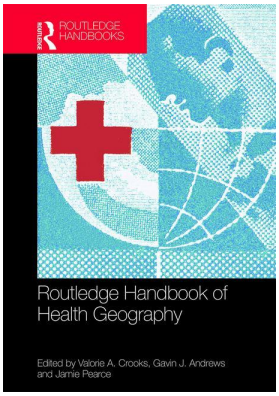

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"THIS PLACE IS GETTING TO ME"
Geographical understandings of mental health

Liz Twigg and Craig Duncan

This chapter outlines the ways in which medical and health geographers have contributed to our understanding of mental health. The narrative presented focuses on mental illness and is divided into two main parts. The first part discusses quantitative modeling of mental-health outcomes, detailing how aspects of individual, household and neighborhood socioeconomic context interact to influence risk. Much of this work is interdisciplinary and is produced in collaboration with medical practitioners working in the field of psychiatric morbidity; it addresses both geography and epidemiology audiences. The second part considers the use of qualitative approaches in elucidating the way in which the identities of those experiencing poor mental health are associated with the features and social meaning of places. While these place-based processes may lead to heightened feelings of marginalization, stigmatization, isolation and helplessness, they can also lead to a sense of empowerment, control and more positive identities. Where relevant, we refer to literature highlighting these positive impacts but generally leave *wellness* to take center stage elsewhere in this book.

Defining "mental illness" is a challenging, chaotic and contested exercise and is not attempted here. Sociological work has shown how designations are fluid, often socially and politically constructed, and neither spatially nor temporally universal. We do, however, make a broad distinction between common mental disorders (CMDs) and more serious conditions that can lead to compulsory hospital stays. CMDs include stress, anxiety and low-level depression and, although less disabling than major psychiatric illnesses, can sometimes cause disruption to usual everyday activities, with the potential to lead on to more severe conditions. CMDs' high prevalence is also a cause for concern (in the United Kingdom, around 20% of the adult population may suffer from CMDs at any one time).

Geographers have approached the nexus of place and mental health from several perspectives. They have, for example, attempted to qualify and quantify those aspects of place that may be detrimental to mental well-being, not only focusing on urban penalties but also recognizing the negative impacts of isolation, stigma and poor service provision in remote rural areas. Emphasis has also been placed on determining the geographical scale at which place effects become important, with a focus often centered on socioeconomic inequalities and relative (income) disadvantage. Increasingly, however, there is a realistic recognition that these overarching influences are not necessarily universal. Instead, there is a constant, recursive interplay between people and places, one that is complex and contingent on other geographical and social contexts.

Mental health outcomes: the role and complexity of place

One of the first geographers to capture the influence of place on mental health was John Giggs – a UK-based medical geographer often regarded as one of medical geography's founding fathers. His (now classic)

research documented the spatial distribution of people with schizophrenia in Nottingham, in the United Kingdom, during the early 1970s (Giggs, 1973). He built on the idea that inner-city conditions, characterized by poverty, instability and exclusion, act as catalysts to *breed* poor mental health. Although often tabled as a contrasting explanatory framework, the *drift* hypothesis outlined a parallel but more nuanced socio-spatial process, whereby individuals, as a consequence of poor mental health, experienced downward social-class mobility and residential shifts to poorer, marginalized areas of the inner city (see, e.g., Lewis et al. (1992) for a continuation of this debate).

A plethora of research now exists that implicates (to a lesser or greater extent) neighborhood context as part of the explanatory framework for mental-health outcomes. As the drift and breeder hypotheses suggest, the role of place is multifaceted. However, national investments in routine mental-health surveys have facilitated some understanding of this relationship and help us illustrate key themes outlined in the introduction.

Scale

Many studies operationalize socioeconomic context via routine measures of deprivation captured at local scales assumed to be synonymous with neighborhood. In reality, this process is usually data-driven, and *neighborhoods* equate to census areas or administrative/governance-related configurations. In ecological (i.e., aggregate) studies, evidence of deprivation gradients in outcomes is usually present across such areas but reduces significantly, or even disappears, once the compositional mix of people living in these areas is taken into account. This leads us to an obvious question – if geography matters for mental-health outcomes, at what spatial scale is it important (Duncan, Jones and Moon, 1995)?

In essence, contextual factors may operate at much smaller scales than administrative geographies and may interact with individual circumstance and other contexts. Some studies of CMDs in the United Kingdom have recognized the importance of *household* as a meaningful everyday context and show that significant differences remain across households that are not explained by the socioeconomic characteristics of the household or the people within them (Weich et al., 2003a), a finding that suggests that clusters of people within households may confer risk upon one another. Parallels can be drawn with prospective analyses, whereby childhood family psychosocial environment can be associated with mental well-being in early older age, highlighting the influence of family context and the life course (Stafford et al., 2015).

Income inequality and socioeconomic incongruities

As with many other health outcomes, Wilkinson's well-established (but often contested) income-inequality thesis stakes a claim in the explanation of mental-health inequalities (Pickett and Wilkinson, 2010). Within this explanatory paradigm, the high income inequality/poor mental health link is due to the stress response of status anxiety. The causal pathway between poor mental health and income inequality may also be mediated by lower levels of community social capital, social cohesion and trust. The assumption here is that neighborhoods with high levels of inequality are too diverse to sustain strong community bonds, and feelings of isolation, social fragmentation and distrust can lead to more depressive symptoms. Findings regarding Wilkinson's inequality thesis remain inconclusive, and the importance of absolute, rather than relative, disadvantage is often documented. In Wales, Fone et al. (2013) show that absolute income deprivation at the neighborhood level is more important than income inequality as a risk factor for CMD. The authors suggest that these null findings for relative income may be associated with the low values for inequality found across the study area. Likewise, but at the other end of the income-inequality scale, Adjaye-Gbewonyo et al. (2016) find that universally high district-level levels of income inequality in South Africa fail to register an influence on mental-health outcomes, but the authors surmise there may be a time lag before inequality effects are felt.

Flint et al.'s (2013) longitudinal work also delves into ideas about relative disadvantage. Their research across England and Wales confirms the substantial link between individual unemployment and poor mental

health but also notes that this is attenuated when the residential context is also characterized by high unemployment. This idea that a socioeconomic alignment between an individual and his or her neighborhood is conducive to good mental health has also been pursued elsewhere. In Auckland, New Zealand, higher treatment rates for anxiety/mood disorder are reported in socioeconomically isolated deprived areas – that is, areas surrounded by more advantaged neighborhoods (Pearson et al., 2013). Albor et al. (2014) show that high-status mothers' risk of depression or anxiety in the United Kingdom is reduced by 41% if they reside in high-status rather than low-status neighborhoods. This was explained by the improved chances of friendship when mothers were living in *socioeconomic congruity* with their neighbors.

Contingencies and the challenge of capturing context

Contextual influences are not universal; they are contingent and may change through time and across the life course. The Whitehall II cohort study of British civil servants has shown that mental-health gradients relating to housing tenure (i.e., owners versus renters) have diminished over time, but significantly higher rates of poor mental health were found across those who continue to experience long-term housing and financial problems (Howden-Chapman et al., 2011). Similarly, Weich et al. (2003b) found that area-level deprivation significantly increases risk of CMD, but only for those who were economically inactive, suggesting that time at home may increase risk exposure. The contingent nature of other environmental contexts has also garnered attention. For example, in a focused study investigating the influence of ethnic density on mental health in the United States across Latino sub-groups, it was shown that the association is dependent on the different migration histories (including reasons for migration and arrival rights) and current contexts across sub-groups (Becares, 2014). It has also been found in the United States that members of ethnic minority groups have reduced risk of poor mental health when they reside in areas with a high density of the same ethnicity (Shaw et al., 2012).

It is not only socioeconomic or socio-demographic context that plays a part in determining mental illness – or wellness. Other chapters in this book discuss how natural surroundings (e.g., blue/greenscapes) or the built environment can play out as *therapeutic*. Sometimes, there may be an interaction between the potentially health-enhancing aspects of neighborhood and socioeconomic context. A Canadian study found that living near a park had a protective effect against depression for people living in crowded conditions, and proximity to health services was also particularly beneficial for those living in deprived neighborhoods. Places classed as socially advantaged and offering cultural services were also protective (Gariepy et al., 2014). The urban penalty associated with mental-health outcomes and the protective effect of rural environments largely disappear when routine measures of population density are used to capture levels of urbanicity. However, when additional, more nuanced aspects of place (e.g., the proportion of residents working in different occupations including agriculture, forestry and fishing) are used to capture rurality, protective effects are detected (Weich, Twigg and Lewis, 2006), thus highlighting the need to capture context in as much detail as possible.

Severe mental-health outcomes

Apart from a brief mention of schizophrenia, our discussion so far has centered on CMDs – a focus largely reflecting data opportunities. More serious conditions usually involve health-care interventions, and many studies investigate service-related administrative data. A recent policy-pertinent example is the English National Study of Compulsory Admissions (ENSCA), looking at geographical inequalities in involuntary hospital admission (Weich et al., 2014). The policy backdrop for this project links to *reinstitutionalization*, a reversal of the trend toward community care (Moon, 2000) and an issue which we return to later in this chapter. ENSCA involved the analysis of approximately 1.2 million individuals who came into contact with secondary mental-health-care services during 2010 and 2011. Cross-classified multilevel models showed that

compulsory admission was greater in more-deprived areas and in areas with more non-white residents after adjusting for confounders, a finding replicated in ecological studies of compulsory admission (Keown et al., 2016). ENSCA also provides evidence of the stark inequalities found across different ethnic groups, with black patients almost three times as likely to experience compulsory admission as white people. Although area-level deprivation and individual- and area-level ethnicity are shown to be important, they do little to explain the residual geography and the large variations in risk of compulsory admission remaining across hospitals and small areas (Weich et al., 2017). This possibly reflects differences in community treatments, bed shortages and *revolving door* practices (i.e., continuous ineffective treatment, referral of patients between inpatient and outpatient health-care-delivery sectors). Future work needs to seek out more appropriate longitudinal measures of residential and treatment context to explain these disparities. Quantitative health geographers, using long runs of geocoded patient records, are well-placed to discern nuanced interactions between individuals, residential geographies and treatment contexts in order to address this gap. Furthermore, qualitative contributions (such as those outlined below) have the potential to enrich these findings and highlight the detailed, dynamic processes linking places to mental-health outcomes.

From outcomes to care

Geographers have been not only interested in describing and explaining mental-health outcomes, but also concerned with the care and experiences of people with mental-health problems. As we shall see, this second strand of geographical work on mental health is differently orientated in several ways: space and place do not feature as a container for organizing and representing data but feature as an active constituent of daily life; people are active subjects whose voices are heard; and theory and methods become multiple and diverse, focused on understanding and meaning. In short, an epidemiological model of mental health centered on medical definitions gives way to a social model in which historical and cultural interpretations take precedence. The idea of mental health, and the care that may be associated with it, is, then, no longer fixed and inevitable.

Confinement

Geographers' attention has often concentrated on the shifts that have occurred in the organization of care for people with mental-health problems. In the United Kingdom, for example, before the 18th century, people with mental-health problems were everywhere, living alongside others. Over the course of the 18th and 19th centuries, however, they came to be placed first in poorhouses, then in private charitable institutions, before finally being confined in large-scale publicly funded hospitals, usually known as asylums and, more often than not, purposefully set apart from urban centers.

Philo (2004) has produced the most detailed history of this intrinsically geographical shift. His work also emphasizes the way in which mental health moved from being a moral concern – disorder, unruliness – to being a medical one – symptoms, conditions. Thus, not only were the *mad* placed in separate physical, material spaces, but also they were put in new conceptual spaces – the term *mad* being used deliberately by Philo and others to highlight, and make a little less natural and certain, the rise to dominance of medical science's way of knowing irrationality as *illness*.

Release

Asylums have now, largely, disappeared due to a process of deinstitutionalization through the second half of the 20th century in which the *mad* were released back into society – most often, though not exclusively, into particular urban spaces.[1] The work of Dear and Wolch (1987) figures prominently here, though many others (e.g., Knowles, 2000) have added to their framing concept of (inner-city) *landscapes of despair*. Through

documenting this shift, people with mental-health problems start to appear as active participants in their lives whose voices are heard. Many studies showed how they had to deal with defensive *not in my backyard* attitudes rather than the warm welcome implied by the standard sobriquet of the time, *care in the community*. Lived experiences proliferate, both within specific communities but also, importantly, within society at large. Drawing on ideas of difference (Who is same? Who is other?), and making connections with studies of disability and chronic physical illness such as the work of Moss and Dyck (2003), workers came to see the treatment of the newly released *mad* as one specific instance of the general way in which different bodies were made invisible in space.

Recapture

While nearly all subsequent health-geography work has concentrated on exploring the implications of the release, it needs to be noted that one further development has been charted in more medically inclined studies of mental-health care (Chow and Priebe, 2013). Although the number of conventional psychiatric beds in hospitals has continued to fall in most Western industrialized countries, there has been a dramatic growth in forensic (criminal) psychiatry places, supported housing places and prison populations. Involuntary hospital admissions, discussed earlier in this chapter, have also risen, and this is considered another part of the process of *reinstitutionalization*. It is, though, perhaps the last setting in the previous list that geographers of mental health need to discover most, at least in some countries. For example, as Scull (2015) has recently pointed out, the largest concentration of seriously mentally ill people in the United States is in the Los Angeles County jail system.

Escape

Work by geographers has, though, remained focused on the escape from confinement, and this is worth a closer look. Parr is the geographer who has done the most work here, and through a series of papers drawn together and expanded upon in a book (Parr, 2008), we have what is, in our view, the fullest, and most subtle and nuanced, analysis of the lived experience of people with mental-health problems by geographers to date. It is life, not as the individual experience of being in the world or the universal human of humanistic geography, but life seen through ideas of socially marked difference and the politics of identity associated with this. Who is included? Who is excluded? Where? Who is valued? Who is devalued? Where? Through close ethnographic, participant-observation-based investigation of a range of mundane, everyday community spaces in both urban and rural locations, Parr remains positive and hopeful that such spaces can provide enough possibility for people with mental-health problems to take some meaningful control of their lives and for others' fear of them to if not subside, then at least be subdued.

Later work by Parr and others has, though, drawn on another way of understanding the lived experience of mental health (Parr and Davidson, 2015).[2] Rather than concentrate on what is going on *out there*, beyond ourselves, attention focuses on what is going on or, perhaps more accurately, has gone on *in here*, inside ourselves. We need, then, to first see interior geographies (how the outside world is organized inside us and how our personality and sense of self is itself organized), especially those that we are not immediately, if at all, consciously aware of, for it is these that affect and shape our external lives and the physical spaces they take place in. In this way, mental life and the problems that can be attached to it are opened up beyond medically defined conditions to include intimate psychic spaces and the full range of human emotions that they encapsulate. Stemming from the work of Freud, and drawing on those who have followed on from him, this psychoanalytical approach has stimulated novel methodological approaches drawing on psychotherapeutic techniques (Bingley, 2003) and provided valuable insights on disruptive and difficult emotions and the debilitating conditions they can give rise to (Davidson, 2003).

Most recently, this desire to investigate unconscious life has led some geographers to take a third, and rather different, approach. Instead of going inward to reveal the long-lasting effects of the unconscious, or outward to expose the enduring differences and identities imposed by social life, Andrews, Chen and Myers (2014) wish to capture all that is going on in the immediacy of the present: lived experience as it takes (and makes) place – before it is understood, before it is represented in understanding. This non-representational approach can be thought of as offering an ecology of mental health in the moment, its metaphors of atmospheres and assemblages seeking to articulate the spontaneous, fluid environments through which, and by which, people with mental-health problems become well (Duff, 2016). In this way, nothing is innate, structured or fixed; instead, recovery is continually produced through the multitude of human, and non-human, resources that come together as the lives of people with mental-health problems quite literally *take place*.

Danger

There is much to celebrate in this second strand of work, and many valuable insights have been gained. The distant, detached calculations of epidemiology have been complemented with knowledge that is *up-close and personal*. Biomedical causes, cures and associations have been augmented with notions of care and recovery. A multitude of often mundane and ordinary places – from Parr's (2008) range of participatory community spaces to Wilton and Evans' (2016) social enterprises – have come into focus. Methodological variety and novelty has burst through, with go-alongs, video-elicitations, autobiographies, and autoethnographies becoming prominent alongside more well-established qualitative research techniques (Chouinard, 2012; Liggins, Kearns and Adams, 2013; Söderström et al., 2016).

Yet, somehow, there is also, at least for us, some danger here. While consideration of the abject poverty of many of those with mental-health problems is acknowledged as missing by Parr, there is no mention of it in the later work by those taking a non-representational approach. Psychoanalytical impulses often seem to lead to playful encounters with urban living more than the harsh, painful reality of city lives disrupted by mental ill health. What is also striking is that so much recent work has talked about *bodies* more than, or even to the exclusion of, *minds*. One correction to this tendency for *mindless bodies* would appear to be recent British work attempting to get to grips with the current vogue for *mindfulness* therapies (Lea, Cadman and Philo, 2015). As the authors make clear, however, and numerous self-help publications now available attest, such techniques aim to move us from mindless to mindful lives by taking us *out* of our heads and *into* our bodies. With their long-standing interest in human-environment interactions, geographers would seem to be well-placed to elicit the ways in which our mental experiences constitute, and are constituted by, the day-to-day material circumstances in which we lead our lives.

Concluding thoughts

This chapter has provided a brief overview of the role of place in understanding mental-health outcomes and care. The part on health outcomes alerts us to be ever mindful of what is relevant as context. Recent political upheavals on global and national stages may have far-reaching impacts on feelings of inclusion, belonging and safety. First World challenges associated with austerity are likely to damage the fabric and levels of community support in our local neighborhoods. Our measures of context must therefore be innovative and sensitive to contemporary potential stressors. The part on health care reflects the move in the broader discipline from social geographies arising from the material structures of society to cultural geographies attached to the workings of power through identity, meaning and representation. In this way, the two strands of work covered in this chapter seem to be moving farther apart, and, for us, it is striking and concerning that currently there is such little *up-close and personal* geographic work examining the mental-health implications for those most affected by the economic and political vicissitudes of recent times.

Notes

1 The trace of asylums can, though, still be found, as work by Moon and colleagues has explored (Moon, Kearns and Joseph, 2006).
2 This approach is referred to in Parr's (2008) earlier work, but only briefly, and is not developed.

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