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All 'in the mind':
Towards a New Model of Embodied Mental Health

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November 2017

Declaration

I, Grace Lucas, confirm that the work presented in this thesis is my own. Where information has been derived from other sources, I confirm that this has been indicated in the thesis.

Abstract

The National Clinical Director of Mental Health for NHS England has said that we need to ‘dump Descartes’, and the authors of one of psychiatry’s principal diagnostic manuals have stated that the term mental disorder is a dualistic anachronism. Existing critical challenges to dualism, including affect theory, new materialism and phenomenology, have sought to reinstate meaning for the material body, and biomedical work exploring the immune system, epigenetics and the microbiome-gut-brain axis suggests that mind over matter is an untenable principle. Moreover, UK government health strategies have come to recognise the relationship between mental and physical health outcomes and are increasingly focused on connecting up care. However, mind and body dualism is deeply and habitually ingrained in medical practice, healthcare structures and research silos. Despite efforts focused on integration, the dominating influence of psychiatric discourse and the focus on mental health within the confines of the head continue to reinforce the split. Working with a transdisciplinary critical medical humanities framework, and guided by feminist criticism gesturing towards making social change, this thesis critiques dominant models of mental health focused on immaterial thoughts or brain dysfunction, both of which overwrite embodied dimensions of experience. It argues that mental health involves physical beings in constant contact with the world and that without a shift in the language, the social, corporeal and environmental aspects of mental health remain tacked on to problematically individualised and internalised constructs. To go against the grain of language, the thesis then moves on to find appropriate tools and models with which to conceptualise non-dualist ontologies and to gesture towards an embodied model of mental health. It concludes that a radical shift in mental health research and practice is urgently needed that drops out of the head and into the ‘being-body’.

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Contents

Abstract	3
Acknowledgements.....	4
Introduction.....	7
Overview: Mind and Matter	7
Background and Context: One in Four	10
The Problem: The Impasse of Language	19
Framework: Critical Medical Humanities	21
Transdisciplinarity: A Diffractive Reading.....	26
Being Critical: Meanings and Manifestations	28
Aims and Argument: Staging an Intervention.....	31
Developing Terms: Towards the ‘Being-body’	32
Developing Terms: Embodied Mental Health	37
Methodology: ‘Matter Matters’	39
The Limits: Spaces and Locations.....	42
Moving Forwards: The Chapters Ahead.....	47
Chapter One: The Problem of the ‘Mental’ in ‘Mental’ Dis/order.....	52
Chapter Aim and Summary	52
Background: Divided Medicine	56
The Immaterial Thoughts Model	58
The Brain Disorder Model	65
Interacting Mind and Body Model	71
The Body Systems Model.....	78
The Implications of Crossing Models.....	88
Conclusions	90
Chapter Two: Narrating ‘Mental’ Dis/order: ‘Anxiety in the soles of my feet’	93
Chapter Aim and Summary	93
Narrative Power: A Medical Humanities Approach	96
Narrative Limits.....	100
Body-Mind-Brain.....	108
Narrative Bodies: ‘All her body became that song’	111
Re-bodying the Self.....	126
Conclusions	128
Chapter Three: Haptic Sounds and Moving Music	131

Chapter Aim and Summary	131
Sonorous Beings	135
Vibrating Matter.....	137
Affecting Energy	140
Sound and Language.....	143
The Touch of Sound.....	145
Matter with Meaning	148
Moving Music	149
Formalism and Intellectual Music.....	151
Embodied Music.....	155
Musical Movement and Space	160
Conclusions	164
Chapter Four: Knowing Bodies	166
Chapter Aim and Summary	166
Somatics: A ‘Generative Concept’	169
Embodied Knowledge; Embodied Research	172
Moving Bodies	177
Body Matter; Bodies Matter.....	188
Social Beings.....	195
Conclusions	200
Conclusion	206
Chapter Aim and Summary	206
Critical Questions.....	207
A Critical Medical Humanities Framework	209
Chapter Contributions	212
Mapping the Meanings: Mental Health is not all in our Heads.....	218
Implications: Beyond Mental and Physical Silos	221
Implications: Embodied Research	228
Limitations	231
Final Thoughts	233
Bibliography	237

Introduction

Overview: Mind and Matter

'Mental' dis/orders¹ are arguably the subject of more analysis than they ever have been before in the UK; framed as an urgent and pressing personal, social, political and economic problem. This may be connected to some key movements and developments. First, the rapid growth in new biological sciences like neuroscience with disorders once considered to be non-organic, or socially constructed, now being increasingly researched as individual brain dysfunctions. Second, the importance of tackling health has risen to the top of the policy agenda – the British Prime Minister, Theresa May, put mental health services and support at the centre of her 2017 annual lecture at the Charity Commission and, in health policy, mental health has repeatedly been offered 'parity of esteem' with physical health.² Third, there has been a vigorous focus on destigmatising mental illness with personal narratives from celebrity figures³, the UK Royal Family⁴ and even mental health policy makers⁵ foregrounding the subject – and centralising the need to talk about mental illness.⁶ Literary memoirs, newspaper articles, television and film representations, and social media accounts have circulated narratives about individual experiences of 'mental' dis/order. Across these powerful medical and scientific, political and cultural discourses, mental health is largely contained to the individual; located as psychology in the head (as opposed to the broader physical body or related to the social

¹ I will discuss the use of the slash and inverted commas in 'mental' dis/order on page 33.

² Gov.uk, 'Press Release: Prime Minister unveils plans to transform mental health support', 19 January 2017 <<https://www.gov.uk/government/news/prime-minister-unveils-plans-to-transform-mental-health-support>> [accessed 9 July 2017].

³ Hollie Brotherton, '23 celebrities speak honestly about their mental health battles', *Marie Claire*, 5 January 2017 <<http://www.marieclaire.co.uk/news/celebrity-news/celebrities-speak-out-about-mental-health-12047>> [accessed 9 July 2017].

⁴ Heads Together, <<https://www.headstogether.org.uk/about-heads-together/>> [accessed 9 July 2017].

⁵ Megha Mohan, 'The NHS mental health chief who had a nervous breakdown', *BBC News*, 23 January 2017 <<http://www.bbc.co.uk/news/blogs-trending-38720826>> [accessed 9 July 2017].

⁶ Time to Change, 'About Mental Health' <<http://www.time-to-change.org.uk/mental-health-statistics-facts>> [accessed 9 July 2017].

world) and often located in the function of the brain. These models broadly speak to a Cartesian mind over matter – or mind over body – model of selfhood.

From totally different perspectives, there has been a call for the meaning of mental illness or ‘mental’ dis/order to be investigated and uprooted beyond the dominant medical models of these internalised psychological or neurological frameworks; this has included research within critical psychiatry, critical mental health studies, sociology and medical anthropology. Concerns about the globalisation and medicalisation – and the increasingly brain-centred emphasis of psychiatry – have drawn considerable bodies of research. Perhaps most especially, the power structures implicit in psychiatry’s classifications of order and disorder have been disassembled by anti-psychiatry critiques from the 1960s onwards, and are still articulated in protests against the American Psychiatric Association’s *Diagnostic and Statistical Manual of Mental Disorders* (most recently *DSM-5*) in recent years.⁷ Further, analysis by the French philosopher Michel Foucault has led and inspired criticism that has interrogated how individual and cultural narratives and understandings about mental health are led and shaped by powerful medical discourse.⁸

In the last decade, there has also been a move from within healthcare policy and the National Health Service (NHS) in the UK towards a sort of self-critique by stitching together physical and mental healthcare into an integrated approach and articulating the fundamental connectivity of mental and physical health outcomes.⁹ Additionally, research from the fields of cognitive science and systems theory has underpinned the notion of embodiment as a ‘major paradigm of psychopathology’ (again shifting the

⁷ American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition* (DSM-5) (Washington DC: American Psychiatric Association, 2013).

⁸ Michael Foucault, *The Birth of the Clinic: An Archaeology of Medical Perception*, transl. by Alan Sheridan (Tavistock, 1973; Oxon: Routledge Classics, 2003).

⁹ Geraldine Strathdee (NHS England), ‘Integrated Care: 3 years of Progress and “Jugular” Actions Needed’, presentation to *The King’s Fund*, March 2016.

<http://www.kingsfund.org.uk/sites/files/kf/media/Geraldine_Strathdee_integrating_physical_mental_health.pdf> [accessed 8 July 2017].

boundaries of 'mental' dis/order).¹⁰ Furthermore, and much more broadly, the corporeal and material turns in critical theory have seen the multiple meanings of the body brought to the critical surface and the notion of the embodied mind theorised and located in a number of disciplinary spaces in the humanities and social sciences, particularly mobilised by affect theory, phenomenology and feminist and new materialist positions.

However, despite all these challenges to the structures and assumptions in the classification and location of 'mental' dis/order, there is, within current healthcare policy, public health narratives and clinical practice, an arguably unrelenting bias to a Cartesian model. The implicit ontological meaning of 'mental' health is often overlooked in clinical practice, which is focused on the action of treatment, not interpretation, and which lacks a language or conceptual framework within which to deconstruct how the language and narratives of 'mental' health and illness may be complicit with dualism, and what the meaning and implications of this dualism might be.

I suggest that this is a problematic gap in understanding how the language and narratives of 'mental' disorder impact on how it is experienced, and how it is dealt with therapeutically. This thesis, therefore, aims to set up an intervention in terms of the way in which healthcare is conceptualised, arguing that a failure to problematise the language of 'mental' health means a continual fall-back into dualist mind over matter assumptions. My thesis enters here to examine and interrogate the meaning of the word 'mental'; to draw in critical, theoretical work from humanities disciplines to dig beneath that which sediments and has become naturalised in this word, and to suggest that its neurological and psychological underpinnings have translated into both popular and policy vocabularies, bringing with them an inherent and unexamined dualism. I suggest that this dualism relates to positive, self-determining ideas of mind over matter, the

¹⁰ Thomas Fuchs and Jann E. Schlimme, 'Embodiment and Psychopathology: A Phenomenological Perspective', *Current Opinion in Psychiatry* 22 (2009), 570-575, p. 575.

body as a project or object, neo-liberalist individualism and is limiting in both defining and treating 'mental' illness.

The aims of this project are twofold; first, to interrogate the main definitions and models underpinning mental healthcare in the UK today. Here, I aim to conduct a discursive analysis of the multiple meanings of 'mental' dis/order in terms of where they emanate from, how they are positioned and by whom. This means analysing the form, shape and function of different narratives and words, and their involvement in – and co-construction of – 'mental' health experience. Second, I aim to search for appropriate analytic tools and concepts to re-infuse understanding of 'mental' health with the vibrating matter of physical life – ultimately signalling to a kind of depth 'mental' body, which I go on to term the 'being-body'. This thesis thus enters into the critical medical humanities, where an emphasis on challenging 'instantiations of the biomedical' supports this domain of enquiry, as well gesturing towards future engagements with clinicians and policymakers.¹¹ This Introduction now moves on to look at some of these overview areas in more detail.

Background and Context: One in Four

One in four adults experiences at least one diagnosable mental health problem in any given year. [...] Mental health problems represent the largest single cause of disability in the UK. The cost to the economy is estimated at £105 billion a year – roughly the cost of the entire NHS.¹²

¹¹ William Viney, Felicity Callard and Angela Woods 'Critical Medical Humanities: Embracing Entanglement, Taking Risks', *Medical Humanities* 41 (2015), 2-7 < <http://dx.doi.org/10.1136/medhum-2015-010692>>.

¹² Mental Health Taskforce for NHS England, *The Five Year Forward View for Mental Health: A Report from the Independent Mental Health Taskforce to the NHS in England* (February 2016), p.4 <<https://www.england.nhs.uk/wp-content/uploads/2016/02/Mental-Health-Taskforce-FYFV-final.pdf>> [accessed 8 July 2017].

In general medicine, research on the causes and cures of some physical illnesses has led to preventive interventions and/or more effective treatments, resulting in a decline in prevalence rates. In psychiatry, on the other hand, the general trend so far is not clearly in this direction, and may be running for some conditions the wrong way.¹³

In this section, I begin to give some context and background to the work, which is then expanded and deepened in Chapter One wherein I aim to disentangle some of the master narratives and models of mental health that underpin psychiatric and political discourse in the UK today, as well as offering a brief overview of how these narratives have emerged historically.

The language of ‘mind’ and ‘mental’ health and illness versus ‘body’ and ‘physical’ health and illness is set up in healthcare institutions (both clinical and policy-based), organisations and charities. Current UK government policy states that there should be a ‘parity of esteem’ for physical and mental health^{14 15} and there is a ‘mental health act’ but not a ‘physical’ one.¹⁶ Mental health charities reflect their distinct territory in their nomenclature including: Mind, The Mental Health Foundation, Young Minds, and Together: For Mental Wellbeing, and, in 2016/2017, the birth of two new organisations: Heads Together and Headcase.¹⁷ ‘One in four’ adults is said to have a mental health problem in any given year, and psychiatry and psychiatrists specialise in the diagnosis and treatment of mental illness outside of general (i.e. physical) medicine.

¹³ Derek Bolton, *What is Mental Disorder?: An Essay in Philosophy, Science, and Values* (Oxford: Oxford University Press, 2008), p. 239.

¹⁴ Department of Health and The Rt Hon Norman Lamb MP, ‘Making Mental Health as Important as Physical Health’, *Gov.uk*, 23 January 2014 <<https://www.gov.uk/government/news/making-mental-health-as-important-as-physical-health>> [accessed 8 July 2017].

¹⁵ Department of Health and The Rt Hon Norman Lamb MP, ‘Achieving Parity of Esteem between Mental and Physical Health’, 20 June 2013, <<https://www.gov.uk/government/speeches/achieving-parity-of-esteem-between-mental-and-physical-health>> [accessed 9 July 2017].

¹⁶ Eric Matthews, ‘Mental and Physical Illness: An Unsustainable Separation?’, in *Law without Enforcement: Integrating Mental Health and Justice*, ed. by N. Eastman and J. Peay (Oxford: Hart Publishing, 1999), pp. 47-58 (p. 47).

¹⁷ Headcase <<http://www.inmyheadcase.com/>> [accessed 8 July 2017].

Despite the firm emphasis on minds as separate and distinct from bodies, psychiatry itself is not a homogenous field and psychiatrists speak in many different directions about their objects of enquiry. In recent years, the rapid growth in neuroscience and the promise of locating ‘mental’ dis/orders in certain brain chemicals or pathways has metabolised research looking at these problems as individual flawed brain functioning. Biological psychiatry targets the investigation of ‘neuropsychiatric disorders’ with its own professional society and journals.^{18,19} This model, as social theorists Nikolas Rose and Joelle M. Abi-Rached argue in their book *Neuro: The New Brain Sciences and the Management of the Mind*, may well be a move ‘Beyond Cartesianism’ because if ‘mind is what brain does’ and the brain is an organ of the body, then ‘mind’ is physical.²⁰ There is a further move that extends the materialist, biological model and is now appearing as part of the tissue of biological psychiatry in its research papers and journals.²¹ Embodied cognition, or the concept of the embodied mind, developed within cognitive science, situates the brain within a systems theory of biology and, thus, cognitive processes (and thereby thought, and thereby dysfunctional or disordered thought) stretch beyond brain matter towards an organism’s sensory-motor systems as well as in relation to the environment.²² Specifically, this impacts a conception of ‘mental’ dis/order by suggesting a much more networked emphasis on the brain and its relationship with other body systems (for example the immune, endocrine, nervous, or digestive systems). As with other biological models, the subject has gained much traction in research. However, psychiatrists are certainly not all aligned with a wholly neuroscientific model of mental health. Social psychiatrists argue for a much more situational and relational model of mental illness – deeply immersed in the

¹⁸ *Biological Psychiatry: A Journal of Psychiatric Neuroscience and Therapeutics* <<http://www.biologicalpsychiatryjournal.com/>> [accessed 8 July 2017].

¹⁹ Society of Biological Psychiatry <<http://www.sobp.org>> [accessed 8 July 2017].

²⁰ N. Rose and J. M. Abi-Rached, *Neuro: The New Brain Sciences and the Management of the Mind* (Princeton: Princeton University Press, 2013), p.3.

²¹ Pochu Ho and David A. Ross, ‘More Than a Gut Feeling: The Implications of the Gut Microbiota in Psychiatry’, *Biological Psychiatry*, 81,5 (March 2017), e35–e37 <10.1016/j.biopsych.2016.12.018>

²² Fuchs and Schlimme.

problems of people's social worlds and life events (this is not to say that a brain-based model totally negates this – via its models of plasticity and change – but for social psychiatry it is the primary focus). I will look at these models from psychiatry in more detail in Chapter One.

The main manuals of psychiatry help psychiatrists across the world to negotiate the complexity of diagnosis in different ways. Although DSM is an American production, based on an American psychiatric context, its power and authority extend beyond the US and it is often referred to as 'The Psychiatrist's Bible'.²³ The other principal manual is that of the *International Standard Classification of Diseases, Injuries and Causes of Death* (latest version *ICD-10*) – a global World Health Organisation-led 'multidisciplinary and multilingual' schema, which is internationally and cheaply available to all countries and contains 'mental' dis/order sections.²⁴ While the ICD is the official classification system for psychiatrists working in the NHS in the United Kingdom, *DSM* is a hugely influential text (impacting on mass-media narratives about mental health across the world), therefore, I will also refer to its influence through the thesis. Both manuals of 'mental' dis/order have been updated and re-versioned a number of times over the past hundred years. The last iteration saw fifteen new disorders added to *DSM-5* in 2013.²⁵ These additions are oft critiqued by some corners of the field, and it should not be assumed that Psychiatry is one stable discipline to which this thesis can respond or address. In an example of this, Sir Simon Wessely, President of the Royal College of Psychiatrists in the UK, positions himself against *DSM* with its creation of 'more and more disorders'. Wessely suggests the need to maintain the boundaries of psychiatry rather than extend them; to ensure that expectable responses to life problems or normal stages and changes

²³ NHS Choices, 'News Analysis: Controversial Mental Health Guide *DSM-5*', 15 August 2013 <<http://www.nhs.uk/news/2013/08august/pages/controversy-mental-health-diagnosis-and-treatment-dsm5.aspx>> [accessed 8 July 2017].

²⁴ American Psychological Association, 'ICD vs. DSM', *Monitor on Psychology*, 40, 9 (October 2009), 63 <<http://www.apa.org/monitor/2009/10/icd-dsm.aspx>> [accessed 18 July 2017].

²⁵ Jen Wiczner, '15 New Mental Illnesses in the *DSM-5*', *MarketWatch*, 25 May 2013 <<http://on.mktw.net/1Kc3xSo>> [accessed 8 July 2017].

in childhood are not pathologized.²⁶ For psychiatry, the line between order and disorder remains constantly 'in flux'.²⁷

Despite these uncertainties about what does, or does not constitute an illness, phenomenologist, Havi Carel explains that 'patients' own understanding of their illness is influenced by medical attitudes and their encounters with the healthcare system' and thus they are 'quick to mimic the medical discourse'.²⁸ In psychiatry, patient diagnosis comes from the psychiatrist, and it is the language of this diagnosis that shapes understanding of mental illness and what is – and is not – normal. The labels, forms and expressions used by psychiatry thereby disseminate into the public imagination as patients take ownership of the labels they are assigned, affirm the disorders as a part of their life, and communicate these problems to others. The powerful delineating labels are reviewed in a critical context by interdisciplinary sociologist Simone Fullagar, who looks through a Foucauldian lens at the 'biopower that operates through health/illness discourses' in regulating individuals specifically in a mental health context. Fullagar suggests 'the rise of neuroscience is shaping mental health categories from schizophrenia to depression via new vocabularies and images of the brain.' Indeed, in her study of women with depression, she found that they, 'exercised agency through performing the subject position of the biomedical consumer as they engaged with the expertise generated by neuroscience and psy-expertise'.²⁹ The neurological and psychological constructions of mental health inflect and underlie personal understandings and

²⁶ BBC Radio 4, 'Simon Wessely on unexplained medical syndromes', *The Life Scientific*, 14 February 2017 <<http://www.bbc.co.uk/programmes/b08dnr3g>> [accessed 8 July 2017].

²⁷ Bolton, *What is Mental Disorder?* p.xviii.

²⁸ Havi Carel, 'Phenomenology as a resource for patients', *Journal of Medicine and Philosophy*, 37, 2 (2013), 96-113. <<http://eprints.uwe.ac.uk/16205/2/Phen%20as%20patient%20resource%20MP2011.pdf>> [accessed 9 July 2017] p.2.

²⁹ Simone Fullagar, 'Foucauldian Theory' in *Routledge International Handbook of Critical Mental Health*, ed. by B. Cohen (London: Routledge, forthcoming 2017) <https://www.researchgate.net/publication/308919923_Fullagar_S_forthcoming_2017_Chapter_5_Foucauldian_Theory_In_Cohen_B_Ed_Routledge_International_Handbook_of_Critical_Mental_Health_Routledge_London> [accessed 8 July 2017].

interpretations of ‘mental’ dis/order; these are the parameters within which mental illness is verified by medical knowledge.

Beyond those formally diagnosed with mental illness, the ‘neuro’ language of biological psychiatry seems to have entered into the popular imagination and so, as Rose and Abi-Rached suggest, to a public immersed in brain culture, ‘mind seems visible *in* the brain itself’ [my emphasis].³⁰ Rose and Abi-Rached point to a ‘spate of books for lay readers’.³¹ Indeed, whole sections of bookshop shelves have become dedicated to neuro-explanations for selfhood and illness³² (something that I will explore further in Chapter Two). A 2016 BBC television series aimed at raising awareness of mental illness, entitled *In the Mind* (from which the title of this thesis is drawn), followed up this trend by focusing on the relationship between mental illness and the brain.³³ The notion of brain-based disorder has personal implications – shifting understanding of mental illness away from immaterial thoughts to a more organic conception of brain dysfunction, providing it with a concretised, individualised and physicalized location.

In addition to the dispersal of psychiatric and biomedical knowledge, within a UK context, government agencies are responsible for shaping informational strategies for how healthcare is provided, divided and understood. The notion of integrated physical and mental healthcare has, in recent years, been inserted into healthcare agendas. The National Clinical Director for Mental Health in the UK has stated that ‘if we make as much progress in the next 3 years as we’ve made in the last 3, England can dump Descartes’.³⁴ This notion of integrated care has been informed by research potentially demonstrating the connections between mental and physical health outcomes, and has been specifically put forward by the Independent Mental Health Taskforce. The

³⁰ Rose and Abi-Rached, p.5.

³¹ Rose and Abi-Rached, p.1.

³² Steven Poole, ‘Your brain on pseudoscience: the rise of popular neurobollocks’, *New Statesman*, 6 September 2012 <<http://www.newstatesman.com/culture/books/2012/09/your-brain-pseudoscience-rise-popular-neurobollocks>> [accessed 8 July 2017].

³³ BBC Media Centre, ‘In the Mind’, 1 February 2016 <<http://www.bbc.co.uk/mediacentre/latestnews/2016/in-the-mind>> [accessed 18 July 2017].

³⁴ Strathdee, ‘Integrated Care’.

Taskforce was launched in 2015 by NHS England (an executive non-departmental public body working with the UK Department of Health), and in its *Five Year Forward View for Mental Health* report of February 2016, it sought to set out ‘how national bodies, including health agencies and government departments, should work together over the next five years to improve mental health.’ The first sentence of the foreword to the report argues: ‘For far too long, people of all ages with mental health problems have been stigmatised and marginalised, all too often experiencing an NHS that treats their minds and bodies separately.’³⁵ Resultantly, the report sets out three main priority actions for the NHS by 2020/21; putting forward a series of recommendations that Public Health England and other partners must take forward in order to deliver ‘a fresh mind-set for mental health within the NHS and beyond’.³⁶ An integrated approach is laid out as one of those top three priorities. This model sets out how:

Mental health support should be made easily available across the NHS, and integrated services should ensure that health checks and programmes such as smoking cessation are made available for everyone with a severe mental illness. To work towards this priority, PHE will support commissioners to increase the offer and take up of information, tests and interventions for people with mental health problems, who are at greater risk of poor physical health. With our partners, we will also support Health and Wellbeing Boards to update their strategies to include mental health and comorbid alcohol and drug misuse, parenting programmes, and housing.³⁷

³⁵ Paul Farmer and Jacqui Dyer, Foreword to ‘The Five Year Forward View for Mental Health’, p.3.

³⁶ Five Year Forward, p.5.

³⁷ Kevin Fenton, ‘Public Health Matters: The new Five Year Forward View for mental health: opportunities for prevention and improving outcomes’, *Gov.uk*, 23 February 2016 <<https://publichealthmatters.blog.gov.uk/2016/02/23/the-new-five-year-forward-view-for-mental-health-opportunities-for-prevention-and-improving-outcomes/>> [accessed 8 July 2017].

Within UK healthcare, the dismantling of dualism and the dumping of Descartes comes in the form of this ‘integration’, which is largely focused on the ‘physical’ health of those with diagnosed mental illnesses in the form of physical checks, programmes, information and tests. Mental and physical health are related and conjoined but remain separately articulated and structured.

In terms of broader public health strategies, campaigns are disseminated via Public Health England (an executive agency of the Department of Health) whose role is to ‘protect and improve the nation’s health and wellbeing, and reduce health inequalities’ by communicating messages directly to the public or through other (more local) partners, agencies and organisations.³⁸ The emphasis within Public Health England’s (PHE) general wellness campaigns (Change4Life, SmokeFree, SugarSmart, OneYou, DaysOff) is largely on issues which are positioned as directly impacting ‘physical’ health outcomes – exercise, smoking, diet and alcohol consumption.³⁹ The Royal College of Psychiatrists has made a direct comment on this emphasis, suggesting that more should be done for ‘mental illness and mental well-being’, and articulating that, historically, public health strategies have overlooked how good mental health underpins the success of its initiatives.⁴⁰ The emphasis within these general campaigns is on the rhetoric of self-improvement: the One You campaign (which provides a through line across all the key areas) encourages people to reappraise their lifestyle choices, put themselves first and commit to addressing their own health needs. It reminds people that it’s never too late to improve their health.⁴¹ Changes are focused on the individual, as people are asked to ‘reappraise’ and ‘do something’. A similar emphasis comes through

³⁸ Gov.uk, ‘Public Health England’ <<https://www.gov.uk/government/organisations/public-health-england/about>> [accessed 8 July 2017].

³⁹ Public Health England, ‘Campaign Resource Centre’ <<https://campaignresources.phe.gov.uk/resources/campaigns>> [accessed 8 July 2017].

⁴⁰ The Royal College of Psychiatrists, ‘No health without public mental health: the case for action Parliamentary briefing’, 2010 <http://www.rcpsych.ac.uk/PDF/Final%20PS4%20briefing_for%20website%20A4.pdf> [accessed 8 July 2017].

⁴¹ Public Health England, ‘One You’ <<https://campaignresources.phe.gov.uk/resources/campaigns/44-one-you/About%20One%20You>> [accessed 8 July 2017].

in PHE's Change4Life dietary messaging. A 2017 strand of this campaign provides an app with which people can scan the food they are buying to understand how much sugar, saturated fat and salt is in products. The campaign 'Be Food Smart' advises parents to 'take control of their children's diet' by 'empower[ing] families' with the scanning application.⁴² Health is positioned as an individual project, and it is the person's own responsibility to control themselves; scanning the shelves and seeking out the healthy produce. Looking after the body is positioned in terms of a project of physical improvement, and associations with 'mental' health are less overtly emphasised. These campaigns arguably fit into a neoliberal social climate, with 'choice', 'responsibility' and 'empowerment' the key watchwords.⁴³ (I will return to the concept of neoliberalism throughout this thesis – mindful that my use of this arguably sweeping term needs some definition. I draw here on the work of Wendy Brown who defines neoliberalism broadly as a political rationality where individuals have responsibility for their own states of health and broader life quality.)⁴⁴ In such a healthist and body-conscious culture, battling with rhetoric around the obesity crisis, the desired and correct body shape is one that is tough enough to stand up against the commercial pull of cheap, processed food, an increasingly sedentary working life and a socially acceptable drinking culture – and, to do so, means being autonomous, self-controlled, and disciplined. The body should be moulded and sculpted in dieting and exercise and 'listened to' when it comes to health and wellbeing. It ties in with a broad cultural script of mind over matter which reinforces, or, indeed, actively mobilises dualist ideas and firmly undoes the idea of mind and body as one.

The Faculty for Public Health UK (the standard setting body for specialists in public health in the United Kingdom) argues that in order to make progress with the

⁴² Public Health England, 'Be Food Smart' <<https://campaignresources.phe.gov.uk/resources/campaigns/55-be-food-smart>> [accessed 8 July 2017].

⁴³ Ruth Barcan, *Complementary and Alternative Medicine: Bodies, Therapies, Senses* (London: Berg, 2011), p.37.

⁴⁴ Wendy Brown, 'Neoliberalism and the End of Liberal Democracy' in *Edgework: Critical Essays on Knowledge and Politics* ed. by W. Brown (Princeton, NJ: Princeton University Press, 2005), pp.37-59.

‘physical aspects of public health’ it is necessary to challenge ‘the firmly held attitudes and beliefs in both health care and public health about the mind-body dichotomy in which mental and physical health are seen as separate’. Indeed, the FPH explains that despite evidence on interventions to promote ‘mental wellbeing’, at present ‘services are provided to address mental health issues independently from services to address unhealthy lifestyles, and although lifestyle interventions are increasingly informed by psychological insights, they do not aim to promote mental health and wellbeing as an important part of the treatment package’.⁴⁵ Public health messages tie together, but at the same time cleave apart the psychological from the physical. In the next section of this Introduction, I turn to how the language of mental and physical health problematises attempts to move past a dualistic framework, despite research evidence that demonstrates their interdependency. I then consider how a critical medical humanities theoretical framework helps me to approach this problem.

The Problem: The Impasse of Language

Most clinical practitioners know (although often in a non-theoretical and intuitive way) that mind and body are inseparable in the experiences of sickness, suffering and healing, although they are without the vocabulary and concepts to address – let alone to probe – this mindful body.⁴⁶

Despite attempts at integration in healthcare policy, and the work within systems medicine focused on the embodied mind, and the traction within professional bodies and public health agencies to insert mental health into public health strategies, an

⁴⁵ The Faculty of Public Health, Relationship with physical health and healthy lifestyles <http://www.fph.org.uk/relationship_with_physical_health_and_healthy_lifestyles> [accessed 8 July 2017].

⁴⁶ Nancy Scheper-Hughes and Margaret M. Lock, ‘The Mindful Body: A Prolegomenon to Future Work in Medical Anthropology’, *Medical Anthropology Quarterly, New Series*, 1, 1 (March 1987), 6-41, p.30.

individual's mental and physical health are still distinctly and separately understood. Strategies targeted at recognising the intersection and cross relation of mental health problems and physical health problems do nothing to counter dualism – mind and body remain separately understood as discrete areas of interest. The language (and narratives) of mental health across psychiatry, policy, public health, and into wider public or lay consumption thereby (often unintentionally) reinforce mind-body dualism. Mind over matter models of hierarchy and control are emphasised in public health discourse and connect up with models of neuro-selfhood and individual brain-mind functioning. (At this point it is important to recognise that it might be argued that dualism is either a natural or useful position to occupy – detaching the ill body from the self, for example, in chronic illness, or in examples where the power of the 'mind' is harnessed in recovery. However, as I will come to argue throughout this thesis, the separation of mind and matter is problematic in a number of ways: leading to bodily dissociation and objectification and impeding the evidence that shows the power of what would be considered 'physical' approaches to healing from 'mental' illness. I will discuss these ideas more fully as the thesis continues.)

A medical model often struggles to find a vocabulary to articulate an integrated perspective and is thereby left in a land of hyphenated moves which try and cross mind, body and world, with phrases such as 'psycho-social' and 'psycho-somatic' or 'mind-body'. While there have been some critical attempts to discuss the issue of dualism in healthcare⁴⁷ ⁴⁸ or to question the language used in articulating 'mental' health and

⁴⁷ Neeta Mehta, 'Mind-body dualism: A critique from a health perspective', *Mens Sana Monographs*, 9, 1 (2011), 202-209

<<http://www.msmonographs.org/article.asp?issn=0973-1229;year=2011;volume=9;issue=1;spage=202;epage=209;aulast=Mehta>> [accessed 8 July 2017].

⁴⁸R. E. Kendell, 'The Distinction Between Mental and Physical Illness', *The British Journal of Psychiatry*, 178, 6 (June 2001) 490-93, p.490 <<http://dx.doi.org/10.1192/bjp.178.6.490>>

disorder,^{49 50 51 52} these positions have often emerged from one disciplinary perspective, and while they have pointed to areas of need that are not answered by a tunnelled or anatomised biomedical approach, a broader perspective – able to engage with the complex cross-permeations of ‘mental’ health in social, individual and medical frameworks – is needed to approach the multiple dimensions of life affected and implicated in mental health. Indeed, while it is encouraging that dualist structures are being challenged from within healthcare, and discussed in critical terms, an approach that can more radically insert itself in between theory, and practice and policy, is required. While the mind/body enmeshment has been critiqued, re-theorised and problematised, this does not straightforwardly translate into practice and the spaces of public health. Without this intervention, there remains an ongoing capitulation to dualist structures and assumptions. Biomedicine cannot fully explain the cultural and social aspects of ‘mental’ dis/order, nor is it adequately equipped to consider their deep imbrications in people’s emotional and physical lives. The ‘tools of biomedicine’ simply do not and cannot stretch this far.⁵³

Framework: Critical Medical Humanities

Because psychiatry deals specifically with ‘mental’ suffering, its efforts are always centrally involved with the meaningful world of human reality. As such, it sits at the interface of a number of discourses: genetics and neuroscience, psychology

⁴⁹ Simon J. Williams, ‘Reason, Emotion and Embodiment: Is ‘Mental’ Health a Contradiction in Terms?’, *Sociology of Health and Illness*, 22, 5 (2000), 559-581.

⁵⁰ Brian Broom, *Meaning-full Disease: How Personal Experience and Meanings Cause and Maintain Physical Illness* (London: Karnac, 2007).

⁵¹ Eric Matthews, ‘How Can a Mind be Sick?’, in *Nature and Narrative: An Introduction to the New Philosophy of Psychiatry*, ed. by Bill Fulford and others (Oxford: OUP, 2003; online 2013)

<<http://fdslive.oup.com/www.oup.com/academic/pdf/13/9780198526117.pdf>> [accessed 18 July 2017].

⁵² Scheper-Hughes and Lock, ‘The Mindful Body’.

⁵³ J. Macnaughton and H. Carel, ‘Breathing and breathlessness in clinic and culture: using critical medical humanities to bridge an epistemic gap’, in *The Edinburgh Companion to the Critical Medical Humanities* ed. by A. Whitehead and A. Woods (Edinburgh: Edinburgh University Press, 2016), pp. 294-309.

and sociology, anthropology, philosophy, and the humanities. Each of these provides frameworks, concepts, and examples that seek to assist our attempts to understand mental distress and how it might be helped. However, these discourses work with different assumptions, methodologies, values, and priorities. Some are in dispute with one another. At various times in the history of psychiatry, a particular form of understanding has become dominant and worked to marginalize the contributions of others.⁵⁴

To move beyond the impasse of language, I turn to a transdisciplinary, critical medical humanities framework, which provides an impetus to articulate ‘across and between disciplines’⁵⁵ and to establish some alternate vocabularies for understanding and articulating human distress. First, I briefly give some background on mental health criticism, before suggesting a space of connection between mental health scholarship and the critical medical humanities. I suggest that the critical medical humanities can provide a framework for engaging in questions of language and policy that gesture towards different conceptual models in which to emphasise the inseparability of physical life and ‘mental’ health. Finally, I set the approach of this thesis as a transdisciplinary one – aiming to generate knowledge beyond the specifics of conflicting disciplinary boundaries articulated in the above quotation by psychiatrists Bracken and Thomas.

While mental health has risen to the top of a national agenda, framed within an advancing and growing biomedical and neuroscientific knowledge base, critical communities have also grown in tandem questioning the notion that ‘mental’ dis/order is an individual brain disease or abnormality.⁵⁶ ⁵⁷ From the 1960s onwards, the anti-psychiatry movement made the notion of the ‘critical’ central to studies of mental health

⁵⁴ Pat Bracken and Philip Thomas, ‘From Szasz to Foucault: On the Role of Critical Psychiatry’, *Philosophy, Psychiatry, & Psychology*, 17, 3, (September 2010), 219-228, (p.219).

⁵⁵ Viney et al, ‘Critical Medical Humanities’.

⁵⁶ Critical Psychology, <<http://www.criticalpsychiatry.co.uk/>> [accessed 8 July 2017].

⁵⁷ Critical Mental Health Nursing Network, <<https://criticalmhnursing.org/>> [accessed 8 July 2017].

as it interrogated the social, political and economic structures that dominated the lives of ‘patients’ thereby challenging the notion of the self separated from the environment, as well as showing the power structures implicit in the man-made lines between order and disorder. In his book *The Myth of Mental Illness* (1961) Thomas Szasz (a key figure in the anti-psychiatry movement) argued that mental illness was metaphorical (not a disease), claiming that suffering was not a medical issue, that there should be no forced treatment, and that psychiatry’s imposition on lives was a negation of civil liberty.⁵⁸ The anti-psychiatry movement provides a powerful example of the enmeshment of psychiatry and politics and how a critical community can stretch to intervene in medical issues and the policies underlining them.

The issues emanating from the anti-psychiatry movement, interrogating the context for ‘mental’ dis/order, continued over subsequent decades in various critical guises, leading to a movement of critical psychiatry in the early 21st century.⁵⁹ Bracken and Thomas (members of the critical psychiatry network) argue that critical psychiatry has largely built on the work of Foucault, outlining the way in which medical power and knowledge is at play in shaping forms of disorder or disease. As an example – oft cited to advance the notion that ‘mental’ dis/order is socially defined and works to chastise certain behaviours or marginalise or exclude certain bodies – homosexuality, which was once categorised as mental illness, was removed from *DSM-III* in 1974. Criticism continues to fall on the revisionary nature of the DSM and the expanding list of disorders. In current mental health criticism, a question particularly emerges about the globalisation of these malleable ‘mental’ dis/orders. As psychiatrist Derek Summerfield argues, the stakes are high. Summerfield protests that psychiatry ‘can’t define [its] primary object’ and essentially has ‘no answer to the question: what is ‘mental’ dis/order?’ except via its own devised way of working. Despite this, the manuals of

⁵⁸ Thomas S. Szasz, *The Myth of Mental Illness: Foundations of a Theory of Personal Conduct*, (Harper & Row, 1961).

⁵⁹ In the United Kingdom, a group called the Critical Psychiatry Network has been in existence since 1999.

psychiatry are used, he argues, as if they are ‘facts of nature identifiable “out there”’, and diagnostic, written criteria of clustered symptoms are interpreted as ‘real’ indicators of mental disease, ‘as is, say, a tree or a broken leg’ even though the demarcation of different illnesses does not arise from any natural fact, but is based on the decision-making of psychiatric committee members.⁶⁰ Indeed, Summerfield complains that, even with this uncertainty, researchers keep researching Western psychiatry’s devised disorders in global populations, labelling those populations, and claiming to educate them about their mental health.⁶¹

In a 2016 publication outlining the project of the *critical* medical humanities, Ann Whitehead and Angela Woods examine how the field can mobilise the notion and practice of critique and how the critical medical humanities relates to other critical turns (such as those highlighted above). For Whitehead and Woods, the medical humanities can provide both a ‘challenge and corrective to the hierarchies of evidence that have come to define, theoretical, practice-based and policy-orientated instantiations of the biomedical’,⁶² empowering those within the field to get involved more explicitly in what Viney et al describe as, ‘ontological questions – in particular, of aetiology, pathogenesis, intervention and cure’.⁶³ In this way, a critical medical humanities theoretical framework helps leverage questions about the dominant dualistic and brain-based models of mental health, focusing both on how these models are enacted but also enmeshed with clinical spaces, healthcare structures and policies. An example of this sort of work within the critical medical humanities is Jane McNaughton and Havi Carel’s work on *Breathing and Breathlessness in Clinic & Culture*, in which they argue that the physiological expression of breathlessness cannot be wholly explained by biomedicine because ‘so much that

⁶⁰ Derek Summerfield, ‘Afterword: Against “Global Mental Health”’, *Transcultural Psychiatry* 49, 3 (2012), 1–12, (p.1).

⁶¹ Derek Summerfield, ‘Against “Global Mental Health”’ presentation at the McGill Division of Social and Transcultural Psychiatry, online video recording, *YouTube* <<https://www.youtube.com/watch?v=DOZ5wKvUZXI>> [accessed 18 July 2017].

⁶² Anne Whitehead and Angela Woods, ‘Introduction’ in *The Edinburgh Companion to the Critical Medical Humanities* (Edinburgh University Press, 2016), 1–31 (p.15).

⁶³ Viney et al, ‘Critical Medical Humanities’, p.3.

influences that expression derives from a cultural context, emotional response, and how illness is interpreted and understood.⁶⁴ When it comes to understanding the meaning of ‘mental’ dis/order, there is a similarly broad context; affecting the whole person, and bound up with social norms and lines of acceptability, stigma, and the invisible dividing line between problems assessed and understood as being in the mind, and those affecting the organic, physical body.

A critical medical humanities’ framework for this thesis also provides a further opportunity to engage with disciplines that the first wave of medical humanities work (with its focus on narrative practice, medical education and ethics) may not have yet explicitly connected.⁶⁵ Indeed, in one example of work of this kind, Volker Scheid’s critical medical humanities chapter on *Holism, Chinese Medicine and Systems Ideologies* engages with medical systems beyond those of Western biomedical practice to suggest that in a climate of ‘criss-crossing globalisations’ a narrow focus on biomedicine negates the importance and relevance of other medical models or fields of enquiry.⁶⁶ This informs the work of this thesis, where I turn to complementary and alternative medicine (CAM), Somatics practices, as well as ‘Eastern’ philosophies in Chapter Four thus expanding beyond the realms of Western biomedicine. The aim here will be to both examine, and learn from ‘bodily practices that claim not to be based in dualisms’ in order to think through the term ‘mental’ in non-dualist ways.⁶⁷ In discussing the remit of the critical medical humanities, medical humanities scholar Jo Winning writes that we need to find a way to ‘create a productive interface between critical theory and clinical practice in order to restore biomedicine to a more holistic sense of the human body’.⁶⁸ Arguably a person with a diagnosed ‘mental’ dis/order is unable to feel this holistic sense

⁶⁴ Macnaughton and Carel, ‘Breathing and breathlessness’, p. 294.

⁶⁵ Viney et al, ‘Critical Medical Humanities’

⁶⁶ Volker Scheid, ‘Holism, Chinese medicine and systems ideologies: Rewriting the past to imagine the future’ in *The Edinburgh Companion to the Critical Medical Humanities*, (Edinburgh University Press, 2016), 66-86 (p.67).

⁶⁷ Barcan, p.48.

⁶⁸ Jo Winning, ‘Afterword: The Body and The Senses’ in *The Edinburgh Companion to the Critical Medical Humanities*, (Edinburgh University Press, 2016), 325-335 (p.329).

of embodiment, if the medicine that attends to her still thinks in surfaces, body parts and Cartesian splits. I, therefore, speak to this critical medical humanities position in trying to find ways across the divide, exploring some helpful language and models with which to do so. The notion that the unruly, fleshy 'body' is a threat to the controlling self in the 'mind' is deeply problematic. Thus, changing the understanding of 'body' is charged with critical and political import, as it contests this hierarchical supposition.

Transdisciplinarity: A Diffractive Reading

With a critical medical humanities framework in place, I now turn to articulate my thesis as 'transdisciplinary'. In her book *Complementary and Alternative Medicine*, cultural studies scholar Ruth Barcan, outlines her project as one which hopes to articulate a 'truly integrative medicine'. She suggests that to reach towards this, specialisation is required not only from Medicine and CAM science but an engagement with what she terms 'critical humanities', and specifically from people willing to 'combine or traverse several disciplines of fields of practice'.⁶⁹ This line of thought sums up my entry here into a transdisciplinary space as I traverse across disciplinary boundaries to start to take down some of the walls created by the language of physical and mental healthcare. At this point, I gesture forwards to the feminist work of this thesis – borrowing from feminist critic Sara Ahmed – I argue that the mental/physical binary is held up by 'histories that have become as solid as walls'.⁷⁰ The notion of the transdisciplinary is useful not only from a theoretical perspective but, because of its non-dualist genealogy, it helps to dismantle some of these walls between disciplines, between subjects and objects and between mind and matter.

In terms of the notion of the 'trans'-disciplinary, I draw on the work of Romanian physicist Basarab Nicolescu, whose name is attributed to a Charter of Transdisciplinarity

⁶⁹ Barcan, p. 217 and p.219.

⁷⁰ Sara Ahmed, *Living a Feminist Life* (Durham, NC: Duke University Press, 2017), p.1.

developed in 1994, and who has subsequently taken the lead in developing a theory and program for transdisciplinary work. In this work, Nicolescu articulates how the imperative in the transdisciplinary is the unity of knowledge rather than disciplinary lines and margins themselves. This new knowledge arises from that which is ‘between, across and beyond disciplines’.⁷¹ Importantly, for this work of this thesis, as Jay Bernstein writes on a review of this type of research practice, Nicolescu ‘urges scholars to go beyond the dichotomous, either/or mentality that, in his view, produced many of the problems that now plague humanity’.⁷² Therefore, the notion of the ‘trans’ has important implications for this thesis, which seeks to begin to develop new concepts to articulate the experience of human distress across and beyond mind and body binaries.

It is perhaps also important to make a distinction between the notion of transdisciplinarity and interdisciplinarity in this work. Nicolescu argues that interdisciplinarity might be best conceived as that which involves ‘the transfer of methods from one discipline to another’.⁷³ This resounds with the notion I am critiquing around ‘integration’, where mental and physical health are conceived as feeding into one another but remain separate; the ‘inter’ does not go far enough. For that matter, neither does the ‘multidisciplinary’ – a well-trodden concept in healthcare where disciplinary specialists are brought together in a multidisciplinary team meeting (MDT) to discuss and contribute to patient cases, but where that knowledge (for example a surgeon, alongside a nurse and a physiotherapist) still remains separately articulated and siloed.⁷⁴ At the start of the section on the critical medical humanities framework, I quoted Bracken and Thomas’ broad-reaching critical context for psychiatry at the ‘interface’ of

⁷¹ Sue L. T. McGregor, ‘The Nicolescuian and Zurich approaches to transdisciplinarity’, *Integral Leadership Review*, 15 2 (2015) <<http://integralleadershipreview.com/13135-616-the-nicolescuian-and-zurich-approaches-to-transdisciplinarity/>> [accessed 9 July 2017].

⁷² Jay Hillel Bernstein, ‘Review: Transdisciplinarity: A Review of Its Origins, Development, and Current Issues’, *Journal of Research Practice*, 11, 1, (2015) <<http://jrp.icaap.org/index.php/jrp/article/view/510/412>> [accessed 9 July 2017].

⁷³ Basarab Nicolescu, ‘Methodology of Transdisciplinarity – Levels of Reality, Logic of the Included Middle and Complexity’, *Transdisciplinary Journal of Engineering & Science*, 1, 1, (December 2010), 19-38 (p.22).

⁷⁴ NHS: National Cancer Action Team, The Characteristics of an Effective Multidisciplinary Team (MDT), (February 2010) <www.ncin.org.uk/view?rid=136> [accessed 9 July 2017].

different disciplinary discourses that aim to provide concepts and paradigms within which to interpret, analyse and assist in understanding ‘mental’ dis/order. As a transdisciplinary medical humanities’ thesis, which recognises the deep entanglement and the hidden connections within different disciplines, I think here not about the ‘dispute’ between disciplines or the ‘marginalisation’ of certain ideas identified by Bracken and Thomas, but more in terms of a ‘diffractive methodology’. Karen Barad’s work on this particular transdisciplinary approach, thinks through this term from physics (related to the combination and overlapping of waves and the bend and spread as they meet and how this can be a constructive point as opposed to simply one of contest).⁷⁵ Generally, this mode of thinking provides me with the ground to take a transdisciplinary approach; finding the intersections, overlaps and unity of knowledge, rather than the lines between discourses. I will return to Barad’s new materialist frame within a feminist context later in this Introduction. This affirmative way of reading across disciplinary spaces now turns to how I insert my work specifically into a critical medical humanities context, and how this project seeks to call out the lines and divisions that divide up minds and bodies in healthcare today.

Being Critical: Meanings and Manifestations

As intimated thus far, being ‘critical’ in the context of mental health, has largely meant being critical of the power of psychiatry and the problematisation of the medicalisation of distress, or the individualisation and implicit self-responsibility for the flawed personality, as opposed to the implications of wider social issues. In this thesis, I examine mental health as an area of practice infused with historical, cultural and philosophical biases that are often overlooked in the clinical context. While I am not attempting a historiographical trace of the development of the area of ‘mental’ illness, it

⁷⁵ Karen Barad, *Meeting the Universe Halfway: Quantum Physics and the Entanglement of Matter and Meaning* (Durham, NC: Duke University Press, 2007).

is useful to draw upon the idea – taken from Foucault – that certain ideas and structures came to be, and certain understandings were normalised often because of particular historical powers and interests. As Bracken and Thomas articulate in their analysis of critical psychiatry, what Foucault’s work is able to do, is to open up the idea that mental illness might, actually, have been conceptualised in a very different way, and that current models of madness situated in the head and brain were not the necessary trajectory for knowledge and understanding.⁷⁶ This opens a space for alternative future conceptions of mental life beyond Cartesianism as necessarily embodied, material and deeply implicated in the environment, as this thesis will go on to argue.

Along with Macnaughton and Carel, I consider it the responsibility of an ethical medical humanities endeavour, not only to circulate ideas and improve understanding in the medical humanities field but to fill ‘epistemic gaps’ in clinical practice and to gesture towards eventual shifts in policy.⁷⁷ Given that critical theory and disciplines from beyond the sphere of psychiatry have been able to raise momentum around certain issues, the entry into the political feels entirely apt. However, given the diffractive and transdisciplinary nature of this thesis, my ‘critical’ is not a direct criticism of biomedicine from any kind of outside or all-seeing perspective (I would contend such a perspective is not possible given the entanglement of biomedicine in culture), nor does it aim to set up any further binaries between scientific knowledge and that which emanates from the humanities. Instead, my project engages with – and builds upon – the critical medical humanities in a number of ways. First, I suggest that there is a sense of urgency, or a critical imperative, that an intervention is made in the language and narratives of mental versus physical health, given how rapidly cultural scripts about brain or neuro-explanations have been disseminated. Further, as I will argue in Chapters One and Two, conflicting models of the meaning and location of ‘mental’ dis/order mean that dualism

⁷⁶ Bracken and Thomas, p.223.

⁷⁷ Macnaughton and Carel, p.294.

is often being reinforced and the language used in clinical and political contexts is one of the major factors in perpetuating the split. Second, this thesis speaks to the critical medical humanities as it connects with social movements (feminism in this case) in identifying structures of domination: mind over matter, head over body, rational over emotional and, individual over the environment. These structures are deeply problematic in isolating 'mental' dis/order to individual brains and creating dissociations between self and body, and self and world. By being critical in this way, I draw upon the notion of making an intervention, as opposed to just circling around issues with layers of discourse. Third, as alluded to above, I draw from a Foucauldian oppositional critique; that which (as Woods and Whitehead argue in their introduction to *The Edinburgh Critical Medical Humanities Companion*), resists 'presumptuous reason and the specific effects of power'.⁷⁸ In this case, my specific aim is to break down some of the commonly articulated assumptions about mental health. Finally, I aim to open up to complementary and alternative medical practices, with the same intention as Scheid, who sets out in his work on Chinese medicine to analyse these practices, 'not as objects of enquiry but as resources for *thinking critically* about the fundamental issues of our time'.⁷⁹ My emphasis (while recognising the limitations of a PhD thesis) is to create a space for a critical conversation about the language of mental health and healthcare in the UK. I situate my work as a space to theorise, and while I recognise that this theorisation is not immediately transferable to policy, it gestures towards it, makes critical links to policy, and engages with questions right at the heart of existing policy-making around mental and physical healthcare.

⁷⁸ Whitehead and Woods, 'Introduction', p.5.

⁷⁹ Scheid, 'Holism, Chinese medicine and systems ideologies', p.82.

Aims and Argument: Staging an Intervention

It is my aim in this thesis to stage an intervention into the ways we think of healthcare in the UK today by attending to the naturalisation and sedimentation of dualistic language within psychiatry as well as health policy and public health discourse – and how this affects and shapes cultural scripts of ‘mental’ dis/order. I aim to consider the relationships between public understandings, individual experience and clinical practice, and the spaces and moments in which dualism is supported or mobilised. I think here about the power of narrative and its relationship to conceptions of ‘selfhood’ and ‘mind’, often at the expense of the sensory and bodily aspects of life. I will then go on to offer some examples of non-dualistic practice that might help convey the embodied nature of mental health (including and exceeding those of cognitive science) and make specific links to their role (or potential role) in healthcare.

This thesis argues that the division between mental and physical health is unsustainable and unhealthy. I argue that a dualist language within healthcare problematically affects and sustains a model of mind over matter, which negates the social world and its imbrications in mental health, as well as de-valuing the materiality of human life, thereby re-inscribing other problematic binaries. I argue for the re-infusion of ‘mental’ health with notions of physicality and create a new term ‘being-body’ to articulate how distress and disorder implicate the whole person in very material and energetic terms. I suggest that although dualism (and its inference of the power of the immaterial mind over the lapsing or faulted matter) might be popularly conceived as a form of control or self-determination, it is a problem in relation to mental illness, which is oft actually experienced in palpably material and physical terms (for example on an NHS website detailing the symptoms of clinical depression for the public, there are a long list of ‘physical’ symptoms).⁸⁰ When it comes to therapeutic approaches, dualism

⁸⁰ NHS Choices, ‘Symptoms of Clinical Depression’
<<http://www.nhs.uk/Conditions/Depression/Pages/Symptoms.aspx>> [accessed 9 July 2017].

matters because the notion of mind over matter problematises any explanation given to how and why ‘physical’ movement or self-awareness of the body would be a therapy for ‘mental’ health. I will suggest in this thesis how policy and public health narratives – far from dumping Descartes – end up re-inscribing dualism, and how ‘integrating’ mental and physical health might not do enough to counter the deep roots of Cartesian thinking. I argue that the language and narratives told about mental health (and its connection and yet separation from physical health) within healthcare and clinical and psychiatric spaces, sweat into other areas of life; over spilling on to the ‘values, morality and experiences of everyday spaces’.⁸¹ Working through a feminist, new materialist lens, I argue that I am never only discussing the linguistic or narrative, but the imprint on becoming and being (discussed below).

Ultimately, the solution to separated-out care domains is not simply fixed by connecting mental to physical healthcare so that one talks to the other, knows what the other is doing or considers the possible impact of the other – but that the patient him/herself is understood as a whole person; a person whose ‘mind’ and ‘mental’ health are not as clearly differentiated from their ‘body’ and ‘physical’ health as healthcare policy makers might think. How to move beyond the existing terms or to re-infuse existing terms with a deeper, less binary-based understanding requires a close look at language and at the terms that I will return to building throughout the thesis.

Developing Terms: Towards the ‘Being-body’

Before I start to construct or suggest alternative terms or concepts, I want to lay down some of the theoretical lineage for these terms to more fully ground them before discussing them in detail later in the thesis. This introductory manner will inevitably be partial, but I will return throughout the thesis to expand and develop these

⁸¹ Whitehead and Woods, ‘Introduction’, p.23.

conceptualisations further. I begin by placing some limits on the existing terms used to describe mental health issues. The words mental illness, ‘mental’ dis/order, mental distress and mental health are used interchangeably, but it is from the dominant discourse of psychiatry that the term ‘mental’ dis/order’ emerges and is supported.⁸² To use the terms of this debate, but at the same time to rupture the meaning inherent in the steeped-in-dualism ‘mental’ dis/order, I once again reach to Foucault. In the preface to Foucault’s, *The Order of Things*, he suggests the ‘propinquity’ of words or concepts might be established only by, an ‘and’ or an ‘in’ or an ‘on’.⁸³ In the forward-slash I make in the phrase ‘mental dis/order’, I want to question the wholeness and separateness of disorder as a concept in itself, and re-establish its fragile boundary with order; to suggest that one necessarily lies within the other. In *Madness and Civilization*, Foucault draws back to a ‘zero point’ where madness is an undifferentiated experience. He writes that ‘Here madness and non-madness, reason and non-reason are inextricably involved: inseparable at the moment when they do not yet exist, and existing for each other, in relation to each other, in the exchange which separates them.’⁸⁴ It is this exchange that the forward slash represents; it is a merging point – a line on which to consider the edges of experiences and to blur and blend some of the distinctions and certainties that are formed in diagnostic labelling. The inverted commas I place around the word ‘mental’ again acknowledge the potency of language and attempt to inject some uncertainty into the language that dominates discussions around people’s lived experiences of distress.

Despite the usefulness of the forward slash and inverted commas, the language is inevitably restrictive in its positioning of ‘mental’ health as something which is not ‘physical’ health. To develop a new concept for the experience of a depth mental body – which is not limited to the space between the ears (either in brain tissue or immaterial

⁸² For example, the APA’s Diagnostic and Statistical Manual of ‘Mental Disorders’.

⁸³ Michel Foucault, *The Order of Things: An Archaeology of Human Science*, trans. by Tavistock/Routledge (Paris: Editions Gallimard, 1966; London and New York: Routledge, 2002), p.xvii.

⁸⁴ Michel Foucault, *Madness and Civilisation: A History of Insanity in the Age of Reason*, transl. by Richard Howard (Paris: Plon, 1961; London and New York: Routledge, 2001), p.xii.

thoughts, or both), I need to approach some vocabulary that itself involves deep roots and histories. It is always going to be problematic developing alternate terms for expressions of different subjective states, but, without them, we get no closer to breaking down problematic language structures. I draw here again from Ahmed, and with a feminist position for this thesis, to attempt to establish a useful term which gets past the impasse of 'familiar and repeated' language. As Ahmed attests (with reference to sexism and racism), 'the familiarity and repetition are the source of the difficulty; they are what need to be explained'.⁸⁵ Ahmed's argument resonates with the breadth and depth of critical material around the mind and body which – although may be 'familiar and repeated' – and known to both academics and clinicians – often falters in practice and policy. Indeed, the habitual, sedimented and naturalised terms are involved not only in naming, labelling and defining, but also affect the process of becoming and being. Segmenting mental life away from material life or, indeed, word from body, fails to take account of the deep interrelationships between them.

In considering how to relay the experience of the whole person – rather than in divided parts – I am reminded of philosopher Merleau-Ponty's distinction between different bodily experiences – the 'habit body' for example – and how, in order to perform some sort of analysis of what it is to get to the grain of bodily experience, he has to cultivate and curate these terms.⁸⁶ This notion of reaching for language to convey experiences and problems typically considered as 'mental' or of the 'mind' but deeply embodied, reveals that I need to engage with a vocabulary centred in the body first of all. In foregrounding 'the body' in my development of the idea of the being-body, I do not, of course, want to set up yet another binary. Instead, my aim is to infuse the 'body' with attributes of conscious materiality, vibration, energy, memory and a kind of thinking and understanding which – via dualism – is normally associated with the immaterial mind, or

⁸⁵ Ahmed, *Feminist Life*, p, 9.

⁸⁶ Patricia Moya, 'Habit and embodiment in Merleau-Ponty', *Frontiers in Human Neuroscience*, 8 (2014), 542 <doi: 10.3389/fnhum.2014.00542>.

brain only. There is no perfect term to describe how distress and illness of any kind can engulf a person, but with my term being-body I hope to lean into the way in which this lives throughout systems and energies and cells, not isolated parts – affecting a person’s very being and becoming. I will now address these two words ‘body’ and ‘being’ in some more detail.

While it is not the aim or intention of this thesis to explicitly synthesise the huge breadth of theoretical enquiries into the body, it is vital to appreciate the multiple meanings and experiences located in this word. In using the term ‘body’ I am not thinking so much in terms of the anatomical vocabulary of medicine, but am drawing on different traditions which consider the body as multiply layered, interacting in its environment, and with energetic dimensions. I think particularly here of models of the body drawn upon in complementary and alternative medicine, where the whole body is felt to be a ‘site of memory’ and where the space of the body is conceived of quite differently to contemporary Western medicine, consisting of ‘fluids and energy’ rather than only a ‘solid mass of bones, muscles and viscera’.⁸⁷ In doing so, I also draw from feminism and new materialism to support the revitalisation of matter and the reinfusion of the language of distress and disorder with an understanding of the physical and vibrational body interacting in the world. I also build on affect theory and its recognition of the body in – what humanities critic Ruth Leys terms – the ‘dynamic, energistic, nondeterministic terms that emphasise its unpredictable and potentially emancipatory qualities’.⁸⁸

I attach and hyphenate the word body with ‘being’. This again brings with it theoretical lineage perhaps, most prominently, again from phenomenology and Heidegger’s notion of ‘being-in-the-world’.⁸⁹ For Heidegger, as Havi Carel articulates, the term is used to ‘denote the human being in the broadest sense. Being in the world

⁸⁷ Barcan, p.152.

⁸⁸ Ruth Leys, ‘The Turn to Affect: A Critique’, *Critical Inquiry*, 37, 3 (Spring 2011), 434-72 (p.441).

⁸⁹ Martin Heidegger, *Being and Time* (New York: Harper and Row, 1962).

includes the biological entity, the person and her environment in meaningful connections.⁹⁰ Phenomenology has been a prominent lens within the medical humanities, particularly in terms of how it might be used to understand the nature of illness and the experience of the patient by focusing on ‘the lived experience of embodiment.’⁹¹ However, the notion of ‘being’ is still knotty and complex. Indeed, ‘being’ has been conceptualised as ‘static and fixed’ and juxtaposed against the idea of becoming, which articulates that things are ‘uncertain and constantly in motion’.⁹² It is not my intention here to be drawn into the philosophical differences enacted here but, instead, to see the term being-body, not in opposition to a conceptualised becoming-body but actually drawing upon it. The idea of inter-relationality – of the always-imbrication of subject and object or mind and matter in a process of becoming – is useful because bodies are not bounded but involved in fluid, dynamic relationality – always able to be differently formed. This has particular implications for ‘mental’ dis/order which – I argue – cannot ever be wholly individualised or interiorised. Karen Barad conceives in her theory of agential realism that ‘the entangled practices of knowing and *being* are material practices’.⁹³ As Barad explains, ‘[w]e do not obtain knowledge by standing outside of the world; we know because “we” are of the world. We are part of the world in its differential *becoming*’.⁹⁴ Barad’s foregrounding of the materiality of *being* and the interconnectedness of person, environment, biological body in a process of *becoming*, describe the ways in which ‘being’ is fluid and practised, not static at all. To expand upon this, in Chapters Three and Four, I will draw on concepts of body and being from outside of Western biomedicine as well as those which are recognised and used within the NHS

⁹⁰ Carel, ‘Phenomenology as a resource for patients’, p.11
<<http://eprints.uwe.ac.uk/16205/2/Phen%20as%20patient%20resource%20JMP2011.pdf>>.

⁹¹ S. Kay Toombs, *The Meaning of Illness: A Phenomenological Account of the Different Perspectives of Physician and Patient* (Dordrecht: Kluwer Academic Publishers, 1993), p.xiv.

⁹² Rebecca Coleman, ‘The Becoming of Bodies: Girls, media effects and body-image’, *Feminist Media Studies*, 8, 2 (2008) < <http://dx.doi.org/10.1080/14680770801980547>>.

⁹³ Barad, *Meeting the Universe*, p.379.

⁹⁴ Karen Barad, ‘Posthumanist Performativity: Toward an Understanding of How Matter Comes to Matter’, *Signs: of Women in Culture and Society*, 28, 3 (Spring 2003), 801-831 (p.829).

– such as yoga with its focus on asana practice and breathwork, which reach to different body states, and acupuncture, where an energetic life force ‘Qi’ dismantles distinctions between the mental and the physical, and works in a systemic way through the person. In such cosmologies, there are understood to be multiple bodies beneath the visible, physical body – interrelated layers – and the energy within those body layers relates to the energy of the wider world.⁹⁵ The being-body is thus an attempt to undo the unhelpful, familiar and repeated language of mental illness and to find some new terms infused with the sensory, energetic and material dimensions of life, to break through the impasse of language.

Developing Terms: Embodied Mental Health

One might [...] claim that embodiment is what makes cognition possible. If this is right then it tells us something important about the ‘self’. For if the self is that which perceives, acts, and thinks, and perceiving, acting, and thinking must be understood in bodily terms, then the metaphysical lesson is obvious: the self is, first and foremost, an embodied self.⁹⁶

The title of this thesis describes a move towards a new model of embodied mental health. In this way, it builds on but exceeds the work of cognitive science which considers the role of embodiment in cognition.⁹⁷⁹⁸ My concept of the being-body is arguably broader – thinking not only about cognitive processes but extending into vibratory materialism and the energetic body, which are not harnessed in these accounts.

⁹⁵ Barcan, p.26.

⁹⁶ Quassim Cassam, ‘The Embodied Self’ in n Shaun Gallagher (ed.), *The Oxford Handbook of the Self* (Oxford University Press, 2011) pp. 139-157.

<www2.warwick.ac.uk/fac/soc/philosophy/people/cassam/embodied_self.doc>.

⁹⁷ Shaun Gallagher, *How the Body Shapes the Mind* (Oxford: Clarendon Press, 2005).

⁹⁸ Antonio Damasio, *The Feeling of What Happens: Body and Emotion in the Making of Consciousness* (New York: Harcourt, Brace and Co, 1999).

In articulating the embodied nature of selfhood – as articulated in the above quotation from philosopher, Quassim Cassam – I come up against two main alternate conceptions of selfhood – one of ‘neuroselfhood’ (where the self is located in ‘brain spheres and chemistry’)⁹⁹ – understood as the ‘brain-body’. In this framework, the rest of the anatomical body is important and relevant for mental health but mostly in terms of its relationship to the brain. The second framework for selfhood is that of the narrative self – emanating more from a Cartesian model, the observing, reflecting and narrating self is the mindful self, and this is positioned against the object body, which might experience or react to the thoughts of the narrating self either in a metaphorical or somatising way. Both of these conceptualisations are largely reliant on an individualised model of selfhood and health. This, in turn, presses upon conceptions of ‘subjectivity’ and ‘experience’; both of which have been centralised in medical humanities work as related to the personal understanding of illness against the biomedical, dehumanizing script and often related to the ability to narrate. I will return to these words and ideas, particularly in Chapter Two when I examine how ‘embodied experience’ and the sensate and sensory elements of subjectivity emerge or are negated in a narrative context. As I develop and flesh out how the being-body emphasises the material depth of mental health, I will look to alternative models where embodied knowledge is foregrounded.

Beyond cognitive science, the paradigm of embodiment has been explored in numerous ways, but Thomas Csordas’ counter-dualist emphasis seems useful to draw upon as I develop a theory of embodied mental health. Embodiment, in Csordas’ view, is something which goes beyond or is added to the physical body and is concerned with the ways in which people ‘inhabit’ their bodies. The body, he writes, is the ‘existential ground of culture’. Embodiment is not simply the body, in this reading, but is about the social and intersubjective being. Developing from Merleau-Ponty’s phenomenological account, Csordas’ view recognises the perceptual and active body but moves towards how the

⁹⁹ Fullagar, ‘Foucauldian Theory’.

social is embodied, obfuscating the dualism of the body versus the social world; there is no demarcated and bounded individual in such an embodied account.¹⁰⁰

Embodiment considered in its social, cultural and perceptual dimensions leads me to specifically think in more detail here about the feminism and why it is so powerful and potent as a methodology in this thesis to think through embodiment in a social context, as it aims to affect cultural change beyond the academy and to move from theory to practice. Feminist philosopher Elizabeth Grosz helpfully articulates the value of a feminist philosophy carving out an embodied subjectivity understood ‘not as the combination of psychological depth and a corporeal superficiality but as a surface whose inscriptions and rotations in three-dimensional space produce all the effects of depth [...] understood as fully material and for materiality to be extended and to include and explain the operations of language, desire, and significance’.¹⁰¹ It is this depth and three-dimensionality of experience that I will return to throughout the thesis as I shape an argument about the whole person’s being-body in the world as involved in ‘mental’ wellbeing.

Methodology: ‘Matter Matters’

Language structures how we apprehend the ontological, it doesn’t constitute it.¹⁰²

This thesis speaks from within – and builds upon – a tradition of feminist theory that provides a particularly engaging way of thinking through body roles, and the subjugation of the body in its material, emotional conception, set against the rational, dominant, cognitive mind. It speaks alongside several critical medical humanities pieces infused

¹⁰⁰ Thomas J. Csordas, ‘Embodiment as a Paradigm for Anthropology’, *Ethos*, 18, 1 (March 1990) 5-47.

¹⁰¹ Elizabeth Grosz, *Volatile Bodies: Toward a Corporeal Feminism*, (Bloomington, IN: Allen and Unwin, 1994).

¹⁰² Stacy Alaimo and Susan Hekman, *Material Feminisms* (Bloomington: Indiana University Press, 2008), p.98.

with an ‘energising and dynamic undercurrent’ of feminist theory – used to engage with questions of ‘the medical, the gaze, the body, affect, power and resistance’.¹⁰³ It uses feminism as a methodology to think about ways in which critical work can aim to move and affect social spaces. In this way, I follow Sara Ahmed to think of feminism as not ‘only a tool in the sense of something that can be used in theory, only then to be put down or put away’ but to think of it in ‘world-making’ terms.¹⁰⁴ Ahmed thinks of the citations she uses as the feminist materials from which she then generates and disseminates knowledge. In this way, I return throughout the thesis to feminist thinkers and writers (inside the academy and without it). I think of these writers as providing a through line of knowledge and scholarship for the thesis (although, unlike Ahmed, I am not limiting myself to them in this particular project) and argue that a range of theories are required to make sense of the multi-dimensional embodied self.

Working with a feminist methodology, I also turn explicitly to Stacy Alaimo and Susan Hekman in their work *Material Feminisms* (as highlighted in the opening quote to this section) working to undo the privilege of discourse over matter. As Whitehead and Woods attest (in relation to a critical medical humanities framework), Alaimo and Hekman ‘observe that without a sophisticated discourse for describing bodily materiality “it is nearly impossible for feminism to engage with medicine or science in innovative, productive, or affirmative ways”’.¹⁰⁵ This head-on engagement with corporeality comes as feminist criticism has wrestled over time with how to think about the body and its meaning and role for women. Indeed, as cultural theorists Rick Dolphijn and Iris van der Tuin write, ‘feminist theory is one of the key sites of critical reflection upon substance dualism.’¹⁰⁶ Historically, women’s bodies were commoditised, seen as an object for others

¹⁰³ Whitehead and Woods, p.8.

¹⁰⁴ Ahmed, p. 14.

¹⁰⁵ Alaimo and Hekman, ‘Introduction: Emerging Models of Materiality in Feminist Theory’ in *Material Feminisms* (p. 4) cited by Woods and Whitehead, p. 14.

¹⁰⁶ Rick Dolphijn and Iris van der Tuin, ‘The End of (Wo)Man,’ in *New Materialism: Interviews & Cartographies* (Michigan: Open Humanities Press, 2012), pp.158-80 (p.158).
<<http://dx.doi.org/10.3998/ohp.11515701.0001.001>>.

and over which women had to fight to gain political and social control. In this fight for 'control' over the body came a sort of implicit dualism because the body was 'something over which the self had rights'.¹⁰⁷ A phenomenological take on female embodiment by Simone De Beauvoir – it has been argued – moved away from this dualist emphasis towards the way in which women lived in their bodies in objectified ways¹⁰⁸ (this work influenced Iris Marion Young whose essays on feminism will be drawn on throughout this thesis).¹⁰⁹ However, in the final decade of the twentieth century, and, in particular, with the work of Judith Butler and her book *Gender Trouble* (1990), theory turned towards discourses about the female body which, she argued, were *constitutive* of the identities they aimed to describe.¹¹⁰ For Butler, there was no unmediated, pure access to an internal experience because of dominant, cultural discourse and the impossibility of separating the body from its social world.

New materialist feminism arose in reaction to Butler's work, seeking to understand bodies not only in their discursive or constructed forms but to think about the 'weightiness' of the body – its materiality. Alaimo and Hekman's work, for example, sought to put the matter of the body at the heart of the work and to unsettle the privileged discursive mode in order to give attention to 'lived experience, corporeal practice and biological substance'.¹¹¹ This work was positioned as urgent political and environmentally-driven action. It followed in the footsteps of feminist science critics including Donna Haraway, whose work *Cyborg Manifesto* argued for the indivisibility of nature and culture.¹¹² It also links to the work of Karen Barad and her theorisation that

¹⁰⁷ Kathleen Lennon, 'Feminist Perspectives on the Body', *The Stanford Encyclopaedia of Philosophy* (Fall 2014), ed. by Edward N. Zalta, <<http://plato.stanford.edu/archives/fall2014/entries/feminist-body/>> [accessed 9 July 2017].

¹⁰⁸ Sara Heinämaa, 'Simone de Beauvoir's Phenomenology of Sexual Difference', *Hypatia*, 14, 4 (Autumn, 1999), 114-132.

¹⁰⁹ Lennon.

¹¹⁰ Judith Butler, 'Performative Acts and Gender Constitution: An Essay in Phenomenology and Feminist Theory', *Theatre Journal*, 40, 4 (December 1988), 519-531.

¹¹¹ Alaimo and Hekman, p. 4.

¹¹² Donna Haraway, 'A Cyborg Manifesto: Science, Technology, and Socialist-Feminism in the Late Twentieth Century', in *Simians, Cyborgs and Women: The Reinvention of Nature* (New York: Routledge, 1991).

matter ‘feels, converses, suffers, desires, yearns and remembers’¹¹³ and that the ‘denigration of nature and the disregard for materiality cannot be entirely disaggregated’.¹¹⁴ Indeed, these critics articulated that a dangerous human environmental disrespect paralleled an indifference to the objectified material body. Re-instating the value and meaning of the physicality and materiality of the flesh sought to address this ethical problem.

The work of the new materialists is particularly relevant in shifting the ground for an embodied model of mental health because of its ‘ongoing, mutual co-constitution of mind and matter’.¹¹⁵ Karen Barad argues that ‘being is threaded through with mattering’ and, therefore, the nature of materiality itself ‘is an entanglement’.¹¹⁶ The idea that the body is simply an object – to be done to and controlled by the elevated, thinking mind – is particularly problematised as feminist new materialism critiques a separated-out version of mental life and troubles the notion of mind against matter. Within the Chapters that follow, I shall engage further with feminist new materialism, to unfold how the matter of the human body is not stagnant and reactive, but active, moving and always ‘entangled’ with the world.¹¹⁷

The Limits: Spaces and Locations

In their paper on fat activism in a critical medical humanities framework, Bethan Evans and Rachel Cooper discuss how:

In the spirit of feminist scholarship, we first contend that one element in the development of a critical medical humanities must be greater transparency and

¹¹³ Rick Dolphijn and Iris van der Tuin, ‘Matter Feels, Converses, Suffers, Desires, Yearns and Remembers: Interview with Karen Barad’, in *New Materialism: Interviews & Cartographies*, pp.48-70, (p.48).

¹¹⁴ Alaimo and Hekman, p. 5.

¹¹⁵ Ibid.

¹¹⁶ Dolphijn and van der Tuin, p. 50.

¹¹⁷ Anna Lavis and Karen Eli, ‘Corporeal: Exploring the Material Dynamics of Embodiment’, *M/C Journal*, 19, 1 (2016) <<http://journal.mediaculture.org.au/index.php/mcjournal/article/view/1088>> [accessed 9 July 2017].

reflection on the modes of knowledge production within the field itself. This requires acknowledging the forms of privilege and the positions from which we write.

Evans and Cooper go on to situate their knowledge within their own ‘lived and embodied biographies’.¹¹⁸ It is my intention to do the same here, firstly, because as I move towards an account of embodied mental health and develop the concept of the being-body, I suggest the importance of embodied knowledge. Second, because this thesis is inevitably limited by a particularised perspective from the UK, from within a privileged Western healthcare system. I come to this work as an author of an illness narrative memoir and someone who has wrestled with how to find a form to inscribe the rhythms and energies of a ‘mental’ dis/order into words. While this thesis is not an autoethnography, it is the notion of how to convey the materiality of ‘mental’ dis/order in linguistic terms that first brought me to this subject. I was further interested in how the physical, sensory and sensate body is objectified in forms of mental illness and its treatment. It is as a feminist, a student of literature, a former mental health service user, and as a writer on mental health that I root my knowledge and particularise my perspective. Further, my work in an NHS hospital and universities as a researcher in Health Sciences/Applied Health Research grounds my expertise in the practical and financial context of the NHS and the way in which evidence is prioritised and implemented. I recognise that my position is limited by the geographical and societal context for this research as well as my own experiences. Indeed, I am cognisant that the meaning of ‘mental’ health and dis/order is different in different places. In order to address this, I aim to primarily consider the way in which knowledge is constructed and distributed in the particular context of the UK.

¹¹⁸ Bethan Evans and Charlotte Cooper, ‘Reframing Fatness: Critiquing “Obesity” in *The Edinburgh Companion to the Critical Medical Humanities*, (Edinburgh: Edinburgh University Press, 2016), pp.225-241.

Mental health implicates not only those labelled with a disorder but a wider population of health consumers working on their individual wellbeing. It affects – and is translated – into numerous areas of life, from economic issues of welfare (in a publicly funded NHS context) and insurance (in a privately funded healthcare system); to the impact of life circumstances and social context on the development of (as well as the relationships between) brains, minds and the environment and whole human biological systems. In this thesis, my ability to connect these areas, and do so in the depth each of them might require, is limited, so at the same time as recognising the benefit and need for transdisciplinary enquiry, I am mindful of making generalisations or dealing with universals. Although I aim to discuss issues relating to the ‘big picture’, I remain grounded in my own location, seeking to work from the small space of my own personal and professional contexts. Drawing again on the work of Susan Hekman (in her feminist analysis of Foucault), rather than a presentation of universal values, I hope to focus on a concrete analysis of a particular national context in an attempt to provide a better understanding of social change.¹¹⁹

In developing a concept of the being-body and moving towards an integrative medicine with its emphasis on holism, there are a number of potential areas which I approach with caution. First, in Chapter Four as I draw on ‘Eastern’ conceptions of mind and body and practices such as yoga, I am wary of potential complicity with a form of Orientalism; of the Western appropriation of ‘the East’ and of unintentionally negating the very different and complex layers that these practices actually entail.¹²⁰ Second, as I engage with Somatics practices (and broader complementary and alternative medicine ideas), I am aware that I might be challenged to consider some of the ‘uncritical rhetoric’ which emanates from some of this material.¹²¹ Third, there has been recent critical

¹¹⁹ Susan J. Hekman, *Feminist interpretations of Michel Foucault* (The Pennsylvania State University Press, 1996).

¹²⁰ Edward W. Said, *Orientalism* (London: Penguin Classics, 2003).

¹²¹ Barcan, p.48.

analysis of the idea of holism – and the need to be wary around attaching to some sort of unquestioned romanticised idea of ‘the natural’ and the holistic. Ruth Barcan’s book on complementary and alternative medicine provides a useful basis for thinking critically about these issues and, like Barcan, rather than dispensing with the idea of wholeness or the possibility of a ‘truly integrative medicine’, I see this thesis as an attempt to ‘think more complexly about what wholeness could mean or might be.’¹²² In my case, this is embodied mental health, affecting the whole being-body in the world. Finally, while I attempt to dissect and disentangle the meaning of ‘mental’ life, I do not have as much space or time to construct as thorough a dismantling of the numerous theorisations of the ‘body’. However, underlying my development of the term being-body is recognition that different paradigms model or anatomise the body in different ways. Indeed, it is through these alternative conceptualisations, that a very different way of conceiving of materiality is explored; one that helps to reconfigure ‘the distinction between thought and matter to dissolve any ontological difference between them.’¹²³

Finally, despite the focus here on interrogating the various labels and forms of ‘mental’ dis/order I still need to use some of psychiatry’s diagnostic clusters as a jumping-off point for discussion. Terms such as anorexia or OCD have become part of the vernacular of contemporary Western societies and are necessary to communicate to popular and academic audiences when discussing issues, even if the classifications of disorder are contentious and often critiqued. I need to drill down below the vast generalisation of the terms mental illness or ‘mental’ dis/order to find some of those smaller spaces to explore. I, therefore, delimit some sections of my discussions to focus on case studies within the ‘neurosis’ end of psychiatry’s spectrum of dis/orders as opposed to those considered as psychotic illnesses. The Mental Health Foundation provides this definition:

¹²² Barcan, pp.24-25.

¹²³ Barcan, p.66.

‘Neurotic’ covers those symptoms which can be regarded as severe forms of ‘normal’ emotional experiences such as depression, anxiety or panic. Conditions formerly referred to as ‘neuroses’ are now more frequently called ‘common mental health problems.’¹²⁴

In the UK ‘combined anxiety and depression is the most commonly diagnosed mental health problem, followed by anxiety, post-traumatic stress disorder [PTSD], “pure” depression, phobias, eating disorders, OCD [Obsessive Compulsive Disorder] and panic disorder’.¹²⁵ I take a case study approach, in that I mostly focus my discussion around some of these diagnoses (anorexia, anxiety, depression and PTSD), but the thesis is not led by them. I will choose to reflect on certain dis/orders at certain junctures because they are raised by particular texts or critiques, or where there is a particular issue – for example, disembodiment – where discussing particular symptoms or experiences feels resonant and useful in moving a point forward.

To give some context to some of these issues, I want to pause briefly on those main case study areas while recognising the limitations of such a brief introduction to complex forms of distress. Eating disorders are in themselves broad ranging, but most are commonly categorised into anorexia, bulimia and binge eating disorder. Within this thesis, I will primarily touch on anorexia nervosa (partly led by my own experience and knowledge of this area). Anorexia is defined by the eating disorders charity B-eat as ‘a serious mental illness where people keep their body weight low by dieting, vomiting, using laxatives or excessively exercising’.¹²⁶ Anorexia is an interesting case study for this

¹²⁴ Mental Health Foundation, ‘What are Mental Health Problems?’ <<https://www.mentalhealth.org.uk/your-mental-health/about-mental-health/what-are-mental-health-problems>> [accessed 9 July 2017].

¹²⁵ Matt Haig, *Reasons to Stay Alive* (Edinburgh: Canongate Books, 2016), p. 55. Further references to this edition are given after quotations in the text.

¹²⁶ B-eat: Beating Eating Disorders, ‘Anorexia’ <<https://b-eat.co.uk/about-eating-disorders/types-of-eating-disorder/anorexia>> [accessed 9 July 2017].

thesis because it seems to exacerbate the schism between mind and body and because its feature of distorted self-perception raises questions about the nature of embodied experience. There are a number of disorders that form around the concept of anxiety. I do not intend to pursue specific disorders and their explicit and specifically defined symptomatology, but I do want to focus on the experiences of anxiety that might throw into sharp relief the idea of the bodily expression of ‘mental’ illness. I also touch upon depression, which is particularly useful because of the problems that seem to develop around language and when words struggle to reach the feelings it induces. As Psychiatrist Femi Oyeboode writes, there are ‘noticeable changes in the volume and intonation of speech in depressed patients’ who ‘speak very quietly with a monotonous voice’. In the most extreme cases, this can produce speech made only of ‘unintelligible syllables, often of a moaning nature’.¹²⁷ Finally, I also consider trauma (PTSD) and its visceral, deep imprint on the body and how this is particularly relevant in forging an embodied account of mental life and ‘mental’ dis/order. I now turn to the chapters ahead and the work this thesis will do to articulate towards a new model of embodied ‘mental’ health.

Moving Forwards: The Chapters Ahead

In Chapter One, I directly address the clinical, cultural and political imaginings of mental health, by carefully attending to the language and narratives of some of the main ‘models’ of ‘mental’ health in UK healthcare policy, public health and psychiatry (and their imbrications in popular and mass media representations). Whilst overlapping, I attempt some disentangling of these models and how they forge and form knowledge about ‘mental’ dis/order. Here, I consider some of the cracks and contradictions in existing integrated structures and in communication about mental health to the public. I

¹²⁷ Femi Oyeboode, *Sims' Symptoms in the Mind: An Introduction to Descriptive Psychopathology*, Fourth Edition (Baillière Tindall, 1988: repr. Saunders Elsevier, 2008), p.178.

will describe a range of existing models – from a metaphysical understanding of **Immaterial Thoughts** to those more connected with neuro-explanations for mental illness in a **Brain Disorder** model. Although these are not totally independent or formally articulated, these models appear to sit beneath these narratives and often perpetuate a mind/body or mind/world split. Across the range of articulations and explanations I analyse, depression, anxiety, anorexia, and other ‘mental’ disorders are largely attributed to chemical imbalances, genes, or disembodied ‘thoughts’, all of which detach the problem from the world and place it into the confines of the isolated individual. Problems are either located in brain chemicals – thereby putting disorder into individual neuro-dysfunction and moving away from notions of choice or responsibility – or chastising the patient for failing to control or manage their unhelpful or irrational thoughts.

The emphasis of the medical humanities in its development as a field across recent decades has been determinedly a narrative one – focused on the subjective experience of the patient and the narrative framework of the clinical encounter. Medical humanities scholarship showed medicine its own innate narrative structures and offered up narrative as a way of interpreting, analysing and understanding the experience of illness and the clinical encounter. In terms of mental illness – the often seemingly incommunicable and internalised distress provides a challenge in terms of linear narrative expression – but words are often attached to healing, catharsis and triumphant overcoming. In Chapter Two, I consider how the dominance of narrative and language (both in personal accounts and therapeutic responses to mental illness) might reinforce a model of individual, internalised, narrated self-management of ‘mental’ dis/order, and consider how a mind over matter model might get in the way of a fully integrative medicine. I build on the questions of the anti-narrative or post-narrative positions raised by some medical humanities critics, to look at how narrative forms and functions support and reinforce mind against body models of ‘mental’ dis/order. I look at some

contemporary narrative accounts of mental illness to show how a mind/body binary continually underscores attempts to describe embodied experience. I argue that looking at this language and attending to what is meant in different shapes and versions of ‘mental’ dis/order expressed there, is a starting place for carving out alternative approaches. I then look backwards – at modernism – and towards literary texts, which suggest that narrative should not be dispensed with, but in their ‘experimental and non-realist modes’ are able to offer a useful model for representing illness.¹²⁸ I discuss how authors play with form and function, using rhythm, cadence, ellipsis and other devices to engage with a full palate of affecting, sensate experience. Indeed, I analyse how these texts offer up sound, dance and music to explore non-dualist accounts of distress and breakdown. In doing so, I argue that words and language do not have to be set in opposition to the being-body, but can draw close to it, emanating from the body with its breath, gesture and pulse. However, I conclude that a focus on narrative as a direct expression of internal thoughts and thereby ‘mental’ life is reductive.

The sonic and the affective strands of modernist texts take me towards Chapter Three – Haptic Sounds and Moving Music – where I approach an account of the vibratory matter of the being-body. Sound – despite being linked to interiority and individualism – emerges from and affects the body thereby complicating Cartesian lines. If language fails because the words ‘physical’ and ‘mental’ are layered in dualism and, that even in connecting them, we arrive at an implicit schism, sound and music engage a different register of experience. This register is already used in medical practice – for example in the percussing skills of medics, or, very differently, in the use of music therapy – but in this chapter, I explicitly link this to a more ‘holistic’ and less anatomically sheared-apart version of the human body. I use theories of music and the emotions to stretch this idea further – specifically taking sound towards movement and

¹²⁸ Laura Salisbury, ‘Aphasic Modernism: Languages for Illness from a Confusion of Tongues’ in *The Edinburgh Companion to the Critical Medical Humanities*, (Edinburgh: Edinburgh University Press, 2016), 444-462.

space. Music literally moves us, outwardly and inwardly, activating imagination and creating spaciousness. If sound and music help show a whole person as affected – moving and moved – then emotional life cannot be contained within existing ‘mental’ parameters and instead needs to be realised through an account of the whole ‘being-body’ in the world.

Building on the work in Chapter Three, I then turn to working models of embodiment in Somatics and bodywork practice. My aim in Chapter Four – Knowing Bodies – is to foreground knowledge through the whole being-body as opposed to directed from the head in a mind over matter conception. In this way, I begin to develop an account of the active, thinking and remembering being-body as opposed to the critical, textual or narrated body. I again emphasise the ways in which the focus on narrative and language often precludes engagement with the embodied state, and the potential problematic for emphasising disembodiment or the split in ‘mental’ dis/order. Somatics (as a collective name for body practice) draws upon the whole body and its key practitioners articulate how understanding, ethical knowing, and change, come through the body (in its multiple levels and layers). This is work for the whole human being – rather than designated into mental or physical spheres. This chapter creates a different non-vertical understanding of knowledge, wisdom and being. In turning to embodied practices, I speak within a body-centred methodology, which learns and develops out of the body’s practical knowledge and understanding. Body work in trauma therapy and yoga for ‘mental’ dis/orders are growing areas within health research, and I here build on this ground but suggest that the evidence points to the need for a richer vocabulary to discuss health for the whole being-body. With these different realms explored as ways through the mental/physical health impasse, I return to language and narrative to suggest how different vocabulary might help excavate the full meaning and significance of the being-body, so that the body is more than the brain, and the mind is more than the head, language and narrative.

In the Conclusion, I return to think about the broader UK health context, and to reiterate the suggestion that health policy should not divide individuals unhelpfully into arbitrarily, and in many cases quite wrongly, separated parts. I suggest that while medicine in some places recognises the failure of Cartesianism – and is offering a plethora of new research into mind-body connections and interactions – it often lacks the terms and vocabularies to articulate beyond it. Further, I suggest that the mind/body distinction has often led to an unhealthy and unsustainable bodily objectification, which might end up feeding and perpetuating ‘mental’ dis/orders even further.

This Introduction has set out the context and background for the need to develop and fully flesh out an embodied model of ‘mental’ health. The Cartesian model of immaterial mind versus mechanistic body has left medicine struggling to see from an integrated perspective. Despite the critique, re-versioning and attempts at integration it still reinforces a variety of explanations and underpinnings for accounts of mental health and mental dis/order. It is to a deeper understanding of these models that Chapter One now turns towards.

Chapter One: The Problem of the 'Mental' in 'Mental' Dis/order

Chapter Aim and Summary

In this chapter, I focus on the language and narratives of some of the main models which seek to account for and locate 'mental' dis/order. These are not formalised categories of understanding as such, but my interpretation of – and delineation between – the dominant (and conflicting) theories that explain 'mental' dis/order. This chapter undertakes a discursive analysis, to show how language within and between these narratives continually falls back into splits and binaries and reproduces dualist understanding. The work of this chapter, therefore, contributes towards the first aim of the thesis to interrogate the way in which mental health is understood in the UK today. The narratives I consider emanate from very different spaces: government health policies, public health materials, psychiatry and medical research, cultural scripts from popular media, literary texts and online cultures. However, as explored in the Introduction, my perspective here follows a critical health perspective, which understands that neurological and psychological understandings of mental health mould and support personal understandings. With this in mind, although I move somewhat freely between narratives produced from different spaces, I remain cognisant of how the dominant medical models and discourses define how 'mental' dis/order is discussed more broadly.

There are four primary models on which I focus in this chapter, that move (somewhat progressively) towards including bodies in their accounts of 'mental' dis/order. In working through these models, however, I aim to demonstrate how the language of the 'mental' forecloses truly integrative accounts of minds and bodies and how the 'body' in its various forms and expressions is flattened by the dominant mind.

This chapter thus locates the limits of existing models of ‘mental’ dis/order and sets up the need for a much more embodied account in physical and social terms.

The first model is a metaphysical understanding of mental illness situated in **Immaterial Thoughts** and located in the language of the ‘mind’. In this section, I consider Cartesian dualism, the relation of thought and inner speech, and therapies for ‘mental’ dis/order that focus on irrational or distorted thinking. I articulate how biomedicine subscribes to this model in the way that it separately treats and attends to physical and mental health and, relatedly, to the organic (real and detected on scans, tests and objective measures) and the functional (undetected symptomatic problems). I problematise, in particular, the inner/outer binary that this model elicits, as well as the missing non-linguistic elements of experience, for which the model fails to account.

The second model provides a neuro-explanation for mental illness in a **Brain Disorder** model; pinning the language of mind to the brain. In this approach, the ‘body’ is involved because the brain is part of the body and ‘mental’ dis/order is attributed to individual brain dysfunction. I suggest that this model lacks an appreciation of other body systems as it works in a top-down approach and, in some cases, over-individualises mental health issues.

The third **Interacting Mind and Body** model supports an integrated model of mind and body but keeps cracks and contradictions in its attempts at integration as cognition occurs in the head, and the ‘body’ reacts accordingly. Across these models, mental health problems exist in either brain chemicals thereby making them into a matter of internal dysfunction, or in irrational immaterial thoughts that need to be managed by an agentic individual. Dualism is underlined in the language used to connect or carve up physical and mental health.

The final model I turn to gestures towards a much more systemic understanding of ‘mental’ dis/order. The **Body Systems** model brings the body’s intelligent systems to the fore. Within this model, I look at concepts around the ‘embodied mind’ in

neuroscience and new turns in biomedicine working on brain and whole-body interactions. While this model articulates a systems-driven account, rather than one driven by heads and brains, it still often stops short of challenging the separated language of mind and body (as it is biomedically orientated its remit is more on the cellular and genetic than the linguistic). The chapter concludes by outlining the implications for these multiple models of mental health, and the powerful cultural work they do in shaping mental health narratives and experience. I end the chapter signalling towards Chapter Two by starting to critique, in particular, the way in which language intervenes in attempts to overwrite dualism and how an overemphasis on the power of narrative (as a healing agent, as *the* method of communicating experience and as providing access to the internal state of ‘mental’ disorder) cuts off access to embodied and sensory states of being.

As I turn towards the models, I aim to problematize their discursive implications; showing first of all where the language comes from and how it is deployed to support and sustain divided conceptions of minds and bodies. While the aim here is to provide some discursive disentangling to review the trace and imprint of language around ‘mental’ dis/order, all discourses are populated and expanded by others. For example, the **Interacting Mind and Body** model draws upon some metaphysical understandings as well as those neuro-based concepts from the **Brain Disorder** model. The single most prominent model of psychiatric discourse – DSM – employs both the language of psychology and biology, so none of these categories can stand alone. Furthermore, this chapter cannot possibly map all of the literature on the huge topic of ‘mental’ dis/order. Instead, the examples used are intended to provide an indication of the range of the different discursive meanings underlying conversations about the meaning of ‘mental’ dis/order, rather than to review the empirical evidence in each territory.

This chapter is defined in relation to the whole by its engagement with the critical medical humanities. In this chapter, I turn to the idea of ‘biopedagogy’. This term

was developed from Foucault's concept of 'biopower', which described how people are governed and controlled through 'practices associated with the body'. In a paper on biopedagogies and the obesity epidemic, Jan Wright uses the notion of biopedagogy to argue that 'truths' about obesity have 'become recontextualized in different social and cultural sites to inform and persuade people on how they should understand their bodies and how they should live their lives.'¹ In a similar way, I use the term in this chapter to think about how 'mental health' is made the project of the individual and the power of that individual to enact self-change. I also consider how 'truths' about mental health are situated and disseminated in government policy and public health initiatives, as well as in the clinic and educational settings and how 'popular media texts can be understood as a crystallisation' of these dominant discourses.² The language and narratives underwriting moralising messages about mental health may be subtle – almost imperceptible at times – but signal how 'mental' life feeds into a discourse of body management in prescriptions of mind over matter. In one example, critical psychiatrist Derek Summerfield looks at the translation of the psychiatric manual ICD into Latvian and how the Latvian concept of 'nervi' was categorised instead as 'depression'. Summerfield argues how the 'traditional language of (largely somatic) distress' embedded in 'disorder or dysfunction outside the self, in wider society and politics', was thus cut away into the individualised diagnosis of depression, thus providing, 'internalisation of a heightened sense of personal accountability for one's life circumstances'.³ The narrative structure of accounts of 'mental' dis/order shapes how citizens are told to enact and understand their bodies and minds as individual, controllable containers. The line between self-control and accountability and that of blame is a fine one, and, I argue, a dangerous one too.

¹ Jan Wright, 'Biopower, Biopedagogies and the obesity epidemic' in, *Biopolitics and the 'Obesity Epidemic': governing bodies*, ed. by J. Wright & V. Harwood (New York: Routledge, 2009), pp.1-14 (p.1).

² G. Rail and M. Lafrance, 'Confessions of the flesh and biopedagogies: discursive constructions of obesity on *Nip/Tuck*', *Medical Humanities*, 35, 2 (2009), 76-9, (p.76).

³ Summerfield, 'Against Global Mental Health'.

Background: Divided Medicine

Before I approach these models in detail, I will briefly consider some historical context for the deep roots of dualist understandings of mental and physical health in the medical model. For many cultural theorists, Rene Descartes (1596-1650) most clearly expressed a set of ideas, which are the precursors of biomedical conceptions of the palpable body versus the intangible mind, found in Western medical ideas about health and morality.⁴ Descartes separated out the ‘physical’ body, as something that could be studied by scientific means and ‘the immaterial, mental spirit’ – a gift from God – something that science could not access. Although Descartes believed that mind and body were able to communicate and relate, his belief was that they were separate.⁵ By the nineteenth century – as psychiatrist R.E. Kendell argues – Cartesian thinking had found an ally in medical dissection which showed that patients diagnosed with forms of madness did not show ‘the obvious pathological change’ that was physically located in other diseases.⁶ As science writer Jo Marchant outlines, the development of the autopsy, alongside the invention of the microscope and stethoscope, meant that doctors could assess patients based on ‘structural, visible changes’, so that, rather than being defined by the patients’ own reports of their illnesses, disease could be identified ‘by the physical condition of the body’.⁷

Cartesian thinking and medical developments were coupled with high profile cases that influenced public perceptions. Kendell cites the case of the ‘madness’ of King George who was successfully treated for his problems by a clergyman rather than a physician. He further points to the opening in 1796 of the York Retreat, which treated patients for distress and brought the term ‘disorders of the mind’ into common use. If

⁴ Scheper-Hughes and Lock, p.9.

⁵ Jo Marchant, *Cure: A Journey into the Science of Mind over Body* (Edinburgh: Canongate Books, 2016), p.xv.

⁶ Kendell, ‘The Distinction between Mental and Physical Illness’, p.490.

⁷ Marchant, *Cure*, p. xvi.

madness was a ‘disorder of the mind’ rather than a corporeal problem, it was felt that this should be treated with philosophic insight and guidance rather than medical opinion.⁸

By the middle of the nineteenth century, medicine started to reclaim mental illness. Historian Mark S. Micale explains how, within a movement of positivist philosophy across Europe, empirical science was hailed as a new research specialism. This was especially the case in Germany, with the emergence of new materialist schools of psychiatry. In Berlin, Wilhelm Griesinger (1817-1868), became the first professor of psychiatry and authored the *Pathology and Therapy of Mental Diseases*, arguing that mental illnesses were diseases of the brain. Griesinger’s work led to changes within German mental health systems and influenced subsequent academic-psychiatrists who turned towards positivist, materialist frames with more ‘secure and reliable’ methods of science than the views of Romanticism offered. However, as Micale argues, this evidence was often ‘speculative’ and ultimately ‘the medical effort to collapse the mind into the body failed’.⁹

Medicine, and its specialism of psychiatry, continued to wrestle with this problem; if disease was defined as a pathological change in the organ then it had to conclude that ‘mental’ dis/order is in the all in the ‘mind’ and that nothing is actually ‘wrong’ or something had to be found in the brain to account for it. The demarcation of functional (cases without visible lesions) from organic disorders (with clear somatic pathology) enabled this kind of distinction to be made.¹⁰ Cartesian influences continued to haunt the language and understanding: functional illnesses were thought of as being ‘all in the mind’ and therefore ‘not real’, and ‘psychogenic’ causes for ‘mental’ dis/orders (non-physical, non-substance-like) underpinned influential theories and techniques of

⁸ Kendell, p. 490.

⁹ Mark S. Micale, ‘The Psychiatric Body’, in *Companion Encyclopedia of Medicine in the Twentieth Century*, ed. by Roger Cooter and John Pickstone (London and New York: Routledge, 2003), pp. 323-47 (p. 326).

¹⁰ Kendell, p. 490.

psychoanalysis – at the end of the nineteenth and start of the twentieth century – and also influenced psychiatric models. I will now move on to look at how the legacy of this vocabulary and understanding is implicated and involved in these dominant models in the UK context today.

The Immaterial Thoughts Model

...anxiety is from our thoughts. Show me where are thoughts physically. [sic]
 They are illusions and not physical, [sic] therefore illusion. Anxiety is not real.
 You create it in your mind.¹¹

The above comment is taken from a thread of an online discussion about anxiety on a popular health news website. It exemplifies a conceptualisation of ‘mental ‘dis/order’ (in this case anxiety) as thought-bound, word-led and bodiless. In this account, embodied experience cannot be implicated or involved because there is no ‘physical’ cause for the anxiety, which is only present as thought that does not tangibly exist and is, therefore, understood to be immaterial. The person in this online discussion theorises that a disorder of the ‘mind’ – because it cannot be seen or materially examined through a microscope as an invasion of cells or tissues – must be self-created and self-sustaining. This is only one small comment circulating among thousands and thousands of online health discussions, but it is something of a microcosm of wider ideas circulated and promoted about the immateriality and metaphysical nature of mental illness.

In this model of **Immaterial Thoughts**, I argue that the legacy of Western Cartesian subjectivity underpins and drives an understanding of the mindful, managing self that overrules its object body. This model defines ‘mental’ dis/order as embroiled in

¹¹ ‘What Anxiety does to your body’, *GreenMed TV* (Health), 1 June 2014
 <<http://tv.greenmedinfo.com/anxiety-body-infographic/>> [accessed 10 July 2017].

problematic, irrational thoughts with little relationship to the embodied self, which only emerges as an afterthought or a sometime-carrier of the symptoms of mental distress. In this model, the self is an immaterial substance, joined to its body, but distinct from it. The ability to have good mental health is linked to ‘managing’ thoughts, with notions of resilience or self-control foregrounded. This model emanates historically from the growth and spread of psychology in the twentieth century¹² and in some aspects of cognitive psychology today, where psychopathology is based on a thought-word-behaviour correlative, and where research focuses on inner mental life, which takes place in words in the head.¹³ The emphasis is on conscious cognition and how to shape or affect thinking with individualised efforts. In current thinking, this model is not necessarily opposed to a neurological or brain-based account for ‘mental’ dis/order, but what it chooses to foreground is the immateriality of thoughts, the power of ‘the mind’, which is made up of those thoughts, the ‘psychology’ of the individual, and the concept of ‘mind over matter’. In this way, this model – often fluently and without contemplation – breaks apart ‘mental’ from ‘physical’ health.

In the **Immaterial Thoughts** model of understanding ‘mental’ dis/order, thoughts are ‘just thoughts’ that can be changed or re-shaped with the power of thinking and words. This idea is articulated by author Matt Haig who explains how, ‘unlike many physical illnesses talk can itself be medicine with mental illness. Because talk can shape thoughts, and minds are all thought.’¹⁴ There is nothing physicalized or embodied in an account where ‘minds are all thought’. This idea is expressed in a lot of public-facing communication on mental health from charities trying to normalise and reduce stigma around mental health issues. In one example, the charity Mind’s website explains it thus: ‘If you feel low or depressed, you may think, "I can't face going into work today. I can't do

¹² Rose and Abi-Rached, p. 7.

¹³ Charles Fernyhough and Simon McCarthy Jones, ‘Thinking Aloud About Mental Voices’ in, *Hallucination: Philosophy and Psychology*, ed. by F. Macpherson, & D. Platchias (MIT Press Scholarship online, 2014) <<http://dx.doi.org/10.7551/mitpress/9780262019200.001.0001>>.

¹⁴ Matt Haig, @MattHaig1 *Twitter*, 17 April 2017.

it. Nothing will go right." As a result of these thoughts – and of believing them – you may call in sick.¹⁵ This discourse may acknowledge the reality of being low or depressed, but in a sense, it is arguably not that far removed from the ‘illusion’ of anxiety cited in the opening citation of this section. In an understanding where mental illness involves irrational or distorted thinking, there is the suggestion that mental health can be resolved on an individual level, which de-materialises it and which keeps it neatly boundaried inside individual heads. In another example, the UK mental health charity Sane circulated an image describing mental illness in exactly this way; separated from the ‘body’ with the text clearly announcing that: ‘Mental health has no visual [...] because it’s in my head, not my body.’¹⁶ The body in an **Immaterial Thoughts** account is public and physical, and the mind (where ‘mental’ dis/order lives and festers) is private and internal – therefore not really a matter of substance at all.

The influence of this model is such, that the main treatments recommended by the National Institute for Health and Care Excellence (NICE) – for example for depression – are Cognitive Behavioural Therapy (CBT) as an initial treatment and ‘mindfulness-based CBT’ once feeling better ‘to stop you from becoming unwell again’.¹⁷ Mindfulness, as Professor Mark Williams, former director of the Oxford Mindfulness Centre explains, ‘allows us to become more aware of the stream of thoughts and feelings that we experience’.¹⁸ Thoughts are the object of these therapies, which focus on the mind, and its invisible material, trying to observe and watch those thoughts, which are intimately involved with language processes.

Words are particularly important in this model of ‘mental’ dis/order. As medical humanities and literary scholar Laura Salisbury articulates, within Cartesianism,

¹⁵ Mind, ‘Cognitive behaviour therapy (CBT)’ <<http://www.mind.org.uk/information-support/drugs-and-treatments/cognitive-behavioural-therapy-cbt/>> [accessed 9 July 2017].

¹⁶ SANE, @CharitySANE *Twitter*, 4 August 2016.

¹⁷ Rethink Mental Illness, ‘Talking Therapies - NICE Guidelines’ <<https://www.rethink.org/diagnosis-treatment/treatment-and-support/talking-treatments/nice>> [accessed 10 July 2017].

¹⁸ NHS Choices, ‘Mindfulness’ 6 January 2016, <<http://www.nhs.uk/conditions/stress-anxiety-depression/pages/mindfulness.aspx>> [accessed 10 July 2017].

language's specific role is as a 'mental attribute' not a bodily one.¹⁹ And in this dualist-influenced model, there is a short step from the thought-led model of the mind, to the theory that 'mental' dis/order must involve a problem with language in some intrinsic way. In a book on depression and narrative, philosopher Jennifer Radden suggests this in her observation that:

Psychiatric symptoms regularly compromise the capabilities required for the expression of any symptoms, so understood – speech, and the shared, intersubjective responses that allow words to successfully convey meanings, actions to make apparent sense, and understanding and communication to take place.²⁰

In the Mental Status Examination conducted by psychiatrists, 'mental' dis/order is defined through an assessment of the 'appropriate' nature of a patient's speech and language including its rate, rhythm, pitch, intensity and fluency.²¹ The voice, and the sound of the voice, supposedly tells psychiatry about someone's internal mental state.²² Words define and diagnose.

The model of worded disruption in an **Immaterial Thoughts** reading of 'mental' dis/order reflects the idea that 'the wounds do not heal' in the course of narrating experience 'so much as insist in the form and language of the narrative'.²³ The shape, texture and construction of words are thought to provide insight into the inner experience of 'mental' dis/order in therapies designed around the idea that talk shapes

¹⁹ Salisbury 'Aphasic Modernism'.

²⁰ Jennifer Radden, 'My Symptoms, Myself: Reading Mental Illness Memoirs for Identity Assumptions', in *Depression and Narrative: Telling the Dark*, ed. by Hilary Clark (New York: State University of New York Press, 2008), pp. 15-28 (p.24).

²¹ T. M. Luhrmann, *Of Two Minds: An Anthropologist Looks at American Psychiatry* (New York: Vintage Books, 2000), p.38.

²² David C. Martin, 'Chapter 207: The Mental Status Examination' in *Clinical Methods: The History, Physical, and Laboratory Examinations*, ed. by H.K. Walker and others, 3rd edn (Boston: Butterworths, 1990).

²³ Hilary Clark, *Depression and Narrative: Telling the Dark* (New York: State University of New York Press, 2008), p.8.

thought, and that talking can be cathartic. However, this model takes the idea further. 'Mental' dis/order is not only evident in speech patterns, but in this theorisation, it takes place on the 'inside' too. As psychologist Charles Fernyhough argues, thinking is 'conscious and it is active. [...] It is dialogic: it has the quality of an internal conversation between different perspectives. [...] And it is linguistic.'²⁴ In Fernyhough's dialogic-thought argument, 'mental' dis/order – which happens in the 'head' and in the thoughts of that head – must have some relationship not only with the spoken word but specifically with inner speech.

If 'mental' dis/order takes place in immaterial thoughts, then one theory is that inner speech in 'mental' dis/order evolves into an extreme version of what might be considered its natural or normative dialogical form.²⁵ In a paper on anorexia nervosa – for example – psychologists Sarah Williams and Marie Reid suggest that the eating disorder exists in the very 'conflict between the anorexic voice' and the 'primary self'. In this particular eating disorder, they argue that mental life becomes primarily 'about' this conflict and the multi-voiced self becomes 'dysfunctional'.²⁶ If this is the case, then the implication is that 'mental' dis/order is somehow created and sustained by this inner speech illness, which is locked in the head.

Psychologist Russell Hurlburt's phenomenological study of the eating disorder, bulimia, advances this argument. His research finds that some bulimic patients report there are two voice streams operating simultaneously – one which appears to be at the front of the head and that sounds like the person's own voice – and a voice at the back

²⁴ Charles Fernyhough, 'What Do We Mean By Thinking?,' *Psychology Today*, 16 August 2010 <<http://www.psychologytoday.com/blog/the-child-in-time/201008/what-do-we-mean-thinking> > [accessed 18 July 2017].

²⁵ Lev Vygotsky, *Thought and Language*, ed. by Alex Kozulin, 2nd edn (Russia, 1934; Cambridge, MA: MIT Press, 1986), p.226.

²⁶ Sarah Williams and Marie Reid, "It's like there are two people in my head": A Phenomenological Exploration of Anorexia Nervosa and its Relationship to the Self, *Psychology & Health*, 27, 7 (2012), 798-815 (p. 810).

that seems softer and quieter. This ‘clutter of simultaneous thoughts’, Hurlburt suggests in an article on his work, can ‘often be cleared by [bulimic] purging’.²⁷

Psychologists Paul Trapnell and Jennifer Campbell argue that inner speech in ‘mental’ dis/order might be problematised because of increased rumination.²⁸ Rumination is considered to be primarily a verbal process where thoughts are stuck, or where there is an obsessive focus on negative past experience and – within psychology research by Fernyhough and others – it is linked to both depression and anxiety.²⁹ ³⁰ If inner speech within ‘mental’ dis/order is over-productive, dialogic, multiple-voiced or ruminative in some way, and if it no longer coordinates, processes or is silent (in the way that it is thought to normally function),³¹ then there is tangible sense of a language-based and thought-based internal ‘mental’ space emerging. Dis/order exists in this space and cognitive psychology chooses to put its therapeutic focus there.

Several assumptions are inscribed in this model which I contest: first the idea that there is a neat division between inner and outer worlds – between what is internally created versus externally made – as well as an assumption that to be able to discriminate between the two is healthy and normal. Indeed, what is an internal sensation and what is an external feeling, and how can such a divide really exist? Some small and particularised examples that unsettle the clarity of this distinction might include: a song which pops into the head; the memory of a teacher’s voice echoing; the sound of a baby’s cry imagined by an anxious parent. Are these internal or external? And where do they begin, start from or generate from? At a broader level, in my emphasis on the power of medical and political discourse to shape bodies and minds (in the biopedagogies of biopower),

²⁷ Jascha Hoffman, ‘Taking Mental Snapshots to Plumb Our Inner Selves’, *The New York Times*, 21 December 2009 < <http://nyti.ms/7ItEGd> > [accessed 18 July 2017].

²⁸ P.D. Trapnell and J.D. Campbell, ‘Private Self-consciousness and the Five Factor Model of Personality: Distinguishing Rumination from Reflection,’ *Journal of Personality and Social Psychology*, 76 (1999) 284–304.

²⁹ S. R. McCarthy-Jones and Charles Fernyhough, ‘The Varieties of Inner Speech: Links Between Quality of Inner Speech and Psychopathological Variables in a Sample of Young Adults’, *Consciousness and Cognition*, 20, 4 (2011), 1586–93.

³⁰ Jennifer Harrington and Virginia Blankenship, ‘Ruminative Thoughts and Their Relation to Depression and Anxiety’, *Journal of Applied Social Psychology*, 32, 3 (2002), 465–85.

³¹ Vygotsky, *Thought and Language*, p.226.

this sort of divide is intangible and unrealistic. Second – as some of the research on inner speech tentatively acknowledges – inner speech is only one part of human experience. Where is the space for the non-linguistic within these accounts? Can inner speech really be equated with, or responsible for, the sensory, the visual and the kinaesthetic, as some researchers in the field claim?³² Certainly, some of the methods of extracting or sampling people’s inner speech experiences (as per the work of Hurlburt et al) seem to be underpinned by a latent dualism, wherein thoughts are verbal and formed in language and are not attached to any particular sense of substance (apart from an implicit attachment to brain states).³³ For proponents of this model, embodiment is simply not an issue of concern. ‘Mental’ dis/order is all in the head, and this is not a space in which to dwell on extended meanings of ‘the body’.

The **Immaterial Thoughts** model is embedded in dualist language and ideals. The focus is on thoughts in the head; in thoughts which make up the mind, and on the language, that articulates or further ‘shapes’ thoughts, pushing physicality out of view. Drawing back to a question mooted in the Introduction: What are the implications of this? Is dualism unhealthy in itself? Indeed, one German study from 2012 provides reasons as to why dualism might actually exacerbate mental health issues. The study, looking at the effects of dualism on health behaviour, hypothesised that ‘holding dualistic beliefs leads people to perceive their body as a mere “shell” and, thus, to neglect it’. The research confirmed that ‘participants who were primed with dualism reported less engagement in healthy behaviours and less positive attitudes toward such behaviours than did participants primed with physicalism’.³⁴ Arguably, those who adhere to dualist tendencies, if facing a ‘mental’ health crisis will assume that the solution must

³² Norbert Wiley, ‘Inner Speech as a Language: A Saussurean Inquiry’, *Journal for the Theory of Social Behaviour*, 36, 3 (2006), 319-41 (p.320).

³³ Russell T. Hurlburt, *Investigating Pristine Inner Experience: Moments of Truth* (Cambridge University Press, 2011)

³⁴ Matthias Forstmann and others, “‘The Mind Is Willing, but the Flesh Is Weak’”, *The Effects of Mind-Body Dualism on Health Behavior*, *Psychological Science*, 23,10 (October 2012), 1239-45 (p.1239).

lie within the level of the ‘mind’. They might admit that exercise, for example, helps them feel better, but think that the ‘real’ therapy has to come from something ‘psychologically’ focused. The dualist narrative of mind and body problematises any explanation given to how and why physical engagement or awareness – for example – might improve mental health, if it’s all in the head. Language, in this sense, cuts into any attempt to articulate the embodied nature of mental health, when it is considered to be immaterial, floating in thoughts and psychogenic experience, and unrelated to the material body.

The Brain Disorder Model

Biological psychiatry: is there any other kind?³⁵

As foregrounded in the Introduction, in recent years, the growth and trajectory of neuroscience has developed evidence to locate ‘mental’ dis/orders in certain brain chemicals or pathways; seeing these problems as individual flawed brain functioning. ‘Biological psychiatry’ drives new research into genes and behaviour via ‘genome scanning, proteomics, electrophysiology, neuroimaging and cognitive function tests’.³⁶

The argument runs that psychiatric disorders that previously lacked empirical explanation are now better understood due to advances in brain science. Conditions once described as functional (or non-organic) can now be described within a neurobiological model.³⁷

³⁵ S. B. Guze, ‘Biological Psychiatry: Is there any other kind?’ *Psychological Medicine*, 19, 2 (1989), 315-23.

³⁶ Richard Brown, ‘The Science of Psychiatry in Uncertain Times: What Does the Future Hold?’ <<http://www.rcpsych.ac.uk/pdf/RCPSYCH%20Essay%20The%20science%20of%20psychiatry%20in%20uncertain%20times%20R%20Brown.pdf>> [accessed 10 July 2017].

³⁷ Ed Bullmore and others, ‘Why Psychiatry Can’t Afford to be Neurophobic’, *The British Journal of Psychiatry* 194, 4 (Mar 2009) 293-95 <<http://dx.doi.org/10.1192/bjp.bp.108.058479>>.

A model of 'biological psychiatry' came to the fore in the second half of the twentieth century with the identification of a possible genetic component of 'severe mental disorders' coupled with the discovery of medications such as lithium and diazepam. Psychiatrist and neurologist Henrik Walter explains how these 'quickly became a major pillar of psychiatric treatment' and how 'mental' dis/orders started to be explained via neurochemical imbalances. This was followed up by progress in molecular psychiatry, cognitive neuroscience and neuroimaging. Neuroimaging, in particular, Walter argues, led to several, oversimplified, headline-grabbing stories about a number of topics including a 'gene' for schizophrenia which circulated a popular narrative of 'mental' dis/order as a brain disease.³⁸

Reductive narratives have been distilled in media accounts, often over inflated in accounts by popular science writers seeking to explain this new vision of humanity. The implications for explaining and intervening in 'mental' dis/order in this model of the brain as mind are vast. As psychologist Peter Kinderman explains, to make mental health problems into brain illnesses is to 'change the way we think about personal responsibility'; it 'locates the problems within the individual', at the same time engendering 'sympathy' because the illness is legitimised.³⁹ Advocates of the **Brain Disorder** model suggest that, by defining mental illness as a brain problem, the ambiguity of the **Immaterial Thoughts** model is taken away. Resultantly, the thorny issue of personal or moral culpability for mental health issues and the problematic boundaries of socially informed disorder appear to be out-manoeuvred.

In a model of 'mental' dis/order supported by disease structures, the body definitely has a role because the underlying conceptualisation is a biological one. Specifically, neurochemical imbalances are highlighted as being a primary cause of

³⁸ Henrik Walter, 'The Third Wave of Biological Psychiatry', in *Frontiers Research Topics: The Philosophy of Psychiatry and Biologism*, ed. by Markus R  ther and others (Frontiers Media, January 2015), pp.8-15 (p.8).

³⁹ Peter Kinderman, *A Prescription for Psychiatry: Why We Need a Whole New Approach to Mental Health and Wellbeing* (Basingstoke: Palgrave Macmillan, 2014), p.3.

‘mental’ dis/order, with the ‘dopamine [...] norepinephrine and serotonin systems’ all implicated.⁴⁰ The argument that ‘mental’ dis/order cannot be seen under a microscope or located on a body scan with ‘organic’ proof is put to the test. Indeed, for some forms of ‘mental’ dis/order – for example, autism or schizophrenia – it is argued that ‘structural and functional abnormalities’ can actually be identified in imaging or post-mortems.⁴¹ This line of argument takes immaterial thoughts and gives them a material location. Even though the evidence from imaging and post-mortems does not apply to most ‘mental’ dis/orders, the view that brain chemistry is responsible has consequences for treatment, as pharmacological interventions are targeted to address imbalances, and as drug companies create new solutions for newfound dysfunctions. Those who argue for the individual brain imprint of each disorder are confident in their language and evidence base as the following quote from the National Institute of Mental Health (NIMH) in America attests: ‘Through research, we know that mental disorders are brain disorders. Evidence shows that they can be related to changes in the anatomy, physiology, and chemistry of the nervous system’.⁴² In some cases, the case is so strongly articulated as to infer that another label should be created for some mental illnesses. The Brain & Behavior Research Foundation in America argues that some ‘mental’ dis/orders should be named ‘brain and behaviour disorders’ instead, stating that: ‘Out of the 10 leading causes of disability identified and tracked in the United States and other developed countries; four are brain and behavior disorders: major depression, bipolar disorder, schizophrenia and obsessive-compulsive disorder’.⁴³

The implications of a biological model stretch beyond psychiatry’s remit and have a financial impact. In America, for example, insurance companies can pay out for

⁴⁰ Luhrmann, p.53.

⁴¹Kirsten Weir, ‘The Roots of Mental Illness: How Much of Mental Illness can the Biology of the Brain Explain?’ *Monitor on Psychology*, 43, 6 (June 2012), p.30.

⁴² National Institute of Mental Health, ‘Brain Basics’ <<http://www.nimh.nih.gov/health/educational-resources/brain-basics/brain-basics.shtml>> [accessed 10 July 2017].

⁴³The Brain & Behavior Research Foundation <<https://bbrfoundation.org/mental-illness-1>> [accessed 10 July 2017].

legitimised, diagnosed disorders only, and drugs are marketed and targeted to each different neurochemically identified problem. As a result of this disorder-insurance-drug triangulation, a psychiatric manual under revision is reported as big news by the financial trading press.⁴⁴ As Rose and Abi-Rached suggest – providing examples from Europe and an American context – the new brain sciences moved from specialised science journals and literature in the mid- to late twentieth century and – after the so-called ‘Decade of the Brain’ as named by President George W. Bush in the 1990s – it began to be taken on and considered in relation to broad reaching government policies.⁴⁵

One of the more extreme consequences of a **Brain Disorder** model is the further medicalisation of psychiatry. In this model, ‘mental’ dis/order is understood entirely as a ‘medical concept’ through, ‘the biological and neurological basis of “real” mental illness’ and via the ‘authority of the psychiatric, medical consultant’.⁴⁶ There is little chance of disorder being confused or conflated with more day-to-day issues. This view is famously illustrated in the US case of the director of NIMH – Thomas Insel – who objected to the lack of validity and objective measurement within *DSM-5* and promulgated that ‘the NIMH will be re-orientating its research away from *DSM* categories’.⁴⁷ For Insel, genetic advances, imaging data, and cognitive evidence are the future of psychiatry, not general, clustered symptoms that cannot be objectively verified or casually explained.

With a medicalised, brain-biology model, ‘mental’ dis/order is situated in physical terms. This conceptualisation has implications for individuals in very personal ways. If ‘mental’ dis/order is not the illusory, intangible, metaphorical business of the mind, but is embedded in brain chemicals, then it can be argued that it is the brain that has the problem. Author and recovering anorexic, Emma Woolf takes up this model to

⁴⁴Wieczner, ‘15 New Mental Illnesses in the *DSM-5*’.

⁴⁵ Abi-Rached and Rose, p. 7.

⁴⁶ Kinderman, p. 21 commenting on the views expressed in: N. Craddock and others, ‘Wake-up call for British Psychiatry’, *The British Journal of Psychiatry*, 193, 1 (Jun 2008) 6-9
<<http://dx.doi.org/10.1192/bjp.bp.108.053561>>.

⁴⁷ Thomas Insel, ‘Director’s Blog: Transforming Diagnosis’, *National Institute of Mental Health*, 29 April 2013
<<http://www.nimh.nih.gov/about/director/2013/transforming-diagnosis.shtml>> [accessed 18 July 2017].

explain her own experiences. Woolf writes that ‘Anorexia is not a choice [...] people blame the sufferer but that’s not right – you don’t blame someone who has epilepsy or eczema, you know they didn’t bring it upon themselves. For too long, anorexia has been treated as a choice and it’s not a choice, it’s a brain disease’.⁴⁸ Woolf feels that the model offers a level of understanding and acceptability for an illness that is often seen as an attention seeking cry for help, or as a socially derived and socially contagious illness. In Woolf’s analysis, it is figured much more securely as a ‘brain’ problem. The ‘body’ as an entity (and a noun) extends to everything within the person’s physical being; this includes the brain which sits in the head. The mind, in this model, is the brain, the brain is the body, and everything comes down to how it functions. The mind is not anything mysterious because ‘consciousness is the activity of the brain’.⁴⁹ The other parts of the body are of interest only because they are under the brain’s control.

Although this model of ‘mental’ dis/order oversteps dualistic notions by making human mental life all about biology and brain processes (and, therefore, putting the mind into the body), it firmly establishes ‘mental’ dis/order as identifiable in localised and internalised spaces. It may well be argued – as Abu-Rached and Rose suggest – that with this model we can ‘consign the Cartesian mind and body split to history’, but I argue that this model remains problematic in a number of ways.⁵⁰ First, it focuses on the cause but not on the symptom or effect; it provides an explanation, but not a meaning for the individual, and arguably subsumes personal voice and feeling under a medical model of faulty brain wiring. Where behaviour is deemed irrational and due to an illness or disease, it becomes separated from the ‘human reasons’ for the person’s feelings.⁵¹ Indeed, as eating disorders scholar and activist, Emma Louise Pudge suggests, the

⁴⁸Amy Stone, “‘Anorexia is Not a Choice’ – Interview with Emma Woolf, *Medical Humanities at the University of Sheffield* <<http://mhs.group.shef.ac.uk/interview-with-emma-woolf/>> [accessed 17 July 2017].

⁴⁹ Steven Pinker, ‘The Brain: The Mystery of Consciousness’, *Time*, 29 January 2007 <<http://content.time.com/time/magazine/article/0,9171,1580394,00.html>> [accessed 28 August 2016].

⁵⁰ Abu-Rached and Rose, p.8.

⁵¹ Kinderman, p. 4.

biological, neurological and/or genetic basis for eating disorders suggested in the **Brain Disorder** model actually ends up consolidating the ‘stigmatised, pathological identity’. In saying that there is something fundamentally wrong with the person – it creates an ‘all-consuming’ identity, reducing expectations for recovery. Instead, Pudge asks the seminal question: ‘What is the practical use for this biological insight?’ Indeed, how might it actually be damaging? What does it mean to ignore the personal, social and cultural circumstances, and the complexity and lived reality of people’s lives – including gender, socioeconomic conditions, sexuality – as well as the political climate of neoliberalism; the context in which lives are playing out?⁵² This takes me to my second point that some researchers working in neuroscience who are fixed to a **Brain Disorder** position, seem to have no problem swallowing the social world inside their model. In one example, brain scientist Eric Kandel argues that social and environmental factors ‘do not act in a vacuum [...]. They act in the brain’.⁵³ This brain-centric model throws up numerous ethical and environmental issues. Returning to the feminist materialist view worked through in the Introduction, if everything is directed from above – from the controller that is the human brain, there is a sense that matter does not matter in and for itself, only in limiting anthropocentric terms; meaning that complex lived and embodied experience is overwritten. Third, a model of the disorder of the brain that pins everything on genetic causes or reduces everything to biological difference stands on shaky evidential ground with studies often underpowered, ‘approximately replicated’ and with ‘stable effects only found in extreme comparisons’.⁵⁴ ⁵⁵ Furthermore, some explanations of psychiatric illness relate to imprecise evidence about neurotransmitters, which is often critiqued.⁵⁶ Despite this uncertain evidence, the ‘biological, pathological

⁵² Emma Louise Pudge, ‘Emma Louise Pudge speaks at the Something’s Gotta Give campaign rally 2016’, online video recording, *YouTube*, <<https://www.youtube.com/watch?v=tH9fZXO7kfg>> [accessed 10 July 2017].

⁵³ Weir, *Roots of Mental Illness*, p.30.

⁵⁴ Kinderman, pp.11-14.

⁵⁵ Walter, *The Third Wave*.

⁵⁶ Bruce G. Charlton, ‘A Critique of Biological Psychiatry’, *Psychological Medicine*, 20 (1990), 3-6.

identity' is widely circulated and used. Fourth, if taken to the extreme, where all mental states are understood to be brain states, then the word 'mental' is redundant and all mental activity is just brain activity, or mental activity is effectively powerless.⁵⁷ This seems like an incredibly extreme position to occupy, and while it is not the aim of this thesis to account for every angle of philosophy of the mind, what is clear from this model is that if the individual, localised brain structure is the epicentre of all existence, then the physical flesh of the body moving among other bodies and interconnecting in the expanse of a complex and often-challenging world, feels blithely overlooked.

Interacting Mind and Body Model

The third model, which I discuss and present here, re-inserts bodies (beyond brains) into concepts of mental health. This model takes pieces of the **Brain Disorder** model and **Immaterial Thoughts** model but connects them up in an attempt to offer a type of mind-body map of 'mental' dis/order. This model presents a vertical line from head and brain into the rest of the body. The body is of interest here because it interacts with the mind; it is related to it. How the mind functions might affect how the body works, and vice versa. Typically, within this model, the body (as a singular physical entity, which is poorly defined but is largely conceptualised as physical life from the neck down) is a project; a set of organs and functions that need maintenance. Powered by a neoliberal ideology, this model – disseminated through government policy and public health literature – foregrounds the notion of biopedagogy asking citizens to manage and discipline their bodies. It is fuelled by the connections demonstrated between mental and physical health outcomes (which impact and put a strain on the NHS) and it models a vision of dealing with these connections with an integrated healthcare approach.

⁵⁷ Walter, *The Third Wave*.

The body is implicated in this model, because poor mental health affects, or shows symptoms, in the connected body. Indeed, this model readily acknowledges the often-debilitating physical effects of having a ‘mental’ dis/order, but these are understood to be symptoms or results of mental illness and remain separate from it. A treatment that is aligned with this model of ‘mental’ dis/order is CBT. The NHS Choices website (the official website of the National Health Service in England – and the UK's biggest health website accounting for a quarter of all health-related web traffic)⁵⁸ explains that in this therapy, ‘you will work with your therapist to break down your problems into their separate parts such as your thoughts, physical feelings and actions’. Subsequently, ‘You and your therapist will analyse these areas to work out if they are unrealistic or unhelpful and to determine the effect they have on each other and on you. Your therapist will then be able to help you work out how to change unhelpful thoughts and behaviours’.⁵⁹ This example demonstrates how CBT separates out ‘thoughts’, ‘physical feelings’ and ‘actions’ into individual parts. These elements are seen as ‘affect[ing]’ one another and it is understood that negative ‘effect’ can be undone by changing ‘unhelpful thoughts’. The theory here is that thoughts can be cognitively reappraised, changed and replaced. If thoughts are changed, then physical feelings and actions might resultantly be improved. This is a head-down model. If we take this model to understand panic attacks from anxiety, for example, a person’s ‘body’ might feel extreme stress formed in the tightening of the chest or a tingling sense, which they sense in the arms and hands. These symptoms might cause the person concerned to feel as though they are experiencing a heart attack. The ‘physical’ symptoms are acknowledged, and the body is important and relevant to mental health in this **Interacting Mind and Body** context, but the person is repeatedly told that it is their ‘unhelpful’ thoughts that

⁵⁸ NHS Choices, ‘What we do’, <<http://www.nhs.uk/aboutNHSChoices/aboutnhschoices/Pages/what-we-do.aspx>> [accessed 10 July 2017].

⁵⁹ NHS Choices, ‘Cognitive Behavioural Therapy (CBT)’, 4 July 2014 <<http://www.nhs.uk/conditions/cognitive-behavioural-therapy/Pages/Introduction.aspx>> [accessed 17 July 2017].

need to be challenged and targeted, and that this will then undo the sensations that occur in their separate body parts. The mental health charity Mind further articulates this idea in its own explanation of CBT:

[CBT] focuses on how you think about the things going on in your life – your thoughts, images, beliefs and attitudes (your cognitive processes) – and how this impacts on the way you behave and deal with emotional problems. It then looks at how you can change any negative patterns of thinking or behaviour that may be causing you difficulties. In turn, this can change the way you feel.⁶⁰

The model of CBT espoused here ('this impacts' and 'in turn'), is one of a vertical top-down system. However, there is much more at stake in this vertical model of head over body than individual dissociation between parts of the self. If 'mental' dis/order is caused by negative thoughts, which can be shifted by being broken down and recreated, and if physicalised symptoms are seen as a by-product of negative thoughts, then the onus for the 'mental' dis/order rests firmly with the individual to get better and to overcome those unhelpful thoughts. Recovery lies in cognitive 'self-management' strategies.⁶¹

The focus for this model might not be as pointed as the oft-critiqued stigma around 'mental' dis/order that simply tells people to 'perk up' or 'get over it', but the emphasis is certainly on the individual's self-control. In her work about embodiment and voice hearing, feminist body studies theorist, Lisa Blackman writes that '[within] psychiatry [...] the hero is one who is able to accept their diagnosis (I have "depression") [...] the victim-to-victor narrative is one where mental distress becomes both a site of self-knowledge and identity work'.⁶² This model of **Interacting Mind and Body** 'mental'

⁶⁰ Mind, 'Cognitive Behavioural Therapy'.

⁶¹ Rethink Mental Illness, 'Tools for Recovery – Self-management' *Rethink.org*, <<https://www.rethink.org/living-with-mental-illness/recovery/tools-for-recovery/self-management>> [accessed 18 July 2017].

⁶² Lisa Blackman, 'Psychiatric Culture and Bodies of Resistance', *Body & Society*, 13, 2 (June 2007), 1-23 (p.8).

dis/order adheres to this biopedagogical trajectory where recovery is a heroic overcoming. The acceptance of the diagnosis of the ‘mental’ dis/order places the individual in a position of self-responsibility. However, there is a dangerously short step from telling people that they need to accept and manage their problems, to a view which intimates that those same problems might be self-created or self-sustained.

This view appears to underpin public health messaging with an attempt to integrate and connect mental and physical health. The emphasis within public health campaigns embedded in the **Interacting Mind and Body** model is on the rhetoric of self-improvement: the ‘One You’ campaign encourages people to reappraise their lifestyle choices, put themselves first and commit to addressing their own health needs. It reminds people that it’s never too late to improve their health.⁶³ Changes are focused on the individual, as people are asked to ‘reappraise’ and ‘do something’ about their lifestyle.

The model of mind over matter may work in terms of economics – shifting the work away from clinical spaces and on to prevention and self-management. However, ‘computer counselling’⁶⁴ (as offered by the NHS to patients with some mental health issues), which features online modules of e-learning to ‘Beat the Blues’⁶⁵ or to be a ‘Fear Fighter’⁶⁶ uses the warrior-like language of ‘fighting’ and ‘beating’ to sustain and reproduce a specific battling rhetoric around ‘mental’ dis/order. Even if this kind of online therapy is only meant to be temporary – for people on waiting lists to see a therapist in person, or for those with ‘mild’ depression or anxiety – there is a strong sense of how ‘mental’ dis/order exists, where it exists and what to do about it. It is not possible to say that severe depression sits in a different model once this location and these tools

⁶³ Public Health England, ‘One You’.

⁶⁴ NHS Choices, ‘Stress, Anxiety and Depression - Self-help Therapies’, 6 January 2016 <<http://www.nhs.uk/conditions/stress-anxiety-depression/pages/self-help-therapies.aspx>> [accessed 18 July 2017].

⁶⁵ Agilisys Ltd and Ultrasis Plc, ‘Beating the Blues: Cognitive Behavioural Therapy’ <<http://www.beatingtheblues.co.uk/>> [accessed 17 July 2017].

⁶⁶ CCBT Ltd, ‘Fear Fighter: Panic and Phobia Treatment’, <<http://ccbtmain.cbtprogram.com/products/fearfighter/>> [accessed 17 July 2017].

are proposed. The overriding take-out is that people with mental health issues should address the thoughts, calm the mind and fix the object body as a result. This model of ‘mental’ dis/order is focused only on wrong-headed worded thoughts, which can be changed. The body takes only a bit-part in proceedings. Psychotherapist, Susie Orbach agrees that since the ‘mentalist turn’ of the 1950’s ‘the body [has been] seen as dustbin for that which the mind cannot cope with’.⁶⁷ Certainly, this idea of the dustbin resonates within this model where there is a trade one way from mind to body.

Judy Segal, writing on the rhetoric of medicine, argues that the dominant preferred plots of individual resistance form part of a ‘textual culture’, which has the power to inform how experience is reported and even how we ‘experience experience’.⁶⁸ Mental health becomes a battle, something to be worked on and includes overcoming the unruly body. Indeed, this idea (and this **Interacting Mind and Body** model) finds itself expressed in alternative health and popular health and wellbeing books, that take on the mantle of self-improvement and sell different solutions to this end. ‘Motivational author’⁶⁹ Louise Hay’s affirmation that ‘every single thought you think and every word you speak’ affect the cells in your body; or the idea that illness cannot exist in a person who thinks positively (Rhona Byrne, *The Secret*)⁷⁰ encapsulate the idea of mental life implicating and affecting physical life. As Ruth Barcan analyses, a lot of this kind of work harks back (perhaps unwittingly) to a kind of Freudian model of mind transferring into matter; of the body, ‘holding and ultimately reflecting emotional or psychological patterning’.⁷¹

Popular science writers attempt to separate themselves from the unevidenced and ‘New Age’ alternative and lay explanations for mind transferring into body illnesses,

⁶⁷ Suzie Orbach and Roz Carroll, ‘Contemporary Approaches to the Body in Psychotherapy: Two Psychotherapists in Dialogue’, in *About a Body: Working with the Embodied Mind in Psychotherapy*, ed. by Jenny Corrigan and others (Hove: Routledge, 1996), pp.63-82 (p.68).

⁶⁸ Judy Z. Segal, *Health and the Rhetoric of Medicine* (Southern Illinois University Press, 2008), p.61 and p.69.

⁶⁹ Louise Hay, <www.louisehay.com> [accessed 10 July 2017].

⁷⁰ Rhonda Byrne, *The Secret* (New York: Beyond Words Publishing, 2006).

⁷¹ Barcan, p.80.

but come back to the same language divides and Cartesian structures. In an example of this, in her 2016 best-selling book *Cure: The Science of Mind Over Body*, Jo Marchant offers up a theory of mind-body medicine wherein she argues that thoughts and perceptions (what she terms our 'mental states') affect our physiology. The mind and body are labelled separately but they also interact. Marchant is interested in how to harness the placebo effect to improve patient care, as well as, 'meditation, prayer, conditioning, and hypnosis' – ways in which the mind may be able to alter bodily states and symptoms. Marchant argues that the mind (in the brain) can change the body, but the mind (in the brain) needs to work hard within certain areas to alter long-term patterns and interrupt cyclical habits (as in the case of stress). The conclusions Marchant reaches disassemble Cartesian concepts by attaching mental thoughts and feelings to physical processes, but they do not make the leap to interrogate mind and body separation in the first place. Indeed, while Marchant's book is an attempt to look at the real 'science' of 'mind-body' medicine, as opposed to the new age's 'wishful thinkers' and 'cynical salesman' (which she disparages) the distinctions and divides in the language Marchant uses, shows the legacy of Cartesianism holding sway.⁷²

The seeds of the vertical model of mental health shaping bodily symptoms and physicality are found in the often-murky waters of psychosomatic illness. The water is murky because definitions are thick with attributions of patient blame and denials of physical symptoms: psychosomatic approaches might treat stomach issues (without an identifiable 'organic' cause) as a somatisation of emotional difficulties, which are seen as somehow unreal or under an individual's control. Issues of the mind translate or fall down to the soma (the way in which 'psycho' precedes 'soma' in the word itself indicates this relationship). In a contemporary context, psychosomatic illness finds itself relabelled in health literature as 'medically unexplained symptoms' (this is defined by the NHS as 'physical symptoms that lack an identifiable organic cause' and for which there is often

⁷² Marchant, p. xvii.

no clear referral pathway).⁷³ The language of mental and physical health interacts but struggles to break out of its containers, meaning that problems that appear to sit betwixt mind and body find themselves lost in metaphorical territory, routeing back to organic (real) and functional (not real) divides.

In an **Interacting Mind and Body** model, policy and research prefer to deal with diagnoses that sit firmly in one camp or the other, and impact one another. Integrated care is thus driven by research evidence which has shown that ‘mental’ dis/order can adversely affect ‘the prognosis of a range of physical illnesses, especially heart disease, diabetes and cancer’.⁷⁴ In the same vein, it is recognised that when someone has a physical problem it might affect their mental wellbeing: ‘According to NICE, people who are diagnosed with a chronic physical health problem [...] are 3 times more likely to be diagnosed with depression than people without it.’⁷⁵ The result of these connected (but separate) systems means that evidence is mounting which demonstrates that ‘physical and mental health comorbidities are common’.⁷⁶ The research investigating these comorbidities takes the terms ‘mental’, ‘physical’, ‘wellbeing’, ‘health’ and ‘illness’ for granted, but the critical meaning behind separated-yet-connected elements is overlooked. In the expression of the relationship between physical and mental health, there is already a presumed disconnection and difference. With the split so engendered in medical practice, it feels almost impossible to go against the grain of language that segments and splits. Thus, while the concept of integrated mental and physical health is raised, the explanation tends to be that one thing causes the other, is a symptom of the other or affects the other, but the mental illness and the physical illness remain as distinct, particularised elements. Even though this **Interacting Mind and Body** model

⁷³ Chris Naylor and others, ‘10 Priorities for Integrating Physical and Mental Health’, *The King’s Fund*, 8 March 2016 < http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/Bringing-together-Kings-Fund-March-2016_1.pdf > [accessed 10 July 2017].

⁷⁴ University of Oxford, ‘Many Mental Illnesses Reduce Life Expectancy More than Heavy Smoking’.

⁷⁵ Diabetes.co.uk, ‘Diabetes and Depression’ <<http://www.diabetes.co.uk/diabetes-and-depression.html>> [accessed 28 August 2016].

⁷⁶ Brenda Happell and others, ‘Nurses’ Views on Physical Activity for People with Serious Mental Illness’, *Mental Health and Physical Activity*, 5 (2012), 4-12 (p. 4).

attempts to go beyond biomedicine's 'tunnels of specialised knowledge', it still, once again, ends up in splits and unhelpful binaries.⁷⁷

The Body Systems Model

Embodiment is the surprisingly radical hypothesis that the brain is not the sole cognitive resource we have available to us to solve problems. Our bodies and their perceptually guided motions through the world do much of the work required to achieve our goals, *replacing* the need for complex internal mental representations. This simple fact utterly changes our idea of what "cognition" involves, and thus embodiment is not simply another factor acting on an otherwise disembodied cognitive processes.⁷⁸

While the **Immaterial Thoughts** model, the **Brain Disorder** model, and the **Interacting Mind and Body** model all end up circularly coming back to Cartesian lines in some way, there is one further model which – as I touched on at the start of this chapter – progresses to a much more whole-bodied account of 'mental' dis/order. This **Body Systems** model leads towards a much more sophisticated and nuanced account of embodiment. Indeed, as touched on in the Introduction, embodied cognition, or the concept of the embodied mind, developed within cognitive science, situates the brain within a systems theory of biology and, thus, cognitive processes stretch beyond brain matter towards an organism's sensory-motor systems as well as in relation to the environment.⁷⁹ A **Body Systems** model exposes the **Brain Disorder** model as an internalised theory; one that neglects the fact that the brain is situated – it is embodied.

⁷⁷ Scheper-Hughes and Lock, p.10.

⁷⁸ Andrew D. Wilson and Sabrina Golonka, 'Embodied Cognition is not what you think it is', *Frontiers in Psychology*, 4 (12 February 2013) p.58 <<http://dx.doi.org/10.3389/fpsyg.2013.00058>>.

⁷⁹ Fuchs and Schlimme, 'Embodiment and Psychopathology'.

When the embodied and extended model is applied to ‘mental’ dis/order it makes it impossible to say that ‘mental’ dis/order only lives in brain circuitry. Instead, the body’s ‘realisation of cognitive abilities’ and relation to the outside environment, mean that processes ‘external to the brain’ are ‘constitutive’ not only for ‘mental processes’ but also for ‘disordered, pathological mental processes’.⁸⁰ The original theories of the embodied mind (Varela et al, 1991)⁸¹ spawned a number of seminal articles and books by neuroscientists such as Antonio Damasio emphasising the close connection of ‘brain structures, whole body functions and aspects of the mind’.⁸² As a leading example, Damasio’s work on somatic markers and the emotions changes the shape of the relationship between mind and body. He argues that physical signals pre-empt the work of the ‘mind’; giving physical life and the emotions much more emphasis, as he suggests the importance of the visceral body that senses first before the brain makes its interpretation and produces a feeling of what has happened. Compared to the dustbin of the **Interacting mind and body** model, or the **Immaterial Thoughts** model, which barely pays heed to the function of the body, this is a much more complex form of understanding embodiment that has an interest beyond the brain.

Beyond the work of neuroscientists like Damasio, who remain largely focused on cognition and often siphon off physical response from subsequent cognitive interpretation, there are burgeoning fields of work underpinning a **Body Systems** model of ‘mental’ dis/order by suggesting more networked emphasis on the brain and its relationship with other body systems (for example the immune, endocrine, nervous, or digestive systems). As with the **Brain Disorder** model, the focus of this work (which constructs bodily functions and organs as holding much more than metaphorical value in mental life) has gained traction in scientific research and, more recently, has found

⁸⁰ Walter, p.15.

⁸¹ F. J. Varela, et al. *The Embodied Mind: Cognitive Science and Human Experience* (Cambridge, MA: MIT Press, 1991).

⁸² Fuchs and Schlimme, p. 570.

leverage in popular science/lay texts – in particular related to gut health and childhood experience. I turn to three specific examples of this – psychoneuroimmunology, the gut-brain axis and epigenetics – to suggest the ways in which the **Body Systems** model thinks about mental health beyond the head. These are huge and complex fields, and so this can only provide a very brief and cursory overview, but this work is important in establishing certain convergences around a **Body Systems** model and how some of this research is translating into practice and public understanding, and what this understanding does for different conceptualisations of mental health.

Psychoneuroimmunology (PNI) is the study of the connections between what it distinguishes as the mind (psycho), the nervous system (neuro) and the immune system (immunology).⁸³ In this work, it has been shown that the immune and nervous systems act in a ‘highly reciprocal manner’ and that ‘brain-to-immune interactions are highly modulated by psychological factors which influence immunity and immune system-mediated disease’.⁸⁴ The outtake is that ‘physical’ and ‘mental’ processes are collaborative – psychological feeling and experience is not cut off in its own separate world of the ‘mind’; it is influential and meaningful throughout the whole body. This field has now made specific connections to psychiatry and it has been proposed that there even might be a new term to define the field – ‘immunopsychiatry’.⁸⁵ As psychiatrist Carmine M. Pariante writes, in an article in the medical journal *Lancet Psychiatry*, in support of the definition:

it suggests that our brain no longer governs the immune system, but, on the contrary, that our behaviours and emotions are governed by peripheral immune

⁸³The Psychoneuroimmunology Research Society, <<https://www.pnirs.org/>> [accessed 10 July 2017].

⁸⁴T. Ziemssen and S. Kern, ‘Psychoneuroimmunology- Cross-talk Between the Immune and Nervous Systems’, *Journal of Neurology*, 254, supp. 2 (May 2007), 118–111.

⁸⁵E.T. Bullmore and M.E. Lynall, ‘Immunologic therapeutics and psychotic disorders’, *Biological Psychiatry*, 75,4 (2014), 260–1.

mechanisms. You cannot cure yourself of a fever by meditation, but fever can make you sad and grumpy.⁸⁶

This is what Pariante calls a ‘hierarchical shift’ – the brain is no longer in charge. Mind over matter is turned on its head.

In a similar vein, research into gut health considers that it is not the brain that rules the rest of the body, but that ‘an unhappy gut can be the cause of an unhappy mind’.⁸⁷ With this model, the top-down, body-as-object conceptualisation is undone as the brain is not transferring problems to the stomach because of depressed or anxious thoughts arising there; the gut is storing, remembering, feeling and ‘thinking’ in itself. Indeed, researchers are considering how a disturbance in the early life of the developing ‘gut microbiota can impact on the central nervous system and potentially lead to poor mental health outcomes’.⁸⁸ This research is not only examining aetiology but possible diagnostic and therapeutic interventions. Indeed, a review looking at the ‘microbiome-gut-brain axis’ has made links to how such work might target treatment future treatment for depression.⁸⁹

Epigenetics is a further developing frontier within biomedicine that dovetails with a **Body Systems** model of mental health and confirms the impact of life experiences on the whole system. At a broad-brush level, epigenetics is explained as:

Additional information layered on top of the sequence of letters [...] that makes up DNA. | If you consider a DNA sequence as the text of an instruction manual that explains how to make a human body, epigenetics is as if someone's taken a

⁸⁶ C.M. Pariante, ‘Psychoneuroimmunology or Immunopsychiatry?’ *The Lancet Psychiatry*, 2,3 (2015), 197-199 <doi:10.1016/S2215-0366(15)00042-5>.

⁸⁷ Giulia Enders, *Gut: The Inside Story of our Body's Most Under-rated Organ*, trans. by David Shaw (London: Scribe 2015), p.139.

⁸⁸ G. Clarke and others, ‘Priming for Health: Gut Microbiota Acquired in Early Life Regulates Physiology, Brain and Behaviour’, *Acta Paediatrica*, 103, 8 (August 2014), 812-19.

⁸⁹ Sarah Dash and others, ‘The Gut Microbiome and Diet in Psychiatry: Focus on Depression’, *Current Opinion in Psychiatry*, 28, 1 (2015), 1-6.

pack of highlighters and used different colours to mark-up different parts of the text in different ways. | [As a result] any outside stimulus that can be detected by the body has the potential to cause epigenetic modifications [...] from chemicals to lifestyle factors to lived experiences.⁹⁰

Rachel Yehuda, professor of psychiatry and neuroscience at Mount Sinai School of Medicine explains, in her work on trauma and epigenetics, that ‘something that happens to you generates a biological response’; things ‘lodge’ in our bodies. Yehuda argues that this can be seen in the effects of trauma. She explains that, when ‘cataclysmic’ events happen, people often say, “I’m not the same person. I’ve been changed. I am not the same person that I was.” Her epigenetic research has shown that this is because the environmental influence is so overwhelming that an enduring transformation is forced; biological systems are ‘reset and recalibrated’. Whereas medicine might have once thought that the body would bounce back like an ‘elastic band’ in a model of homeostasis, at the level of the ‘whole entire person’, Yehuda argues, this is not the case.⁹¹

The legacies and understandings of all of this (very different and complex) work are slowly translating into the public domain via the work of public health agencies and researchers, as well as through popular media and science writing. Public Health Wales recently commissioned research looking into the way that early life trauma affects neurological, immunological and hormonal development and its impact on future health.⁹² Ideas around ‘Toxic stress’ and ‘Adverse Childhood Events’ and their impact on

⁹⁰ Cath Ennis, ‘Epigenetics 101: A Beginner’s Guide to Explaining Everything’, *the Guardian*, 25 April 2014 <<https://www.theguardian.com/science/occams-corner/2014/apr/25/epigenetics-beginners-guide-to-everything>> [accessed 18 July 2017].

⁹¹ Rachel Yehuda, ‘How Trauma and Resilience Cross Generations’, *On Being with Krista Tippett*, online podcast, 30 July 2015 <https://www.onbeing.org/program/rachel-yehuda-how-trauma-and-resilience-cross-generations/transcript/7791#main_content> [accessed 10 July 2017].

⁹² Steven Morris, ‘Abused children more likely to be seriously ill as adults, says report’, *the Guardian*, 1 November 2016 <<https://www.theguardian.com/society/2016/nov/01/abused-children-more-likely-to-be-seriously-ill-as-adults-says-report>> [accessed 10 July 2017].

future disease have been made into a documentary film directed by a Hollywood film star and are increasingly reported in the national press.⁹³

The outcome of these very different systemic approaches is that responses once thought to be ‘psychological’ and thus (in dualist terms) not ‘physical’, and so manageable only by individual behavioural change, have a deep cellular imprint, which it is not possible to simply ‘get over’ by ignoring. As the **Brain Disorder** model has captured the attention of the public and harnessed a more physicalized understanding of ‘mental’ dis/order, this sort of research is capturing the public imagination but currently remains at the fringes of practice (there are few examples of practicing ‘integrative psychiatrists’ in the UK⁹⁴ as well as a British College of Integrative Medicine⁹⁵ and British Holistic Medical Association).⁹⁶ Returning to a point made in the Introduction from critical psychiatrists Bracken and Thomas, there is a way in which it might be perceived that this particular form of understanding (with the funding and prioritisation of biomedical research behind it), will become dominant and marginalise others understandings. Like all of the models presented here, it works with its own ‘assumptions, methodologies, values, and priorities’; formed from a materialist approach, focused on individual bodies, powered by a biological focus, rather than panning outwards to social issues.⁹⁷ It is not possible to look at any of these models without considering the factors that influence and shape their becoming and dissemination into popular understanding.

One of the interesting drivers behind the wider discussion around this model in popular and cultural material is its synergies with complementary and alternative medicine in terms of beliefs about whole body interactions. As Ruth Barcan explains,

⁹³ ‘Resilience: The Biology of Stress and the Science of Hope’ <<http://kpirfilms.co/resilience/>> [accessed 10 July 2017].

⁹⁴ Dr Richard Fry and Associates, ‘Integrative Psychiatry’ <<http://drfry.org.uk/integrative-psychiatry>> [accessed 10 July 2017].

⁹⁵ British College of Integrative Medicine, <http://www.integrativemedicine.uk.com/what_is_im.php> [accessed 10 July 2017].

⁹⁶ British Holistic Medical Association, <<https://bhma.org/>> [accessed 10 July 2017].

⁹⁷ Bracken and Thomas, p.219.

alternative therapies are ‘an increasingly popular new form of *cultural* practice bound up in new forms of bodily understanding and perception and new forms of selfhood’.⁹⁸ As Barcan continues, bodies ‘know, think, communicate and intersect in radical ways’.⁹⁹ These different ways of knowing about the body (beyond the body-as-object) – radically invested and involved in selfhood and not all directed from the thinking brain alone – lay a fertile ground for the popularised ideas about the **Body Systems** model. Indeed, the biomedical systems view of the body resonates with notions of the energetic body in alternative medicine – understood as a ‘set of unbounded bodies, most of which are invisible to ordinary perception’. These energetic layers are found in the ‘subtle’ body model that underpins traditional Chinese Medicine – including acupuncture – where the subtle energy is *chi* and yoga where the energetic life force is named *prana*. Barcan makes the point that the connection with biomedical **Body Systems** models is via their (albeit different) understandings of relationships within the body. The flow and exchange of information in body systems go deep into the DNA, moving around the body in constant process, and in ‘ebbs and flows’.¹⁰⁰ This sort of connection – between biomedical practice and alternative therapies – drives forward the transdisciplinary lens for this thesis, and resounds with the idea of a ‘diffractive methodology’ looking at constructive connection rather than conflict.¹⁰¹ Indeed, yoga and acupuncture both have their place in NHS practice and are an increasing focus in health research from cancer to depression. Yoga has been offered under social-prescribing schemes in the UK,¹⁰² and acupuncture is available in many NHS general practices, as well as the majority of pain clinics and hospices in the UK.¹⁰³

⁹⁸ Barcan, p.2.

⁹⁹ Barcan, p.3.

¹⁰⁰ Barcan, p.65.

¹⁰¹ Barad, ‘Meeting the universe halfway’, Chapter Two.

¹⁰² The King’s Fund, ‘What is social prescribing?’, 2 February 2017

<<https://www.kingsfund.org.uk/topics/primary-and-community-care/social-prescribing>> [accessed 10 July 2017].

¹⁰³ NHS Choices, ‘Acupuncture’, 22 August 2016

<<http://www.nhs.uk/conditions/Acupuncture/Pages/Introduction.aspx>> [accessed 10 July 2017].

Despite these synergies and connections, the divides remain driven by different interpretations of what constitutes evidence and knowledge. The NHS Choices page is keen to differentiate between ‘Western medical acupuncture’ and ‘Traditional acupuncture’ and is clear to demarcate for which conditions the evidence base affirmatively supports its use (migraines and pain).¹⁰⁴ This kind of attitude towards acupuncture speaks of what Barcan calls ‘incorporation’ rather than ‘opening out to other paradigms or other experts’.¹⁰⁵ The Western evidence based practitioner very much remains the ‘expert’ here and medical discourse dominates understanding and interpretation. Furthermore, among the formal medical associations set up to drive forward an agenda of integrative or holistic medicine, there is a message that they are now drawing away from their association with CAM fields by constructing their definitions of what ‘holism’ means and aligning themselves with the language of evidence-based biomedical **Body Systems** research.¹⁰⁶ As Ruth Barcan discusses, the concept of holism remains a challenging one; for so long the central tenant of CAM practice pulling together ‘full human functioning’ including social, emotional and biological facets and opposed to biomedical segmentation, but strongly critiqued. Sociologists have conceived of these practices as a mechanism for self-surveillance – and part of an increased medicalisation of social issues – or viewed them as ideologically problematic in appropriating Eastern traditions, or related to uncritical and universalist theories around the ‘natural’ and or the ‘human’.¹⁰⁷ While these issues cannot be easily reconciled, it is the aim of the next chapters of this thesis to build on some of the connections of these different discourses, and to suggest that these alternative ways of thinking about the body, might provide an entry point for thinking differently about mental health beyond the head, going beyond dualism.

¹⁰⁴ NHS Choices, ‘Acupuncture’.

¹⁰⁵ Barcan, p.15.

¹⁰⁶ British Holistic Medical Association, ‘The BHMA journey’, <<https://bhma.org/about/>> [accessed 10 July 2017].

¹⁰⁷ Barcan, pp. 24-25.

Before turning to the implications of these different models of ‘mental’ dis/order, I want to touch briefly on the way in which phenomenology connects with the **Body Systems** model, and how it has been used by critical medical humanities scholars to think about the embodied experience of illness. Havi Carel, for example, has put forward the idea of a toolkit of phenomenology for patients as a way to try and move beyond confining or limiting scripts for illness, which, she argues, are provided in contexts where illness experience is discussed.¹⁰⁸ This is a very different conceptualisation to that of a bodiless selfhood driven from the head. Indeed, Merleau-Ponty’s work *The Phenomenology of Perception* focuses on embodied knowledge; the importance of the body and its ‘being in the world’. The ‘body’ is the ‘core of existence and the basis for any interaction with the world’.¹⁰⁹ The body is not a fact like other things in the world because it is a vehicle through which that world is experienced. It, therefore, cannot be considered in the same way as an object or a mechanical thing because we ‘are’ our bodies; we do not just ‘have’ them.¹¹⁰ Indeed, Merleau-Ponty argues that the body has its own knowledge and its own way of knowing, which perceives, relates to, and makes sense of the world. This is not a matter of a separated mind or consciousness telling the body how to do things, but a deeply embodied knowledge.

Carel uses the work of Merleau-Ponty to suggest how the body is, ‘central to any notion of agency or subjectivity or achieving any goal’ and how illness impairs and affects this. Illness – Carel suggests – deepens the understanding of normal embodied experience. However, for illnesses like anorexia, the shift is complex, and the emaciated physical body contrasts with the lived experience of fatness.¹¹¹ Listening to, and valuing this embodied experience, might be able to contribute something radically different to understandings of ‘mental’ dis/order – something diametrically opposed to the medical

¹⁰⁸ Carel, ‘Phenomenology as a resource for patients’.

¹⁰⁹ Maurice Merleau-Ponty, *The Phenomenology of Perception*, trans. by Donald A. Landes (Paris: 1945; repr. Abington: Routledge, 2012), p.146.

¹¹⁰ Merleau-Ponty, p.204 and p.151.

¹¹¹ Havi Carel, *Illness: The Cry of the Flesh* (Durham: Acumen, 2008), p.29.

model with its dominant expertise. Indeed, in another example of a phenomenological, embodied interpretation of ‘mental’ dis/order, in a paper on body dysmorphic disorder (BDD), philosopher Katherine Morris suggests that some sufferers of eating disorders, ‘feel as if they are fat’ in a comparable way to how an amputee might, ‘feel as if he has a limb’. This is not a mind in the head, thinking floating, disembodied thoughts, but a mind very much embodied.¹¹² Some body-image activists might argue that ‘fat is not a feeling,’ but, in a reading that is grounded in the body’s position and interaction with the world, fat actually is a feeling – it is a bodily feeling with substantial form and meaning for the individual.¹¹³ Phenomenology starts to open up space where ‘mental’ dis/order might be understood as related to some kind of discord of bodily experience because the body cannot but be implicated in its account of being in the world. The body is not just an object to be dumped into from the head down, or relevant only because it ‘contains’ the brain, but because – as Merleau-Ponty argues – it is the ‘core of our existence and the basis for any interaction with the world’.¹¹⁴

The **Body Systems** model of ‘mental’ dis/order admits that the body as a whole is not a disconnected vessel or an object, and, in some ways, parts of the theories that underpin it create a sense that the body in itself is able to ‘think’. However, that ‘thinking’, is often still separated and split off from brain cognition, even at the same time as it demonstrates an implicit and explicit connectivity. This model takes us towards interesting convergences and spaces for transdisciplinary work to diffract and towards the meeting points and methods from historically conflicted disciplinary territories. However, to really engage with the meaning of embodied mental health, or to break out of the trappings of the ‘mentalistic vocabulary’¹¹⁵ there is a way in which – as

¹¹² Katherine J. Morris, ‘The Phenomenology of Body Dysmorphic Disorder: a Sartrean Analysis’, *Nature and Narrative*, ed. by Bill Fulford and others (Oxford University Press, 2003), pp.171-186 (p. 177).

¹¹³ Shape your Culture, ‘Fat is not a Feeling’, <<http://www.shapeyourculture.org.uk/?p=1616>> [accessed 17 July 2017].

¹¹⁴ Merleau-Ponty, p.146.

¹¹⁵ Aldo Mosca, ‘A Review Essay on Antonio Damasio’s *The Feeling of What Happens: Body and Emotion in the Making of Consciousness*’, *Journal Psyche*, 6, 10, (October 2000), p.2. <<http://www.theassc.org/files/assc/2468.pdf>> [accessed 18 July 2017].

feminist critic Iris Marion Young writes – ‘thematized bodies [...] analysed bodies or discourses about bodies as texts’ need to be truly ‘felt in the flesh’.¹¹⁶ I return here to the feminist materialist work gestured to in the Introduction (that provides a through-line for this thesis), which asks for an acknowledgement of the sensory and sensate intelligence of being. CAM’s blithe focus on an idealised holism might be conceptually problematic, but its alternative understandings of knowledge drawn from the body – and from body experiences themselves – provide a way through and beyond dualistic ideas and language. In the chapters that follow, I suggest that it is from some of these non-dualistic models that we might be able to garner a new language with which to think about the ‘body’ in less objectified ways.

The Implications of Crossing Models

Before moving on to consider a more useful and coherent model of embodied mental health that radically challenges dualism and implies a new structure for thinking about ‘mental’ dis/order, it is worth pausing on the implications of the contrasting models presented in this chapter. The conflicting positions (pitched within the models outlined here) that sit beneath the words ‘mental’ dis/order are powerful, and there is a great deal at stake in the linguistic markers attached to them. The discourses driving and funding the mental health agenda – public health, psychiatry, policy, biomedicine and neuroscience – shape and feed into public perceptions and understandings.

The latent dualism that underscores the terms ‘mental’ and ‘physical’ health cuts across all of these models to some extent. Even an arguably radically different **Body Systems** model struggles to disconnect from those terms. Complementary and alternative health practices despite their often ‘counterculture’ emphases have grown within a ‘neoliberal present’ and ‘consumer culture’,¹¹⁷ where the idea of self-

¹¹⁶ Iris Marion Young, *On Female Body Experience: Throwing Like a Girl and Other Essays* (Oxford: Oxford University Press, 2005), p.6.

¹¹⁷ Barcan, p.37.

responsibility and self-control are the dominant frameworks for understanding health and wellbeing. When it comes to ‘mental’ health, a neoliberal climate focused on personal responsibility assumes that people should be able to think their way out of a thought-based problem. Furthermore, the neoliberalist body project dissociates individuals from their object bodies as it teaches them ways to buy into modifications and improvements. Despite the interest in seeing mind and body as one, or investing in the idea that mental and physical health are deeply implicated, the cultural axiom to ‘listen to your body’ already inherently creates a split:

Me was a floating head [...] I began to see my body like an iPad or a car. I would drive it and demand things from it. It had no limits. It was invincible. It was to be conquered and mastered like the Earth herself. Vegetarianism, not smoking – all forms of disassociation – like planting a vegetable field on a freeway.¹¹⁸

As author and activist Eve Ensler suggests, in describing how she re-became her body after cancer, the typical model in Western culture is of a ‘floating head’ directing and mastering its dissociated, moving object body. This imprint of dualism affects how people want to be treated and how they understand treatment to work – so asking someone to take a perceived ‘physical’ treatment for ‘mental’ dis/order is confusing and contrary to their understanding. A lived dualist model means that people may observe their bodies, or exercise them, but will not see the movement as a part of their mental health, only something that separately and consequentially makes their mental health feel better.

The effect of the legacy of Cartesianism and biomedical clinical practice focused on individual anatomical structures has meant the loss of bodily integrity. Resultantly,

¹¹⁸ ‘Eve Ensler: Suddenly, My Body’, *TEDWomen*, online video recording, December 2010 <http://www.ted.com/talks/eve_ensler.html> [accessed 18 July 2017].

we are left with the idea of what anthropologists Scheper-Hughes and Lock call ‘the selfless body’.¹¹⁹ This is the ‘body as a project’; to be flattened or toned with diet and exercise and monitored and measured with health technology applications – biotech – in a biopedagogical imperative. The ‘mind’ is less well theorised as it hovers between the above models; it emanates from – or is related to – the brain, it is composed of thoughts, it is linked to language, it is largely considered an individual and internal property in either immaterial or material locations. N. Katherine Hayles in her book *How We Became Posthuman* considers how the body of liberal humanism is ‘possessed’ but ‘not usually represented as *being a body*’ [my emphasis].¹²⁰ Biopolitical power defines ideal neoliberal citizens as those who manage, monitor and track their owned bodies. It is my aim in gesturing here towards an alternate model of the Being-Body, to draw away from this emphasis by focusing on *being* not *possessing*. Indeed, the work of this thesis is to try and find some ways of conceptualising mental life as deeply enmeshed in physical life. This cannot be done by re-circling over all of the above arguments, or by admitting defeat and inserting some slashes and inverted commas around words, or adding ‘so-called’ before writing or speaking about mental or physical health.

Conclusions

In this chapter, I have examined the language and narratives of some of the main models of ‘mental’ dis/order. I have analysed some of the sources of these models, and how the language within and between the narratives they produce, falls back into splits and binaries and reproduces dualist understanding. I have considered how certain dominant discourses from medical, psychiatric and political spheres define how ‘mental’ dis/order is discussed and the implications of the divergent understandings of what is meant by the ‘mental’ of ‘mental’ dis/order do to people trying to understand and locate their own

¹¹⁹ Scheper-Hughes and Lock, p.22.

¹²⁰ N. Katherine Hayles, *How We Became Posthuman: Virtual Bodies in Cybernetics, Literature, and Informatics* (Chicago: University of Chicago Press, 1999), p.5.

distress. In this closing section of the chapter, I suggest that language is a particular problem – not only in naming ‘mental’ and ‘physical’ disorders as separate – but in focusing on narrative as a way of dealing with the problematic thoughts of ‘mental’ dis/order in a dualistic paradigm.

When a person is engulfed by trauma; in a prickly, edgy state of anxiety or feeling heavy, languid and depressed, or starving and divided; when too much is happening in the head and there is a feeling of bodiless-ness, these sensations are not ‘just thoughts’, they are not all able to be addressed by ordered words. Language plays a huge role not only in naming, defining and diagnosing but also in treating mental illness. Talking therapies are a keystone in the treatment of many mental illnesses. However, language has become very detached from an embodied context in its association with particular functions of the brain, and with the research focus, in particular, on inner speech, which turns language inside, and localises it.¹²¹ Narrative accounts of ‘mental’ dis/order are not just confined to the discourse of government policy and public health but are increasingly shared by service users, disseminated in online spaces, and popularised in memoirs and media articles. As argued in the Introduction, scholars in the field of the medical humanities have turned to narrative as a way to reclaim the intimate and individual experience of the patient against the powerhouse of reductive biomedicine. Borrowing from, supporting, and replicating the models of ‘mental’ dis/order in this chapter, narratives of personal experiences of mental illness, as well as fictional representations, offer up an insight into ‘thoughts’ from the head. Language is modelled in a Cartesian framework as uniquely positioned to draw upon those thoughts, and often analysed as taking the shapes of overcoming, healing or battling disorder in agentic, self-actualising terms. Narrative is powerful and speaking and opening up is considered

¹²¹ McCarthy-Jones and Fernyhough, ‘The varieties of inner speech’.

healthy and cathartic. However, arguably the emphasis on language feeds the mind over matter model, which separates words and thoughts from the flesh.

In Chapter Two, I consider how the dominance of narrative and language (both in personal accounts, in therapeutic responses to mental illness and in medical humanities criticism) might reinforce a model of individual, internalised, narrated self-management of 'mental' dis/order. In doing so, I find a number of problems in the reliance on words which – despite attempts to foreground the experiential end up being drawn back into the expert medical discourse – trapped in the language of 'mental' illness, which confines and boundaries experience and attaches sensory or corporeal experience to symptoms alone. As I move through the next chapter and towards Chapters Three and Four, I start to argue that words and language do not have to be set in opposition to concepts of the body but can draw close to it, emanating with breath, gesture and, sound, vibration and pulse. Coming back to the depth and three-dimensionality of Elizabeth Grosz's notion of embodied subjectivity, I aim to reconnect language with physicality and materiality. In doing so, I intend to challenge the dualistic understanding of 'mental' dis/order, as thoughts dropping in vertical lines from head to 'body' as the dominant models of this chapter have problematically consolidated and continue to reproduce.¹²²

¹²² Grosz, *Volatile Bodies*.

Chapter Two: Narrating 'Mental' Dis/order: 'Anxiety in the soles of my feet'

One woman said depression was like 'a black pit', another said it was like 'a million bees buzzing' in her head. One man said it was like 'trying to run through treacle.' Still another man said it was like 'rotting in the depths of hell.' A number of people described the way they felt totally cut off from their feelings and from other people'. It was like being 'locked in' and isolated behind Perspex or 'inside a very thick balloon' [...] People had trouble knowing anything solid about themselves during depression. One man described it as if 'your whole self gets put into the mixer and could come out in any old form'.¹

Chapter Aim and Summary

In this chapter, I think through the tight-knitted relationship between mind, 'mental' dis/order and language, and the well-developed argument in the medical humanities that language – specifically in the form of narrative – conveys, unpacks and represents experience. I pay close attention to how these understandings serve to reinforce the concept of mind over matter, and how the primacy of narrative might be problematic in certain dis/orders where narrative is somehow linked to the experience of distress itself. I build on the questions of the anti-narrative or post-narrative positions raised by some medical humanities critics, to suggest that attributing too much power to the potential for narrative to cross boundaries between patients and clinicians, to 'truthfully' represent experience, or to act as a healing agent needs to be questioned and critiqued.² I do not suggest that we give up on language in its entirety, nor do I deny that telling stories can

¹ Healthtalkonline, 'Depression', *HealthTalk.org* <<http://www.healthtalk.org/peoples-experiences/mental-health/depression/experiencing-depression>> [accessed 10 July 2017].

² For example, 'Angela Woods, 'Post-narrative – An appeal', *Narrative Inquiry*, 21 (2011), 399-406 <<http://dro.dur.ac.uk/8918/1/8918.pdf?DDD45+DDC51+DDD24+dac4ss1>> [accessed 11 July 2017].

be helpful and therapeutic in many cases. However, I suggest that we must be careful not to unintentionally reinforce a dualism by over-emphasising the power of narrative. This doesn't mean a flight from language altogether, but a much more critical position vis a vis the primacy that narrative takes in medical humanities criticism and in clinical practice itself.

I consider where there might be space for writing about 'mental' dis/order which does not objectify the body. I will look at two broad areas. First, I will discuss contemporary mental illness memoirs and the sorts of dominant shapes and scripts that are emphasised here (drawn from the leading models described in Chapter One) leaving little room for an embodied context for mental health. In once again reaching an impasse in the language that divides mental and physical health, and the overriding dualist principle of mind over matter, I then turn to modernist texts, which in their 'experimental and non-realist modes' are able to offer a very different model for representing illness in language.³ I consider how selected texts from this period – by Jean Rhys, Virginia Woolf and Emily Holmes Coleman – write about 'madness' without a top-down objectified stance on the body. I excavate how the embodied, unruly woman is a problem and how bodily acts become subversive ones by defying the confining shapes set for them by medical discourse. I discuss how these texts foreground the palpable materiality or physicality of 'mental' dis/order. Furthermore, I start to develop the idea – drawing from these literary works – that other registers of experience outside of narrative (sound, music, dance, for example) can tap into, intuit and represent embodied experience.

When examining literary sources, once again, I embed my work within a literary critical medical humanities frame, which is – as Whitehead and Woods set out – 'concerned more with opening up new perspectives on the history of ideas (including about the nature of mind, imagination and affect), and examining in detail the aesthetic

³ Salisbury, 'Aphasic Modernism'.

and narrative strategies through which literary texts model cognitive and affective processes', rather than using literary texts as a window into the illness experience, for therapeutic value, or as an educational, humanistic endeavour.⁴ I understand this approach to literary texts to prioritise the contexts that are being underlined in these representations, rather than a way through which subjective experience can be re-inserted into medical understanding.

Psychiatrist Femi Oyebode articulates how manifestations of distress change over time; so how distress is signalled in terms of signs and symptoms is not a constant (he points towards early twentieth-century hysteria and early twenty-first-century anorexia to illustrate this). Resultantly, what is used to represent that distress alters too, and how a text indicates to its reader that it is talking about 'mental' dis/order moves within the culture of its production.⁵ I suggest Oyebode's theory also resonates with different narrative forms because how narrative represents the experience of 'mental' dis/order is dependent on the shapes promoted or prioritised by the dominant discourses or available models of literature at the time. Specifically, for my research question embedded in a contemporary UK context, the very fact that 'mental' dis/order is interpreted, diagnosed and re-told first and foremost in narrative terms is important. In this chapter, I consider how this absolute emphasis on narrative might be damaging or oppressive, re-articulating mind and body divides.

I do not aim to negate the power of narrative altogether but to be more cautious about its ability to heal and help and to thicken it with other sensate and sensitive understandings. It would be foolish to dismiss a century and more of therapeutic approaches offered in talking therapy or the research supporting them. This is not the idea here, but to suggest some spaces where this emphasis is troubled in relation to

⁴ Whitehead and Woods, 'Introduction', p. 17.

⁵ Femi Oyebode, 'Madness at the Theatre', *Beckett and Brain Science workshop*, 18th September 2012, University of Warwick, audio recording <<http://www2.warwick.ac.uk/fac/arts/english/research/currentprojects/beckettandthebrain/warwick/>> [accessed 18 July 2017].

dis/orders that are disturbed by words. In the case of anorexia nervosa, for example, narrative overrides body in such a way that the notion of mind over matter is problematically re-inscribed. Depression often causes a sinkhole in external language but causes deep, troubling narrative rumination. Furthermore, I seek to extinguish the binary of word versus body, or written expression against other expressive forms. A full range of expression is necessary to reflect the full palate of human experience. Language (more readily when taken apart from constricted narrative templates) can reflect and draw upon other textures, movements and embodied feeling beyond the linearity and control promoted in strands of illness narrative criticism.

This chapter takes forward the questions of the thesis to understand the relationship between narrative and mind over matter dualist ideas. It gestures towards the chapters which follow that seek to insert fully embodied experience back into an understanding of mental life, and how this might include but exceed linguistic forms. It suggests that narrative can only take us so far. In keeping representation and articulation to constructed and shaped narrative forms, a disembodied expression of ‘mental’ dis/order continues to rule.

Narrative Power: A Medical Humanities Approach

In a first-person narrative about her experience of anorexia nervosa, journalist Habiba Khanom describes how she was asked in therapy to write a letter from her body to her ‘self’.⁶ Khanom publishes the letter in her newspaper column and ends it thus:

You only have one body. Please don’t hurt me anymore. Please please take care of me. Haven’t I been tortured enough?

Lots of love,

⁶ Habiba Khanom, ‘Anorexia: A Letter from my Body’, *Huff Post*, 14 February 2017 <http://www.huffingtonpost.co.uk/habiba-khanom/anorexia-a-letter-from-my_b_14692188.html?> [accessed 10 July 2017].

Your body

Khanom's letter appears to maintain this split between her 'self' and her 'body' as she writes from one to the other, but there is a further division which she also invokes between her 'self' and anorexia. She writes: 'I know anorexia was the one who made you do those things. But you are better than that.' Khanom's injection of a split between her 'mental' dis/order and her 'self' resonates with approaches from narrative therapy. Therapists using this approach help eating disorder clients to create alternative and separate stories for themselves against the anorexia, which is positioned as an invader or intruder.⁷ Placed into a narrative structure, the 'self' is rearticulated in words. In this example, anorexia is pushed into a corner, away from what is pieced together as the 'self', which is located in the mind and within the words in the head. This therapeutic approach reflects the wider prominence of illness narratives as cathartic, able to pull order from chaos, or providing access to a renewed sense of identity.

Narrative has come to have a powerful place in medical humanities scholarship. As Catherine Belling writes, 'The humanities have, in their application to medicine, become almost synonymous with narrative'.⁸ Angela Woods takes this further, suggesting that the field has been 'under the thrall of narrative'.⁹ In explaining this synonymy, in a chapter on narrative in *The Edinburgh Companion to the Critical Medical Humanities*, Brian Hurwitz and Victoria Bates explain that it has emerged as a valuable response to a 'confusion of tongues' between doctor and patient (each of which speaks a different language) and has been essential in countering hegemonic discourses by focusing on individual subjective experiences.¹⁰ Narratives in the clinic are those told by

⁷ M. White and D. Epston, *Narrative Means to Therapeutic Ends* (London and New York: W.W. Norton & Company, 1990).

⁸ Catherine Belling, 'A happy doctor's escape from narrative: reflection in *Saturday*'. *Medical Humanities*, 38 (2012), 2-6.

⁹ Woods, 'Post-narrative - An appeal'.

¹⁰ Victoria Bates and Brian Hurwitz, 'The Roots and Ramifications of Narrative in Modern Medicine' in *The Edinburgh Companion to the Critical Medical Humanities*, pp. 559-576.

patients communicating their experiences to health care professionals and are re-formed by medicine and psychiatry in case reports. Beyond communication in the clinic, narratives of illness circulate widely – in memoirs, on social media and blogs, in qualitative research – contributing a personal and apparently subjective voice against reductive biomedical discourse. More broadly still, a narrative turn in the humanities and social sciences has linked narrative to the ability to give meaning to experience, as necessary for identity formation, and as a universal and omnipresent activity – as narrative scholars have asserted that everything is a narrative or requires a narrative to be represented.¹¹¹²¹³ Illness has been analysed as rupturing this story-making, but overcoming that temporary fracture with words sees a person triumphant, successful over their chaotic experience and returned to their former (if somewhat altered) self.¹⁴ Sociologist, Arthur Frank's influential account of illness narratives suggests that telling one's story is a form of testimony and that it is the patient's job to make that story a 'good' one.¹⁵ Anne Hunsaker Hawkins, in her book *Reconstructing Illness: Studies in Pathography*, feels that the written form of illness narrative should strive for clarity, purpose and order. She writes that narrative form gives experience 'a definite shape', and writing what she calls a 'pathography' (an illness story), involves 'an individual's mastery of a set of circumstances'. It is, she claims, '[the] act of constructing' [illness experience] 'into a coherent whole'.¹⁶ Narratives master, order and sort thereby providing explanation and guidance to what is a confusing and self-altering experience.

The same argument is applied to narratives of 'mental' dis/order. Public Health academic, Deborah Flynn – thinking specifically about depression – argues that narratives assist those diagnosed with mental illness to maintain or reclaim previously

¹¹ Marya Schechtman, *The Constitution of Selves* (Ithaca, NY: Cornell University Press, 1996).

¹² Rita Charon, *Narrative Medicine: Honoring the Stories of Illness* (New York: Oxford University Press, 2006).

¹³ Jerome Bruner, *Making Stories: Law, Literature, Life*. (New York: Farrar, Straus and Giroux, 2002).

¹⁴ Arthur Frank, *The Wounded Storyteller: Body, Illness, and Ethics* (Chicago: The University of Chicago Press, 1997).

¹⁵ Frank, p.60.

¹⁶ Anne Hunsaker Hawkins, *Reconstructing Illness: Studies in Pathography* 2nd edn (West Lafayette: Purdue University Press, 1999), p.25.

established notions of self.¹⁷ In a straightforward analysis of the illness narrative, it might be argued that the embodied experience of dis/order can be articulated in words; that the subjective, affective, physicalized experience represented in narrative form does something to answer back to the discourses of Chapter One. The notion of narrative as subjective insertion is a powerful one; it motivates people to speak up, and speak out. It is an attempted reclamation of experience from psychiatric criteria and labelling.

The healing and transformative power of words for mental illness, of course, has deep roots in the past century with Freud's development of psychoanalysis and the influence of psychodynamics on psychiatry. Talking therapies remain a key part of treatment for many 'mental' dis/orders.^{18 19} This notion within the clinic that talking is cathartic and healing arguably underpins the idea that narrative is needed to think through and articulate suffering more broadly. Certainly, in terms of campaigning and activism around 'mental' dis/order, a great deal of emphasis has been put on talking about, discussing and narrating experience to diminish stigma. The circulation of narratives has been given powerful ethical weight – to narrate is to open up, to counter stigma and misunderstanding and thereby to make a personal (and indeed political) change. The emphasis on the inequities in mental and physical health in funding, policy and practice has led to a seemingly louder and more vocal presence from mental health campaigners and mental health service users, who aim to break the silenced position 'mental' dis/order has commonly held. The mental health awareness movement 'Time for Change' holds a national 'Time to Talk' day.²⁰ These things are linked. Talking is change. Narrative is power. Personal experience tells all.

¹⁷ Deborah Flynn, 'Narratives of melancholy: a humanities approach to depression', *Medical Humanities* 36 (2010), 36-39 (p.37).

¹⁸ Mental Health Foundation, 'Talking Therapies' <<https://www.mentalhealth.org.uk/a-to-z/t/talking-therapies>> [accessed 11 July 2017].

¹⁹ NHS Choices, 'Benefits of Talking Therapy' <<http://www.nhs.uk/conditions/stress-anxiety-depression/pages/benefits-of-talking-therapy.aspx>> [accessed 11 July 2017].

²⁰ Time to Change, 'National Time to Talk Day', February 2017 <<http://www.time-to-change.org.uk/about-us/about-our-campaign/time-to-talk>> [accessed March 2017].

Narrative is so entrenched, and often unquestioned, as the method of both understanding and describing experiences that a question may occur as to what else would be possible to help people engage with and communicate their experiences, especially those classified as 'mental' experiences with their link to internal thought and language. Indeed, some narrative proponents suggest that every experience, at some point, requires narrative representation to be externalised, even if at first it is presented in corporeal or visual terms.²¹ In this way, such critics argue that in order to communicate humans require narrative, in order to make sense of our selves we need narrative: narrative becomes a defining characteristic for selfhood – for expressing, representing and understanding who we are. Leading this line of thought, philosopher Marya Schechtman argues that, 'a person creates his identity by forming an autobiographical narrative – a story of his life'. In her 'narrative self-constitution view' of selfhood, Schechtman draws on two sets of ideas. The first is that 'persons are self-creating' and the second is that 'the lives of persons are narrative in form'.²² In the next section of this chapter I suggest that this assumption is limiting; articulating a view of subjectivity led entirely through self-determined mind over matter; narrative here is internalised, individual, shorn from the world and reducing everything to ordered forms of language.

Narrative Limits

In a challenge to the narrative focus within medical humanities scholarship, questions have been raised as to whether narrative and its link to selfhood and improvement or self-knowledge might be damaging and even oppressive, failing to take account of other non-storied ways of being. Angela Woods questions the assumptions: 'Tell us your story, because it is true (to the human condition), because it is yours (an authentic expression

²¹ Claire Charlotte McKechnie, 'Anxieties of communication: the limits of narrative in the medical humanities', *Medical Humanities*, 40 (2014), 119-124.

²² Schechtman, p. 93.

of your individual experience), and because it is good for you (as part of the healing process).²³ I will use Woods' questions here to start to think through the way in which narrative forms dominate and shape mental dis/order, and how the emphasis on narrative might be potentially problematic and even dangerous in some cases.

Woods raises questions over how narrative is presumed to access – to act as a window to – internal subjective truth. Carel expands on this idea arguing that 'even in contexts where illness experience is discussed (e.g. support groups, online patient fora, 'pathographies') dominant and culturally specific approaches to illness provide a script for the ways illness "should" be experienced'.²⁴ It is clear that patient experience and engagement has shifted up the health agenda in health research and that experience is often relayed in the form of words. In one example, a growing website or 'patient fora' *Healthtalk.org* 'provides free, reliable information about health issues, by sharing people's real-life experiences' and allowing people to voice their stories. The mental health section has funding support from the Department of Health. In the opening long quotation of this chapter, taken from the website, patients' words are used to articulate the discombobulation of depression. While these words usefully present the corporeal, all-encompassing nature of depression, which is hardly limited to metaphysical spaces, these 'free', 'reliable' and 'real-life' stories have arguably been subsumed back into medical discourse – becoming part of a health website funded by a government department. These testimonies may not be as reliable and real as those who give them think, or those who reproduce them claim, as they are shaped by the aims and objectives of research and the research questions being asked – the boundaries set by the researcher, to research the categories or criteria of the 'mental' dis/order. Indeed, reliability is a troubling concept when it comes to narrating illness or disorder.

²³ Woods, 'Post-narrative' <<http://dro.dur.ac.uk/8918/1/8918.pdf?DDD45+DDC51+DDD24+dac4ss1>> p.4.

²⁴ Carel, 'Phenomenology as a resource for patients'.

Those who choose to write books about ‘mental’ dis/order may find themselves speaking to texts and ideas already written and circulated; a memoir is not an isolated individual act, but one replicating and fitting in with existing examples. As humanities scholar Rebecca Garden rightly illustrates, a book is not a straightforward articulation of experience packaged into words.²⁵ Books about mental illness speak to those that have gone before them (often making explicit reference to those texts);²⁶ they are moulded and often altered by editors and publishers, and they are often asked (either explicitly or unconsciously replicating the narratives around them) to take preferred forms all of which might translate an initial account into something very different. Author David Adam explains in his account of obsessive compulsive disorder (OCD) that when he was initially offered Prozac for his illness, ‘Elizabeth Wurtzel’s best-selling account of her depression, *Prozac Nation*, had made those little green and cream pills almost a fashion accessory.’²⁷ A narrative of personal experience represented (and at the same time enabled and made acceptable) taking a pharmaceutical drug for mental illness. Narratives of subjective experience are involved in what Susan Sontag describes as a ‘struggle for rhetorical ownership’.²⁸ It is difficult to articulate an inner sense of ‘mental’ dis/order without drawing upon other references or metaphors that have already been used. As critics of narrative have posited, there is no unmediated raw experience, which is then produced into words, and seen through a clear window.

In the two memoirs that I draw upon here as contemporary examples of narratives about mental illness, (*Reasons to Stay Alive* by Matt Haig and *The Man Who Couldn’t Stop* by David Adam), references to other narratives are peppered throughout the texts; structurally underpinning the exploration of personal experience. These

²⁵ Rebecca Garden, ‘Telling stories about illness and disability: the limits and lessons of narrative’, *Perspectives in Biology and Medicine*, Winter, 53 (2010), 121-35.

²⁶ Emma Seaber, ‘Reading Disorders: Pro-Eating Disorder Rhetoric and Anorexia Life-Writing’, *Literature and Medicine*, 34, 2 (2016), 484-508.

²⁷ David Adam, *The Man Who Couldn’t Stop* (London: Picador, 2014), p.186. Further references to this edition are given after quotations in the text.

²⁸ Susan Sontag, *Illness as Metaphor and AIDS and its Metaphors* (New York: Anchor Books, 1989), p.181.

different texts recount what are palpably different experiences, and it is not the intention here to give a detailed reading of them, but to suggest that the features and structures of these texts tell us something about the way in which ‘mental’ dis/order and narrative fit together, and how ownership of a neuro-model of selfhood is addressed.

The review of Adam’s book in the London newspaper the *Evening Standard* coins the phrase ‘neuro-memoir’ for this type of writing that blends ‘brain-science and personal history’.²⁹ Personal and biological narratives are woven together within the cultural context of a rising neurobiological basis for mental illness. Matt Haig’s bestselling book – a memoir about depression – is a story that is also constructed between a wide range of contemporary cultural and scientific references. He cites publicly-successful bestselling texts such as Ben Goldacre’s *Bad Science*. He cites other people’s mental illness memoirs (including David Adam’s). He cites statistics from the World Health Organisation, national newspapers and mental illness charities. He draws on Tweets from members of the public, and the research theories of evolutionary psychologists. Haig’s sources suggest the bio-social context for 21st-century personal experiences of ‘mental’ dis/order, which can never be wholly inner or uniquely internally subjective because they are a part of an age of technology that diffuses and circulates theories about ‘mental’ dis/order like particles in the air.

These books re-create the narratives gone before them, and add their own stories to debates about ‘mental’ dis/order. The reviews for Adam’s *The Man Who Couldn’t Stop* praise the way in which Adam has such a scientific approach to writing about a personal experience. The *Literary Review* applauds Adam’s ‘humour and detachment’ and *The Sunday Times* argue that Adam is ‘uniquely placed’ to examine mental illness because of his background as a science writer and editor at the journal *Nature*.³⁰ Adam’s memoir is

²⁹ Melanie McGrath, ‘When worry consumes our whole being’, *Evening Standard*, 10 April 2014 <<http://www.standard.co.uk/lifestyle/books/when-worry-consumes-our-whole-being-9251181.html>> [accessed 11 July 2017].

³⁰ David Adam, Book jacket reviews.

as thick with historical narratives, articles and scientific research as it is with his own story. Indeed, this is an attempt to explain, justify and elucidate obsessive compulsive disorder as much as it is to write out his personal experience among complex and opposing contexts and a 'mass of vague terms and a mess of overlapping meanings' (p.61). In a contemporary context, ordered narrative, scientific form and empirical explanation are favoured over narrative experimentalism. The neuro-memoir puts together fragmented subjective experience with grounding, objective material.

The complexity of the relationship between narrative and truth has powerful implications, as readers may be emotionally invested and looking for templates, guidance or advice to relate to – or deal with – their own experiences. Within medical humanities criticism, illness narratives have been analysed as a space in which to overcome, order and control. For Arthur Frank, illness is a state of narrative chaos and wreckage, and new ordered stories are needed as therapy to draw experience towards meaning.³¹ Indeed, the type of healthy narrative shape emphasised has been one of reconciliation, sense-making and continuity. As literary scholar Shlomith Rimmon-Kenan points out, in contemporary post-modern times, 'when fragmentation is both prominent and valorised in postmodern writing, it is strange that illness narratives tend to preserve, even strive for, coherence and continuity'.³² However, in a culture where 'Get Well' continues to be the answer to illness and 'recovery' is a key term for mental health, the imperative to be mended arguably thwarts other kinds of stories or emphases.³³ As Rimmon-Kenan explains, when it comes to published first-person accounts: 'publishers tend to favor the nonfragmentary, for reasons of intelligibility, but also because coherence is likely to be interpreted as a sign of control or mastery, and readers usually

³¹ Frank, 'The Wounded Storyteller'.

³² Shlomith Rimmon-Kenan, 'The Story of "I": Illness and Narrative Identity', *Narrative*, 10,1 (2002), 9-27 (p.19).

³³ Andrea LaMarre and Carla Rice, 'Normal Eating Is Counter-Cultural: Embodied Experiences of Eating Disorder Recovery', *Journal of Community & Applied Social Psychology*, 26, 2 (March/April 2016), 136-149 <<http://dx.doi.org/10.1002/casp.2240>>.

prefer stories of triumph'.³⁴ Fragmentation is threatening and does not provide the answers or explanations, which are favoured in a culture where mind can solve the problem of unruly matter. A conservative model with a linear approach to getting better and managing and resolving problems is a perfect neoliberal cultural fit in terms of mind over matter, self-control and self-determination. If readers want to see weakness and raw, unmediated language, they also want to see that there is a way beyond this; that there is recovery and an afterward.

In some narratives, the idea of salvaged chaos, of doing good and of clarifying subjectivity in recovering from a 'mental' dis/order, is problematised because of the nature of that dis/order. Anorexia nervosa provides a case here of troubled narrative, because of its attached notions of contagion and transmission through words. Medical humanities scholar Emma Seaber, in a paper on how the rhetoric of a pro-eating disorder culture feeds off anorexia life-writing, suggests that:

there does appear to be a special relationship between particular writing and reading practices and anorexia identity formation and maintenance for some readers with a predisposition to eating disorders. Certain experiences and accounts of anorexia [...] seem to rely upon peculiar ways of approaching, producing, and consuming written texts.³⁵

In this way, narrative (reading the narratives of other anorexics) may be actively damaging as it propagates (albeit unintentionally on the part of the author) the dis/order. Seaber uses the example of the bestselling anorexia memoir *Wasted* by Marya Hornbacher as an example of how a book becomes an object of 'devotion' for anorexia nervosa patients looking 'to exacerbate their anorexic thoughts and behaviors'; arguably

³⁴ Rimmon-Kenan, p.22.

³⁵ Seaber, p. 465.

anorexics may feed their anorexia with narrative.³⁶ Thus, while Woods questions the notion that narrative will always alleviate suffering, instead foregrounding its potential capacity to ‘harm and hinder’, I suggest that anorexia provides an especial example of this potential.³⁷ Indeed, while narrative may be co-extensive with the notion of control and order – and while these can be potentially empowering and self-determining concepts – words may also (more troublingly) be twisted and over-emphasised, problematising the concept of embodied subjectivity.

Language, in Cartesianism, is a ‘mental’ attribute, not a bodily one; it directs from above.³⁸ Arguably, in reinforcing the importance of words, in both the clinic and in the context of scholarship, which seeks to understand and analyse personal experiences of ‘mental’ dis/order, this may unwittingly replicate the form and shape of the illness itself, which thrives in words or obsessive thoughts. Indeed, a question arises as to whether this ‘urge to narrativize overrides the invitation to “rebody yourself”.’³⁹ This can be seen once again in the example of anorexia. Literary scholar Gillian Brown analyses anorexia as an extreme enactment of ‘liberal humanism’ with its focus on individual self-control. She argues that the anorectic’s struggle to ‘decrement’ the body is possible because the body is seen as something that can be mastered and directed from the head, as opposed to being recognised as inextricable part of being.⁴⁰ Anorexia festers and grows in the gap between mind and body; in the ideal of mind over matter. Eventually, existence is driven only from within that ‘mind’. It is commonly reported that an anorexic ‘voice’ takes over in the head, commanding further self-starvation.⁴¹ Words are on the attack. Eventually, existence is driven only from within that restricted ‘mind’ of self-sabotage and embodied recovery becomes an elusive concept.

³⁶ Seaber, p.485.

³⁷ Woods, ‘Post-narrative’.

³⁸ Salisbury, ‘Aphasic Modernism’.

³⁹ Barcan, p.85.

⁴⁰ Gillian Brown, ‘Anorexia, Humanism, and Feminism’, *Yale Journal of Criticism* 5,1 (1991), 189-215.

⁴¹ Williams and Reid, ‘It’s like there are two people in my head’.

Haig's account of depression suggests his own severance between thought and body. Depression causes him a profound sense of self-alienation and 'derealisation' (p.157); he writes that his 'physical body seemed unreal and abstract and partly fictional' (p.134). Even Haig's own body becomes a sort of narrated 'fictional' abstract object. He describes this is like, 'you are controlling your body from somewhere else' and that 'the centre that is you has gone' (p.158). *Reasons to Stay Alive* suggests the stark result of the dualist split; ravaging thoughts overtake and the objectified and controlled 'body' is left hanging, it is a mere symptomatic vessel that is hardly involved in 'being' at all. While it may generally be the case that sensory experiences can be excavated with verbal or text based responses (even if those responses are not fully fledged narrative articulations), if a sensory understanding of the world has been suppressed by the disorder itself, then perhaps there is an inarticulacy because illness has effaced the corporeal.

This idea draws to the surface further potential for narrative harm. In the experience of a 24/7 voice on loop in anorexia, or in rumination, which is said to be a feature of depression, or with the obsessive drilling of thoughts in OCD, there emerges the inescapability of overactive churning narrative and the constant battle with a headful of words. In this way, as Rimmon-Kenan argues, telling and writing 'both may sometimes be entrapments in the chaos they tell' and, in these forms of intense distress, may be viewed a sort of internal imprisonment 'an issueless re-enactment of traumatic events, it narrates (or fails to narrate).'⁴² If this is the case, then, as Woods rightly questions, we need to interrogate whether narrative should 'remain the privileged form for the interpretation or restitution of that self-experience.'⁴³ Both Adam and Haig touch on the power and pain of worded thoughts. Adam's text opens with a quote from an unknown source:

⁴² Rimmon-Kenan, p.23.

⁴³ Angela Woods, 'The limits of narrative: provocations for the medical humanities', *Medical Humanities*, 37 (2011), 73-78, (p.75).

Watch your thoughts, for they become words.

Watch your words, for they become actions.

Watch your actions, for they become habits.

Watch your habits, for they become character.

Watch your character, for it becomes your destiny.

This is a model of 'mental' dis/order that is very much top-down, from thought into language into action and into being. Adam's text is immersed in addressing the depth and despair of his compulsive thoughts turned into potent and self-destructive language. Narrative struggles to access the body or embodied feeling in such a vertically ordered plane of existence.

Body-Mind-Brain

In Chapter One I considered how neuroscience has come to dominate understandings of mental health, with brain-based vocabularies widely disseminated into public consciousness. Mental health service users negotiate and move between these vocabularies, and those of psychology, to articulate their problems. When it comes to depression – for example – Deborah Flynn explains how 'shifting ideas', confound the experience, expression, and ultimately the treatment of depression'.⁴⁴ Changing scientific paradigms concerning the cause and course of depression, as well as changing attitudes and beliefs both about depression and those experiencing depression, contribute to this lack of clarity. These conflicting models are pronounced in the texts by Adam and Haig. Haig's memoir offers an insight into the problem of the language of 'mental' dis/order. His book takes his experience of depression and threads it through with the contemporary biomedical explanations for his illness. Throughout the text, Haig jostles with the competing physical and mental aspects of depression. He openly struggles with

⁴⁴ Flynn, p. 37.

how to fit together what brain science owns and claims about depression and the corporeal feelings that often overpower him: the panic wherein his hands are shaking, his heart is 'beating too fast' and he struggles to speak – a feeling he likens to a 'flood' (p.24). The opening page sets up the neurobiological model. Haig explains that, at the beginning of his health issues, he felt an initial sort of 'pulsing or intense flickering', what he interprets as a 'biological activity' at the rear of his skull. He identifies this place as 'the cerebellum' and continues, 'I did not yet know of the strange physical effects depression and anxiety would create' (p.9). Haig takes the biomedical brain disorder discourse and connects it up with his flickering sensation; this is not a subjective narrative set against objective facts, but interplay between the two.

Throughout the text, Haig draws back to the corporeal symptoms including 'a kind of near-aching, tingling sensation' in various parts of his body (p.46) and 'an inner trembling' (p.47); he describes how his tears 'came from [the] gut, [the] stomach' (p.57). Time and again, Haig reaches to the incongruity of the 'physical aspect' of 'mental' dis/order. When he draws upon metaphors, it seems to be all about incommunicability, as the physical body is overcome and 'trapped in a tunnel' or heavy at 'the bottom of the ocean' or raging 'on fire' (p.125). This corporeality is not what is taught about 'mental' dis/order in a dualist culture, and the experience struggles to sit with the idea of an enclosed mind within the skull. In this perplexing terrain, Haig decides that the physical symptoms of his depression and anxiety must be an accompaniment or a side effect of his 'mental' ill health (p.78). For Haig, the mind still sits in the head, even if the problems do not all happen above the neck and are diffused throughout the person (p.156).

Adam's account is also an attempt to connect up those thoughts of his mind with the science around the brain. Adam feels that the **Brain Disorder** model is potentially too limiting and has focused too much on small parts of brain activity. Instead, he theorises that the elements of the brain work together as an 'orchestra' (p.274) and the

mind arises from this combination so that, ‘the sum is greater than the parts’ (p.172). The conclusion he draws, from all the academic, scientific and popular representations he discusses around the mind/brain conundrum, is that ‘it’s my mind, the brain’s lodger, which has the OCD’ (p.200). The mind, in Adam’s account, is clearly in the head. Adam brings together an updated model of William James’ ‘stream’ of thoughts with the ‘electrical and chemical signals’ (p.171) channelled by the brain. The metaphors he uses for the mind are taken away from nature (with its streams, eddies and currents) and are much more mechanistic in tone, as he writes that ‘the mind is a thought factory’ where the ‘conveyor belt...always rolls’ (p.113). The tone perhaps reflects something of the ambivalence he feels about the power of these thoughts, which control him and vastly disrupt his life. Thoughts are his ‘enemy within’ (p.207) and Adam questions why ‘mind over matter’ is always couched in such positive self-determining ways.

Adam’s account is interesting because it suggests the entrenchment of mind/body separation as is popularly conceived and understood. As Western dualist metaphysics dominates narrative shapes of mental and physical health, this feeds back into the way the world is actually experienced. The more that bodies are disconnected, alienated and objectified, and the more people live in their heads, and the more the idea of embodiment becomes difficult to explain or engage with. Adam’s memoir shows the intractability of the mind and body separation. The issue is implicit in the very structure of science and medicine – as I intimated at the start of Chapter One – separation and specialisation reinforce Cartesianism. Adam writes that ‘Neurologists work with brain tissue. Psychologists grapple with the functions of the mind. Psychiatrists have a foot in both camps; they diagnose problems of the mind and treat them as problems of the brain.’ (p.200) It is difficult, as a mental health service user, to negotiate this terrain, and it is unsurprising that an explanation for dis/order is found somewhere between the ‘ephemeral’ mind and ‘material’ brain in this jumble of explanations and responses (p.201). I return here to an impasse, where the language of mental and physical health

obfuscates attempts to articulate symptomatology or support therapies that negate these medically defined spaces.

Narrative Bodies: 'All her body became that song'

Both Haig and Adam can articulate the intensity of the physicality of their 'mental' illness experience but it is within constricted forms. Narrative gets so far but is bounded by medical models and re-inserted into dominant frameworks. However, as Laura Salisbury articulates, there has perhaps been an incorrect assumption, in the construction of a 'post-narrative' position for the medical humanities, that language is the same as narrative. Salisbury stresses the difference between the propositional within narrative – where words are in context, modified by one another to 'form a proposition' – with other forms of language – the poetic, rhyme, idiom, for example. Salisbury's argument moves towards a 'critical questioning of the centrality of particular forms of language and narrative to medical humanities, without giving up on language's resources or reframing illness as a state of exception beyond the linguistic'.⁴⁵ Language is much more than its formation in structured, propositional, self-controlling narrative. She considers language that 'cleaves to the embodiment of mind' by burrowing into the 'resistant matter' of language, away from contemporary versions of coherence and continuity, and towards modes that came to 'scientific, philosophical and aesthetic visibility in modernity'.⁴⁶

Building on Salisbury's re-visioning of language via modernism; I argue that modernism's novel modes of narrative representation help provide much more of an embodied context for language. Modernist texts help to shift understanding about what narrative is and can do; it is not just the closed-down, confining structures that Woods warns against. These modes reveal how language can access the corporeality of distress

⁴⁵ Salisbury, p.446.

⁴⁶ Salisbury p.458.

and disorder, without re-inscribing Cartesian assumptions about mind and matter. Modernist literary texts are useful precisely because they push and play with the notion of how the intending thought can be conveyed into words, as they investigate the very material nature of language. This is valuable for this thesis because, in ‘mental’ dis/order, where language is disruptive, unreliable, inaccessible or somehow unrepresentative of feeling, the notion of a coherent, self-controlled narrator starts to unravel. The modernist novels used as case studies in this chapter, both respond to and extend, the challenge of representing inner mental life. In their non-linear, experimental forms and with fragmented and unsettled prose, they evoke the sensory and bodily disturbance of life in breakdown. These texts are resistant to neat explanations and suggest the deep involvement of the corporeal in memory, experience and feeling.

Virginia Woolf’s essay, *On Being Ill*, provides a useful starting point for this discussion. In an introduction to this text, biographer Hermione Lee writes that Woolf insists on the body in illness as she discusses how corporeality is often neglected by writers in favour of a focus on the turnings of the mind.⁴⁷ As Salisbury describes, Woolf is critical of the way in which mind is emphasised as separable from the ‘stubborn materiality of the body’.⁴⁸ Woolf posits the need for a new language that is, ‘more primitive, more sensual, more obscene’ than what is usually admitted by ‘intelligence [which] domineers’.⁴⁹ Words are pieces of matter in themselves, and, as Salisbury articulates, this notion provides, ‘the possibility of taking language back to the affectively charged, embodied materiality of words’.⁵⁰

Woolf’s emphasis on the body in illness also turns towards form, as she suggests that there needs to be a break in the ‘long campaigns’ of the prose narrative line.⁵¹ She argues that it is necessary to smash existing structures and to deliver ‘something of the

⁴⁷ Virginia Woolf, *On Being Ill*, (Richmond: Hogarth Press, 1930; MA: Paris Press, 2012), p.6.

⁴⁸ Salisbury, p. 448.

⁴⁹ Woolf, *On Being Ill*, p. 7 and p.21.

⁵⁰ Salisbury, p.450.

⁵¹ Woolf, *On Being Ill*, p. 19.

exaltation of poetry, but much of the ordinariness of prose' to convey the sensations that illness evokes.⁵² The punctuation, the cadence of words, or the rhythm of a passage can reach towards an energetically-charged language, dipped in the body's currents. Woolf's diary recounts her depression and echoes the rise and fall of the depressive wave in this way:

Oh, its beginning is coming – the horror – physically like a painful wave swelling about the heart – tossing me up. I'm unhappy, unhappy! Down – God, I wish I were dead. Pause. But why am I feeling like this? Let me watch the wave rise. I watch. Failure. Yes; I detect that. Failure, failure (The wave rises.) Wave crashes. I wish I were dead! I've only a few years to live I hope. I can't face this horror any more – (this is the wave spreading out over me).⁵³

The passage echoes the sensation of being tossed up and down in an uncontrollable surge. The parenthesis at the start marks the gasps and gaps as she wrestles with the weight of feeling. She stands back from it for a moment to 'pause' and question, only to feel it coming again. As the wave spreads out, she is obliterated, unable to feel that she can pass beyond it. The body is involved – this is not simply a line of propositional thoughts one by one occurring in a separate controlling head space. Language (especially with the poetic emphasis that Woolf discusses) is formed with sound and rhythm, which intimately connects with the body's vibrations and pulse.

To think in more detail about how modernist texts allow language about mental distress to invest in embodied sensation, I am now going to look more closely at two novels – Jean Rhys' *Good Morning, Midnight* and *The Shutter of Snow* by Emily Holmes

⁵² Virginia Woolf, 'Poetry, Fiction and the Future', in *Selected Essays*, ed. by David Bradshaw (Oxford: Oxford University Press, 2008), pp.74-84 (p.80).

⁵³ Virginia Woolf, *The Diary of Virginia Woolf: Volume 3: 1925-1930*, ed. by Anne Olivier Bell. (New York: Harcourt Brace, 1980), p. 110.

Coleman.⁵⁴⁵⁵ These texts explore the notion of embodied language that stubbornly maintains a sense of the physicality of experience. These two examples cannot hope to illustrate anywhere near to all that modernist literature says about minds and bodies, but, they usefully reach to sensate experiences beyond language – sound, music, dance – to articulate dimensions of affective feeling. In doing so, they create a bridge between narrative and bodies, and this chapter with those that follow. This is writing which sounds and breathes, where the body of language is experienced in affective terms, not detached narrative order. Mind emerges from matter; it does not control and objectify it.

These texts contribute to an understanding of the meaning of embodied mental health by beginning to gesture towards a model of the ‘being-body’ where distress and disorder implicate the whole person in material and energetic terms. I return once again here to Elizabeth Grosz, who theorises embodied subjectivity as the body in ‘three-dimensional space’, conceived in its full materiality and including language.⁵⁶ The modernist texts I analyse here bring these ideas to the fore.

Both novels have something of an autobiographical context despite being written as fiction. Their fictional status draws them far apart from the memoirs of Haig and Adam, and this is not an attempt to make a comparison between very different forms, but to suggest ways in which these modernist texts articulate ‘madness’ with an open ended and experimental approach to narrative, that opens up the possibility for narrative to excavate (and not control) embodied expressions of distress. These two novels do not deal with diagnosed and labelled ‘mental’ dis/orders – and this again contrasts with contemporary memoirs led by dominant medical frameworks – but these texts do speak

⁵⁴ Jean Rhys, *Good Morning, Midnight* (Constable, 1939; repr. London: Penguin, 2000). Further references to this edition are given after quotations in the text.

⁵⁵ Emily Holmes Coleman, *The Shutter of Snow* (New York: George Routledge & Sons Limited, 1930; Normal, IL: Dalkey Archive Press, 1997). Further references to this edition are given after quotations in the text.

⁵⁶ Grosz, *Volatile Bodies*.

to the experience of marginalised, ‘mad, bad and sad’ women experiencing different forms of despair.⁵⁷

In Emily Holmes Coleman’s *The Shutter of Snow*, the female protagonist, Marthe, is committed to an asylum after giving birth to her son. The book is based on Coleman’s own experiences of a ‘postpartum depression’ after her son’s birth in 1924 and was her only published novel.⁵⁸ In a letter to her father, Coleman explained how the ‘extravagant imagery’ and ‘dream’ forms of the ‘Freud era’ provided opportunities for her writing of ‘poetry and poetic prose’. This ‘poetic prose’, she felt, provided her with a unique ‘imaginative’ approach to documenting life in an asylum.⁵⁹ Jean Rhys’ novel of 1939 deals with the alienated character of Sasha Jensen – alienated because of her gender, her class, and because she is sexually active.⁶⁰ Rhys later talked about the autobiographical content of all her novels: ‘People have always been shadows to me. [...] I have never known other people. I have only ever written about myself.’⁶¹ Rhys’ narrative does something to collapse oppositions between past and present, memory and amnesia, inside and out, and the body and the world. To achieve this, it also collapses narrative into ellipsis. In a similar vein to Coleman’s novel, it is not always clear in the text where the narrative voice speaks from (both temporally and spatially). These off-beat narrative devices help evoke a sense of distorted perception and distressing experience, which is pushed to the margins. Marthe is an embodied trouble taken out of society and put into an asylum, and Sasha wanders the streets alone; a female body displaced, traumatised, alienated and dwindling towards death.

⁵⁷ Lisa Appignanesi, *Mad, Bad and Sad: A history of women and the mind doctors from 1800 to the present*, (London: Virago Press, 2008).

⁵⁸ Sophie Blanch, ‘Writing Self/Delusion: Subjectivity and Scriptotherapy in Emily Holmes Coleman’s *The Shutter of Snow*’, in *Depression and Narrative*, ed. by Clark, pp. 213-27 (p.213).

⁵⁹ Coleman’s letter to John Milton Holmes (16 September 1929, F.1595), in *Rough Draft: The Modernist Diaries of Emily Holmes Coleman, 1929-1937*, ed. by Elizabeth Podnieks (Maryland: University of Delaware Press, 2012), p.xxx.

⁶⁰ Judith Kegan Gardiner, ‘Good Morning, Midnight; Good Night, Modernism’, 11, 1/2, *Boundary 2* (Autumn 1982-Winter 1983), 233-51 (p.233).

⁶¹ Harold Bloom, *Caribbean Women Writers* (Chelsea House Publishers, 1997), p.137.

The prose in Emily Holmes Coleman's *The Shutter of Snow* is confused; it refuses to make coherent sense of Marthe's sense of turbulence as metaphors collapse and time unravels. Indeed, Coleman achieves this by 'undercut[ting] the concept of metaphor (as connection maker) by unhooking the subject from the predicate in terms of logic and meaning'.⁶² Coleman produces a narrative shape but puts cracks in its containing structures. There is a sense of a story being told in the novel, but the voice is not reflective or controlled because Marthe's experience is chaotic and unpredictable. Coleman does not provide a clear narrative – the events of the novel are hazy – instead, she offers an immersion in feeling and sensory, corporeal experience. There is a refusal in the text to allow propositional language to control the chaotic negotiation between inner and outer worlds. This is an experience that draws the shape of narrative to the fore – madness teases out questions of how to represent itself in words, and Coleman refuses an answer by making metaphors collapse and rejecting a clear temporal structure. Language in its embodied, sonic qualities is always present, bringing us closer to the body, not always pitched above or against it.

Coleman stifles any sense of movement in the text; instead, a stilled iciness hangs over the asylum and snuffles out the outside world with ever-present snow. The novel appears to lack time-space as, from the outset, it launches into an unremitting description of women and their bodies, and the noise, screaming and singing, which infuses the air around them. These exposed and vulnerable women held in the asylum nestle against hard, permanent and fixed objects such as metal beds and cold, hard bathtubs. They are controlled by faceless nurses and doctors, while often deeply immersed in the imaginary spaces of their dreams and delusions. At the end of the text, dates appear and time is reinserted, and outside and inside meet as Marthe 'presse[s] her face against the window' (p.124) and prepares to leave the building. However, Coleman's

⁶² Julie Vandivere, 'Framed Liminalities: Antonia White's *Beyond the Glass* and Emily Holmes Coleman's *The Shutter of Snow*', in *Hayford Hall: Hangovers, Erotics, and Modernist Aesthetics*, ed. by Elizabeth Podnieks and Sandra Chait (Southern Illinois University Press, 2005), pp.46-69 (p.63).

story is not a linear progression, neither is it a tale of an ordered head overcoming the emotional body, nor is it a straightforward presentation of words and thoughts achieving a triumphant recovery over an irrational illness. Instead, Coleman's text is a complex negotiation of bodies and world in flux.

Coleman's text helps to articulate the idea that language is not only about the signifier and signified or the propositional, but the vibration of sound emerging in speech and song. The novel's evocative opening is laced with sound and voices. Madness is defined by the sounds the women make and their relative 'goodness' is defined by their level of noise (p.21). In the asylum, quietness is appropriate and internalised. Screams and shouts transmit; they vibrate and perturb others – the kind of affective relation that the asylum attempts to suppress. Sound comes from bodies; it touches other bodies, and madness lurches through the asylum. The text starts with sound in its opening line:

There were two voices that were louder than the others. At night when the red light was out in the hall and there was someone sitting in a chair in front of the door clearing her throat at intervals there would be voices far down the hall mingling with sobs and shouts and the drones of those who were beginning to sleep. (p.3)

These voices call out and sound-out distress, but they come from no specific location. Instead, random bodies make noises, and long asylum corridors transmit pain. When a loud voice on the other side of the wall to Marthe's room stands out from the generic throb, it becomes 'entangled in the blankets and whistled the ice prongs on the wind' (p.3). This is noise, and it is physical, solidified and powerful. Despite the best efforts of the asylum staff, bodies cannot be separately and individually contained. 'Madness' is not simply a matter of something happening between the ears quietly taking place in

internal thought space. The charged energy of sound evidences bodies that are vibrating, energetic and affecting one another.

Coleman's text gestures towards the sensory depths of subjectivity, which do not always correspond to straight narrative propositions, as she foregrounds the corporeality of Marthe's experience. Marthe struggles to keep her own voice held in and her body held back as the asylum demands she must. She takes a slipper and rocks it – as if it was her baby – and sings to it, as a lullaby earworm plays over and over in her head. Marthe is unsettling the other patients, so is told to stop. However, her whole being is involved and enmeshed in her distress and so she jumps from bed to bed, whispering into the ear of a sleeping woman. Sound shakes and moves a sleeping ward:

The woman turned suddenly and screamed into the ceiling. All the beds began to tremble and all the voices began intermingling, stooping and rising. After the scream there was only the movement of the voices, like the waters of a lake when the wind has passed. (pp.61-62)

Sound vibrates, channelling the body and its presence: 'her deep voice pitched in trembling supplication. It shook her body and her head shook with her voice' (p.85).

Sound is vital, material, reconnecting word with body. The physicality of sound is intense as it shakes and moves the air, and the bodies within its resonating space feel the imprint. In the asylum, sound breaks into violence. The atmosphere is palpable as bodies become rooms, and rooms become bodies, and as energy surges and fights break out.

Coleman writes, 'The room was tottering on yellow spindle legs. There were a thousand white nurses [...] the throbbing of her wrists and her hair' (p.43). Sound is made by bodies, felt by bodies and moves bodies.

In *The Shutter of Snow*, madness is not a quiet or bodiless act wrapped inside the narrating, thinking head. Marthe believes she is God, and with this strong conviction,

Coleman writes how 'she tore from her tender skin the rough nightgown' and 'pounded' the door (p.5). Marthe's body is strong and she strikes and shakes off a nurse 'like autumn leaves'. Resultantly, she is pinned down, put under a thick blanket and held fast. At this moment, her body is hidden – made immobile – because its motion and power are too difficult and too present for the asylum to deal with. Marthe's body is under the asylum's control. Coleman describes how 'she was lying with her arms bound behind her back in the spiralled casket with the canvas sheet all over' (p.25). In this setting, women must not be too strong, too loud or too bodily, because too much body signals the emergence of sound, voice, feeling and potential disruption.

It is useful here to draw on Iris Marion Young's feminist essay *Throwing Like a Girl* – which I will also return to in later chapters. Young writes how female movement is restricted and inhibited, not due to a natural property, but because of social conditioning and oppression, and the resultant expectations and limits imposed upon them. As such, a woman's body is 'a thing'; it is both 'looked at and acted upon'.⁶³ Holmes Coleman's asylum space is a microcosm of this bodily context; bodies must not take up space, be active, over-exuberant or too powerful. Marthe represents an act of rebellion as she connects with embodied sensation through movement. As Marthe dances, the lines of her body appear to flow into space around her. Coleman writes that 'she lifted her limbs to the lights over her head and bowed her body down to her feet. She was a fair white stream gushing down the ill-poised canyons of a dream.' (p.51) In this sense of abandon and dangerous imagination, comes the freedom to move and enter her body fully. Marthe is the opposite of the quiet, silent and internalised restraint the asylum demands and she is 'wild' (p.52). Marthe's physical and moving energy projects outwards and affects the other women on the ward who, 'mumbled their lips together and chafed their hands' – holding their 'twitching' and 'murmuring' bodies in, containing their natural

⁶³ Iris Marion Young, 'Throwing Like a Girl: A Phenomenology of Feminine Body Comportment, Motility and Spatiality' *Human Studies* 3 (1980), 137-56, repr. in *Throwing Like a Girl*, ed. by Young, pp. 27-45 (p. 39 and p.42).

fluidity and energy as their voices rise and fall energetically and physically 'like a wind on a roof' (p.52). Self-expression is more than a simple narrative ordered line and bodies are not neatly contained but relational, affective and powerful.

Music theorist Naomi Cumming – in questioning the inner-ness of identity located in Cartesianism – argues that gesture and music accompany language as ways of forming subjecthood, which is not located in some private ineffable space, but in social and interactive contexts. Following the work of other feminist music critics, Cumming discusses the relationship between her instrument – the violin – which is an extension of her body; the embodiment of her subjectivity. She asks, 'Does the self form the sound, or the sound the self?'.⁶⁴ In doing so, she questions the notion that a musician simply expresses their subjectivity in music, arguing for more of a relational aspect – how the musician takes on the character of the music. This idea resonates in *The Shutter of Snow*.

For Marthe, the energy of music is a way of feeling the physicality and spaciousness of the whole being instead of the enclosed and trapping asylum space and music seems to become the woman, or woman becomes the music. When Marthe sings, there is release: lines and edges are blurred, her body enters the voice and, as she inhabits the music, it releases her from the confines of the body-object into an active, feeling freedom:

It was a song, a perfect song, a note of clean and fixed control. It came to her in that moment, and in the drunkenness of sound she was in a trance of silver goblets and all her body became that song. (p.31)

When Marthe plays the piano, Coleman writes how she 'plunge[s]' into the keys, 'lean[ing]' her body into the instrument, feeling the 'wide spaces between her fingers';

⁶⁴ Naomi Cumming, *The Sonic Self: Musical Subjectivity and Signification* (Bloomington IN: Indiana University Press, 2000), p. 7.

actively creating and bringing to life a 'dream she had been keeping' (p.73). Music appears to provide release and space as if the music reveals her defiant wholeness and unruly, sensual, physical being. As Cumming emphasises, music contributes to conceptions of selfhood, and language in its poetic and playful experimentalism is able to connect with this sensate, embodied feeling.

I now turn to Jean Rhys' *Good Morning, Midnight*, which like *The Shutter of Snow*, refuses a simple narrative arc with clear developed order. Rhys' prose is fractured and splintered as she writes the story of Sasha Jansen, a woman who is saturated by memory and who wanders the streets of Paris from bar to bar in search of her next drink. In these narrated hours and days, Jansen meets strangers and potential lovers and encounters her own melancholic past and her ageing future as she recalls earlier footprints across the city. Rhys' text plays with how to represent Jansen's episodic experience and confused sense of reality. The narrative freely incorporates sound and songs, dreams, memories, flashbacks and present tense, all of which collide in Jansen's distorted (and often painful) imagination. There is a sense of Jansen's heightened inner mental chatter as voices shout at her: 'when the absinthe went really to my head I thought I was shouting [...] to shut up. I even heard my voice saying: "Shut up; I hate you". But really I didn't say anything.' (p.102) While Jansen's inner voice is shouting, aggressive and vociferous; there is a sense of the dissolve of embodiment. She is a 'cerebrale' whirring round in her own spinning head (p.136) while her physical body feels as though it contains 'stagnant water [...] the bitter peace that is very near to death, to hate' (p.128).

Rhys does not provide a coherent, self-directed narrative for Sasha to hold the text together. Sasha does not have access to a narrative of her life with a clear sequence of events, but this does not mean that language cannot articulate her feeling. She is unable to answer the question, 'What's your story?' (p.76) because she is never sure which way she will go, what she will say, or who she will be at any moment. She is asked by the boss of a dress-house she works in, about her time as a model, but is left hollow,

as she thinks to herself, 'How long ago was it? Now, everything is a blank in my head – years, days, hours, everything is a blank in my head.' (p.18) Rhys ends Part One of the novel with Jansen in bed, covers pulled over her head, wishing to shut 'the damned world out' (p. 69) but Part Two opens with the sentence, 'All the same, at three o'clock I am dressing to meet the Russian.' (p.71) Rhys use of the opening words 'all the same' suggests Jansen's passivity: things happen and one place just turns into another, one mood quickly melds into something very different. The experimental form of this novel defies the idea of a closed down narrative structure holding life in place with clear chapters, and linear, organised time. The idea that thoughts can be overcome by words or that thoughts define action comes undone. Jansen's narrative suggests there is little personal control: 'I never thought we should really get married. One day I'll make a plan. I'll know what to do...[Then I wake up and it's my wedding day' (p.96). Rhys' use of ellipsis implies the tailing off of Jansen's decision-making into passivity and formlessness. Rhys writes, 'It's not that these things happen or even that one survives them, but what makes life strange is that they are forgotten.' (p.118) There is no master narrative, as sentences throughout the novel dwindle without closure. It seems to echo the sense of inevitability in the novel, that time is heading only one way and that a neat narrative explanation is a forgery. Jansen reflects that 'it can be sad, the sun in the afternoon, can't it? [...] sad and frightening.' (p.120) Towards the end of the novel, Jansen admits that 'when I think "tomorrow" there is a gap in my head, a blank – as if I were falling through emptiness.' (p.133) The text replicates this sense of falling; the narrative does not – and cannot – overpower these experiences of despair.

Jansen lacks a grounded sense of her physical body and, thus, life appears entirely ephemeral and insubstantial; her body is an object defined by others – barely inhabited, it is looked at and gazed upon. As Young writes about this sort of female bodily objectification, 'The source of [...] objectified bodily existence is in the attitude of others

regarding her, but the woman herself often actively takes up her body as a mere thing'.⁶⁵ Objectification is not only a problem of misplaced value – being taken only for how one appears on the outside – but means a lack of proprioception and a lack of touch with the world. Jansen longs for invisibility because the objectification is too strong.

Despite Rhys' emphasis on the inner voice, cerebral thoughts and on the whirring machine of Jansen's mind, Rhys seems to suggest that ultimately the body cannot be escaped, because it is not only the narrating thought stream that is involved in memory and feeling but the whole energetic being. Rhys writes of Jansen's body memory: 'my hands are shaking, my heart is thumping, my hands are cold. Fly, fly, run from these atrocious voices' (p.22). Jansen's body is unable to conceal her feelings; her hand 'shakes so violently' under the glare she perceives from those around her. She cannot hide her deep rooted and visceral fear: 'can I help it if my heart beats, if my hands go cold?' (p.46). Jansen's memories, responses, thoughts and feelings are in her body, they pulse through it rhythmically, and her narrative line cannot conceal this deep-seated body memory, which underlines every utterance made. Returning to Naomi Cumming's notions of embodied subjectivity, body language and body gestures are intricately linked to the story of the self.

As in *The Shutter of Snow*, music seems essentially linked to the body and body memory in *Good Morning, Midnight*. Music is powerful; it sits deep in the body and holds Jansen close to past feeling and experience. The effect can be all-consuming as it raises those feelings back to the surface and appears to transplant a person back in time. Rhys writes how earworms possess Jansen, who senses that she needs to be distracted from 'trailing around aimlessly with cheap gramophone records starting up in your head' (p.14). Even with a chink of resistance, she soon feels overtaken by the streets and bars she visited in the past as they bring back her memories, and are accompanied by a melody: 'The gramophone record is going strong in my head: Here this happened, here

⁶⁵ Young, 'Throwing like a Girl', p.44.

this happened.’ (p.14) As she walks to ‘the music of L’Arlesienne’ she remembers a coat she wore and is transplanted to a café, to a man and seemingly, to another time (p.73). As Jansen feels in her coat pocket, she is thrown, because the pocket she can feel is not the coat she remembered so vividly, nor the moment she thought she was in, but another time, years later, and she realises that she is another, older self (p.76). Music makes memories as much as narrative does, and its imprint is strong and sensual. Narrative goes part of the way, but music does something to articulate the past in a way that ordered versions of events constructed in narrative forms might neglect.

Sound binds Rhys’ novel together; there is a rhythm and a pulse, which runs through it, and thatches the disjointed prose. Sound and music represent memory and feeling and they provide the current for Jansen’s experience of living between ‘fire and wings’ and ‘blackness’ in a way that the ordered words of the buzzing ‘mind’ fail to do. Rhys invokes a thick, sensory, palpable atmosphere in the text. A banjo player plays music that haunts Jansen – she is drawn to it and its evocative sound, and to the memories it brings to the surface. In this music is ‘all the music [she has] ever loved’ (p.155). Jansen wants to close down the memory of youth, happiness, dancing and making love, all of which the song powerfully evokes (p.155). Jansen wants to stop the voice in her head, which talks and narrates and tells her what to do and where to go, the inner voice that sings, what she calls that ‘damned voice’ (p.157). Narrative has the potential to deepen the imprint of distress. Jansen finds it hard to escape.

Rhys’ text wrestles with the restricted and objectified female body and the need to find some sort of subjective identity and meaning for it. In undercutting a sewn-up, ordered narrative form with experimental, disintegrating and confused prose, Rhys questions the smoothing over of the female body’s submissive and docile position. In Jansen’s first experience of Paris, she spent time with her husband Enno. As a married woman, she is quickly told that ‘you mustn’t talk, you mustn’t think, you must stop thinking’ (p.98). As a result, Jansen starts to disappear. Rhys explains she is living ‘with

that expression in your eyes when you are very tired and everything is like a dream' (p.102). Somehow, she is here, waiting – not talking, not doing, not living as an active subject – just being pulled and told what to do by Enno: 'Peel me an orange, he tells her.' (p.108) Somehow Jansen does what he says and she goes with it and goes with him because the experience is 'much too strong – the room, the street, the thing in myself' (p.108). This 'thing' in her allows her to be walked on and to be used. Jansen cannot fight, even though it is circulating in every pore. For a woman, in this time, there is no power; there is only the power of men with their money, their thoughts and their bodily objectification. Jansen dreams of writing a book in a flash of futurity but concedes that 'to be accepted as authentic, to carry any conviction, it would have to be written by a man' (p.135). Women's bodies are restricted, their worlds are reduced and their bodies ache to feel the world with space and fullness. It is no wonder that Jansen takes refuge in her head.

Marthe in *The Shutter of Snow* feels a similar expectation to Jansen to be quiet and appropriate. Coleman writes that in the asylum 'you must be quiet [...] to show that you are better' (p.58). While the body is treated as an object or cut off from the psychology of the head, a sense of release into deep feeling is restricted to fleeting moments: in the energy of music and the movement of dance. These are the times when the whole physical being feels and moves with the world. To prove that mind is in control of matter, the body must be docile, obedient and acquiescent. Its materiality and physicality must not surface, except in objectified ways.

Modernist aesthetic experimentation is particularly useful in terms of its alternative narrative shapes, its questioning of the conscious and the unconscious and of inner and outer lines, and its interest in pushing the boundaries of form and language to access states of disorder and distress. In these two texts, 'mental' dis/order is silenced, either closed inside an asylum – its speech and sounds refused an audience (*The Shutter of Snow*) – or locked inside the inner churning of memory and mental chatter,

marginalised because of its femaleness and sexuality (*Good Morning, Midnight*).

Modernist textures agitate formal narrative structures as words define, diagnose and treat, and as thoughts flow on an ever moving and rushing stream. Narrative modernism develops and represents this sense of inner mental life as the feeling, sensing and three-dimensional body presses and pulses beneath the surface, aching for representation and defying constraining forms.

Re-bodying the Self

In this chapter, I have analysed how some modernist authors play with form and function, using rhythm, cadence, ellipsis and other devices to engage with a full palate of affecting, sensate experience. Returning to the aim set out at the start of this chapter, my focus has been on the 'aesthetic and narrative strategies' used to represent and model the affective experiences of madness and sadness. The texts that I have approached in this section offer sound, dance and music to explore non-dualist accounts of distress and breakdown. In doing so, I posit that words and language do not have to be set in opposition to the being-body, but can draw close to it; emanating from the body and with its breath, gesture and pulse, and that a focus on narrative as a direct expression of internal 'thoughts' and thereby 'mental' life is reductive. Modernist texts suggest the important differentiation between controlled narrative that is about fixing, overcoming and explaining, and language which resonates, draws from embodied experience, surfaces in shards and does not attempt to control the matter it describes. As Salisbury has also usefully articulated, there is a big difference between the limiting models of narrative pushed through the medical humanities models in the last decade (and the dominance of talking and narrating both in and out of the clinic) and the materiality and sensuality of language in these experimental forms.

Personal narratives about 'mental' dis/orders are now regularly sharing a physicality of experience which struggles to sit with a vertical model of mind over

matter. In an example of this, in an article published in *the Guardian* newspaper, Australian author Anna Spargo-Ryan writes about her anxiety:

I feel the fear not in my head but in my very self [...] I feel it [...] hissing there in the soles of my feet, shouting at me from the pain in my knees, from the weakness in my hands, from the tingling in my jaw. It lurches from my throat like a wave of black tar and I choke on it and the world caves in around me and I am drowning.

This is anxiety felt in the ‘very self’ of the body; it is violent, noisy and physical and leads to a sense of suffocating enclosure and sensory shutdown. Spargo-Ryan continues, ‘I can’t breathe. My throat has closed. I’m going blind. Some days the fog is thick and it rolls in around us and we suffocate’.⁶⁶ The theory that anxiety filters down from thought in the head, capitulates to the sheer physical force of Spargo-Ryan’s description; anxiety (as the title of this chapter highlights) is in the ‘soles of [her] feet’. The body is not a meaningless weight below the neckline, or something that incorporates the brain and therefore reduces everything to itself. Anxiety can equally rise from the ground up.

To understand how to feel the body and to experience that body, learning might need to come from the body itself. Indeed, what Matt Haig finds to ease his mental pain is not the offerings of brain chemical altering drugs or the thought-dissection of CBT, but ‘exercise [...] yoga [...] absorbing [himself] in something or someone[he] loves’ (p.77) and, in particular, ‘running’ (p.153) which, he writes, produced the kind of ‘wonderful feeling’ that made his depression and anxiety seem to ‘evaporate’ (p.154). Haig’s remedy begs the question of how to start to understand or make meaning from ‘mental’

⁶⁶ Anna Spargo-Ryan, ‘I Exist in a Fog. Some Days it Blows Away, but Some Days it’s Heavy and Suffocating’, *the Guardian*, 2 March 2015 <http://www.theguardian.com/commentisfree/2015/mar/03/i-exist-in-a-fog-some-days-it-blows-away-but-some-days-its-heavy-and-suffocating?CMP=share_btn_tw> [accessed 18 July 2017].

dis/order with something other than narratives and language (without setting up further binaries).

Conclusions

‘It would seem timely to ask how we transform biomedicine back into a sensately fluent discipline’.⁶⁷

Medical Humanities scholar Jo Winning points to ways of approaching the human body which ‘folds in both rational thought and sensory information at the same time’. For Winning, the talking cure can be the meeting point of the psychic embedded in the somatic; having language listened to, she argues, can allow the body to heal. Indeed, Salisbury argues that language as representation ‘enables the subject’s intersections and interactions with the phenomenal world to become meaningful’.⁶⁸ However, in some forms of ‘mental’ dis/order where embodied subjectivity is thwarted, a question might emerge about how linguistic representation can address embodiment, and how this can be meaningful if it is sheared from concepts of subjectivity. To begin to re-engage with embodied experience, a sort of physical attentiveness and cultivation might need to be developed that does not always start or end with layers of words; one that engages with and foregrounds – for example – the rhythm and pulse of experience or the body language; the creaks, hunches and stresses of the entire body and the context of the world that body moves within. This is especially the case in a contemporary culture where narrative is perceived – across media, literary and healthcare discourses – as a resolution or meaningful interpretation from the top down. Indeed, my sense is that we need to find other methods to engage and heal, rather than think that narrativisation

⁶⁷ Winning, ‘Afterword’, p.333.

⁶⁸ Salisbury, p.454.

and talking are the main or only answers. In communicating and understanding, we may reach for words, we may hug or hold someone, we may breathe with them or we may look into their eyes. In the movement of the body in the flow of a body-based practice, or in communal spaces where bodies intersect and move together, or in the unspoken contact between a bodyworker and a client, there may be many readings and understandings and expressions of distress that do not require narrative ordering, and where the pressure or demand to narrate the experience, sometimes might not be appropriate or available. Indeed, by not forcing experience into narrative shapes the pressure of having to convert feeling into an illogical or irrational worded equivalent is removed. It is no longer about the story, the reason, about what happened; it is about finding a form for feeling.

Tackling 'mental' dis/orders like depression or anorexia as experiences that always move from thought into word into action will not get to the core of this. Experiences are imprinted in the whole body (not only a set of thoughts in the head), and knowledge can be gained through physical experience (which does not have to be articulated into words to be useful or therapeutic). Ultimately, this may lead to words but is mediated first through a reconnection with physicality. One is unable to speak about the body if one is not able to feel it, if one is totally detached and acting only as a body disciplinarian. As important as it is that time and space is given to talk about mental illness,⁶⁹ there may also need to be a renewed focus on the sensate body and its sense of the world. If (as some critics have argued) this is not possible because narratives are everywhere and always demanded to make cognitive sense and communicate, then it is worth considering what this implies about the dominant dualist structures in which lives are lived and bodies are objectified.⁷⁰

⁶⁹ Time to Change. 'National Time to Talk Day'.

⁷⁰ McKechnie, p.123.

The practice of yoga, the movement of the runner, the shape of the dancer, the engagement with music, all can be involved in sense-making through sensation. In a paper, which explores how the guided practice of digital storytelling can explore the embodied experience of eating disorder recovery, social theorists Andrea LaMarre and Carla Rice discuss how such work ‘involves a rewriting of the embodied self, a remapping of its physical/mental surfaces and boundaries, a re-routing of its energies and flows.’ These practices, which foreground the embodied self, usefully start to ‘cultivate subjectivities’ that are not based on dualist structures.⁷¹ In this chapter, modernist texts have helped me to show the energetic and flowing potential of sound and music, and the vibrational and physical nature of subjectivity, for excavating meaning from bodies. In the next chapter, I will go on to explore how a vibratory materialism developed in sound theory and feminist music criticism helps provide vocabularies and concepts which stretch beyond constrictive top-down narrative accounts of ‘mental’ dis/order.

⁷¹ Andrea LaMarre and Carla Rice, ‘Embodying Critical and Corporeal Methodology: Digital Storytelling With Young Women in Eating Disorder Recovery’, *Forum Qualitative Sozialforschung / Forum: Qualitative Social Research* 17, 2 (2016) <doi: <http://dx.doi.org/10.17169/fqs-17.2.2474>>

Chapter Three: Haptic Sounds and Moving Music

[Sound makes] corporeality explicit: guttural, abrasive, intimate, explosive, vocal and assertive, sound may amplify the inherent forces and drives of physical experience and what it means to be a body.¹

Chapter Aim and Summary

The separation of body and mind in the dualist language of contemporary constructions of ‘mental’ dis/order can become mirrored by a sense of separation between bodies and the world. Mind over matter approaches divide individuals and their neurochemical, emotional or thought-based problems from the contexts in which they live, thus obscuring the role of environmental or sociocultural influences that affect and shape individuals. Recovery, in this individualised view, becomes a narrated, self-managed and enclosed act. I argue that this is ethically troubling – either blaming individuals for their disorders or over-identifying people with individual diagnoses, giving them no way out. Returning to the aims set out in the Introduction – and once again to my feminist materialist position – it feels essential to find ways of crossing those divides. This chapter thus speaks to the second aim of the thesis, to find appropriate analytic tools and concepts to re-infuse understanding of ‘mental’ health with the vibrating matter of physical life – ultimately signalling towards the assimilated being-body.

In this chapter, I think about human life in terms of social and environmental contexts and the specific locations of individuals in material and energetic terms – as I aim to attend to human health beyond surfaces and sections. The modernist texts in Chapter Two explored how sensory experience (and, in particular, sound) captured the

¹ Brandon LaBelle, *Acoustic Territories: Sound Culture and Everyday Life* (New York: Continuum International Publishing Group, 2010), p.104.

forces and drives of physical experience. I turn here to philosopher Michel Serres who writes how the senses are a configuration ‘whereby the body mingles with the world and with itself, overflows its borders’.² This notion of the mingling senses usefully takes me towards the potential for sound, and its energetic and vibrational qualities, to articulate the idea of crossing boundaries between mind and matter. If being is a matter of vibration, it helps undo the idea of an intact, hearing-thinking-doing self, and leads to a renewed paradigm within which to consider the meaning of ‘mental’ health and dis/order.

As I discussed briefly in the Introduction, there is no perfect term to do justice to a ‘holistic’ approach to understanding health and illness running through the whole person, but as I discuss in this chapter (and the next), cultivating knowledge through the whole body, means I that I need to foreground corporeality. Sara Ahmed generates the term a ‘sweaty concept’ to describe something that is difficult and which resists comprehension. She thinks of such concepts as ‘the worlds we are in’ rather than from the arguably exterior position of academia. Sweat, she writes, is bodily, and these kinds of concepts come from bodies, which do not feel at home in the world. ‘The task’, she says, is to ‘stay with the difficulty’.³ I develop the ‘being-body’ as a way of practically articulating the vibrational and material ways in which distress and discomfort implicate and involve the whole person, which is always moving, changing and becoming. The word ‘mental’ is laced with all sorts of implications from the models presented in Chapter One. The word ‘body’ of course, has its own problems and multiple definitions but enables me to think about conscious materiality, vibration and energy, and a kind of thinking and understanding which – via dualism – is normally associated with the immaterial mind, or brain only.

² Steven Connor, ‘Introduction’ to Michel Serres, *The Five Senses: A Philosophy of Mingled Bodies*, trans. by Margaret Sankey and Peter Cowley (London and New York: Continuum International, 2008), pp. 1-16 (p.3).

³ Ahmed, p.13.

With the term being-body, I turn towards how a person's being and becoming is shaped by all the body's systems and energies imbricated in the world. This moves us towards a radically different shape of knowledge – not directed from the head or from 'a position of exteriority', but implicated in the world around; just as Ahmed suggests, these concepts come up by 'practical experience of coming up against a world or the practical experience of trying to transform a world'.⁴ Moving back to Karen Barad's conception that 'knowing and being' are material practices, the being-body starts to articulate and tend to the sensory and the physical. This is not a body possessed, owned or objectified, or separately listened to, but one that is part of the self. Mind does not rule matter, but is an active part of matter, thus breaking through the divisive language.

This chapter has two parts. First, it turns to sound theory and then to music; exploring some different facets of the question of how mental health might be embodied. An engagement with sound helps to dissolve inner and outer binaries, to consider the physical imprint of life events on bodies – and bodies on each other – and to reveal the interconnectedness of sound and touch. The concept of *haptic sounds* thus provides a way of thinking about sound beyond interiorised scapes of ears and heads and to the tingling and vibrational imprint on the skin and beyond. Sound helps to engage with the notion of vibratory materialism and – as the opening quotation of this chapter taken from sound theorist Brandon La Belle argues – it also demonstrates 'what it means to be a body', not just have a body. This contrasts with representation imposed on bodily sensation in the afterward of the narrative account, but it does not mean a dispensation with language altogether. I discuss, rather, how language and sound are in the body and affect the physical body. Language is embodied because breath and voice in their vibrating and physical qualities are at the source of the spoken. I argue that sound is connective, touching and relational, and how these aspects cut across dualistic lines of mind and body.

⁴ Ahmed, p.14.

I then turn to music (and, in particular, the theories of music and the emotions developed in feminist criticism) and how this helps address the importance of rhythm and of movement in space, and the connection between *moving music* and embodied subjectivities. I think of music through acts of performance and perception. I argue that music highlights the energetic body, once again connecting with feminist criticism to emphasise the indivisibility of matter and mind.

Within this chapter, I consider the use of sound and music as therapeutic – as healing forces – and as already involved in some ways in medical practices. However, I recognise the limits here too – the cultural and social locations of music mean that there is never a universal or one human reaction to music and sound. While sound may be used in therapeutic contexts, and music may be couched in terms of a sort of universal language, it is important to emphasise how this language differs in different contexts and cultures. Indeed, as Ruth Barcan writes, music therapists tend to talk in much more ‘culturally mediated terms’ about music.⁵ I take up this position here, to make sure that perception and vibration are not couched in insular terms but are understood as immersed in their social and environmental contexts.

I remain wary of suggesting that sound and music are healing and positively affecting in all cases, as they can disturb and alienate, as much as they can bind and relate. As sound theorist Steve Goodman articulates in his book *Sonic Warfare*, sound influences and shapes crowds and it can damage the ears, affect the heart rate and blood pressure.⁶ There are examples of the potency of sound – its use in war torture, for example, and, on smaller levels, as sound theorists Marie Thompson and Ian Biddle testify, ‘ominous, out-of-place’ sounds can make the ‘heart race’.⁷ Sound asserts physicality and this can be deeply confronting and – at times – inescapable. Indeed,

⁵ Barcan, p. 119.

⁶ Steve Goodman, *Sonic Warfare: Sound, Affect and the Ecology of Fear* (Cambridge, MA and London: The MIT press, 2010).

⁷ Marie Thompson and Ian Biddle, *Sound, Music and Affect: Theorising Sonic Experience* (New York and London: Bloomsbury, 2013), p.11.

rhythm is a constant touchpoint for this chapter as I consider how bodies beat from within, and how the rhythm of bodily events affects breath, muscle and energy.

Sonorous Beings

In a book on sounds and perception, Casey O’Callaghan and Matthew Nudds explain that ‘traditionally sounds have been grouped with the colors, tastes or smells among secondary or sensible qualities’. In this grouping, the nature of sounds has been tied to the human experience of them. This led some twentieth-century philosophers to understand sounds as subjective and private mental experiences – providing ‘auditory perceptual access to the world’ – something that is registered inside the head.⁸ In this version of sound, a hermetically sealed notion of selfhood is approached. Sound remains an internalised property of the individual, rather than something that helps dismantle dualistic notions. Indeed, communications theorist Jonathan Sterne – in his book *The Audible Past* – argues that the differentiation between sound and sight (what he terms the ‘audio-visual litany’), emanates from ‘the role of hearing in salvation’.⁹ Such an interiorised understanding of sound suggests that it gives access to a personal and internal world, drawing lines around the individual.

Indeed, my first move towards sound came from the model of **Immaterial Thoughts** and the sense that ‘mental’ dis/order might have its own inner soundscape in the form of distorted inner speech. In accounts of ‘mental’ dis/order, and in research on inner speech, experiences of sound are pronounced as enlarged, distorted and warped. Perhaps sound could provide a way of understanding the inside experience of ‘mental’ disorder? However, sound understood in this interiorised way circles right back into mind and body dualism.

⁸ Matthew Nudds and Casey O’Callaghan, *Sounds and Perception: New Philosophical Essays* (Oxford: OUP, 2009), p. 4 and p.5.

⁹ Jonathan Sterne, *The Audible Past: Cultural Origins of Sound Reproduction* (Durham NC: Duke University Press, 2003), p.14.

Sound is a useful methodological tool is because it emphasises something else much more visceral; the vibration of bodies and the rhythm of bodies deeply connected and affected by the world around. Through this, it helps to demonstrate two things. First, borrowing from Simone Fullagar, the impossibility of an interiorised account of the ‘mind’ or of ‘mental’ dis/order located ‘*within* the neurochemical self’ and cut off from social forces.¹⁰ Second, it helps to ‘cultivate subjectivities’ beyond those of the narrative self, which controls and dominates selfhood in a top-down manner.¹¹ Indeed, sound theory helps to reach towards an ontological position of being based in vibration. This is resonant for states of disease because, as Ruth Barcan argues, the body in pain has lost its rhythm; things are out of sync.¹² Underpinning this ontology is the idea of energy – bodies and the world around are made up of fundamentally the same stuff. This is not materialism heavy and weighted with inert matter, or sectioned into separated anatomical parts, but one which is moving, sensate and boundary-dissolving.

In my suggested term of the being-body, I argue that the ‘body’ is not the dustbin for ‘mental’ thoughts hanging below the head but needs to be re-evaluated in energetic terms, deeply related to the social and cultural environment; in constant contact with the world. Arguably, any account of sensory experience could help to unfold the experience of the being-body, but sound (and therefore music) has a particularly interesting place in this thesis: it links body and language, it is used in different ways in Western mainstream medical practice and in alternative medicine, and it sits at the heart of a rhythmic understanding of life as is expressed in physics and medicine.¹³ While a **Body Systems** model of ‘mental’ dis/order draws close to finding a way to express

¹⁰ Simone Fullagar, ‘Diffracting mind-body relations: Feminist materialism and the entanglement of physical culture in women’s recovery from depression’, in *Moving Body: Sporting Ecologies, Assemblages and New Materialisms*, ed. by J. Newman, H. Thorpe and D. Andrews (Durham, NC: Duke University Press, forthcoming 2018)

<https://www.researchgate.net/publication/316488529_Fullagar_S_forthcoming_Diffracting_mind-body_relations_Feminist_materialism_and_the_entanglement_of_physical_culture_in_women's_recovery_from_depression> [accessed 19 July 2017].

¹¹ La Marre and Rice, ‘Embodying Critical and Corporeal Methodology’.

¹² Barcan, p.119.

¹³ Barcan, p.117.

physical and mental assimilation, it is still set within the language of physical and mental health. In this chapter, I more radically trace a model of the being-body that is embedded in vibratory and rhythmic subjectivities. Indeed, as Barcan usefully posits – also referring to the work of Elizabeth Grosz – conceptualising sound is ‘not just a question of the physiological effects of sound on the body, mind, or emotions; rather, sound is in a very crucial sense *of* the body itself. Living beings are vibratory’.¹⁴ Such a ‘vibratory materialism’ – where sound resonates below the surface of sensorial perception – probes ‘deeper than the merely auditory’ (and what is heard) towards the ‘primacy of the synesthetic’ where the whole being-body is engaged.¹⁵ I will now turn to explore these ideas in more detail.

Vibrating Matter

The problem with narrative linearity – in the sense in which one event follows another – is that it is often seen (certainly in terms of illness narratives used to document or share experience) as one thing *causing* the other. When memories come to be discussed and described they are lined up in sequential order, once again putting mind over matter; narrative structure overlaying fragments or layers of memory. A theory of sonic materialism shapes this rather differently; in focusing on the vibrating matter of all things, memories start to be seen as residing all the time and all at once – bouncing, shaking, vibrating in much more energetic terms. Sara Ahmed articulates her own body memory of violence in this way as she writes, ‘experiences like this: they seem to accumulate over time, gathering like things in a bag but the bag is your body.’¹⁶ In this account, Ahmed argues that the body collects, stores and lets sediment; changing the layers of feeling and sensation and experience of that body over time.

¹⁴ Barcan, p.119 citing Elizabeth Grosz, *Chaos, Territory, Art: Deleuze and the Framing of the Earth*, (New York: Columbia UP, 2008), p.33.

¹⁵ Goodman, p.9.

¹⁶ Ahmed, p.23.

The sensational body can be seen from the critical vantage point of the analogue wave; the imprinted vibration on the body and the world which refuses a mental and physical split, by emphasising the very physical structure of sound itself. Analogue recording stores sound in impressions made by an original sound wave. Philosopher Christoph Cox argues – via media theorist Fredrich Kittler – that the phonograph, in its analogue audio recording, registers the ‘messy, asignifying noise of the world’, which is the ‘perceptible plenitude of matter that obstinately resists the symbolic and imaginary orders’.¹⁷ Sonic materialism reacts to textual representation by reaffirming its physical imprint. In a world where eyes increasingly interface with a screen, and where mental life is constructed as life in the head, the physicality of sound on the body helps to redefine the value of the body in contact with the world. Life layers into the whole being-body.

Indeed, taking this argument further, sound can make and imprint meaning, even if it is un-heard by the ear. In this manner, ‘mental’ dis/order can never be truly ‘inner’ because the world does not happen in the bounded bits of the brain; the world is all around, affective, inside and outside all at once. Indeed, Musician Will Scrimshaw’s notion of ‘non-cochlear sound’ helps to remove sound from being singularly registered within the ear and transmitted to the brain – the inside ‘mental’ and subjective place – it is instead based on vibration and resonance.¹⁸ The notion of sound ‘un-heard’ is expressed further in sociologist Patricia Clough’s personal piece of writing about childhood memories where the ‘affect’ of sound is deeply felt. She writes of her mother’s scream,

¹⁷ Christoph Cox, ‘Beyond Representation and Signification: Toward a Sonic Materialism’, *Journal of Visual Culture*, 10, 2 (2011), 145-161 (p.154).

¹⁸ Will Scrimshaw, ‘Non-Cochlear Sound: On Affect and Exteriority’, in *Sound, Music, Affect*, ed. by Thompson and Biddle, pp.27-44 (p.27).

Her screams penetrated my body unheard.

more like a vibrating afterward

In the violence of this scream, Clough's ear-drum bursts and she explains how there was a burning feeling, the 'blistering' of this 'noise' without 'voice'.¹⁹ Sound is felt as a body and through the body. Sound does not need to be 'heard' because its 'vibrating afterward' is powerful, present and whole-bodied: 'But the body cannot always refuse. Screams can enter unheard [...] a shattering body of sound, shattering the child's body'.²⁰ The body of sound – formed from a body, and forming its own body – enters another, and attacks it. The experience of sound is not simply about waves meeting an ear drum; it resonates, circling the whole person, affecting and shaping as it does.

Clough argues that 'an ontology of vibrational force lets sound come to the rescue of thought rather than the other way around, forcing thought to vibrate, loosening up its organised or petrified body'.²¹ Indeed, sound theory helps expand upon – and further focus on – the entanglement of matter and meaning discussed in the feminist material in the Introduction. Whereas biology has often been critiqued by feminists for its reductionist understandings, sound suggests a much more malleable account of biology because it moves and changes. Sound shakes up and breaks up a constricted, internalised thinking-doing ontology with energy. The self is not bounded but hugely connected to the world around it; it cannot seal off against the socio-cultural or environmental forces. Indeed, as Ahmed implores, feminism is 'sensational'; bodily sensation communicates and forces awareness of a sense of dis-ease with the way it is represented and treated by the world around.²² The whole 'being-body' feels and reacts and the body is itself energetic; it holds energy and is moved by energy. This account

¹⁹ Patricia Clough, 'My Mother's Scream', in *Sound, Music, Affect*, ed. by Thompson and Biddle, pp.65-72 (p.65).

²⁰ Clough, p.67.

²¹ Clough, p.69.

²² Ahmed, p.22.

disrupts the idea of a closed-down or contained individual subjective self. Bodies in contact with the world experience life through vibrations that move, shake, energise and transform them. They similarly can imprint and transform and alter the world.

Indeed, a 'medial' account of sound immerses the hearer and the object in the medium; this is how sound waves are understood.²³ Sound is created by the 'pattern of disturbance caused by the movement of energy traveling through a medium'.²⁴ This idea that sound is immersive and energetic offers a connective account that starts to dismantle the idea of the fixed body and instead offers a suggestion of evolving bodies. Sound acts as a connective tissue as it binds bodies to the world in a way that emphasises relationality. Sound does not just happen between the ears because it refuses the distinction between inside and outside and between mental and physical.

Affecting Energy

The relational aspect of sound brings me towards affect theory, which I want to touch on here because it ties so closely into the material on sound, and because it finds synergy with notions of the energetic body. However, I also want to emphasise its limits, and why the language used often does not go far enough to move beyond dualistic terms. As humanities scholar, Ruth Leys writes, in her analysis of the 'affective turn' in the early twenty-first century, the affective frame sought to put the body back at the centre of experience, which rises from the body and from the world in which that body is situated.²⁵ As such, and as is emphasised by philosopher Teresa Brennan, affect is material with an 'energetic dimension'; it travels and transmits.²⁶ The movement – or 'transmission of affect' – starts to undo the idea of a bounded individual separate from

²³ Roberto Casati and Jerome Dokic, 'Sounds', *The Stanford Encyclopedia of Philosophy*, ed. by Edward N. Zalta <<http://plato.stanford.edu/archives/fall2014/entries/sounds/>> [accessed 17 July 2017].

²⁴ Margaret Rouse, 'Sound Wave', *WhatIs.com*, September 2005, <<http://whatis.techtarget.com/definition/sound-wave>> [accessed 17 July 2017].

²⁵ Leys, 'The Turn to Affect'.

²⁶ Teresa Brennan, *The Transmission of Affect* (Ithaca: Cornell University Press, 2004), p. 6.

the world in which she/he moves because it expands beyond and between individuals. Importantly, Brennan argues that the 'social' is not just a theory or concept of world dynamics – a 'non-real' thing, split from the 'real' thing of the physical or biological. The social is embodied – 'it actually gets into the flesh'.²⁷

Affect might be thought of as an 'in-between' in terms of the extra or excess of its transmitted energy. In this way, it is not possible to seal against the world because the world and body are all energy. As Thompson and Biddle explain, affect is about 'divesting the body of something, making "autonomous" what the body imagines as its own'. Resultantly, it is 'something that is connected [...] to the bodily' and yet also 'allow[s] for nodes of connectivity that sometimes (often) omit or bypass [...] bodies'.²⁸ This notion opens up a space between phenomenological perception – where the individual body is centralised – and those 'nodes of connectivity' which travel beyond or in excess of individuals. As Thompson articulates – a person can be 'overwhelmed or traversed by affect [...] it spills over what we consciously know, or feel, or experience of it'.²⁹ This can be demonstrated by thinking about affect in a room full of anxious people: the palpable tension, the heat in the air, the shuffle of bodies tapping and shifting and the texture of the space. In the rhythm of interaction, anxiety transmits within the air, through the ground and between and beneath perception.

This idea of spill-over – or of excess – begins to dismantle the cognitive position of controlled thought or feeling – where a person simply reframes or rejects unhelpful or irrational thoughts in an enclosed act of individual transformation – because inner and outer worlds are interwoven and inextricable. Human life is never wholly self-contained within the outline of the flesh. Anxiety is not a property of a person, but a tangible, visceral and physical energy, and can be created and sustained between people. This

²⁷ Brennan, p.25.

²⁸ Marie Thompson and Ian Biddle, 'Somewhere Between the Signifying and the Sublime' in, *Sound, Music and Affect* ed. by Thompson and Biddle, pp.1-24 (p.13).

²⁹ Marie Thompson, 'Three Screams', in *Sound, Music and Affect*, ed. by Thompson and Biddle, pp.147-162 (p.160).

view matters in terms of mental health because a person with a **Brain Disorder** model neurochemical problem or an internalised issue with **Immaterial Thoughts**, which are supposedly fixed by thinking or managing better, can never actually be separated from the context of their lives.

While these theories around affect, both enhance and support a vibrational and sensory account of human embodiment, some affect theorists have injected a split between conscious thoughts (and their accompaniment in words) and visceral matter. This can be seen in the work of social theorist Brian Massumi, who argues that affect cannot be fully realised in language because it exists ‘prior’ to and/or outside consciousness. For Massumi, there is a time lapse between body and word because the body is pre-conscious; ‘the skin’, he argues, ‘is faster than the word’.³⁰ In Massumi’s account, the body is foregrounded, and affect is positioned as a precognitive and visceral force that can influence thinking and judgements, but it is essentially separate from these. A line is drawn between bodily responses to an event – to the shake of a traumatic incident, for example – and the cognised, interpreted or reimagined version of that visceral bodily force. The corporeal is split apart from the cognitive. Goodman’s affective account of sound takes up a similar theme; the body reacts to sound and to its vibration and movement before conscious ‘minded’ perception of the event. Sound is made equivalent to the body and is listened to with ‘every pore’ of that body. The body once again precedes the word where ‘the gut reaction is pre-empting consciousness’.³¹

In this dialectic, the body senses anxiety before the ‘mind’ reacts. This appears to be directly opposite to an understanding of ‘mental’ dis/order where the mind leads the body – where ‘unhelpful’ thoughts cause the body to react – impelling a tight chest or a tingling arm in response, and where the subsequent treatment is to deal with the person’s thoughts and see the bodily reaction as somehow secondary. This inversion also

³⁰ Brian Massumi, *Parables for the Virtual: Movement, Affect, Sensation* (Durham and London: Duke University Press, 2002), p.25.

³¹ Goodman, p.48.

raises a question: even if the body is put first, does it come first? And if it does come first, then what does that mean for re-inscribing a sense of duality, rather than overcoming it? In giving the visceral body its place back at the centre of experience, and in destabilising the prominence of the rational, cognitive mind, some affect theorists seemingly reinforce the mind/body split. As Ruth Leys discusses, just because we might be familiar with a ‘wrong, disembodied model of the mind’, it does not mean that the alternative model of viscerality and affect is non-conscious or devoid of meaning and sense.³²

Sound and Language

There is something about sound’s impact and relationship to affect, which begins to explode into broader concepts of how sound traverses being-bodies but also exists in excess of them. From the point of view of understanding embodied mental health, this idea of sound that stretches beyond a mentalist, enclosed and interiorised perspective, helps to emphasise the very physical and material ways in which people connect and engage with the world. A vibrating energetic force might be small and unheard, but it demonstrates how affect impacts beyond – or in excess of – worded representation.

Therefore, it is not the case that the word follows or trails the bodily response, but rather that not all thought is worded or needs to be represented in narrative terms. This is a big leap to make when thought and language are so intimately connected in the Cartesian model but it is important to recognise – as Karin Eli and Rosie Kay write in their medical humanities focused work researching a dance project for women with eating disorders – that the sensory nature of illness can become somewhat lost or overwritten by a focus only on narrative explanation and verbal sense-making.³³

³² Leys, p.458.

³³ Karen Eli and Rosie Kay, ‘Choreographing lived experience: dance, feelings and the storytelling body’, *Medical Humanities*, 41(2015), 63-68.

For Marie Thompson, the scream actively exemplifies the notion of experience that transcends linguistic representation.³⁴ Its energy is not one of a neatly structured signifying form, but of a shaking, embodied noise. This is a noise with feeling and vibration; this is a noise that can haunt and hurt. Indeed, as Clough explains, she writes in the role of ‘an ontologist of vibrational force’ in describing her childhood rather than someone telling her ‘autobiography’.³⁵ Her account is one of physical memory inscribed through sound, not simply one word following another word. In conveying the personal account of the ‘affect’ of her mother’s scream, she seeks something other than the ‘technical remove’ of a linear narrative which seeks to ‘story the self’. In retelling (or re-feeling) her childhood memories, she wants instead to ‘translate statistical populations of radicalised lives’ in the neighbourhood in which she grew up, ‘into vibrations, coming up from the street, affecting me bodily, resonating with the slow painful beating in my stomach and the fast irregular beating of my heart’.³⁶ The visceral and physical nature of Clough’s slow painful stomach-beating and ‘fast irregular’ heartbeat permeates her writing. This physicality and vibrational force are put into words, but words are not containers – the gut and organs push through words; they pulse and beat from within them. The body in the world is implicated in everything; thoughts or feelings packaged into words can provide only a part of human experience. The matter of her body, the matter of the sound wave, and the matter of her experience all have meaning. Both these authors suggest that the thought-word correlation might fall short in conveying the sensational and vibrational texture of experience.

The aim of this chapter is not to disconnect language from the body, more to trouble the dominance of the former in describing the latter. Indeed, sound can helpfully connect word and body, rather than divide them. To do this, I return once again to the concept of embodiment developed by Grosz where she conceives of embodiment as

³⁴ Thompson, ‘Three Screams’, pp.147-162.

³⁵ Clough, p.69.

³⁶ Clough, p. 67.

understood as ‘fully material’ and inclusive of language.³⁷ To illustrate this in practical terms, I draw upon the example of the yogic mantra or vibration ‘Om’. In this chanted word, the materiality of sound is inseparable from its meaning. As Barcan articulates, it is ‘simultaneously physical and metaphysical’. It means something and it does something. It is not a separate worded or narrative representation of a bodily experience; it creates bodily experience. Indeed, as Barcan explains, ‘mantras are not just symbols’ but are a form of ‘energy encased in [a] vibrational structure’.³⁸ In practical terms, what this means is that different body parts are activated in the vibration of making different sounds. The tongue makes different sounds affecting different parts of the body as it moves. Matter and meaning are intimately connected. Indeed, when sound is used in healing – for example with chanting or toning or with the use of Tibetan singing bowls or Chinese meditation gongs – this is not only about an ethereal, detached and floating energy; it is a vibrating, physical energy to which there is a non-divisible response.³⁹

The Touch of Sound

In a whole being-body account, where vibration and energy underscore experience, the senses are interrelated. Clough develops a theory of what she calls the ‘transsensorial’ as she remembers watching the night-time patterns on the bedroom wall of the cramped apartment in which she grew up:

unhearable sounds, vibrating, jumping on to my skin and pushing in.

Once I was made to swallow the pattern whole.

Choking I could not control

³⁷ Grosz, *Volatile Bodies*.

³⁸ Barcan, p.133.

³⁹ Jeffrey D. Thompson, ‘The Clinical Use of Sound’, *The Center for Neuroacoustic Research*, <<https://www.scientificsounds.com/index.php/center-for-neuroacoustic-research/articles/the-clinical-use-of-sound.html>> [accessed 17 July 2017].

the screaming now inside me echoing silently.⁴⁰

The sounds are sensed through the organ of the skin, rather than directly listened to by the ear. The sounds 'push in'; they are given a sense of physicality by Clough and there is a feeling that they are deeply imprinting on her body. The senses are not neatly defined and marked out; they cross over throughout the whole person.

In his book *Sinister Resonance*, composer and musician David Toop emphasises this connection between sound and touch, in particular. His examples give a perceptible feeling to the experience of the touch of sound. He writes,

Lying down, I experience sound as physical sensations [...] I feel sounds (loud or soft, familiar or uncanny) as a shock or surprise; shivers, a sudden prickling sensation, shudders, small waves of hearing that are haptic more than aural, as if a hand has brushed across my scalp, as if a quick jolt of electricity has been shot into my back.⁴¹

Sound is felt. It touches and moves the skin and it connects the body to the world; energy against energy and vibration against vibration. Sound helps articulate a model of embodied subjectivity, which is deeply embedded and involved in its social and environmental context; one where the idea of inner sounds and interiorised individuality is difficult to support.

Toop's mention of waves of hearing that are 'more haptic than aural' leads me to unpack the meaning of haptic and its possible relationship to sound. While the Greek roots of haptic align it with the 'sense of touch' or 'tactile sensations',⁴² I am working

⁴⁰ Clough, p.68.

⁴¹ David Toop, *Sinister Resonance: The Mediumship of the Listener* (New York and London: Continuum International Publishing Group, 2010), p.56.

⁴² "haptic, adj. (and n.)." OED Online (Oxford University Press, June 2016) [accessed 17 July 2017].

with a definition that connects with concepts of embodiment. Haptic expands the reach of touch from the ‘cutaneous surface’ towards the more ‘inwardly-orientated senses’ of proprioception and kinesthesia.⁴³ These senses inform perceptions of ‘inside’ and ‘outside’ and of inner and outer space as they help locate the body in the world. Rather than being discrete and separate, these senses act together. If sound is also haptic – involving a feeling and impression on the skin and a physical, vibrational energy – then sound also provides a sense of connection to what it means to inhabit a body. A conceptualisation of haptic sounds adds depth to both touch and sound; it is part of a being-body’s world relationship and something that is much more than a thought-constricted experience, it is deeply layered and deeply felt.

Different paradigms offer touch as a form of body listening and body knowledge, from acupuncture to massage-based bodywork. The relationship between listening to, and feeling for, knowledge about the body is interestingly explored within medical practice too, in a way that counters a segmented and siloed anatomical view of human bodies. Anthropologist of medical practices, Anna Harris, discusses how doctors percuss bodies and how this process involves the ‘feeling of the vibration’ – suggesting a tactile resonance to doctors’ work. Percussion is a key tenet of the basic clinical examination taught to medics in training. It is ‘a method of tapping body parts with fingers, hands, or small instruments as part of a physical examination’ to assess ‘the size, consistency, and borders of body organs’ or the ‘presence or absence of fluid in body areas’.⁴⁴ Importantly, as Harris articulates, it is a form of ‘listening touch’. For medics, the practice of feeling and listening is very much ‘integrated’. Textbooks tell them to simultaneously ‘listen and feel for the nature and symmetry of the sound’.⁴⁵ Sound here is given a tangible depth and structure. The blend of these two sets of understandings – moving from

⁴³ Mark Paterson, *The Senses of Touch: Haptics, Affects and Technologies* (Oxford: Berg, 2007), p.4.

⁴⁴ Linda J. Vorvick, ‘Percussion’, *Medline Plus*, 31 January 2015 <<https://medlineplus.gov/ency/article/002281.htm>> [accessed 19 July 2017].

⁴⁵ Anna Harris, ‘Listening-touch, Affect and the Crafting of Medical Bodies through Percussion’, *Body and Society* (12 November 2015), 31-61 (p.35-36) <<http://dx.doi.org/10.1177/1357034X15604031>>.

‘physiological anatomy’ to ‘subtle anatomy’ usefully taps into a transdisciplinary space that medical practice often struggles to connect with or articulate in its evidence-based spaces of knowledge. In terms of my research question, this is also useful for dissolving mind and body binaries, providing a body modelling that does not separate out matter from the immaterial.

Matter with Meaning

David Toop articulates how the physicality described in a vibrational-material account of sound has to sit against ‘the aerial (or ariel) nature of sound [...] which always implies some degree of insubstantiality and uncertainty’.⁴⁶ This duality does not engender a separation but is a way of conceptualising two parts of the same thing. A material or corporeal approach to understanding subjectivity does not cement that subjectivity in fixed cells and blunt ends; instead, it reveals how the body is energetic, fluid and malleable. The argument runs further; it is not a case of body against mind because mental life is a part of the body. Steven Connor writes that sound can be ‘imagined in the same two-sided way as skin: both as that which touches and which is touched’.⁴⁷ This concept of the two-sidedness of sound feels resonant in thinking about how it complicates or agitates different states. It is akin to a dismantling of dualism; inner and outer, body and world, touching and touched, the pairs cannot be separated.

Sound has a physical presence and is assimilated by the being-body; it suggests a space of connection and crossover to work through the mental and physical binary in both the invisible fibres of vibration and the larger connective tissue of bodies as a part of the world around them. Sound helps detach thought from the head alone; it shows the thinking being-body alive, vibrating, energetic, and immersed in a world beating along with it. This immersive picture points to the value of context not universality; to the

⁴⁶ Toop, p.24.

⁴⁷ Steven Connor, ‘Edison’s Teeth: Touching Hearing’, in *Hearing Cultures: Essays on Sound, Listening and Modernity*, ed. by Veit Erlmann (Oxford and New York: Berg, 2005), pp.153-172 (p.163).

sensation of the body, to the feeling on the skin, to the way in which the world accepts or challenges that body, and how the body is then shaped in return. As Ahmed writes, when the context is violence – for example – the body begins to expect it, and the body becomes differently inhabited, differently moved in anticipation.⁴⁸ This is the process of becoming. It is a process of being in the world, and learning from that world; a body defined and redefined in relation to the energy it creates, anticipates and experiences, and in relation to space it is offered or refused. I will now turn towards music to deepen the understanding of embodied subjectivity – understood through the moving, performing or perceiving being.

Moving Music

As a performer, I act on and with what we ordinarily call music with my body; as a musicologist I have been formed to act on (and with?) what we ordinarily call music with my mind, and only with my mind. Thus, my musicological habitus inclines me to think about music's fixed, textlike qualities, an inclination that is perpetually at odds with the way my performing self inclines to think about and respond to music.⁴⁹

In this quotation, feminist musician and critic, Suzanne Cusick argues that musical theory has become dislocated from the bodies that are so involved and essential to the very practice it seeks to describe. In this way, music criticism struggles with a mind/body binary as much as medicine does. In this section of the chapter, I look at music theory, and specifically criticism around music and the emotions, to help further foreground an account of mental life that is vitally embodied. To develop this position, I consider how

⁴⁸ Ahmed, *Feminist Life*, p.24.

⁴⁹ Suzanne G. Cusick, 'Feminist Theory, Music Theory, and the Mind/Body Problem', in *Music/Ideology: Resisting the Aesthetic: Essays* ed. by Adam Krims (Amsterdam: G+B Arts International, 1998), pp. 37-56 (p. 38).

feminist criticism has focused on the emotional and embodied experience of music, to help unthread it from the dualist underpinning inherent in cognitive, rationalist models. Music is relevant and resonant for the question of embodied mental health because, as Barcan usefully conveys, its therapeutic use (in medical settings and in alternative practices) bridges scientific and humanistic discourse. Music therapists refer to both the physiological and to the affective and energetic without division.⁵⁰ This bridging is vital because it provides a space from which to think through difficult questions and those ‘sweaty concepts’ around ‘mental’ dis/order in a transdisciplinary way. However, I couch this discussion once again within limits; music is not a singular thing, and there is no universal human reaction to music, but many cultural and social influences that shape responses. Despite these limits, music has the potential power to cross mind and body divides and to demonstrate an indivisible, sensation-based response that clarifies the idea of moving energy and embodied existence.

In twentieth-century Western musical discourse, music has often been conceived in cognitive or rational terms, which seems to miss out a whole spectrum of emotional, imaginative and bodily resonance. As with discourse around sound, the philosophy of music and the emotions has been largely led by a model of mental life enclosed in **Immaterial Thoughts** model and underlain by dualist beliefs. Philosopher Paul Boghossian, in a long line of philosophers discussing music and the emotions, argues that, because a ‘brute physiological explanation’ would not be satisfactory in an understanding of how and why music relates to emotions, we must, therefore, look to explain ‘the rationality of our emotional response’. He wonders, ‘How is it possible for mere sound, lacking speaker intention, or any of the other resources which make linguistic meaning possible, to express meanings?’⁵¹ In this quotation, Boghossian inscribes several assumptions that I seek to counter in this chapter. First, that a

⁵⁰ Barcan, p.123.

⁵¹ Paul Boghossian, ‘Explaining Musical Experience’ in *Philosophers on Music: Experience, Meaning and Work*, ed. by Kathleen Stock (Oxford: OUP, 2007), pp.117-129 (p.117-18).

materialist position would necessarily be 'brute' in its bodily context; second, that such a response would not involve 'rational' thought and, by the same token, that there is a split between rational and bodily responses; third, that the elevated, rational view is to be admired and that the 'right' response is a matter of intellectual appraisal; fourth – the overarching position that this chapter seeks to undo – that language makes all meaning and that 'mere' sound cannot be meaningful.

Formalism and Intellectual Music

In order to move past a cognitive, detached and theoretical appraisal of music, and towards an embodied account, it is necessary to journey across some of the most influential evidence within the philosophy of music and the emotions. This is a richly developed field, and I cannot account for every perspective within it, but it is my aim here to consider how these accounts take music away from the body in dualistic and mind over matter terms. These accounts cling to individualist models of enclosed minds, unaffected by the matter of the body and sensation, in ways that, I argue, irresponsibly neglect and negate the context in which music is made, listened to and felt.

The most cognitive and rationally focused model of music takes a formalist approach. In this understanding of music, any meaning in the music is intellectual. Therefore, the study, appreciation or understanding of that music comes in its 'pure form without any extra musical content'.⁵² Such an approach is non-referential; the music does not have to refer to the world outside because its meaning is internal. This position is taken up by philosopher Nick Zangwill who argues – in an often-cited account taking this perspective – that music should not be understood in terms of emotion at all – that music does not have to 'possess emotions, arouse emotions, express emotions or represent emotions'.⁵³ For the formalist, meaning is in the context of the work itself – in

⁵² James O. Young, *Critique of Pure Music* (Oxford: Oxford University Press, 2014), p. 1.

⁵³ Nick Zangwill, 'Against Emotion: Hanslick was Right about Music', *British Journal of Aesthetics*, 44, 1 (2004), 29-43 (p.29).

the very sound structure of which it is composed. A formalist model is unhelpful and uneasy against theories of embodiment and it gapes with holes in terms of how music is created by embodied beings, moves bodies, connects bodies and is played by bodies, all of which it takes no interest in.

A differently-angled formalist approach is that of expressionism wherein it is felt that music communicates or expresses emotion. In expressionist accounts, it is thought that the emotions expressed in music are a cathartic release or a presentation of the composer's own emotions. Other varieties of this theory focus on the way in which music might express the kinds of emotion that the composer understands, even if he or she does not personally feel them at the time of composition. However, these theories fail to explain how the music holds or transmits those emotions, or how or why others might have an emotional response to them, only that it expresses them. Furthermore, such accounts are not particularly interested in the seat of those emotions, or in an embodied understanding of emotional life.

The formalist model bends a little further for some critics who argue that music can be *expressive of* emotion. In these accounts, emotion exists within the structure of a piece of music itself. Listeners understand the emotions created in the piece within a sort of shared code of musical and emotional meaning. The emotion is within the music – its dynamics and form – and the 'knowledgeable' listener will experience music's expressiveness in this cognitive appreciation.⁵⁴ There are specific versions of resemblance theories that describe the 'shared code'. The work of Peter Kivy suggests that music is expressive of feeling because 'it has the same "contour" as expressive human behaviour of some kind'.⁵⁵ Philosopher Stephen Davies' theory of 'appearance emotionalism' argues that people recognise sadness in a piece of music because it is reminiscent of other

⁵⁴ Peter Kivy, *Sound Sentiment: An Essay on the Musical Emotions Including the Complete Text of "The Corded Shell"* (Philadelphia: Temple University Press, 1989), p.38.

⁵⁵ Jenefer Robinson, 'The Expression and Arousal of Emotion', *The Journal of Aesthetics and Art Criticism*, 52,1 (Winter 1994), 180-189 (p.180).

expressions of sadness. He articulates how we come to see emotion by ‘appearances’.

Davies’ account is based on the idea that there is a shared understanding of, for example, sadness as ‘slow and quiet downward movement’.⁵⁶

Kivy and Davies start to put the body into view because there is some reflection or representation of the body in music. However, the body does not actually take part in that process of identification: it is not involved in feeling it, embodying it and reliving it while listening to music. If identification with music only exists in ‘perceive[d] resemblance’⁵⁷ or cognitive memory about how an emotion is typically felt or experienced, this arguably implies the negation of body-memory itself, which feels particularly problematic in a musical context. Furthermore, these critics make some assumptions about types of experience and feeling and the sensations attached to them, which are problematically universalising in tone.

Susanne Langer’s chapter ‘On Significance in Music’ in her book *Philosophy in a New Key* argues that the relationship between music and the emotions is one of symbolism. Langer argues that, if music has emotional content, then it “has” it in the same sense that language “has” its conceptual content – symbolically’.⁵⁸ Langer’s emphasis is on the structure and complexities of feeling and the abstracted and imagined quality of experience. In her view, music can only express certain qualities of emotion, rather than the emotion itself. Langer’s work is important in moving music from the static and textual towards motion. She suggests that music’s fluidity reflects the ‘morphology’ of feeling, as music’s ‘[dynamic] patterns of motion and rest, of tension and release, of agreement and disagreement, preparation, fulfilment, excitation, sudden change’ suggest, or figuratively represent, a sense of human inner life.⁵⁹ The structure of

⁵⁶ Stephen Davies, ‘Artistic Expression and the Hard Case of Pure Music’ in *Contemporary Debates in Aesthetics and the Philosophy of Art*, ed. by Matthew Kieran (Oxford: Blackwell, 2005), pp.179-191 (p. 181).

⁵⁷ Stephen Davies, *Musical Meaning and Expression* (Ithaca and London: Cornell University Press, 1994), p.229.

⁵⁸ Susanne K. Langer, *Philosophy in a New Key: A Study in the Symbolism of Reason, Rite and Art* 3rd edn (Cambridge, MA: Harvard University Press, 1957), p.218.

⁵⁹ Langer, p.228.

music symbolises the scope of the body of emotions and the tension and resolution of these feelings. However, this (and other) symbolism accounts remain referential and metaphorical. The symbolism approach keeps music's reception in an emphatically disembodied space. At this point in the curve of critical perspectives, the story of the expressiveness of music tips into something more than a conventionalist or representational theory can hold together. The gap between the idea that music is expressive of emotion because it resembles the motion of emotional bodies, and the notion that those bodies might remember and feel that emotion when listening to music, begins to feel so small as to be untenable.

Indeed, even where formalist accounts make room for the emotional reaction or response of the listener, it is within limits. Davies, for example, admits that a 'listener can be moved to feel the emotion that the music expresses' but the metaphors he leans on to exemplify this include contagion, transmission, communication, and osmosis.⁶⁰ The body is tangibly reacting to the emotion but what is missing from this theory is any sense of meaning for the person in their reaction, which is purely automatic. This is a bodily response, but not an embodied one.

Moving beyond formalist accounts, an 'arousal theory' claims that emotion is in the perception and the person perceiving, and so music is sad because it arouses sadness in the listener. Jenefer Robinson's paper in this area, *The Expression and Arousal of Emotion*, takes up this view, but once again inscribes a split between body-physiology and cognition.⁶¹ Robinson argues that at the more 'primitive' end of the scale are emotions such as 'tension, relaxation, surprise' and at the other end there is the more elevated and cognised 'unrequited passion'. In the case of those basic or 'primitive' emotions, they are aroused by the music and then translate into something else more

⁶⁰ Stephen Davies, 'Music-to-Listener Emotional Contagion', *Affective Sciences and Music - International conference*, University of Geneva, transcript, 27 June 2009 <<http://www.unige.ch/emotionalpowerofmusic/conference.html>> [accessed 28 August 2016] (p.1 of 10).

⁶¹ Robinson, p.186.

complex via the imagination. In this way, a simple sensory emotion such as surprise jolts the body and the imagination then works on this feeling to translate it, reimagine it and rearticulate it. Robinson's account sees an emotional response to music at the 'simple' level as more operational and mechanical than meaningful. Indeed, it is hard to find a position for the emotions when, one on hand, they are related to judgement, appraisal and cognitive, brain-based calculations and, on the other hand, where it is said that the body has a significant role but the argument collapses into sensation without meaning. The body and mind split still overshadows the interpretation, and the dualistic language remains ingrained.

Embodied Music

In this section, I aim to consider how the body is immersed in music, moved by music and, ultimately, how music acts to dissolve the binaries presented in the above formalist and referential accounts. Indeed, embodied musical accounts foreground the feeling of music making, or the experience of listening to music, as they are interested directly in the impact on a person.⁶² Leaning back towards the words of Suzanne Cusick, the practice of music is always an embodied discipline so why should musicology seek to defy this? Cusick describes the problem of the dominant theories of musical criticism as wrapped up in a 'mind-mind' relation wherein, 'the composer has come to be understood to be the mind that creates patterns of sound to which other minds assign meaning'. There is no room for an embodied response to this because the music is identified as being a product of 'mind' and only to be deciphered and interpreted by mind. As Cusick identifies, 'we end up by ignoring the fact that these practices of the mind are nonpractices without the bodily practices they call for about which it has become

⁶² Chris Stover, 'Musical Bodies: Corporeality, Emergent Subjectivity, and Improvisational Spaces', *M/C Journal*, 19, 1 (April 2016) <<http://journal.mediaculture.org.au/index.php/mcjournal/article/view/1066>>. [accessed 19 July 2017].

unthinkable to think'.⁶³ Music is not only a score, nor the production of the score into sound, but to embody and to become body in the act of playing, as well as in the act of listening/perceiving.

A feminist modelling of musical criticism understands the mainstream philosophical discourse of music and the emotions as a gendered one. Susan McClary writes that music has been effectively disembodied and rationalised in an attempt by male musicians to define music as the 'most ideal (that is the least physical) of the arts by insisting emphatically on its "rational" dimensions'. Historically, she asserts, musicology attempted to 'remasculinise' music away from any sense of feminine or affective influences.⁶⁴ For Cusick, this means that interpretations of music that find an embodied response or a body story are denied. This interpretation of music and emotion feeds into a wider cultural tendency to see emotions as weak and bodily. Sara Ahmed develops this point to explain how emotions have been narrated as 'a sign of how the primitive exists in the present'. As Ahmed explains (reminiscent of Robinson's interpretation), emotions have become stratified, with some emotions 'elevated as signs of cultivation' and others cast down and away, seen as weakness and very often couched in soft or negative feminine terms.⁶⁵ Music criticism and analysis suffer the same hierarchicalism.

The disembodiment of music criticism is linked to a wider notion that the body in its weighty or physical materiality only surfaces when things are wrong.⁶⁶ From this perspective, in day-to-day life, a person should be unencumbered by the physical body, which is – at most – able to react or respond in visceral, autonomic ways. However, the performance of music raises very a different view of bodies, which ascend in physicality and where the player is an active and engaged subject. The physical body is valuable,

⁶³ Cusick, p.6.

⁶⁴ Susan McClary, *Feminine Endings: Music, Gender and Sexuality*, (Minneapolis: University of Minnesota Press, 1991), p.17-18.

⁶⁵ Sara Ahmed, *The Cultural Politics of Emotion* (New York: Routledge, 2004), p.3.

⁶⁶ Drew Leder, *The Absent Body* (Chicago and London: University of Chicago Press, 1990), p.4.

present and productive; it moves from the position of object to subject. This is of particular importance within feminist discourse as critic Lauren Steyn writes:

Women are viewed as passive flesh and therefore the potential object of another subject's intentions and manipulations, rather than as a living manifestation of action and intention [...] For the body to be effective, it must not be seen as an object, but rather as a subject (i.e. active).⁶⁷

McClary's work puts musical discourse back into subjective bodies. The body is not the opposite of ideal and pure abstract intellect but is necessarily bound up with subjectivity. When music is understood in this way – pushing aside mind and body binaries – it is a productive source of embodied understanding. Indeed, McClary puts it this way, 'Music has an uncanny ability to make us experience our bodies in accordance with its gestures and rhythms'.⁶⁸ When bodies have been so far objectified by a cultural emphasis on mind over matter, and when women's bodies have been asked not to take up too much space, or have inhibited their movement due to repeated violence or objectification, or when 'mentally' ill bodies have been stigmatised and ostracised, an embodied conception of music is a valuable way of renewing and actively demonstrating embodied subjectivity.

Rhythm, in particular, cements the connection between bodies and music. Music communicates with its rhythm without the need for an accompanying or representative narrative. Musicologist Carolyn Abbate in her book *Unsung Voices* provides an example of a piece of opera music where a female vocalist 'transforms herself into a kind of musical instrument, a sonorous line without words and unsupported by any orchestral

⁶⁷ Lauren Steyn, 'Iris Marion Young: A 'New Look' Female Bodily Experience', *Bluestocking* 1 April 2008, <<https://blue-stocking.org.uk/2008/04/01/iris-marion-young-a-new-look-female-bodily-experience/>> [accessed 19 July 2017].

⁶⁸ McClary, p.23.

sound'.⁶⁹ She explains that this expression is about 'sonority' rather than 'story' and that the musical voice, 'exists in present time, as a physical and sensual force, something beating upon us'.⁷⁰ This focus on the physical beat and energetic force of rhythm provides meaning without linguistic representation. Rhythm transmits and it recreates; it is felt and received and imprinted. This is not just an abstracted or a metaphorical experience but an intensely physical one. The rhythms of music are implicated and imbricated in the body's own rhythm; led by its own internal metronome – the heart. This ongoing beat inside the chest, affected and moved by the external music, starts to unsettle the boundaries of the body. The work of music goes inside and underneath the skin, or, to take this even further, the body makes its own beats and the internal and external separation is undone.

In theorising the body's response as important in listening to music, and the body's essential role in producing music, it is essential to think about how knowledge can also come through embodied experience, as opposed to a subsequent working through with words. Indeed, musicologist Gascia Ouzounian's piece in *Contemporary Music Review*, helps frame this idea, as she argues that we need to move the 'listening point from the ears to the tissues of the body – a tangle of information, memories and physical and psychic relationships' – and that this then, 'requires a new model of aural reception and analysis'.⁷¹ An embodied listening challenges the formalist, neutral or disembodied stance and, in doing so, it 'reveals the body's biases, tendencies and aims – its history'.⁷² As Ouzounian listens from a space of embodiment, she explains how, 'all parts of my body act like antennas, turned on and receiving sound, changing my psychic image of myself'.⁷³ Bodies are not only text-objects, to be discussed or held at a distance;

⁶⁹ Carolyn Abbate, *Unsung Voices: Opera and Musical Narrative in the Nineteenth Century* (Princeton NJ: Princeton University Press, 1991), p.4.

⁷⁰ Abbate, p.12.

⁷¹ Gascia Ouzounian, 'Embodied Sound: Aural Architectures and the Body', *Contemporary Music Review*, 25, 1/2 (February/April 2006), 69-79 (p. 70).

⁷² Ouzounian, p.70.

⁷³ Ouzounian, p.75.

they are not simply there to observe or analyse. An embodied mode of listening uncovers meaning in the whole being-body and brings sensation to the fore, rather than at a representational arms-length.

There is something within the ‘tissues of the body’ and body memory that feels essential to both connect and to tease apart the experience of playing music from the experience of listening to it. While I have sought to question musicology, which negates the body, because the body is absolutely at the heart of musical practice, this is not the same as saying that playing and listening are identical processes.⁷⁴ Could it be that when the body is engaged in creating music by pressing itself against a string or a key, or when lip meets mouthpiece or when hand pounds a stick – when body memory is involved and implicated – that the imprint is stronger or deeper, that it is embedded in muscle and being-body? Roland Barthes considers this notion of embodied music-making in the essay *Musica Practica*. Barthes writes that ‘the music one plays is a muscular music [...] as though the body were hearing [...] the body as inscriber’.⁷⁵ The body does not ‘inscribe’ or play ‘muscular music’ without the whole person being drawn into the playing of it. The body is involved in music-making whether that be through the grain and texture of the human voice, or the imprint of different body parts against wood or nylon or steel, or through hearing and feeling the crawl of bass over the skin. This centring of the body within music sees it as collusion with sound, not an intellectual response to a detached and separated score.

Music reveals the imprint on the body, of what the body experiences, and what it learns from those experiences. Music, of course, will not always evoke deep reactions (some music may wash over, or may produce no discernible effect) and different types of music will evoke different reactions in different people. This is not an argument for

⁷⁴ Anita Collins, ‘How Playing an Instrument Benefits your Brain’, *TED-Ed lessons*, online video <<http://ed.ted.com/lessons/how-playing-an-instrument-benefits-your-brain-anita-collins>> [accessed 20 July 2017].

⁷⁵ Roland Barthes, ‘Musica Practica’ in *Image, Music, Text*, trans. by Stephen Heath (London: Fontana Press, 1977), pp.149-154 (p.149).

universality, but one for context, and one for the impression and immersion of bodies in the world as opposed to enclosed and internalised brain-based or psychological mental states, for which only individuals have responsibility or can be held to account. An embodied account of music is one in which the whole being-body can be deeply affected and shaped in listening or involved in complex and non-dualistic thinking in playing. As musical scholar Chris Stover writes in an article about 'Musical Bodies', in this way, musical scholarship has something to learn from feminist scholarship as 'emergent musical subjectivity' is inscribed through both 'performance and perception'.⁷⁶ Performance and perception help unfold patterns of embodied subjectivity. From here, I want to look in more detail at the relationship between music, movement and space, and how this is revelatory of a being-body always moving, beating and becoming.

Musical Movement and Space

The idea of static music with fixed properties, which are then interpreted or analysed by the critic, is undone by the relationship between music and listener – between the rhythm conveyed by the musician and the rhythm received or beating down on the listener, who takes part in that rhythm with their own body and often moves to it. Music is not only representative or symbolic of human movement, but it actively brings out those movements in the listener. The idea of reciprocity in musical exchange is exemplified by composer Antonia Barnett-McIntosh in a piece entitled *Quintet*, which explores the way in which music emerges with and from movement. *Quintet* is an interesting example because it inverts the idea of the musician composing and playing music and subsequently bodies listening, responding and dancing to the composition. In Barnett-McIntosh's piece, dance and music start on an equal footing so that 'dancers contributed to the sound world and musicians to moving in the space'.⁷⁷ Rather than

⁷⁶ Chris Stover, 'Musical Bodies'.

⁷⁷ Antonia Barnett-McIntosh, *Quintet: Collaboration with Nathan Johnston*, Robin Howard Theatre, The Place, 25- 26 March 2010 <<http://antoniabarnettmcintosh.com/Quintet>> [accessed 19 July 2017].

dance forming in reaction to sound and music – evolving from the bass or rhythm – Barnett-McIntosh's piece sees music being created with bodies and from dance. There is no simple response to a thing; it is a musical co-production.

Indeed, music is moving, but it is not only in that physical sense because it moves in an emotional sense too. Music moves or 'affects with emotion'; the word emotion stems from 'a movement of the soul' and from the Latin root *motio* meaning movement.⁷⁸ This etymological root provides a useful way of connecting the motion of music with the emotion of its experience and with a tangible sense of what the embodied mind might mean. Being-bodies are moved inside and out, or to further this notion, those inner and outer positions are dissolved away.

Music does not need to make movement happen perceptibly or externally to involve motion and emotion within the body. A person does not have to be dancing wildly to be moved by music. Indeed, if we take the idea of motion away from that explicit external bodily movement and towards a sense of motion such as an internal sense of a drop in sadness or despair, or the stomach-flutter of excitement – movement is understood as an integral part of emotion, not only an outwardly projected sign. Stilling the body is, in fact, a difficult process and involves a concerted effort, what Eldrich Priest defines as 'choreography of non-acts or counter movements'.⁷⁹ Music draws body responses and body concepts to the surface. The body is not an unthinking 'physical' object but part of the thinking and feeling being. When it is said that music is moving, that movement is not a detached, cognitive, head-controlled response to an object, but the reaction of the whole person, whose being is breathing through a body that remembers, feels and beats with and through the music.

Perhaps the most useful model of music to help rethink the divides between mind and body (and thereby the extension of mental life through the body) is one where

⁷⁸ "move, v." *OED Online*. (Oxford University Press, December 2014) [accessed 20 July 2017].

⁷⁹ Eldrich Priest, 'Felt as Thought (or Musical Abstraction and the Semblance of Affect)', in Thompson and Biddle, eds., *Sound, Music, Affect*, pp.45-63 (p.47).

music is understood as an act of release or a space of dissolve. As philosopher Don Ihde attests, ‘music – can overwhelm inner presence’ and provide a ‘temporary sense of the “dissolution” of self-presence’.⁸⁰ Music dissolves the idea of a bounded self, impenetrable to the outside, or somehow individually able to overcome with the power of mind over matter. Chris Stover agrees that music helps us see the always-becoming of the body; and we cannot know what this ‘is’ at any point, as the ‘porous thresholds’ that music reveals help to problematise ‘where one body stops and the next begins’.⁸¹ Drawing back to the questions of this thesis – centred in providing a social and physical context for ‘mental’ dis/order – such ideas of boundary dissolving, or of bodies constantly affected and affecting, and moving and interacting, which are offered up by embodied music criticism, help to provide a tangible realisation of these theories.

Taking this idea further, the psychoanalytic music critic David Schwarz is interested in why music can cause goose bumps, and why these bumps on the surface of the skin (as the visible edge of a body) might be significant. He writes that listening is an ‘all around’ pleasure, and that through music the boundary separating the body from the external world seems dissolved or crossed in some way. Schwarz argues that music is an ‘oceanic’ fantasy comparable with ‘sleeping, swimming, having sex, being absorbed by a movie, by a religious experience or a landscape’.⁸² These experiences overwhelm and overtake. Such oceanic fantasies are compared with the ‘sonorous envelope’ – the surrounding of the foetus with the maternal voice – which Schwarz argues is the first model of auditory pleasure.⁸³ Music then finds its roots in nostalgia for this ‘sonorous womb, a murmuring house’.⁸⁴ Music is not the thing itself, but the fantasy of the thing – it is visceral but it is also imaginative. Schwarz argues that whether music represents the

⁸⁰ Don Ihde, ‘Auditory Imagination’ in *The Auditory Culture Reader* ed. by Michael Bull and Les Back (Oxford and New York: Berg Publishers, 2003), pp.61-66 (p.61).

⁸¹ Stover, ‘Musical Bodies’.

⁸² David Schwarz, *Listening Subjects: Music, Psychoanalysis, Culture* (Durham, NC: Duke University Press, 1997), p.7

⁸³ Schwarz, p. 8.

⁸⁴ Schwarz, p. 7 cites Guy Rosolato, ‘La Voix: entre corps et langage’, *Revue Francaise de Psychanalyse*, 37 (1974), pp. 75-94.

‘sonorous envelope’ in terms of either being structured as this ‘fantasy thing’ or as it articulates the ‘sonorous fantasy space’, it represents the crossing of thresholds.⁸⁵

In the accounts by Schwarz and Idhe, the body is touched by music in a very visceral and physical sense, as well as connecting to its imaginative power (which is not separate but connected and integrated with that physicality). If music represents this sense of space – yearned for and recalled through certain moments or movements that seem to cross back to that sonorous womb – then when that ‘fantasy space’ is entered into, a boundary is crossed, and goose bumps appear with the memory of feeling reimagined. Body memory is foregrounded; memory that is created even before linguistic signification is learnt or constructed. In this understanding, music is an enabling force for understanding subjectivity through embodiment. In a culture of habituated disembodiment, where models of the mind and body are split, and where the head and brain are viewed as dominant, music articulates the possibility for something else – a different model of being a sensible body. The ‘affect’ of music – of movement and of being moved – is visceral and embodied and meaning is deeply embedded within this.

Music provides a sense of spaciousness and it actively articulates the constancy of the thinking body in motion. Musician, Jo Hamilton, demonstrates the whole body immersed in a dance-like choreography with an instrument called the ‘Airpiano’; an instrument which is played without being touched. As her hands and arms move above a slab, sensors detect those movements in 3D space.⁸⁶ Watching her hands lift, release, wave, open and close, there is a real sense of how music is created through space and through the movement of the body within that space. The moving, opening and soothing that music can enable, provides a pathway through the problematic head-body verticality which is culturally dominant and leads our current perspectives on ‘mental’

⁸⁵ Schwarz, p.8.

⁸⁶ Tom Lamont, ‘Jo Hamilton: “Playing an AirPiano is Almost Dance-like”’, *the Guardian*, 10 July 2011 <<http://www.theguardian.com/music/2011/jul/10/jo-hamilton-airpiano-air-piano>> [accessed 19 July 2017].

dis/order and the solutions psychiatry and psychology offer to address them.

Conclusions

In carving out a conceptualisation of mental life as running through the being-body, I needed to find a tool with which to practically grasp and to articulate this notion. In this chapter, I have discussed how the notion of haptic sounds brought forth the body and its presence; where sound as physical energy imprints, moves and vibrates the skin and self. I then worked with theories of music and emotion to suggest that music moves in ways that grant space to the body to move beyond habit and to feel an embodiment often denied in an individualist, head dominant culture. I argued that a detached, separated and abstracted notion of musical experience rests on the belief that mind rules matter. Conversely, I suggested that music is both produced and felt by bodies, which both shape music and are shaped by music, thus helping to dissolve boundaries between object and subject, and self and other. With these arguments in place, the bubble where thought is held inside words – and where ‘mental’ dis/order is a problem of this specific, compartmentalised aspect of human life – starts to explode into something physical and amorphous, potentially testing and transcending the boundaries of narrative form. This chapter has taken the thesis from the re-hashed spaces of narratives circling around the problematic dividers of ‘mental’ and ‘physical’ health to push towards the material, practical feeling of being a body. I have foregrounded how ‘emergent musical subjectivity’ in both performance and perception/reception of music surfaces aspects of bodily-being that reach beyond the confines of narrative selfhood presented as essential in some dominant spaces in medical humanities scholarship. Indeed, in the next chapter, I move to think about body practices that focus on the experiential; where meaning and knowledge is located within being-bodies rather than in subsequent and separate interpretation or representation. I suggest that these practices are important in helping to wrestle with the difficult work of addressing the language of ‘mental’ dis/order, and

that a radical reconsideration of what this means needs to draw from practices and understandings that start to enquire about 'mental' health and life from embodied roots, rather than as an afterthought or unthinking relation.

Chapter Four: Knowing Bodies

Chapter Aim and Summary

In order to further explore some of the methods and structures of embodiment as they relate to health, I turn in this chapter to models of working with the body grounded in non-dualist principles, to move beyond the consistent binaries engrained in medical knowledge and practice. I work through a number of paradigms of understanding the body, not only in terms of organs, bones, muscles and nerves – the anatomical maps of western medicine – but with an energetic and vibrational understanding, and how these aspects help to inform and develop an account unhindered by ‘mental’ and ‘physical’ divisions. This chapter thus builds and develops the work of Chapter Three, where I argued that sound and music agitate neatly contained notions of static bodies and beings, with individually contained mental lives. I once again here situate the argument in a line of new materialist feminism, which – as Simone Fullager suggests – is useful because it ‘reorients questions about what bodies “do” and how matter “acts”’ as opposed to seeking to define and confine what a body must be. I thus build on the work of Chapter Three where musical subjectivities helped to reveal the fluidity of moving bodies. Indeed, I argue that there is more to bodies than the enclosed thinking-narrating model of selfhood allows, as I seek to understand – as Simone Fullager frames it – ‘how embodied matter contributes to ways of knowing.’¹

In the Introduction, I articulated that I would build upon recent calls for the medical humanities to challenge and act as a corrective to biomedicine’s evidence hierarchies. In this chapter, I put the notion of what constitutes evidence and experience at the centre of my argument. I argue that there may be forms of knowledge about distress – the prickling sensation in a state of anxiety, or the heavy depths of depression, or the pump of fear in an eating disorder – that are not about the narrating, talking self.

¹ Simone Fullager, ‘Diffracting mind-body relations’.

Indeed, distress may be about relationships with the world that cannot be solved or disentangled. In this chapter, I am interested in how these things may (or may not) be relieved in dropping into a feeling of the physical and energetic body rather than objectifying or exiting from it. In this way, this chapter broadly advances some of the issues discussed as part of the wider corporeal turn. As philosopher and choreographer Maxine Sheets-Johnstone puts it in her book *The Primacy of Movement*, this ‘calls upon us to attend to something long taken for granted [...] to be mindful of movement [...] to be silent, and, in our silence, to witness the phenomenon of movement [...] of self [...] and world’.²

In this chapter, I attend to the ‘silence’ and the meaning of movement by analysing a range of body models that re-vision or re-shape both ways of thinking about bodies, as well as knowledge and experience of those bodies. However, I do this within some critical parameters. I do not suggest (in the way that complementary and alternative medicine often does) that these alternative models simply provide the answers to distress. Furthermore, when mental health is linked to physicality and body movement in government policy or public health spaces (and in the accounts of individuals replaying and reconstructing these discourses) this tends to focus on promoting the benefits of exercise. While exercise has proven and growing benefits for ‘mental’ disorder, in such constructions the ‘body’ is still attended to in objectified, anatomical ways. I thus examine these ideas critically – considering how they propagate more internalised self-management solutions to socially and environmentally related issues. Indeed, I assess how these body-based techniques may (and have) become instruments of promoting more internalised and further individualised responsibility for mental health – in similar ways to the cognitive behavioural strategies discussed in Chapter One.

² Maxine Sheets-Johnstone, *The Primacy of Movement*, (Amsterdam, Netherlands; Philadelphia PA: John Benjamins Publishing Company, 1998), p xviii.

I, therefore, keep to the critical through line of this thesis to think in depth about the neoliberal structures supporting certain prioritised notions of how health and recovery can be accessed. Fullager provides a useful context here in an analysis of physical activity and women's recovery from depression. She discusses how physical culture – often used as a message of empowerment for women (for example in the *This Girl Can* campaign) – is not a 'neutral' or 'inherently good or bad for emotional wellbeing' but is based on ideas of individuals finding or summoning up the willpower and energy needed to engage in exercise, which is often countered by the languid, painful body experienced in depression.³ In response to this point, I draw a line between the relational, worldly and deeply-felt sense of embodiment and 'physical activity' or 'exercise' that is involved in 'doing to' or moving the object body in functional ways. My emphasis in this chapter is how knowledge is formed about 'mental' dis/order and how 'mental' dis/order is experienced, and how these things should not be directed in a model of head-down, mind over matter understanding, where narrative – aligned with thought in the head – is the only form of knowledge. I propose that embodied mental health is not about bodies doing physical things to feel better, (although for some people this might be part of their process of becoming well), rather I argue that embodied mental health reveals bodies imbricated and involved in their social worlds. I have already troubled the idea of neatly contained and boundaried bodies in Chapter Three, and I have touched upon concepts of embodiment, which are not wholly based on individual sensations, or in individual methods of self-improvement, but are instead understood as affective and vibrational. In this chapter, I develop this further by drawing on disciplines where embodied knowledge is foregrounded.

Finally, this is not an attempt to provide a comprehensive view of several body-based practices spanning vast fields with huge integral differences, but to find useful connections in order to provide meaningful models of embodiment. I return once again

³ Fullager, 'Diffracting mind-body relations'.

to the notion of the transdisciplinary and to drawing out the intersections, overlaps and unity of knowledge in an affirmative reading of distinctive areas of work. My aim in this chapter is to consider how these models are both non-dualistic and offer useful ways of reconceptualising and understanding 'mental' health. It is also an appeal to different knowledge forms, beyond the textual and the verbal in the narrative-led medical humanities.

Somatics: A 'Generative Concept'

There are numerous ways of cutting the fields of bodywork therapeutics, which might include those of anatomically-based physical therapies, the tradition of embodied psychotherapy, or subtle body models in a more 'spiritual' tradition such as the chakras in yoga or acupuncture meridians from Chinese medicine.⁴ However, in 1976, Thomas Hanna (1928-1990), who was a movement practitioner and philosopher, identified a collection of embodied disciplines sharing an approach to first person practice through sensory awareness and named the field Somatics.⁵ In Hanna's definition, Somatics is differentiated from general studies of the body by its first-person perspective; it is the body proprioceptively as perceived from within.⁶ As Hanna explains in an instructional film, in which he relays his methods, from the interior of a body there is a perceptive ability that no one can have from looking at or being outside of that body.⁷ Hanna argues that the somatic viewpoint is engaged with the idea that 'everything we experience in our lives is a bodily experience'.⁸ ⁹ This even applies to language, which is not denied or set in opposition to this body-sensation but comes from both the body and the breath. Following the lead of philosopher Don Hanlon Johnson (in his edited collection of

⁴ Barcan, p.151.

⁵ Don Hanlon Johnson, *Bone, Breath and Gesture, Practices of Embodiment* (Berkeley, CA: North Atlantic Books, 1995), p. xv.

⁶ Thomas Hanna, *Somatics*, 1 (Spring/Summer 1986), pp.4-8 (p.4).

⁷ Thomas Hanna, 'Unlocking Your Body (excerpt)', Online video, YouTube, 21 August 2010 <https://youtu.be/_cWnoZqjZ8g> [accessed 20 July 2017].

⁸ Association for Hanna Somatic Education Inc. <<http://hannaSomatics.com/>> [accessed 20 July 2017].

⁹ Thomas Hanna, *Somatics: Reawakening the Mind's Control of Movement, Flexibility, and Health*, (Cambridge: MA, De Capo Press, 2004), p.xii.

Somatics' essays, *Bone, Breath & Gesture*), in this chapter, I use this term, which groups different bodywork practices and practitioners, as a 'generative concept' that creates the opportunity for collaboration and augmentation of once conflicting or disparate traditions.¹⁰

The roots of Somatics body-based practice are often attributed to the work of François Delsarte (1811-71). Delsarte lost his singing voice 'through poor instruction' and so turned to a focused enquiry on movement and breath to help him.¹¹ His work – the *Science of Applied Aesthetics* – examined 'voice, breath, movement dynamics, line and form' with the body seen as an 'expressive agent of the human impulses, mind, spirit, and vital instinct'. Delsarte's work is the acknowledged root source of inspiration for the first generations of modern dancers.¹² It was also studied by dancer, choreographer and movement theoretician Rudolph von Laban (1879-1958) and taught by actor F. Matthias Alexander (1869-1955) before they each developed their own practices. Furthermore, one of his students – Steele MacKaye – established the first professional acting school in America.¹³ Subsequent bodywork practitioners grew out of these foundations and their mutual influence and connection have been well-documented. As Don Johnson affirms, like Delsarte, many of these body practitioners were inspired by their own illness or diseases that were not solved by conventional medical approaches. Other practitioners were motivated to bring out the clarity and self-awareness they found in bodywork to fields of more mechanical methods of exercise.¹⁴ This bodywork was not simply about moving, toning, honing or refining the body below the neck via stilted exercises, it was

¹⁰ Don Hanlon Johnson, 'Somatics', <<http://www.donhanlonjohnson.com/Somatics.html>> [accessed 13 July 2017].

¹¹ Carola Speads, 'Ways to Better Breathing', in *Bone Breath and Gesture*, ed. by Johnson, pp. 36-49 (p. 39).

¹² Joe Williams, 'A Brief History of Delsarte: The Delsarte System of Expression', *The Delsarte Project* <http://www.delsarteproject.com/?A_Brief_History_of_Delsarte> [accessed 20 July 2017].

¹³ Stacy Marsella, Sharon Marie Carnicke, Jonathan Gratch and others, 'An Exploration of Delsarte's Structural Acting System' in J. Gratch, M. Young, R. Aylett and others, (eds) *Intelligent Virtual Agent, IVA 2006. Lecture Notes in Computer Science*, vol. 4133 (Berlin: Springer, 2006)

¹⁴ Johnson, *Bone, Breath, Gesture*, p. xi.

centred on developing something much deeper, that challenged the split, or that was used in a healing capacity.

Somatics practices including the Feldenkrais technique, Mind-Body Centring or the Alexander Technique are understood to be methods of self-improvement based on attending to, and becoming aware of, the skills and movements of the body in everyday life. Within these practices, the work is on activating knowledge through observing the body in action. Learning to develop this mode of attention comes through practice and it is garnered through physical engagement. As I think about Somatics as a 'generative concept', I draw on practices and dance methods with their roots in this lineage of bodywork, but I also think (in broad terms) about Eastern influences on Western body practices (with the examples of yoga and martial arts). While there are clear differences between dance geared towards performance and bodywork conducted in classes – as well as between the complex historical lineages of yoga and modern bodywork – I suggest that the work connects around a communal vocabulary and understanding of the value of cultivation and practice.

While the contexts for different bodywork including manual and movement therapies may be diverse, I focus on three specific points of connection that contribute to understanding what embodied knowledge means and enlarge the concept of embodied mental health. The first part of the chapter turns towards notions of moving (and changing) bodies and how movement in space relates to embodied knowledge. The second looks at the way in which the mass or matter of the body absorbs experience and, in particular, how trauma and memory affects or alters that matter, which is not dull, flat and inert but energetically driven. Finally, I suggest in the third part of this chapter, that ethically committed bodywork foregrounds how individual understanding and embodied knowledge confirms the ways in which beings are affected and affecting. This is a much more rounded and complex account of how distress is created, perpetuated and sustained in social and cultural contexts, and how the mind is not an internalised zone

between the ears. I consider how embodiment can be thought of in more critical terms related to surrounding contexts and social worlds. Before I come to think about these three areas, I turn first to the issue of knowledge, and the limits of evidence-based medicine; limits that reinforce mind over matter and dualistic models of understanding concepts of health and illness.

Embodied Knowledge; Embodied Research

The tenacious split between mind and body infects even those who vigorously criticize it. One of its most widespread manifestations is in an institutional split between theory and practice.¹⁵

The above quotation is taken from Johnson's compilation of a range of perspectives from leading bodywork practitioners. This quote usefully wrestles with the issue of how a mind and body split affects the division between theory (which is constructed by minds) and practices (fulfilled by bodies) – this is very clear in the context of medical practices where physical and mental health are treated in separate departments and institutions. In this section, I consider the importance of recognising ways of knowing beyond such dualistic and reductionist categories of thought. A medical model based on evidence-based medicine – centred on objective and distanced third person research, struggles to incorporate embodied, sensate and subjective ways of knowing in its understanding of health and illness. Experiential evidence is downgraded in terms of its quality and value versus empirical and expert evidence in terms of evidence hierarchies in healthcare.¹⁶ However, I argue that embodied knowledge is vital, in terms of coming to know and understand 'mental' dis/order, which is far more complex than the reductionist medical

¹⁵ Johnson, p. xii.

¹⁶ See, for example, the GRADE criteria: BMJ Clinical Evidence, 'What is GRADE?' <<http://clinicalevidence.bmj.com/x/set/static/ebm/learn/665072.html>> [accessed 13 July 2017].

models can describe or account for. This chapter is thus also about methodologies and ways of knowing about the body or embodied sensations. I argue once again here, that language should not be severed from the body, but that it might be necessary (as medical humanities researchers thinking about ways of knowing about ‘mental’ dis/order) to approach that which has been ignored and disconnected first. I will now turn to discuss what the meanings (plural) of embodied research might constitute. I turn first to Eli and Kay’s research project looking at dance as an embodied practice specifically for anorexia as a practical example. They write:

We aimed to design a study which foregrounded the body, and where sensory experience and the memories thereof would be expressed first through the body, rather than forced into immediate verbal translation in interview.¹⁷

In this dance work, Eli and Kay describe how participants in their project choreographed, danced and watched others perform solos about their eating disorders. The communication here was one of ‘visceral empathy’ and it was through the practice of dance that participants could ‘identify and address’ their embodied feelings. Kay and Eli articulate how the practice of dance led participants to begin to describe their experiences in words. Arguably, through engaging directly with the physical movement of the body – the ‘shaping and expressing of each dancer’s habitus’ – a sense of embodied feeling may occur, which enables a language connected with that experience to begin to articulate that which has been severed and split. If you want to come back to the body, you must come to the body first, and then to words. Indeed, Eli and Kay articulate this point, explaining how one participant’s dance in their study focused on ‘a feeling-centred

¹⁷ Eli and Kay, ‘Choreographing Lived Experience’, p.63.

body of knowledge on her eating-disordered experience', and how this was about 'embodied, rather than discursive sense-making'.¹⁸

Eli and Kay's paper, which speaks to insights about the importance of valuing the sensory or physical, might be applicable to the methodologies that researchers use. Gender studies theorist Rachelle Chadwick considers this very point as she surveys a range of what she calls 'embodied methodologies'.¹⁹ Chadwick convenes a range of methodologies including 'embodied reflexivity' wherein the researcher makes clear their own embodied position or state; body-centred methodologies including work focused on the depth sensation of memory; sensory prompts in interviews including tactile objects, and body-anchored interviewing that concentrates on opening up the body sensations in participants' accounts. Chadwick concludes that most of these techniques end up coming back to 'talk about the body'.²⁰ This leads me to the important point emphasised throughout the thesis, that language does not have to be divided from embodied knowledge, when the energy of the body is understood not as static, flat matter but as energetic and rhythmic; that which moves and powers words.

Somatics practices provide ways of actively working through the trouble of what Sheets-Johnstone terms 'linguaging experience'.²¹ In such practices, sensory experiences provide knowledge, and language taps into this to connect with this body knowing. Resultantly, Somatics practices undo something of the dominance of the overruling thinking subject in Cartesian frameworks. Indeed, in speaking to this point, Johnson writes that Somatics practitioners have an element of 'feistiness'; viewing their history as resistant to dominant notions of the cognitive, thinking self that overrules the knowledge of the body. Somatics practitioners attend to the silence of body

¹⁸ Eli and Kay, p.65.

¹⁹ Rachelle Chadwick, 'Embodied methodologies: challenges, reflections and strategies', *Qualitative Research*, 17, 1 (2016), 54-74.

²⁰ Chadwick, p.57.

²¹ Maxine Sheets-Johnstone, *The Corporeal Turn: An Interdisciplinary Reader* (Charlottesville VA and Exeter: Imprint Academic, 2009), Chapter XV.

communication against ‘rational verbosity’ by working with ‘the quieter intelligence of the flesh’.²² These ideas take me to the broader question about the kind of epistemology that underpins Western understanding of mental health, where intelligence and thinking are largely separated out from body systems – even in those models that come close to describing an integrated understanding of bodies and minds.

In his book, *The Body: Toward an Eastern Mind-Body Theory*, Yuasa Yasuo considers (largely through Japanese thinkers, as well as other Eastern philosophy) Eastern body-mind relations contrasted with Western concepts, as well as their methodological differences. Although there is no such thing as one Eastern view, Yuasa asks in broadest terms what might be a distinguishing feature of how knowledge and wisdom is conceived in methodological terms. He argues that although Western philosophers – including phenomenologists – have taken up the question of how to overcome dualism, they approach this in a ‘strictly conceptual that is, mental fashion’.²³ Yuasa suggests that whereas Western thought has maintained a difference between philosophy and empirical sciences (or between theory and practice), in Eastern terms philosophy is not only a theoretical speculation but a practical, applied and lived experience. Yuasa explains that the ‘wisdom of *satori* [metaphysical insight or enlightenment] is empirically verified in a process of cultivation’.²⁴ The theoretical position one reaches is based on this lived experience; this is experiential verification of felt and embodied knowledge.

This cultivation is not the same as Western notions of ‘praxis’, which is generally opposed to theory and is focused on the *application* of knowledge. Instead, in Eastern conceptualisations, knowledge is attained through this ‘practical process’. Indeed,

²² Johnson, p.xiii.

²³ Thomas P. Kasulis, ‘Editor’s Introduction’, to Yuasa Yasuo, *The Body: Toward an Eastern Mind-Body Theory*, ed. by T. P. Kasulis, trans. by Nagatoma Shigenori and T.P. Kasulis (New York: State University of New York Press, 1987), p. 6.

²⁴ Yuasa, p.27.

‘theoretical cognition of the truth is possible only *through* practice’ [my emphasis].²⁵ To illustrate this, Yuasa quotes the medieval poet Shenga who explained that ‘no matter how much one is exposed to sacred teachings and books, attainment is not his unless he knows for himself what is cold to be cold, what is hot to be hot’.²⁶ Cultivation can only be understood ‘by personally experiencing the whole body-mind’, as opposed to an intellectual comprehension through a detached analysis. Resultantly, knowledge is not a cognitive, empirical object obtained through distance; embodied knowledge might need to be worked upon, practised and developed.

These very broad insights are useful to work towards ways in which embodied sensation and embodied practice might inform knowledge and understanding about mental health, which does not have to be directed from the head down or objectified or conceptualised from the detached perspective of theory. Indeed, it is useful here to contemplate the ways in which medicine is, in itself, a ‘practice’. Drawing back to the work of Anna Harris and the use of percussion by medics to use their bodies to listen through touch, Harris confirms that:

perception is not, or not always, a registration of some world out there by means of separated sensory organs, but rather an intricate engagement in which knower and known are crafted together, through sensing in movement.²⁷

Knowledge through practice, rather than practice demonstrating knowledge, is at the centre of this paper and is an inversion of the contemporary conceptualisation of what medical practice is about. Davis’ interest is in how doctors’ own bodies develop and evolve through the process and practice of percussion. This is a fully embodied knowledge in the context of medical practice and reveals a diffractive space in which it

²⁵ Yuasa, p.85-86.

²⁶ Yuasa, p.103.

²⁷ Harris, ‘Listening Touch’, p.50.

connects with Eastern spiritual practices and bodywork. However, this investment in doctors' 'sensory acumen', which is 'a way of knowing of, and through, the resource always at hand; one's own living breathing body', is largely overruled by the idea that knowledge and research are verified through the objective, rational mind.²⁸

Moving Bodies

Unsticking ourselves from our physical location can help dislodge our unhappy mental state. Movement is the antidote to fixedness, after all.²⁹

In the above quotation from Matt Haig, whose memoir of depression was discussed in Chapter Two, he suggests that moving the body might be a way of operating against a negative 'mental state'. In this way, he parallels ideas about exercise and movement suggested at the start of the chapter – of the body (in its separate physical sphere) moving to relieve or disperse negative mental thoughts. However, in this section of the chapter, I argue for something much more integrated, by suggesting that movement may be a way in which a person can attend to, observe and drop into the sensations of their physical form. As Fullager explains in her account of women's experiences of exercise with depression, movement is not only about building motivation, or helping people to feel empowered, or about causing chemical changes in the body, but is much more about, 'affective possibilities in new and forgotten embodied pleasures – relaxation, immersion in movement, doing "unimportant" things.'³⁰ Movement might provide a different way of being a body; an inversion of the top-down control of mind over matter.

²⁸ Harris, 'Listening Touch', p.31.

²⁹ Haig, p.144.

³⁰ Fullager, 'Diffracting mind-body relations'.

I consider how the movement of bodies also relates to the limits and spaces afforded to them. Indeed, as Fullager writes, the ‘new corporeal therapeutics’ that promotes physical exercise to overcome mental health difficulties, might in some cases cut out the ‘conditions under which distress materialises’ as well as becoming ‘another practice in the line of moral and gendered imperatives to manage one’s health’.³¹ Indeed, as this chapter discusses, embodied mental health is not so simply dealt with by prescribing people a few weeks of exercise classes, but is much more about staying with the difficulty; the messiness of the problems, which aren’t so swiftly detached from social contexts.³² The ways in which bodies are allowed or enabled to exercise and move, and the ways in which they may be prevented or excluded from this (in particular how female bodies might be denied space or have their movements inhibited, or disabled or ill bodies might be restricted or disempowered) suggests that the relation between movement and embodiment is not straightforward. Finally, I suggest that we need to reconceptualise what is meant by ‘exercise’, by borrowing from Somatics practitioners; to think in terms of movement dynamics and in terms of practice and cultivation – about the possibility of dropping in to connect with embodied knowledge.

In a countenance to the notion that words are the primary way of communicating thought, theorists of movement, such as Maxine Sheets-Johnstone have put forward the primacy of movement, explaining that we are not ‘stillborn’ but come into the world moving. The acquisition of language, she explains, is ‘post-kinetic’. Sheets-Johnstone argues that movement is ‘our mother tongue’; it is the way in which we come to know our own bodies and the way we related to the spaces around us. Movement is formative as an infant; the contact of a hand grasping and reaching for objects around it

³¹ Fullager, ‘Diffracting mind-body relations’.

³² The National Institute for Health and Care Excellence (NICE) recommends that people with mild to moderate depression take part in about three (exercise) sessions a week, lasting about 45 minutes to one hour, over 10 to 14 weeks <<http://www.nhs.uk/conditions/stress-anxiety-depression/pages/exercise-for-depression.aspx>> [accessed 13 July 2017].

and the way it comes in contact with the world and comes to think about the world.³³

The idea that movement might, in itself, be a form of thinking and knowing (and have meaning in and of itself), counteracts those disciplines that seek to decipher or draw out the meaning from such experiences. If the meaning is in the bodily event and is not external to it, or after the fact, it may not need to be narrated into any kind of coherent linear structure. We cannot demand or command narrative out of movement, it may well speak for itself.

For Somatics practitioners, movement involves physical awareness; developing and honing the kinaesthetic sense. Once physical opening through movement starts to occur, and the experience is attended to, felt and practised, then a whole-self shift can take place. There are many examples of this approach in both Somatics work and in bodywork influenced or shaped by Eastern philosophies, but I seek here to focus on a couple of cases that speak to this point. As American dance and movement therapist, Mary Starks Whitehouse (1911 – 1979) writes, ‘Movement is the great law of life. Everything moves’.³⁴ Whitehouse, like Sheets-Johnstone, argues that an engagement with the dynamics of movement and a self-awareness of the kinaesthetic sense is not valued and is also underused. With the cultural axiom of mind over matter, paying attention to physical sensation and feeling is not considered to be a way of self-examination, and, if it is, then the relation is commonly conceived as being metaphorical. As Whitehouse continues, ‘the more [the body] becomes an appearance’, the more it ‘moves from anything to do with one’s *self*’.³⁵ Whitehouse trained as a psychotherapist and went on to pioneer ‘Authentic Movement’ – improvised free movement with closed eyes, following the impulses from within and responding kinaesthetically to develop value and awareness of the intuitive moving self.

³³ Somatics Perspectives, ‘Maxine Sheets-Johnstone: Dance, philosophy & movement’, <<https://somaticperspectives.com/sheets-johnstone/>> [accessed 13 July 2017].

³⁴ Mary Whitehouse, ‘The Tao of the Body’, in *Bone, Breath and Gesture*, ed. by Johnson, pp.239-252 (p.244-45), p.239.

³⁵ Whitehouse, p. 245.

The freedom and fullness developed in Whitehouse's work, echoes Fullager's rounded account of how movement can create complexes of feeling beyond contemporary reductionist accounts of muscle building or calorie burning found in the exercise and physical activity guidelines of public health literature. However, as martial arts and movement guru, Peter Ralston argues, in contemporary Western society people often forget how to feel with their bodies, or move without inhibition, because, after basic physical education is given to children there is 'no opportunity to investigate the basics of sensation, movement and interaction for their own sakes'.³⁶ In cultures bound to models of Cartesian separation and intellectual development situated in the brain, the body is reduced to a brain carrier and physical exercise is often contained to repetitive exercises based on moving muscles in certain ways. With the type of conscious movement Ralston advocates (or in the improvised impulsive movement of Whitehouse's Authentic Movement) a different feeling of the body emerges, one which Ralston argues that 'makes us more conscious of every aspect of being a body'.³⁷

A leading Somatics practitioner who influenced others in the field – and who noticed this gap between movement focused on form and movement that developed self-awareness and feeling – was German therapist Elsa Gindler (1885-1961). Gindler explained that 'Gymnastik' (bodywork that began in Germany in around 1900), 'are a means by which we attempt to increase intelligence'.³⁸ Gindler's aim was not to get people to achieve a perfect movement, as in other Gymnastik teaching (which had this emphasis on form at its centre), but to change what they felt was wrong so that learning and self-knowledge come about through motion. Charlotte Selver (1901-2003) (a pioneer of the Sensory Awareness method) explains how she learnt through studying with Gindler, that there was a difference between performing an ordinary exercise – as one would in a

³⁶ Peter Ralston, *ZEN Body-being: An Enlightened Approach to Physical Skill, Grace and Power* (Berkeley, CA: Frog Books, 2006), p.22.

³⁷ Ralston, p.32.

³⁸ Elsa Gindler, 'Gymnastik for People whose Lives Are Full of Activity', *Somatics* (August/Winter 1986-87), pp.35-39 repr. in *Bone, Breath, & Gesture*, ed. by Johnson, pp.5-14 (p. 7).

physical *Gymnastik* practice – compared to the questions that Gindler asked her about her movement. These questions included: ‘Do you feel that you are going through space?’ ‘Do you feel the air around you?’ ‘Do you really want to jump?’³⁹ The movement asks its own questions about where the body is, how it feels and where it is going. This sort of Somatics work is not just about exercising the objectified body but living in it. As Gindler explained, her work was not about fixed exercises but an exploration of how movement works and where the connections lie.

Movement cuts through the idea that learning must always be top down. Learning comes from personal experience, as Gindler articulates: ‘Breathing, relaxation and tension [...]. As long as they remain just words, they create mischief; as soon as they are imbued with experience they become great mediators of life’.⁴⁰ To tell someone to relax, or to explain why they feel tense in words, is very different from asking someone to move their body and feel where the tension exists, then to breathe deeply into that tension and create a sense of bodily space. Gindler felt by bringing awareness to a problem that a person becomes already ‘equal to the situation’.⁴¹ However, this is not just a process of ‘thinking about it, alone’, a person must instead ‘open [the] senses to these phenomena’ because the work cannot come from without.⁴²

Somatics and forms of movement influenced by Eastern spiritual traditions are further connected by a specific awareness of the breath and their development of different non-vertical shapes for human subjectivity. Eastern forms of meditation always begin with training respiration with ‘control of (Yama) the life-force (the prana, the Ki)’; attentiveness to the breath is essential in deepening a felt sense of connectivity.⁴³ Somatics breathwork practitioner Ilse Middendorf (1910-2009) describes her breath work technique as growing ‘spatiality’; as the breath offers a sense of the body opening up to

³⁹ John Schick, ‘Interview with Charlotte Selver’, *Bone, Breath and Gesture*, ed. by Johnson, pp.15-24, (p.21).

⁴⁰ Gindler, in *Bone, Breath, & Gesture* p. 8.

⁴¹ Gindler, p. 9.

⁴² Gindler, p.12.

⁴³ Yuasa, p.212.

the world. She argues that her work can be approached from any side – it's not like a ladder directed to one place, instead, it is like a 'sphere'.⁴⁴ A vertical model of selfhood, which is directed from the head down, is altered by the way in which breath inflates and expands the felt sense of the body.

This notion of space becomes vitally important as I think about the possible limits of an account of movement as productive for an embodied understanding of 'mental' health. Returning once again to the work of Merleau-Ponty and to questions of being and becoming, he writes that, it is this 'spatiality' of the body, which is 'the deployment of its being as a body', because the body is not just 'in' space, but it actively, 'inhabits' space. This can be most clearly seen when 'the body is in motion' because 'movement is not content with passively undergoing space and time, it actively assumes them'.⁴⁵ While breath provides more internal space, or a different shape of conceiving of body-mind relationships, the space in which bodies are 'deployed' and 'assume' movement is not equal or universal. Indeed, it is perhaps too easy to eulogise about movement, or to think uncritically about it in a moralistic healthcare climate demonising obesity and sedentary behaviour. Normalising or universalising movement as a healthy state, or a way to connect with the self, is a potentially sizeable issue when the freedom or ability to move is not possible. I will turn now to think some more about these possible limitations and to practitioners whose own limited personal movement ability helps to rethink this connection as well as reconceptualising movement in energetic terms.

Iris Marion Young in her work on the roles and limits ascribed to female bodies argues that the subject/object dichotomy – wherein bodies are objectified and disconnected from self-concept – comes from 'a lack of practice in using the body and

⁴⁴ Elizabeth Beringer, 'Interview with Ilse Middendorf', *Somatics* (Autumn/Winter 1988-89), 15-17, repr. in *Bone, Breath & Gesture*, ed. by Johnson, pp.67-73 (p.71).

⁴⁵ Merleau-Ponty, *Phenomenology of Perception*, p.105.

performing tasks'.⁴⁶ Young analyses what it is like to learn to 'throw like a girl', which, she contests is not an inherent factor of gender but a socially shaped reaction and movement. To throw in a limiting way is not a personal or internal failure, but a response and reaction to the ways in which bodies are taught by society that they can operate. Drawing back to Ahmed's analysis of female bodies, when those bodies shrink away from violence, they try to take up less space; they move nervously, hesitantly or cautiously, or they rule out movement altogether. This can be seen in the work of two writers who describe the massive bodily reaction they endured after being raped. Roxane Gay, in a memoir about her relationship with food and her body, writes how after she was raped as a young girl, 'I remember eating and eating and eating so I could forget, so my body could become so big it would never be broken again.' Her response to the trauma was to make her body into a 'cage' – it was, she describes, 'a cage of my own making'. But this was an act to 'keep men away'; her eating was an act of self-defence against the violence she had faced. This was a body shaped by trauma, pushed to re-define itself as a result of a violent world.⁴⁷ Poet Rupi Kaur also discusses this idea in a TED talk about her experience of rape. She describes how she encountered, after the event, a feeling of homelessness in her body; and so, she refused it – she showered in the darkness, she craved physical pain and vandalised her skin through self-harm.⁴⁸ These brief examples suggest how distress and trauma are entrenched in the folds of the body and how this is not an internalised or self-created act, but part of the world's entangled imprint.

Young and Ahmed's analysis raises the question: when the physical body is compromised by the social world, and the natural development of a felt sense or

⁴⁶ Young, 'Throwing Like a Girl', p.35.

⁴⁷ Roxane Gay: 'My body is a cage of my own making', *the Guardian*, 1 July 2017 <<https://www.theguardian.com/books/2017/jul/01/roxane-gay-my-body-is-a-cage-of-my-own-making>> [accessed 13 July 2017].

⁴⁸ Rupi Kaur, 'I'm Taking My Body Back', TEDxKC, online video recording, *YouTube*, 20 July 2017 <<https://www.youtube.com/watch?v=RIToQQfSILA>> [accessed 13 July 2017].

kinaesthetic awareness is troubled, how can a sense of embodied knowledge develop? The idea that exercise is always helpful – when sensations have been cut off, or when bodies have been refused movement, or when fear has frozen bodies into stillness or sealed them off with layers of fat – needs to be interrogated. Moving a body is not simply an action but a reaction and – as Fullager describes – one which is an affective relation. To bring this back once again to the questions raised by this thesis, ‘mental’ dis/order can’t be universally solved by helping people to discover embodied movement, or to gain a better kinaesthetic connection; policy also needs to be committed to making social changes that improve inequality and that recognise the social determinants of distress and disorder.

These questions are pushed even further – and in a different direction – when the body can’t feel because of degeneration or paralysis. I turn here to two examples of re-defining embodiment, to tend to a much more energetic conception of embodiment, one which isn’t wholly defined by moving the object of the flesh, bone and muscle. In my first example, the educator and writer Bruce Kramer (who suffered from the degenerative condition ALS – motor neurone disease) made the connection with his energetic body, rather than his weakening muscular frame, through yoga, which he started to practice after his diagnosis:

The first yoga class that I was in, I suddenly realized it was music [...] And I realized that there was a depth to this mind/body relationship that they were trying to teach us that is very similar to the mind/body relationship that one has, especially as a singer. So, for example, when I would work with the choir, I would ask them to ground their feet, to be very present. And as you breathe, breathe into your toes, and as you exhale into this tone, let this tone go out the top of your head [...] so there I am, and I'm thinking, ‘Oh, my God, I'm practising music again. [...] I am a musician again’.

This energetic understanding of the being-body draws back to music (and the work of Chapter Three). Kramer discusses the cellist Jaqueline Du Pre, as he makes sense of his experiences. He explains that, in Du Pre's performance, you can see 'the spine and the body and the sound coming up out of the body and you see this connection you are not aware of unless you are practising [yoga] that connection is almost super human [...] and it allowed me as the physical challenges of ALS have become greater and greater to remain engaged'. In his yoga practice, Kramer describes something of the sense of inside space opened up to him, even though his external movement is restricted and minimised:

There's the concept of peeling an onion [...] the idea that as you are physically engaging and mindfully engaging that physicality, as you are recognizing the energy that flows through you, out of you, into others, and others' energy flowing into you, that there's more to it than coming to a moment of bliss. [...] I was overwhelmed by this centre that I could perceive that I had delved into something I didn't even know was there.⁴⁹

Kramer's metaphor of the onion – of the energetic core, which is an internal presence and the centre of the being-body – is felt in this yoga practice. Furthermore, the body is not one thing; it has multiple levels or dimensions, and connects in relational and affective ways with the energy of other bodies. Indeed, in yoga, beneath the gross body (the physical body) lies the subtle (or astral) body consisting of energy channels or nadis.⁵⁰ Yoga has several meanings but is largely defined from the Sanskrit word *yuj*

⁴⁹ 'Bruce Kramer – Forgiving the Body: Life with ALS', *On Being with Krista Tippett*, online podcast, 26 March 2015 <<https://www.onbeing.org/program/transcript/7422>> [accessed 20 July 2017].

⁵⁰ Sivananda Yoga Europe, 'The 3 Bodies' <<http://www.sivananda.eu/en/meditation/the-3-bodies.html>> [accessed 20 July 2017].

meaning ‘to yoke or bind’ and is often interpreted as a ‘union or a method of discipline’.⁵¹ At the heart of yoga is the focus on bringing together parts of the self that are often understood as mind and body. Part of this connection (or union) is about the vital energy that comes with the integration and fusing of movement with breath. Connectivity can be ruptured or unsettled in distress and illness and so practical, physicalised movement with connected respiration (like yoga practice) can start to enable a differently defined embodiment on an energetic, rather than a muscular or bony plane.

This idea of different bodily levels and the notion of energetic movements within a deeper seated bodily system might begin to provide a conceptualisation of human life, which is neither the physiological body nor the mind. Like Ilse Middendorf’s spherical and spatial way of thinking about embodiment, yoga practice undoes the notion of the thinking mind (on top) with the body (below). Kramer’s onion metaphor helps to think about a sort of ‘depth’ mental body and how movement and breath explore that process of opening. In such a depth, multiple and shifting reading of the energetic body, the concept of mind over matter is challenged.

While Kramer’s energetic and musical connection with his degenerating body helped him to invest in feeling and sensing his body in a new way, in my second example author Matthew Sanford’s work suggests that embodied knowledge is far greater than can be accounted for by even ‘feeling’ the body. In his memoir, *Waking*, Sanford writes about his chest-down paralysis following a car accident as a teenager.⁵² Later in life, he became a yoga teacher and author and went on to work in the field of mind-body integration. In his memoir, he documents years of his own felt mind/body split following the crash. In the paralysis, he began to feel like a ‘floating head’ and after immense and chronic pain; he explains how he began to try to hold himself ‘thinner and thinner,

⁵¹ Cyndi Lee, ‘Yoga 101: A Beginner’s Guide to Practice, Meditation, and the Sutras’, *Yoga Journal*, 7 October 2014 <<http://www.yogajournal.com/article/beginners/yoga-questions-answered/>> [accessed 20 July 2017].

⁵² Matthew Sanford, *Waking: A Memoir of Trauma and Transcendence* (Rodale, 2006).

making less of [him] for them to break'.⁵³ Doctors, who saw his physical body as unfeeling and broken, advised him to ignore it. His mother suggested that he abandon his body and concentrate on 'developing [his] mind' in his studies. Sanford explains that he felt he'd been given permission to leave his 'body behind'.⁵⁴

It was a yoga teacher who helped Sanford, 'through his body', to release the trauma of the accident and to come to experience a sense of his body energetically. While the medical community suggested that feeling his lower limbs was impossible, Sanford explains how his internal sense of his own body might be different to someone who is not paralysed, but there is a definite sense of what he terms its 'energetic presence'. Sanford feels this presence and taps into it, as he comes to an awareness of the present-ness in his body.⁵⁵ He describes this experience of his paralysed limbs as a feeling of heaviness and of consciousness; this is a quiet feeling that comes about 'when we learn to soften the organs of perception'. As Sanford explains, even for someone who cannot feel every part of their body, 'The spaces you don't feel are not loss or absence, they are part of your strength.' He provides the metaphor of wood, in which it is 'not just the grains of wood but spaces in between that make it strong'.⁵⁶ Sanford works through subtle sensations that those without an injury (of any sort) might not easily find. The sensation – a change in gravity – may be different but it is real and acutely felt.⁵⁷

The implications of these alternative versions of movement, space and feeling in both world-engaged and energetic terms, suggest a much richer and thicker account of embodied 'mental' health, one which is necessarily situated in its environmental and social context, and one which moves, breathes and is affected energetically. Movement is not just about shaking out negative 'mental' thoughts, or releasing mood-boosting

⁵³ Sanford, *Waking*, p.64.

⁵⁴ Sanford, *Waking*, p.68.

⁵⁵ 'Matthew Sanford: Volvo for Life Awards Documentary', online video, YouTube, 17 April 2008 <<https://www.youtube.com/watch?v=JpmbzAwL5ws>> [accessed 20 July 2017].

⁵⁶ Matthew Sanford 'The Body's Grace', On Being with Krista Tippett, online podcast, 3 May 2012 <<http://www.onbeing.org/program/bodys-grace-matthew-sanfords-story/185>> [accessed 13 July 2017].

⁵⁷ Matthew Sanford, 'Transform 2009 – Mind Body Awareness', online video recording, YouTube, 28 Feb 2013 <<https://www.youtube.com/watch?v=-mw4WoDc8RU>> [accessed 20 July 2017].

chemicals or empowering individuals to take control of their lives, nor is it a given ability, or a free expression for all people in the same way. A deeper and more critical exploration of movement (even externally imperceptible energetic movement in breath or in subtle sensations) starts to trouble the concept of mind over matter, as it gestures to knowledge and feeling in much more complex dynamics, where bodies are fluid, moving, responding and in constant, chaotic change.

Body Matter; Bodies Matter

In this part of the chapter, I build on the energetic understanding of bodies, focusing on how body matter absorbs and deals with everything it experiences. I think, in particular, about the impact of trauma, where there has arguably been the loudest volume of research activity about the physical body in this area of ‘mental’ health. One illustrative example of this connection in research is within a study by the French National Institute of Health and Medical Research (Inserm) that looked at the impact on children whose fathers were killed or badly injured during World War I. The study, of more than 4,000 people born between 1914 and 1916, found that the lives of those children who experienced such loss or trauma were shortened by a year on average, thereby suggesting the possible long-lasting ‘physical’ impact of what are termed ‘early life adversities’ (ELAs).⁵⁸ These children were not connected by ‘physical’ illness or injury but by ‘mental’ trauma. This new evidenced connection for medical research underlines what Somatics practitioners have intuitively felt and new materialist scholars have critically articulated – body matter, matters.

Trauma is usually an area where medicine likes to insert a mind/body split: a physical trauma to the body is an injury (the impact of a knife wound, for example) and a psychological trauma is defined as affecting mental or emotional dimensions (an

⁵⁸ Janice Wood, ‘Babies of WWI Dead Had Shorter Lives’, *Psych Central*, September 2016 <<http://psychcentral.com/news/2016/09/11/babies-whose-fathers-killed-in-war-have-shortened-life-expectancies/109653.html>> [accessed 20 July 2017].

overwhelming event or something that threatens the integrity of the self, whether through a single incident or repeated ‘blows’).⁵⁹ However, in this section, I argue that a trauma – whether the blade of a knife or the blow of losing a parent in war – affects the whole. Matthew Sanford’s work does something very important to advance this indivisibility. He articulates in *Waking* how, in the aftermath of the car crash, his body ‘continue[d] to become an object.’ He adds:

I judge it rather than connect to it. I leave it rather than feel it. This only deepens my sense of separation. It also gives me better access to anger and disgust. Both are effective ways ‘out’ of a body. Ask an anorexic.⁶⁰

Sanford’s bold move from paralysis to anorexia disobeys conventional illness models of the mental versus the physical. However, for Sanford, the connection is obvious and the issue is one of the traumatic gap that forcibly balloons itself between ideas of mind and body (whatever the illness or disability).

Bodywork practices are useful to draw upon to cement this point because of the way in which whole bodies are understood to hold onto memories. There are several different expressions and accounts of this idea, and rather than give a synoptic overview, I focus here again on a couple of examples that speak to the issue of the imprint of trauma. The Rosen Method – developed by Marion Rosen (1914-2012) – is hands-on work that stems from the belief that emotional and social pressures ‘become structured in the body, and [...] require muscular tension to maintain’.⁶¹ The trauma settles into the structure of the being-body and it is the job of physical and practical manipulation to unlock it by listening to it, rather than just by plying the tissues. In this method, the

⁵⁹ Esther Giller, ‘What Is Psychological Trauma?’ *Sidran Traumatic Stress Institute, Inc.* <<https://www.sidran.org/resources/for-survivors-and-loved-ones/what-is-psychological-trauma/>> [accessed 20 July 2017].

⁶⁰ Sanford, *Waking*, p.69.

⁶¹ Elaine Mayland, ‘The Rosen Method’, in *Bone, Breath and Gesture*, ed. by Johnson, pp.53-64, (p.63).

practitioner observes the changes in the muscle and breath, releasing built-up, stored tension.⁶² Within a similar framework of sensory understanding, somatic trauma therapist Peter Levine takes the specific view that a person who has experienced a traumatic event 'locks down' the energy and stores it within their body. Painful symptoms that might emerge in later years are, therefore, the re-emergence of 'fragments of sensory body memory'.⁶³ Trauma embeds into physical tissue structures which are not separate from 'mental' or 'emotional' structures.

The impact of trauma is not only locked into tight muscles, but Somatics breath-based practitioners also point to the effect of trauma on breathing. Carola Speads, (1900-1999) who studied and taught with Elsa Gindler, discusses the way in which breath is affected by events and that 'we often cling to the changed ways of breathing even after the events that brought on the disturbance have passed'.⁶⁴ While it may be widely acknowledged that a traumatic incident such as a car crash would cause the heart to race and the breath to become erratic and uncontrolled, the idea that this pattern might be altered after the event, or that breathing can subsequently be habituated into restrictive, shallow spaces, is a further stretch, and one which is not often explored in the main models and medical discourses around trauma and 'mental' dis/order.

The impact of life events on bodies and breathing also extends to memories, which are not simply contained in immaterial thoughts and metaphysical mental landscapes but are dug into the fibres of the ever-changing state of the being-body. Dance is aptly able to think through this idea, as a practice that comes to life through the body and one that is memorised in muscle and movement. As a connecting example, (and in the spirit of working with a broad generative concept of bodywork), I consider a dance performance by theatre director and performance theorist Anna Furse and dancer-

⁶² Rosen Method, The Berkeley Centre, 'Bodywork' <<http://rosenmethod.com/rosen-method/bodywork/>> [accessed 13 July 2017].

⁶³ Peter A. Levine, 'A Summary of Trauma and Somatic Experiencing', online video recording, YouTube, 17 August 2009 <<https://www.youtube.com/watch?v=ByalBx85iC8>> [accessed 20 July 2017].

⁶⁴ Carola Speads, 'Ways to Better Breathing', in *Bone, Breath and Gesture*, ed. by Johnson, pp.36-49 (p.41).

turned-artist Esther Linley's *When We Were Birds*. Furse and Linley were both students at the Royal Ballet in the 1960s and, in 2012, revisited the space where they once danced and performed. As the two dancers listened to the music and began to move, they started to remember choreography they once learnt and performed. Furse and Linley recalled themselves as performing bodies on stage, remembering as they started to dance, the 'complex patterns' that the 'the body goes into' as well as something of the emotional resonance of their past experiences. *When We Were Birds*, therefore, became a duet about the body 'as memory' to think about, 'how when we re-embody past learnt movement the mind opens up to forgotten events of the past'. The piece 'overlaps personal memory with historical memory to explore, via the dancing body and its memory, how our sense of self is deeply tied into our embodied experience of the world'.⁶⁵ Furse and Linley's piece explores how the repeated structure of body practice creates and builds embodied knowledge and how memory can be explored in three-dimensional spaces.

It may seem like a great conceptual leap from the notion of the body in performance practice to dealing with 'psychological' trauma (or the specific 'mental' dis/order of PTSD as defined in psychiatric terms), however, psychiatrist and author Bessel van der Kolk who runs a trauma centre in America, and has authored a bestselling text *The Body Keeps the Score: Mind, Brain and Body in the Transformation of Trauma* makes a very similar move. He argues that the physical and practical movements of actors and dancers may have something to 'teach psychiatrists about healing from trauma'.⁶⁶ Kolk explains that the practice of the movement of the body can inform clinical practice. In an article in *The New York Times* looking at van der Kolk's work, journalist Jeneen Interlandi documents how she attended a 'psychomotor therapy'

⁶⁵ Anna Furse, 'When We Were Birds 2012/13' *Athletes of the Heart*

<<http://www.athletesoftheheart.org/present.html>> [accessed 20 July 2017].

⁶⁶Jeneen Interlandi, 'A Revolutionary Approach to Treating PTSD', *The New York Times Magazine*, 22 May 2014 < http://www.nytimes.com/2014/05/25/magazine/a-revolutionary-approach-to-treating-ptsd.html?_r=0> [accessed 20 July 2017].

session for patients with PTSD. The approach, she explains, was developed by Albert Pessó, a dancer who studied with contemporary dancer Martha Graham (whose work also links back to the teaching of Delsarte within the Somatics field). In the psychomotor therapy session, a group of people with various issues relating to trauma come together in the room and take up roles in character to act out a traumatic memory of one of the participants. Interlandi gives the example of a veteran of the Iraq war, Eugene, and his killing of an Iraqi man:

Eugene would recreate the trauma that haunted him most by calling on people in the room to play certain roles. He would confront those people – with his anger, sorrow, remorse and confusion – and they would respond in character, apologizing, forgiving or validating his feelings as needed. By projecting his ‘inner world’ into three-dimensional space, Eugene would be able to rewrite his troubled history more thoroughly than other forms of role-play therapy might allow.

Embodied trauma here re-inhabits the body in space; it is replayed as the affect and energy between people, rather than confined to an unseen void – an ‘inner world’ – between the ears. However, putting the body into motion in space, and in a room with other bodies, is something that is largely ignored in cognitive approaches to trauma. Van der Kolk argues that cognitive therapy is ‘benign’ when it simply asks patients to ‘alter behaviour through a kind of Socratic dialogue’ [and] ‘recognise the maladaptive connections between their thoughts and their emotions’. He protests that, in fact, ‘trauma has nothing whatsoever to do with cognition’ but it is to do with a ‘reset[ting] of the body’.⁶⁷ For van der Kolk, at the heart of trauma is a problem with narrative itself. In traumatic experience, the story cannot fully integrate and cannot, therefore, account for,

⁶⁷ Interlandi, ‘A revolutionary approach’.

explain or solve the layers of experience embedded within the body. Trauma, he argues, is not about being reasonable or verbal or articulate. The response of talk therapy is largely inadequate because it ignores bodily and spatial elements of experience.⁶⁸ Mind needs to come back to matter.

Contrary to Western medicine's dividing definitions, all 'psychological' traumas have a 'physical' impact. Where bodies are violated, shattered, thwarted or fail in the moment of trauma, it is those same bodies that react to the world and shudder, cower or shake as the trauma resurfaces. In psychomotor sessions, and in other similar approaches that involve 'paying careful attention to patients' physiological states', the therapy attempts to reconnect traumatised patients with their own mass and to help them to tolerate their own 'physical sensations', which they have been forced to stifle.⁶⁹ Van der Kolk's work starts to approach the question of how paying attention to physical sensations might lead to first being able to tolerate, and then being able to understand or articulate, what those sensations feel like or where they come from.

Matthew Sanford's experiences led him to set up an organisation 'Mind Body Solutions' with a mission to: 'transform trauma, loss and disability into hope and potential by awakening the connection between mind and body'.⁷⁰ His organisation has worked with a range of clients, from people with eating disorders to those injured in accidents, to war veterans experiencing paralysis or disability in different forms. A part of the therapy he has developed involves placing comforting weights on to bodies to help people sink into their own flesh. Sanford describes this as 'feeling your substance'. This is a novel concept for anorexia, which tends to shift the sufferer out of the corporeal body (that it tries to efface and reduce) and into a whirring head of thoughts. Asking anorexics to relax into the still, weighted body is a very different kind of approach than battling

⁶⁸ 'Bessel van der Kolk – Restoring the Body: Yoga, EMDR, and Treating Trauma', *On Being with Krista Tippett*, 30 October 2014, online podcast <<http://www.onbeing.org/program/restoring-the-body-bessel-van-der-kolk-on-yoga-emdr-and-treating-trauma/5801>> [accessed 20 July 2017].

⁶⁹ Interlandi, 'A revolutionary approach'.

⁷⁰ Matthew Sanford, <<http://www.mindbodysolutions.org>> [accessed 20 July 2017].

their thoughts with more thoughts and words in talking therapies. Sanford suggests the same sense of ‘calming compression’ provided by the weights can be explored in yoga poses, which can provide a sense of release into the body structures, helping clients to feel the ground and the pull of gravity and weight.⁷¹ He compares the energetic sensation of yoga to the ‘feeling of getting into a warm bath – the relief, the feeling of nourishment, the calm and quieting’.⁷² Sanford writes how the feeling of dropping into the body creates a sense of ‘landing’.⁷³ This physical feeling of containment might also be experienced in the release into someone else’s weight in the process of being hugged or held, or it might be felt as the body sinks into bed. These feelings are not about objective body movement but about a deep drop into the energetic and sensate body – an internal feeling of being not having a body.

To get back to an embodied feeling might take practice, especially if the weight and matter have either been forcibly suppressed (as in anorexia) or savagely taken away in the trauma of a car accident or in conflict in a war zone. The idea that a person’s sense of embodied mass and physicality is important, and that something is skewed with this relationship in the traumatic body, feels resonant in someone suffering from an eating disorder who can’t bear his or her sense of weight and who wants to get rid of the fleshy, physical object hanging below their head. It also feels pertinent for a person having a panic attack, who misreads or is confused by a racing heart and chest pains and is unsure of how their body should feel, or for a woman scarred by rape and feeling homeless in her own flesh.

As Sanford explains, in Western culture, the drop, release or surrender into the energetic, feeling and depth body does not fit with vaunted models of heroism and of overcoming. It does not align with the fighting ideal of mind over matter; of trying to undo the irrational thoughts of a panic attack or the illogical food-phobia of an eating

⁷¹ Sanford, *Waking*, p.50.

⁷² Sanford, *Waking*, p.168.

⁷³ Sanford, ‘The Body’s Grace’.

disorder. Sanford comments that he also ‘duly followed the traditional approach to rehabilitation’ and explains, ‘I learned to make my upper torso really strong to overcome my body. That’s a metaphor for everything, because you can’t overcome your body’.⁷⁴ If bodies can’t be overcome with theory, cognition or narrative and if matter matters in all the above ways, then the question for this section of the chapter starts to move towards what happens to the treatment of ‘mental’ dis/order when notions of whole person ‘mental’ health are re-magnetised back to the body; to the corporeal and the sensate, not only the verbal and textual. The question of treatments for embodied distress cannot escape or avoid physical connection when the body ‘keeps the score’.⁷⁵ While the **Body Systems** model of mental (ill) health provides us with a gesture towards a space beyond dualism, the techniques and epistemologies of biomedicine remain largely detached from seeing either touch or body movement in therapeutic terms. As Barcan identifies, touch in Western medicine is largely objectifying, analytical or information-gathering (measuring, weighing, palpating) or comes through the distant or virtual touch of technology.⁷⁶ Movement is about exercise, which tends to be researched in terms of improved functionality or objective measures to add to the evidence base. Body based practices define something other; the possibility of communicating through the flesh and through energy, as they uncover the indivisibility of the feelings involved in embodied distress.

Social Beings

As I argued at the start of this chapter, bodywork practice may be thought of as deeply individualistic and connected to internalised self-management prescriptions for recovery

⁷⁴ Tim Rushby-Smith, ‘Yoga Won’t Help Me Walk Again. But it has Allowed me to ‘Feel’ my Legs for the First Time in Years’, *the Guardian*, 26 September 2011

<<http://www.theguardian.com/lifeandstyle/2011/sep/26/wheelchair-yoga>> [accessed 20 July 2017].

⁷⁵ Bessel van der Kolk, *The Body Keeps the Score: Brain, Mind, and Body in the Healing of Trauma* (Penguin, 2015).

⁷⁶ Barcan, p.150.

from 'mental' dis/order. However, in many cases, the explorations of Somatics practitioners have focused on intentionally externalising objectives, which help to move beyond what might otherwise be just further attempts to divide being-bodies from contexts and social worlds. I turn here, therefore, to the idea of bodies without limits; to consider bodies as social beings rather than individual agents, and to suggest that a truly embodied model of mental health is one that takes the energetic and moving matter as deeply embedded and interacting with nature-culture. It is useful to once again draw back to the work of new materialist feminist scholars who talk in terms of the relational. Fullager usefully positions this work in terms of how it contributes to re-thinking subjectivity 'beyond liberal assumptions of a voluntaristic, (ir)rational self by positioning agency as distributed and profoundly complicated in relational ontologies, multiple forces and complex affects.'⁷⁷ If agency is affective and affected, the being-body is not static or enclosed, but open, moving and shifting, and embodied distress is not only about the connection between body, breath and self-awareness, but the air that body breathes, and the social climate in which that body is moulded.

Embodied self-knowledge is connected in Somatics practices with doing ethical work. In one example of this, Barcan cites the writing of fascial therapist Thomas W. Myers who, in his book, *Anatomy Trains*, explores the necessity of new modes of perception, and of kinaesthetic awareness; what he terms the 'felt sense'. Myers argues that, in order to engage with the wider world and to respond to the social and environmental issues of the current century, an attentiveness and embodied knowledge is necessary.⁷⁸ The attentiveness or consciousness of movement is a theme that runs through a range of Somatics practices. The underlying philosophy is that it is impossible to be flexible or agentic in the world if one is narrowed by physical habituations. The link, endorsed by a range of somatic practitioners and performance theorists is one that

⁷⁷ Fullager, 'Diffracting mind-body relations'.

⁷⁸ Barcan, p.215.

connects body self-knowledge, self-awareness and undoing the habitual, with making a positive socially directed change.

It is useful here to once again reflect on van der Kolk's offering of the knowledge and practice of performers whose connection with embodied sensation and the depth and meaning of movement helps to explore the idea of working through habituated body patterns. In order to perform as dancers and actors, a form of knowledge is developed that requires conscious attentiveness and learning through the body. Dancers and actors who work with their bodies in performance must refine their kinaesthetic sense – their coordination with movement.⁷⁹ In his book *Games for Actors and Non-Actors*, Brazilian theatre director Augusto Boal focuses on how actors can improve their body knowledge through exercises to help expand and develop that sense. The rigour and discipline of performers' bodywork deepen the imprint of their practice. Boal argues that the body is the most important element of theatre. It is not possible to separate out the body because a human being 'is a unity, an indivisible whole'.⁸⁰ Furthermore, for Boal, bodywork is not simply an internalised tool for professional actors, but all bodies (on stage and within the audience) can help affect social and political change. Boal founded the Theatre of the Oppressed, with the belief that the impetus for change could come from the 'spect-actors', who acted simultaneously as participants and audience members.⁸¹ Boal's book of exercises or 'games' aims to de-habituate bodies that, he argues, may become 'hardened by habit'. He writes that by 'always carrying out the same movements, each person mechanises their body to execute these movements as efficiently as possible, thus denying themselves the possibility of original action every

⁷⁹ Whitehouse, in *Bone, Breath, & Gesture*, ed. by Johnson, p.244.

⁸⁰ Augusto Boal, *Games for Actors and Non-Actors*, trans. by Adrian Jackson (London and New York: Routledge, 2nd Edition, 2002), p.49.

⁸¹ Andrew Robinson, 'An A to Z of Theory | Augusto Boal: Theatre of the Oppressed', *Ceasefire*, 29 March 2016 <<https://ceasefiremagazine.co.uk/augusto-boal-theatre-of-the-oppressed/>> [accessed 13 July 2017].

time the opportunity arises'.⁸² Habits need to be de-tuned so that emotion and sensation can be tapped into or recognised anew.

Somatics practitioners similarly focus on the importance of breaking down habits. As Thomas Hanna writes, human physicality can become so habitual that it gets locked in a form of 'sensory-motor amnesia'.⁸³ It is a theme approached in the writing of Deane Juhan, who, like Thomas Hanna, studied the practical methods of embodiment. Juhan also became a leading teacher of the Trager Method, which is a partly hands-on and touch-led method of movement.⁸⁴ Juhan explains that bodywork has an effect, in general terms, because of its ability to help people 'understand their bodies and their own sensations from a fresh perspective'.⁸⁵ The touching involved in some bodywork – the physical manipulation or adjustment work – aims to penetrate the reciprocal relationship between 'our habitual behaviour and the chronic conditions of our tissues'.⁸⁶ As new movements are made, and new pressures are applied, the idea is that the person can see themselves apart from the ingrained habit.

Ideas around ingrained habits are important for understanding notions of embodied mental health because they actively demonstrates how bodies hold on to and can be released from certain practices, as well as how new patterns can be accessed. In a practical example of this relation, I move here to the Alexander Technique, which highlights the interconnections within the whole person and provides a valuable practical articulation of what is meant by the health of the whole being-body. F. M. Alexander writes in his book, *The Use of the Self*, about how he came to try to resolve the voice-hoarseness he developed when reciting lines in his work as an actor.⁸⁷ He came to understand that 'the wrong use of the self' led to 'muscular tension' through unconscious

⁸² Boal, p.29-30.

⁸³ Hanna, *Somatics: Reawakening the Mind*, p.xiii.

⁸⁴ Trager.com, <<http://www.trager.com/approach.html>> [accessed 20 July 2017]

⁸⁵ Deane Juhan, 'Job's Body: A Handbook for Bodywork (Excerpts)', in *Bone, Breath & Gesture*, ed. by Johnson, pp. 355-378, (p. 364).

⁸⁶ Ibid.

⁸⁷ F.M. Alexander, *The Use of the Self: It's Conscious Direction in Relation to Diagnosis, Functioning and the Control of Reaction* (Methuen and Co Ltd, 1932; Victor Gollancz, 1985; London: Orion, 2001), p.28.

habits of ‘mis-use’.⁸⁸ Alexander argues that this habitual doing and action might intuitively ‘feel right’ because it is what a person feels comfortable with, and is used to doing, but it actually needs to be ‘consciously inhibited’ to allow the body to move dynamically.⁸⁹ The Alexander Technique suggests that changes can be made to improve overall movement and, importantly, that through this improved movement there will also be improvements in overall health. The process starts with stopping the habits, which are ingrained in the body, and which affect and influence the whole person. Understanding habit is important because it shows the integrity of the body and how one part of the system affects another. Indeed, Alexander found through ‘practical experimentation’ that it was ‘impossible to separate the “mental” and “physical” processes in any form of human activity’ and he, therefore, needed a technique to ‘deal with the body as a total entity’.⁹⁰ In one example that develops this idea, Alexander writes that when working with people who have a stutter, ‘every stutterer stuttered with many other parts of his body, besides his tongue and lips’. The stutter does not begin in the mouth, but is connected to a series of habitual movements that sediment throughout the body and it is therefore ‘associated with other symptoms of wrong use and functioning in other parts of his organism’.⁹¹

The habitual movements and connections of interconnected body parts speak to a wider issue of the importance of recognising that humans are interconnected beings in their social worlds. When a human ‘organism’ is understood to be a part of the world that she/he exists in; pressed upon by the brackets and expectations of gender, race, sexuality, or the air that the organism breathes in, or the conditions in which the person is housed or works, the idea that ‘mental’ dis/order is an inherent part of the flawed individual feels reductive and problematic. Indeed, in this chapter, I have emphasised

⁸⁸ Alexander, p.76.

⁸⁹ Alexander, p.19 and p.97.

⁹⁰ Alexander, p.21.

⁹¹ Alexander, p.69-70.

that understanding what is meant by embodied mental health is not as simple as associating physical exercise with individual overcoming of distress. Instead, I have orientated to a model based on meaningful movement or depth forms of touch engaging with meaningful matter; recognising both the possibilities and limits of embodied knowledge and connection. Embodied mental health is about embodied lives; lived and deeply imbricated in the world around them.

Conclusions

At the start of this chapter, I cited the philosopher-dancer Maxine Sheets-Johnstone, who, in discussing the corporeal turn suggests the need to attend to movement, which may evoke silence. This silence might turn attention to aspects of the world and self that are largely ignored in a focus on the masterful 'mind' and the narrative self. Van der Kolk articulates some similar issues when discussing movement for trauma. He suggests that:

in order to recover, people need to feel free to explore and learn new ways to move [...] only then can nervous systems reorganise themselves and new patterns be found. This can only be done by investigating new ways of moving, breathing and engaging, and cannot be accomplished by prescribing specific actions geared at fixing.⁹²

The notion that new forms of movement might be a therapy for trauma (or indeed other forms of mental health issues) appears to be at a tangent to the fixing programme of cognitive therapy that focuses on identifying and resolving 'dysfunctional beliefs and cognitive errors'.⁹³ Embodied therapy addresses habitual and learnt physical fears, anxieties and stresses through touch and movement and breath, and most likely will not

⁹² Bessel A. van der Kolk, 'Foreword' in Peter A. Levine, *Trauma and Memory: Brain and Body in a Search for the Living Past* (Berkeley CA: North Atlantic Books, 2015), p. xv.

⁹³ David Adam, p. 204.

be involved in developing or discussing what is rational or irrational, functional or 'dysfunctional', truth or 'error'.

It is useful to reflect here again on Alexander's model, which stretches beyond an understanding of the importance of body awareness or connectivity in and for itself, but to the way in which illness is diagnosed and treated. There is not a clear dividing line between what is a 'physical' ailment and what is a 'mental' issue because, in Alexander's view, 'the harmful use of the "psycho-physical mechanisms"' is present in a range of conditions from 'constipation' to 'so-called nervous and mental troubles'. For Alexander, all illness has a psycho-physical aspect and indeed when there are not 'organic' causes or explanations it is usually related to 'undesirable conditions of use of the self'.⁹⁴ This is not a model of psycho-somatic illness (where psyche causes symptoms in the soma) but a whole person view. When it comes to an illness considered as being 'mental' in form, like anxiety, Alexander uses the same rationale that he would if presented with a 'physical' problem like a hoarse voice. For Alexander, the point is that the person is 'unable to make a change within themselves, which they have reasoned out would be a desirable change' and, therefore, the question of whether the approach is applicable to a 'mental' or 'physical' aspect is redundant.⁹⁵ With this view, pointing out that something is 'mental' and related only to 'thoughts' is unhelpful because such a neat box does not exist, nor can it be extrapolated from the whole.

Alexander concludes that all human illness cannot be divided and classified as either physical or mental and that the focus in ameliorating or educating needs to be on the unity of the human entity. Alexander uses the example of the processes involved in, 'lifting an arm, or of walking, talking, going to sleep, starting to learn something, thinking out a problem, making a decision' and argues that these can never be isolated as either physical or mental acts.⁹⁶ This has implications for medical practice, because, as

⁹⁴ Alexander, p.86.

⁹⁵ Alexander, p.102.

⁹⁶ Alexander, pp.22-23.

Alexander explains, diagnosis needs to account for this unity, rather than emphasise compartmentalisation.

The aim of this chapter has been to move away from the body as object and body as text, to the feeling, lived, active experience of the being-body. The development or cultivation of this relationship can only come through a first-person experience of the body, as opposed to third person objectification of it. As Carola Speads explains, ‘The heart of [the] work [is] the experience of it’.⁹⁷ However, embodiment is not an internalised state that is always controllable by the intending self. Somatics and CAM more broadly have been rounded upon by social and cultural theorists for not being critical about their approaches, and for using terminologies that can oversimplify the accessibility of therapies, ignore the privileges of participation and negate social or environmental contexts. Further, ideas about embodiment in Somatics, understood as a felt – or kinaesthetic – sense, appear to map and construct internal body spaces and feelings, as opposed to broader concerns about how bodies are affected and embodied in the world. However, returning to the words of Volker Scheid in his medical humanities chapter on Chinese medicine, my aim here has not been to analyse these practices ‘as objects of enquiry’ nor to claim that they fully explicate the complexities of mental illness, but to use them as ‘resources for *thinking critically*’ [my emphasis] about ways to blur the lines of mind and body and articulate non-dualist ideas⁹⁸

As Alexander reportedly said, ‘any word I use has got barnacles on it [...] I really need to invent a new language; but if I had, nobody would have understood a word we said’.⁹⁹ The fact that it is difficult to communicate the sense of embodiment, or that people may not realise they are living in a ‘disembodied’ way, perhaps points to a wider lived sense of bodily possession rather than bodily being (exacerbated by social and

⁹⁷ Thomas Hanna, ‘Interview with Carola Speads’, *Somatics* (Spring/Summer 1981), repr. in Johnson, ed., *Bone Breath and Gesture*, pp. 25-35 (p.34).

⁹⁸ Scheid, ‘Holism, Chinese medicine and systems ideologies’, p.82.

⁹⁹ Joan Schirle, ‘A Conversation with Marjory Barlow’ in, *Bone, Breath and Gesture*, ed. by Johnson, pp.85-92 (p.91).

cultural emphases on mind over matter) touched upon in the preceding chapters. The models of mental life articulated in Chapter One reveal how the body (as the physical form of bones, muscle and flesh below the neck) is controlled by the head and brain. The structures of contemporary narratives discussed in Chapter Two show how the body is kept in this model – words represent and sometimes struggle to connect with the intensely physical sensations of ‘mental’ dis/order. The dominating language and categories of psychiatry get in the way. If – and when – physical health is linked to improved mental health, the overriding message is that it would be a positive thing to engage the body in some kind of physical activity because of the close links between physical activity and improved mental wellbeing on a series of objective measures defined by medical and social science researchers.

Embodiment has become a paradigm of interest for cognitive science but this conversation remains limited by the framework of ‘mental’ health. This can be seen by briefly turning back to the paper on psychopathology and disturbances of embodiment, where psychiatrists Fuchs and Schlimme suggest that specific types of embodiment issues might be present in different diagnoses of ‘mental’ dis/order. They argue that schizophrenia and depression affect the integrity of the subject body, whereas anorexia or body dysmorphic disorder disturbs body image and awareness.¹⁰⁰ Fuchs and Schlimme provide an interesting rereading of psychiatric disorders but, ultimately, it is reductive to try to fit different problems of embodiment into already defined models of disorders of the mind. This is especially troubling when those diagnostic categories are so unstable in the first place.

If the body always remains an object – something to be worked on or overcome – a dualist mental health conceptualisation remains inevitable. However, in this chapter, the lineages of Somatics and performance, as well as the influence of some forms of

¹⁰⁰ Fuchs and Schlimme, ‘Embodiment and Psychopathology’.

Eastern spiritual practices, have shaped alternative understandings of bodies. These bodies are not defined by the anatomical dividers of biomedicine, nor are they objects to be researched only through the lens of objective third-person approaches. This chapter has drawn on a few case examples of practices that connect with the energy of movement, which is not a meaningless act, but an expression of the space bodies are given, and the memories they carry. Further, I have analysed some therapies for trauma working directly with physical matter rather than streams of thoughts carried in narrative form. Finally, I have kept to the critical medical humanities' perspective of this thesis, in augmenting the accounts of Fullager and Barcan who have respectively approached the worlds of exercise science and complementary and alternative medicine with a critical engagement. This chapter thus develops an account of embodied mental health invested in the feeling and knowing sense of bodies in the contexts in which they develop and live. The chapter has thus directly suggested, and shown ways of conceptualising, mental life as deeply imbricated in physical life. On this note, I conclude this chapter with the words of Matthew Sanford discussing the work of Mind Body Solutions:

I have a very, very simple premise. If I leave the healthcare system, more connected to my body rather than less – we can talk for a long time about what that means – I'm going to take care of it better over time. That's what's going to occur. And if I take care of it better over time, I am going to end up back in less often, and it's going to save money for somebody [...] one of the things that drives the work of my non-profit Mind Body Solutions is how do you teach mind-body awareness to me the end user? What does a healthcare system look like that makes that one of the things that's happening?¹⁰¹

¹⁰¹ Matthew Sanford, 'Transform 2009 – Mind Body Awareness', online video recording, *YouTube*, 28 Feb 2013 <<https://www.youtube.com/watch?v=-mw4WoDc8RU>> [accessed 20 July 2017].

Sanford's questions lead me towards the concluding chapter and the implications for research and practice in a new model of embodied mental health.

Conclusion

Chapter Aim and Summary

If mental health is in our heads, then we had better put our ‘heads together’; so speaks a campaign launched in 2016 by the Duke and Duchess of Cambridge and Prince Harry aimed at tackling the stigma around mental illness.¹ In this thesis, I have asked what is meant by the ‘mental’ of ‘mental’ dis/order and whether a focus on heads and brains has come at the expense of more physical and socially embodied models. I have considered different models, from those centred in an understanding of mental illness in brain chemistry and function, to others which conceive of ‘mental’ dis/order as linked to metaphysical thoughts, through to concepts of mental health integrated with physical health. I have also asked how the evidence that points to the role of whole bodily systems in mental wellbeing fits with divided clinical areas of physical and mental health. I have unpacked what is at stake in this confusing terrain because how ‘mental’ dis/order is ‘language’d – and by whom – affects how it is understood, and how it is understood informs how it is treated: if it is in the brain, treatment might be via drugs, but if it is in inner speech, then targeted talking therapy might be deemed more appropriate. However, if it is in the whole person – from head to toe and linked to that person’s social and environmental context – then a different vocabulary, understanding and clinical approach might be needed.

In this thesis, I have begun to shape a space for mental health beyond the head; developed and sustained in the whole being-body. Indeed, I have argued that by putting ‘heads together’, a dualist framework and vocabulary remains; one which puts theory and thinking in front of practice. In the preceding chapters, I have argued that models that split apart mental health in the head, from bodies in the world, are not only confusing

¹ Heads Together, <<https://www.headstogether.org.uk/about-heads-together/>> [accessed 20 July 2017].

but that they undermine – or cut out – both the social and environmental aspects of people’s lives, as well as the physical and sensory. In this way, my research is an original contribution to knowledge through its critical analysis of the language used in medical and policy discourses and personal narratives about ‘mental’ dis/order, as well as its development of an embodied model of mental health that breaks out of heads and into shifting, affective bodies in constant contact with the world.

This Conclusion will revisit the warrant for this research and the problems I have sought to answer. It will reassess the questions that were posed and the methods used to address them. I will consider how the chapters addressed the perceived gaps in research and understanding, briefly revisiting how each chapter contributed to the analysis of dualistic ‘mental’ health discourses, and some of the alternatives I posed in return. I will then move on to consider the meaning and implications of this work, as well as addressing the limitations. I will end this Conclusion by returning to the embodied model of mental health that I argue is so essential in being able to dispense with dualism and take people’s experiences of distress out of narrow, internalised, narrated containers, into being-bodies in the world.

Critical Questions

In this section, I consider why it was important to address the meanings of ‘mental’ dis/order and the overall questions that the thesis sought to answer.

With the oft-cited statistic that one in four people has a mental health problem at some time in their lives, and with stark evidence pointing to the growth of these issues, particularly in young people,^{2 3} there is a sense of critical urgency around mental

² Natasha Devon, ‘How to Promote Good Mental Health Among Teachers and Students in your School, *the Guardian*, 1 March 2016 <<https://www.theguardian.com/teacher-network/2016/mar/01/how-to-promote-good-mental-health-among-teachers-and-students-in-your-school>> [accessed 17 July 2017].

³ Peter Tait, ‘Causes of Growing Mental Health Problems Sit Largely Within Schools’, *The Telegraph*, 2 December 2015 <<http://www.telegraph.co.uk/education/educationopinion/12025711/Schools-largely-to-blame-for-rising-mental-health-issues.html>> [accessed 17 July 2017].

health. Political and biomedical responses to the problem are growing – in terms of promises of increased funding, clinical trials and public awareness campaigns. Mental and physical health are increasingly known to impact one another and the issue is highlighted in charity lobbying,⁴ policy initiatives⁵ and personal testimonies⁶. However, the clinical structure of the NHS – divided into physical and mental areas since its conception in 1948 – and the language that supports the divide – continually re-inscribes a dualist understanding of divided minds and bodies. Indeed, while there are moves towards integrated healthcare and growing developments and focus on systems medicine, it is the language and diagnostic tools of psychiatry that shape and give meaning to public understanding of ‘mental’ dis/orders. A failure to problematise this language means the continual fall back into mind over matter assumptions. These expand from an individual level of the mind in the head (as superior or controlling the physical, object, unthinking body below), to wider notions of self-contained individuals, separated from their social and environmental contexts and implicitly responsible for their own internal problems.

From the outset, this thesis thus posed the questions: How can we offer solutions to ‘mental’ dis/order if the meanings and understandings are tangled and torn between constantly moving and competing accounts? Where is the room for embodied accounts in a psychiatric diagnostic culture, which splits out and categorises through narrative means, potentially thereby missing affective, sensate, physical experiences that can’t easily be translated into preferred modes of storytelling and rational explanation? As articulated in the Introduction, the aims of this thesis were two-fold. First, to conduct a general discursive disentangling of the language and narratives of mental health in policy, public spaces, and medical and psychiatric literature and, second, to find

⁴ Mental Health Foundation, ‘Physical Health and Mental Health’, <<https://www.mentalhealth.org.uk/a-to-z/p/physical-health-and-mental-health>> [accessed 14 July 2017].

⁵ Strathdee, ‘Integrated Care: 3 Years of Progress and “Jugular” Actions Needed’.

⁶ In *Reasons to Stay Alive*, for example, Matt Haig states that the term ‘mental illness’ is misleading because ‘it implies all the problems that happen, happen above the neck’ (p.156).

appropriate tools and models with which to conceptualise non-dualist ontologies and to gesture towards an embodied model of mental (ill) health by breaking down the ‘familiar and repeated’ impasse of language.⁷

A Critical Medical Humanities Framework

In this section – and drawing back to the Introduction – I discuss how a critical medical humanities approach helped me to answer the aims of the study, and how I drew upon notions of the transdisciplinary to gather and analyse material from traditionally bounded disciplinary spaces. The concept of the ‘critical’ medical humanities has been discussed and interpreted by scholars working in the field in very different ways, but for the purposes of this thesis, it had some very specific meanings and has provided some clear points of engagement.

First, I have argued for a critical imperative that the language of ‘mental’ dis/order and mind over matter is unpicked and that an embodied account is foregrounded. I have continually drawn on evidence showing the size and scale of the problem in the UK – often couched in the language of ‘epidemic’,⁸ the confusing terrain of competing accounts and explanations, and the limitations within biomedicine and psychiatry to deal with embedded dualist language.

Second, psychiatry has oft been critiqued, and the areas of critical mental health studies and anti-psychiatry, in particular, have emerged to resist the hegemony of psychiatric power and the labelling and expanding of disorders – particularly from one culture into another, or the wiping out of social problems into personal ones. Indeed, I have argued that dominant medical discourses lead public understanding and that the scripts that are disseminated about ‘mental’ dis/order shape how experience is

⁷ Ahmed, *Feminist Life*, p.9.

⁸ Mark Rice-Oxley, ‘Drugs alone won't cure the epidemic of depression. We need strategy’, *the Guardian*, 3 July 2017 <https://www.theguardian.com/commentisfree/2017/jul/03/drugs-alone-wont-cure-epidemic-depression-we-need-strategy?CMP=fb_gu> [accessed 14 July 2017].

understood and felt. Medical humanities scholars have drawn on the concept of 'biopower' to show how dominant discourses are 'crystallised' in popular media – and thus ideas about minds and bodies are built, sustained and reproduced.⁹ These dominant discourses focus on individual overcoming, self-management and personal responsibility and inflect public health messaging in the UK. These messages are focused on accountability; getting people to manage themselves and ask for help less, so as not to drain the publicly-funded health service, and are supported more widely by a neoliberal climate, where the body is an object to be done to, with body solutions to be bought for improvement or self-betterment. However, these messages put incredible pressures on individuals, 'ghosting' the powerful social and cultural effects on being-bodies.¹⁰

Third, a critical medical humanities framework has helped towards the insertion of the 'critical' as a gesture towards policy, and the theorisation of mental health underpinning policy. In a debate about mental illness run at the University of Oxford in 2016 by Mark Brown (editor of *One in Four*, a national mental health magazine) the promotional material for the meeting contended that 'mental health and mental illness are higher on the policy agenda than they have ever been yet, to date, the area has not seen the levels of innovation and disruption present in approaches to other social challenges'.¹¹ I have returned throughout the thesis to notions of breaking down walls, to feminist models of disruption and challenge, to the way in which feminist criticism models how academic work can engage with notions of social change beyond the academy. Feminism has provided a model of disruptive thinking (especially around the value and meaning of bodies in contact with the world), that I have returned to throughout, with the aim of disrupting the idea of separated out 'mental' health. In this

⁹ Rail and LaFrance, 'Confessions of the flesh and biopedagogies'.

¹⁰ Fullager, 'Diffracting mind-body relations'.

¹¹ Mark Brown, 'New Mental Health Mini-hack', Oxford, 14 April 2016 <<https://marmalade.attending.io/events/new-mental-health-mini-hack>> [accessed 20 July 2017].

way, I began the thesis locating my own body and biography for this work, and will return to the possible limits of this position later in this Conclusion.

Finally, being critical in the context of this thesis has also been defined in relation to how evidence is conceived and hierarchized. I have suggested that embodied methodologies in broad terms might be useful to tap into the felt quality of ‘mental’ dis/order when narrative strategies fail, are unhelpful, or – in some cases – toxic. I have suggested that there are alternative ways of knowing that are not conceived in terms of thinking mind over unruly matter. While I have carried out a narrative analysis within this thesis – looking at a range of narratives from newspaper articles, policy and charity documents, and memoirs and fictional representations of ‘mental’ dis/order – I have also attended to the limits of narrative itself and suggested how it can close down or confine experience. I will come back to this when I consider both the limitations of this thesis, as well as the possibilities for future research.

I have positioned my entry into the critical medical humanities as transdisciplinary. I have turned to the transdisciplinary and the notion of the trans- rather than inter- or multi- disciplinary to break down walls by not focusing on either/or: mental or physical, science or humanities, subjects or objects, mind or matter. Building on Nicolescu’s notion that transdisciplinarity offers new knowledge that arises from the ‘between, across and beyond’ disciplines, I have used this to gather together alternative body-mind models from a range of spaces – dance, bodywork, music and sound theory, literary texts – trying to read and analyse (in Barad’s term) ‘diffractively’ about the possibilities for non-dualist readings of embodied distress.¹² I will now turn to the work of the individual chapters of this thesis, and how they have started to address the questions I set out to explore.

¹² McGregor, ‘The Nicolescuian and Zurich approaches to transdisciplinarity’.

Chapter Contributions

In **Chapter One** I mapped different discourses about mental health to perform a discursive disentangling of how ‘mental’ dis/order is positioned, understood and conceptualised in medical, psychiatric, policy and public health spaces. I drew (somewhat fluid) lines around four models of ‘mental’ dis/order that emanated from these spaces and considered the implications of these models for individuals looking for expert opinion and answers to their distress. In this way, I revealed the multiple and often confusing models of ‘mental’ dis/order and how they manipulate everyday understanding. I presented in this chapter somewhat of a hierarchy of models – each taking more interest (in very different ways) in physical life, and eventually gesturing to a systems model playing with the language of embodiment. However, I argued that this did not go far enough to dismantle underlying dualism.

The first model of **Immaterial Thoughts** places ‘mental’ dis/order in the head, closely linked to language and distorted inner speech. Understood in this way, treatment – like CBT or mindfulness – targets the conscious mind and the worded thoughts of that mind. However, this internalised, thought-into-word model leaves a whole tranche of the experience uncharted. The trajectory of the model of ‘mental’ dis/order confined to internalised thoughts, whirring heads, problematic inner speech and narration, largely disregards the body. It raised an important question about how this dualistic model might actually provoke unhealthy behaviours towards that objectified body – barely registered as involved in this conceptualisation of subjectivity.

The second model I explored – the **Brain Disorder** model - puts psychiatry in (much firmer) biological territory. The model also does apparent favours for those with diagnosed mental illness. It detaches a person from the responsibility of – or vagaries of – having an illness of the mind, and pins the illness to the brain instead. The model has obvious advantages: it reduces the slipperiness of the term dis/order (which is removed from issues of social flux) and it does not mind too much about the word ‘mental’, which

it thinks of as an old-fashioned synonym for the brain. The body is relevant in this model because the brain is part of the body, so there is a sense of a real physical ground for ‘mental’ dis/order. The problem with this model arises when ‘mental’ dis/order is equated with internalised brain chemistry alone and physical life is the brain. Furthermore, this model sits on some shaky evidential ground. Indeed, the rest of the body is merely the receptacle of the brain’s orders, and the concept of embodiment (in terms beyond the brain) is often swept aside.

In this chapter, I explored a third model of **Interacting mind and body**. I analysed how this model was fuelled by linked outcomes between physical and mental illness. Herein, the body is understood to express the mental anxiety, depression or stress in physical ways – a racing heart, problems sleeping, a sense of heaviness and languidness. This model certainly recognises the physical implications of ‘mental’ dis/order. Furthermore, it posits the need to better integrate mental and physical health, as it accepts that one might affect the other and that people who have poor mental health have poor physical health outcomes. The startling statistics that depression is ‘a risk factor for mortality [...] comparable in strength to smoking’¹³ and that it is ‘independently associated with increased cardiovascular morbidity and mortality’¹⁴ firmly support the adage that there is ‘no health without mental health’.¹⁵ However, this model does not push hard enough to understand why these links are so powerful or to explore why they remain separately described and articulated. The model remains vertically shaped. Recovery remains a heroic overcoming and ‘biopedagogies’ about how to live

¹³ A. Mykletun and others, ‘Levels of Anxiety and Depression as Predictors of Mortality: The HUNT Study’ *British Journal of Psychiatry* 195, 2 (2009) 118-125.

¹⁴ Judith H. Lichtman, ‘Depression and Coronary Heart Disease: Recommendations for Screening, Referral, and Treatment: A Science Advisory From the American Heart Association Prevention Committee of the Council on Cardiovascular Nursing, Council on Clinical Cardiology, Council on Epidemiology and Prevention, and Interdisciplinary Council on Quality of Care and Outcomes Research: Endorsed by the American Psychiatric Association’, *Circulation*, 118, 17 (October 2008) <<http://dx.doi.org/10.1161/CIRCULATIONAHA.108.190769>>.

¹⁵ HM Government, ‘No Health Without Mental Health: A Cross-government Mental Health Outcomes Strategy for People of all Ages’ (2 Feb 2011) <https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/138253/dh_124058.pdf> [accessed 20 July 2017].

well are inserted into public health narratives. This model is also found in some areas of complementary, alternative and psychosomatic medicine, where minds affect bodies, thought causes illness, and where body symptoms express the contents of the mind metaphorically or symbolically. The splits and binaries persist and the internalisation of 'mental' dis/order continues.

The final model of the chapter – **Body Systems** – suggests somewhat of a progressive move towards the importance of embodiment in human distress. It tends towards a more sophisticated and nuanced account of minds and bodies, gesturing towards a hierarchical shift away from mind over matter. A range of disciplinary perspectives speak to this model, and the transdisciplinary nature of this study emerged as valuable in being able to place the (not unproblematic) holism of CAM next to cognitive science and theorists of the embodied mind such as Damasio and Varela, and biological work into the 'gut-brain'. These are complex and very different areas, with radically different understandings and conflicting interpretations. However, the focus on body systems provides an interesting synergy and one that widens the understanding of mental life beyond the brain. In the final part of Chapter One, I considered the implications of these models, which, on the whole, focus on floating heads above an objectified body. I suggested that none of these models focus on what it might mean to be a body, rather than possess a body.

While Chapter One argued that narratives of 'mental' dis/order are powerful in naming, clustering and segmenting issues of mental (ill) health, in **Chapter Two** I discussed how scholars in the medical humanities have viewed narrative as an essential form of communication, as the reclamation of subjective experience against biomedical dominance, and as able to clarify, order, control and overcome chaotic experiences. Furthermore, that the focus on talking therapies in the clinic has extended into the morality of everyday life wherein talking is associated with breaking the mental illness stigma. As a result of this important focus on narrative, a question has arisen among

medical humanities scholars: what else if not narrative, to communicate the experience of mental illness? In this chapter, I troubled this relation, suggesting that personal narratives can be subsumed back into master models and discourses, reinforce particularised 'get well' scripts of illness overcoming, and underline the idea that mind can solve unruly matter. Indeed, I also argued that narratives can be damaging in some cases, or feel inescapable. However, rather than concede to a totally post- or anti-narrative position, I felt I needed to consider narrative more carefully, rather than simply agreeing that its linear, confining models would be unfit to represent embodied subjectivity. Words, after all, come from bodies. As I worked with modernist case studies – texts that push the limits and edges of narrative form – I showed the malleability of narrative structures and the ability of words to convey the experience of the being-body in distress and disorder. Emily Holmes Coleman and Jean Rhys' novels explored how to access a sense of the unruly, marginalised, failing, affective body in words. A close reading of these texts showed how sound and music acted as enablers to convey the embodied residues of pain and breakdown. Narrative was not so stringent and constricting that it foreclosed the expression of the body's materiality, but a reliance on narrative as the only way to access feeling, or to communicate, needed to be challenged.

Chapter Three turned to sound and music, and to the second aim of the thesis, to work with subjectivities that are not based on dualism. I began the chapter thinking about how the senses 'mingle' with the world, and how sound as vibration helps to cross the divide between mind and matter. In order to break down the language of 'mental' dis/order, I argued that the effect on bodies needs to be foregrounded and, hence, I put forward the 'being-body' while recognising the difficulty of developing terms that define subjective states. I argued that sound is useful because it reveals sensation and experience beyond the narrative self through its moving, vibrating energy. Sound theory helped to define what it is to 'be' a body, rather than subsequent representation. However, I reiterated the integrity of language, which is embodied, both in the physical

terms of sound and breath, but also (beyond the spoken), what can and cannot be said is shaped by the context of the body in the world. I drew back to feminism, and to the idea – offered by Sara Ahmed – that feminism starts with bodies made to feel uneasy. The sensation of a body in contact with the world shapes that body. This is the process of becoming; through the energy it anticipates, and spaces it is offered or refused. I developed this idea to reflect how vibrating matter helps to reveal how bodies store memories. I drew synergies between sound and affect theory to undo the idea of a bounded individual able to contain and manage their ‘mental’ health. Sound foregrounds the inarticulate and sensory, which might be hidden by a focus only on verbal and textual representation. When sound is understood as energy that imprints, the division between mind and matter is closed.

As I moved on to consider music, the literature revealed just how much the intellectual and cognitive academic traditions based on mind/body divides also impacted theories of the emotions in music. At every turn, dualistic discourse seemed to confirm and collaborate with mind and body divisions. However, voices from within feminist criticism, and those engaged with concepts of embodiment, helped me to articulate that music is always an embodied discipline – both in playing and listening. A body engaged in playing music also tells us something about body memory, which does not start top down. Music is useful in supporting the concept of the being-body, as it dissolves thresholds and reveals the always becoming of the body – we cannot know what that ‘is’ at any moment because it is always changing, unfolding, absorbing, and moving. This chapter thus drove forward the thesis by developing the idea that whole being-bodies feel, absorb, react, and are involved in knowing; they are immersed in their social and environmental contexts, thus outstripping the confining models of ‘mental’ dis/order articulated in Chapter One.

Chapter Four expanded on the work of Chapter Three by developing different paradigms of body knowledge. I returned again to feminist new materialism to think

about what bodies do, and how embodied matter might contribute to ways of knowing. I argued strongly here that embodiment is much more than having a sense of the body, but about relations with the world. In this way, I augmented critical literature, which discusses how distress is about relationships with the world that cannot be disentangled because conditions of being in the world affect bodies. I argued that physicality in relation to mental health is much more than just about exercising bodies in enclosed acts of self-management – this is not what embodiment means. Indeed, I emphasised instead, first of all, embodied feeling and knowing body states, thus revealing the body as an essential part of being, rather than just something to dictate and direct from the head-mind. In order to access these sorts of ideas, I returned to a transdisciplinary perspective to bring together dance, bodywork and yoga practice as sites of interest in body knowledge and cultivation.

I argued for the importance of embodied understanding, which can come through practice. This is practice, which is not relegated below theory but is physical, sensory and knowing. However, there is a point at which embodied practices become further instruments of internalised neoliberal ideals of individual responsibility. In this chapter, I underlined that bodies are not on even ground; female bodies are denied certain movements or space, bodies with different limitations and disabilities do not feel or form embodied knowledge in the same sense of muscle or bone. I suggested that an energetic understanding of embodiment, explored by writers including Matthew Sanford, helped to nurture a much less vertical relation of mind over matter, towards bodies as breath and energy. This chapter also turned towards trauma, and to the way in which medical divides between physical and mental trauma are undone by the way in which ‘the body keeps the score’.¹⁶ I used a range of Somatics practices to think through this problem, which offered ways of understanding ‘psychological’ trauma as deeply imprinted into physical bodies.

¹⁶ van der Kolk.

The final section of this chapter looked at the importance of social change: of working with knowing bodies to undo habits, to find new ways of moving, to work through internal connections to help address wider connections with the world. In this way, this chapter offered me a connection in itself; to show that embodied mental health is not only about the visceral emotional body in cognitive science, or about integrating mental and physical comorbidities or fitting classified 'mental' dis/orders into different types of embodied trouble. Embodied mental health is about moving and being-bodies in complex, entangled worlds.

Mapping the Meanings: Mental Health is not all in our Heads

I now turn towards the meaning of the work outlined in these chapters; to assess how this work has addressed the problems the project outlined, and how the work speaks to and adds to existing literature about mental health.

In this thesis, I have conducted an analysis of the language and narratives of mental health in policy and public health spaces, which transmit and are reproduced in personal narratives – from social media to published memoirs to self-help forums. While this has inevitably been partial, I have argued that the powerful medical discourse and public health literature shapes public understanding. I have argued that the meanings of mental health are constantly being revised, countered and moved between different locations, but I have analysed that 'mental' dis/order is often drawn back to individual brains and dysfunctions, and how this has provided, for many people, a sense of physical grounding for distress, which often feels invisible and unreal. However, I have critically analysed how this internalisation might stick people to pathological labels from which there seems to be little escape, and lead to situations of self-blame and self-responsibility; ultimately suggesting the intractability of the disordered self. I have found that psychiatric labels help provide meaning and give expert shapes for people's distress, but at the same time may close off certain feelings and experiences. This is particularly

an issue when narrative is a main method of communication (and therapy) for ‘mental’ dis/order. I have confronted this idea by suggesting that narrative is not always possible (and in some cases even detrimental) and that it may omit and circumvent the palpable sensory and physical feelings that don’t always translate to coherent, rational, ordered narrative forms. In this respect, I have built on the anti- or post-narrative positions conceived in medical humanities criticism – especially that of Angela Woods. Indeed, I have returned throughout the thesis to the challenge of ‘linguaging experience’¹⁷ especially when bodies (conceived as physical entities below the head) are degraded, unthinking pieces of matter and muscle – as is popularly conceived in the popular adage of mind over matter.

The title of this thesis proposes a new model of embodied mental health. There is a wide range of salient literature focusing on embodiment in terms of perception and emotion and cognition – from cognitive science to phenomenology to psychology – but I have found gaps in what these understandings of embodiment do for the meaning of ‘mental’ dis/order. I have built upon a body of critical mental health and anti-psychiatry literature, which supports the notion that mental health is socially and culturally enmeshed, but found much less attention paid to embodied distress in energetic, rhythmic, physical and felt-sense aspects. To address this, I have critically engaged with Somatics, bodywork and sound and music theory to build an embodied account developed from much more of an energetic than anatomical bodily perspective. I have found the work of feminist critics like Elizabeth Grosz useful in bringing together the many possible layers of embodied experience, and the difficulty of extracting the ingredients of embodied life, which includes discourses, materiality, and the body’s energies and rhythms and, in this project, I have taken this approach towards the implications for understanding what the ‘mental’ might really mean.

¹⁷ Sheets-Johnstone, *The Corporeal Turn*.

I have suggested that an embodied account must include the social and environmental. A lot of the literature I have drawn upon has returned to the social aspect of people's lives and how embodied distress cannot be separated from these contexts. I have repeatedly returned to the deep problem of the language of the 'mental' in this regard – wherein mental life is considered to be an individual state – as the wording of two new charities set up to address stigma communicates, mental health is in our 'heads'.¹⁸ Without either a new language or a new interrogation of the language, mental health issues will continue to be defined and confined inside the skull. I developed the concept of the being-body to counteract this and to drive forward the value of 'being' a body in the world, and what this means for how individuals are able (or not) to address, attend to, or improve their health states. I continually recognised the difficulty of this sort of language, but felt it necessary to stay close to bodies, to emphasise being and becoming, even if my terms still were awkward, 'sweaty'¹⁹ and covered in 'barnacles'.²⁰

In terms of the second aim of this thesis, I have looked at tools and models that conceptualise non-dualist ontologies to get past the impasse of language. I took on the challenge to use non-dualist models in cultivating alternative subjectivities – for example in complementary and alternative medicine or Eastern forms of spiritual practice. Following and building on Ruth Barcan's cultural studies analysis of CAM practices, Volker Scheid's plea to the critical medical humanities to look to frameworks other than Western biomedicine, and William Viney's challenge to the medical humanities to intervene more explicitly in 'ontological questions', I have explored alternative body models based on energetic, vibrational and rhythmic understandings.²¹ I have reached out to practices such as sound and music therapy, bodywork (manual and moving

¹⁸ 'Heads Together' and 'HeadCase'.

¹⁹ Ahmed, *Feminist Life*, p.13.

²⁰ Alexander cited by Joan Schirle, in, *Bone, Breath and Gesture*, p.91.

²¹ Viney, p.3.

therapies of very different kinds) that come into contact with notions of healing and embodied distress or traumatic experience. I have suggested that these models usefully foreground the notion of practice, communication which is often unspoken, and bodies that know and intuit, and how this might be useful not only for understanding or re-conceptualising embodied distress, but potentially for treating it too.

This thesis suggests that mental life is not all in our heads. Indeed, a new embodied model of mental health in this thesis does two things. First, it suggests that ‘mental’ health is profoundly physical, and therefore that these words will remain an obstacle unless challenged further. Second, that physical life is not only in the brain, or only contained to individual bodies, but is deeply embedded and connected with social, cultural and environmental conditions.

Implications: Beyond Mental and Physical Silos

In this section of the Conclusion, I turn towards the possible implications of this work – to address what this study might mean for practice and policy. While this is a PhD thesis (and with the limitations, I will come on to explore) I intend to gesture towards these areas and suggest lines of possible future activity.

I began the thesis by discussing how the whole notion of mental health versus physical health has been informed by Cartesianism and anatomically-driven Western medical practice. While psychiatrists and members of the medical community might intuitively know that dualist divisions are unhelpful, they lack both the language and the research frameworks within which to unpick these lines, and so constantly return to the known segments of mental or physical health when defining and diagnosing. At present, the NHS lacks a clear framework or a paradigm within which to situate the growing evidence about (what are currently explained as) connections between mental and physical health. Indeed, my findings speak to the literature on integrated healthcare but trouble the way in which this is expressed.

I turn here briefly to two examples to ground this analysis and point to real-life settings of clinical practice. First, in some UK NHS Trusts, there are clear initiatives that seek to join up care and treatment. This can be seen in King's Health Partners Academic Health Sciences Centre (a collaboration between Guy's and St Thomas', King's College Hospital and South London and Maudsley NHS Foundation Trusts and King's College London) where it is explained:

From screening people for depression in acute outpatient appointments and providing psychological support for people with diabetes and other long-term conditions, to improving the physical healthcare of people with severe mental illness, we are working to improve the outcomes and experience of the care we provide.²²

While this is an attempt to join up mental and physical healthcare and to recognise the inseparability of these domains, my research suggests that this could be taken much further, and my particular angle has been to think about how the very language separating these areas troubles attempts to make pockets of good practice into a common understanding.

The problem of mental and physical silos can be further seen in clinical practice in the TV programme 'Behind Closed Doors' on Channel 5. The programme follows life inside British GP (primary care) surgeries and in one small example of practice, shows the difficulty for clinicians in communicating a health issue that is perceived to cross physical and mental categorisation. In one episode, a GP carefully articulates the physical reality of a woman's fibromyalgia watching her language so as not to infer that the

²² King's Health Partners, 'Joining up mental and physical health: an introduction to mind and body healthcare', <http://www.kingshealthpartners.org/assets/000/000/871/Mind_and_Body_4pg_invert_original.pdf> [accessed 14 July 2017]

problem is all ‘psychological’ (with the possible negative connotations that might have in inferring that the problem is not real) at the same time as suggesting that CBT (with its focus on thoughts in the mind) might be a possible therapeutic approach.²³ The ‘syndrome’ cannot be seen on scans and x-rays – its ‘organic’ cause is not known. The NHS Choices website offers up ‘an emotionally stressful event’ as a possible cause, as well as brain chemicals, implicating ‘low levels of the hormones serotonin, noradrenaline and dopamine’. The symptoms equally stretch over traditional mind and body divides involving pain, stiffness and dizziness as well as anxiety and depression. A variety of health professionals are involved in its treatment from a rheumatologist to a psychologist, and a variety of approaches are evidenced to help with symptoms. The personal and subjective assessment of what works – the embodied lived experience rather than the expert view – remains on the fringes, as the NHS information attests: ‘There's little scientific evidence that such [alternative] treatments help in the long term. However, some people find that certain treatments help them to relax and feel less stressed, allowing them to cope with their condition better’.²⁴ The evidence hierarchies of healthcare do not trade so much in the sensate business of coping and feeling as the scales of symptoms on validated questionnaires.

I began this project asking how it is possible to offer solutions to ‘mental’ dis/order if the meanings and understandings are tangled and torn between constantly moving and conflicting accounts. I questioned how embodied distress might be felt and taken seriously in a psychiatric diagnostic culture that splits out and categorises through narrative means, potentially thereby missing affective, sensate, physical experiences that can’t easily be translated into preferred modes of storytelling and rational explanation. Reaching back to Anna Davis’ paper on doctors’ sensory involvement in reading and

²³ Channel 5, ‘Season 3: Episode 42’, *GPs: Behind Closed Doors*, 7 August 2016, <<https://www.my5.tv/gps-behind-closed-doors/season-3/episode-42>> [accessed 20 July 2017].

²⁴ NHS Choices, ‘Fibromyalgia – Treatment’, 1 March 2016 <<http://www.nhs.uk/Conditions/Fibromyalgia/Pages/Treatment.aspx>> [accessed 20 July 2017].

diagnosing bodies, the gap between clinical practice and bodywork practice is perhaps not as big as is imagined. However, tactile and embodied medical practices are overlooked and seen as somehow relegated to the history of medicine, which is now future-focused on technological innovation – touching from a distance – and on quantifying bodies and their functions, rather than engaging with subjective – sensory, palpable or non-verbal – experiences.²⁵

This thesis has tried to unpack and then break out of the containers, and to move beyond the notion of a vicious circle spinning between physical and mental elements. Clinical practice will remain stuck – awkwardly trying to offer up physical solutions to mental problems, or unable to clarify to patients the many health problems that do not fit into physical and mental boxes – without a paradigm-shift out of containers and towards a new language and understanding of the health of the whole being-body. Indeed, in a truly embodied model of mental health – as this thesis has gestured towards – people’s lives and contexts (from the air quality they breathe, to the histories they embody, to ways in which their bodies are (un)acceptable compared to societal ‘norms’, to the social context for their lived lives) would all be seen as part of embodied health or illness states. A model of embodied mental health would also see a reworking of the vocabulary so that irritable bowels, a racing and panicking heart, or tense, stressed shoulder pain would not be seen as physical manifestations of separately contained mental thoughts (as stress or anxiety filtering from the head down) but forms of the stress, anxiety, worry and distress itself. The physical expression of disorder and distress is not merely a representation, or a manifestation, or a reflection, or a metaphorical rehashing of issues based in the immaterial mind.

While this thesis has not been focused on analysing mental health policy in depth, it has returned to the way in which policy and its iterations in public health

²⁵ Emma Louise Pudge, ‘Self Knowledge through Numbers: The Quantified Self of Eating Disorder Recovery’, University of Exeter Advanced Critical Theory Conference, online video recording, *YouTube*, 6 May 2017 [accessed 20 July 2017].

messaging continue to (arguably unconsciously) underline dualist notions by addressing physical and mental health in separate (financial and organisational) silos. However, this does seem to be changing, as from within government and from organisations lobbying or campaigning on health, there is a broad move towards joining up mental and physical healthcare. The independent charity, The King's Fund has set out ten top priorities for the integration of mental and physical health in what it calls 'a new frontier for integrated care'. The first of these is the incorporation of mental health into public health programmes on tobacco, alcohol and obesity. As an associated report by Naylor and others explains, 'Mental health prevention and promotion activities account for less than 0.03 per cent of NHS spending on mental health, and the majority of joint strategic needs assessments (JSNAs) have little or no coverage of mental health and wellbeing'.²⁶ Indeed, this statistic feels stark when placed in the context that mental health issues 'represent 23 per cent of the burden of disease in the UK'.²⁷

As this thesis set out from the Introduction, the big public health issues all have mental life implicated in them – smoking, drinking and eating are all issues of the whole person and have complex emotional and sociocultural aspects. As is clear from The King's Fund report, the importance of the 'body' and physical health for mental health is on the rise. However, this still has an objectifying tone and content – focused on exercise, quantifying steps, counting calories, measuring body weight, rather than some of the much more embodied directions that this thesis has suggested. The crevice between the two areas remains; with initiatives simply targeted at reaching across the divides, rather than thoroughly integrating them via the person. Health campaigns that silo off physical health as a sort of object-thing continue to miss the point. In an example of this, information from the charity, Mind, tries to explain why physical wellbeing

²⁶ Naylor and others, 'Integrating Physical and Mental Health'.

²⁷ Charlie Cooper, 'Government is Breaking Pledge on Mental Health Policy, Warns Former Minister', *Independent*, 28 March 2016 <<http://www.independent.co.uk/news/government-is-breaking-pledge-on-mental-health-policy-warns-former-minister-a6956971.html>>.

informs mental health: 'We all know that being physically active is good for our bodies. But our physical health and mental health are closely linked – so physical activity can be very beneficial for our mental health and wellbeing too'.²⁸ However, the issue is much more pervasive; being physically active can be good for the body because the body is not a separate thing, but deeply related to the world and, thus, 'mental' health runs through the whole. The effects of not developing good 'mental' health (and not understanding what is needed to help foster that), have huge implications for public health generally, as I have repeatedly addressed. The effects of poor mental health develop throughout the whole person, hence poor mental health is a major risk factor implicated in the development of cardiovascular disease, diabetes, chronic lung diseases and a range of other conditions.

If mental health is approached in a ground-up strategy, it must also take account of the seeds of good mental health – the foundations that support its development. A report by the British Heart Foundation in 2016 reflected on the growing problem of the societal move away from physical activity, with only nine per cent of children aged between two and four meeting UK guidelines that recommend at least three hours of activity a day. In an article on the report published in *The Telegraph*, it is claimed that the effect of the 'inactivity crisis' wherein 'two-year-olds [are] spending increasing amounts of time hunched over gadgets, instead of moving about', ripples through to teenage years and adulthood.²⁹ The issue of physical activity in childhood is treated within physical health policy strategies, for example within the government's childhood obesity strategy.³⁰ However, the same sort of evidence about the importance of physical

²⁸ Mind, 'Physical Activity, Sport and Mental Health', July 2015 <<http://www.mind.org.uk/information-support/tips-for-everyday-living/physical-activity-sport-and-exercise/#.VxXudHpi8uM>> [accessed 20 July 2017].

²⁹ Laura Donnelly, "iPad Generation" Means Nine in 10 toddlers Live Couch Potato Lives', *The Telegraph*, 20 January 2016 <<http://www.telegraph.co.uk/news/health/news/12108895/iPad-generation-means-nine-in-10-toddlers-live-couch-potato-lives.html>> [accessed 20 July 2017].

³⁰ HM Government, *Childhood Obesity: A Plan for Action* (London: Department of Health, Prime Minister's Office, 10 Downing Street, HM Treasury and Cabinet Office, August 2016) <<https://www.gov.uk/government/publications/childhood-obesity-a-plan-for-action>> [accessed 20 July 2017].

activity emerges in mental health reports on the growing problem of ‘mental’ dis/order in children and young people.³¹ Indeed, the obesity ‘crisis’ cannot be solely considered as a physical problem.³² The obesity strategy, in which primary schools are called on to provide children with at least thirty minutes of physical activity each day, and which asks parents to do the same,³³ is based on doing-to the body, rather than teaching children about embodied self-awareness. None of the current mainstream models found in dominant discourse about mental health and, analysed in Chapter One, go far enough in tethering together physical and mental issues into one public health space.

The implications of a siloed model of mental health are profound; the dishing out of separate physical and mental health measures is unlikely to resolve some of the biggest health issues that are deeply implicated in the whole person in the world. The issue of asking people to take on physical activity and separate out parts of their wellbeing harks back to an objectified model of the body, which must be done to and acted upon, as opposed to being conceived as integral to selfhood – in many different and changing ways. The preceding chapters of this thesis have often returned to issues of disembodiment or disconnection with the object body in mind over matter constructions. While this thesis is not about the effects of technology on mental health, it is a relevant and pressing question that emerges in accounts of ‘mental’ dis/order, and fits within a culture where the emphasis is on living in the head, or understanding the self as existing within the brain and its attached mind.

³¹ Denis Campbell and Sarah Marsh, Quarter of a million children receiving mental health care in England, *the Guardian*, 3 October 2016 <<https://www.theguardian.com/society/2016/oct/03/quarter-of-a-million-children-receiving-mental-health-care-in-england>> [accessed 14 July 2017].

³² Annalijn Conklin, ‘Obesity Crisis is Not Just a Lifestyle Issue’, *Gates Cambridge – Blog*, 19 August 2014 <<https://www.gatescambridge.org/multimedia/blog/obesity-crisis-not-just-lifestyle-issue>> [accessed 20 July 2017].

³³ BBC News, ‘Childhood Obesity: Plan Attacked as “Weak” and “Watered down”’, 18 August 2016 <<http://www.bbc.co.uk/news/health-37108767>> [accessed 20 July 2017].

Implications: Embodied Research

In this section, I turn to the implications of this thesis for research and some suggestions about what might be needed next. I turn to two areas here – first in terms of methodologies, and second in terms of how the critical medical humanities can contribute further to the work that I have begun to explore in this thesis.

In Chapter Four – Knowing Bodies – I suggested that a re-evaluation of the importance of body knowledge, rather than the privileged intellectual ‘mind’, challenges the disembodied methodologies used in health research where the researcher’s body is only useful for its ‘ears, eyes, and maybe a hand that takes notes’.³⁴ As Somatics practitioner, Carola Speads explains, ‘intellectual development, not the development of our body sense, is emphasized in our culture’.³⁵ The work of Somatics practitioners, and others invested in bodywork practices, provides a vocabulary that can be used to support physical experience, as well as theorisation that emanates from that physical work, to create knowledge about mental health. The ideas in this chapter are not usually cited in academic work for a number of reasons. First, bodywork practitioners teach with their bodies, not always with their pens, and hence the specifics of their approaches have often not been well documented. Second, ideas about movement or the body are often associated with the New Age movement with its very broad-brush approaches to holism, which – as I have gestured to in this thesis – have tended to lack ‘quality’ evidence as is conceived by the dominant research frameworks, as well as failing to engage with critical perspectives. Third – and related to the second point – knowledge gained through the body has been regarded as subjective, fallible and emotional, the opposite of rational, objective clinical understanding.

³⁴ Anna Lavis, ‘Myrrha: Embodied Emotion, Corporeal Resonance’, *The Body and Being Network – Reflections*, 20 August 2015 <<https://bodyandbeingnetwork.org/category/reflections/>> [accessed 14 July 2017].

³⁵ Speads, in *Bone, Breath and Gesture*, (p.44).

However, this thesis suggests that further research might be conducted into how embodied distress can be researched and how to move beyond the near-mandatory idea that narrative ordering or sense-making is essential to externalise or to engage cognitively with experience. This thesis has assessed the ways in which narrative (in certain contexts) might be damaging, unreliable, or limited, and that embodied methodologies need to be further explored. Furthermore, the prejudices and dominance of evidence-based medicine that prioritise systematic reviews and randomised controlled trials above qualitative evidence, and which positively detach researchers' own bodies, struggle to accept or make room for evidence based in sensation or feeling. Experiential evidence is downgraded in healthcare, but this thesis suggests the need to turn to the body first, rather than to ideas or theory. Language does not have to be severed in embodied methodologies, but it can come afterwards, and it does not hold all the power. Indeed, biomedical research keeps the felt-sense of knowing bodies out of research, both limiting what kinds of experiences and sensations can be understood, as well as perpetuating dualist mind over matter frameworks into the very structure of research itself. This thesis argues for the value of embodied methodologies that break down these hierarchies of biomedicine and, arguably, in doing so, break down hierarchies of minds and bodies.

For the critical medical humanities, I believe that this thesis adds to a body of critical work assessing the language and discourse of health and illness. It lays the ground for further work analysing public health messaging and policy around the dualism implicit in mental health. I return here again to the point made by McNaughton and Carel that ethical medical humanities research needs to not only circulate ideas within the field but to push towards eventual shifts in policy.³⁶ In this way, the work here suggests that the emphasis for treatment would not be so much on re-imprinting the problematic mind and body split that is already emphasised in naming and dividing up 'mental' health

³⁶ Macnaughton and Carel, 'Breathing and Breathlessness'.

issues but allowing for embodied engagement in physical, proprioceptive ways. Such practice might turn to the evidence about the role of yoga³⁷ or exercise³⁸ or to a practical framework for phenomenology³⁹ as ways into thinking about embodied mental health.

As well as engaging with the physical and felt-sense aspects of embodiment, this thesis calls for research that deepens questions about how physicality and social context might be excluded by presumptions about the boundaries of ‘mental’ health. This concept has been discussed in an article entitled, ‘America Is Utterly Failing People of Color With Eating Disorders’, which highlights the some of the universalising ways in which ‘mental’ dis/orders are addressed, and the problematic assumptions research, policy and practice can make about how bodies experience the world:

It’s easy to understand how the tumult of puberty may trigger the onset of an eating disorder: The painful awareness of our bodies going through tremendous physical and emotional changes is laid out against the backdrop of our culture’s unreasonable standards of beauty. But for people of color, queer people, and transgender people, eating disorders can be traced to other structural and cultural factors that have been in play—quietly, insidiously, even unconsciously—for most of their lives.⁴⁰

The affect and the imprint of these ‘structural and cultural factors’ (prejudice, poverty, violence – for example) mean that bodily experiences vary, and the ways in which being-bodies feel, experience and deal with distress is never simply an individualised or

³⁷ The Minded Institute, ‘Yoga in Healthcare’, <<http://themindedinstitute.com/yoga-in-healthcare/>> [accessed July 2017].

³⁸ V. Ravindran and others, ‘Canadian Network for Mood and Anxiety Treatments (CANMAT) 2016 Clinical Guidelines for the Management of Adults with Major Depressive Disorder: Section 5. Complementary and Alternative Medicine Treatments’, *Canadian Journal of Psychiatry* 61,9 (2016), 576-87.

³⁹ Carel, ‘Phenomenology as a resource’.

⁴⁰ Angela Garbes, ‘America is Utterly Failing People of Color with Eating Disorders’, *Fusion*, 5 July 2017 <<http://fusion.kinja.com/how-america-fails-people-of-color-with-eating-disorders-1793858224>> [accessed 20 July 2017].

enclosed decision or ability. With the framework of embodied 'mental' health, and the concept of the being-body that this thesis offers, it gestures towards and beckons further research that practically engages with clinicians and health care professionals in all areas of care, to assess their own understandings of mind and body and mental and physical health relationships.

Limitations

As I approach the end of this thesis, it is important to reiterate the limitations of this work. First, I think about some of the limitations of the research and then – reflectively – about the limitations of my own capacities and location as a researcher.

This thesis has addressed a broad and ambitious question about how the language of mental health supports or articulates dualism, as well as proposing alternative frameworks with which to counter this. There are a number of limitations to this. First, due to the breadth of material I have covered to engage in a transdisciplinary approach to address the multiple areas this question affects, I have had to restrict myself to cases and examples, rather than to pursue depth in one particular area. Furthermore, in aiming to construct alternative terms with which to think through the problems I outlined upfront, I have, at times, engaged with practices or theories that lack robust literature or critical mass behind them (for example, different bodywork techniques that talk about the capture or lockdown of trauma in the body). While I have suggested future connections between esoteric practices and work within systems medicine (for example in epigenetics) this is not straightforward; the science behind such fields is complex and cannot be dealt with thoroughly in the scope of a humanities' thesis. Indeed, media reports on a systematic review that analysed how mind-body medicine interventions changed gene expression and how these molecular changes are related to

health⁴¹ were critiqued for ‘abusing’ emerging science by making such sweeping connections.⁴² Moreover, mind-body medicine often assumes forms of Cartesianism in the first place. To counter these sorts of problems, I have aimed to think through such mind-body practices critically and carefully, but recognise my ability to engage in depth with these issues is limited by my own sites of expertise. In this way, my own position working in health sciences in the NHS and university settings, has informed my understandings of healthcare evidence bases and methods, and challenged me to think about how a financially-stretched, publicly funded health system can engage with ideas and critical theories that seem abstract and distanced from the demands of working practice.

In the Introduction, I also positioned myself as someone invested in mental health as a former service user and as the author of an illness narrative. In both these capacities, I have approached the problem of ‘mental’ dis/order with my own embodied histories. As a former anorexic, I have notions about what may or may not be helpful in therapeutic terms. In the process of my initial recovery, I narrated and re-narrated my experiences. Towards the end of my own illness narrative memoir, *Thin*, I write, ‘In her story lies her survival’.⁴³ My self-help therapy was narrative in form; the anorexia was pushed into a corner, away from what I pieced together as my ‘self’, which I located entirely in my mind and within the words in my head. This thesis has been a part of a radical shift in this view, and I have aimed to reflect on this throughout the process; cautious not to prioritise my own embodied experiences, as I have focused so much on the contextual factors that affect individual bodies.

⁴¹ Ivana Buric and others, ‘What Is the Molecular Signature of Mind–Body Interventions? A Systematic Review of Gene Expression Changes Induced by Meditation and Related Practices’, *Frontiers in Immunology*, 16 June 2017 <<https://doi.org/10.3389/fimmu.2017.00670>>.

⁴² David Gorski, ‘Can mind-body practices “reprogram” our DNA?’, *Science-Based Medicine*, 26 June 2017 <<https://sciencebasedmedicine.org/can-mind-body-practices-change-the-way-our-genes-react-to-stress/>> [accessed 14 July 2017].

⁴³ Grace Bowman, *Thin* (London: Penguin, 2007).

Indeed, as I considered in the Introduction, the term ‘mental’ dis/order covers so much, and I have based my reading in small pockets or territories of eating disorders, depression, anxiety and trauma. There are huge swathes of experiences that I haven’t been able to mention, and there is a gap – even a discomfort – between those who speak out as recovered or recovering and those in the depths of severe, critical distress. I recognise that this is not easy to reconcile. Although this thesis has focused on the language and terminology of ‘mental’ dis/order, it has also come to touch on therapeutic suggestions and the arguably positive readings of embodiment, which make cuts in a vast landscape of research and understanding. Indeed, as I touched on in the Introduction, it is important to remain cognisant that for some people, a dualistic self-understanding may be beneficial, particularly for those whose bodies don’t fit harsh and oppressive ‘normative’ societal expectations.

Final Thoughts

It has been the aim of this thesis to unpick the dualist threads in different forms of discourse around mental health and unpack a model of embodied mental health where embodiment is more than a brain or object-body. My research raises a number of questions about how mental health and ‘mental’ dis/order are articulated, narrated and explained. It demands an urgent reconsideration of what might constitute knowledge about mental health, which might extend beyond linear overcoming narrative structures to incorporate a fuller felt-sense of embodied experience.

I have understood that the thinking subject has obscured the embodied subject both in terms of knowledge and experience. Furthermore, I have analysed how ‘mental’ dis/order has been packaged up within individual mental lives; tied to individual brains or misaligned thoughts, with recovery bundled up as an individualised, agentic issue – possible to achieve with the power of words, cognitive reflection, or improved physical self-management techniques. Social landscapes, embodied histories and felt or sensory

experiences are awkwardly fitted into brain functioning. The brain-as-king model has some powerful leverage, especially when it links to theories of plasticity wherein experiences affect the brain and the brain then responds and adapts. In this conceptualisation, the brain is malleable and can change; it is not simply an internalised organ but is related to life events and experiences.

However, with such a brain-dominant model, as Fullager neatly articulates, the ‘social is a ghostly presence’ with scientific knowledge, ‘that articulates a naturalistic ontology of mind-body relation.’⁴⁴ This thesis has suggested that the dominant dualistic ontology is supported and underwritten in dominant medical and political discourses, and that – following Foucault – this is not natural, but inscribed over time, and has recently become a useful man-made prop for a strained national health service in a neoliberal climate. However, while dualism – and mental and physical healthcare separation – might be the dominant mode of discourse and practice, there are a number of insurgencies. Indeed, there are numerous pieces of research and pockets of practice that already embrace an idea of ‘embodied mental health’ in some shape or another. As I have been much more focused on language and its meanings and its implications, I have not reviewed these in detail, but it is important to state that these practices exist both in the UK and globally, and an evidence base is growing, for example, the work of ‘integrative psychiatry’, which talks about treating the whole person; to changes in national guidelines (in Canada) for psychiatrists to recommend exercise as a ‘first-line treatment for mild to moderate depression’ and as a second-line treatment for more

⁴⁴ Fullager, ‘Diffracting mind-body relations’.

severe cases;⁴⁵ to research into the effects of poor nutrition and air quality on mental health problems.^{46,47}

A 2015 survey by the Wellcome Trust showed that mental health is one of the top medical issues in which the UK public are interested.⁴⁸ Mental health memoirs have become number one bestsellers and there is an almost daily barrage of press reports, personal stories, healthcare innovations and policies focused on providing mental health with an equal footing with physical health and determined to validate the experience of sufferers to end stigmatisation. However, the parameters of what mental health is, and what it means, continually shift. The landscape is confusing and the result arguably stigmatising. How is it possible to determine the experience and meaning of mental health if its form keeps shifting: if one moment, it is a chemical problem about serotonin levels, and the next minute it is couched as a disease of thoughts, if it is not physical health, but it is linked to physical health, or if it is mended by a myriad of solutions targeting bits of minds, brains, emotions and body parts one by one? Psychiatric and medical interactions name people's disorders and provide powerful expert labels that lead and structure public understanding. Health policies and public health messages focus on specific health issues and increasingly focus on the power of agentic individuals to deal with their own health problems and take responsibility without an engagement with the context of individual lives. Anatomically driven healthcare departments and specialists divide individuals into separated parts. A history of mind over matter thinking, and mind over body dominance has reduced body matter to functional and object-like status. While medical practitioners and policy makers seem to increasingly

⁴⁵ Ravindran and others.

⁴⁶ John Frank, 'Finding the Right Ingredients: Improving Mental Health and Wellbeing through Food-centred Activities', *University of Edinburgh – Edinburgh Research Explorer*, <[http://www.research.ed.ac.uk/portal/en/projects/finding-the-right-ingredients-improving-mental-health-and-wellbeing-through-foodcentred-activities \(1a5cf536-c40a-443c-809b-678eaa3022cf\).html](http://www.research.ed.ac.uk/portal/en/projects/finding-the-right-ingredients-improving-mental-health-and-wellbeing-through-foodcentred-activities (1a5cf536-c40a-443c-809b-678eaa3022cf).html)> [accessed 20 July 2017].

⁴⁷ Yale School of Public Health, 'Bad Air Contributing to Poor Mental Health and Being Unhappy, Study Finds', 24 April 2017, <<https://publichealth.yale.edu/news/article.aspx?id=14877>> [accessed 14 July 2017].

⁴⁸ Ipsos Mori, 'Wellcome Trust Monitor, Wave 3', (London: Wellcome Trust, 2016) <<http://dx.doi.org/10.6084/m9.figshare.3145744>>.

ascribe to the limits of Cartesian thinking – with integrated care, and mental and physical connections driving new research – language is so powerful that it holds back these moves as the binaries persist and pulse below the surface. While the National Clinical Director for Mental Health feels that England can ‘dump Descartes’⁴⁹ this thesis suggests that it is only when embodied distress is given context, is directly addressed in research and practice, and a language underpins this structurally, that the meaning of ‘mental’ health will have the depth and context it requires.

⁴⁹ Strathdee, ‘Integrated Care: 3 years of Progress and “Jugular” Actions Needed’.

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