Chapter One

Geographies of Difference: Understanding Mental (Ill) Health and Social Space

Introduction

As a child, and then later as a young teenager in Nottingham, I remember regularly visiting my three cousins who lived several streets away from me, nearby to an old asylum. On one particular day during one of these visits we were not allowed out of the kitchen door to play in the backyard, and an unexpected fuss was being made by my cousins' parents about where we all were. It transpired that a patient from Mapperley Hospital, as the old asylum was then known, had wandered into their garden and the parents had wanted to protect us kids, thinking that we might be in some kind of danger from this confused stranger. Although the patient was safely transported back to the hospital after a phone call to the wards, the pronounced reaction to this person stayed with me. It had immediately evoked a particular kind of fear and uncertainty in everyone involved and an urgent need for my cousins' parents to establish a spatial separation between us and him. Here the family backyard and the mental patient seemed to be 'unlike categories', to use a particular academic vocabulary.

Years later, as an older teenager, I attended Mapperley Hospital for counselling in the adolescent psychology department, following the sudden death of my father. I remember walking into the large redbrick building for my appointment, hoping that no one who knew me would see, in case they thought that I might be potentially dangerous or strange, like the patient in my cousins' backyard. I remember feeling uncertain, scared and quite ashamed that I had needed to access such a service. These early first encounters with both patients and mental health services were important moments, as they brought home to me in very real ways how people with mental health problems could be rendered different, and how that sense of difference might be internalized. Even later, when studying social geography at university, it became clearer that these

moments – their spacings, uncertainties, constructions and experienced subjectivities – could be interpreted as part of a complex but evolving history and geography of difference and differencing.

Moving away from these autobiographical starting points, this chapter attempts to lay out how mental health, mental health care and, more especially, the lives of people with mental health problems might be interpreted spatially. These are partial and strategic markers, but ones establishing an empirical and conceptual framing for the book that follows. My potential contribution is to argue that there are now new possibilities emerging that can reframe the encounter with the patient in my cousins' backyard. This basic argument is substantiated by recently researched case studies where such people are shown to be substantially engaging in the everyday social world in positive and creative ways, and through a surprising variety of spaces. I suggest that mainstream social spaces and mental health patients are not completely 'unlike categories' after all, and further that people with mental health problems can be seen as trying to 'actively re-place themselves [in order] to create spaces in which marginality and marginalized collective identities can be embraced and valued' (Chouinard, 1999, p. 142). Although such processes are often ambivalent and problematic, there are signs that the predominantly negative figuring of 'the mental patient' is now being reworked in and through new embodied geographies of inclusion.[1] This argument does not ignore the need for an ongoing critical stance on contemporary forms of discrimination and stigmatization of this group, nor attention to their often abject material poverty (Knowles, 2000a, 2000b; Wilton, 2003, 2004b; and see the concluding chapter), but nonetheless a cautious optimism is forthcoming.

I start by outlining a broad-brush introduction to the spatial history of madness and mental illness, demonstrating how people with mental health problems have been constituted as a particularly marginalized group in Western Europe, North America and elsewhere through discourses of medicalization and its attendant 'otherings'.[2] I then turn to different conceptual frameworks that can help us to understand the institution of the asylum, its meanings and its failings for 'the mental patient', and how we might begin to think differently about the contemporary social situation of this controversial figure in an era of deinstitutionalization. Although this picturing of people with mental health problems initially pivots around the potency of social exclusion and its spatial consequences, the chapter also begins to introduce an alternative account. By explicitly acknowledging agency, resistance and empowerment in the everyday lives of this group, the discursive and material construction of 'the mental patient' will be disrupted and questioned. Taking cues from the anti-psychiatric literature, disability theory, and social and health geography, the iconic figure of the isolated and disempowered patient is reconsidered, and a call for the revisioning of

people with mental health problems emerges. This call, integrated with an introduction to the remaining chapters of the book, argues that new geographies of collectivity and creativity accomplished by this group are facilitating experiences of psychological and social stability in ways that also engender fresh spatialities of inclusion.

A brief spatial history of madness and mental illness I: The birth of the asylum

It is necessary to establish a *schematic* spatial history of madness and mental illness in order to illuminate the current social geographies of mental health featuring predominantly in this book. My analysis weaves from historical accounts of asylums in England and Wales, to twentieth-century geographical analyses of North American deinstitutionalization, to twenty-first-century Scotland and new case studies of community care. Although these spatial contexts differ in important ways, they are also *complementary* and comparable in terms of the revealed responses to madness and illness in the West (see Rothman, 1971). Philo (2004, ch. 2) has commented on problematic accounts of madness and psychiatry that have been less than attendant to questions of time and space; studies risking the 'draining' from history of 'details, difference and geography' (p. 22). My inclusion of literature spanning UK and North American geographic contexts is both specific to particular versions of 'West', but also seeks to avoid collapsing these onto each other in regard to mental health genealogies. Rather, I use geographic literature from each context selectively, my reading concentrating on the different exclusionary and inclusionary trends or phases constituting the distinctive geographies at stake, but which also speak across space. What links the literature produced on deinstitutionalized geographies of mental health across North American and UK contexts, in particular, has been the predominant emphasis on stories of neglect and marginalization, and this is acknowledged here before being disrupted in the text that follows.

To begin with a more generic reference point, however, Szasz (1973) famously wrote of 'the manufacture of madness' into illness, an analysis that Porter called 'a conspiratorial form of scapegoating' (Porter, 1987, p. xi), but one that he also admits reflects a deeply profound reaction to the 'disorientation' evoked by those who embody madness in those who do not. Across several academic disciplines, inclusive of sociology, psychology, political science, history, geography and critical psychiatry, the different ways in which madness has been 'manufactured' or configured as mental health and illness has been traced. Such disciplinary scholarship is often underwritten by reference to the controversial philosophically informed empiricism of Foucault (1967, 2006), who outlined a specifically spatial

impulse in the historical disciplining of Unreason (as madness) by Reason. Here this impulse was productive of a nuanced governmentality, anchored in the emergence of a specialist science of the mad mind (mental science, later psychiatry), itself housed in special scientific spaces (the asylums); spaces which in turn legitimated psychiatric theory and practice.

The big story of madness and its transformation into mental illness is hence fundamentally a story of geography, as detailed at greater length by Philo (1987a, 1987b, 1995, 1997a, 1997b, 2004; and also Elden, 2001). Philo traces a deep history of the social and spatial relations surrounding and constituting madness in England and Wales, work that evokes the geographies *in* varied conceptions of madness from the 800s to the 1860s, but that also traces the geographies *of* madness and societal responses to it in worldly locations of care and treatment. He makes us aware that madness itself has had different interpretations down the ages, but it is nonetheless clear that people who think, feel and behave in ways that somehow fall 'outside' the social norms for a particular time and place have often provoked particular 'environmental' responses. These responses have embraced a toleration of the popular, but mythologized, 'village idiot' in the everyday spaces of civil life, or on occasion a will to care for such people via situated 'folk psychiatries', perhaps ones also involving shelter in various religious institutions, monasteries or hermitages (Philo, 2004, ch. 3). The noting of a 'condition' which might be associated with madness has been present in historical records from ancient Greece, and is traceable through and beyond the medieval period in Europe (Scull, 1996). Interpretations of this condition have ranged from associations with demonic possession, divine inspiration, witchcraft and versions of illness, leading to what Philo (2004, p. 139) calls an 'untidy geography' of social responses. It is by no means clear, however, that these understandings and responses have *always* and uniformly demanded spatial separations or exclusions, the first special 'institutional space' allocated to the mad only being traceable in England to around the 1400s, when the quasi-religious hospital of 'Bedlam' began to acquire a reputation for this sort of work.

Despite nuanced readings of a deep history of Unreason, and evidence of diverse *inclusions* of embodied madness in the everyday lanes, bars, places of worship, ritual, churches and other spaces of civil society, where the 'shrieks' of 'the witless and weird' were an everyday occurrence (Porter, 1987, p. 140), there was undeniably a creeping geography of separation emergent in eighteenth- and nineteenth-century British society, a phenomenon also witnessed in North America (Rothman, 1971; Hunter et al., 1986). In the 1700s and 1800s, the evolving British state with its attendant conceptions of population and territory, wrapped up in the beginnings of industrial capitalism with its emergent class-based society, were important determinants for new geographies of social life, with profound implications for

those who embodied madness. In the context of what might be called a new governmentality of the poor, witnessed through their 'great confinement' in various receptacles (Foucault, 1967), the mad were gradually identified as requiring particular attention. There were several 'key moments' in this gradual process of identification that can be seen as important precedents for the later asylum solution in a British context. Philo (2004, p. 177) identifies one in the Vagrancy Act of 1714, decreeing that the 'furiously mad' could be apprehended by local officials and taken to 'secure places' (in practice a range of locations including gaols, houses of correction and so on). The first legislative powers for special spatial containment for mad people were arguably established at this point. A diversity of poorhouses, houses of industry, houses of correction and gaols accepted and cared for an increasingly large number of lunatics in what became widely regarded as the 'secure space' of confinement for this group pre-1834 (Philo, 2004, pp. 214–262). The Poor Law Amendment Act in 1834 established that the able poor should be harshly disciplined in such institutions, and that ideally only the non-able poor should really be retained inside workhouse walls (all able-bodied/minded paupers being sufficiently deterred from entering so as to 'find' honest work). The result was that workhouses became increasingly spaces where workhouse administrators began to classify the non-able bodied and non-able minded, and so started to identify the lunatic poor as a special group warranting particular managerial and even medical attention, perhaps in specific internal locations or 'wards' (Driver, 1993).

The unruly disposition of the mad in mainstream pauper provision helped to lead, through a century of growth in state-led 'disciplinary technologies' (see below), to the lunatic poor being distinguished as particularly different and troublesome. As Foucault argues:

> More than once, in fact, they figured in their singular fashion within this uniform constraint. In the workshops in which they were interned, they distinguished themselves by their inability to work and to follow the rhythms of collective life. (Foucault, 1967, p. 58)

In the emerging capitalist logic of the industrial economy, the mad, along with other poor cohorts such as the old, disabled and sick, were simply not 'productive' enough (see also Scull, 1977, and Gleeson, 1999, for comments on non-UK spatial contexts). This inability to 'fit in' with the industrious life of capitalist society, the new workhouse regimes and other similar sheltered places for the poor, led, Foucault continues, to a decisive 'event' in the history of madness; namely, when 'madness began to rank among the problems of the city' (Foucault, 1967, p. 64). The birth of the asylum as one spatial solution to this problem was hence conceived.

The birth of the asylum in the late 1700s and early 1800s can be seen as another possible outworking of the 'great confinement' of the poor, but this is not to collapse these two processual 'events' onto one another, but to recognize them as related but also distinct processes. There are a myriad of *other* explanations and interpretations for the asylum impulse, including both medical and moral imperatives. Since the early 1600s there had been private 'madhouses' for the rich; profitable spaces where carers reflected on the nervous dispositions of their wealthy clients, contributing to some sense in which madness might be conceived of as a medical condition (Parry-Jones, 1972; Philo, 2004, ch. 5). Alongside this provision, and partly because of the need for a more mixed economy of care for non-elite clientele, charitable lunatic hospitals emerged from the early 1700s onwards and these were at first associated with general voluntary hospitals, also helping to ensure an emergent 'medicalization' of the mad (Philo, 2004, ch. 6). However, perhaps the most famous of these facilities in a British context was the York Retreat, the charitable rural asylum retreat in Yorkshire, first opened in 1796, and run by the Tukes, a Quaker family (Digby, 1985). This famous model for the *moral* management and treatment of the mad served

Figure 1.1   Glasgow Lunatic Asylum: sourced from Stark (1807), reproduced in Chapman (1812). Permission granted by the Archives and Special Collections Department of the Glasgow Mitchell Library.

as an ideal(ized) blueprint for the reforming potential of the public asylums that were soon to follow. Although mad people here were classified as patients, and deliberately spatially segregated from the stresses and supposed evils of the industrial city, the Tukes' asylum was *not* primarily a medical space but rather one seeking to establish a moral(ized) relationship between disciplined domesticity and recoverable rationality. It was the later public asylums which were to establish a medical emphasis much more clearly, and through which medical expertise was able to 'insinuate itself within the moral impulse of the asylum' (Philo, 2004, p. 489). There is not space here to elaborate the complex relationship between moral and medical influences in these newly emergent geographies of madness/illness; suffice to say that both are traceable in a range of ways in different institutions and secure places (Philo, 1987a).

More relevant is the fact that it gradually became apparent to the emerging state (and various lunacy commissions/ers) that the private and the charitable asylum solutions were not sufficient to cater for the large numbers of poor people starting to be identified as mad, perhaps as a result of increasing awareness of this (problematic) category of the lunatic, and perhaps as a

Figure 1.2   Gartloch Asylum, Glasgow. Copyright held and permission granted by Sharon Halliday for www.hiddenglasgow.com.

result of increasing numbers of psychological 'casualties' of capitalism (Scull, 1979). In 1808, the UK state, largely as a result of a key Select Committee report into the state of criminal and pauper lunatics, articulated a vision for a public asylum system to be funded by the public purse, one that was to be eventually provided – following further legislation in 1845 – in every county and borough in England and Wales (Philo, 2004, ch. 7).[3] These asylums were gradually located in rural areas, away from centres of population, for a variety of medical and moral reasons (Philo, 1987a, 2004), serving to separate spatially those people designated as mad from mainstream society, an act constituting a hugely powerful geography of differencing with lasting implications. This spatial separateness contributed to a dark iconography of the asylum, these looming and distant buildings becoming stigmatized places of containment (see figures 1.1 and 1.2, and Parr et al., 2003).

The increasingly large institutions catered for huge numbers of segregated people, a system in which any initial therapeutic optimism for reform soon largely vanished. As Scull (1996) notes, while 'the lunacy reform movement was driven forward … by a utopian vision of the possibilities of asylum life' (p. 8), the effect was one of warehousing the mad:

> The community becomes unwieldy; the cases beyond the capacity of the medical officers; personal intimacy is impossible; recent cases are lost and overlooked in the mass; and patients are treated in groups and classes. An unhealthy moral atmosphere is created; a mental epidemic arises, where delusion, debility and extravagance are propagated from individual to individual, and intellect is dwarfed and enfeebled by monotony, routine and subjection. (Browne, 1857, p. 8, cited in Scull, 1996, p. 18)

The sheer numbers of lunatic poor resulted in the kinds of problems noted in 1857 by W.A.F. Browne, the superintendent of Crichton Royal Asylum in Scotland, and also accompanied the rise of an army of new specialists in the care and management of lunatics. Both of these processes arguably contributed to the necessity for new kinds of categorizations of lunatics and their behaviours. An emergent 'medical science of the mind', epitomized through the changing name of the *Asylum Journal* to the *Journal of Mental Science* (see also Philo, 1987a), thus began to herald a new way of conceptualizing and managing the lunatic, one through which mad people were also redesignated as 'mentally ill patients'. As has been noted by many commentators, the gradual redesignation of madness as 'a medical category with specified symptoms and aetiology' (Rogers and Pilgrim, 2005, p. 42) also heralded a new era in the constitution of the difference of the mad. By 1850 their place in special, and specifically medical, spaces was assured and their separateness from mainstream social life further enabled. This was to have a lasting social and spatial legacy.

A brief spatial history of madness and mental illness II: Community care

Throughout the nineteenth and most of the twentieth centuries, the asylum solution to mental difference held sway in Western Europe and North America. Its purpose as a self-legitimatizing solution to the problem of madness deepened, alongside the expertise of 'mental scientists', variously contributing to the disciplines of psychiatry, clinical psychology and (later) psychoanalysis, although the first of these disciplines is most relevant in the context of this particular spatial history. It was not until the mid-twentieth century that alternative visionings for the possibilities for mental health care became commonplace. From the 1950s onwards, particularly in Britain and North America, and notably Italy (Jones, 2000), there was increasing pressure from different political and social actors to close asylums and to reintroduce patients into mainstream social life and spaces, in what was to be rather optimistically termed 'community care'. The postwar policy shift towards community care has been explained by the social reactions to war-time 'shell shock' (Barham, 2004), the introduction of anti-psychotic and anti-depressant drugs, and criticisms of the disabling effects of institutional care as advanced by the so-called 'anti-psychiatric' movement (Goffman, 1961; Foucault, 1967; Laing, 1967; Cooper, 1968). These conventional explanations have been attacked by more radical critics such as Scull (1977), who links the demise of the asylum to more capitalist concerns, arguing that community care was simply conceived as a cheaper alternative to asylum/hospital care (a notion now largely rejected) and therefore a key factor in its development. Whatever the true impetus for the community care movement, it is undoubtedly the case that during the mid-to-late twentieth century a raft of policy changes focused directly upon the plight of the institutionalized 'mentally ill', as a result of which the geography of mental health care changed significantly (see chapter 2 for a more detailed commentary on these developments and their legacy).

While the asylum and its demise is discussed more interpretatively below, here it is sufficient to note that the move towards 'care in the community' also created new forms of segregation for those designated as ill. As far back as 1974, Wolpert and Wolpert identified the spatial concentrations of released psychiatric patients appearing in the community, particularly in North America:

> The massive discharge of tens of thousands of mentally disabled people from state institutions in the last decade has added a new indigent group to the inner cities of our large metropolitan areas. The disabled must now compete with other welfare recipients for community based treatment, care and services. The former asylum residents, not unpredictably, have become ghettoised

in those sections of the cities that have run-down boarding houses and seedy residential hostels, the dumping grounds for the disadvantaged and their caretakers. (Wolpert and Wolpert, 1974, p. 63)

The difficulties for ex-patients in attaining social integration were increasingly obvious to commentators and social policy makers alike. This pointed to the irony of isolation being experienced by many individuals *within* the community, with some arguing that 'one form of confinement has been replaced by another' (Wolpert and Wolpert, 1974, p. 69). The work of Dear and Taylor (1982) and Dear and Wolch (1987) and more recently Knowles (2000a) has laid bare this exclusionary geography of deinstitutionalization, together with the socio-spatial processes that Dear (1977, p. 588) claimed have constituted new 'psychiatric ghettos':

Inner portions of North American cities may be becoming the location of an asylum without walls for psychiatric patients discharged from mental hospitals.

There is a wealth of geographical studies about this phenomenon, and its causes, that are well documented elsewhere (for summaries, see Philo, 1997a; Wolch and Philo, 2000). Suffice to say, this latest manifestation of 'spatial containment' contributed a new dimension to the differencing of the mental patient – who remained isolated, poor and often uncared for – *but* in community settings, excluded by neighbourhood 'purification' strategies (Evans, 1978), attitudinal stigma articulated as a 'not-in-my-back-yard' (NIMBY) syndrome (Dear and Taylor, 1982), and ignored by over-stretched human services (Dear and Wolch, 1987; Knowles, 2000a). However, outright rejection was sometimes overstated and certainly geographically differentiated (Sixsmith, 1988), with studies in the UK 'testing' relevant hypotheses about North American cities in order to qualify the evidence about the extent of service-dependent ghettos and community oppositions in Western urban, semi-urban and rural contexts (Moon, 1998; Milligan, 1996, 1999).

In the last decade of the twentieth century, more contemporary developments in community mental health care, especially in a UK context, have emphasized the role of joined-up health and social services that (ideally) help people to live more integrated lives in community settings, as well as helping to facilitate the possibilities for their re-entry into paid work and arguably, by extension, mainstream social life. This has also been accompanied by a slowly developing legislative framework over the course of the century regarding both the provision of social support and care, and the exercise and limits of psychiatric power, in ways that have had implications for the rights and citizenship status of mental patients (Gostin, 1983; Mental

Health Alliance, 2005). These latter themes are explored more critically below and in chapter 2, but for now it is enough to note that the spatial history of madness has itself been intimately tied up with the making of mental illness and the mental patient. The spatial shift from asylum to community-based care has clearly not eliminated the relations of difference between the 'sane' and 'insane' that the asylum both invented and cemented. Even so, it *is* the case that community care has involved a rethinking of both the geography of mental health care services and the 'place' of service users in a variety of ways.

Until recently, studies of the history of madness, asylums and community care have revealed little of substance about the *lived geographies* of (ex- and present) mental patients (but see Knowles, 2000a, 2000b). In fact, the latter remained rather 'faceless factors' in both the planning and patterning of services and analyses of community reactions to small-scale facilities, often reduced to 'client characteristics' or sets of demographic indicators through which geographers and others might infer local community attitudes to mental health (Dear and Taylor, 1982) or speculate upon 'coping mechanisms' (Laws and Dear, 1988) in deinstitutionalized settings. A few anomalies to this trend have arisen: for example, Smith (1975a, 1975b, 1980, 1981) sought to differentiate 'community' into types of 'receiving' neighbourhoods, ones that could then be interpreted through a humanistic conceptual lens 'as centre(s) of personal meaning for an individual' (Smith, 1980, p. 365), emphasizing that attention to *informal* support patterns and the lived spaces of ex-patients might be important to contemplate. Kearns (1986, 1990; see also Sixsmith, 1988; Pinfold, 2000) found inspiration here, noting a range of personal social geographies in which people with mental health problems might carve out small, transitory niches of survival in the exclusionary city:

> At the outset for instance I presumed that certain donut shops were just what they appeared to be – places for consuming coffee and donuts. But I rapidly discovered that the primary meaning projected on to such establishments is one of sanctuary and congregation with ex-psychiatric peers. For this population, the inner-city environment offers few places of rest. (Kearns, 1986, p. 13)

Here the social situations of ex- and present patients are not seen as just being prescriptively or passively constituted through and by environments; rather, there is an implication that patients are creatively engaging with the city in order to effect their own coping mechanisms.[4] In addition, Wilton has recently shown how this group actively contend with material poverty (2003, 2004a, 2004b).

My own work has also built on earlier endeavours and has sought to extend their focus, bringing more sharply into view the faces and voices of

people with mental health problems and the community geographies that they occupy and embody (e.g. Parr and Philo, 1995; Parr, 2000; Parr et al., 2004, 2005). In examining local service-user collectives and access to the public spaces of the city (Parr, 1997a, 1997b), for example, as well as the embodied experiences of madness/illness (Parr, 1999a, 1999b) in both rural and urban environments, this work begins to articulate what community life *feels* like. It seeks to bring 'to life' emotional geographies of exclusion *and* inclusion in order to examine further the relations of – and disruptions to – social difference (Davidson et al., 2005).

This orientation, informed by particular theoretical positions, helps to address what Porter (1987, p. 230) has argued is a lack of voices in histories of madness and mental health. All too often, he argues,

> They [the mad] were mutes or muted, or we catch the depressed, disturbed or deranged only though the talk of others – the families, doctors, legal documents or asylum registers.

Attention to the lived experiences of those with mental health problems, historically in the asylum and contemporarily 'on the streets', is not merely to correct a methodological imbalance, but necessary in order to articulate how the story of madness and illness is not simply, or just, one of exclusion, subjectification and outsiderness. Instead, people with mental health problems should also be understood as creative actors, often capable of resistance, self- and collective empowerment and determination in the diverse spacings of madness, illness and mental health care (see Barnes and Bowl, 2001; Sayce, 2000). In what follows, I argue that these 'other stories' require us to chart not only the rise of service-user movements (for example) in reconceptualized analyses of the limits of (say) psychiatric power in deinstitutionalized settings, but also to examine how this group experiences and builds community lives *beyond* specifically health services (see also Desjarlais, 1997; Knowles, 2000a, 2000b). In this way, more attention can be paid to how people with mental health problems live meaningful social and cultural lives in community settings. I now turn to think about the relevant conceptual resources that might enable this endeavour.

Understanding the Geographies of Mad/Ill 'Others': Conceptual Perspectives

In the sections above, I have moved from charting a spatial history of the asylum – with its profound exclusion of and marginalization for the mad – to community care, where isolation and ghettoization are still evident, but also where other possibilities for empowerment, voice and inclusion are

identifiable. This rather crude summary belies a range of conceptual resources that might help us think in more nuanced ways about the trajectories involved, and provide useful resources for the case study materials that follow in later chapters. I now *selectively* outline some resources for understanding the transition from asylum to community, and for envisioning new ways in which to 'refigure' the mental patient.

Understanding 'incomplete' asylums and patients

Foucauldian approaches to the study of madness emphasize how the mad have been disciplined into ill-difference by a rational governmentality from at least the seventeenth century onwards (Foucault, 1967, 2006). As Philo (2004, p. 36) has argued, Foucault (1967), in his seminal work on *Madness and Civilization*, (initially) assumes a mad state-of-being beyond mental illness that institutionalized psychiatry effectively 'makes' into clinical categories through a grand exercising of Reason over Unreason. Indeed, it is crucial to understand the asylum as both a symbolic, and also an operative, disciplinary technology. The internal workings of asylums, and the practices that constituted them, undoubtedly held a disciplinary impulse. This impulse sought to regulate the disruption that was madness for the sake of both the individual and the collective (for a 'common good' scaled from the institution to the nation). Discipline was rendered effective on and through the minds and bodies of inmates – and as Foucault further demonstrates in *Discipline and Punish* (1977), *The Birth of the Clinic* (1979) and *Psychiatric Power* (2006) – by virtue of a whole machinery of technologies in the shape of architectures, wards, cells, corridors and the like, but also inmate conduct, uniforms, working tasks, timetables, hierarchical rankings, diagnostic categories, medications and so on. Although Philo (1989, 2004) does much to disabuse this as a 'totalizing' cartography, the space of the asylum still evokes an epistemology and iconography of 'same-ing' through these wide-ranging disciplinary strategies. In this project of 'same-ing' mad difference, the human patient is rendered rather powerless. Although occasionally disruptive and problematic, the patient is ultimately configured as the subject of a relentless psychiatric coding that contributes to a wider carceral geography of power which seeks to control and correct all kinds of deviancy (Foucault, 1977).

In relation to this grand but disempowering reasoning, Sedgwick (1982, cited in Philo, 2004, p. 37) notes that Foucault's text 'does not form a patient's-eye view of psychiatry, so much as a doctor's account of what, in any particular epoch, he [*sic*] thought [that] he was doing.' The asylum as a spatial container, productive and insistent on difference, is portrayed in Foucault's work as an exemplar of disciplinary technology *par excellence*,

although Philo's (2004) spatial history *also* reveals the many 'incomplete' geographical inflections of the rationalist impulse to segregate the mad. Philo (2004, pp. 46–47) is important in arguing for recognition of Foucault's mission to 'de-universalize' social and spatial segregation – and although Philo is arguably more empirically successful in this endeavour than Foucault – it is the broader logic of the argument that is of importance here. This logic suggests that the disciplining and socio-spatial exclusion of mad people/mental patients is not the *whole* story of the history of madness/illness after all. The grand vision of 'same-ing' is thrown into relief by Foucault's own resistance to the idea of a 'total history' (Foucault, 1967; Philo, 1992). If we are also to take seriously Philo's points about rescuing Foucault's intentions to render the history of madness as an uncertain story, between the 'dust' of evidential historicism and the 'clouds' of philosophical reflections on the spacings of a rationalist modernity (Philo, 2004, ch. 8), then we must *also* reconsider the category of mental patient a little further, and from situated viewpoints, rather than from just 'panoptic' theoretical positions. This manoeuvre can do two important things. Firstly, it might help render the complex social and spatial projects of the psy-disciplines as not simply and only oppressive, a possibility we must consider (see Bondi, 2005a). In addition, and perhaps more importantly, this move might also help rescue the mental patient from being an unreachable 'other' in the history of the asylum, an 'other' merely subjected and silenced into a docile body.

Before moving to consider the agency of the mental patient and the possibility of 'other stories' of asylum life itself, I want to pursue another particular contextual reading of the relationship between asylum and society that acknowledges the capacities of the mad. Even Foucault's account of the spatial impulse to contain the mad is acknowledged to have drawn in part on a fairly orthodox historical materialism in positioning asylum space as intimately connected to the growth of industrial capitalism. Gleeson (1999, pp. 59, 102) has also noted that in the transition from feudal to industrial capitalist economies, the 'somatic flexibility' of the former system, in which discontinuous labour time and the interweaving of social intercourse into work left room for 'individual limitations', was progressively replaced by a new wage-labour relation that 'confronted impaired people with powerfully disabling forces'. Although his focus is physically disabled people, Gleeson's arguments are also relevant in the consideration of madness and illness. While arguing forcefully that industrial capitalism was responsible for creating the rise of dependency and the institutionalization of 'incapable' workers, Gleeson also retains the possibility for embodied disabled disruptions to the emerging economic geographies of industrial capitalism, as they reshaped the home, the factory, the city and the street. In particular, he highlights the residual disabled bodies on streets and in public view in the

nineteenth-century city, those individuals who both survived on petty commerce (street traders or performers) and were anti-commerce (beggars). He argues that overarching understandings of disabled people (and this would include the mad) as simply swept up and routinely institutionalized into a docile 'reserve army of labour' does not do justice to their resisting of such processes:

> … by clinging to society on the streets, some disabled people resisted 'the duty to attend the asylum' (as Foucault would have it), that weighed increasingly heavily upon them as the century progressed. (Gleeson, 1999, p. 110)

Understanding the mad (and the disabled) as (just) rejected human categories, warehoused because of their inability to conform to new working patterns, is hence legitimate but limited. It is legitimate in that this was clearly one factor in the confinement of these 'disruptive workers'. Institutional and medical discipline also enrolled a 'productive power', a Foucauldian notion (Foucault, 1977), in which the possibility of improvement, and therefore *reinclusion* in the mainstream economic and social spaces of society, was centralized. Indeed, in both workhouses and asylums inmates were routinely 'put to work' through various forms of disciplinary training. This point has a contemporary relevance, in relation to current twenty-first-century welfare reform (see chapter 2) whereby disabled and ill people are increasingly required to (re-)enter mainstream workplaces. The asylum, then, functioned to retain the possibility of same-ing, as well as serving to create difference, in its role of training 'potential workers'. Yet understanding the asylum as an 'incomplete container' from materialistic perspectives also allows an emphasis upon other spaces of survival and resistance for mad and disabled people, particularly in terms of the home (the mad *could* be retained as limited household workers as a result of affective relations) and the street (as a liminal space of material accumulation). The mad here are not simply categorized as ill or different, but rather hold some capacity for inventiveness with regards to the material and social resources for everyday life, even in a time of great confinement. This is an important notion for the arguments that follow.

So far, we have a very schematic understanding of the rise of the asylum as both an incomplete disciplinary technology and an incomplete warehousing solution for casualties of capitalism. In each 'take' on mental health geographies, however, the figure of the patient is understood as powerfully 'made' and little attention is given over to considering the agency of the patient, even given Gleeson's comments above. We also know little about embodied or resistive interactions within asylum spaces themselves. The work of the sociologist Goffman (1961) has addressed this deficiency to some extent in his detailed research on what he calls 'total institutions'.

Alongside others such as Laing (1967), Cooper (1968), Szasz (1973) and much later Estroff (1981), Goffman was suspicious of the workings of psychiatric power, signalling this by distinguishing between 'the mentally ill' and 'the mental patient'.[5] His work helped to 'flesh out' the mental patient figure, and also contributed a damning critique of the social functions of the asylum in ways that contributed to its demise in the mid-twentieth century. Through detailed ethnographic observations of the routines of institutional life in an (unusually large) 7,000 in-patient psychiatric facility, Goffman both confirmed and disrupted Foucauldian understandings of the disciplining of the mad. Goffman showed how asylum practices effect what he calls a 'mortification of self', through personal defacement (a loss of 'civil' identity), submission and regulatory conduct(s). Indeed, Goffman argued that 'total institutions are fateful for the inmates' civilian self' (1961, p. 47).

However, he also limited this visioning by his detailed ethno-analysis of asylum life, which documents how patients can act in solidarity with each other and also how patients might resist social and medical disciplining by 'situational withdrawal' and refusals to co-operate (ibid., pp. 61–62). In effect, he allowed for the agency of the patient, albeit an agency 'stripped bare' of the influence of civil life. This position considers the institutional mortification of self to be incomplete, an analysis complementing Foucault's ultimate disavowal of the 'total' power of the asylum. Mental patients in Goffman's asylum are shown to abuse resources, and gain tacit agreements with staff in order to occupy 'geographies of licence'; places 'pervaded by a feeling of relaxation and self-determination' (ibid., pp. 230–231). In Goffman's work, then, the 'incomplete patient' enrols space in the project of retaining the self:

> The patient curling up at the window, looking outside through the bars, pressing the nose of his whole body against the outside, and in this way somewhat removing himself from the ward and somewhat freeing himself from its territorial restriction. (Ibid., pp. 237–238)

While Goffman's methodological approaches and 'reinterpretations' of observed behaviours have been called into question (Gronfein, 1999), his work *also* helps to limit the idea of asylums as 'forcing houses for changing persons' (Goffman, 1961, p. 12, cited in Gronfein, 1999, p. 88). Gronfein (ibid., p. 90) notes that 'inmates are not presented by Goffman as either helpless or totally determined by these [asylum] practices'. As Prior (1993, p. 161) also argues, his empirical detail and analysis 'gave lie to the image of the patient as a passive receipt of medical discipline'. In the mid-twentieth century Goffman's (flawed) critique of asylum spaces actually had a pronounced impact on social policy in both the US and the UK (Gronfein, 1999), contributing in various ways to the community care movement,

simultaneously damning the asylum for inhumane institutionalization and rescuing the category of 'mental patient' as more than simply equating with a docile body.

Understanding 'differencing' in non-institutional spaces

Understanding the category of 'mental patient' as something more than just a docile body is a crucially important theme elaborated in this book. Understanding the 'mental patient', or rather the 'person with mental health problems', *outside* of institutional space is also necessary. In the context of community care, for example, exciting possibilities for reclaiming a lost or institutionalized 'civil self' exist, ones partly constituted by inventive uses of mainstream social spaces. In analytical terms, this also offers avenues for further 'fleshing out' Goffman's still rather 'faceless patients' (Gronfein, 1999, p. 98), a theme addressed below. As noted earlier, community care has *still* been equated with geographies of isolation and exclusion for the patient, a depressing scenario in which the asylum can be argued to extend its power in a Foucauldian 'carceral archipelago' through a network of mini-institutions and draconian mental health laws (Foucault, 1977; Gostin, 1983; Cadman, 2006). Of interest here is how we might understand these *continuing* geographies of exclusion and isolation – socio-spatial segregation – in the context of community care. What are the social and cultural processes contributing to the phenomena of the psychiatric ghettos and how best can we understand these? What processes also make for the pronounced economic and cultural marginalization of the mental patient? Although there are many possible lines of reasoning here, one stands out as particularly useful in this regard, and can be broadly termed 'psychoanalytic' in orientation (for introductory explanations, see Philo and Parr, 2003; Bondi, 2005b).

In the last decade psychoanalytic perspectives have increasingly been utilized by geographers seeking explanations for 'the relationships between the self and the social and material world', specifically elaborating 'geographies of exclusion' (Sibley, 1995, p. 5). I only want to highlight some aspects of this literature, but in ways that might illuminate why mental patients have continued to be socially and spatially segregated, even when *outside of* the asylum. In discussing Freudian and post-Freudian theories of the self, for example, Sibley (1995) enrols Object Relations Theory to explore how learned experiences of boundary separations in infancy (between good and bad, dirty and clean) inculcate entrenched divisions between what we understand as 'same' (self) and 'other'. Sibley and the theorists upon whom he draws emphasize the self as a cultural production, formed in a 'perpetual restructuring' which constantly references 'social and cultural symbolism' (ibid., p. 7).

Importantly for my argument, the sense of border that emerges between the infant self and not-self involves a series of rejections; of matter, objects and, eventually in adulthood, of other people. As Sibley (ibid., p. 7) articulates:

> The boundary between the inner (pure) self and the outer (defiled) self, which is initially manifest in a distaste for bodily residues … then assumes a much wider cultural significance.

Indeed, 'the initial sense of border in the infant in Western society becomes the basis for distances from "others".' Who and what is categorized as 'other' is a constantly evolving cultural attribution, but, in his critique of the obsessions of the West, Sibley also notes that symbolic 'associations are made between faeces, dirt, soil, ugliness and imperfection' (ibid., p. 7). For those who are culturally and symbolically classified as dirty or imperfect, social and spatial distance might be evoked as a deep-seated psychological reaction to difference. Here the (pure) 'same' and the (defiled) 'other' become 'unlike categories', as referenced at the start of the chapter. Sibley's work ranges over a host of possible others and otherings as a means of demonstrating these perspectives, but the relevance of the mad and the disabled is marked out in several ways (Wolch and Philo, 2000).

The significance of the mad/ill in relation to this thinking might best be illuminated by turning to Wilton (1998), who extends Freudian notions of subjectivity in specifically spatial terms. In particular, he highlights the Freudian *unheimlich* or 'uncanny' that refers to the evocation of familiar, excited fear. Wilton argues that this notion can be deployed to 'indicate something that is unsettling at the same time that it implies the reappearance of something which is familiar, but has been concealed' (ibid., p. 176), a state best described as 'uncanniness'. Wilton uses this idea to help theorize human feelings about *difference*. He takes the uncanny to refer to how human selves carry memories of early psychic transformation and trauma (usually from infant life) which can be awakened, even re-enacted, prompting 'a regression to a time when the ego had not yet marked itself off sharply from the external world and other people' (Freud, 1919, p. 236, in Wilton 1998, p. 177). Wilton is clear that this disturbing 'awakening' might occur when in proximity to behavioural difference. He details Freud's thoughts about the effects of 'uncanniness', particularly when confronted by incidences of 'madness' and illness, ones that might prompt unstable memories for the voyeur: '… the strange behaviour of the epileptic or madman [*sic*] triggers a fundamental anxiety about a loss of control within the self' (Freud 1919, p. 236, in Wilton, 1998, p. 177). In this case *proximity* to people with mental health problems, and the anxieties that this evokes, is a key explanatory feature of exclusionary spatial practices. These exclusions are promoted not only by a Western cultural symbolism that assigns rejection and difference to

the 'ugly' categories of mad and ill, but also because embodied proximities to difference might confirm mad/ill people 'as not different enough' from the self/same (Wilton, 1998, p. 178). In Wilton's terms, this occurs precisely because 'spatial proximity weakens social distance between self and other and challenges the integrity of individual identity'. These perspectives are useful as they point to troubling and deeply held feelings about difference, while simultaneously outlining their socio-spatial (relational) constitution.

Compounding these 'interiorist' explanations for social and spatial exclusions are studies highlighting how attitudinal hierarchies of mad/ill difference have been conceived in the last decades of the twentieth century. Dear et al. (1997) and Wilton (2000) explore 'hierarchies of acceptance' studies in ways that critically illuminate social constructions of disabled states of being. Wilton (2000, pp. 588–589), for example, shows that in the last part of the twentieth century mental illness was ranked as bottom (as least acceptable), or near to the bottom, of ranked lists of 'acceptable disabilities' in a range of studies. Rankings for care facilities also show a similar story, with Wilton citing the 'unusual behaviour' of patients as a key reason for consistently low scores on both scales (see also Smith and Hanham, 1981a). While the *limits* to hierarchy studies are noted by Wilton (2000), the notion of enduring stigma and negative attitudes to behavioural difference complements the uncanny thesis that he proposes above. Such perspectives risk rendering societal responses to mad and ill difference as somehow fixed, but nuanced readings of psychoanalytic materials retain possibilities for envisioning individual and collective change, as well as an 'opening up' and not closing down of encounters (see Bondi 1999, 2003). Indeed, these theories often understand selves as fully relational endeavours and therefore capable of movement from entrenched positions; and, as Wilton also makes clear, analysis of dynamic and contextual encounters with difference show that attitudinal 'change can occur' (2000, p. 589) among so-called 'sane' majorities. While the possibilities for changing responses to difference appear in later empirical materials in ways that speak to a 'reinvention' of the unstable category of 'mental patient', it is clear that very difficult issues can confront people with mental health problems in community spaces. These issues revolve around complex psycho-social 'othering' processes, including a widespread lack of understanding and stereotyping about embodied ill-experience. It is to this particular concern, and another set of resources, that I now turn.

Understanding ill and disabled lives

As community care has become a reality in the social spaces of Western urban and rural landscapes in the twentieth and now twenty-first centuries, a diverse panoply of care homes, drop-ins, hostels, day centres, clinics, social

projects and independent living arrangements are emerging as geographies for people with mental health problems (Parr, 1997a, 2000; Knowles, 2000a, 2000b; Milligan, 2001; Conradson, 2003a, 2003b; Parr and Philo, 2003b), alongside *re*institutionalization and homelessness (Dear and Wolch, 1987; Desjarlais, 1997). Critical work on such spacings 'disturbs the cosy picture of civility and its wholesome certainties about the nature of community imagined as "community mental health"' (Knowles, 2000a, p. 5; see also Gleeson and Kearns, 2001). The mentally ill, as Knowles argues so forcefully, are 'reinserted into the texture of the city', but in ways showing how the 'significance of the mad lies in their social *insignificance* … analysis of [which] raises important questions concerning levels of social tolerance' (2000a, p. 29, my emphasis). How can a group so marked by their subjection, difference and rejection simultaneously be rendered insignificant? The answer lies in many registers, not least by reference to neo-liberal welfare regimes in which the vulnerable are arguably both invisible and abandoned (Wilton, 2004b). However, it is not this particular trajectory that I wish to pursue here, but rather an appeal to a literature critically exploring the 'insignificance' of embodied difference more generally through reflections on lived disability and chronic illness.

Both disability and chronic illness studies (Barton, 1996; Butler and Parr, 1999; Gleeson, 1999; Barnes et al., 2002; Moss and Dyck, 2003) have engaged in detail with how contemporary Western society succeeds in rendering different minds and bodies 'invisible' in various ways. As Chouinard (1997, p. 380) outlines,

> ableism refers to ideas, practices, institutions and social relations that presume able-bodiedness and, by doing so, construct persons with disabilities as marginalized, oppressed, and largely invisible 'others'.

In ableist geographies, which may also incorporate an ableism implicating those with 'mental differences', 'others' may be simultaneously marked (for example by stares in public spaces: see Butler and Bowlby, 1997) and *yet also* remain invisible (in 'hidden' domestic spaces: see Dyck, 1995). Although there are vital differences between those people who identify as disabled and are physically ill or mentally ill, there are also pronounced similarities in terms of embodying a difference that challenges conventional norms and conceptions of minds and bodies in ways that result in states or spaces of exclusion (Butler and Parr, 1999). Significantly, critiques of ableist discourse and practice have circulated around how we might 'know' illness and disability in ways that challenge ableism. There have been critiques of 'medical models' of understanding, for example, whereby disabled or ill people are reduced to a series of individualized pathologies which do not 'fit' with societal or embodied norms. The 'social model' of disability, at the same

time as revealing structural forms of ableism, has also recently been called upon to engage more with the lived materiality of disability and illness, in terms of attention to pain and limited body-mind spaces (Crow, 1996; Hall, 2000).[6] In relation to both models, there have been calls for an emphasis on 'disability as an experience, as a lived thing … we need more than medical facts' (Brisenden, 1986, p. 173). Such developments provide a useful conceptual context for acknowledging lived experiences of madness and mental illness (see also Parr 1999b), and do so in ways encouraging a recognition of the person behind the patient label.

So far in this chapter, the figure of the mental patient has been depicted as 'made' by medical discourses and then isolated first in asylums and then in community settings as a result of psycho-social stigmatization and ableism. One key factor in this sorry tale of exclusion and marginalization has arguably been the presumed unpredictability of the mad person – an unstable and unreliable figure that has (always) required some sort of avoidance, containment and control. Recent writings on chronic illness have also addressed the notion of 'ill instabilities' in ways useful as a conceptual counter-point to these scenarios. Moss and Dyck (2003, p. 16) have emphasized how chronic illness is often unappreciated as 'a state of waxing and waning … uncertainty, indeterminacy … fluctuation'. That this is unappreciated not only by social theorists, but by the state, family, colleagues, insurers and so on, 'is a problem for people with chronic illness whose state of health is in flux and the course of disease progression and recovery unknown'. Moreover, Moss and Dyck argue that it is 'only when unpredictability, instability and unsteadiness are valued that persons with chronic illness can be no longer seen as "different"' (ibid., p. 17). Such a demand requires both a radical praxis with regard to embodied ill uncertainties, and also a conceptual flexibility that requires we think in terms of flux when writing ill experiences and identities. In elaborating this position, Moss and Dyck emphasize a politics and practice of 'reinscription' – the different possibilities for rescripting bodies, ill identities and experiences – and call upon progressive exercises to 'engage in rewriting the body with and through competing renditions of what it is to be ill and what it is to be healthy' (ibid., p. 100). In envisioning this embodied rescripting, people with chronic illness are often cast as knowledgeable actors, tentatively but expertly reworking their mind and body-spaces in unstable 'recovery' movements (see further below). Rescriptive recovery movements are always incomplete, and never completely autonomous, but nonetheless they are possible, a particularly challenging notion when thinking about chronic long-term illness.

In conceiving how this kind of theorization might resonate in terms of chronic mental health problems, a curious juxtaposition emerges. The great instability and unpredictability assumed of the mental patient leads to

highly stable and even static social ascriptions of difference. In this light, notions of 'recovery' (from illness and ill identities) are not easily attributable to this group, and yet this is exactly what the material in this book seeks to demonstrate. Such an ambition is not only important in terms of contributing to 'hopeful' writings about ill embodiment, but also reflects recent UK policy initiatives about mental health. What is interesting here is a realistic refusal, even in policy discourse, to understand recovery as a simple movement from illness to wellness, and rather to acknowledge its non-linear, complex patterning (e.g. see www.scottishrecovery.net). This reflects a recent international literature on recovery which understands this term as referring to 'the extent to which someone can recover a fulfilling, satisfying and meaningful life, whether or not they continue to experience symptoms' (Bradstreet, 2004, p. 4), after and during periods of profound illness. Recovery has also been identified as comprising different key elements, including hope, meaning, change and control (Repper and Perkins, 2003; Curtis, 1997; Anthony, 1993), components which have traditionally been rather sparse in the lives of people with severe and enduring mental health problems. Such thinking has been – to greater and lesser extents – endorsed in the US (for example, in the Surgeon General's Report on Mental Illness: Sacher, 1999; New Freedom Commission on Mental Health 2003; Jacobson and Curtis, 2000) and particularly in New Zealand (Curtis, 1997) among other places. Visioning such recovery movements critically, however, necessitates questioning how much policy discourse and practice cultivate *particular* expectations of 'ill citizens' (see chapter 2). Furthermore, it is necessary to understand recovery and reinscription as both thoroughly social and spatial, and as processes that are refracted differently through different geographies, an agenda addressed in the remainder of this text.

In outlining some conceptual resources for understanding the geographies of mad and ill 'others' above, I have sought to cross-reference ideas about mental patients with a résumé of their movement from the asylum to the community, in order to make sense of their social situations. In the transition from asylum to community, my reading of both the relevant literature and the geographies of patients can also be said to have 'moved' from a story of disciplined subjection to a point where the embodied personhood of the patient is foremost in our minds. Although this is a movement that might be critiqued in all sorts of ways, it is nonetheless useful to arrive at a point whereby contemporary social theory and writings about embodiment provide openings for imagining different 'rescriptive' geographies of recovery. Moreover, the empirical chapters of this book chart the various ways in which people with mental health problems begin to build sustainable senses of locatedness in the social and material spaces of their everyday lives. They do so by engendering different kinds of stabilities in order to 'rescript' their recoveries. These 'rescriptings' offer a simultaneous access to

senses of rootedness, emplacement *and* fluidity, as their more fluid social selves move from static and stigmatized positions of (pure) difference. These geographies of mental health are contradictory, simultaneously hopeful and difficult, facilitative and limiting.

Deconstructing the mental patient: From objectification to empowerment

This book offers new work on the 'representational geographies' of mental health, as envisaged through the voices and narrated lives of people with mental health problems. Questions of representation are important in reference to this group, partly because of a history of objectification, some of which has taken a literal-visual form in terms of diagnostic imaging, as demonstrated in early illustrations of the physiognomy of madness (see figure 1.3 and chapter 5). The logics underlying such images assume not only that mental patients are passive surfaces of inscription, but that also they are humans largely incapable of reshaping their faulty bio-genetic destinies. These are not images of social agents capable of movement; they are pathologized others, held in an iconography that perpetuates static subjectivity and is an instrument of objectification. What kinds of seismic *re-imaging* could possibly disrupt such a history and the social relations that it has helped to engender? While the use of alternative visual tropes has sought quite literally to counter this kind of pathological picturing (as in the visual 'See Me' campaign: chapter 2), it is actually other sorts of 'representations' that best enable a revisioning of the mental patient. These representations are ones where mental patients can be seen as active agents, resistive workers and even semi-professionals,[7] engaged in different 'fields of contention' in and around psychiatric care (Crossley, 2006). The very different 'imagings' involved here are not necessarily visual, however, but rather constitute political representations that are emergent in and through local and national 'user movements' around mental heath care. These representational movements seek to replace the outdated visual stereotypes referenced above, and are ones documented and critiqued by a range of personal, policy and academic writings (Barnes, 1997; Chamberlin, 1992; Barnes and Bowl, 2001; Parr, 1997a, 1997b; Sayce, 2000; Wilton, 2004a), as well as comprising tangible achievements on the ground in terms of 'contesting psychiatry' (Crossley, 2006).

Crossley (2006) argues that individual and collective resistances to psychiatric power and control have been neglected in writings on mental health and illness. As such, he traces a history of psychiatric service 'user movements' or what he calls 'social movement organizations' in mental health in the UK from the early 1950s, charting the development of well-known examples like the Mental Patients Union, MIND, Survivors Speak
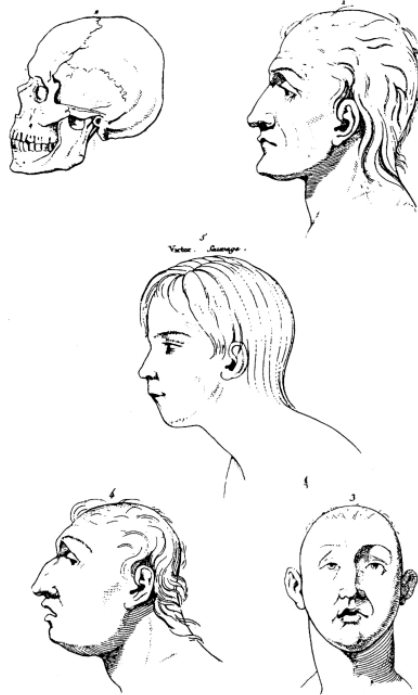
Figure 1.3   A 'physiognomy of madness' in Jacques Louis Moreau de la Sarthe's translation of Lavater (1807), sourced in Gilman (1982).

Out, United Kingdom Advocacy Network, Mad Pride and so on. Here, the very containers of their subjugation, the asylum and diagnostic technologies, have, according to Crossley and others, formed 'the very conditions for group formation' that usual theories of medicine devalue (Parsons, 1952; see Crossley, 2006, p. 159).[8] Once 'internal' asylum regimes arguably began to relax in the 1950s, the political contexts of the 1960s and 1970s were conducive to the development of pronounced collectivity, even among this marginalized group. Although mainly focused on 'internal' politics of radicalism, conservatism and dissent in the development of social movement organizations for mental health, Crossley's research also shows how mental patients have successfully articulated a powerful voice within and beyond specific services. Crossley, and Barnes and Bowl (2001), locate the collectivity of mental patients in relation to both dominant and alternative politics and protests in the last half of the twentieth century, ranging from antipsychiatry, to Marxist, feminist and identity politics, in addition to self-help, recovery and consumerist influences. In these developments mental patients

are indeed reconfigured (variously, through different interest groups) as 'survivors', 'users', 'people with mental health problems', 'consumers' and 'activists', among other labels that clearly seek to rescript 'the mental patient'. In pressing for changes ranging from body and ward spaces (Parr, 1999a) to the rights of patients contained under mental health legislation, the reach and influence of collective patient organization has been effectively scaled up.

Significantly, these scalings, movements and rescriptings are not ones that have been entirely outside the state (which has previously worked in tandem with psychiatry in producing histories of containment and marginalization). Rather, due to the widespread need from the 1990s onwards for state health and social service developments to be legitimized by 'user voices' with the rise of market and consumer-orientated social welfare, the state has 'listened to' patients (and indeed this is a legal requirement following the implementation of the UK NHS and Community Care Act 1990). This 'listening' has taken many forms, from consultation (predominantly) to service monitoring, 'involvement', joint working and evaluation (Barnes and Bowl, 2001, p. 57). Questions have also been asked about the politics of this user representation: exactly whose experience it represents, whose rescriptings it effects and whether there is evidence of uneven radicalism incumbent in these processes (Parr, 1997b).

There are undoubtedly some parallels between the rise of collective action among psychiatric service-users and the disability movement in the UK and elsewhere, although the former is often perceived as a poor relation in this regard and still undermined by stigma concerning the validity of the voice of the person with mental health problems (as rational and competent). Despite this, Barnes and Bowl (2001, p. 152) argue:

> The demonstration of competence in analysis, deliberation and action which user and survivor groups provide, presents a challenge to the association between madness, irrationality and incompetence. At an individual level participants experience this as personal empowerment arising from processes of peer and outsider valuing, while collectively this acts to challenge the categorical connection between severe psychological distress, irrationality and incompetence which underpin the more controlling aspects of mental health policy and practice.

This has resulted in:

> People who had been written off by the medical profession and society, people with labels of schizophrenia and manic depression, and people who had been institutionalized and regarded as unemployable … finding new roles as mental health educators, advocates, organizers of self-help services and consultants to purchasing authorities. (Wallcraft, 1996, p. 188, cited in Barnes and Bowl, 2001, p. 155)

Although these celebratory outcomes should be treated with caution (see Wilton, 2004a), it is nonetheless the case that a combination of service-user collectivism, social welfare reform and the effects of wide-ranging post-structuralist identity politics have combined to make it possible to reinvent the static mental patient subject. These gains are not universal, and there are tensions within both service-user communities (around identifications such as 'mad', 'user', 'survivor' and so on) and policy circles (around a rein-stitutionalization of the mentally ill) about what it means to have serious and enduring mental health problems in the twenty-first century. Further questions also need to be asked about how people with mental health prob-lems are reinventing themselves and experiencing acceptance and valida-tion in spaces *beyond* mental health services, and this forms a key focus for this book.

Conclusion: Rescripting Geographies of Mental Health

It is clear that even in the partial picturing that is strategically documented above, new possibilities are emergent concerning the 'personhood' of the mental patient and its political and social power. This re-evaluation of a previously static, disciplined and objectified figure is not a simple outcome of geography: in other words, the dismantling of the asylum as a container of difference has not straightforwardly led to the dismantling of the differ-ence that surrounds and even constitutes madness/illness, as the work of geographers who have documented *community*-based segregation and rejec-tion has shown. Rather, various local and national 'movements' in combina-tion with different policy and cultural contexts have all contributed to a gradual redefining of mad/ill difference, and of the people who embody it. Certainly, in the last twenty years in the UK and elsewhere (for a commen-tary on the North American context, see Sayce, 2000), there has been a concerted effort (with varying results) to 'empower' the mental patient *within* psychiatric services. These developments are clearly important, but what is their broader significance when it comes to community life for people with severe and enduring mental health problems? How are more dynamic subjectivities embodied outside mental health services? How is the category of 'mental patient' received, subverted and celebrated in other sorts of spaces? What do people with mental health problems actually do in communities? How do they feel about community life? Are they 'citizens'? And if so, what does this mean in practice?

The remainder of this book seeks to answer these and other questions, thereby critically evaluating the diverse 'replacement' strategies that people with serious mental health problems, and others working with them, have engendered, in ways that enable their inclusion in social and cultural spaces.

In order to implement this analysis, I specifically look at how rural, natural, artistic and technological community spaces are implicated in the deconstruction and reconstruction of the mental patient category. Attention to these diverse geographies is deliberately focused *beyond* medical spaces and relations, and *yet also* inflected by them. The spaces listed above are understood through use of in-depth research on participation in rural communities, gardening projects, artistic networks and Internet forums. These examples are chosen to elaborate how analyses of different settings for the negotiations of ill identities reveal people recovering from illness in ways that disrupt conventional readings of mentally ill subjectivities. Although the chapters can 'stand alone' as separate in-depth social-geographic analyses, each one also shows the subtle ways in which 'identity movements' might be possible for people with mental health problems. In other words, there is attention here to potential movements from an 'enclosed identity' as mental patients – where this label signifies negative and static connotations, as traced above – to 'disclosive identities' whereby embodied participation in particular spaces is seen to enable multiple disclosures of the skills, abilities, strategies, tactics, personalities and achievements of the people who participate. These disclosures can enable identity movements as well as senses of recovery – in turn contributing to the possibility of rescripting chronic illness outcomes. Each chapter traces such disclosures in a different way, ranging from the difficulties of embodying revisionist identity movements in specific rural places, to the flexible opportunities presented in virtual support networks. In negotiating these different social, cultural and material locations, people with mental health problems struggle with the effects of psychological distress, but also make significant contributions to their own and others' recoveries. These recoveries are, then, simultaneously psychological *and* social.

Elaborating spaces of participation and recovery for and by people with mental health problems is addressed relative to changing ways in which community social life is conceived by particular aspects of state discourse and different class, ethnic and interest-based groups. In particular, it is apposite to mention that in the UK the intensive development of a 'social economy' is seemingly unrolling a new 'participatory democracy' (Amin et al., 2002, p. 8), building on a history of the voluntary (or third) sector in providing both welfare and work (see also Dear and Wolch, 1987; Wolch, 1990; Fyfe and Milligan, 2003; Milligan and Conradson, 2006) and changing 'community' landscapes. In this wider reworking of the basis of civil life, a new emphasis has been bestowed on 'active citizens', people locally responsible for making communities 'work' and achieving social inclusion (Amin et al., 2002). While clearly a large, problematic and differentiated undertaking, which can be critiqued from different vantage points (see chapter 2), there are new possibilities here for people previously marginalized

in community settings. As such, the empirical chapters address the different kinds of 'citizenships' that are engendered by this group through their participation in the spaces listed above. The notion of 'citizen' and 'active citizen' holds promise for people with severe mental health problems, although caution has to be exercised towards what might be described as 'neo-liberal solutions' to difference (Laurie and Bondi, 2005a, 2005b).

In many ways, this book elaborates different versions of 'social inclusion', though not solely ones related to common policy descriptors, but rather social inclusions as experienced and embodied through a range of spaces, and with reference to the conceptual resources outlined above. The voices and lives of people with mental health problems are highlighted in order to understand how this group 'feels' community, citizenships and progressive change. Critically exploring these new geographies of community participation throws into relief the *limits* to social inclusion for people who can only ever partially live out the ideals of 'active citizenship' as they are currently configured by the state. Although there are important limits to how participation in 'innovative spaces' facilitates belonging and stability for this group, significant gains are nonetheless emergent in terms of the changing social status of 'the mental patient' from inert non-citizen to valued and relational social agent.

Chapter 2 critically highlights the policy context in which concerns around social inclusion and mental health have emerged. It outlines the contested realities of 'community care' and recent state ambitions seeking to address the entrenched inequality, isolation and marginalization that often constitute the community lives of people with mental health problems. Taking the concept of 'citizenship' seriously, the chapter offers different takes on how best we might view this in relation to mental ill-health. Chapters 3 to 6 move from rural to urban to virtual geographies of participation, showing how particular environments involve different opportunities for and barriers to overcoming stigmatizing social relations. A central theme concerning *proximities* to difference is evoked, and the empirical materials show how small rural communities, community garden projects, artistic geographies and Internet forums involve particular kinds of intimacies and distances both between participants (people with mental health problems) and other community members. These proximities and distances are implicated in producing new and different possibilities for the social citizenships of people with mental health problems as they disclose their subjectivities in new and positive ways. Finally, chapter 7 offers a conclusion and argues that we should understand community mental health with reference to revised patient identities, and not only fearful proximities and distances. Summarizing the main arguments of the book, the conclusion seeks critically to evaluate the idea of the 'new' community-based mental health patient who participates and is partially included in community life through

innovative relational spaces. Returning to Chouinard's (1999, p. 142) comment on how marginalized people might be seen actively to replace themselves in social spaces where marginality is valued, my case studies are compared to interrogate their relative effectiveness in this regard.

This beginning chapter, and indeed the book as a whole, offers an 'opening up' of the debates around geography and mental health, and asks for these to be about more than just stories of institutional spaces and enclosed medical identities. It speaks to and across several sub-disciplinary fields in human geography, and beyond, as well as contributing to current debates in social and disability theory concerning embodied difference. Above all, it seeks to provide new possibilities for rethinking the incident in the family backyard with the patient from Mapperley Hospital, and in so doing it contributes to what might be called a 'hopeful ontology' where such spaces of intimate encounter might in future be infused by a respect for, and a valuing of, embodied difference.

NOTES

1   The terms I am using need explanation, as language is often a source of contention in disability and mental health politics. I variously reference 'the lunatic', 'the mad', 'the mental patient', 'people with serious and enduring mental health problems', 'people who are ill' and 'users' to describe the people written about in this book. These terms are reflective both of popular and problematic terminologies used at particular points in history (e.g. 'the lunatic' in the 1800s), but also to signify differences in how such people are understood from different philosophical perspectives. By using the term 'mad', for example, I signify a Foucauldian point about understanding madness without a burden of Reason. Rationality renders irrationality (madness) legible as 'illness', made so through Reason's technologies; the various 'psy' disciplines. To use the term 'mad', then, is to understand it as a state of being rather than a diagnosed state of illness. To reference 'the mental patient', conversely, is to acknowledge a rather static and singular figuring of people who have been diagnosed with a mental illness, one that I attempt to disrupt throughout the text. The term 'people with mental health problems' is reflective of a current social policy discourse emphasizing 'the person' rather than 'the patient' in acknowledgement of individuality and subjectivity beyond diagnostic categorization, and so it predominates here. 'User' and 'survivor' are terms referencing the collective organization/political grouping of psychiatric service-users, although these are contested in various ways (Crossley, 2006).

In a book elaborating the unstable pairing of people with mental health problems and 'social inclusion', I use the latter term to reference the various perceptual, emotional and subjective ways in which this 'group' (and it is internally differentiated) experience social connectivity through different social spaces. My work involves qualitative methodologies (in-depth interviews and

ethnographic encounters) and contact with research respondents has been initially established through various 'voluntary sector' and user-led networks. These non-medical access points often do not offer diagnostic categories to characterize the people who participate in the research. Such categories are not sought nor are they routinely recorded, and therefore do not form part of my analysis or discussion in explicit ways. For methodological discussion relating to work with people with mental health problems, see Laurier and Parr (1999); Parr (1998a, 1998b, 2001, 2002a, 2007b).

2 Much of the literature and arguments used in the book refer to the 'West', and a post-colonial geography of mental health and illness would consider both similar and different issues (see Potter and Phillips, 2006). This text does not cover such ground, but see Beng (2002), Colebourne and MacKinnon (2003) and Parle (2003) for studies of other international contexts.

3 Scotland followed suit later in 1857 with an Act that authorized district asylums (Henderson, 1964).

4 It is notable that rural landscapes of community care were considered largely irrelevant or simply neglected in these studies (see chapter 3).

5 Referring to the institutionalization of people with mental health problems.

6 Disability studies have been marked by the split between medical and social models of disability. As Gleeson (1999, p. 19) has argued, theoretical debate has moved from explaining disabled difference as merely reflections of nature (a 'medical model'), to the social constructionist positions typified in the 'social model' that has been widely accepted among disability activists as this is 'inherently politicizing and valorizing, insisting that disability is a real social identity – rather than an objective fact in nature to be endured'. There are, however, many 'social models', the majority of which have been critiqued as straying too far away from the embodied reality of impairment and pain in attempts to highlight the marginalized social positions of disabled people (Hall, 2000). Recently, there have been attempts to bridge this 'gap' by paying attention to embodied 'being', in addition to a focus on the wider social and structural forces involved in the making of disability.

7 Unpaid but involved.

8 Crossley (2006) argues that Parsons' theory of the 'sick role' serves to locate patients primarily in relationship with doctors and their families. Psychiatric hospitalization confuses this assumption due to the (previously) long periods of time that patients spend in each other's company. In Crossley's terms, 'the asylum collectivized mental patients' (p. 159). Although he recognizes that psychiatry and asylum management were capable of preventing collective action as 'total institutions' (Goffman, 1961), the beginning of the deinstitutionalization era produced a situation whereby 'patients were sufficiently networked to consider collective action but also sufficiently free of surveillance and control to be able to try' (2006, p. 160).