misery, the bizarre embodied changes, to make sense of a world that seems to be falling apart and relationships that are suddenly under profound duress. It provides a framework to allow for thinking about cures and recoveries and the promise of 'being better' through professionals, and doctors and institutions who hold, through their diagnoses and treatments, the magic keys to escape from where they currently are. It is at present not only the dominant framework but largely the only conceptual framework that people with misery have at their disposal. And this is partly why one of the authors of this book repeatedly tries to get David to a doctor.

We have other close relatives, colleagues and friends who have long histories of severe distress. As with many who share these experiences, they have found themselves party to a range of diagnoses, treatments, medications, incarcerations and periods of wellness. One of our close relatives, let's call him Paul (and he's agreed that we can write about this in our book), has a mental health history that has been variously diagnosed as bipolar, schizophrenia, major depression, generalised anxiety disorder, obsessive compulsive disorder and Asperger's, often at the same time. He has experienced being sectioned on a number of occasions and has taken a range of medications over the last 25 years. These vary from atypical antipsychotics, which brought about substantial weight gain and type II diabetes, to almost every antidepressant known to humankind. Some of the labels above have been useful in the sense that they allowed him access to time, space, to feel numbed and allowed access to sympathetic and understanding professionals. Other times they have contributed to stigma, entrained passive docility, caused confusion and rarely overall have they contributed to his feeling better.

Last year Paul experienced a period of crisis. His behaviour was chaotic, disorganised and hyper. Thus followed a period of two years where his behaviour transitioned to what he described as depressed, low and very anxious all of the time. For Paul, his family regularly set up what can best be understood as an amateur 'drug procurement team'. That is, they work together to help this relative to get the drug that he believes he needs and that has intermittently been helpful in the past. This is the case despite the fact that no one in the family has much faith either in the psychiatrists that the relative visits or indeed the medications he receives. Paul's supporters are all well aware that research[40] has shown that often they work by placebo. They are also well aware of their sometimes startlingly disabling side effects and know that the profits of companies who make them are intimately tied up in the naming of disorders and prescribing practices of GPs.

Our amateur drug procurement team try to get these despite the fact that they know that he experienced recent and or distant life experiences that related directly to his misery. They do this despite their knowledge that nobody yet has a biological marker for the condition that his misery has been called, and despite the fact that previous visits to psychiatrists have left him (and the team) with a nagging feeling that they have little understanding of what embodied distress actually is. These do not stop our drug procurement team's visit to the office to get hold of medication.

Over a nine-minute duration the doctor finds out that Paul is profoundly unhappy, is eating poorly and is occasionally prone to suicidal thoughts. The doctor thumbs through his monstrous 25-year mental health file that is littered with psychological therapies, Selective Serotonin Reuptake Inhibitors (SSRIs), atypical neuroleptics, lithium bicarbonate, serotonin syndrome, adverse reactions and gaps in time. Will it have side effects? The doctor is unsure. Will it make him better? The psychiatrist, with a degree of unsurprising certainty and authority, says that it will, as long as he keeps taking it. Off they go then with a prescription that may, if Paul is lucky, make him feel less miserable.

The biomedical discourse has become so dominant in the west that it is the framework through we have access to knowing misery, even for those with little faith in it. And so, three people who are writing a book find themselves repeatedly sitting nicely in the psychiatrist's or psychologist's office, each party playing their role in the mental health consultation play.

Understanding and Misunderstanding Recovery

Fast forward a year, and Paul definitely looks like he's on the mend. Indeed, people start talking to him about being 'in recovery'. Paul nods, but when one of us talks to him about what he understands by this, he's not very sure. And he's not the only one. For a word that is used so commonly in relation to mental distress, there is very little consensus for what 'recovery' actually means.[41,42] Largely due to the prolonged period of service user activism, the recovery movement rearticulated what had been a dominant understanding of recovery as the alleviation of mental health symptoms and a consequent return to wellness. Instead recovery became about building a meaningful and satisfying life, as defined by the service user. It came to refer to social inclusion, meaningful and satisfying social roles, even if experiences of distress are still present in the person's life. However, it has been argued that the idea of recovery has been removed from its roots in psychiatric survivor activism.[43]

For example, Harper and Speed[44] suggest that there are three versions of recovery that are commonly understood at present: a biomedical version, based on symptomatology; a more socially oriented approach focused on quality of life; and the psychiatric survivor movement approach focused on liberation rather than cure.

Harper and Speed suggest that there are key issues with the way in which 'recovery' is now understood, and these are that it is still based on a model of deficit and sustains the subordinated status of the service user. Here, individual journeys, whether understood as recovery from symptoms or recovery as personal experience, tend to be journeys focused on changes in identity that do not speak to the questions of inequality, social injustice and social marginalisation that can be so intimately related to misery. They would likely contest Svanberg and colleagues' framing of recovery as simply having a positive sense of self whether or not mental health is present. That recovery isn't just about people but about social, economic and political processes. Paul's experience sits in these debates. He has come to define recovery as having less pronounced symptoms.

Recovery is a contested concept. For Ridgway,[38] it is about people breaking through the frozen state of suspended animation and being able to once again participate in social life. Here people heal themselves of the notion of being an outsider and leave behind the alienation that comes not from the misery but from the boring, barren, lifeless treatment environments into an acceptance that the personal context relies on a thousand events and many mysteries that may not be understood by the user or others. If helplessness and isolation are the core experiences of psychological trauma, then empowerment and reconnection are the core experiences of recovery.[45]

We would suggest that it is better to understand that there are as many recoveries as there are people. Recoveries have personal, collective and political dimensions; that they can incorporate experiences of social reconnection, empowerment and inclusion; that meaningful inclusion, as defined by people themselves, is key; and that who you speak to will depend on what version of recovery you might get.

In our current audit culture, leaving definitions open and variable does not facilitate the development of coordinated national services, accountability, consistency of practice and understanding. The notion of many recoveries makes it difficult for health managers, medics, psychologists and psychiatrists to provide a consistent framing of knowing and treating misery. But this perhaps addresses the heart of one of the key tensions between statutory professional and bureaucratic needs and the needs of those experiencing misery. And so we have instead a series of misconceptions about misery that sustain a statutory system to treat people. The fictions revolve around naming misery, what causes it, treating it and recovery. Sometimes these fictions serve people well; very often they don't.

Misunderstanding Treatments

Those organisations whose responsibility it is to commission mental health care in the UK today have mostly adopted some version of a stepped care model that has been recommended by the National Institute for Clinical Excellence.[46] This means organising people and designating them appropriate treatments based on diagnoses. Depending on severity and nature of the 'condition', people are recommended self-help resources, CBT (or a low-intensity stripped-down version) and/or different forms of psychotropic medication. The focus is on choice as well as appropriate care, and the DSM remains at the centre of this care because its allotted disorders relate to given pathways of treatment.[1]

There are now over 50 million prescriptions for antidepressants written, and as many as one in six adults are prescribed monthly antidepressants in some parts of the UK.[40] However, despite the supposedly robust evidence base that attests to the efficacy of many forms of psychotropic medications, there are a number of key problems with both the premises underlying these approaches and the evidence itself. With regard to medication it as not been demonstrated that many psychological disorders are caused by an imbalance in serotonin or any other brain chemicals implicated in their causes.[1] Indeed, there is little evidence that drugs exert effects that return 'disordered brains' to 'normal', that is, that they have an antidepressant effect or an antischizophrenic effect. Rather it appears that if medications work (and sometimes they are experienced as beneficial), then they do so by placing people into drug-induced states with uncertain pharmacological impacts. Antidepressants as a form of sedation are an often useful form of anaesthetic to people's difficulties.[1,2,36] However, antidepressants 'fix' depression no better than a painkiller fixes a root canal.

Furthermore, the supporting research is problematic. There is a long history of inadequate controls, an excess reliance on selected individuals and use of abstract numerical measurements with diagnostic inventories that have little clinical meaning. Most bruisingly, there is a bias towards selective publishing and reporting of success stories, while the dozens of trials that show them as having, for most, little more potency than sugar pills are withheld.[1,40] A recent review of five studies of early psychosis found that those treated without medication fared better than those on medication.[9]

In the debates on what constitute appropriate, patient-centred approaches to mental distress, psychological therapies are often constructed as the humane side of psy practices. Here the corrupting activities of big pharma, and the often debilitating side effects and the frustrations of the inappropriateness of a biochemical agent masking underlying psychological disturbance, are replaced with a sensitive, appropriate and ethical approach to distress.

However, psychological therapies are also problematic. Waldegrave[47] notes that therapy typically refers to the healing and problem-solving discourses that the helping professions carry out, where professionals focus on interpersonal experiences that are typically framed through individual or family dynamics. Through non-specific processes of clarification, support and empathy,[2] the experience of this kind of therapy can be comforting. Yet comparisons of qualified practitioners with amateurs with no specific training suggest few meaningful difference in effectiveness (regardless of how they were measured).[6,48] Moreover, psychotherapy can foster the illusion that misery is an internal failure requiring expert correction.[2] For the many whose distress links to violence, addiction, poverty, poor housing and/or unemployment, these models of therapy can at best be understood as making those in poverty feel a little better and at worst as a practice which silences the voices of the poor.[47] Look, we know that a lot of you reading this won't be practicing like that. But quite a few people do. Indeed the lack of inequalities imagination in the psy professions is worrying.[48,49]

As with much of the pharmacological research, research on the effectiveness of psychotherapies is prone to long-held biases towards selective publication and reporting. Also at play here are inadequate controls and excessive reliance on selected individuals that conceal that there are large numbers of people for whom therapy has been unsuccessful.[1] Again there are abstract numerical measurements with preset diagnostic inventories with little personal or clinical meaning and practices which inherently steer the client into the therapeutic model. Both parties expect improvement and that improvement is normal, and to expect or to admit anything else is an admission of personal inadequacy.[1]

But as well as this, counselling has come to be seen as the answer to almost every type of personal and social problem—boredom, loneliness, overexcitement, rejection, unattractiveness, workplace change, marital infidelity—and in 2010 nearly 20% of British people had consulted a counsellor and nearly half knew someone who had.[1] Paul Moloney suggests that a key problem with therapies like CBT is that the focus on thoughts and feelings, without a meaningful focus on the social lives that frame them, is like studying a snowstorm paperweight without reference to whether it had been shaken.

Do We Throw the Baby Out with the Bathwater?

So far in this chapter we have provided the reader with what appears to be a relatively unproblematic flaying of the precepts and practices of mainstream psychology and psychiatry. Such mainstream conceptualisations suggest a version of distress that fits with how people are broadly thought about in society. Most people are rational, reasoned thinkers who exist in a state of wellness, and that disorders, diseases or illnesses are the things that are responsible for stopping people being rational and well. As such, we need doctors to diagnose and treat these disorders so that they can get better and get back to being rational-thinking, well people.

So far our critical story has largely denigrated the conceptual and empirical basis of this system. We make the point that psychiatrisation prepares people very little for community life.[50] It overlooks the intrapsychic and intersubjective processes that contribute to a sense of self,[51] and constitutes an infinite variety of 'have to's' that are thrown at people before they can reach some elusive ideal of normality[52] and where cure and recovery seem to be promised. When one treatment fails, another is initiated ad infinitum until the 'right' treatment is found to cure 'ill' people, and professional psy people are the only ones able to define the distress, make these choices and give these treatments.

However, what we don't do is address other difficult issues thrown up by any wholesale rejection of psy. Some of these could be summarised as follows.

- It's currently considered to be all we have.
- The current system is replete with well-meaning, passionate and tireless supporters of suffering people.
- What use is this conjecture for people/families/carers who are working through a crisis that, at its most extreme, could end with the death of a suffering person? Isn't such conjecture just an intellectual luxury that means little to those and their loved ones in crisis?
- What about the good that this flawed system does? What about the people who have been helped/supported/cajoled/understood and stood alongside with, and who as a direct result have emerged from the immense suffering?

This current system is all we have but it doesn't need to be all that we have. People, unless sectioned, have the option of not engaging with traditional mental health services. However, when people are exhausted, confused, immiserated and suffering, and everyone around them tells them that they need help, and that they need to contact their GP for support, and where they see very few alternatives on the horizon, they very often do feel that their single option is to start or indeed resume their trajectories as mental health service users. But it need not necessarily be this way. A well-known critic of psychiatry, Thomas Szasz, understood distress as problems of living that we all have to get on with and resolve as fully responsible moral agents.[53] If we collapse the authority of psychiatry we are left with a range of difficult scientific, ethical, legal and political challenges which are obscured by psychiatric theory and practice. However, there are growing alternatives that provide meaningful context-specific support instead of de-socialised diagnoses. For instance, peer recovery workers and recovery colleges are becoming commonplace, where you don't always need to take on the identity of a patient to receive support and guidance.[54] Here the focus is on rebuilding lives rather than reducing symptoms that are worked on by 'experts' and 'patients'. We need to stop diagnosing non-existent mental illness and recognise that our primary role is in supporting well-being.[54]

In the next chapter we rethink some possible social- and community-based alternatives to the traditional biomedical approaches and explore why, thus far, such alternatives haven't been incorporated into mainstream care. The current biomedically dominated mental health care system is replete with problematic disorders, medications, problematic pharmaceutical links to practitioners, and panels which create the disorders. It is replete with singular narrow and profoundly problematic notions of recovery, and with some fundamental misunderstandings of suffering and recoveries. It is characterised by a problematic privileging of the individual over the social in both the genesis of distress and the constitution of distress. However, it is also replete with passionate, committed, effective and tireless people doing invaluable work with people who are distressed. And some people benefit from psychotherapeutic encounters. Some benefit from the respite that some medicines give at some points in their lives. But many will not. Many will suffer horribly on such medications and many won't be interested or find useful the practice of talking therapy.

However, we do not need to buy into the idea of the discrete and disordered individual at the mercy of their neurotransmitters/negative thoughts and feelings/hearing voices. We do not need to accept the conceptual and ideological baggage that comes with the dominant psy discourse to make sense of why having space and respite from lived experiences of misery can be useful, or why some medications might be useful sometimes or indeed why sitting in a room with an empathic, non-judgemental and insightful human being might be useful. Some physicians give medications to impact specific neurotransmitter pathways to treat or cure socially constructed 'disorders' and end up helping by simply numbing somebody for a while. Some therapists seek to mobilise complex psychoanalytic or cognitive behavioural technologies and end up being effective because the other person likes talking to them.

It is our contention that we have been pointing our theoretical and critical energies in the wrong direction. We have been supporting, critiquing, exploring and providing evidence for highly specialised theoretical technologies that dominate our professional disciplines, and in so doing supporting and legitimising the need for the exclusivity of a single or multiple, very closely related professionalised approaches to the care of distressed people. Instead, what we should be doing is to consider the multiple forms of expertise, the 'everyday magic' as resilience researchers might call it, mobilised on a daily basis by friends, loved ones, carers, colleagues and community organisations. There really are many other social spaces that are hugely effective for distressed people, and we don't require the de-socialised, medicalised, ethically compromised, disempowering and conceptually limited concepts of the mainstream psy industries. However, before we get to explore some of these spaces, the following chapter will attempt to examine how such spaces might be good for mental health well-being.

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3

Social Approaches to Distress: From Enclosures to Fluid Spaces

One day, while I was being light heartedly told by a centre user that I would eventually follow the ‘monkey with a typewriter in a room’ scenario and fluke a decent cup of tea, I realised that there was a woman sat in the corner. I noticed her because she looked out of place. I asked who she was and I was told that she was a worker from the local mental health charity, Mind, who did afternoon mental health sessions where people could informally pop over and chat to her. I had already been told that the majority of people using the centre were current or recent mental health service users. However, very few people seemed to be going over to her corner. I remember being a little surprised by this at the time. She certainly seemed like a pretty approachable and friendly person.

The quality of my tea might have improved over time had I spent less time staring at what was happening in the room and more on the tea itself. Eventually I was removed from tea bar altogether. They were polite and said that, since they found out I was an academic, they had decided my volunteering could be put to better use helping them with their research evaluations. But we all knew deep down that it was due

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to the quality of the tea. Nonetheless what I had learned, and continued to learn, through evaluations with the organisation and through later becoming a trustee, was that the Mind worker eventually stopped coming. And yet she had been the only person with mental health training in a building where the majority of people identified as currently or recently experiencing mental health difficulties.

What subsequently became obvious through various conversations and pieces of research was that most people who used the centre said they had found it beneficial to their mental wellbeing. A good number said the activities they were involved in had been fundamental to what they referred to as their recovery. And this had happened despite the loss of their only trained mental health professional. Unless I was misunderstanding what was happening in the centre, this appeared to be an informal setting where valuable and sometimes invaluable mental health work routinely occurred through activities, technologies and 'things' that most would consider relatively banal and unspecialised. And it was this experience of making bad tea and watching an informal therapeutic landscape unfold in practice that ultimately led to the case studies in this book.

All three authors of this book have had such experiences in their personal lives, as supporters of loved ones with mental health issues, as volunteers and as researchers in diverse settings. And even for Angie, in that part of her life where she worked as a mental health practitioner in a child and adolescent mental health service, informal spaces, community groups and the actions of people who weren't mental health professionals repeatedly revealed themselves to be fundamentally important to people's recovery. Those experiences were something of an impetus for the community development research she has done over the years on resilience-based approaches to mental health which is gaining some ground in the realm of children's mental health.[1,2,3] And yet the dominant narratives, and most of the money, as we saw in the previous chapter, continue to be tied up with the healing powers of medics, psychologists and various professional therapists. And even at best, community-based approaches are seen as referral routes or sites of prescription by medics and psy professionals.

Enclosing the 'psyCommons'

A good way of thinking about how we currently understand psychological healing is to start with the idea of a 'therapeutic culture'. Furedi suggests that recent history in the West has seen a 'therapeutic turn' that has encouraged victims of past wrongs to frame their claims within the language of psychology.[4] We now live in a therapeutic culture that is so powerful that it provides the coordinates that we use to make sense, not only of our distress and the distress of others, but also of our day-to-day experiences in the world. He suggests that it disposes many to interpret emotional problems through the disease metaphor and means that distressed people and their loved ones come to regard themselves as objects of passivity to be fixed and changed rather than as subjects of their destiny.[4] If this is the case, how has this come to pass?

Exploring this requires us to reflect on the idea of 'the commons'. The commons is the great variety of natural, physical, social, intellectual and cultural resources that make our everyday survival possible.[5] They are assemblages, groups and ensembles of resources that human beings hold in common and that we draw upon for our everyday living. The social commons is often organised around access by users to social resources created by specific kinds of human labour. Caring for the sick and educating children are examples of social commons, and all polities have some variety of social commons. Many social resources, as commons, are organised around family, kin and local affiliations. However, what can be understood as 'common resources' is also fiercely contested. There are conflicts not only about control of common material resources but also for control of the cultural meanings. Here common property can be distinguished from state or private property.

Denis Postle has discussed the 'psyCommons' as the universe of rapport and relationships between people that we draw from to navigate through our daily lives.[6] It describes the beliefs, preconceptions and the learning and experience that we all use routinely when we interact with other people. The psyCommons is a living, growing multitude, a rich ecology of negotiations, conversations, meetings with family, friends and co-workers—the myriad conversations of 60 million people in the UK. Herein lies a rich source of ordinary wisdom, insights and understandings on a whole range of 'issues of living', from growing up, to caring for people to supporting neighbours in difficulty, and together they make up this psyCommons, the rich stock of psychological knowledge to which people have access.

One of the messages in this book is that the psyCommons, like many other forms of commons, has been encroached upon and enclosed. In this case, largely by the psy professions of psychiatry, psychology, counselling and psychoanalysis. These professional institutions have, through their privileged discourses, legitimising systems of professionalisation, and forms of evidence, fenced off and claimed ownership of an increasing proportion of the psyCommons. They have extracted value from them through developing services and charging for them. Indeed the pursuit of privileged status through professionalisation has protected and strengthened these enclosures.

While distress is a very real and embodied state, the social category 'mental illness' is a product of the professional psychological enclosures that are reproduced through the 200,000 psy practitioners in the UK who engage in the practice of enclosing ordinary wisdom. This can be framed through the commons lens as a systematic encroachment where dominant cultural narratives are established that extend the psy terrain that 'belongs' to psy experts. These boundaries and limitations of conduct are constantly negotiated and renegotiated through time and within cultures. The right of some sections of society to use a given resource can be revoked as the resource is removed into the realms of a given professional practice. Through this perspective, therapy can be understood as the enclosure and formalisation of empathy and positive regard towards those experiencing distress. The assumption from within the enclosing institution would be that such enclosure practices would lead to greater outcomes for those now understood as clients. However, evidence, even the kind of evidence that Psy researchers and policy makers draw on, to support this assertion is equivocal.[7,8]

We would contend that many of the inherent problems of the psy institutions touched upon in the previous chapter—both in the making of embodied experiences of psychosocial distress into disorders and in the formalisation of treatments for these disorders—are driven by, and indeed drive and sustain, these practices of professional enclosure.

One of the major casualties of the activities, technologies and enclosures of the traditional psy disciplines has been our collective responsibility and capacity to heal and support ourselves and others simply as human beings. The psy disciplines have, in the process of privileging professional understandings of distress, potentially facilitated a corrosion of the dignity of 'lay' human selfhood [9] where human beings in the West no longer have any sense of public agency in the understanding and amelioration of their distress. The exclusion of non-professionals from the care of the hurt or sick has resulted in new demands for medical services, and it has become almost impossible for non-professional people to be officially understood as having expertise in psychological care.[10]

The dominance of psychiatric enclosures has meant that psychiatric remarks have become the preserve of the traditional psy professions despite 'ordinary people having perfectly sufficient descriptions of themselves'.[9] Instead, actively constituted subjects (people) come to know themselves through the potentially problematic diagnoses reproduced and regulated by traditional psy practitioners. The dominant cultural narrative around distress has it that these necessary practices have enabled processes of recovery for people and their families who are experiencing the most pronounced suffering. For some service users and their loved ones, this is undoubtedly how they have been experienced. However, this has led in many cases to the removal of people from socially valued sources of support.[11] Furthermore, there has been a diminution of support networks in the community that work to prevent the existence and escalation of crises, and that hold people until de-escalation without medication or violence.[12]

For some, this casualty of our collective commons is simply too much and they question whether the profession of medicine has any legitimate role at all to play in human misery.[13] In this chapter we wish to explore the ways in which new vocabularies of helping, often divested of much (although not all) of the emotion talk enclosed by psy institutions, operate around the fringe of these enclosures and have considerable impacts on people's distress. We explore the informal landscapes, settings and spaces that exist to some degree beyond the psy enclosures. Only to a degree because psy discourse on emotions and therapy is so all-pervasive in the twenty-first century that one would have to have lived under the ocean to truly escape it.

In such settings and spaces it is quite possible for distress and suffering to be understood as everyday artefacts of modern life that do not require institutions of expertise to legitimate certain states of being at the expense of others. Moreover, they often require no central reliance on a system of pharmaceutical treatments or therapeutic techniques to radically alter the way that distressed people feel and think about the world. Such settings do not share with the dominant discourses of the psy sciences the requirement for people feeling distressed to be categorised and subject to the symbolic and material practices of othering that mental health service users often experience and that can reinforce discrimination, marginalisation and stigma.[9] To make sense of these settings requires a focus not on the therapeutic but on the helpful.

Everyday Magic and Helpfulness

The first thing to say is that the idea that ordinary things can help people experiencing distress is not new and dates back 25 centuries to when Hippocrates helped his readers distinguish between 'unhealthy places like swamps and healthy places like sunny breezy hillsides'.[14] In the 1940s Cassel considered the healing of fractured families an essential venture for post-war psychiatry in order to ensure collective as well as individual healing.[15] In Richmond, the Cassel Hospital for Functional Nervous Disorders undertook psychosocial experiments on 'therapeutic community' where they treated patients' mental disorders as part of a wider network of social relationships and an instance of social, rather than individual, breakdown, encouraging patients to take active roles in the hospital management. However, it could be argued that it is only recently that public health has started to rediscover the importance of community and place in people's recoveries.[14]

So, how do ordinary people, ordinary places and ordinary pursuits work for people experiencing sometimes acute distress? Why do people in hospitals with tree views have significantly shorter hospitalisations, less pain medication and fewer negative nurse notes than those without?[16]

Why do people so often report outdoor space to be therapeutic?[17] Why is a sense of community integration and connectedness to other people so important?[18] How is it that volunteering in a community arts programme is considered therapeutic for some people experiencing psychological distress?[19]

Well, central to understanding this requires a reimagining of what constitutes a 'therapeutic space'. The term 'therapeutic landscape' has had prominence in recent years in health geography. Therapeutic landscapes allow for an understanding that environmental, social and individual factors interact in certain natural or built environments and that these facilitate the experiencing of subjective well-being. As part of this shift there has been an emphasis on the idea that ordinary places have potential for well-being—places like the home, local community amenities or the garden.[20–22] Here, *any* specific space or setting could have potential for well-being albeit with the proviso that context is central and the challenge is to bring about an understanding of how health and well-being are emergent in and through these complex contexts of experience.[1,20] This notion that many everyday activities and spaces can be therapeutic has been increasingly incorporated not only into professional but also public discourse.

If you ask most people in your street they'll likely be able to tell you about things, people or places that they find therapeutic. They might tell you that walking by the river or painting or reading a book or hand-gliding or any manner of other things are therapeutic for them. And herein lies a strength and weakness of Furedi's therapeutic culture. On the one hand lies an opening for those proponents of the social model on mental distress. Some of our work here is already done. We have a growing public acceptance for the wide benefits of non-medical interventions on psychological well-being. On the other hand, to some extent, we are still problematically restricted by that word—'therapeutic'. As a term, therapeutic is one still mired in the discourse of biomedicine. Its meaning in the dictionary is 'relating to the healing of disease' and synonyms include 'healing', 'curative' and 'medicinal', among others. In recent years we have seen the words 'therapeutic' and 'therapy' move beyond the realms of medicine into the common vernacular where people regularly talk of retail therapy, bibliotherapy and all manner of other therapies.

One might conceptualise this as part of Furedi's 'therapeutic culture', made possible through the enclosing tendencies of the psy institutions to appropriate themselves into an increasing number of areas of ordinary life (and, we stress again, sometimes helping people in doing so).

Some might argue that this concept of the therapeutic will, however, always be problematic since the 'therapeutic social', the walks in the countryside, the art groups and the other non-professional settings, spaces and places that people experience positively are always delegitimised in the hierarchy of medicinalities. Here, social and cultural 'things' can be therapeutic but always *less so* than biomedical and professional 'things'. The social, the informal and the community will always find itself underprivileged in this hierarchy of value. The appropriation of medical terms to make sense of the social irrevocably refracts the informal and the social through the lens of biomedicine, framing such practices and activities within the realm of doctors and disorders and disease and other medicines. It reproduces biomedical distress and privileges biomedical interventions, even in their absence.

For some, the concept of therapeutic will ultimately continue to reinforce a biomedical approach to distress. The lay understandings, lay activities and knowledges, the impact that many non-trained, non-expert, non-psy ventures and activities that don't fit within the medical model, but which many say have value, will remain inferior to the specialist preserve of medicine and its practitioners. So we may sit making bad tea on the tea bar at the local unemployed families centre project and watch people reap enormous psychosocial benefits from doing art in a place where nobody knows their history and where they have no built-in labels and stigma that walks through the door before they do, talking to people, sharing space, getting advice, doing yoga and volunteering. They might tell us about the massive impact this has on their mental well-being, more so than any statutory service has. The staff might tell us the same thing. Talk to staff and volunteers about whether this is a mental health centre or a mental health intervention, and the answer is that it is definitely neither of these. They have no professionals here to do that kind of work. There is no ownership. The centre is understood as therapeutic but not the therapeutic that can be provided by experts. They are *really* therapeutic. The centre is just *a bit* therapeutic.

So the problem is that the word therapeutic really has two meanings. 'Therapeutic' is predominantly a medical term (but only predominantly). It is also a lay term. One therapeutic is the medical therapeutic of experts and distress; it encompasses a range of interrelated medical activities including diagnoses, treatments, psychiatrists, psychologists, psychotherapy, pharmacology, experts, research, scientific evidence and the National Institute of Clinical Excellence (NICE). It is a term owned, enclosed and defined by the practitioners of medicine. And then there is 'therapeutic-light'. This is *our* therapeutic, the public's therapeutic. Things that are 'therapeutic-light' can be beneficial, healing and healthy, but some might argue that they can never truly be understood to be 'properly medical therapeutic' because to be this involves experts, diagnoses, therapies, evidence-based medicine and research. And as long as we describe any single activity of social life as therapeutic, we are immediately relegating it into the 'therapeutic-light' bracket. Because experts, scientists and practitioners are the only ones who have the keys to the properly medical therapeutic term. When we say things are therapeutic, we are automatically saying they are not as therapeutic as medical things. And this is no good if you think that what some people experience, for instance, at the centre above, is actually superior to the 'properly' professional biomedical therapeutics that they have experienced in the past.

Relationships of power are manifest in daily language through words, phrases and language forms, and the assumptions they carry.[23] Some of these assumptions are very visible and some, like the implications of the word therapeutic, are less visible. Nonetheless, they are there and can be problematic when you try to shift the way an issue is understood when the only language you have is from the paradigm that you're trying to shift in the first place. We live in a therapeutic culture[24] where citizens are understood as emotionally fragile and confused, in need of guidance from wise experts with a privileged hotline to the truth. The widespread use of therapeutic jargon and techniques for 'better relating' has made it harder for many people to use their own intuitions to see how their feelings arise from what is going on in front of their noses. Moloney suggests that the therapeutic outlook and language have become all-pervasive, and that their mastery is essential to success in education, work, play, love and everything else.[25]

One way to start addressing this issue of linguistic connotations is to just drop the word 'therapeutic' and substitute it for 'helpful'. Now some people won't like this because they insist that they have successfully reclaimed the concept of therapeutic, and for them its connotations have shifted towards a greater sense of community and/or self-ownership. Others have argued that many psy professionals value these other kinds of spaces and support systems alongside formal therapeutic processes, so what does it matter that they use the term therapeutic to describe them? But we are suggesting that it does matter. If we accept that therapy and the therapeutic are irrevocably mired in medicine, passivity and lay impotence, then it's clear that we need to rethink our concepts.

So let's say that the word 'therapeutic' is no longer fit for purpose. Therapy and the therapeutic are not what happens in these spaces. People don't engage actively in curative and healing practices and techniques; they don't do therapeutic things. That's it. Goodbye to 'therapeutic' and all the baggage it carries with it.

And it's hello to helpful. We are going to talk about helpful practices, settings, spaces, organisations and landscapes. Helpfulness is characterised not by curing, healing and medicine but by humanity, neighbourliness, communitarianism and connectedness. By support and compassion and benevolence. Here we have a word that sums up the massively beneficial impacts of many routine human practices and everyday forms of expertise. Also inherent in this term is that it allows us to reposition distress as banal, albeit incredibly debilitating, artefacts of everyday life. We argue that it allows an emphasis on the fundamentally social nature of distress and trajectories away from distress as well as a broadening of our understanding of what constitutes that which is helpful.

Understanding what constitutes a helpful space requires a consideration of the multiple ways in which social experiences can reveal valuable impacts on people's lives. Helpful spaces can provide environments where people encounter a range of resources, activities, experiences and relations without assuming the identity of a person receiving therapy or indeed a deviant that waits behind the glass partition. Formal health policies traditionally tend to overlook the importance of intersubjective processes that contribute to a positive sense of self.[26] Indeed if people are given access to such metaphorical and physical space, they can experience superior outcomes than by trying to work on their problems while enveloped in regimes of alien and sometimes uncomfortable power and authority. Helpful spaces can support disadvantaged people to develop helping networks in ways that are often difficult in statutory services.[27]

As part of the tradition of 'geographies of wellness', sense of place can be understood to be created through a process of coming together of various environmental, social, cultural and historic factors. How this relates to subjective well-being relates not only to what a place has to offer in terms of amenities and opportunities, but to whether one feels safe and secure.[28,29] Recent empirical work has suggested that the development of what we are now, still a little self-consciously, calling 'helpful spaces' can incorporate a wide array of contextual settings. They could include social firms where people can benefit from workshops in bicycle maintenance.[30] Here people can experience a much-needed distraction, an accepting social group and a sense of being 'held' by the interpersonal environment. Helpful spaces may take the shape of 'walk and talk' groups[31] which both those with histories of statutory service use for their distress and those without can meet for organised walks at the same time and day each week. In such groups, research suggests that walkers report benefits that include 'being with people with similar experiences' and 'taking an active role in something'. Some have suggested that the psychosocial benefits of exercise depend on the environment it is performed in, with walking reducing what the authors call anxiety, depression and anger, and increasing revitalisation and tranquillity.[32]

The arrangement of space can confer information that make landscapes more or less interesting and make space more or less beneficent. Numerous studies incorporate the restorative impact of green and waterside environments on mood.[17,33] It has been suggested that there is an inverse relationship between living less than one kilometre away from green space and what the authors of that text refer to as depression and anxiety. Indeed, each additional weekly use of natural environment lowers the risk of poor mental health.[17,34–36]

Other work has suggested benefits for people through volunteering in community arts organisations[19] and in various forms of arts participation[37,38] including music, painting, drama and dance.[39–41] There is evidence to suggest that community arts projects can have a significant impact on mental well-being, especially with regard to reducing isolation, and improving self-esteem and confidence.[42,43] Engaging people in creative activities, and using a mentor-based approach, has been found as a way of improving social networks, reconnecting people with their local communities and improving psychological and physical well-being.[44] Creative art activity also often allows people to explore life in a safe environment, to find their own structure rather than having it imposed on them; it allows the collective and individual expression of emotions nonverbally which can, for many, be vital and liberating.[45]

The Helpful Social

Helpful spaces can facilitate the advantages of socialising with others in a group, of gaining recognition, often in a space characterised by a lack of judgement and respect from others.[19] Sometimes they can offer alternative social worlds where people can feel that they belong to a group and where different criteria of worth may be applied making possible positive identities and status.[46] People can experience relationships of mutual support either formally or informally within these settings where loss, guilt, isolation, social marginalisation and stigmatisation can be ameliorated by the psychological sense of community, emotional support, role models, practical information, ideas on coping, opportunity to help others and mutually supportive relationships.[47] Here discourses of disability, victimhood, powerlessness and dependence can, for some, become recognition, belonging and a sense of control.[47] In such spaces people can learn new ways to perceive and interact with the environment, acquire new skills, experience the reawakening of hope after despair, and no longer see themselves primarily as persons with psychiatric disorders.[48] For some, helpfulness can take the form of a move from a personal to a shared social identity when the context itself shifts to being structured in terms of intergroup relations rather than the interpersonal relations between a client and therapist.

Helpful spaces can furnish forms of *collective* resilience—a term used to describe communities' coping processes—that is, the relational bonds and networks that hold communities together and provide support and protection, facilitating refuge in times of extreme stress.[49–51]

And then there are the practical impacts that can be provided by some settings where advice, advocacy, information and support can help people to address key community and personal difficulties, like poor housing, unemployment, benefits issues and opportunities for volunteering.[52] Volunteers have higher personal and neighbourhood well-being, social integration and connectedness,[53–55] allowing people to embed their lives in a given social context. Some volunteers experience 'ways of being' in the community that may have been disrupted or lost[56] and where people come to see the value of their own participation and contribution through the eyes of others.[57]

Invaluable care work is being carried out in informal social, recreational and community settings where an array of circumstances, experiences, relationships and events provide beneficent encounters. Informal caring can take many guises in many settings.[58] Work in three neighbourhoods in Glasgow shows that the nature of informal care and helping is often blurred and can constitute, sometimes through small acts of kindness and practical help, a deep emotional significance that can underpin subsequent emotional disclosure and help to create a sense of connection between people. Moreover, a shared sense of identity can provide a strong basis for mutual support.

This is something that is often manifestly missing in the relationships between psy practitioners and clients.[59] 'Mental illness' often creates a sense of being different and often of being alone. Clinical processes can emphasise, highlight and reinforce this. Everyday experiences can lead to greater satisfaction than those mobilised by specialists, a reason why some suggest that clinicians need the modesty to remember that many people find non-clinical ways to manage distress.[60] Indeed one of the strongest and most effective ways that mental health services can be involved is to strengthen community-focused ways of supporting the everyday solutions to the difficulties people experience.[60,61]

Central to journeys from distress are connectedness, finding space to rebuild positive identities and status, often within a context of stigma and discrimination. They include ways of finding hope and meaning, and a purpose in life and being able to rebuild a life that feels worthwhile.[62] For many, this can include facilitating the pragmatics of those in distress—a focus on debt, housing, food and benefits. For some, it may be the provision of space where people can rediscover competence and connectedness, and reframe identities. For others, it might be to have a place of safety and refuge, and for some, the desire to explore trajectories through volunteering.

The infinite variety of have-to's thrown at people rendered mental health clients before they reach an elusive idea of normality ignores the very real need for people to participate in the natural rhythms of community life.[57] People's lives can change hugely simply by having other people to spend time with and spaces where they can give support and help as well as simply receive it from someone paid to do so.[57] Moreover, for many who have had repeated experiences of labelling, coupled with negative and hopeless encounters with mental health services, the labelling becomes incorporated into their identity.[63] So finding contexts with a sense of belonging, commonality with others, and agency can start to unravel some of these ingrained assumptions of personal deficit—spaces where people are chosen, included, deemed worthy of others' attention not due to deficits and problems but due to capacities, talents and status as deserving contributing people.[63] Informal social settings and spaces appear to be key in enabling people to redefine themselves beyond illness and provide opportunities to construct new meanings for both themselves and their worlds. Mezzina[63] suggests that goals like social inclusion and community integration can *only* be provided by communities themselves rather than through the technical procedures of institutions that situate themselves on the periphery of these communities.

Helpful settings can take a varied and wide form, but what they often have in common tends to be a sense of safe space, companionship, a lack of judgement and a capacity to define oneself beyond one's distress. Holmes[31] suggests that settings like arts centres, libraries, river paths, sports fields, education centres and others can allow for a variegated and multiple notion of 'recoveries' where there are as many recoveries as people. Where isolated people make friends, receive support,[64] go for a walk, experience the countryside companionship and solidarity or share information, meeting up with like-minded people and sharing experiences. Where they might be listened to and experience well-being in ways that cannot be measured by the traditional metrics of modern well-being and that, crucially, very rarely need a psy professional on hand.[31] Helpful spaces can improve well-being but cannot easily be verified through randomised control trials (RCTs), and the clinician's preferred methodology,[65] and so they tend to flounder as abstract phenomena on the periphery of statutory approaches to distress. RCTs cannot capture the complexity of spaces where the rational construction of life orientations, so central to the technologies of conventional therapy, is supplanted by multifarious settings where passive and indirect life orientations emerge in stark contrast to the transcendence of never-ending rational setting of goals.[66] The case studies in this book go some way towards articulating the complexity of some of these spaces, and just how helpful they can be.

The path that distress takes is far from inevitable or determined purely by individualised, static 'symptoms'. Rather it unfolds as part of a complex interplay between personal experience, space, embodied movement, as well as relations with others and the material world. However, to present social spaces as an unbridled panacea for all distress would be both naïve and wrong, with public space being often cited as particularly problematic for some. For some the more fluid, dynamic, active nature of being out in the world, doing things, seems to promote a more powerless position in relation to their distress. However, our argument in this chapter is not for the ameliorating effects of all public relational spaces for all. Rather spaces of helpfulness *can* be fundamental to well-being because for many people, it is through social contexts that they can start to reconstruct their sense of self, status and agency in the world. It is human encounters, so often comfortable, banal and removed from the formal practices of care, that are so important.

Helpful and Fluid Spaces

Okay so we are suggesting that certain types of spaces not (yet) enclosed, or fully enclosed, by psychiatric, psychological and psychotherapeutic logics can be beneficial. That point was hopefully evidenced above. However, helpful spaces that can be so useful for mental distress are actually hugely variant in nature. After all, we could be talking here about a walking group in the countryside, a cooking class, tantric meditation, a cycle repair workshop, a community choir, a local social or community club, a community art class or other education classes. It could be yoga, music or a mutual support group. It could be an advocacy and information service for people using benefits, debt guidance, employment advocacy or advice on local facilities for a disabled family member. Or just sitting down with other people in a space and that isn't your house. What, if anything, do these helpful spaces share other than such abstractions as humanity, compassion, connectedness and practical information? Is there something that is key to allowing all of these things to occur in these spaces or indeed something that is produced in all of these spaces? We would argue in this final section that there is, and to understand it requires us to think about the very nature of how we understand and perform mental distress as a social 'thing'.

Annemarie Mol[67] foregrounds practices so that objects like 'distress' are not passive things to be seen from different perspectives. Instead, they come into being and disappear with the practices within which they are manipulated. That is, objects can be differently enacted in different practices and in the different sites that these practices occur.[68] She talks of an ontological approach which rejects the absence of the body's physical reality where the body has been sacrificed at the realm of meaning. This approach foregrounds practicalities, materialities, events and what is done in practice. Mol and Law allow us to explore the notion of spatial types.[69] Rather than 'the social' existing as a single spatial type, they believe that the social can perform different types of space. They discuss the way that objects, such as embodied distress, can exist in different types of spaces depending on the nature of the networks which enact these objects.

Conventional contemporary biomedical psychiatry positions extreme distress essentially as immutable disorders. And while these disorders may change over time, they don't effectively change in one single time point over different social contexts. For instance, patients whose distress is called 'clinical depression' are patients with 'clinical depression' regardless of whether they are sitting at home, at their desk at work, inside a psychiatrist's office or at a local art class. They may experience these places differently, they may act differently in these contexts but in effect they remain patients with clinical depression across space. Here distress as the object of interest is an essential immutable in a given time point.

However, we would say that distress as an object is not an immutable disorder as is routinely held in biomedical psychiatry. As it moves from the centre to the periphery of the biomedical network, for instance from the psychiatrist's or GP's office to a local social club, the truths which form it become progressively less reliable.[69] The space in which the object of distress moves behaves rather like a fluid. Mol and Law suggest that some social spaces take a fluid form.[69]

In helpful spaces where mental health practitioners and expertise are absent, the people in these spaces still encounter a given shape of distress and still go on working, relating and sharing with distressed people. Many in those spaces will not carry the conceptual tools that make distress a certain thing, and some will; some will carry versions of distress that appropriate some elements of its shape in biomedical settings. In many of these spaces there will be no psy technologies and treatments and so detecting specific versions of distress is not urgent or important. In some locations in the fluid spaces, distress is enacted in a certain way and with certain implications; in other parts of the fluid space, it will be enacted differently with different implications. Helpful spaces are those that embrace the fluidity of distress. Helpful spaces allow fluid objects to be non-visible or visible in different ways; they fix few if any rigid boundaries around objects. Unlike terrains of biomedicine which seek to hold objects in rigid spaces within rigid networks of relations, definitions, roles, expectations and narratives, helpful spaces do no such thing. It is for this reason that they so often allow the flourishing of so many of the factors key to well-being—agency, connectedness, humanity, benevolence, support and safe space.

But now what have we got to say about the arenas of biomedicine? One *might* say that the practices, technologies and institutions of psychiatry have sought to enclose distress, to constitute it, fix it, and measure it as something that can be acted upon. One *might* suggest that they have had great success in the sense that their apparatuses have largely achieved 'ownership' of distress but great failure in their attempts to fix boundaries around objects that are fluid and move in fluid spaces, resulting in an utter misunderstanding of the nature of distress and spatial conditions necessary for amelioration. However, presenting such a picture is to simplify the activities of most of psychiatry to the point of obfuscation. This is because psy spaces are themselves not uniform, rigid and boundaried. These spaces themselves are fluid, perhaps less so than other social spaces, but there is fluidity in the spaces of psy with great variation in the degree to which practitioners constitute the object of distress and great variation in how they do, or do not, mobilise the enclosing, fixing and constituting apparatuses of distress through the biomedical framework.

Psy spaces have fluidity and with this fluidity comes possibilities. Some psy spaces recognise and observe the fluidity of distress and make visible very different versions of the object than others. These might be said to have beneficent properties encompassing humanity, benevolence and compassion. And many helpful informal spaces are infused with discourses of psy, of the apparatuses that encourage boundarying and the fixing of distress in some way or another. The point is that distress is a messy, fluid object that moves, transforms, fixes, is reconstituted, is invisible or is differently visible in different spaces. The spaces that offer the greatest potential for helpfulness are those that will ultimately be most useful. There is no linear relationship between these properties and a notion of well-being or recoveries. While these spaces are *promising*, they offer no promises for recoveries because distress is too messy an object that one cannot pin down to cause and effect. Helpful spaces offer conditions of possibility that offer greater promise than those that are not. No more, no less.

Conclusion

This chapter, through reflecting the apparatus of enclosure, and through beneficent spaces and fluidity, has sought to try to make sense of a range of informal practices that people experience as useful in terms of their distress. What seems clear is that so many of these practices do not require the discourses, expertise and professionals from psychiatry and psychology. Nor can we guarantee to help people any more than those who practice without our assumptions and forms of expertise. As long as we construct ourselves as doing so and use our medical dominance to distort understandings of the fundamentally messy, social characters of both misery and recoveries, we will remain both useful and problematic. The key is perhaps not to look at distress as one entity that can be understood differently through different viewpoints but one that can take different shapes in different contexts and spaces.[70] So this outlook constitutes a move from sole interest in objects to an interest in the processes which constitute objects in certain spaces.

The next six chapters of this book seek to build on the themes developed in this chapter and the two previous chapters. They provide a range of quite different case studies on helpful spaces in order to explore the rich variation and textures of informal care, to show how much such spaces differ and how much they are alike. They draw on informal practices, groups, settings and spaces and they seek to engage with exactly what it is that makes these given spaces beneficial for so many of the people who inhabit them. And most of all, they will show that people know a lot. Everyday non-trained, non-expert people have huge reservoirs of expertise, knowledge and capabilities that make possible the fundamentally banal textures of helpful spaces, and in so doing, have such marked impacts on people's lives. These case studies mark a movement from the dominant and institutionalised ideas of biomedicine to celebrate the everyday spaces, communities, organisations and encounters that allow some people to journey from misery through survival and recovery to thriving.

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4

'Bike Minded'—Normal Human Encounters (on Bikes)

As this is a book about the ways in which very normal settings, groups, activities and social relations can have often subtle and profound impacts on people's mental well-being, it would probably be remiss to exclude an example of a project that included some form of exercise. After all exercise is something that most people can do to some extent and that doesn't require a great deal of expertise. At this juncture the reader may begin to experience a creeping sense of dread that this may be one of the many chapters and papers that informs the world that exercise is good, not only for physical health, but for mental well-being too. And Lord knows there is plenty such research out there. So much so that people may be forgiven for developing a yet to be named sense of 'exercise is good for mental health fatigue'—an increasingly widespread syndrome whereby normal people keep hearing how good exercise is for their mental health. To name but a few, recent years have seen publicly disseminated research showing that exercise creates pleasant mood,[1,2] that those who exercise with regularity experience reduced anxiety, depression and anger, and a positive sense of revitalisation and tranquillity.[3] We also know that it is beneficial for the mental well-being of people experiencing a variety of medical conditions[4] as well as those in perfect physical health. Cycling

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in particular has a raft of recent publications illustrating its positive impact on mental well-being,[5] and these few studies are only the tip of the iceberg.

So it appears that we can say with some confidence that exercise is, on the whole, good for us.

The question is, will this chapter be yet a further iteration of this by-now, overstated cultural maxim that exercise is good for you? And the answer is no. In focussing on 'Bike Minded', this chapter opens up an understanding of community exercise initiatives that transcends the simple link between exercise and endorphins and instead portrays them as both complex and yet in some senses very straightforward, multifaceted social relational spaces that do a great deal more than give vulnerable people a temporary endorphin rush (although they do that too). So let's start with the project.

Okay, so 'Life Cycle UK' is a cycling charity that's been in Bristol for 17 years. In their own words they do 'all sorts of things' and are driven by a general ethos of helping to get people on a bike, start cycling and enjoy cycling safely. They do cycling training in schools and adult cycle training, and they run cycle maintenance courses. They run what they describe as a range of inclusive cycling projects and it's within this context that their 'Bike Minded' mental health project sits. This they describe as a cycling project 'for people who have experienced or are living with emotional or mental health problems'. This offers opportunities for people to get a bike, learn bike maintenance and go for group rides in the countryside with others.

We spoke to a number of people from Bike Minded, including service managers, volunteer ride leaders and service users. We conducted semi-structured interviews to talk about how people experience the service. In order to contextualise this project through the lives of some of the people who use it, we've drawn the various accounts of people we spoke to and put them together into the account of a single fictional service user in order to show the way in which a project like Bike Minded can impact a person's life. What follows in this chapter is an eclectic account of the data we collected during this research. Rather than presenting a range of individual voices, we provide an assemblage of the data through a stereotypical character associated with 'Life Cycle UK'. So let's meet Ron.

'Ron'

Ron is 56. On his good days he's a young 56-year-old or at least he's a 56-year-old without a paunch and who still has his hair, which amounts to much the same thing. People used to liken him to David Essex until Essex got old whence he was described as looking like a young David Essex. Ron was married until eight years ago to Kathy. Unfortunately Kathy finally tired of his intermittent habit of staying in bed all day for weeks at a time and not eating. He's been single since Kathy left and, on account of the fact that he rarely leaves the house, has remained so. You don't get much of a chance to meet people between his flat and the newspaper shop. And besides, 'little Ron' seems to have given up the ghost years ago anyway. Ron lives on his own in a flat on the outskirts of the city. He has a daughter, Chloe, and Chloe has a son, David, who is 17. David sleeps around Ron's when he's been smoking pot or drinking and so he sees his grandson quite a lot.

Ron worked in a bank for nearly 20 years until they too got a bit funny about him staying in bed for weeks at a time. He was a personal account manager and, when he wasn't hiding in a dark room with the curtains closed, was very good at his job. He hasn't worked for four years now. On the plus side this means he has one less thing to feel guilty about when he's on a bad day, but on the negative side the only person he ever sees is his hung-over grandson, and Dave and Jackie, Ron's next-door neighbours.

Ron was diagnosed as having bipolar disorder a number of years ago after he was sectioned for taking photographs of the people who were following him around Bristol. He told the police that Kathy would explain that they were probably secret service, but she didn't and instead he spent two weeks in an inpatient facility watching aggravated people chain smoking through a fug of Olanzapine and Lorazepam. Just recently Ron has been on his way back from one of his more severe depressions. Days of endlessly watching reruns of Ice Road Truckers and Top Gear, and binning letters from debt recovery agencies, were central to Ron's transitional process towards fresh air, walks, watching his beloved Bristol Rovers and even putting in an appearance for the Anchor's pool team. He's still a bit shaky and prone to some very bad days but at the moment the good are outnumbering the bad. His bad days consist of trying to figure out which motor disease is currently causing his shaking hands as a way of avoiding listing his top five methods of killing himself, together with pros and cons. On those days he feels nothing but an agony of emptiness that makes him want to double over in pain. His good days are pretty much anything other than this.

When he's struggling, the utter silence and emptiness of his house allows no distractions from the job at hand, which is summoning up the strength to finally choose one of whatever suicide methods are top of the list that week. When he starts to breathe again though, that house suddenly feels very, very empty.

And it was during one period where Ron was starting to emerge from a particularly prolonged and savage bout of misery that he came across something unusual. He was starting to regain his appetite which meant that he had to go out and get some food. As he opened his door and the sun bounced off his squinting eyes, he second guessed whether this food run was a day or two too early. But he pushed himself on anyway. On the way back from the supermarket he saw a flyer in the library for a local project called 'Bike Minded' which, from what he could see, was a cycling project for 'people who have experienced or are living with mental health problems'. As he hadn't cycled for over 30 years, he was unsure what it was about the advert that caught his attention. A few weeks ago the idea of being on a bike talking to people would have been hell on earth; now it suddenly contained some mystery appeal. Ron was unsure of the old maxim 'you never forget how to ride a bike'. In his case he was more worried about his shorts bursting under the strain of his aging frame, or falling under a car. There would have been times when that would have been preferable but not right now.

So he called them up, and they explained they could help him to get a bike to just get around (which he needed) and invited him on one of the rides. And there was no commitment. The lady he spoke to explained that he could just come for one ride or come along to further rides if he found that he liked it. On the morning of his first ride he was nervous. He'd fished out some old cycling shorts and an over-tight football top. Dave, his friend next door, asked him if anyone unusual had told him to dress like that. Ron understood what he was getting at and explained that his unusual choice of clothing wasn't the result of a new psychosis, but instead a new local bike group he was going to. Dave said he thought that was a great idea.

First Arrival

When he arrived for the ride he suddenly started feeling very nervous, that this was a bad idea. He looked around to see if he could make a surreptitious exit. And then he remembered the flat, its deathly quietness, stillness and emptiness—he'd give it a go. As this was a mental health project he waited for the initial assessment process. He'd had that feeling of being processed a lot, of being put into a category, or diagnosed or put somewhere in accordance with how his mental state was faring at the time. But nobody seemed to be doing any assessing. People were just saying hello and getting ready to go for a ride. In fact it looked just like a bunch of people riding bikes. Ron wasn't sure how he felt about this, but his reflections were pushed aside by the altogether more urgent anxiety of trying to remind himself how to relate to people in this kind of context,[6] in addition to answering questions about himself, who he was, what he did and why he was here, without just saying that he was someone who watched Ice Road Truckers and slept most of the day. Ron had held a lot of identities in the past, husband, father, friend, employee, manager and Rovers Supporter, but these seemed to have faded away[7] leaving only one to ruthlessly command centre stage—that of a 'bipolar'.

The first ride was tough, not so much physically as the ride leaders made sure everyone went at their own pace. It was tough because he had to shake the rust off his social skills and get them going again. But he also knew immediately that there was something in these rides that he liked. He liked the feeling of being able to not talk if he didn't want to. And the novel feeling of giving something back[8] rather than constantly taking, of listening to others who were struggling and offering advice. And sometimes just listening was enough, making them laugh (he remembered that he used to be quite funny when the fancy took him), and the sudden and ephemeral rush of self-worth that invades your psyche when you can reciprocate, help and support other people.[8] He remembered that from way back. And he liked it because it was normal, it wasn't exotic or unknown and it didn't come with side effects (apart from the constant worry over splitting his shorts). And it didn't happen in a stuffy room with strangers. That's not to say that time spent in stuffy rooms with strangers hadn't been useful for him in the past—it had. It was just that right now he was ready for something different. It wasn't perfect; some weeks he'd narrowly miss a car or receive abuse from intolerant drivers. His favourite was the driver who turned his music down in order to give the group a wanker hand sign, as if he needed to hear himself shake his hand.

A Fluid Space

He liked that people didn't know each other's background beyond what they decided to reveal about themselves, mainly because he didn't really like his own background, or at least his immediate history of nothingness and alienation, but also because you arrived there with pretty much a blank slate. Ron liked that the people got to define who they were to others and choose when they decided to define it. Whenever he'd done anything in the past for his mental health, or had anything done to him, he'd always start from a base camp of 'Bipolar Ron' or 'Ron who's hearing voices'. Here he started as Ron the dad who used to work in a bank and couldn't keep his front wheel straight when he was talking to people. This was refreshing.

There were times in Ron's life where he felt that he'd needed someone to actively take on his voices for him, usually when his mind raced so hard that he could barely stand up. But here on these rides, nobody tried to break things down, his low moods, voices or anxiety. Instead they seemed to dissolve, as if stepping on the bike released an invisible safety valve through which things could just slowly seep out into the ether. He noticed that different people came for different things. There was a chap called Callum, a younger guy. He never spoke other than when ride leaders occasionally asked how he was. But that was okay, because he always seemed to enjoy the rides and always came back. Maybe he came on these outings to not speak.

For Ron, these rides were open spaces where he and the others got to decide on the vocabulary that defined things. Whereas previously he carried this bipolar chain-weight around his neck that people had a good look at before anything else, here he was a cyclist, a member of a club, a friend, a listener and somebody that was part of a group. In this context his bipolar felt like it slipped to the fringes of the space through so many chats that normalised what had previously been diseased, exotic, weird and worrying.[9] Misery, voices, worry and isolation came to be talked about as simply a part of life for a number of people in the group—not an easy part of life but no more unusual than happiness, excitement or jealousy.

For Ron it really was a different thing here. The practice of riding, talking to other people, listening, chatting, laughing, and being with others with shared understandings and experiences made it a different thing. And it often made him feel *better.* Not a 'better' that lasted indefinitely; often it was fleeting, as if it was stuck to the people, bikes and words around him and couldn't be picked off and packaged to take home to his flat. On other days it seemed to immerse him and he took it with him for days. That *better* didn't come from him and it didn't sit in him. Rather it was a thing that existed in the assemblage of relations Ron had with other people on the bike, with his own bike, with the atmosphere of the encounter, the memories it promoted and the memories that it subdued.[10]

A 'Humanistic Flexibility'

On one of the rides, Ron's mind drifted back to the first time that he started to properly struggle with his mental health. Sure that he was being followed on the way to the shops, Ron decided to lock himself in his house and cover all of the windows and doors. Dave had popped over to deliver a package but only received a glut of barely sensible warnings about the CIA through a disembodied voice drifting through the slightly open letter box. He finds the thought of Dave chatting to him through the letter box quite funny now but it wasn't at the time. He'd tried to explain to Dave *why* these group rides were so useful but in the context of the above experience he could understand Dave's confusion.

For Ron, one of the benefits of these rides was that the language, the relationships and the expectations were not at any point dominated by the 'technical'. That is, there was what one volunteer ride leader told Ron a 'humanistic flexibility', where the standardised tools, methods, therapies and medications for standardised diagnoses, which could leave some pretty unstandardised people slipping beneath the joins, were replaced by untrained acts of humanity, compassion and support. That is not to say that these encounters were not without forms of expertise in the more conventional sense. In trying, mostly unsuccessfully, to explain to Dave why riding your bike with a bunch of other people could have a massive impact on your well-being, Ron came to appreciate that among many of the routine human practices and exchanges in the groups were real acts of expertise.

It might be the ride leaders or volunteers knowing how and when to pitch a conversation and when to leave riders with some space, and knowing when to talk to people about their distress and when to bring it back to something lighter, for instance, talk about cycling, the ride or other stuff. There was recognition of a need for sensitivity, a capacity to tune into where the riders were at that point and to respond appropriately. To watch how the volunteers and ride leaders worked was, for Ron, to watch a form of everyday mysticism, simply normal people being open, listening, not passing judgement and being supportive. The biggest impact that they had was simply by being themselves, by not being an expert or professional or someone explicitly mobilising techniques or programmes but rather enabling a bit of space and everyday human interactions. In so doing, the biographically situated meaning of what people were experiencing, something that often (although not always) disappears into the ether during diagnostic processes of symptom elicitation,[11] was present at the forefront for those so inclined to share it. A sense of shared awareness, understanding and experience that often wasn't to be found in the very different relationships that people form with professionals and where small acts of practical help like offering food or bike advice could be emotionally significant and help to create a sense of connection between people.[12]

Belonging

Ron noticed the other day that as well as people sitting and having their sandwiches together, people had started to bring in packets of biscuits. Small acts perhaps but ones which confirmed a sense of togetherness and group identity, a feeling of being part of something. This was something new for Ron and some of the others who had spent too long feeling part of nothing. There are weeks where Ron couldn't attend the rides, weeks where his misery got the better of him and limited him to the familiar diary of Ice Road Truckers repeats and cigarettes. But these are getting fewer and further between, and on most weeks it's the big red cross in the calendar that he counts down to, the 'thing' he's got to do, the event where people will notice he's not there, and the one where he'll laugh and be useful.

Like many others Ron is rebuilding a life and this feels like a foundation on which other things are being layered on top of, like the first coat of messy opaque paint before you eventually get to the shiny gleaming coat that other people seem to have and that he used to have. But with more and more rides and more and more coats of paint, Ron started to feel a long-lost sense of belonging—to something, to people and to a thing.[8,13] This belonging meant that through the eyes of the other people in his group he could see himself again, or at least a version that he liked. A version that could care and talk and listen and laugh and be purposeful. This was an alternative social world and he belonged. He was just Ron who liked cycling and had had some rough times.[14] What he was, who he was, how bipolar affected him, whether bipolar was talked about, everything was up for grabs here in these groups. Everything could be redefined by Ron in conjunction with the people around him. Although not always. Whilst Callum never spoke to Ron, or many other people for that matter, it wasn't because Ron was 'in treatment', 'ill' or 'mental'. It might just have been because he didn't like Ron, which was infinitely better. Here in this group he was recognised, he was valued and he could value other people who looked like they hadn't been valued in a while.[15]

'A Nice Atmosphere'

On the way back from a ride one day Ron was thinking about all of the treatments he'd had. Olanzapine, Lorazepam, Paxil, Cetalopram, cognitive behavioural therapy, counselling, sleeping pills, Imipramine and the others that he couldn't remember. Some of them helped. The very best of them probably saved his life. But they all had one thing in common.

Waiting Rooms

This was where he had become a patient. He might walk in from the betting shop or from watching a match at the pub but those Rons stopped. Grandad Ron, Rovers Ron, Ron who loses too much money on the horses, all stopped. Here in the waiting rooms that peppered his memory, 'bipolar Ron' started.[16] As he sat in the waiting rooms he became a collection of symptoms, sleeping patterns, eating patterns, voices heard, moods swung and pills taken. When he got to his appointment he got told to take something or do something or be someone. There was an intervention he could see and that he should follow. And some helped during the darkest days; they really did. But what was 'Bike Minded'? Here he just sat and chatted, just saw people and got out of the house; here he wasn't a mental health person but just a person. Here there was a nice atmosphere and he remembered parts of himself that he liked and discovered parts of himself he had never seen. It was all so ordinary.

All of a sudden Ron was back in the bank in his role as personal finance advisor, with Kathy and Chloe framed on his desk and his colleagues and friends around him. He had his lunchbox in his drawer, food for a body that had a purpose and a reason for needing fuel. People, customers, would come in and treat Ron with status, as 'a somebody'. This wasn't the Ron who disappeared into a world of daytime television and repetitive rituals with the bathroom tap. This was a Ron who could sort people's problems, guide them, mentor them and support them when they needed it most—people in real desperation, whose finances had spiralled out of control, chased by bailiffs and worried about losing their houses and their partners who were living in idyllic ignorance that they were actually broke. And in most circumstances Ron would simply help them to construct a list of financial incomings and outgoings. It looked like the simplest activity. On one level it was. But behind this simplicity lay a story of everyday magic. Here was a person, a customer, who was reaching out for help. And how Ron responded to this request could be life-changing for this client sitting in front of him. And with Kathy and Chloe looking at him, with the lunch that fuelled him in his drawer, with emails on his screen from people who needed to send him messages because he was a person worthy of messaging, Ron would reach back and help them.

Simple things but it wasn't simple—a person helping another to face up to a situation he or she avoided. It could be artful. It involved finding out what they were capable of, helping them to reorient their spending, helping them to address the letters that had built up at the door and most of all, telling them that it was going to be okay if they just did one or two simple things, and then watching the load disappear from their shoulders—watching them breathe again. That was his life. And he recognised it in glances and sometimes more than glances on these rides. He had moved around the desk, from being the person coming to ask for help with his mental health and isolation, about his lack of self-esteem and his confidence, to being the one who talks to other people about their difficulties—from the recent Ron to the old Ron. In so doing he re-awoke an identity that he liked. One who had purpose, who gave to people, who had expertise, and who people saw as having use[17] and having value. He hadn't figured out how to get round to the other side of the table on his own, the side where Kathy and Chloe looked at him as he helped people. Bike Minded did this.

There was expertise at play on these rides, but it was an everyday expertise where technological paradigms and tools and therapies and medications had been sacrificed at the altar of healing relationships[17,18] that were unconditionally positive, empathic and most of all that didn't judge. This was people finding non-clinical ways to manage their mental distress[18]. For Ron nothing and everything happened on these rides. There was complexity there, every bit as much as happens with any technical paradigm. Rides brought to life assemblages of social relations, people, conversations, changes of scene, freedoms, histories of suffering, endorphin kicks and transitioning identities. There was a congress of embodied and embedded social practices that built new ways of being, different ways of knowing and all filtered through an 'atmosphere' of compassion and warmth[10]—no rules, no controlling; it was a microcosm of fluid, situated, relational living. And it was all so unforced because they were on the bike. They weren't sitting around a table in a support group, being routinely thrust into the worlds of others whether they wanted to be there or not. The bike let them pick and choose, dip into conversations and dip out, to relate or to pull away and just look at the road. The bike was an essential part of this practice because it gave them the luxury of time. People weren't there to heal; they were there to cycle and talk, the rhythm of the bike lending itself to convivial chatting, just like other people do, to laugh and take the mickey out of others, to have fun and 'do normal stuff' with people who not only tell you that mental illness can happen to anyone but have lived through it happening to their anyone. And it was also just a group of people cycling together. For Ron this was infinitely better than watching 'Homes under the Hammer'.

Conclusion: Some Reflections on Ron's Experience at Bike Minded

'What then must we do?' This is the question David Smail[19] asked when faced with the central conundrum of psychotherapy. Thus, although the clinic was far from the most appropriate site to address psychological distress, it would be barbaric to subscribe to some form of hyper-liberal, Szasz-esque closure of all therapeutic institutions. And so he concluded that we cannot escape the clinic. Ron's story above was a fictional summarising of the accounts told to us by the users and volunteers from the Bike Minded project. What do these experiences offer the conundrum that Smail and others wrestle with?

What was interesting about the experiences of the people on Bike Minded and what was so key was 'the atmosphere'. The atmosphere was Rogerian in a sense that has been lost in many of the psychotherapies. As Smail notes, Carl Rogers focussed on unconditional positive regard and empathy but in so many psychotherapeutic encounters, these have come to be instrumental tools mobilised to *achieve change*, to move clients from A to B. On a project like Bike Minded, that atmosphere that so many spoke of was the realisation of these factors, unconditional positive regard, empathy and non-judgementalism, as ends in and of themselves. The people who went on rides were not being subject to remote technologies of change that extolled clients to assume responsibility for whatever their set of life circumstances had deposited upon them as embodied suffering.

As Smail notes, much of the time, change is exactly what clients cannot do and not because of incompetence or a lack of motivation. Inherent in the way that projects like Bike Minded operate is an appreciation of this. It is easy, as we frequently do in this book, to compare and contrast the formal and informal settings where psychological care is experienced. But where therapy works best is exactly where a regular bike ride for people with mental health problems is also at its strongest. It is when there is an acknowledgement of the ordinary humanity of social relationships and their mobilisation as a source of solidarity rather than as a setting for instrumental change projects.

The beneficent properties of everyday human encounters exist when compassion and positive regard can be routine and which allow relief to be an emergent product of social relations in a social context[7] that is mercifully free of the tyranny of a fixation with change. Bike Minded highlights how assemblages of people, machines and processes can coalesce into an informal milieu that confers positive identities, feelings of acceptance[5] and feelings of being involved; through which some degree of subjective change is often an emergent property.

There is no such thing as recovery. That is not to say that people don't move from states of extreme distress through time to states of wellness. They do. Just that there is no consensus over what recovery actually means to people who are suffering.[20] Divesting ourselves of the enlightenment fantasy that we can, through our evidence-based tools, heal sick people with mental health disorders does not mean that we cannot usefully support and help people. Instead an understanding that 'environments of recoveries',[20] where complex people with embodied pain can be held by interpersonal environments for a period, seems appropriate. Indeed, 'environments of recoveries' off individuals a space in which they can contribute, be useful, be distracted, be accepted and treated as an equal, providing them with 'places to be'[21] which are embroiled with much needed support. These environments can happen in a multiplicity of places, settings, people, experiences of refuge and escape, to experience a supported socialisation where they are not invisible but not observed,[21,22] with experts and non-experts, and they can be impeded in just as many places, settings and relationships.

Places emerge through social interactions but also through a myriad of interactions between people, machines, textiles and vehicles,[23] and most therapeutic landscapes involve movement away from an everyday domestic location. But recovery can't be *done* to people, Recovery involves learning new ways to perceive and interact with the environment, acquiring new skills, the reawakening of hope after despair, no longer seeing oneself primarily as a person with a psychiatric disorder and reclaiming an at least fleeting positive sense of self,[24] moving from alienation to a sense of meaning and purpose. Environments can be created that may help some people, some of the time. Bike Minded was one such environment.

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5

Fishing and Youth Work, or 'What Is It about Fishing that Makes Life Better'?

Kate Pahl, Hugh Escott, Johan Siebers, Richard Steadman-Jones with Jean Simmons, Marcus Hurcombe, Kirsty, Anglers from Phoenix and Parkgate Junior Angling Club

> Jean (youth worker): I think it is the opposite of your busy life style. You go from busy, busy, busy to sat gazing, I mean gazing, watching the water, watching the float. It is like your whole being is watching the water, watching the float. To go from the very first day, like I said to go from all of these kids going from a different community, to beside the water, they went from hating each other, to being around the water, the transformation was—I was totally gobsmacked at the transformation. If this can do this for young people then all young people should have the benefit from it, whatever background you are from, whatever school you are from whether you are a girl or a boy, none of that comes in to this no prejudice. (Discussion November 2013)

Our chapter is about the benefits of fishing for young people who might be having a hard time, particularly those at risk from bullying or anxiety issues. We describe a project where a group of young people went fishing every week, and, together with some academics, an artist, a poet and a

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philosopher, plus some helpful youth workers and fishing coaches from an angling club, attempted to answer this question:

> *What is it about fishing that makes life better?*

Below we tell you about our project, but meanwhile, here are some thoughts from Kirsty to give you an idea of what fishing can do for young people who experience mental distress. Kirsty (aged 14) talked to Kate (one of the project team) about why fishing is good for young people. In a conversation with Jean, a youth worker, she told us what it meant to her:

> Jean (youth worker): Kirsty had never been fishing before in her life and she loved it.
> Kirsty: I had never been before and it were something new. I liked it because of how calming and peaceful it were, to just sit there. It's just peaceful and it takes your mind off other things.

One of the things fishing could do was to put children at risk of bullying or feeling down into a different place—as Kirsty explained here (Fig. 5.1):

Fig. 5.1 Kirsty catching a fish

> The thing with fishing, projects like this, it gets kids off the street instead of—kids my age can be sat by the side of the riverbank instead of being out late at night. When they are sat by the side of the riverbank they are like, admiring the nature of the place. Fishing ain't gonna solve a problem but for the amount of time you are doing fishing it takes your mind off a problem, because its focusing on what you are doing. (Kirsty)

Our key argument is that activities like this, which slow you down, are quiet and meditative, and in natural surroundings, are important for young people and they give them something special.

How We Got to Write the Bid

Our story began when a group of boys came into the youth centre one day. Kate (co-author) and Marcus (youth worker) were chatting. The boys began to be a little bit aggressive and also mention some involvement they had in Far Right activities. I was wondering about doing something on fishing and asked the boys for help. Immediately the group became calm and helpful and started to create a shopping list from their own experience of going fishing with uncles and fathers, for what we would need, which we immediately wrote into the bid as follows in the Justification for Resources section:

> *Other Directly Incurred Costs:*
>
> A £1000 provision has been included for the purchase of fishing tackle to be used during the situated encounters, for use by participants. This sum includes floats (£12), poles (£70), rods (£50), reels (£30), nets (£20), landing nets (£15), keep nets, bait (£50), hooks (£12), a box (£60), keep net (£15), whips (£15), fishing licenses (£35) licenses for under 16's (£5) and shot (£15) for 6 young people.

This bid was considered at an Arts and Humanities Research Council (AHRC) panel meeting and the money was secured. The young people had helped write an AHRC bid. When young people's skills and expertise are repositioned and valued, they are able to offer things to society. In our fishing project we could look at ideas about hope, resilience, purpose and the meaning of life, but locate these ideas through the experience of going fishing together. Fishing can provide a way of being that calms young people down, and, as Marcus said, 'they throw away their cigarettes and don't answer their mobile phones'. The experience of fishing is profoundly calming, as Jean (youth worker) and Kirsty (young person) describe here:

> Jean: I can't describe the tranquillity that comes over you when you sit on that seat. Whatever you are thinking, whatever is bothering you prior to sitting on that bank, it goes that way, and you are sat here, and it is you are in this big bubble…
> Kirsty: You just go into your own world…
> Jean: Proper special bubble with your own thoughts, ideas, no pressure. I don't like being in large groups of people. We are just normal people who see things differently. There is no pressure from people, nowt at all, if you catch one it's a bonus… The school day is so structured. In fishing there is no structure, you just plonk your stuff. So do you think it is the freedom of no structure and no pressure? Total me time?

Here, Kirsty and Jean describe the experience of fishing as being in a 'bubble' and providing an unpressured space, that is 'me time'. It provides a sense of tranquillity in a crowded world.

So How Did Our Project Get Started?

Our project 'Communicating Wisdom: A Study of the Uses of Fishing in Youth Work' was developed in partnership between youth workers Marcus Hurcombe and Jean Simmons from Rotherham Youth Service and the Rotherham-based Phoenix and Parkgate Junior Angling Club, together with a group of academics.[1] Through co-produced research the team tried to better understand how the reflective space of fishing provided a place for valuing the know-how that is situated within

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[1] Johan Siebers, Philosophy, University of Middlesex, Richard Steadman-Jones at the School of English and Kate Pahl and Hugh Escott at the School of Education at the University of Sheffield. The team included a poet, Andrew McMillan, and a visual artist, Steve Pool. The project was funded through the Arts and Humanities Research Council's Connected Communities programme.

communities and that challenges established ideas of wisdom, skill and knowledge. We worked with young people and older anglers in order to reposition knowledge and understanding of the people who went fishing. We wanted to find out about the kinds of learning, communication and reflection that take place in the angling space.

The project engaged young people and older people in intergenerational learning and explored the idea of how knowledge and skills are shared. Rather than seeing young people as without skills, in this project, young people were able to reposition themselves as skilled fisher people with the support of older, more experienced anglers. Young people came to a quiet, reflective space where they could forget about difficulties at home or at school but were able to sit still and watch the water. The project was part of the youth service's anti-bullying work, and, in particular reflected the work of youth worker Jean Simmons, who was keen to support young people who felt vulnerable at school and ran an anti-bullying scheme. Fishing, she felt, was the ideal activity for such young people.

We think fishing is important in creating contemplative spaces for young people. These spaces create opportunities for young people both to reposition themselves as able and skilled, and also to become calm. Fishing offers a possible space for positive mental well-being. It is where young people who might be experiencing bullying, problems at home or some mental distress can experience wellness. Recent research has shown that while bullying is often identified, 'how to' strategies for supporting young people through bullying are less often described.[1] Fishing can provide an alternative space for young people going through troubles at home or at school.

What Did We Do on the Project?

In our project we drew on participatory methodologies that incorporated visual and sensory ways of knowing to understand what fishing meant to young people. Young people made films about fishing to show to others. We incorporated a particular research methodology by which young people were co-researchers with the project team about the benefits of fishing. Kate Pahl and Hugh Escott from the School of Education, University of Sheffield, accompanied the young people fishing, and wrote ethnographic field notes after each trip. These were coded and analysed by theme. The fishing trips, where young people met with anglers who coached them in fishing, ran weekly from early May of 2013 to late July 2013. Follow-up discussions about the project were held in November 2013. The team also immersed themselves in the practice of fishing and read books and texts about fishing. The young people created films about the experience of fishing and wrote about fishing and its benefits.

Hope and Making Sense Together

In our work, we focused on ideas of hope, wisdom and fishing. Johan Siebers worked with the concepts of Ernst Bloch, a philosopher.[2] Bloch's major work, 'The Principle of Hope', written over a period of years between the 1930s and the 1950s, was concerned with a philosophy based on hope. In our project, the aim was to translate Bloch's text 'On the Concept of Wisdom' with a focus on the relationship between fishing and wisdom. Bloch's conception of wisdom, which tries to activate the motivating kernel of hope in our lives, is particularly well suited to understand the healing effect of 'contemplative' activities such as fishing in a contemporary context. Blochian wisdom is always a communal wisdom; it points towards a shared agency, shared in our case especially between young and old, and empowers everyone equally to act for a better life and a better world. We could apply these ideas to the gentle learning that took place between the anglers (often the same age as the young people's grandparents) and the young people.

The young people, the ethnographers, the artist and writers together with the youth service and anglers, made sense of fishing together. The concept of making sense together comes from the work of Somerville[3] in thinking about sense making through place and learning through landscapes. We considered the experiential aspects of fishing, and drawing on visual ethnographic methodologies from Sarah Pink's work,[4] the project team were able to immerse themselves in the experience.

Learning by inhabiting the landscape, and thinking through this process, became the way ideas were generated.[5] Rather than see the research as external to the project, the experience of doing the project generated the research. This perspective comes from arts-based methodologies, for example, the idea of practice as research.[6] Knowledge created in this site was informed by the material properties of the site, of the embodied knowledge created there. This idea of 'material thinking' comes from a different place of practice, where the meanings and experience generated inform theory.[7]

Skills and experience resided within the anglers, the young people, their families, and in the community. We considered the community 'funds of knowledge'[8] as important when setting up the project, and saw the skills, knowledge and experience encoded into the fishing process as important resources for hope and sites of possibility. We recognised that the young people were in the process of becoming adults[9] and drew on the work of James in seeing young people as agentive and skilled in their everyday lives.[10] We do not position young people solely as being in distress, but consider, from their perspective, how fishing can support well-being and resilience to withstand difficult life experiences such as bullying and problems at home or at school. Fishing as an experience offers a safe space away from the dangers of the street as well as difficult home situations.

Here, we talk about aspects of fishing that we think are particularly important when working with young people. We begin by talking about fishing as *knowledge exchange*. The young people we worked with brought their store of knowledge to the fishing project and exchanged these ideas with the angling coaches as equals in the process. The angling coaches respected and supported their knowledge. We then talk about fishing as a *calming and contemplative activity*. It can be seen as a *mode of being*. Finally, we think about *fishing and beauty*. We argue that aesthetic and embodied experiences of beauty are important in mental health recovery. Our writing is constructed between field notes written by Kate Pahl and Hugh Escott, conversations with young people, writing by young people and by youth workers, and includes our thoughts and ideas generated through sitting on the bank of the pond fishing.

Fishing as Knowledge Exchange

The fishing project was supported by a group of experienced anglers who taught the young people to fish. The nature of this teaching was tacit, embodied and supportive. The project opened a shared space for the participants to reflect on the complex meanings that lie dormant beneath the surface of a familiar activity. The project focused on how knowledge can cross between and develop within communities of practice that share a very different vocabulary and sets of priorities. Of particular interest was the way in which different kinds of knowledge surfaced across the project, and hierarchies of knowledge were destabilised. The concept of the academic as 'knowing best' was contingent within a wider structure of thinking. Wisdom, in this case, the lore and understanding of fishing, could be found within the anglers, or within the young people. Part of the project involved writing field notes, which documented sitting by the pond watching young people fishing. In the field notes, discussions were recorded which showed how fishing could be a site of knowledge exchange.

Conversations about fish between the coaches and the young people tended to have a quality of exchange rather than instruction. Here is an excerpt from our field notes, where Hugh (ethnographer) is discussing with Jordan (young person) and Terry (angler) about whether a fish is a particular kind of fish, called a rudd:

> When he caught a fish we discussed whether it was a rudd as it had an orange eye. When I came back later and he caught another fish he showed me how rough its scales were and pointed out that the other fish was really slimy, we talked further about the fish's eye. I asked him if the fish was a rudd because I was trying to learn them and Terry had pointed out the orange eye to distinguish them. Jordan was a little unsure but when he caught the next fish with the rough scales he made a point of showing it to me and discussing it to make sure that we were right when we said that rudd had orange eyes. (Hugh Escott, field notes, June 2013)

Here, the discussion is contingent on observation, and knowledge exchange, with the young person, Jordan, becoming the expert and the ethnographer the novice. We found that fishing could be regarded as a different kind of knowledge from 'schooled' knowledge, one that required recognition of different kinds of expertise. For example, here is an extract from Hugh Escott's field notes where he is talking about the skill of fishing with Reece (a young person) and Terry (an angling coach):

> When Reece caught a fish I took the opportunity to go and sit with him and Terry. Terry spoke at length about coaching and fishing. Especially about how you can tell in 5 minutes if someone has a natural talent for snooker or football but you can't tell if someone will be a natural fisher. He spoke of people he knows who aren't 'very bright' but were incredible fishermen. All the while he was watching over Reece's shoulder and discussing what he was doing with him. Reece joined in with what he thought about certain aspects of fishing. Reece spoke to me for a while about his success in match fishing and his preference for carp fishing which Terry also preferred. (Hugh Escott, field notes, 23/04/2013)

The coaches were respectful of the young people's expertise while at the same time providing deep expertise in the craft of fishing. In our project we were able to differentiate between different sorts of wisdom, 'school' wisdom and 'life' wisdom. Johan Siebers helped us understand the different types of wisdom, as shown here:

> The investigation of wisdom as a form of life, as a reality of the life everyone lives, is one way of looking at the objective of the fishing project. The ethnographic material we gather can be read through the lens of the question how wisdom is communicated, manifested, present, in the experiences researchers and participants have with the practice that we are exploring. In an approach that is reminiscent of grounded theory, we do not want to bring a ready conception of what happens in this practice to the interpretation of the material, but rather we want to let the material speak, bring its own contrasts, dynamics and distinctions[2]

Here, we recognise the wisdom that the young people themselves hold. While sitting watching young people fish, I (Kate) was frequently aware of how bad I was at fishing and how well the young people fished. This required concentration and the ability to keep still and be quiet, so as not to put the fish off. I (Kate) watched Dylan, for example, one sunny afternoon:

> I decided to sit on the bank and watch Dylan. Dylan sat very still. He dropped his line very low in the water. He watched and did not do anything else, speak or chat or move. Every so often he would catch a fish and he would bring it in, carefully, inspect it, take the hook out and throw it back in. Once or twice he needed the landing net. When he caught a fish he drew it in quietly and gently. He did not boast or show other people. It was part of the process of fishing. (Kate Pahl, field notes, 04-06-13)

This piece of observation repositioned Dylan as a quiet source of knowledge and skill. The other anglers admired Dylan as a fisherman and thought he was very talented. I (Kate) realised that I was the person in need of coaching as I tended to talk too much and scared the fish away. Young people became repositioned as experts within the fishing community. They were able to provide coaching for the research team, and helped us understand the process of fishing.

> Dylan told me to fish between two patches of lilies and very quickly I caught a big rudd which Dylan said was a fat one. I asked him about fishing and he said he fished in the canal near Asda a lot and that he went fishing a lot with his uncle. (Hugh Escott, field notes, 07-05-13)

Many of the young people learnt to fish with older relatives such as uncles and grandparents. The presence of inherited wisdom in the areas where we were doing the project, that were characterised by being ex-mining areas, and considered as areas of socio-economic deprivation, was important in repositioning the knowledge and skills of the community. Rather than seeing the community as ‘lacking’, the community could provide skilled knowledge that was of benefit to young people’s well-being and mental health. As a team, the older anglers supported this process and quietly coached the young people to achieve their potential.

Fishing as Calming and Contemplative

> …the very sitting by the Rivers side is not only the quietest and fittest place for contemplation, but will invite an Angler to it[11]

All of the project team found that fishing calmed them down and helped them with life. While sitting on the side of the pond where we were fishing, Hugh engaged young people in conversation about the benefits of fishing. Here is an extract from his field notes:

> I told Jordan that he was now my co-researcher and that he was better at researching than me. We talked about what he had been doing and then we walked round the other side of the pond with Marcus to get some video of everyone fishing. Kieran came with us and Marcus, and he talked about fishing. Kieran talked about how it was calming. (Field notes, 18/06/2013)

Hugh observed that the topic of fishing being calming and tranquil is something that everyone discussed. In our discussions, we explored why fishing is so good for mental health and resilience and how other young people can benefit from fishing. In a discussion with Kirsty, aged 13, and Jean, youth worker, together with Kate, researcher, about the benefits of fishing from their perspective, Kirsty observed:

> Kirsty: I had never been before and it were something new. I liked it because of how calming and peaceful it were, to just sit there. It's just peaceful and it takes your mind off other things (Discussion, November 2013)

Jean, youth worker, likewise observed:

> Jean: Coming into fishing offers alternative mode of being. There is no pressure at all. There is no pressure to catch a fish. (Discussion, November 2013)

When discussing fishing, the youth workers and the young people talked about the special effect of sitting by the river bank. Many of the young people talked about the calming effect of fishing and how it alleviated their stress. Young people, especially the young women, talked frequently about the dangers of being out late and night and being on the street, and these feelings were borne out by the recent report on child sexual exploitation in Rotherham.[12] Rotherham at night was not a safe space for young people. The benefits of fishing as a stress buster was also echoed by the boys, who talked about how fishing calmed them down, and helped them forget problems at home. Youth workers also found fishing helped them in their work and also supported their anti-bullying work, particularly with girls.

Fishing does not require talking; rather, it requires concentration. In that sense, fishing can be seen as a form of mindfulness that supports focus and quiet. Fishing was perceived by the youth service as offering opportunities to deal with wider issues of mental distress such as bullying and problems at home. In the extracts below, Jean and the young people were talking about bullying while fishing:

> Whilst I [Hugh Escott] continued to fish Jean, Chantelle and Ellen talked about bullying. Both Chantelle and Ellen had been bullied and Jean has worked with them to address this. Jean was telling them that they should just ignore bullies and Chantelle and Ellen talked about bad approaches to bullies. The bullying conversation started because Ellen said that she had heard about someone hanging themselves because they had been bullied. Chantelle said that she would like to set up a company that dealt with bullies and helped young people. I asked some questions about bullying and Jean and the girls explained what they did to work on self-esteem etc. (Field notes, 07-05-13)

From a youth work perspective, fishing was important as it offered a space to talk to young people. Hugh describes below his conversations with Jean, youth worker, about the girls and the importance of the girls fishing:

> I talked to Jean about how it made a lot of sense that she brought the young people fishing as I saw how it caught the attention of the louder kids but there was a space to talk to others, like the girls, who had lower self-esteem. Jean described how one of the young girls had been dissuaded from going fishing by her dad, saying, 'that's not for people like us' (people on benefits).
>
> I said that I could see why older people could be jaded but that it shouldn't interfere with a young person's potential. Jean thought that it was important for someone like Chantelle to follow her dreams and that she thought that coming fishing was the only thing that Chantelle got to do

> away from her family and that she hoped she would come again. Jean also said that Chantelle had said to her last year that fishing was like a dream. (Field notes, 21-05-2013)

Fishing was described by the young people as providing a space 'like a bubble' and being a safe space. The dream-like quality of fishing is echoed by the work of Ernst Bloch, who highlighted the importance of the day-dream in creating the conditions for hope and possibility.[13] Fishing was a form of 'possibility thinking'[14] as it was about the hope of catching a fish.

Fishing as a Mode of Being

Our team included ethnographers, young people, artists, poets and philosophers. However, one of the very complex aspects of the project was the way in which the young people were confronted with the reality of possible death. When it came to disgorging a fish—that is, take a hook out of the fish's mouth—young people sometimes became anxious. However, if this anxiety was overcome, it could also be a positive experience. Hugh described this experience:

> Ellen caught a tench [type of fish] and I had to help her disgorge it, I did a bad job of it and Ken had to help us. He called the fish a bar of soap because young tench are really slippery because of their mucus.
>
> Chantelle caught a big tench and we struggled to disgorge it. Ken had to come and cut the line because the hook had got so caught in the tench's lip that we could only pull the line out once the line was cut.
>
> Ken (angler) was very calm and relaxed and we all watched patiently as he produced some scissors from his pocket and cut the line. After we released the fish it dropped on the floor which was a bit distressing for us all as it had been out of the water for a long time. (Hugh Escott, field notes, 30/04/2013)

Here, the real possibility within fishing of the death of the fish is foregrounded. At the same time, Hugh was acknowledging the distress that the young people felt when unhooking the fish. We noticed that with young people, who might be experiencing mental distress in their lives, this paradox of catching a fish and then dealing with its life or death was important in relation to mental health. The experience opened up a new kind of mindfulness, which was both about hope and the experience of success (catching the fish) but also about the real possibility of the fish losing its life (death). Within that space, the young people have to engage with the reality of possible loss. Within the field work we have done, these issues of life and death, and losing animals have recurred over time.[15] While schools often might not want to deal with the realities of death, in fishing, these issues were present, but also held in the balance. We argue that the 'near-death' of a caught fish instils a sense of responsibility and care in young people. This perspective links with a perspective that sees fishing as another mode of being. It is a space of practice which presents its own ethical issues which are separate from, but also relate to, the young people's daily lives.

Life (as in being alive) is also very present in fishing. Video games and other electronic equipment, even mobile phones, were forgotten when the young people sat on the bank. They had to focus on the water, and watch the float. Here, this extract from Hugh's field notes shows how the experience of fishing contrasted with playing video games:

> Marcus (youth worker) linked this catching of a fish to aspiration and realization, he also got Jordan to talk about how he found fishing relaxing and how he dealt with stress or unhappiness (emotional intelligence), Jordan and me talked for a while about video games, he asked about my video camera, Marcus linked video games and fishing by talking about the sense of reality that fishing creates and how it is difficult for people who play loads of video games to understand what is virtual and what is real. (Field notes, 18/06/2013)

The concept of the 'real' and the alive world of the fish was very important to the young people. We began to see how young people could be given a way of being through interaction with the fish that helped them become calm. Mental distress could be alleviated by paying attention to the externally beautiful moments of watching the float, and catching a fish. The mental focus of fishing was on the moment, and on recognising what it meant to catch a fish and then return it to the water.

Fishing and Beauty

> Martin said he had got up at 4.30am that morning and he had gone fishing. He said Steve [the artist] would have liked it as the mist rose in the water. (Kate Pahl, field notes)

To sit on the bank of the pond and watch the dancing flies, the sparkling water, the light on the water, is a profoundly beautiful experience. What is clear to us is that aesthetic aspects of fishing, the contact with nature, the slowing down of activity and the need to remain quiet, are integral to its ability to provide a space of contemplation for young people who might be having a hard time.

In the process of doing the project, young people and the youth workers described the experience of fishing. In these descriptions, the aesthetic experience of fishing comes to the fore. Silence, contemplation and stillness, as well as beauty, become core parts of what it means to fish. Passing on fishing from generation to generation required an aesthetic appreciation of what that might mean, how fishing is taught and transmitted. This is a different way of knowing from an instrumentalised notion of skill and wisdom, but is more situated and contingent upon experience.

> Jean (youth worker): The beauty envelops you, the sun reflecting on the water, the little midges above the water, reflections in the waves, little frog, birds, and then you get the almighty snake swimming past, as much as the sun shining on the water, we have sat under an umbrella, it were pouring down, we didn't care did we, we were sat in it, weren't we, we didn't care. We wanted to catch a fish weren't we? It were pouring with rain—that's another world, the pitter patter and pouring off edges and then you see it from a different angle (Discussion, November 2013)

Kirsty[13] echoed this with her own comment:

> Kirsty: Fishing helps you because it calms you down when you are sat there. What I found, with the pond, when I was watching it, I was really calm just watching the water. When it were like spitting a little bit it looked amazing on the water because it was so peaceful, you could see the little rings just spreading out. (Discussion, November 2013)

Here the poetic elements of these descriptions, the ‘spitting’ of the water and the sun reflecting on the water, permeate the experience of fishing. In films about fishing, light bounced across the water, and the heat and sunshine made the experience rich and meaningful.

Conclusion

As I (Kate) write this, my heartbeat slows down and the world gets more silent. Traffic stills and I no longer feel the need to surf the internet, and go on Twitter. Instead, the momentary pause of fishing envelops me. In our joint work, with young people, youth workers, artists, poets and philosophers, and anglers we go beyond university spaces, into our own embodied experience. By ‘learning through country’[3] we are able to fully enter the experience of gazing into the water. We learn too, along with the young people. Boundaries of expert and instructor dissolve, and we combine our ways of knowing in a situated experience of loss, rebirth and hope.

The implications of practice for young people with mental distress include the need to focus on the heritage, skills and practices young people bring when working across generations. Knowledge exchange becomes a way of being, so that young people can exchange knowledge with their elders in equitable settings. Community knowledge, often hidden from academic domains of practice, can become important in these contexts. The importance of calm, contemplation and mindfulness for young people is emphasised in this project, whereby the slowness of the activity and the need to be silent and still, instils a quiet and peaceful feeling. The beauty of the surroundings also plays an important part. The wisdom in fishing involves an understanding of the terrible prospect of death, as the fish is caught and held, as well as the possibility of life. These inherent possibilities of fishing create spaces of transcendence and hope for young people to live within. The space of fishing is one of co-learning across generations. It is accessible for working class young people who might not access beautiful natural spaces without this support. Fishing offers a world of silence, contemplation and beauty that is also accessible, inclusive and congruent with what young people do with their uncles, grandparents and fathers. Fishing is situated, draws on everyday

Fig. 5.2 Dylan's fish

knowledge in communities and is located in the spaces that young people are. The emphasis on quiet and silence, which is important as that is how you catch a fish, enables young people to zone out and have their own 'bubble' or 'me-time'. Best of all, you get to catch fish.

To end, here is a conversation between Jordan and Reece about fishing (Fig. 5.2):

> *Two boys are disgorging a fish:*
>
> *Jordon*: What can I say….This is Jordon interviewing Dylan at Bakers pond. He has just caught a nice fish here. This is him trying to get a hook out of its mouth which he's pathetic at (pause)
> *Dylan:* 'Pathetic' Jordon is such a negative word
> *Jordan:* Is it out yet?
> *Dylan:* No it's not
> *Jordon:* Pull it hard?
> *Dylan:* Every time I try to pull it out it goes back in
> *Jordon:* Does he want that maggot?
> *Dylan:* Yeah

Jordon: I were asking what he likes about fishing and what calms him down, stuff like that
Dylan: Stuff like that (train sound)
Jordon: What calms you down when you're fishing?
Dylan: When I catch summat like that! When I catch nice decent size fish. (Transcript from Jordan's film)

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6

'Helping Them Hold Up Their World'—Parents of Children with Complex Needs and the Beneficent Organisation

> …preparation, organising yourself, identifying outcomes, what you want to get out of meetings or from the services, to empower parents to do it themselves or just be there in the background helping them hold up their world, you know (Manager, Amaze)

In a lovely article on many of the inherent contradictions of being a clinical psychologist, David Smail[1] said that 'we cannot escape the clinic'. When it comes to helping people experiencing mental distress, it would be a callous society that stood back and offered them nothing on the presumption that, as Charles Waldegrave points out, therapy is little more than making poor people feel a bit better about themselves.[2] Perhaps the problem however is not with therapy per se but with what therapy has become. The therapeutic relationship, when understood as an instance of ordinary humanity and as a source of solidarity *can be* eminently valuable. When it is treated as a technology of change with a progressive emphasis on what's inside people's heads, and that culminates in people becoming patients schooled to bear responsibility for circumstances beyond their

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control, then it loses its value.[1] If we pare back the therapeutic process to understand Roger's unconditional positive regard and empathy, not as tools to achieve change, but as an end in and of themselves. We arrive at a position where compassion, rather than change, becomes the overriding impulse allowing us to see just how many other sites of social solidarity, compassion and humanity, can be understood within this broader care framework. This is because empathy, support, positive regard and compassion can be delivered in most places, by most people.

Just recently a local organisation that works to support the parents of children with complex needs asked one of us if we might be able to help out with some work that they were doing. Amaze, a Brighton-based charity, were hoping that they might explore the impact of their services on the parents who use them. Specifically they run a service called the Disability Living Allowance (DLA) project which they said contributed to a reduction in poverty in the local area. Believing that they would expect academic things from us, we duly did some academic things. We did a literature review of the experiences of parents of children with complex needs. The organisation had told us that by complex needs, they were referring to children with a range of physical and behavioural difficulties, diagnosed or undiagnosed. Sure enough we were confronted by an array of papers that appeared to indicate that the parents of children with chronic pain, developmental difficulties, physical disabilities and behavioural difficulties are more likely to experience a vast range of suffering and disadvantage, including depression, anxiety and illness.[3,4] It also seemed to be pretty uncontested that if you have a child with some form of disability, the child will be more likely to grow up in poverty.[5]

> They used to feed him at school, obviously I have him all the time now and that has an impact on how much food I've got and then there's washing clothes and things like that because he's been a bit incontinent and he has got better but sometimes he just can't control things like that (Deborah, parent)

On top of this range of stresses and pressures, it also appears to be the case that parents often receive a poor deal from their interactions with health professionals. One of the problems with categorising people[6] is that we then tend to assign more value to some people than to others. And when a system of knowledge assigns less value to someone, you can also be sure that those who subscribe to it—be they academic, medical or the public—go on to assign responsibility for this low value. Previous work seemed to suggest that, as with so many indicators of poor social performance, it was the parents who were routinely blamed by other people for their failure to produce and manage 'typical' children.[3]

Another potential problem frequently encountered by parents of children with complex needs is that they and their children find themselves becoming objects of intense observation and documentation—a process reserved for those who perform outside of the 'typical' range. The tools of objective science (e.g. questionnaires, categorisations and inspections) are generally agreed to be the best way forward to try to put in place support for these children and their families. One potential problem is that these tools privilege those with expert scientific and/or technical knowledge. So parents often find themselves encountering paediatricians, psychiatrists, psychologists, counsellors, nurses, teachers, SENcos (special educational needs coordinators), head teachers and other professionals who frequently discuss their children in inhospitable environments where parents' knowledge—failing as it does to embody the authority of science—can be neglected, sidelined and disqualified.[3] That parents spend almost every hour with their children, observing them, caring for them, devising ways to help them to develop, be content and comfortable, and have built up a huge reservoir of detailed knowledge of their children, is often lost or marginalised in this system. They are often deemed incapable of objectivity, and with less experience in the languages of medicine, law and education that are often used to describe their child, this means that their huge reservoirs of knowledge and understanding can be marginalised into bit-part roles that one may, at a (big) stretch, refer to as 'Participation'.

And so one of the first things we learnt from carrying out interviews with many of the parent carers from Amaze was that their experiences agreed with the literature above. Many had experienced exclusion from decision-making and were struggling financially. For many, the marginalisation, isolation, stigmatisation, financial strain, loneliness and exhausting vigilance of complex regimes of care gets too much.[7] Many had experienced periods of prolonged and debilitating distress, coupled with feelings of despair and helplessness.[4,7] All of these parents had at some point found themselves sitting in their GP surgeries talking about 'depression' or about 'anxiety'. At the end of this appointment, they would be referred to taking antidepressants or talking to a counsellor. These conversations about pills and therapy were thought necessary because it was often assumed that neurotransmitters and/or negative thoughts and feelings were the primary *cause* of their difficulties rather than, for instance, a consequence.

> Yeah, I've been prescribed sleeping pills for probably about five years, and back and forth, and they've spoken to me about, well you know when are you going to come off of these, and I say well you know what I've got at home. They all know [child] at the GPs'. And you know, in some ways I'm just sort of thankful that I'm here and I can look after [child] and you know, if the price is sleeping pills, well so be it you know (Penny, parent)

Let's at this stage engage in an (admittedly limited) thought experiment. Below is a table of the various experiences that many parents of children with complex needs often have. Under the assumption that most parents will be directed to psychotherapy or medication, let's think through which of the following we think are most likely to cause the high mental distress, low mood, exhaustion, desperation and hopelessness that many experience.

Social explanations-actual things happening in their lives	Biomedical explanations-things we think are happening in their heads
Anger, impotence, frustration and the need to battle hard to have their knowledge and opinions taken seriously by schools and medical professionals who deemed them unfit or unsuitable to pass comment on the care of their child.	neurotransmitters and negative thoughts/feelings
Having to stay up through the night because your child can't sleep; of having to sleep on the door mat at the front door to prevent your suicidal 13 year old daughter disappearing for a month in London again	neurotransmitters and negative thoughts/feelings
Being excluded from the workforce due to care responsibilities, of being prevented from earning a living wage and from having a group of colleagues to talk to, share experiences with, moan about the boss with and laugh about the email attachment that made Colin in accounts look like Shrek	neurotransmitters and negative thoughts/feelings
Soiled sheets at night, the endless need for special clothes and toys, expensive forms of transport, special dietary requirements and a failure to afford suitable, specialist childcare	neurotransmitters and negative thoughts/feelings
Trying to carve a life around a three year old daughter with Tracheomalacia, vocal cord palsy and a laryngeal cleft, for whom at least once a week, you provide CPR to on the floor of your flat when she stops breathing	neurotransmitters and negative thoughts/feelings
Explain to your 11 year old daughter, newly diagnosed with ADHD, who is crying about the fact that nobody at school talks to her, nobody invites her to parties, and who tells you that she is worthless and wants to kill herself	neurotransmitters and negative thoughts/feelings
Endless financial strain, the grind of poverty and debt, crippling exhaustion, desperate loneliness and guilt	neurotransmitters and negative thoughts/feelings

Okay, it's time to confess. These comparisons are silly because of course it isn't an either/or. They are of course *both* intimately linked to the embodied, visceral distress that many people experience. But only one can really be understood as causal. Cognitive and biological aspects are secondary to the social, material and discursive relations that cause people to be distressed. All experience is *enabled* by biological capacities which constitute our embodiment in the material world. But these biological capacities do not *cause* these things. Distress is an acquired, embodied way of being in the world[8] and it is one that means that every parent we talked to was taking, or had very recently taken, antidepressants.

When discussing the reasons behind their distress, there was certainty that the range of extreme challenges that they had experienced as a parent of a child with complex needs played a significant part. They were overwhelmingly of the opinion that the sadness, apathy, tearfulness and inability to sleep that the doctor had called depression might just be related to the range of traumas, social dislocations, oppressive relationships, isolations and strain of poverty and disadvantage that had gone on for so long. They described going to the doctors because they were at the end of their tether, running on empty, or having had enough. Of course as we all know, 'being at the end of your tether' isn't technically an illness. But it can be converted into an 'illness' and an illness that needed treatment. Experiences of distress are often understood as symptoms, but they can be better understood as complex attempts to maintain survival, dignity and integrity in the face of past and current trauma.[9]

So does every parent of a child with complex needs end up distressed enough to visit their GP for treatment? No. But an awful lot of them do. These parents described repeated breakdowns and the seemingly inescapable need for medication to cope with their everyday lives. They saw medication as the cost of being able to look after their children and saw it as inevitable that if you have a child with complex needs, you will suffer from prolonged distress and will almost certainly be on antidepressants.

> Of course, many of the parents, myself included, have serious depression. I was very depressed when my son was diagnosed and yes, when the school summer holidays and vacations are coming up all our parents from the support group say 'OK, it's time to be alone again.' [Laughs] So it is a lot of stress, many antidepressants, it is normal to be on antidepressants (Donna, parent)

However, something else interesting transpired from these conversations. It turned out that there was another therapist in the midst and quite an odd one at that. As a therapist she was pretty disinterested in norepinephrine, serotonin and synaptic clefts. Okay, maybe no surprise there. But she was also pretty disinterested in cognitive distortions and cognitive behavioural therapy. This therapist hadn't received any professional training in mental health and didn't seem to know much about it. Now at this point some of you might be thinking about evidence-based practice and the National Institute of Clinical Excellence (NICE), wondering why this irresponsible person hasn't been struck off.

Except it isn't a person. This therapist is a community and voluntary sector group led by parent carers and they have struck upon the therapeutic approach of helping people with the things they are actually struggling with.

Meet 'the Therapist'

Amaze is a registered charity active in the Brighton and Hove area. Their mission is to inform, support and empower parents of children with disabilities and complex needs. The organisation is parent-led and works with parent carers of children with any complex need or disability aged 0–19 years. It runs a number of services and projects, including a DLA project, which tackles poverty and social exclusion. This project aims to maximise take-up of disability-related benefits amongst families with disabled children in Brighton and Hove, by providing a trained volunteer to support parent carers to complete successful DLA applications. This is particularly important since many of the approximately 7000 children in Brighton and Hove diagnosed as having complex needs live in the poorest parts of the city, and because over 50 % of disabled children live on the margins of poverty.

Typically, trained volunteers visit parents for between three hours and a whole day to work through the completion of the form. The project was set up to aid the many parents who were unsuccessful in their claims for child DLA support, not because their range of experiences didn't merit it, but because they did not know how to complete the 41-page form in such a way that maximised their chances of a successful claim. In 2005 Banks and Lawrence suggested that 97 % of people found it a difficult form to complete and over 40 % of claims are incorrectly rejected due to the complexity of the form.[10]

So essentially the DLA project helps people to fill in a form. And this seemingly minor intervention, helps people to feel better. This 'therapist' was helping parents to unpick and disentangle their multiple challenges and overcome the various elements of their constellated disadvantage—not all, not by a long way, but some, and in so doing was making a huge difference to their daily lives.

> And we just, we just went through it and I, I, well then I began to realize well actually, he teased it all out. He then gave it language, he was then able to link the things that I couldn't do, he could make links that I just couldn't see (Kathy, parent)

So what was it that our 'therapist' actually did that prompted every parent to locate it as having had not just a crucial impact on their mental distress, but for many, *the* most significant impact on their mental distress? Firstly, as we said, it helped parents to complete the DLA form successfully. All of the parents spoken to received an award after help from volunteers at the DLA project. Parents spoke of the importance of having someone else see through their 'rose tinted glasses' to provide a more accurate account of their carer experiences. These glasses are essential to help parents focus on the positive side of their child's disability and to highlight their child's strengths, and are a vital tool for getting through each day. They are, however, a complete hindrance when having to fill in a lengthy form that requires you to make a clear case for needing help and financial assistance.

Parents unanimously discussed the way in which the resulting award had contributed significantly to both their financial and mental health. Every parent suggested that their award had led to significant knock-on effects in terms of the well-being of their child and the rest of the family. For some, the award helped with the everyday essentials of living, providing reassurance that they would be able to meet the daily challenges that they faced. For others, it enabled them to reduce the unbearably long working hours that were necessary to support the family's extra costs, and which had put a considerable strain on their relationships. For some, the effect was to provide the financial opportunity to reduce the debilitating isolation that they had experienced for so long, by giving them the means to go for a coffee or pay for appropriate childcare and transport.

The Importance of the Amaze DLA Therapist: Validation, Finance and Mental Well-being

What was also important was the *way* in which this 'therapist' worked. Parents were able to provide an account of their child that, while providing the necessary information on the difficulties and deficits experienced by the family, also allowed parents to balance these with positive accounts of strength and the joy of parenting their child. This 'therapist' could skilfully extract the relevant information without the parent being forced into a hideous negative information extraction process, which left him or her feeling despair.

For most of these families, deeply challenging and exhausting care regimes have simply become part of their everyday lives and as such, have come to be constituted as 'normal' by the parents. This can be a problem when completing the form, since such an interpretation of their activities would impact negatively on the likelihood of their receiving an award. Through carefully teasing out and helping parents to reflect on the nature of what is and is not considered 'normal', our 'therapist' was able to help parents to understand that what had become normal for them may not be understood as 'normal' in terms of typical parenting practices. In addition, our 'therapist' was able to help provide parents with the language they needed when they struggled to articulate the nature of their difficulties.

Many parents talked about the importance of their award in terms of validating their understanding of the child's difficulties, when very often they had felt minimised or pathologised by other agencies. For a number of parents, their suffering, trauma and difficulties were understood and upheld by their receipt of the award. It confirmed the sense that their child had complex needs and it endorsed their approach as parents in the various battles to help their child receive the support that he or she needed. Moreover, a successful claim acknowledged the extra and previously invisible work they had been doing, often in the face of accusations and suggestions of overbearing and/or poor parental practice. A successful award had genuine symbolic significance above and beyond the financial reward.

Many parents of children with complex needs benefit from extra support to cope with their difficulties,[11] and the strengthening of the financial and social resources of parents can be incredibly important. Through our 'therapist', parents were also able to receive information on, and access to, a range of relevant activities, services, support groups and financial offers that had a significant impact on their lives. For some it opened up a wealth of opportunities that they had been unaware of. Many parents initially contacted our 'therapist' for help filling in the form, but ended up receiving substantial support and advocacy in the problematic experiences that they had been having with their child's school and/or medical professionals. Indeed some schools were thought to dislike our 'therapist' because they failed to understand why these parents' voices should be heard, advocated for and supported in organisational decision-making. For some parents, the extra information and understanding they had gained had increased their confidence such that they now felt able to challenge some of the problematic practices that had made their lives so difficult. For many parents their contact with the DLA service had helped to open up a range of activities that they and their children could be part of. For parents who had felt excluded, the benefit of this should not be underestimated.[7]

> I can't really, to be honest, remember what it was like, I've always remembered living on a shoestring, we always have. And now because of the DLA and all the other stuff I get, I don't have to stress about, like I do about my phone bill and stuff like that, I still stress about bills, it's not as stressful (Lucy, parent)

So this 'therapist' does a whole range of things. It supports people in real, structurally mediated financial strain and works with them to try to alleviate it. It does this by helping them to complete a form where the complexity of its technical challenge is matched only by the brutality of its emotional challenge. It guides people through it with patience and care and saves them from demonising their child along the way. It supports people who are isolated, lonely and excluded and finds ways for them to build links with other people who understand and empathise and share their experiences. It welcomes people who have been marginalised, condescended and excluded from the care of their child and listens to them, supports them and validates their experiences. It appreciates that these parents have valuable expertise essential to the well-being of their children and it takes them seriously.

A Social Perspective on Distress for Parent Carers

> For our other courses the Insider's Guide and the Looking After You courses, we have sort of, it sort of dawned on us that what we are doing is interventions that support people's mental health (Manager, Amaze)

So it's a pretty clunky rhetorical device to push the agency of the term 'therapist' from individual psy experts on to the diffuse and disparate set of practices, people and settings of a community and voluntary sector organisation. But herein lies the essence of informal care practices. They challenge conventional notions of expertise and accepted hierarchies of care and knowledge[12] and where interventions don't need to be standardised, evidence-based technologies of a given professional field but rather they can be, organic, needs-driven and constituent of relationships themselves. They can be advocacy, or they can be listening to people, helping them to fill in a form, all the while carefully thinking about how other practices inside and outside of that organisation could be useful and how to best link people to these. The technological paradigm has seen a colonisation of human experiences by medical and psychiatric language. However, meaningful practices of care do exist beyond these colonies. They reside in the material possibilities and relationships that people experience in places like Amaze.[13] Grant[14] suggests that some non-expert spaces can provide care practices better than those of the psychological or medical professions but to a degree that rather misses the point. This false dichotomy of expert/non-expert minimises the inherent expertise in the everyday care practices that happen in community and voluntary sector organisations like Amaze. Take the quotes below from two of the managers at Amaze:

> Yeah. I mean, I think, and parents say this to us again and again in lots of different contexts that there's something about having contact with the service that it's about genuinely understanding where they are and what life is like for them and not pushing it away do you know what I mean—not sort of let's pretend this isn't happening or let's gloss over that or let's imply that you're making a fuss or you know that, we always try to never do that sort of judging or pushing away or like you are making too much of this or you know why are you seeking a label for your child (Manager, Amaze)
>
> …and I have often think with the calls it's about kind of summing up what parents have said and saying you know that you know this is what you want you know (Service Manager, Amaze)

What is happening here is what often happens in the most useful statutory psychological care practices—that is, those that eschew the fetishisation of technologies, techniques and change projects in favour of focussing on the encounter—encounters that are non-judgemental, empathic and understanding, where a form of social solidarity is developed between someone who has reached out for help and others who are in a position to respond. Where our organisational therapist can transcend even the most empathic professional, however, is in opening up a range of diverse responses to the person who has reached out. Their care practices are varied, multifarious, informal and often ad hoc. However, taken as a whole, they open up a diversity of beneficent experiences, practices and opportunities, some of which are experienced therapeutically,[13] others as more pragmatically helpful. These sites make possible the 'everyday work of recovery' that accounts for why so many of the people we talked to said that Amaze had helped their mental health more than anything else they had experienced.

If care practices—and that ultimately has to be our focus, rather than professional expertise or staid inflexible knowledge paradigms—are only talked about in terms that are not appropriate to their specificities, then they will be submitted to rules and regulations that are alien to them.[15]

If we only recognise the formal channels of care and use the conceptual coordinates, we have to evaluate *their* effectiveness. If we try to apply these to informal settings, then we will almost certainly miss the care practices in these spaces. Care, whether silent and implicit or visible and tangible,[16] can best be understood as sets of disparate practices[17] that are choreographed into a pattern that people sometimes experience as useful and meaningful. If we want to know about the nature of fluid innovative care practices, then there is a need for methods that are sensitive to this fluidity.[18] The utility of an organisation like Amaze is that it implicitly understands well-being not as a set of entities to be acquired or as internalised qualities of individuals but instead as relational practices of specific times and places.[19] This is an organisation run by parent carers for parent carers, and rich forms of knowledge accrued and negotiated between them arises out of the everyday practices of caring for a child with complex needs. And these knowledges implicitly recognise the social codes, habits, instruments, needs and ways of making sense[20] that resonate so powerfully with other parent carers who reach out for help.

> For some people it's literally a one-off for a, you know, key bit of signposting or information or whatever but a lot of people I would say will dip in and out over the years on that trajectory, on that journey you know when, when things go up and down or they come across new things that they need to know about or get support with and, and then we have a sort of smaller minority that are, sort of, are in quite regular contact, as it were (Assistant manager, Amaze)

Here the role of parent carer is understood as a journey where a range of informal and formal care practices have been oriented around the different parts of that journey. And the key is that what this journey looks like and the range of care responses that have been developed are fluid, variable and responsive to those needs. This might be giving some information or signposting; it might be doing things that save a parent carer time and energy; it may mean listening to them on a telephone helpline when they are at the end of their tether and in crisis, or helping them to fill in a form; it may be advocating and supporting them in meetings where they sense their knowledge is not given the same value as others. It may be, as in this example, a form of advocacy which is complex, demanding, multi-stakeholder and seemingly intractable:

> So, the volunteer will arrange a suitable time for the parent to meet to find out what the issues are for the parent so for example it may be that the parent really doesn't know what to do, communication with the college has broken down completely, the young person's been excluded from college but the parents feel sort of that it's because of that young person's say special needs or disabilities that haven't been taken into account, haven't been supported properly so then the volunteer will unpick what that situation was, ask the young person maybe if they're able to describe exactly what happened, unpick how that was and then try and facilitate a good a sort of meeting with the college, with the parent and with the young person trying to support the young person to say it from their perspective, trying to then also support the parents to keep calm around it and to you know but also encourage the college staff not to be defensive but open and in the long term you know facilitate that young person going back to college and you know and being happily sort of involved so that, that's something that reason (Project Manager, Amaze)

The scenario above is complex but representative of the kinds of work done and reveals a subtle and nuanced care practice that results from a range of actions—helping a young person to express himself or herself from his or her perspective; working out how the young person's complex needs have not been taken into account and thinking through ways to address this; facilitating a meeting of parties where communication has broken down, supporting parents to remain calm and supporting school staff to be open and receptive in the face of institutional challenge to their practices; and then facilitating and supporting a longer-term transition for the young person. Responding to such complex circumstances requires not only flexibility, fluidity and expertise, but also multiple forms of knowledge, and knowing and appreciating that supporting someone who is in distress and has reached out can require care practices that are complex sets of embedded relational and material activities. On another level for some parents, such a set of complex circumstances and work isn't what they require when they reach out. For some their experience could be described as beneficent in the sense that, rather than being characterised by curing, healing and medicine, it is characterised by communitarianism and connectedness, support, compassion and benevolence:

> If you ask the parent's feedback on the event you know number one for what they liked about it was just that they were with other people in the same position (Manager, Amaze)

For many of the parents who reach out to organisations like Amaze, it isn't deep-seated trauma that needs to be worked through, nor negative thoughts or feelings that need to be challenged via a mechanistic therapy, nor indeed rampant neurotransmitters that need to be culled. The issue at hand for people who have found themselves ensconced in the often individualising, pathologising, and sometimes helpful mental health system is that the problems they face are, on the whole, practical, social, relational and financial. What was clear from the accounts of the parents was that they needed support, advice, information and companionship. They needed to be respected and listened to and have their knowledge privileged in the various consultation processes that they found themselves party to. They needed greater financial support, flexible employment opportunities and meaningful respite. For these we need a different type of therapist, a therapist oriented towards looking outside rather than solely inside the parent carers' internal world.

Psy practitioners have things that people won't find anywhere else; they have tools, theories and paradigms, and techniques that can impact upon people and help them. The thing is—so do other people who are not psy professionals. Normal people, untrained in psy techniques and whose care practices are unburdened by the need to buttress their professional status, pay mortgages and build careers. They too bring empathy, understanding and non-judgemental social spaces, and they also bring grounded, practical support and expertise to formulate forms of care that address the real sources of people's suffering.

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7

I'm Singing in the Rain

Eddie, a 65 year old male diagnosed with 'High Functioning Autism Spectrum Disorder' sits alone on a park bench. Staring at the masses of people walking through, and playing, in Central Park, New York, he reflects on how all of his life Eddie has struggled to relate to people and the world outside. Here he sits, the noise of the yellow taxis, the subway, people shouting, laughing, crying; the noise, Eddie needs an escape and he needs it quickly. People not understanding Eddie has been a source of sadness for him his entire life, but when last week he was arrested under the 'Homeland Security Act' for monitoring and recording planes flying in and out of John F Kennedy Airport to establish the exact levels of CO_2 clouding the New York air, something changed for Eddie. No longer could he go on unable to understand the people around him, knowing they will never fully understand him. Thinking back Eddie could see this moment coming for a long time, it was a time bomb waiting to go off. But now it was real, Eddie looked up one last time to see the chaos in front of him and put his hand in his pocket, he pulled out the Citalopram pills he had been stockpiling in his bedsit, along with some Citalopram oral solution to wash

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down the tablets. Ironically perhaps, a means to help Eddie through this suffering has been right under society's nose all along.

'He Who Sings Drives Away Sorrow'—Italian Proverb

Singing can be traced back nearly as far as the transition from 'Neanderthal' to 'Human'. In fact, in his famous book '*Language: its nature, development and origin*' Danish linguist Otto Jespersen argues that before humans developed the ability to talk, they engaged in 'singing',[1] albeit not singing like we know today but more of a basic communicative tool before the expression of thoughts, feelings, words and instructions were possible through formative language use. Since then, societies have long celebrated those considered, at the time, to have a good voice and singing has been a central element to many religious and community groups throughout the ages. From the Egyptians in the New Kingdom (1700–1500 B.C.), to the Ancient Greek poet Sappho, singing has always been a central element to human existence. Indeed singing as a resource has been said to bring communities together in times of war, whilst also being used in times of peace and celebration. Depending on your definition of what constitutes 'singing', it can be said that people from all walks of life regularly engage in the practice without necessarily being aware they are 'singing', be it in the shower on their own, on the terraces at a football match, or in silence when the latest pop song with a catchy tune rings around their head in the most inappropriate places.

So why then has singing been central to human existence for such a long time? Here we need to turn to the growing body of research highlighting the positive effects of singing. For example, in a large-scale UK-based study it was found that participating in a singing group was perceived by participants to be of significant benefit to their well-being, with the singing groups seen to be a key way the individuals coped with life events and challenging personal situations.[2] Another study highlights how singing as a practice has the ability to counteract anxiety due to the focus on breathing and deep breathing when singing.[3] In research looking at the impact of a scheme introducing singing workshops into the workplace, Purcell and Kagan show clear well-being effects of the singing workshops including making employees happier, less stressed, more confident and more engaged with their fellow employees, and improved perception of their physical health.[4] Further, Skingley and Bungay undertook research looking at the effect of a UK-based singing club on elderly people and found that participation in the club had a positive effect on their mental health and well-being, social interaction, physical health, memory and recall, and their general cognitive abilities.[5]

However, such findings are not specific to research in the UK; in Australia, for example, researchers examined singing groups in Victoria and found that engaging with a singing group improved people's feelings of connectedness, sense of belonging, stress management and emotional well-being.[6] In addition, they argue that such benefits are not contained to the individual but that singing groups have a positive impact on general social capital and thus such benefits filter through to the relational and community levels. Also in Australia research has uncovered the benefits of singing groups on dementia clients and their caregivers; such benefits included increased communication, better memory recall, enhanced social interaction and positive feelings in relation to the enjoyment felt whilst participating in the singing group.[7] Similar findings have also been found in the UK.[8] In Glasgow, Sue Hillman offers a comprehensive account over a 12-year-period with elderly people participating in the 'Call That Singing?' group.[9] Her research not only finds that elderly people participating in the singing group receive all of the benefits mentioned above in previous studies (e.g. improved well-being) but also takes the argument further to show that:

> Participants reported no overall deterioration in their perception of health over the 12-year period since the project started: this is despite the high recorded incidence of illness and bereavement during the same period to be expected of people of this age (p. 163)

Such findings are corroborated through a range of additional research examples including boys in church choirs,[10] disadvantaged adults,[11] the general public,[12] people with a chronic respiratory disease,[13] people with Parkinson's disease[14] and young people with cystic fibrosis.[15]

Case Studies

This chapter draws on data collected in the UK and Canada through two singing enclaves, one more formal, and one a project-based collective. So, let's hear about these enclaves.

Canada: Surrey Place Centre

This is a specific clinical service with a distinct focus on responding to and improving people's health and well-being needs. It is based in the city of Toronto, Canada, and is constituted of a largely interdisciplinary team of experts including psychologists, speech and language therapists, psychiatrists, occupational therapists, nurses, counsellors and behavioural therapists. The focus of the centre is on providing help and support for children and adults 'living with developmental disabilities, autism spectrum disorder and visual impairments' to reach their 'full potential'. The services also extend to family members, guardians, caregivers, alongside a range of community-based work in schools and community agencies. Whilst the majority of the services offered by the Surrey Place Centre are through referrals, the centre is committed to open access and allows for assessments of individuals to be made via referrals from family members, caregivers, community workers and self-referrals. The singing group, the 'Symphonic Passion Chorus', at Surrey Place Centre started as an idea from one of the speech-language pathologists, Bruce Edwards. Originally established in 2005, the group has since been facilitated by Bruce and fellow occupational therapist Christine Hein. The singing group is aimed at adults with mild to moderate developmental disabilities, often with no literacy skills. Since its inception it has grown from 14 to 30 members and 2–8 volunteers. In its public performances the group has performed to audiences as small as 40 and as large as 40,000. The choir sessions run once a week from September to December, and are two hours long (90 minutes singing, 30 minutes pizza dinner). The choir itself is not a specific well-being service offered by the centre, rather it is conceptualised more as a choir for interested people to make their lives more enjoyable and thus it doesn't function as a 'treatment' in its own right. What follows in this chapter will offer an insight into the choir to explore the ways in which it potentially alleviates some of the distress the service users experience.

UK: Arts Partnership Surrey

Unlike the Surrey Place Centre the UK component to this chapter doesn't function as a specific centre; rather it was a collective looking to explore the ways in which individuals experience singing groups in the South East of England and if there might be any benefit for governments to consider the possibility of understanding singing groups in the context of health and well-being benefits. Arts Partnership Surrey (APS) includes Guildford Borough Council, Mole Valley District Council, Runnymede Borough Council, Spelthorne Borough Council, Surrey County Council, Tandridge Leisure Limited, Waverley Borough Council and Woking Borough Council. APS aimed to build a sustainable creative project that offers the opportunity of referring community members who may benefit from being part of a singing group project with the aim of improving the individual's health and well-being. For the Singing Surrey project each local authority participating in the project identified an appropriate community group who would benefit from the development of a new singing group. This chapter reports on observations, interviews and focus groups with a range of individuals participating in six singing groups across Surrey (South East England), resulting in around 120 individuals being observed, and approximately 60 directly involved in focus groups and/or interviews. None of the singing groups were set up with a specific focus on health, mental health or well-being; however, it was clear from the data collection many of those involved had, or were currently, experiencing distress.

If in Doubt, Sing It Out…

A New Identity

When we think about Eddie and all the other people out there that suffer silently due to the way society has forced them to feel 'different', lonely, disconnected and even pathologised as 'mentally different' by a range of psy-professionals, we often wonder if there is hope.[16] Yet what if there were a space in which such individuals simply could gather? Not as a group specifically set up and administered by psy-professionals, which whilst being a valuable service to some, could have the potential to make others feel further pathologised. Rather, we are thinking of a space where people can 'take off' their individual identities and personal inhibitions at the door and hang them next to their coats—a space where an achievable and enjoyable collective goal is set and the people in this space dedicate all of their focus to achieving that goal, the goal being collective singing, sometimes for a performance, sometimes not. It is as simple as that, the coming together of a group of people irrespective of their talents or problems, a space in which they can feel free of judgement. As Christina, one of the workers in Surrey Place Centre, Canada, comments, 'we don't really judge, we don't actually care if they are tone deaf cos it's not a requirement to have a great voice for choir, it's that you enjoy singing'.

Such is the nature of a space in which individuals aren't judged that even if they feel shy or nervous when they first start out in the groups, these feelings tend to drift off as they engage more and more in the singing exercises. Bruce, the leader of the Surrey Place Centre singing group likens this removal of inhibitions to that of the 'blossoming of a flower'. As Bruce suggests, 'People that are incredibly shy you know incredibly anxious when they first start especially you know if they are new and everyone else has been there and knows each other you know, and then to see them like just blossom you know and just you know change over the course of even just a couple of weeks you know and really open up and really you know develop their self-confidence'.

Of course, it isn't just the practice of singing in a safe space that creates such feeling and positive well-being effects. This isn't simply singing in the shower to yourself; rather there is something special noted in the collective element of the singing groups. As Luke, a member of one APS group, rather clearly states, 'First of all you've got to sing in a group, it's much better than singing on your own.' Such is the power of this 'safe space' where individual identities no longer define the person but the collective sense of belonging, a shared goal, and active learning become the focus of their engagement with the groups. As Gemma, a member of one

APS group comments, 'Every week, I'm looking forward to going back to learning new songs and meeting up with people again. A group of people I most probably wouldn't come in to contact with through any other way. There is a great sense of being part of the group now which is really nice.'

Through this activity members of the group are able to 'free their mind' of the daily stressors and issues they face. This space allows for a childlike sense of fun to be returned to their lives, something many don't often feel, particularly those that have become isolated from society due to a range of factors, including those Eddie highlights at the start of this chapter. As Francesca, an APS group member, comments, 'I think it is good for you, for me I don't think about anything else when I'm there. There's a lot of laughter that goes on in our choir, it's a happy choir, I don't know everyone yet, but everyone is very friendly.' Thus, at its very basic level a singing group could have potentially offered Eddie the space he needed to feel part of something, to feel understood for once in his life and to feel he has an achievable collective goal to follow. That appears to be the magic of collective singing—'The fact that we can sing together, without ever singing together before in our lives' (Darren, APS).

Overcoming 'Symptoms'

People in distress often find it difficult to interact; such difficulties are often amplified by the range of 'conditions' individuals in distress are said to suffer from. For Eddie, it was the case that his high functioning autism spectrum disorder contributed to his difficulty to understand other people, and indeed for other people to understand him. Symptomatic to such situations is the overt avoidance of personal and physical contact with others.[17] Whilst this potentially acts as a logical unconscious defence mechanism, or cognitive coping mechanism, the result of such situations is an increase in isolation, potentially resulting in the intensification of mental distress symptoms.[18] And so the cycle continues and often spirals downwards to the final situation in which a person is socially withdrawn and arrives at Eddie's position. But as we witnessed in the section above, there are spaces in which people can leave their identity as 'patient' behind and go and have fun with a group of people they probably don't know or would be likely to meet in their everyday lives. This place not only enables that, but it also appears to offer individuals the chance to overcome what could be seen as ‘symptoms’ of their ‘condition’.

For example, as Christina observes in her Canadian group, ‘I’ll look at attention to be able to sit in the seat, sit beside someone that perhaps would have been very uncomfortable because of some sort of trauma you know and girls sitting beside a guy there’s a lot of that kind of stuff, the whole sensory need learning to relax, listen to each other, that sort of thing so I mean we are able to, it’s quite lovely when we can pull that together.’ Bruce makes similar observations in Canada with regard to the individual attending the group that have autism. He comments how, like we have seen with Eddie throughout this chapter, people with autism often struggle with noise, personal space and social interaction. However, with the group in Canada, around 40 are all in a room at once, often learning a song or talking in-between songs. This situation would therefore appear very uncomfortable and potentially very threatening to many autistic people, but as they are specifically there to engage in a shared goal (see section above), and to sing as part of a group, this potentially difficult situation actually acts as a method to help the individual overcome this element of distress. As Bruce comments, ‘there’s a lot of noise so autistic people that are able to tolerate closeness and loudness a lot better as a result of being in the group’.

For people who experience both psychological and physical symptoms, the groups can offer something really unique. The motor and learning skills the singing groups implicitly enhance can have a real effect on an individual’s physical ability. Whilst there are of course currently rehabilitation clinics which utilise expertise to enhance someone’s physical/motor abilities, the difference with the singing group is that there isn’t the explicit focus on improving these abilities and thus there isn’t the associated pressure. Rather as Christina (Surrey Place Centre) comments, ‘We have people also who are not ambulatory so you, one person, pretty affected in a wheelchair, speech is actually quite affected but he loves to sing even though he, he had trouble forming words at all and he’s sometimes delayed but between everyone else ironically he is probably one of the smarter of the group so there’s that you know carried out like misconceptions so he’s actually really into opera he keeps wanting to sing opera with us.’

Much research has focused on the links between social isolation and pathologised conditions such as depression and anxiety. But trying to get individuals who are often very anxious about social situations to socialise in order to help combat some of their distress is very difficult, and at times very problematic.[19] However, within the UK singing groups, the effects on people's experiences of being diagnosed with depression, and experiences of happiness, are clear to see:

> From the first evening when I went home with a big grin I have been really enjoying it. I have been quite down and the choir has been part of my recovery (Participant from focus group)
>
> In the last 12 months I've been juggling with medication and I am now on a full dose of medication. It's the first time I've been up to that level. So my mental health has definitely improved since I've been singing in the choir but how much is because of the medication and… I think it's probably some and some. I'm definitely in a better place than I was in March before the choir started (Jayne)
>
> I had a nervous breakdown in 1996 and when I was well enough I went to a singing and movement group. It was lovely (it offers you) the chance to sing, to move, to relax. It cheers people up it makes people smile (Darren)
>
> You feel a lot better by being in the groups. You're so busy thinking about the songs that any other problems you've got you forget about (Luke)
>
> I have been less stressed and singing helps … I love hearing the sound we all make, when we are singing I don't think about anything else, I just think about the singing (Francesca)

Unlike the group in Canada, these individuals in the UK were not in a formal mental health intervention/treatment system; rather the groups were community based and run for anyone. Yet as these individuals clearly articulate, singing groups offered a significant improvement to how they perceived their mental well-being.

Spilling Over into Everyday Life

In both Canada and the UK, the singing groups were not only seen to provide individuals with a safe space and offer them the chance to free their mind from their everyday stresses, but this effect was also seen to carry through into their everyday lives. From small things like an increase in confidence, or just simply having fun once a week with the singing group, it appears that individuals who were in the case of the Canada group, experiencing acute learning and developmental needs, and those in the UK experiencing psychological distress, became able to manage their well-being outside of the group much more. Bruce, the leader of the group in Canada suggests that the process of socialising in a situation in which singing is the main focus has the biggest effect on the members' well-being. Highlighting how members of his group often struggle in social situations, he suggests, 'It's the social effects, that's going to impact there and will, the biggest difference is going to be made I think.'

Whilst you could argue that any social event would have a similar impact and help facilitate these spillover effects, we have seen in the above sections that there seems to be something more specific about the nature of signing, be it learning the songs, producing a collective song or having a shared goal. This is a point Christina (Surrey Place Centre) elaborates on when she talks about how the group has impacted the everyday lives of its members. As she comments:

> I'm working on getting someone to be able to get up in the morning because they just have a hard time and they are I don't know they have autism and just everything is that much more difficult… they can make decisions that a lot of them their self-esteem really increases because they feel like oh I feel like we have a goal, we, we go and perform at concert and they are able to do that and they are very proud of themselves afterwards (Christina)

Here the goal of the singing group's public performance is presented as a core facilitator for spillover effects of the group members. The difficulty of fulfilling everyday tasks, such as getting up in the morning, is in no way suggested to be completely overcome through simply being a member of a singing group. Rather, through the increased self-esteem, feelings of achievement and just simply having something to work towards, Christina suggests that the singing group members have a new sense of purpose in their lives, something often lacking for individuals in serious distress,[20] and this sense of purpose helps to motivate them to push through the struggles of everyday life.

In the UK groups the public performances were also singled out as a key contributor to the ways in which self-confidence and general feelings of achievement can be enhanced. For example, Mark highlights the ways in which singing provides him with an element of purposeful challenge; even if this does evoke some anxiety, the overall effect is positive. As he comments, 'It (performing) tests us, which is good, we could probably do without the tension, but it's good that we stretch ourselves a bit, otherwise you can become complacent.' In another interview Gemma comments that the group performance also helped her in how confident she feels in herself and how testing herself in a different area of life has been a positive experience for her. Talking about her experiences Gemma states that 'for someone who is a fairly confident person, or perceived to be confident, but when it comes to things like that [public singing performance] I'm not, but I've noticed that change in myself'. Luke highlights similar spillover effects that the singing group has had on him:

> You're a bit shy at first but once you start singing and let yourself go … I thought I can sing in a choir as it doesn't matter what you sound like… and they get you better and you get your confidence back. It builds your confidence and it's even good for public speaking. It trains your voice to get better. I think it's fantastic

Whilst confidence appeared to be one of the key positive effects that being part of the singing group had on the members' lives, Francesca also highlights the effects that being part of a singing group had on her more general cognitive ability. As she comments, 'It helps your memory as you're getting older because you have to remember the words'; thus in this sense it could be seen as a type of mental exercise that keeps the brain 'fit' and healthy in much the same way that cycling keeps the body fit and healthy. This mental exercise could be seen to be part of the reason Francesca feels much better in her general life as suggested by her comments later in the interview: 'I must confess I feel very content at the moment and singing must have something to do with it.' These spillover effects are clearly articulated by Jayne when she talks of her partner's reaction to how she is when returning home after a singing group meet. As she notes, 'I came back at the end of the session and my partner, said to me "you have a big fat grin all over your face". I just know that at every session it just lifts me and I know it energises me.'

For the Love of Music

In this final section we hope to explore the simple love for music as an activity that enriches and binds people from all types of situations. Such is the uplifting effect of music that Eddie perhaps could have found some relief from his all-consuming experiences of distress. As highlighted in the introduction to this chapter, singing is one of the longest standing social activities for humans. Throughout history singing has featured in all manner of aspects of people's lives. As we have seen above, it appears to have a significant impact on the ways in which people in distress come to manage their situation. What then makes singing such a special activity? Whilst we don't wish to speculate on the range of chemical processes that singing might facilitate, we do wish to show what the members and workers in the UK and Canada have to say about the special nature of singing, particularly singing in a group, as the following quotes articulately show:

> I don't feel that singing has had an impact on my health as such, but it does make me feel good … When you hear a choir sing it is a very positive and uplifting experience (James)
>
> I feel so good when I stop singing, and whatever song, not all the songs are what I would like necessarily, but I just enjoy singing, and then you hear a group of people singing together, it always sounds so good, even when we make our mistakes … I always leave on a high (Francesca)
>
> A feeling of almost euphoria (Gemma)
>
> Everyone in the choir loves to sing, just the act of singing together week after week I mean that in of itself is, is really you know therapeutic for a lot of people (Bruce)
>
> Generally you feel good in yourself and you feel more energetic. I seem to feel I have more energy afterwards (Luke)

As is clear in all of the above quotes, the practice of singing makes people feel better about themselves. For some it makes them feel energised, and for others it provides a sense of feeling 'on a high', feeling positive, uplifted, and perhaps as Bruce notes, provides a type of therapy. For Gemma though, it is perhaps even more than this offering her a feeling akin to euphoria. Indeed, Bruce (the leader of the Surrey Place Centre) suggests that not only does singing uplift those participating in the activity, but when performing in public the positive effects of the activity also have a significant impact on the audience. As he comments, 'the joy on the faces of the people that are performing and singing and you know it, it's just that, it's so palpable to anyone who, who's in the audience'.

Conclusion

Fortunately, Eddie never did do what many people see as 'the unthinkable'. By sheer chance, as he looked up with his tablets and Citalopram oral solution, he noticed tied to the silver railings of Central Park, a banner advertising a community singing group. It was a blues group and Eddie thought to himself, 'what have I got to lose?' From that day on, Eddie regularly sang with the community blues singing group and for the first time in his life he felt as though there was some purpose; whilst he still experienced his suffering every waking moment of every waking day, he had a way to manage it and at least he had a regular activity where he could just 'be himself'.

As we have seen throughout this chapter, singing as a fairly banal activity holds a special place in society; it always has and perhaps it always will. But it is not just singing that this chapter has been interested in, but rather group singing as a regular activity to help alleviate some of the distress many people experience in contemporary life. Whether it is through the common goal group singing offers, the way singing groups enable individuals to shift their central focus from their distress to something different, the way it helps build self-confidence, or simply the upbeat nature of collective singing and the joy of music, we cannot say with any certainty, but through the accounts presented in this chapter we can say that it is certainly having a positive effect on many people who regularly experience distress and suffering. Perhaps singing groups attract and thus 'work' for certain 'types' of people, or perhaps music more generally is the underlying key to all of this; again, we do not wish to speculate beyond such propositions but only hope that this chapter has shown how singing groups touch the lives of many and deserve more credit.

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8

'A Place to Be'—A Cut and Shut of the Brighton Unemployed Centre Families Project

A cut and shut car is apparently one of the biggest dangers to a car buyer. A cut and shut consists of two or more cars welded together. Usually, this happens when a car is damaged enough to be written off by insurers and is patched together with another car to hide the damage. Needless to say these contraptions are not especially safe and don't run especially well. Nevertheless, we've decided to use the concept as a template for an academic chapter. And as we're not going to drive this chapter anywhere at high speed, we suspect that the worst that might happen is that it reads a bit odd.

So, this is a cut and shut chapter. As such, it's a little bit of a concept chapter, a little bit like the concept albums that progressive rock supergroups used to do in the 1970s. So, regardless of what the reader thinks, we think we can rest safe in the knowledge that Jon Anderson and Rick Wakeman from Yes would admire it. The idea is that we will give you the academic material and the quotes from a standard qualitative piece of work based on the interviews in the centre above. However, this doesn't always automatically translate into pictures of lived experiences, of key concepts playing out in often the most banal, humane, annoying and enriching ways. And so the hope is that the titular

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centre will be brought a little further alive in the imaginations of our readers if we borrow a mechanism from amoral mechanics all over the country.

The following five people are people that we met on our travels at the centre. Their names have been changed but the histories, stories and the experiences below are all true. They happened outside of the research context described below and were noticed by us anecdotally in what could ambitiously be referred to as a period of (very) informal ethnography.

1. *Ros lives with her two children. Zane is 3 and Poppy is 5. She skipped breakfast that day because she wasn't sure whether she'd need the food for the kids later in the week. She's been out of work but childcare is tough so it makes sense to use the free crèche at the centre. It gives her a couple of hours' break. She has gone to the doctor recently because she's not been feeling herself. She doesn't know why.*
2. *Alan helps to run a group at the centre. He came to the centre as a user years back when he was desperate and describes how the centre 'held out a hand to him' in his darkest hours.*
3. *Sally works at the hospital. She pops into the centre on occasion for advice on things like benefits and housing. She doesn't really use the centre much other than that but it's always nice to see some of the old faces when she pops in. Her daughter, Tilly, is 8.*
4. *Gary described himself as a handyman and a bit of a drifter. He'd been in Brighton for a number of years and had been coming to the centre on and off for the best part of 8 years. He described himself as being in 'real trouble' mental health wise, and said he had attempted suicide recently.*
5. *Lilly was a volunteer. She'd been off work with depression for 18 months and wanted to use the centre as a way to get some volunteering experience so she could get back into work and get a reference. A lot of things about the centre pissed her off but she needed it at this point in her life.*

The Centre

The Brighton Unemployed Centre Families Project (BUCFP) is a registered charity that was founded in 1981. Today the centre provides a number of facilities, projects and services that combine to allow the centre to fulfil its principal charitable objective 'to relieve poverty, distress and hardship amongst unemployed, unwaged and low waged people'. It's open Monday to Friday 10 am–4 pm and is characterised by an often hectic, sometimes quiet, large open plan area. This area is open to any member of the public and includes a play area for children. It has a tea bar and a few computers with internet access, and also contains a number of tables, chairs and sofas. There are several other adjoining rooms that, together with the open plan area, house the services and activities on offer at the centre. The floor below houses the main office and the offices of the paid workers. The people who use the centre come from a diverse range of backgrounds with many drawn from people living in poverty. Recent internal surveys of the centre suggest that 61 % of the centre users say they have difficulties with their mental health. The centre has a substantial number of volunteers who administer many of the projects and services and these volunteers are typically drawn from centre users.

It is estimated that the centre has in the region of 100 visitors per day and they expect to serve around 40 large, (very) low-cost vegan meals and 20 kids' meals at lunch, although this number fluctuates. The centre also has an allotment project where volunteers, centre users and staff work together to tend a piece of local land and produce food for the centre.

The centre provides confidential drop-in advice sessions on a range of social welfare issues. This includes benefits advice, representation for tribunals and appeals, employment advice, housing advice and telephone advice. It offers a range of affordable computer and language courses, as well as healthy living classes in art, photography, yoga, dance, cookery and creative writing. It houses a free, high-quality crèche for children up to the age of eight years.

Experiences of Being a Centre User

Different Centre Users, Different Needs

In its capacity to meet the needs of a wide range of people in the community, and through an infrastructure that catered for, but didn't impose, personal development as a result of the multiple opportunities to transition between roles and responsibilities, there was a feeling that the centre was, like other family centres in the UK,[1] very much more than a sum of its parts.

Although some people who came to the centre were in extreme distress, a great number weren't and a substantial number of people came to 'use say, the playroom and that enables them to have some time to themselves or some time to do something else when their children are very small, that they couldn't get anywhere else'. In catering for those without specific instrumental needs—such as the use of services or the low-cost food—the centre takes on a crucially important preventative capacity for many of the users.

> *Sally was trying to hold it together. She'd received an eviction notice from her landlord that said she had to be out by the end of the week. There was no way that she could manage that. She had to work for the rest of the week and had a 3 year old daughter. She was in a panic. She felt she was drowning. She went in to talk to Helen, one of the housing advisors. Helen told her that 'reasonable notice' referred to the length of the rental payment period. Sally was paying monthly and so she needed to be given a month's notice. This news was like the piano that had been sat on her chest since she got the letter this morning getting yanked off of her. She could breathe again. She got that very unique sense of euphoria that you get when, just as you think your life is about to fall apart, it turns out that it doesn't. She'd experienced that a little too much in recent years. She had a cup of coffee with Gary, who she knew from years back, and then went back to her work. A month would be long enough.*

For some the importance of the centre lies in its capacity to help them make the most of the period during which they have found themselves out of work. For these people, the centre provided not only a constructive means to use their time but a means through which to help them make the transition from worklessness to employment. For these centre users, their volunteering was used as a tool through which to gain skills, confidence and, in some cases, a reference to help them move back into work. For others, volunteering at the centre was an end in itself, a worthwhile way to contribute something to the community.

Another group of people were those who were characterised as being in dire or desperate circumstances. Although this group did not necessarily constitute the majority of centre users on any given day, the sheer magnitude of their needs, and indeed the huge impact of the centre on their lives, makes it important to recognise this contribution. In line with its charitable objective, the centre fundamentally focussed its activities on disadvantaged families and individuals, providing urgent and often crucial services to socially excluded members of the community who felt that they had no other place to turn. In many cases the work of the centre made a difference regarding whether people were able to eat or not. The centre was able to provide practical support, social support and respite for many people experiencing despair and destitution.

> I think literally, kind of saving people's lives occasionally with the benefits advice. We're making a tremendous difference to people's lives just by giving them the kind of advice and filling forms in for them that they wouldn't get done anywhere else (Participant 5, staff)

There was a feeling both from centre users and staff that a substantial element of the centre's work concerned people who found themselves in situations characterised by severe deprivation and despair.

> It's not about dysfunction this place, it's about displacement, and this is a place for the displaced. And they can't fit the model, they cannot, I couldn't survive within the model (Participant 8, volunteer)

Many of these were people who had become displaced and drifted to the margins of contemporary society. The centre had the capacity to work with many, although by no means all, of these people in innovative and compelling ways. Of course, this notion of 'displaced' fails to really describe the many different histories, motivations, ambitions and needs of what in effect is a wide array of people who regularly draw upon the centre. For some, the practical support that the centre offers in terms of low-cost hot meals is simply an essential part of everyday survival. For some, it offers a key support in the battle to facilitate accommodation. For others, the centre is a base that provides a level of reassurance and peace of mind that there will always be forms of support for some of the complex challenges that might befall them. Here practices of care are often multiple and varied,[2] choreographed by staff, volunteers and other centre users in sometimes explicit but often implicit and hidden ways.[3]

A Place to 'Be' and a Place to 'Do'

> *Ros can feel herself recharging, like a battery. Albeit a battery that never really gets enough time in the charger. As the kids go into the crèche she can feel her body unwind, the tension seeping from her muscles, the breath creep from her lungs and she flops on to one of the couches. She can see the myriad activity around her but she just wants stillness.*[4] *Some parents catch up on things when their kids are in the crèche, they write letters, or fill in forms or call people. She catches up on her stillness and, as it envelopes her, she finds some clarity returning to the thoughts that fleetingly penetrate her mind. And she likes the stillness she gets here—a kind of stillness in the middle of a storm of activity. She can't feel stillness when there's silence around her, just loneliness and yearning for something. But here in the centre with people talking, groups happening, she can get a stillness in the world. If she's not managed to eat for a while it gets pretty hard to get to that stillness because you can't lose the agitation of real hunger but she loads up on the cheap lunch and that helps.*

The centre allows different people to understand themselves differently at different time points, sometimes receiving help, sometimes giving it.[5] In one sense, the BUCFP resembles healthy living centres like Bromley by Bow[6] in terms of the range of creative and healthy living classes that are on offer. However, one key difference is in the ethos, the 'feel' of the centre, and the ways in which paid workers, volunteers and centre users interact. The central focus of many healthy living centres is to position centre users in such a way that they actively take responsibility for their own lives[6] or are manoeuvred into active projects of self-work. In this sense, the centre differs. For some of the people who come to the centre, people who actively seek support and assistance in specific ways, for instance with regard to employment or education, the centre is undoubtedly well equipped to provide support. However, it is not incumbent on centre users that they must in some sense use the centre to move towards a preordained endpoint that they may not currently, or indeed ever be, ready to move towards.

Volunteering is one pathway and activity in the day-to-day running of the centre and there is literature that outlines the different ways in which people can benefit from volunteering.[7]

> *The honest truth is that Lilly didn't really fancy becoming a volunteer. She didn't really know much about the centre but felt it was full of too many people who wouldn't take responsibility for their own lives. Lilly was trying to do just that. After months stuck indoors and a period of inpatient treatment, she wanted to try to get back on the mend but she knew she'd need a reference to get a job. People didn't like giving jobs to nutters so she needed to build up a more endearing back story than 'months smoking fags while her skin crawled'. That day she was on the front desk and was taking loads of calls, the phone was almost constant and she had people walking into the office with queries too. But she'd figured out a system to organise her time. It was nice when she got through a session without asking for help. It means she coped with it herself.*

Not only are volunteers at the BUCFP able to learn new skills, which impact their confidence hugely,[8] but the many volunteering opportunities at the centre like cooking, caring for children, educating others and administration in the office allow them to reconnect with old skills, abilities and habits, which may not have been used for a number of years following the difficulties that they have encountered. For some, there is a reawakening or a reconnection with previous capabilities and of previous 'ways of being' in their neighbourhoods and communities:

> I was suffering from depression, from being poor and, sort of, alienated, and so I can only, best example is to use myself. When I started coming here it changed my whole outlook on my situation, realising that 'God, you can get involved, you can do this, you can do that' and going home thinking 'Oh that was really, you know…' and that was, I, self-worth, you know, going home thinking 'Oh, I made a little bit of a difference today', you know what I mean? (Participant 3, trustee)

Volunteering not only helps people gain in confidence and reassess their perceptions of themselves and their abilities, but it also provides a regular structure to challenge the debilitating isolation that many centre users have experienced. Indeed as the Institute for Volunteering research shows, volunteering acts as a point of social contact, a source of friendships and an opportunity to work as a team.[9]

For a number of the people who regularly attend the centre and volunteer, their activities and labour at the centre lead directly to employment opportunities. The experience of volunteering, of coming to understand the contribution that they can make through the eyes of other people in the centre, helps them to develop a sense of self-worth.[10] Volunteering can help to mobilise such a fundamental change as regaining a sense of personhood and citizenship, not through specialised professional interventions but through working in a meaningful way with other people who are often in similar circumstances.

> So I did the Council-run training, which is held here, the welfare rights training, and that gave me the skills to become a welfare rights volunteer. So then I did that for over, for nearly a year, I think, that's a rough date so I can't remember exactly, and then through the experience of being a welfare rights volunteer I got my current job, so I was two-and-a-half years unemployed (Participant 3, trustee)

A Place to Be

> *Gary cycled everywhere, to be honest he was fucking bored of cycling but it was either that or stay in the house because he didn't have money to get around. He saw someone come in with a cycling helmet. He thought about saying hello but didn't really have the energy for it. It wasn't one of his good days so he just sat and watched instead. It was good to just sit and see things, feel things going on around him rather than his empty flat. At home he often felt like the world had forgotten about him. Here he was a part of the world. He noticed one of the kids from the crèche was struggling to do a puzzle because the elephant wouldn't fit in the board. The boy was smashing the wooden board against the ground to see if that would help. Gary ambled over and found him the board that the elephant did fit in. The boy didn't acknowledge the help. That was okay. Gary popped back to his seat after that.*

Many people are not ready, capable or interested in active projects of development or rehabilitation. For a number of people the centre provides a safe, comfortable space where people can come and benefit in a number of ways. A significant proportion of these people may have long histories of relationships with a variety of service providers such as welfare agencies, unemployment services and the mental health services. These relationships have often been characterised by their being persuaded, cajoled or forced into certain behaviours and activities. Many people who came to the centre had previously been subject to inflexible rules and agencies that had little to offer those who were not immediately willing and/or capable of undertaking what often constituted low-wage, entry-level jobs.

Whether through dependence on mental health services, the welfare system or a combination of these, some centre users had been repeatedly exposed to the pathologisation of their non-working lifestyle.[11,12] The ethos of the BUCFP in some sense provides a route which counters this dominant discourse—it provides a set of potential options that allow the different centre users to find their own route to self-sufficiency. Hence the hands-off approach, that is, providing a space where people are not pushed into behaving in certain ways or doing certain activities, is key to the popularity of the centre.

> *Alan was nearing the end of a session with the art group. He went around the group looking at the paintings and pictures. He never tired of seeing how people's art changed in response to the things that were happening in their lives. Geoff had been coming for a while and had occasionally helped Alan run the group. Left alone to relax during the class he would almost always say that the great thing about art was that nobody told you what to do, that that was the beauty of it. You could almost set your watch by it. Geoff comes in, sits down, engages in small talk, starts painting, period of silence and then boom—reflects on his autonomy in an art group, almost as if the paint-brush were compelling him in line with some invisible clock. 'Very true Geoff, very true'.*

The BUCFP provides, uniquely, both support for short-term pathways into employment *as well as* viable, worthwhile and fulfilling alternatives to such pathways. Moreover, there is an acknowledgement that paid work is not the only way to achieve social inclusion.[13]

> We're not trying to stop people working but, on the other hand, we don't believe in pushing people towards employment. We're quite happy for people to be unemployed and remain unemployed should they wish to do so. If people don't want to be employed that's fine by us (Participant 5, staff)

Some people who have been away from the labour market for a prolonged time, the displaced and 'losers of society' mentioned earlier, cannot readily be positioned into immediate work for a variety of reasons. And a dominant feature of the centre is that there is no concerted impulse to do so. People are free to come to use the services, to spend time, to be with other people and to leave without being framed in certain ways as regards their future activities and aspirations. For people who have been used to being the subject of such disciplinary practices, the centre is a welcome and refreshing space to spend time. In fact one might argue that the very freedom and flexibility offered by the centre, in combination with ready opportunities to reconnect with people, to volunteer and take on responsibility, means that it provides an effective means of restoring a notion of citizenship to those who have been displaced from the mainstream activities of society.

Moving people on is fine as long as they've got somewhere to move on to but I don't see the centre just as a purely moving on place, it's to provide people with the support that they need on an individual basis rather than just having an idea, which I don't think anyone's got, you know that people shouldn't be here more than six months or six years or 16 years or whatever (Participant 16, staff)

The Provision of a Safe Social Space

Alan was having a cup of tea at the tea bar. He could overhear Terry and Gabe having a debate. Terry said that Dances with Wolves was called that because Kevin Costner's character literally danced with wolves. That's why the Native

> *Americans gave him that name. Gabe said the name was symbolic and they called him it just because he was brave. That there were no actual dancing wolves in the film. Terry said that if it was just a symbolic name then they would have gone for dances with lions or dances with gorillas, not wolves. Because it's not so brave to dance with wolves. Gabe said he thought it was because he saw a horror film where wolves ate everyone and so he wouldn't want to do it. Besides, he said, Native Americans think wolves are sacred. Terry asked him how he knew that and Gabe said because they were brave, hence the title of the film. And so on. Gary piped up that he wasn't sure it mattered either way. As he found himself laughing, Alan wondered where these two would have gone today if not here, who they would have had a silly conversation about a film with.*

Safety looks different for different people. It can be the familiarity of people around you, being away from a hostile home world,[14] or from any sites of fear, shame, struggle and emotional toil. It can be refuge and escape,[15] being warm and dry, and feeling a part of the world rather than alone. Often such places like the centre have power not necessarily because of what they are but because of what they are not.[4] The poor are often vilified for having the wrong kind of identity[16] and people on low incomes can often be made to feel different or apart from others because of certain experiences that they have.[17] A majority of the centre users have experiences of mental distress, many have experiences of the depredation, suffering and stigma of being unemployed or seeking welfare payments. For those who had lived with stigmatised identities, who had grown used to being excluded from everyday economic and social life, living a precarious existence and relying on an unsympathetic welfare system, the centre offers an alternative social world to the one that they had lived in. It offers access to a social space where people's perception of them is not dominated by whether they work or not, or whether they had been treated for mental health problems.

The open space and tea bar, where anyone can come along and have a cup of tea, rest, use the internet and/or socialise with others, is a central feature of what many people described as the beneficial properties of the centre. The benefits of previously isolated people being able to socialise with others are manifest and they include gaining personal recognition from others.[18] Specifically, many of the people who come to the centre are given space and, where appropriate, support to deal with their problems. Formal health policies often overlook the importance of being with other people in the development of a positive sense of self. At the centre, the capacity of people to reconnect with their communities, to redefine identities, enhance skills and/or their sense of self, through being with others perhaps while undertaking health and creative classes—like art, photography and education classes—was an essential part of what the centre offers to users. It was suggested by participants that such an environment is crucial for centre users to transition from feelings of hopelessness and despair, to experiencing self-worth and capability:

> If somebody needs help, sometimes it's really, the hardest thing is to go and ask for help, so you can come along here, you don't have to ask for help, you don't have to, you know, engage on that level but you're getting support and help and acceptance and that friendly word and, a sort of, just somebody saying 'how are you?' (Participant 1, worker)
>
> *A new volunteer on the tea bar had started that day. Penny had been a centre user on and off through the years and had decided to volunteer for a day a week. Sally was watching how she was making the tea and decided that an intervention might be useful. She said that the art of a great cup of tea was in how you stirred it rather than the proportions of milk or sugar but that not a lot of people knew that. She said Penny was just waggling the spoon about whereas it had to be a consistent firm stir. To be honest Penny couldn't see any difference between their stirring styles but she was happy to humour Sally and thank her for the advice. They then went on to have a chat about how things were going more generally.*

One of the key elements that places the centre in a strong position to challenge the experiences of social isolation and alienation that many users have experienced is the low-cost meal. In an instrumental sense, the low-cost meal is an essential service that can be the only regular meal that many centre users have during a given day and this makes it an incredibly important local provision. However, the inherently social nature of communal eating is also very important as a natural vehicle with which to bring people together and this was a central feature of lunchtime at the centre. Research shows people's lives change very significantly when they have people to spend time with[10] and lunchtime at the centre provides such a context. This is especially important in Brighton where the problem of isolation is particularly acute:

> But the food itself, the whole eating aspect of it, makes people talk (Participant 8, volunteer)
>
> *The lunch was the central point of the day, it felt like the heart of the centre and Gary liked that all of the people in the centre, even the ones he didn't know, would come together for that every single day. He could feel the buzz as it approached. Gary knew from personal experience that the lunch was a lifeline for some people but it was more than that. Gary liked coming to the centre for lunch, not just because he could actually afford it but because he was dining with other people. At lunch today he didn't recognise the others around his table. One of them, an older chap, remarked that the lunch was nice today. Gary nodded in agreement and said he liked it when Gabby was cooking. She could make decent grub out of anything. The older chap nodded and they went back to eating their lunch in silence. It was good to eat with other people.*

Conclusion: Is the BUCFP a Centre for Mental Well-being?

One of the things we've attempted to show with this rather clunky 'cut n shut' format is that the actual workings of well-being encounters and practices often tend to be quite banal, implicit, silent and indecipherable within the terms of the typical apparatuses used to assess impact and improvement. But if we understand well-being not as an internalised quality but as sets of effects variably produced in specific times and places, and as situational and relational,[19] as complex assemblages of relations not only between people but also between people and places, material objects and less material constituents of places including atmospheres, histories and values, then we can think about spaces like the centre in different ways. Duff[20] talks about the 'everyday work of recovery' and the importance of routine, social inclusion and access to diverse beneficial spaces. The BUCFP can be viewed as an enabling place and one that is made or nurtured as much as it is 'discovered'. To date, the balance of evidence regarding the therapeutic character of places has emphasised the characteristics of those places in contrast to activities and practices of users and inhabitants. When you look at Lilly, Gary, Ros, Alan and Sally, their encounters show that they actively make them places of their well-being or convert them into places of recovery.

Mental health professionals and employment rehabilitation professionals typically plan rehabilitation activities targeted to assist people to acquire and apply new skills, and access the resources to live a meaningful life in the community.[21] The people that were interviewed provided a picture of a centre that offer these opportunities but implicitly rather than through a routinised plan of care and self-development. In so doing, it provided a community platform for some of the centre users to move from alienation and lack of purpose to finding a sense of meaning through working with people experiencing circumstances and histories similar to theirs.

Centres like the BUCFP foster networks and opportunities for disadvantaged people in a way that statutory services can find difficult: where an environment is provided that allows people to get help, information and community interaction without waiting behind a glass partition,[11] where they aren't required to develop the identity of the 'helped' in order to access this.

> So if you can, if you can treat people like human beings and give them a bit of you know feeling like they're worth something rather than I think a lot of agencies turn up and say well that's it, you've only got an hour here, you have to go (Participant 9, staff)

Many people who come to the centre have been subject to repeated experiences of being negatively labelled by others around them and are passive recipients of interventions to improve their conduct in some way. People don't tend to come to the centre to engage in projects to reconstruct their sense of self, sense of self-worth and capacity to integrate in society. They will come to the centre to use a high-class crèche, enjoy a low-cost meal and receive urgent advice to maintain their benefits or their home. Some might want to come to the centre to get away from some people, or to be around other people, to try something new by joining an art class or a computer or language class. The reasons that draw people to the centre are wide and varied. Through the centre they come to feel worthy of other people's attention and not due to their deficits but due to their capabilities, talents and status as a deserving person. For some who use the centre, it provides a natural bridge between previous experiences of mental health and welfare dependency in what Mezzina et al.[22] call the 'naturally occurring opportunities and rhythms of community life'.

People talked about the reconstruction of the self that can occur at the centre. This occurred as a result of the provision of a safe space, meeting people in similar situations through which they can empathise and build networks, a social meal that provides a context for social engagement, and through the more structured and formal volunteering opportunities so central to the development of self-worth and value. It is for this reason that the BUCFP can facilitate changes in some centre users' mental well-being.

> I did change, yeah, so it was very good for me, yeah... it's just that I reconnected with the world, I… you know, and I got back to being myself eventually, it took six months, you know, I'd just have extreme anxiety when I

> was depressed, extreme, extreme anxiety and that carried on a little bit... I was being here, being busy doing other things, I wasn't in my head, at home on my own in my head (Participant 12, volunteer)
>
> I actually got in the, sort of, suffering from depression, from being poor and, sort of, alienated, and so I can only, best example is to use myself. When I started coming here it changed my whole outlook on my situation, realising that 'God, you can get involved, you can do this, you can do that' and going home thinking 'Oh that was really, you know' and that was, I, self-worth, you know, going home thinking 'Oh, I made a little bit of a difference today' you know what I mean? (Participant 3, trustee)

For some people, they receive respite, safety, warmth and food. For others, they get the chance to talk to other people, socialise and interact at their own pace and in a manner that feels comfortable to them. The centre allows people a place to be, a place to reconnect at their pace through activities like photography, art and yoga, that they may never have experienced in the past. The centre can provide a platform for people to address the incredibly damaging and difficult experience of complete isolation that is experienced by so many people in the margins of society, who have struggled with poverty, unemployment and mental distress. The ethos of the centre is such that these people are catered for and allowed to just 'be'. It is a place where people can come to be social, to be well and to be productive in a multitude of ways that are not recognised by a strict workfare agenda and its notions of citizenship. An implicit acceptance that people have different needs and that they move at different paces is an antidote to previous paternalistic and corralling contact with impersonal institutions interested in pushing them into certain identities, regardless of their histories, capabilities or readiness. The ethos of the centre, hands-on for those who are ready, and hands-off for those who are not, provides a context for people to relate to others in ways that don't feel forced or strained.

More than one interviewee from the paid workers' and trustee board specifically outlined that the centre was not a mental health project. However, the accounts of many of the people who use the centre suggest that, while the centre has not been formulated with the intention of explicitly improving the mental well-being of centre users, it has, through numerous mechanisms, had a very significant impact in this area. Indeed if one is to adopt a social view of mental well-being that moves beyond clinical practice, the activities that take place at the centre can be viewed as fundamental to many centre users' mental well-being.

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9

The Joy of Sex

Meet John. His story is an amalgamation of the insights we've got from a number of people one of us has interviewed over the years for various different projects related to sex. He's just come back from a hippy tantra festival overseas. He thought it might help him with his porn addiction. He doesn't call his problem a porn addiction, but like many men in the UK, if even conservative estimates are anything to go by, he's addicted alright.

And he's not just addicted to watching grown up women earn an honest crust to buy their kids' school uniforms. John has far more sinister urges. It's not that he feels good about that. It wasn't something he meant to do, but he found himself straying into sites where he could watch young girls at work, after he got bored with masturbating over housewives his own age. He didn't even think about it—nor about why those girls would want to be prancing round for his pleasure. They must like it, right? And he wasn't doing any harm, was he? Just looking. And well, a bit of masturbation. Where was the harm in that? More of that in a bit.

Anyway, when his wife Mandy threatened to run away with their two little kids, he finally agreed to go to Relate. But by then, Mandy was past trying to patch things up. She'd never known about his online Thai

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school girls, but she had seen the way he looked at their daughter's friends and it made her stomach churn.

Even John was feeling that it had all started to spiral out of control. But he was still thinking that it wasn't really his fault. He and Mandy hadn't had sex for years. Not since the kids came along. What was the big deal about a bit of porn? Mandy kicked up a right stink—she said it was disgusting the kids were the same age as John's. That was ridiculous. John never thought about his own kids that way!

Sex between John and Mandy had been weird for a long time, and when they did it was as if neither one of them was a part of it. Mandy had also come to hate his laptops, and she knew deep down that there was something decidedly odd about the fact that he was always breaking them.

John and Mandy have never heard of the Diagnostic and Statistical Manual of Mental Disorders, the psychiatrist's bible we discussed earlier in this book. But given how much it does cover, isn't it funny that internet pornography addiction and online sex addiction are *not* official diagnoses in it. You may have gathered from our earlier chapters that we're not huge fans of this manual (well, one of us isn't especially). But even he reckons that if anything was going to be documented in this manual, some people think those would. Of course, this isn't a straightforward issue though. There is considerable debate about whether addiction exists, for example. The addiction cycle of dopamine describes the response to pleasure but does not necessarily constitute addiction. But however you look at it, there is certainly something very wrong with John.

With Mandy and the kids out of the way, the opportunities for John to access the porn increased. In fact, almost any time he wasn't working or sleeping. But the hours online didn't seem to be satisfying—he ended up spending more, and more, and more time online. And visiting more and more out-of-the way places along the way. In fact, sometimes he felt so disgusted afterwards, he wanted to trash his computer. In the last year, John had to buy seven new laptops because he'd smashed them all in fits of frustration and anger at his behaviour. Always in the early hours, always when he'd ejaculated to the gentle moans of Thai schoolgirls tortured by men who looked like mates from his local pub. One Sunday, dawn broke as John wept on the phone to Samaritan Jean. Jean gently coaxed him to put down the razor blade and hold a tight cloth to the wounds on his wrist and allow her to call an ambulance. John told the hospital psychiatrist that he was just a bit fed up because his wife Mandy had left and wasn't letting him see the kids. He was fine now and had never meant to actually take his own life. The weary psychiatrist made him an outpatient appointment and sent him on his way.

That night, to the moanings of five different Thai kids, John nearly finished the job off properly. He didn't think it was lucky at the time, but fortunately for him his lodger Nirdosh came back from his weekend away early and called an ambulance. Luckily for John, Nirdosh saw what was on his laptop and insisted he got help. It was either that or the police. If he were a real person instead of an assemblage of people we know, we'd be livid that Nirdosh didn't call the police anyway. You might be sharing our sentiment. But whatever you think, that is how John ended up at the tantra festival, posing as a sexual explorer. It seemed like an unlikely place for John to end up, but Nirdosh knew a few hippies who'd helped other blokes just like John. And since Nirdosh was the only one who knew his dirty little secret—apart from Mandy—John felt he had to take his guidance. After all, maybe there was more to what he was doing than seeking solace through escapist porn.

He needed to connect his cock properly with his heart and brain, Nirdosh explained. They were good at helping people do that—conscious sexuality he called it. These people didn't seem to be that conscious to him—more like off their faces. Granted that at times they dressed it up in what seemed like a cross between a Baptist church service, a yoga class and a scene from a Dennis Wheatley novel. Only problem was, all that prancing about in white robes, incense and cross-legged Sarong ceremonies didn't do it for John. And he was in agony in some of the punishing cross-legged yoga poses because he could hardly sit up straight for 10 minutes, let alone four hours. Something else bothered him about it; although he was a right pervert, John was politically correct in a few ways. He'd noticed how heterosexist a lot of the tantric stuff was and he didn't like that. And some of their drivelling on about women as essential Shakti energy irritated the sociologist in him. But still, having lost his wife and children, he was desperate, so he suspended his doubts.

When he arrived, the first session was already in progress. And the organisers seemed to mean well (well, in a heteronormative kind of way);

all women are beautiful goddesses to be respected, and when she says no she means it. John didn't notice any mention of age taboos, and as the weekend wore on, he began to feel uncomfortable about the way in which a couple of the older male workshop facilitators seemed to delight in thrusting themselves rhythmically into the crotches of a succession of young girls desperate for attention. Funnily enough, it was seeing other men behave in such a deeply dodgy way, alongside other chaps there who were making profound spiritual connections, which became John's tipping point. He threw himself into tantric practice and began to experience a change in his attitude to his own body and his own erotic feelings. He got excited about the amount of sexual freedom at the workshop and kept coming back, and back, gradually understanding how the women were both different from men and the same. As the workshop facilitator he particularly gelled with explained, regardless of gender and sexual orientation, we all want our basic needs to be met. Yes, maybe he did become more conscious, and after a ground-breaking darkness retreat in Bali, he ended up retraining as a tantra teacher. Along the way he saw a psychologist about his attraction to young girls, and he felt she'd helped him a bit. But most of his change process, he says, was down to getting into tantra.

Fast forward 10 years and now you'll find him happy as Larry. He tours the world supporting men to appreciate sex and relationships in a more respectful way. And he helps people to really enjoy sex and be technically fabulous at it. Most importantly, he no longer lusts after young girls and he has even hooked up with a tantric goddess two years older than him. And yes, he wears a kaftan and sandals sometimes. And yes, he doesn't need to break his laptops anymore. Shame he doesn't see his kids very much though. They're teenagers now, but Mandy still won't risk letting them stay with him.

Sixteen-year-old Vanessa, a sexual abuse survivor got a lucky break at the tantra festival too. She'd pretended to be 18 when she signed up for it, but early on she confessed to a facilitator who announced to the group that they all needed to take care of the young people at the festival. He made it clear that if anyone had any difficulties with the behaviour of any one individual, they should seek him out, and he'd see to it that they'd 'never walk again'. The facilitator was joking about the last bit, and yes, it doesn't sound very spiritual as a behavioural practice, but it seemed to work by putting the wind up some of the men who would have behaved that way. Unexpectedly the festival gave Vanessa a chance to connect with the other goddesses and explore her lesbian side with some of the other young women there. She's never looked back.

And 39-year-old Louis got something out of it too. Louis is a member of a club for people with disabilities. He'd plucked up the courage to attend the tantra festival after going on a trip to Berlin with a few mates and some support workers. In Berlin he'd paid a prostitute and actually had sex with another human being for the first time in his life. It wasn't that much fun, but the second time he did it with a lady who advertised herself as a sexual surrogate, it was much better. There was a bit of a drama about it all when he got back home to his group. A few managers kicked off about him spending some of his benefit money on sex, but the dust eventually settled. He felt it was worth it as now he feels he's beginning to see himself as a sexual person, so much so that he even visited a cuddle party in Berlin on his next trip and had a couple of sexual encounters without paying anyone. He hadn't noticed many disabled people there, but the few that were out clubbing that night provided good role models. Just a year ago, he was a profoundly lonely and clinically depressed virgin about to pay a prostitute for sex, and just look at him now, cheerful as ever in his sarong, gazing down into the eyes of a cross-legged goddess who was returning his gaze with something that felt like love.

Looking back at the other chapters in this book, we've probably not been short of writing about charities or non-profit-making organisations that have, as a by-product, often without knowing it, helped people whose mental health is tied up with a very unhappy relationship to sex. In our interviews with these organisations, we didn't explicitly ask anyone about sex. Looking back to the interviews now after writing this chapter, perhaps we should have. But let's just explore that narrative anyway. It's not too far-fetched to imagine the unemployment centre worker who finds a couple of men confiding in them about their porn addiction, or the cycling club organiser who doesn't even know that cycling in his group helps a woman who's never had a consensual relationship, or an orgasm for that matter, feel just a little bit more trusting of men than she has ever done in her life. You get the picture. And as well as the support that the kind of organisations we've discussed in this book offer, of course there are formal statutory and voluntary sector structures that give explicit support with sexual health, for example, GPs (in the UK at least) and sexual health clinics.

And for young people, Personal, Social, Health and Economic (PSHE) education lessons at school help them to grasp some of the basics, although the curriculum is largely deficit focused—how to deal with the negative side of sex, almost completely ignoring pleasure. Attempts in the UK to introduce a General Certificate of Secondary Education (GCSE) in sex which would be an opportunity to really explore the positive have been thwarted.[1] In relation to young people again, one of our interviewees for this chapter was from YoungMinds, a UK national charity. They support young people with mental health issues, and campaign for better services. YoungMinds explained to us about the frequent calls to their helpline from parents and young people asking for support with negative sexual experiences such as sexting, pornography and online bullying. We explicitly asked them whether they are ever asked by a young person about how to have nice sex, just to help them feel happier per se. Maybe as an alternative to some kind of therapeutic intervention even. Or by a parent about how to talk to young people about the joys of sex. Nobody at YoungMinds could recall ever having such a conversation.

Of course, YoungMinds is not explicitly a sex helpline so perhaps it's not surprising that their workers don't recall ever being asked that question. However, even thinking about many of these avenues for people to access explicit support around sex, one thing is very striking. They are to a large extent connected to supporting people with problems, so they are deficit focus. There are a few good internet resources that support young people, with Scarlateen being a good place to start (www.scarlateen.com).

Looking at what academics have to say about sex and sexual practices confirms our idea that much of what we see and hear about sex, and support for sex, is deficit focused. For example, there exists a plethora of research looking to explore the 'risk factors' associated with individuals engaging with unsafe sex or 'risky sexual behaviour' (e.g.[2,3,4]). Research has also explored the determinants of teenage pregnancy as an outcome of problematic sexual behaviours (e.g.[5,6,7]). Other areas include research exploring issues around sexual offenders;[8] the negative impact of pornography on expectations of sexual practices,[9] sexual aggression,[10] female disempowerment[11] and compulsive pornography consumption has had a great deal of attention.[12] Whilst the purpose of this chapter is not to provide a systematic review of this literature, perhaps it will suffice to highlight to the reader that sex in these core areas of research is generally perceived and presented in a negative light, as a 'problem'. It's left us wondering ever more, where do regular people, not necessarily those with porn addictions, find support simply to help access the joy of sex? Especially young people.

Sex is arguably one of the most natural forms of pleasure known to humans, yet it really does seem that it has largely been understood as a devious or morally problematic set of practices in many parts of the world.[13] This hasn't always been the case. For example, Foucault[14,15] argues that in classical antiquity, sex and sexual practices were understood through entirely different discourses (e.g. pleasure, reciprocal relationships, affect). He and many others (e.g.[16]) arrive at the rather damning conclusion that this positive representation of sex and sexual practices remains largely absent in much of contemporary society.

In the absence of a long list of not-for-profit organisations that we would feel comfortable sending friends and family off to for support with sex, we are turning to wider influences and research that other people have undertaken to bring out the joy of sex. Some attempts within society have been made to challenge this dominant understanding of sex. For example, let's consider the publication of Alex Comfort's illustrated book *The Joy of Sex* in 1972.[17] What a controversy that book caused by, on the one hand, being a book that spent 11 weeks at the top of *The New York Times* Best Seller list, yet, on the other hand, being kept out of USA libraries by religious groups. More recently the launch of the book, and subsequent film, *Fifty Shades of Grey*,[18] reawakened some of the debates and taboos associated with sex and sexual practices. Still we've not yet been part of any conversations that have involved a sensible discussion of how playing with Mr Grey might have helped his lady friend feel happier in life and stay free of an Increasing Access to Mental Health (IAPT) intervention.

Ok. We're clutching at straws now, so how about we get scholarly again? Let's consider what support there is for the fundamental argument that sex is good for mental health. Experiments by Brody and colleagues[19] did find that people who had recently had penile-vaginal intercourse were less stressed than those that hadn't had any sexual activity. All a bit heterosexist of course, but you get the idea. Mr Grey's lady friend take note.

Exploring the empirical literature some more, there is further support for our argument here, although it has to be said that studies concerning themselves with the benefits of sex, especially the mental health benefits, represent a minority of the research on sex.[20] For example, Gott and Hinchliff[21] explore the importance of sex for elderly individuals finding that all participants that had a sexual partner rated sex as 'very' or 'extremely' important. In addition, Diamond and Huebner[22] argue that positive sexual functioning plays a 'unique' and 'fundamental' role in an individual's health and psychological well-being. Finally, Blanchflower and Oswald[23] analysed data from 16,000 Americans to explore the possible links between money, sex and happiness, finding that sexual activity is positively correlated with happiness. Therefore, whilst Foucault highlights the notion of pleasure in ancient historical understandings of sex and sexual activities, this seems to have been placed secondary to the 'darker' side of sex.

Considering these academic and popular culture avenues have convinced us all the more that it's worth trying to uncover something of the joy of sex for mental health, part of a wider programme of work taking a positive resilience-focussed approach to supporting mental health, rather than a deficit-focussed approach (Hart et al. 2016, Hart et al. 2007, Boingboing, 2016). So this chapter attempts to build on the rather marginalised research exploring the more positive aspects of sexual activity on an individual's psychological health and well-being. Research for this chapter has found us combing the world looking for great organisations that don't (just) focus on safer sex, but rather on the joys of sex. Well, we haven't literally combed the world. We have mostly looked on the internet, read some books and have interviewed a handful of people on Skype. One of us has also been to a few hippy festivals and interviewed various colourful characters for this book. But the festivals were paid for out of personal finance in case anyone from the *Daily Mail* is reading this and wants to have a good moan about universities wasting public money.

When we first decided to include a chapter on sex in this book, we didn't think it would be so hard to find not-for-profit organisations focusing on sex, which we felt happy to include in this chapter. But it has been. So let us fill you in what we have discovered.

First, The Pleasure Project based in Sussex, UK, has been "putting the sexy into safer sex since 2004… Because sex education is rarely sexy. And erotica is rarely safe." (The Pleasure Project, 2013) – we couldn't have said it better ourselves. Whilst they don't explicitly mention mental health, the site is most definitely focussed on the joy and pleasure of (safe) sex. They've scoured the internet to provide a hub of resources including training information and ideas for sex educators, links to other sex-positive websites, and a global Pleasure Map of other "people and resources who promote pleasure and sexy safe sex in the public health world". Remember the plethora of deficit-focussed sex research we mentioned earlier? The Pleasure Project have published research showing how promoting female condom use as a pleasure-enhancing erotic accessory, has changed attitudes and acceptability, for sexy safe sex in several different countries (Philpott et al., 2006). If you, or someone you know, are practicing what they preach, you can submit your details for inclusion in the website. Perhaps our tantric guru, John, can add his respectful sex and relationship coaching for men to the Pleasure Map. And if you're interested in finding out what's available in your neck of the woods, or you want to point your teenager at some joyful content, perhaps to balance whatever their mates send them on the latest sexting app, this might be a good place to start.

We're also going to put in a plug for our good old National Health Service (NHS) in the UK. On the NHS Choices website there are a few pages discussing how sex can be really beneficial.[29] It's all a bit 1970s, and they don't go into the mental health side of sex particularly, but at least there is something positive about the health benefits. They even include some sex tips which actually touch on how to have good sex, rather than warning of its hazards. Mind you, they can't resist discussing cleanliness issues which might put a dampener on things if you are seeking advice. Still if you're wondering about the best practice in how to wash a penis, alongside many other useful tips, such information can be found here.[30]

Whilst the internet provides privacy and information, it's probably not going to give you warm and meaningful sex-positive experiences. For the human element, there are individuals, groups and organisations that offer telephone and face-to-face support and information. Think back to John's sexual rebirth which we introduced at the beginning of this chapter it's not that we're exactly enthusing about tantra organisations and practices here. Most of them seem to be private organisations or freelancers, with a great variation in the technical quality and ethics of their work. Not that, at least overall, there is that much money to be made from it. With the exception of the occasional very rich Australian guru type who was too busy, or who didn't want to be interviewed for this book (after he said yes can you believe and teased us with emails back and forth, you know who you are!), tantra practitioners, are in the main, people who have spent quite a lot on their training and yet they don't earn a vast amount of money. Partly we're clutching at straws telling you so much about tantra because there are relatively few community organisations or activities that have a really positive take on sex compared to sex doomsayers. In the remainder of this chapter we will discuss a few organisations not mentioned elsewhere who support people's positive sexual expression. The first is an organisation that helps disabled people. The others are personal development centres. We will come back to them later.

Earlier on in this chapter we mentioned Louis, a member of a charity that supports disabled people. Outsiders is the kind of charity that Louis might belong to. It's a social, peer support and dating club run by and for socially and physically disabled people.[31] They have written a book based on their experiences[32] and they receive funding from places like the Big Lottery Fund.

For this chapter some of the volunteers from Outsiders were interviewed and this is what they told us about how people use the club. First we will fill you in a bit about the kind of people who are involved with Outsiders. There are members of the public—disabled people with sexual problems and their health professionals—who call the Sex and Disability Helpline for support with the problems, which normally takes around four minutes. Some people send emails which is more difficult and takes longer, with a yoyo of questions/answers. The main coordinator told us that one young disabled lady took 52 emails of advice support to enjoy a satisfactory orgasm. That's dedication, both for the young lady and the coordinator emailing back and forth.

Then there are the disabled people who join the Outsiders Club, to meet new people, find peer support and find a partner (or whatever sexual/social relationship they seek). They are restricted to 'people who can handle their own affairs' and this excludes some with learning difficulties, mental health problems and brain injury. The coordinator said that the volunteers requested they stick to this original arrangement very strictly, because 'they are not able nor willing to cope with the trouble caused if we don't'. Funding never stretches to paid staff but interviewees said that everyone felt very bonded and happy in their work. Some people come in from outside, usually people with physical or hidden impairments, as trustees, lunch workshop/discussion facilitators, designers, webmasters and so on. They have a team of sexual advocates across the country and abroad, for disabled people and health professionals who need support with negotiations, including sexuality as part of holistic care and places where they feel stuck. Part of this work is supporting disabled people to have a positive experience with a sex worker.

Within the Outsiders Club there are the Sexual Health And Disability Alliance (SHADA) members, social and health professionals who work with disabled patients and clients in a holistic, person-centred fashion, including their sexual expression. SHADA has a chair, secretary, coordinator, convenor and scribe. They meet in London twice a year and are just beginning to form pressure groups to support pioneers who find themselves blocked from putting their policies into practice.

The coordinator of the group, Tuppy Owen, said that she felt that the group had been of enormous help to people's mental health, helping them feel more stable and happy. On the other hand, she stressed that mental health wasn't really their domain and they were wary of supporting people with serious mental health problems. That said, it certainly seemed like Outsiders had done a lot to help people in this regard. One example she gave to illustrate this was that of a blind man who said he'd joined Outsiders after his (happy) marriage had broken up because he could no longer cope. He explained that for the first two years post-marriage, all that happened was that he was in telephone contact with other severely depressed women. Then he met his current girlfriend, also blind, and they have a wonderful relationship, and have even discussed starting a group (along the lines of swinging) for blind couples. Result. Another man she mentioned, who is partially sighted and very bright, with Asperger's, says that if he doesn't get out to mix with other people for too long, he begins to wonder if he is the right gender, if he is gay, or even if he is a paedophile because of the way his anxieties spiral out of control. So it seems vital to her that he come along to Outsiders. Mixing helps him to ground his self-talk in reality. She also mentioned that they were planning a workshop on how depression impacts on masturbation. Important here too is for people to be aware of how antidepressants can impact on sex drive. So clearly issues of mental health crop up in their orbit on a frequent basis.

In general, volunteers tended to concur with Tuppy's view. For example, here's Barry, who said that he suffered from depression and post-traumatic stress disorder, talking about the effect that being part of Outsiders has had on his mental health. He said, 'Since joining Outsiders I have become more open-minded than before and equally closer to understanding what true equality is.' Barry went on to say that he had found a warm, friendly group of people who have also shared similar issues and difficulties with forming relationships and exploring their sexual identity. As he comments:

> We are able to share knowledge and therefore lessen the barriers we have experienced. Providing travel to and from any event or lunch has gone well and without major difficulty, in general, I have felt a great uplift in mood, with memories to treasure on quieter and more difficult days in life. My circle of friends and acquaintances will have greatly improved with which to network with via multimedia or to meet up with in the future

In particular, Barry found the openness helpful with regard to sex and relationships and the issues people face. He appreciated others offering suggestions and help in a friendly manner to attempt to solve these issues. Talking about sex normalises the issues and integrates them into the individual's self-perception.

Important to note here is that in no way is this organisation trying to promote itself as supporting the mental health of disabled people.

However, through helping people connect with their sexual selves and challenging societal attitudes through their information and advocacy work, they are clearly doing work that hits this spot. Imagine if access to this club was seen by our society as a potential therapeutic intervention to tackle Louis's depression and to work with dealing with earlier trauma through healing touch grounded in trusting relationships. Imagine if it were included alongside therapeutic interventions in research programmes. How different might the recovery story be?

There are two personal development organisations that are also worth mentioning in our discussion of positive support for sex and mental health. The first is *Living Love*, created by Jewels Wingfield. She offers a programme of tantra workshops, courses, solo retreats and events both indoors and in nature, as well as private sessions for couples and women. Jewels shares her vision on the website but it is a bit vague and for those of us who aren't in the tantra world, quite hard to understand from the vision exactly what they do. See how they describe it on the website:

> Living Love seeks to serve the awakening and evolution of the individual and collective human consciousness and return humanity to living as interconnected Sacred beings with all life in the context of an Earth based spirituality

From what we know, most people are attracted by experiencing a taste of her work at a summer festival or workshop in nearby Bristol. Jewels's couples work is grounded in her work with women, women's cycles, red tent gatherings and other spiritual activities, and her approach with couples is to support better communication. For those who just want a bit of help spicing up their weekly sex session to cheer themselves up a bit after a night losing at bingo, it might come across as somewhat esoteric and bewildering. Still, it certainly seems to offer the chance for people to connect with their sexual selves and improve their mental health as a result. Unless you are a carnivore, you might well enjoy a short séjour to find out for yourself. At the time of writing, none of us has been there so we can't tell you what we thought. Its home is four acres of land and a forest temple in the middle of the 200,000-acre ancient Forest of Dean, near Bristol in the UK. They do seem to be a private company, but they offer a sliding scale and we don't get the impression that they are in it for the money. Most of the workshops happen in the forest temple and some in other cities around the UK. Jewels is the guardian of this land, EarthHeart—and the website says that it 'offers a place for people to come and reconnect with how to honour Nature as Sacred and a gateway to reconnecting ourselves as a living embodiment of this'.[33] Perhaps they could benefit from a translation section on their website for cynics or people totally new to the world of Conscious Sexuality. You could really get put off by this, or just be totally confused. But we don't mean to be unencouraging. At least she's trying to do something sex positive.

Another UK-based personal development organisation that inadvertently supports people's mental health through working with sex is Osho Leela in Dorset.[34] They have a somewhat controversial connection to the Osho Sanyasin movement which we won't go into here, but you can read more about it, if you fancy.[35] Over the years, the centre has changed to some extent, catering more and more for people who aren't specifically connected to the Sanyasin movement. Osho Leela run a variety of personal development workshops and festivals. They describe themselves as a therapy, training and personal growth centre. On their website the language is less complex than that of EarthHeart: 'Well known for its festivals, parties and celebrations, Osho Leela is supported by a vibrant community that resides in a beautiful manor house in the heart of the Dorset countryside.' To give you a flavour of what they do, some activities are music based and others oriented around dance. Massage and gardening get a look in too, and some are tantric, although they too refer to this side of their work these days as 'conscious sexuality'. All have a meditative focus.

There are some caveats we should mention here about what they offer at Osho Leela and this goes for other conscious sexuality outfits potentially too. Osho's take on 'therapy' developed in the era of confrontation and catharsis, so their approach works best for people who are fairly robust. The people who run self-development workshops are not required to be therapists in the strictest sense of the word as people would understand it in modern Britain—by which we mean they're not qualified, supervised or members of professional bodies. Although most of the facilitators have had some formal training, they don't all receive ongoing regular supervision, and aren't all registered with a professional body. Given the complex psychological dynamics that go in such group contexts, it would seem sensible to at least ensure that the facilitators have some kind of supervision structure in place. Some sort of therapeutic support for those who get triggered or re-traumatised by their robust approach is also necessary in our view. You might think it is a bit hypocritical saying this after those earlier chapters in this book questioning the current make-up of the formal psych industry. What can we say, except you are right and so are we. We never said all this was easy to sort out.

Nevertheless, interviewing people who have been to Osho Leela, it's clear that the tantric side of the work that goes on there that they host, can support positive mental health. For example, a regular visitor to the centre highlighted how it had really helped his clinical depression to explore his sexuality with a group of like-minded people, and through the group he attended he had made friends with some people who he connects with regularly back home. A woman at the group simply said that it made her feel much better about her body exploring her sexuality in this environment; previously she had felt unattractive. Good stuff there then.

And so we could continue this chapter with even more snippets from the bricolage we have assembled from the research we conducted. This bricolage is the end result of a somewhat thwarted quest to support the original ambition of illustrating the important work that organisations do to promote good sex, rather than respond to deficits. During the research for this chapter we have come across many freelance sex therapists who support people with positive sexual expression, in particular using tantric techniques and philosophies in their work. Both within and beyond the world of tantra, the interviews highlighted the fact that a number of people have found sexual practices to be of great benefit to their mental health. These range from everyday folk who spoke about how having sex with their partner frequently chased their blues away, to a man who eschews sexual relationships with others, yet masturbates every day. He noted that daily masturbation calms his mood and helps him feel more cheerful. And the link between good sex and positive mental health isn't just about sex in the raw. We could tell you about Josie, a woman interviewed for this research, who reports to have transformed her mood by accessing an online site that encourages people—men, women and transgender folk—to play with their sexual selves and those of others in a form of sexual second life. It is quite literally on the Second Life website.[36] So just go there yourself if you're curious! But possibly not on your work computer if you work, and have one.

We would be the first to admit that we started this chapter with a deficit story and haven't really been able to snap out of it for more than a few short paragraphs. The material is simply not there. The cultural pull towards negativity around sex is very strong. Foucault was right. Still, it's been good to get it out there on the table. Perhaps one of you reading this chapter will set up your own not-for-profit organisation that is primarily about celebrating our sexual selves. It could do wonders for people's mental health. Maybe even more than official therapy does. Or if not, it might at least constitute a worthy second fiddle.

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10

Some Possible Directions for the Future

Building Underwater Sea Empires

When we were children watching the various James Bond movies that repeatedly played on our televisions over the years, we were struck by a thought. The same thought each time. This was the case whether it was Max Zorin seeking to trigger an earthquake to flood silicon valley in order to take over the world microchip market (A View to a Kill, for those interested), Hugo Drax seeking to destroy all life on earth (Moonraker) or Stromberg pursuing his nuclear missile launch to destroy Moscow and New York City and hence triggering a global nuclear war (he would survive in an underwater sea empire of course). The same thought occurred—if they'd only been a little more modest in their aims, then there was a fair chance that their outcomes might have been a little more favourable. We can't say in all honesty that James Bond was at the heart of our epistemological reflections when we sat down to write this book but what has become clear, now that we are at the end looking back, is that we never set out with the intention to 'James Bond' the world of mental health. Indeed our aims were far more modest and there are a number of reasons for this.

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Firstly, attempts to smash the intellectual battlements of biocognitive psy activity often tend to verge dangerously close to replacing one restricted dogma with another—a trade for a reductionism founded on biology and cognitive activity for one focused on the social and economic world or on language. Straight from the off we were concerned that building a metaphorical undersea kingdom to survive the destruction of global biocognitivism might not be all that it's cracked up to be.

Secondly, and crucially, when you set out to write a book that is critical in orientation, you tend towards supplanting the consistency of narrative on one reductionism with a consistent narrative on another. Academic parlance doesn't typically reward hesitancy, uncertainty and disagreement between the authors. Most books present nice neat stories—x is bad, y is good, let's change x to y. And all of the authors are on board with this change. For our book, all three of us were broadly on board but there was also tension, debate and compromise. Through the course of this book, we debated (a lot at times) the value of the idea of 'therapeutic', the utility of the Diagnostic and Statistical Manual of Mental Disorders (DSM) endeavour, the use of conventional psychotherapies or indeed what was actually happening when people received some form of treatment or intervention for mental distress. So we're even not sure that we could necessarily agree on what our undersea kingdom should look like. Sure we could get past wallpaper and furniture, but the overall structure? That could be tricky. But we agreed on a lot too, enough to collectively write a book on rethinking some of the core ways in which we think about and 'do' mental distress work.

And the third issue was that, whichever way we decided to frame and problematise the formal activities of the psy institutions, we were faced with the fact that many people have experienced life-saving support from committed professionals, many of whose actual practice varies widely from some of the foundational biomedical and cognitive precepts that might be typically thought to inform them.

The quote below comes from Emma Shephard, who set up 'CardTherapy', a creative and therapeutic endeavour borne out of a severe period of postnatal depression that led to her and her seven-month-old child being admitted to a Mother and Baby Mental Health Unit:

> I think it has been a multi-faceted approach to my recovery. I would say number one was the anti-depressant because that had an impact so quickly I would credit the drug first saving my life to be quite honest because it completely changed how I felt in such a short space of time that there was nothing else to credit. But you know it was almost like waking up so I can't discount that and I think that the drug keeps me well now, I have tried to come off it twice unsuccessfully and you know there have been many different reasons for that—perhaps it wasn't the right time, perhaps the drug is just so physiologically addictive that you just that it's just a tricky one to get off, I don't know, I don't know, but it keeps me well. I also had really good therapy that was really painful to go through and again that helped me deal with another aspect of what had contributed to my depression so there was that. The drug worked on whatever was going on physiologically, the therapy helped deal with what was going on emotionally, the support from my husband helped me deal with things practically and then finally this (Card Therapy) has been like another piece of the puzzle towards me feeling completely recovered is this something I have come up with myself, something that is dependent on myself, something I am in complete control of and that, that feeds my own desire to you know get up and get on with my day gives me a focus is this so I think that they have all contributed in their own ways but just any one on their own wouldn't have done it, wouldn't have been enough but yea I feel like this is the final puzzle piece

Emma's experience, as do our own day-to-day experiences and those of others represented in this book, ring forever in our ears. They potentially mess around with any crude reductionisms that we might have wished to mobilise in order to establish the 'brave new world' of informal anti-psychiatry approaches to mental distress, as they do to any attempts we might have made to neatly demarcate what happens in formal biocognitive practices and the informal practices that we have discussed in this book.

And this is where Martha, our Martian in Chap. 2, didn't exactly tell the whole story. Just as our Martian critiqued the one-size-fits-all approach to what constitutes 'good' evidence, how professional practice plays out and how we define people in distress, she herself was giving a 'one-size-fits-all' account to her Martian superiors. And they would have picked her up on the irony of this. Because they (and I'm aware that we are treading on thin ice by implying knowledge of Martian superior's thoughts here) might have noted the reality that, while the discourses and practices of biocognitivism are prevalent and dominant and abusive and life-saving, they are also routinely misunderstood, subverted and reconstituted in the everyday practice of mental distress work. And as nice as it would be to have our cake and eat it, that is to render visible a fixed caricature of biocognitivist mainstream psy practice to take shots at while luxuriating in the diverse, holistic, fluid, beneficent and person-focused orientation of informal practices, we are going to have to work a bit harder if we are going to chart a way to rethink how we should support immiserated people.

The Big Question

This book began with some admittedly outlandish imagining of what the future might look like for the way that, as a society, we think about people experiencing distress. We were critical of the ways in which the current practice privileges the biomedical, psychotherapeutic and professional expertise, at the expense of everyday social arenas. And then we provided a range of settings, groups and activities which outlined the way in which everyday people doing everyday things could have tremendous and sustained impact on the mental well-being of the people who encountered the services. However, whenever you start to write something that is critical of contemporary mental health practice, or introduce ways of supporting people during periods of distress that are outside of the more typical biotherapeutic domain, you can sit back, count to ten and wait for someone to ask:

> ‘What about people in extreme crisis?’

It’s the question designed to sink the airy pretensions of academic dilettantes. How can we replace hard science, professional expertise, biocognitivism and evidence-based practice with the altogether softer social, relational, creative and everyday practices of care which are often barely understood as ‘care’?

'What about People in Extreme Crisis?'

Well a good place to start with this is to think through what is happening currently with, or to, people in extreme crisis. All three of us have an awful lot of experience, both personal and professional, of being inside acute inpatient treatment facilities in recent years, and of trying to support people to keep out of them. There is one such acute facility not far from where we live. It sits in a relatively leafy area just off a main road. The acute wards emerge into sight after what seems like a prolonged walk through an array of dark and winding corridors that would leave a rabbit begging for a compass.

And so the question is, what is the magic that happens once we emerge from the corridors? What is happening inside this heartland of biomedical care for those in severe distress that means that it is *the only way* to address severe crisis? Well when you go into these centres what you see is the following. The first thing is incarceration. For some at least; other people are in there voluntarily. Sometimes people experience both—at some points they will be incarcerated and at others they may ask to go there. Second, the people who are being treated there will be given medications, often different types of different doses, to try to find something that 'stabilises' them. Some academics will weave the beneficial activity of these drugs around a narrative of medical pharmacology,[1] others will posit that they are little more than broad brush sedatives[2] (albeit effective ones), while it is also important to note that up to two-thirds of medicated schizophrenic patients relapse, despite being constantly treated.[3]

By 'stabilise' this often means stopping the uncontrolled flourishing of mania, to reduce or dim the frequencies of voices they hear, and/or to manage the delusions and hallucinations in order to bring such people back in touch with reality. Inpatient pharmacological practice often looks more like trial and error than a carefully crafted evidence-based intervention, although it will almost certainly be informed by experience. Other than this a core activity is sitting around smoking cigarettes. A lot of people watch TV, some sit in their rooms, most smoke prodigiously and there are many quite sentient conversations between the people being treated and staff and between each other. You could even argue that therapeutic encounters sometimes take place. These spaces can be frighteningly loud and hectic and also quiet and relatively still.

You could characterise them as places where people try different sedatives, smoke cigarettes, and watch television in slightly grotty surroundings until they transition out of immediate crisis. Or you could say that they receive expert medical care, supervision and space in which to build towards a recovery. Part of the reason for the prevalence of different narratives, discourses and institutions surrounding distress and suffering is that, thus far, we have tended to *enclose* distress well but yet haven't really *captured* it.

Capturing versus *Enclosing* Distress

Research shows that from the early 1980s to 2002 prescription drug sales tripled to \$400bn worldwide; between 1993 and 2002 NHS prescriptions grew from 1,884,571 to 15,500,000 for Selective Serotonin Re-uptake Inhibitor (SSRI) antidepressants and from 3500 to 161,800 for Ritalin.[4] Over the last 40 years the diagnostic criteria for Attention Deficit Hyperactivity Disorder (ADHD) widened such that nearly 50 % of children now satisfy ADHD symptom criteria.[4] As academics we tend to take very dichotomous approaches to statistics like these. In fact we are obsessed by dichotomies or conceptual wrestling matches. We have done it through this book with the formal versus informal, statutory versus non-statutory, biocognitive versus social, and abusive versus therapeutic. And to be honest we feel a bit bad about it. Because important things get lost in these simplifications. The inpatient facility above does a number of things. We could view the activities through some of the standard dichotomies above but it's more useful not to. You could argue that it sedates, incarcerates and traps them and/or that it gives them space and relief. You could also argue that the facility puts them in contact with professional carers understood as warm, empathic, and supportive and/or short-tempered, dismissive or neglectful. They might experience themselves talked about as patients, given a diagnosis by groups of qualified people who scrutinise them, try out different sedatives and/or experience most care practices in there as little more than friendly chat and the delivery of access to television and cigarettes. You could say that for many distressed people who end up in here, they simply just need a breather from relentless and difficult proximal life events and people. Perhaps some or all of these happen. But make no mistake, there is no magic.

If we think back to our community singing chapter, Eddie had a regular activity where he could just 'be himself'. As we saw throughout that chapter, some might think that singing is a fairly banal activity but one that holds a special place in society. Here, group singing on a regular basis helped alleviate some of the distress people experience in contemporary life. It enabled people to shift their central focus from their distress to something different, build self-confidence, or simply embrace the upbeat nature of collective singing and the joy of music. And there was no magic there either.

For the many problems resonant within our contemporary therapeutic culture, good things are experienced in formal therapeutic spaces. We are pretty well positioned by now to pick out the bad things that happen but less so when it comes to recognising and naming the good things that happen in more formal environments of mental health care. When the technological paradigm of biocognitivism is used as the lens through which to study formal psy practice, we can miss the opportunities to make visible the real humanity, expertise and care practices that recognise the ordinary humanity of the therapeutic relationship—one that is a source of solidarity rather than a mechanistic technology of change.[5] But it is when formal mental health practitioners operate on the assumption that they are curing static illnesses that *demand* the tools of expert practitioners that so many 'non-compliant' service users are likely to engage in deceit and subterfuge when managing relationships with psychiatric services.[6]

Yet we are still dogged by an inability to articulate what works and why, and we have tended to pursue the solution to this issue through the reification of inadequate dichotomies (that we have also been guilty of reifying to meet our own ends at times in this book). When you look at Bike Minded, this issue stares us in the face. What was interesting about the experiences of the people on Bike Minded was why 'the atmosphere' appeared so key. The atmosphere was Rogerian in a sense that has been lost in many of the psychotherapies. On a project like Bike Minded, the atmosphere that so many spoke of was the realisation of unconditional positive regard, empathy and non-judgementalism, as ends in and of themselves. And there were other things that didn't lend themselves to the static disorder model and the randomised control trials that maintain its prominence—friendliness, openness, patience, stillness, silence and status. There was a sense of safety and refuge. For some there was a sense of escape[7] that wasn't separate or peripheral, but central to what people talked about as their recovery.

For the parents who turned up at Amaze, it wasn't deep-seated trauma that needed to be worked through, nor negative thoughts or feelings that needed to be challenged, nor rampant neurotransmitters that needed to be culled (although various sedatives certainly eased the path). The issue at hand for people who have found themselves ensconced in our individualising, often pathologising, and sometimes helpful mental health system, is that the problems they faced were, on the whole, practical, social, relational and financial. What was clear from the accounts of the parents was that they needed support, advice, information and companionship. They needed to be respected and listened to, have their knowledge privileged in the various consultation processes that they found themselves party to. They needed greater financial support, flexible employment opportunities and meaningful respite. A worthwhile psychology of distress needs to embrace the demystification of the psy colonies, where clinical predicaments are interpreted in a way that people know there is nothing they could have done. That they are not to 'blame' for their distress and that it is *possibly* not within their grasp, or the grasp of an expert, to fix.[5] That they don't need to be fixed using complex techniques, rather they just need a bit of a hand.

What these case studies of informal spaces highlight is that what can be so useful for mental distress is actually hugely variant in nature. It could be a singing group, a cycling group, an organisation to support parents of children with complex needs and/or a sedative. It could be an advocacy and information service for people using benefits, debt guidance, a tantric encounter, employment advocacy or advice on local facilities for a disabled family member. Or it could be just sitting down, with other people in a space that isn't your house.

What we have tried to show in this book is how we can understand and experience mental distress as a social 'thing'. Here though, the social isn't a single type; its form is fluid and when objects and the social spaces through which they emerge and travel are understood as fluid, it allows us to focus on what is done in practice, in different settings. Objects like distress are not passively immutable. They are actively brought into being dependent on the practices through which they are enacted. Different practices in different sites create different things.[8]

This book has sought to act as a celebration of spaces and situations that fix few, if any, of the rigid boundaries attempting to contain fluid distress. Unlike terrains of biomedicine which—at least in theory if not always in practice—seek to hold objects in rigid spaces within rigid networks of relations, definitions, roles, expectations and narratives, informal spaces tend to do this less. But the technical paradigm is a territorial endeavour that has reached far and wide, often perforating the spaces and settings that we have called nominally 'informal' in this book. We have set up a nice easy demarcation between fluid possibilities and active informal settings, and the rigid psy forms of knowledge and spaces of passivity. But what of spaces where the formal and informal breaks down? For instance, peer support groups led by a therapist inside a community group? Or an advocate from the mental health charity Mind working in the Unemployed Centre Families Project? Or a GP doing social prescribing? Or an advocate in an inpatient facility getting someone some cigarettes on the way up for a chat? Some informal settings have practices that fix fluid objects using the apparatuses of the psy institutions and some psy spaces have fluidity, and with this fluidity comes possibilities perhaps not recognised by the critical fetishists. And so what to do?

A Practice Future

Well what to do is to build on the primary innovations associated with the notion of enabling places—that is, the privileging of a relational account of place that acknowledges the resources for the 'everyday work of recovery'.[9] Such an understanding of place would include an acknowledgement for the diverse objects, assets and benefits that circulate in and through local communities. These include intangibles like companionship, empathy, atmosphere, hope and non-judgementalism, and more tangible things like practical support, advice and advocacy. A focus on practice—not on expertise or experts, immutable clinical categories, technologies and fixed knowledges—might allow us to appreciate that knowledge, status, relief, atmosphere and solidarity are constituted in practice.[10] Knowledge is not a tangible asset that can be moved between organisations or individuals. Instead it manifests itself as actors engaged in practices with other human and non-human agents.[10]

A practice lens might help us to strip away what happens, from what is supposed to happen, in clinical settings and to articulate with a little more surety what is useful and why. Within the dominant knowledge paradigm of distress, there are clearly constituted caregivers and care-receivers and certain forms of care are recognised, practised and legitimised as care. But we need to think about the way that we recognise these care practices. If multiple care practices are only talked about in terms that are not appropriate to their specificities, they will be submitted to rules and regulations that are alien to them.[11] If care can only be understood as 'care' if practised by the correct people (e.g. psychologists, therapists or psychiatrists), then we miss the practices that happen both in formal and informal settings.

Our current fascination with the static rationalist knowledge regime of positivistic biocognitivism not only misses care practices and fluid knowledges articulated in various informal settings, but it also does scant justice to the spaces of psy practitioners themselves. Moreover, when taken to its extreme, a strict adherence to this rationalist knowledge paradigm presents an altogether warped, inflexible and frankly bizarre set of arrangements between those deemed to be 'professionals' and 'patients' (particularly bizarre for psychotherapists who receive psychotherapy by another practitioner to help them deal with the distress experienced from having to listen to the distress of others). A focus on care practices moves us away from rationalist versions of the human being with the understanding that, in enacting solutions together, people collaboratively shape what the problem is, what form it takes and how it can be addressed.[12]

If we use a questionnaire for depression, in the presence of a medical professional, immediately following the time spent in a waiting room that transitioned the individual from 'person' to 'patient',[13] this tells people how to talk about their distress and what terms to use; subsequently we enact an illness requiring treatment. Alternately if the same persons ring up the advice line of the local support organisation to discuss the desperation they feel because of the lack of sleep they have had and because they don't feel they are being listened to by their children's school or doctors, then different problems may be attended to in different ways.

If we want to recognise the fluid and innovative nature of the many variegated care practices, then a future course for a social science of distress is to develop and celebrate methods that are sensitive to this fluidity. It is difficult to recognise fluidity using the static snapshots enabled by all quantitative and many qualitative methods. Care practices can be done, rather than known or told, and they may be silent and implicit, as well as explicit and recognisable.[14] So it appears that there is a need for a social relational approach that embraces the fluid complexity of misery and eschews the careerism that tends to enclose, fix, hold static and monopolise rationalist forms of knowledge, knowledge that can too often displace, colonise and damage care practices which are less formal.[14]

The tendency of capitalism to colonise new areas of social and psychic life[15] has privileged models of care that cannot recognise well-being as anything other than a set of internalised qualities to be produced via financially rewarded technologies and treatments. However, we can also think about well-being as sets of effects produced in specific times and places, and as something that happens through the interface of complex assemblages of people, places, material objects[16] and other intangibles that we recognise and often crave, but can barely define—things like atmosphere, shared histories, sense of place, values and feeling safe.

When you look at a setting like the Brighton Unemployed Centre Families Project, where people eat a decent meal together, feel a sense of safety, stillness and space, and feel enabled to enact some form of change in their lives, you can see that while the social materialist realities of distress are complex, the enabling practices of recovery can be relatively straightforward. Here we can recognise the ordinary humanity of the care relationship, between people and people, places, atmospheres, activities and things. Ordinary is the key word but not because we need some oversimplified, anti-intellectual drive to strip care to some artificial edifice that anyone can do, but because both simple and complex care practices exist within and outside the formal settings. A key element, however, is a general recognition in informal care settings that recovery cannot be *done* to a person. Rather it is something emergent from the complex set of transactions between a person and his or her broader socio-environmental setting.[17] In our fishing chapter, the authors discussed the value of 'learning through country' and how in so doing, the boundaries of expert and instructor dissolved. In these spaces people combined their ways of knowing in a situated experience of loss, rebirth and hope. Such experiences can act as valued counterpoints to the intensity of their home setting, provide platforms where people could assert themselves differently at home and could have power because of what they are *not*, as much as what they are.

So what might a focus on practice look like? Well one might say the social prescribing model could edge us in that direction.[18] Here we have examples of primary care settings collating information on local groups and community-based support. This uses agreed referral routes and criteria, requiring up-to-date information on the local community and voluntary sector organisations. And of course it can only work if a vibrant community and voluntary sector exists. Social prescribing as a model has its challenges, not least an insistence on primary care as the primary mode of expertise determining people's direction of travel. Moreover, as this book is being written (2016), the sustained funding squeeze for local authorities in the UK, and by proxy the community and voluntary sector, means that our public infrastructures are being savaged with an unparalleled ferocity. As a result, the rich and varied forms of local innovative expertise which have arisen through communities to be able to respond to critically important local needs are being dismantled. The crushingly obvious impact of this is that more and more people are being driven towards woefully overstretched health services. For any of this to work, this situation needs to be addressed fast.

Other work in recent years in East Sussex, UK, namely the 'Options' programme, was predicated on a similar notion where, instead of receiving traditional counselling, meetings between people in distress and two 'options practitioners' heralded a discussion which sought to open up multiple perspectives on difficulties in order to develop a different, and potentially liberating, understanding of the issue. Here the person in distress was an active part of the discussion rather than a passive recipient of care. Such a service sat somewhere between signposting and traditional forms of psychotherapy. In this way it can provide a timely opportunity for people to explore whether they can find their own ways forward, without the need for counselling or longer-term intervention or support. Organising such a service located in a community hub and staffed not necessarily by psy practitioners, but by a range of people, could have potential as a gateway service for people in distress.

There are other encouraging practices emerging right now. Even in more formal therapeutic contexts, activities like gardening and mindfulness have become part of the fabric of 'treatment'. And the Recovery College model, in which service users are paid to co-deliver mental health courses to anybody who wants them, alongside health care professionals, is gaining ground. Granted they are mostly attended by other service users, rather than by other members of the community. And granted the service users aren't paid as much as the professionals for their teaching input. But it is a start that might never have been imagined a few years ago.

The 2013 joint commissioning panel for mental health, in their 'values-based commissioning in mental health' moved the commissioning debate some way to where it needs to be in order that care practices—rather than clinical institutions and forms of expertise—become the focus of orientation.[19] They privilege the perspectives and values of people in distress and their carers. However, the emphasis is still on *clinical expertise* and there is some way to go before a commissioning that is oriented to mental distress values aspects such as diverse beneficial care practices, enabling places and a relational account of care places. A key element for the future will be, not only to privilege the recognition of such enabling places and practices, but to link the everyday work of recovery to community-based services and develop brokering access to such enabling places. Service users should be central in the creation of peer support and mentoring programmes to foster access to local enabling places and resources.[9] Here, peer mentors could assist with the task of enhancing the quality of an individual's existing care practice sites and to open up novel but possibly useful care practice sites.

It will need collaborative work with commissioning frameworks that allow for the use of scarce funds to privilege the multiple forms of different practice that foreground the everyday work of distressed people and the people and things around them, that they find useful. And we need to work towards developing ways to think through what constitutes 'useful' within such a value-based approach if we are to make a convincing case for sacrificing the rational atomised 'before and after' archetype that has missed all but the most mechanistic of care journeys. If people want to bring fluid innovative care practices to the fore, then not only do we need methods sensitive to this fluidity,[12] but we need such methods to be understood as having value in the commissioning arenas of the future.

Doing this requires us to move from the narrow captivations of science, but it should not leave us foundering in the new age fascinations of anti-science, where as Smail puts it, 'rhyme is preferred to reason'.[5] Such an approach should not, however, be seen as a rendition of the neoliberal orthodoxy of public services cuts in search for some mythical version of the big society. To begin to operationalise the modest radicalism we advocate in knowing, naming and privileging practices of care for those in distress, we need an authentic common solution beyond the market that will see the redistribution of resources and power through smaller, local contexts, and then scale up. And it will need a radical investment in public service and the community and voluntary sector settings that make many of these variegated encounters in care possible. Care practices are, after all, knowledgeable collective actions that forge relations and connections despite the constraints present.[20]

When we started this book we rather optimistically started with a vision of the future that was replete with the many tropes of science fiction which have enlivened films for the last 50 years. We were throwing hoverboards, unbearable land temperatures and corporate dystopian exemplars around like they were going out of fashion. We can't of course say with any certainty whether the future is going to be marked by teenage hoverboard enthusiasts. But we do think that a path towards a radically different mental health world can be charted where there is a welcoming of the 'human paradigm'[6]) into the care practices, spaces and settings of mental well-being. This must honour the capacity for human beings to deeply absorb, interpret and appropriately respond to the stories of others. Where an embodied moral practice, grounded in material and cultural circumstances, personal histories, and relationships, edges out the technologies and rationalist knowledge focus as the authoritative paradigm.[6] This means we need to focus on what is actually done in practice and to remember that the practicalities of actually doing distress work and receiving support in everyday contexts need to be made visible and nurtured.[8] This is what we have tried to do in this book.

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Note: Page numbers followed by “n” refers to notes.

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