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genealogy

Article

Plant Fetish: A Creative Challenge to Mental Health Stigma

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Abstract: People of BAMME (Black, Asian, Minority, and Migrant ethnic) heritage in the UK experience various anomalies when engaging with mental health services. Typically concentrated at secondary and secure levels of care, these discrepant experiences interact with a reticence to uptake mental health support at the primary care level. Official, national anti-stigma campaigns often reproduce messages that do not connect with BAMME communities, raising questions about how best to challenge stigma in this context. This research paper describes a case study of an alternative means to address stigma, drawing from a dramatic comedy performance, *Plant Fetish*, written and performed by an artist who carries a diagnosis of complex post-traumatic stress disorder (Complex PTSD). The study comprised of an individual interview with the artist, audience feedback, and a group discussion conducted after the show. Data were subject to interpretative phenomenological analysis. Findings are discussed in relation to the importance of using creativity to increase public awareness of mental health and inform efforts to reduce stigma. We conclude that such approaches show promise and merit further exploration in a context of growing discursive interest in mental health amidst acknowledged deficiencies of contemporary anti-stigma efforts, especially as they apply to BAMME people, their families, and their communities.

Keywords: anti-stigma campaigns; Black; Asian; Minority and Migrant ethnic groups; Complex-PTSD; creativity; mental health services

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Soil of Tropical Rainforests

Breaking down, breaking bad, clouds break, why can't I?

My traumas are torrential, my traumas are ocean, pacific 70% of Land

I am brown like earth, tears rain down, fertilising your stigma.

Grow like plants. Thoughts, like seeds breaking their shell.

Germinating through mental distress, I have a breakthrough.

Chanje Kunda, performance artist

1. Introduction

This paper discusses a case study of a performance art piece that utilises comedy and biography to engage with the lived experience of mental distress in a context of social relationships. We draw upon critical perspectives to explore the potential for such performativity to provoke meaningful reflection on mental health issues amongst the audience and thus contribute to efforts to dismantle stigma and discrimination. The performance artist had BAMME heritage, as did a majority of the audience, and the dramaturgy also engaged with intersections of race and ethnicity with mental health. In this regard, we contend that such alternative creative approaches to tackling stigma may have more appeal or impact for BAMME communities who are subject to both anomalies in care and treatment received from services and may feel excluded from the reach of mainstream anti-stigma campaigns.

1.1. Background

Serious mental health problems, typically defined by psychiatry as psychosis or schizophrenia, affect around 1% of the population across the life-course (Pediaditakis and Durand 2018), although simplistic diagnostic taxonomies are contested (Johnstone and Boyle 2018). Indeed, issues regarding labels such as schizophrenia are hugely problematic, not least within a context of ethnic and cultural concerns and demographics typified by over-representation and various anomalies in care and treatment (Fernando 2003). Complex post-traumatic stress disorder (Complex PTSD) is defined as a psychiatric condition caused by repetitive traumatic events that mainly occur during childhood and mirrors PTSD, but with additional symptoms such as shame, constantly feeling permanently damaged and powerless, feelings of threat, dissociation, and suicidal ideation (Giourou et al. 2018). More recent general interest in the role of trauma in the genesis of mental distress has led to developments in trauma-informed care (Sweeney et al. 2018) and are arguably congruent with a shift to social understandings of mental health and stigma (Beresford et al. 2016).

1.2. Mental Health Stigma

However defined, the stigma attached to mental health and illness, and associated discrimination, has long been identified as a major concern in healthcare services and across communities (Sartorius 2006; Thornicroft et al. 2007). Goffman (1963) defined stigma as an attribute that is deeply discrediting and proposed that the stigmatised person is reduced "from a whole and usual person to a tainted, discounted one" (p. 3). Research suggests that the internalisation of stigma has a harmful effect on the wellbeing and recovery of individuals diagnosed with serious mental health problems (Aakre et al. 2015). Stigma is heavily influential in deferring initial appropriate help-seeking and acceptance of mental health needs (Islam et al. 2014). Treatment discontinuation can occur in those who experience self-stigma (Kamaradova et al. 2016). Experiences of stigma and discrimination among individuals who identify with mental health problems may be slightly decreasing over recent years in the UK, but there is no concomitant increase in social capital (Corker et al. 2016).

One of the most potent ways in which individuals are stigmatised in relation to mental health is an insidious linkage of mental ill-health with violence in the public consciousness and media depictions (Corrigan et al. 2004; Mckeown and Clancy 1995; Seeman et al. 2016). Such views can often persist, including within families, despite circumstances in which personal experience contradicts the dominant-negative association (Philo et al. 1994). That is, people can know or be related to non-violent individuals who carry a particular diagnosis yet be fearful of violence from others, based simply upon the diagnostic appellation.

Current research on stigma and mental health has recently expanded the stigma construct beyond the individual levels to consider broader, macro-social forms of stigma named structural stigma (Hatzenbuehler 2016). Structural stigma is related to a set of norms, policies, and procedures from public and private bodies that limit the rights and opportunities of individuals experiencing mental ill-health and consolidate social exclusion and inequalities (Mora-Ríos and Bautista 2014), amidst a "hierarchy of labels" impacting on individuals, their family and friends, and organisations (Huggett et al. 2018). To date, little research has explored structural stigma and its effects on individuals diagnosed with serious mental health problems from Black, Asian, Minority ethnic, and Migrant (BAMME) communities.

Alternately, emerging from post-structural philosophy, the importance of epistemic power in constructing the social world, and psychiatry within it, has been highlighted as crucially influential in shaping how madness or mental distress is conceived of and thus reacted to, resulting in various injustices and damage to identity (Fricker 2007; Liegghio 2013). From this perspective, the very ways we have of thinking about concepts such as madness or mental health are what brings these phenomena into being as we know them, squeezing out possibilities to think about them differently, and sowing the seeds for unfairness and injustices of treatment and social relations.

1.3. Family, Community, and Shared Stigma

Goffman (1963) claimed that close relatives of the person affected by a particular stigma can also be stigmatised through association with the stigmatised person. Thus, stigma does not only affect the individual diagnosed with a mental health condition but also extends to people they are closely linked with, such as family members (Zhang et al. 2018). This is known as affiliate stigma (Chang et al. 2015). Family members with affiliate stigma may not feel that they can provide the necessary support for the individual. Feelings of shame and burden can be experienced amongst the family members of stigmatised individuals. It is important to note that the family members are the closest to the stigmatised individual, which means they will often have to play an important role in care and support given. However, if they experience affiliate stigma it can be a barrier to the provision of effective support (Shi et al. 2019).

Having knowledge of a family member's mental distress can also influence the process of stigmatisation (Koschorke et al. 2017). Previous research has demonstrated that people who have increased knowledge about mental distress are less likely to have stigmatising attitudes (Erritty and Wydell 2013). Little is known about the links between such knowledge and subjective stigma experience, particularly amongst relatives of people who are diagnosed with serious mental health conditions. These gaps in our understanding must also be seen in the context of generally inadequate levels of family support provided within mainstream services (Fadden 2018). Moreover, there is a specific lack of meaningfully designed culturally sensitive family support; with most family support and therapy models distinct for their ethnocentricity. This is despite observed networks of inter-dependencies within BAMME communities in contrast to the favoured western model of autonomous, independent individualism, which to some extent underpins bio-psychiatric care systems (Edge and Grey 2018).

1.4. Intersection with Race and Ethnicity: Big, Black and Dangerous

Research into mental health stigma and ethnicity has established that negative social experiences of individuals within ethnic minority groups, such as discrimination and exclusion, may contribute to their increased risk of experiencing mental distress (Cantor-Graae 2007). In ethnic minority communities, shame was identified as the most prevalent response associated with avoiding help-seeking from health services, and severe mental health problems were not seen as a medical condition but pejoratively labelled as madness (Knifton 2012). Gary (2005) showed that individuals from ethnic minority groups may experience "double stigma", whereby racism within and outside mental health services contributes to the public and internalised stigma of mental distress, which in turn prevents help-seeking. This indicates a need to understand the various perceptions of the stigma that exists amongst Black minority ethnic group members.

The radical and revolutionary psychiatrist Frantz Fanon has been relatively neglected in modern times, but his writings on the detrimental consequences of colonialism for society and mental health care perhaps merit more attention. Arguably, Fanon's ideas laid the groundwork for future efforts to deinstitutionalise psychiatry and render its practice more sensitive to ethnic and cultural differences

(Fanon 1963; Fanon and Azoulay 1954; Fanon and Geronimi 1959). His work is replete with attention to the importance of place and space in considering the social position of the mentally distressed and how best to provide care, and various commentators have argued for such ideas to be more thoroughly taken up in the present (Hopton 1995; McKeown and Wainwright 2019).

In the BAMME context, the aforementioned public conflation of mental ill health with a propensity for violence is compounded by enduring racialized representations, equating young Black men in particular with physicality, aggression, and risk. This has proved so much the case that a number of deaths of Black men detained in UK psychiatric institutions, often whilst being restrained and forcibly medicated, have been understood in terms of a pervasive "big, Black, and dangerous" stereotype (Lipsedge 1994). Due to the influence of media narratives, critical scholars have argued that any public means of challenging stigma need to engage with mass media output and producers of media (Philo 1997). Latterly, some decrease in stigmatising coverage or more sympathetic depictions of mentally distressed individuals has been noted in British newspaper stories, and this may have been influenced by anti-stigma programmes, such as *Time to Change*, but optimism regarding substantive change is tempered by persistent continued stigmatisation of specifically defined categories, including personality disorders, schizophrenia, obsessive compulsive disorders, PTSD, and eating disorders (Rhydderch et al. 2016).

In the UK, various alternative Black mental health and advocacy services were established ostensibly to counteract the range of negative experiences within mainstream psychiatric care provision, having their heyday in the 1980s (Christie and Hill 2003; Wright and Hutnik 2004). Studies of specific initiatives have demonstrated the strengths and appreciation for place-based community BAMME care and support, delivered by and for local communities (McKeown and Wainwright 2019; Wainwright et al. 2019; Wainwright and Mckeown 2019). Latterly, such culturally sensitive alternative provision has dwindled in the face of serial funding cuts. In response to a notorious death of a young Black man, Rocky Bennett, whilst detained with mental health services, the government initiated a systemic policy response titled Delivering Race Equality, the notable achievement of which was the employment of a substantial number of community development workers charged with carrying forward key equality objectives (Department of Health 2005). Despite some successes, this initiative has been criticised for failing to re-ignite support for community-based alternative BAMME centres. In addition, a perverse consequence of legislating for a right to independent advocacy for individuals subject to compulsion under the Mental Health Act was to homogenise advocacy provision and further squeeze the available resources for BAMME advocacy organisations (Newbigging et al. 2015).

1.5. Anti-Stigma Campaigns

Issues in anti-stigma campaigns may be the cause of the lack of uptake of mental health support in individuals from BAMME groups. As there is a growing awareness about stigma in mental health/illnesses, the UK has launched numerous initiatives to improve public perceptions (Henderson and Thornicroft 2009; Mehta et al. 2009). *Time to Change* is the largest anti-stigma reduction campaign launched in 2009 in England to reduce stigma and discrimination against people with mental illness (Henderson and Thornicroft 2013). The evidence regarding the effectiveness of campaigns such as Time to Change in addressing stigma in BAMME groups is limited (Knifton et al. 2010), as is the case for numerous international initiatives (Kakuma et al. 2010).

Shefer et al. (2013), working within a psychiatric frame, conducted focus groups with individuals from BAMME communities. A key finding was that anti-stigma campaigns in the UK are effective in increasing recognition of mental illness and individuals are ready to accept messages about the consequences involved in hiding mental illness. However, anti-stigma campaigns are failing to incorporate culturally appropriate components, such as multi-racial images, role models, or translated language in their campaigns. Knifton (2012) highlighted that people from BAMME groups have not seen people of their own ethnicity in any of the media advertisements or volunteer speakers in the media. In addition, they also felt that the multi-racial images should be more balanced but not have a high proportion of people from the BAMME groups, as this can suggest that the communities are "mad", which can reinforce racism.

1.6. Arts, Performance, and Community Mental Health

There is growing evidence that participation in creative artistic activities can have certain therapeutic or well-being benefits, although the quality of such evidence has been remarked upon as being anecdotal (Clift 2012; Leckey 2011). These have included endeavours deploying drama as the focus of therapeutic activity (Orkibi et al. 2014), opening up interest in the power of imagination in healing (Chapman 2014). It may be the case that such initiatives are most in tune with engendering those outcomes latterly associated with a turn to recovery within services, such as strengthening a sense of self, meaning, and purpose, building coping strategies and fostering hope (Spandler et al. 2007).

Similarly, linking arts and mental health, for example, within exhibitions, programmes of performing arts or film screenings, and national festivals, has become part of the repertoire of anti-stigma interventions; among other impacts, engaging people at the level of their emotions (Lamb 2009; Michalak et al. 2014; Quinn et al. 2011; Twardzicki 2008). Under the rubric of a Disability Arts Movement, performance art and associated curricula have been exhorted to take on board the tenets of disabled people's movements to explicitly challenge discrimination and stigma (Barnes and Mercer 2001; Eisenhauer 2007). Furthermore, in the context of serious mental health problems, theatre can be utilised to create more democratic spaces that bridge art and science, connecting lived experience with an audience (Boydell 2011).

Comedy can offer positive potential in highlighting and addressing stigma (Corrigan et al. 2014; Jones et al. 2014; Twardzicki and Jones 2017; Valenta 2018) or, in some instances, be a negative influence that contributes to stigma or reinforces lazily stereotypical representations (Németh 2009). Comedy also traverses the intersection of race and mental health, with both affirming and stigmatising tropes (Haggins 2007). There is a rightful objection to latter-day media gawping at mental distress, such as that experienced by celebrities, and this can seem not so far removed from the earlier parading of asylum patients as objects of ridicule and entertainment for visiting sightseers (Porter 1987). Media commentators who have pointed out such continuities of bad taste humour also recognise some legitimacy in poking fun at the peculiarities of psychiatry and refrain from placing madness itself completely off-limits for comedy. Indeed, such comedy has been exploited for progressive ends by comics with lived experience of mental distress and organised service user and survivor movements to counteract processes of psychiatric othering (Cross 2013). Arguably, mainstream anti-stigma campaigns also use comic elements, such as the use of ironic postcard messages highlighting absurdities of othering or the alienation of stigma in the *Time to Change* programme. Yet, these remain framed by a totalising bio-medical view of mental distress, suggesting an opening for alternatively conceived approaches.

1.7. Anti-Anti-Stigma Campaigns

Several critics have addressed perceived inadequacies of mainstream anti-stigma campaigns, and certain of these failings have, indeed, been recognised by some key protagonists within the mainstream (Sartorius 2002; Stuart et al. 2011). The weight of critique, however, comes from commentators situated externally to the psychiatric orthodoxy, and new voices have emerged latterly, associated with the relatively new field of mad studies (LeFrançois et al. 2013).

From a broader critical perspective, Pilgrim and Rogers (2005) raised important questions about whose interests are being served in anti-stigma campaigns and highlighted implicit and explicit tendencies within a psychiatric paternalism to reinforce singularly medical-psychiatric understandings of mental health problems, the importance of psychiatric interventions, and necessary compliance with these. Harper (2005), indeed, has pointed out that much of the critique of the media in this regard is, itself, guilty of misrepresentation, lack of theoretical sophistication and weak argumentation. The wide-ranging focus of anti-stigma campaigns, attempting to influence the general public as a whole, has been questioned, given that people who spend more time with individuals in mental distress, such as psychiatric professionals, are just as likely to hold stereotypical, negative, and stigmatising views (Lauber et al. 2006). Bates and Stickley (2013) further contended that professional tendencies towards risk aversion and the undermining of personal autonomy implicit within mental health legislation both contribute to the consolidation and perpetuation of stigma. Indeed, when asked, people subject to mental health stigma prioritise changes within services they rely on, over and above action within society at large (Pinfold et al. 2015).

The central message of many anti-stigma campaigns, that mental illness is an illness just like any other, somatic, illness, has been challenged from critical perspectives, which view the message as a fallacy (Chrtkova 2016). Similarly, this core message has been challenged by researchers within the psychiatric field, who see it as particularly ineffective, as the public do not agree with it, and highlight the lack of evaluation of many anti-stigma campaigns (Lauber 2008). Henderson (2018) has drawn attention to the tendency within television drama to consolidate mainstream orthodoxies, because psychiatric interventions such as medication can "work" dramatically as a simple and comprehensible set of solutions for complex storylines. This author went on to suggest that alternative perspectives reflecting the political context and debates within the survivor movement: "might provide a productive alternative vein of storytelling that could broaden our understanding of the social meaning of suffering and thus help to challenge stigma" (Henderson 2018, p. 115).

One such set of alternative discourses can be found within mad studies; a field not averse to mixing activist, artistic, and scholarly endeavours and interests to challenge psychiatric orthodoxies and injustices. Taggart and Speed (2019) developed a critique of the theoretical and conceptual basis of standard anti-stigma campaign messages and argued that critical knowledge and ideas from survivor perspectives, such as those propounded within the emergent mad studies movement, offer the potential for "epistemic resistances" that better reflect the available plurality of understandings of mental health within the mission to challenge stigma. Allied to mad studies, Costa et al. (2012) reflected on the *Recovering Our Stories* campaign in Toronto, challenging the appropriation of individuals' lived experience narratives to serve the interests of mental health organizations rather than the intended emancipatory motives. These authors used the phrase "patient porn" to emphasise the sense of grievance at the perceived misappropriation of individuals' stories, whilst acknowledging the power of biographical stories in campaigning for change. Similarly located in the mad studies oeuvre, in a piece that mixed excerpts of creative writing and scholarly commentary, the self-styled mad artist, community organiser and scholar Eales (2016, p. 66) extolled the social action potential of performative writing that: "offers me an opportunity to evoke the unspeakable aspects of madness".

1.8. Plant Fetish—Indirectly Challenging Stigma

The *Plant Fetish* show was created by performance artist Chanje Kunda when she first discovered that plants relieve stress. The show maps her journey coming to terms with her experiences and distress, eventually diagnosed as complex post-traumatic stress disorder. The performance illustrated these themes in a comedic interpolation with experiences of relationships and everyday challenges; engaging with nature and creative arts to illustrate personal strategies to overcome mental distress and its intersection with race and gender in contemporary society. The staging, itself organised by another survivor of Complex PTSD, featured a group of beautiful tropical plants that dressed the stage. Taken as a whole, the show created visual imagery of people from diverse ethnic communities openly expressing their mental health journey, bringing an alternative perspective on challenging stigma.

2. Methods

This research study adopted a qualitative case study design focused upon the *Plant Fetish* show, involving analysis of interview data from the artist and audience reception data. As the purpose of this research was to increase our understanding of the use of creative arts in raising awareness of stigma in the context of mental distress, a qualitative approach was deemed appropriate. The project received ethical approval from the University of Central Lancashire Psychology and Social Work Ethics Committee and the study was conducted in accordance with the Declaration of Helsinki (1975).

2.1. Case Study Interview

The semi-structured interview was designed to capture Chanje's experiences with Complex PTSD and gain a deeper understanding of the content and performance of *Plant Fetish* from the artist's perspective. The interview took place in a private university room and lasted for 104 minutes. Before the interview, the participant completed a consent form. The interview was audio-recorded and transcribed verbatim. The team were reflexively positioned as supportive of relational democratisation of both mental health care and forms of inquiry. As such, we viewed these interviews and subsequent analysis as essentially participatory and co-creative acts, transacted between the interviewer and interviewee, with an opportunity for the team to share the provisional analysis with the interviewee and for her to be involved in checking and refinement before analysis was finalised. This commitment to a participatory approach extended to the facilitated processes of audience discussion, but for logistical reasons, it was not possible for participatory checking of analysis. Given the co-produced nature of the artist interview and the fact that the artist created the performance piece, we felt it legitimate to include Chanje as co-author of this paper. She has also provided the introductory verse at the top of the article.

2.2. Audience Reception: Post Show Discussion

The post show discussion was conducted at HOME in Manchester, a medium sized theatre venue located within a larger arts-complex where the show was in the middle of a short run of performances. The audience numbered around 130, the majority of whom were BAMME, and consisted of individuals from diverse backgrounds, such as service users, healthcare professionals, and activists. The discussion aimed to create an environment where individuals were able to share their own experiences enthusiastically with the panellists. The aims of the discussion were explained prior to the show and participants had the option of staying after the show to participate. The discussion was facilitated by a panel that consisted of the artist/performer, the set designer, and two researchers from the University of Central Lancashire. The session was video recorded and transcribed verbatim. The audience members were encouraged to speak and express their own ideas, and conversations between the audience members were encouraged and enhanced the discussion.

An interpretative phenomenological approach (Smith 1996) underpinned the data collection and analysis for the case study interview and post-show discussion. This form of analysis was used due to the interest in individuals' experiences and how they make sense of them. Analysis proceeded through close reading and re-reading of verbatim transcripts. A first step was to look for themes within the transcripts after familiarisation with the data. The second step was to look for connections and links for all the themes identified. The third step was to organise the themes and clusters according to identified relationships between them. Finally, a matrix of themes was created reflecting the identified relationships, established and explication of meaning.

3. Findings and Discussion

3.1. Audience Response

The audience discussion was voluntary, and we estimated that more than half of the total audience remained behind for this part of the event, and this smaller group was proportionally reflective of the ethnic and gender diversity of the total audience. A smaller proportion ($n = 15$) was verbally active in the discussion. The audience embraced their own mental health experiences and expressed ideas of self-growth and acceptance. Audience members consistently remarked that the theatre setting and the performance offered a safe space for disclosing shared experiences of mental distress and stigma. Ironically, given the titular framing of the *Time to Talk* days within the national anti-stigma programme, *Time to Change*, encouraging attempts to start and change conversations about mental health, there was a view expressed that talking about one's experiences without such a sense of security could be a sure way of inviting stigma. People were legitimately wary of such risks.

The discussion revolved around the value of art in relation to mental health stigma. The idea of articulating our distress was a common topic discussed, covering language, dance, and art therapy as alternative means for expressing their mental distress. Audience members challenged the notion of having medication as the "go-to" response to mental distress and discussed other ways to approach care and treatment. The discussion highlights were the audience's ability to disclose their personal mental health journeys and views of Chanje's outlook on how to reflect on the challenges faced in her journey.

More than one audience member remarked upon the aspect of the show that dealt with notions of beauty in imperfections. This was a reaction to the imagery and symbolism of a broken pot, mended with gold so that the cracks in the ceramic became the best part, and how this worked as a profound metaphor for human repair and recovery from trauma. This led to a longer discussion of the use of poetics and metaphor, both in the script and the set-design.

One audience member highlighted certain dramatic aspects of the performance, contrasting the authentic voice of a traumatised person in this show with other writings where such authenticity may be more questionable. For this person, authors may be better at times writing other people's trauma and less prepared to face up to their own. From this perspective, it was "thrilling" to hear Chanje's voice in this performance.

Other audience members showed their affinity for the use and visibility of plants, and how these may be implicitly or explicitly therapeutic in everyday life. One person linked her own role as a horticulturist in a psychiatric unit with a question about democracy within such roles and wider services and how such alternatives may be more cooperative and respectful. This developed into a discussion of more relational alternatives to standard services or medication, a theme that was illustrated within the performance, where the main character refuses to make use of a medication prescription. In this sense, for at least one audience member, identifying as someone using psychiatric medication was itself stigmatised. The experience of stigma in this regard was not, thus, a wholly negative occurrence if it then became the spur to seek out alternative forms of help and support. Nevertheless, the artist herself denied that it was stigma that motivated her disposition towards medication. She did, however, in explaining her treatment choices emphasise aspects of identity, and how she might prefer other ways to deal with even distressing emotions than attempt to first smother them with "meds". Kat, the set designer, concurred and added that understanding the traumatic cause of her distress meant that a short-term fix from a prescription may be futile, as the experience of trauma itself has not been addressed.

In some ways associated with these critical views about medication, one audience member decried the extent to which the psychiatric system has focused attention on a very individualised notion of pathology, rather than seeing mental distress in, arguably less stigmatising, community terms. This was linked with the performance context by a suggestion to think about different modalities for challenging stigma or promoting well-being, such as forum theatre; a participatory, emancipatory approach to working in communities:

> . . . allowing them, the community, to step, literally step into the story and change the course of the play. And it's meant to help you feel empowered and understand that you can have control of your narrative when you can . . . and negotiating a community response for that and include the community in care and response rather than putting the individuals at the heart of the problem. But also, I think is an interesting tool for the individual as a way of safely like re-enacting and control their traumatic situations. [audience member (AM) 13]

One audience member movingly disclosed his own childhood trauma, and another revealed his own experiences of Complex PTSD. Both spoke in different ways about the experience of not having recourse to a vocabulary that could adequately explain their own pain or articulate their feelings. An extension of this contribution was to commend the performance for doing just this sort of articulation, setting it in a context of healing, and accomplishing this by way of entertainment. One person had been so moved by an earlier performance that he had determined to come back this evening with the advertised audience discussion so that he could give voice to these viewpoints. The rest of the audience warmly received his contribution, by listening attentively, applauding and responding supportively. Chanje spoke of the affirmation for her of having work published and performed, and how this played into her ambitions for her work, including a positive impact for her mother.

Another contribution stressed the idea that even these alternatives may not be wholly divorced from neuro-scientific explanations; making the case that a rejection of too simplistic, biological reductionism need not be at the expense of thinking about how affinities for plants, or playing sports, for example, may indeed have a positive effect on brain biochemistry. It was shared in the discussion that both Chanje and Kat had been diagnosed with Complex PTSD and experienced Eye Movement Desensitisation Reprogramming (EMDR) treatment. Some of the positive effects and benefits of experiencing therapies such as EMDR, which also featured in the performance, could also be illuminated with reference to neuroscience. The consensus in the room appeared to coalesce around affinities for holistic understandings, rather than singular or binary standpoints.

One of the ways in which the audience reaction related to considerations of stigma was the view that the performance depicted a normalisation of extraordinary or distressing experiences, as expressed by this audience member:

What I wanted to say was what you are talking about is normal reactions to abnormal events in life. And that's we all encounter, and we can see it under the umbrella of mental health if we want to. But that's what you're talking about tonight. And I applaud it and celebrate it. [AM 7]

At least one audience member reflected on the role of stigma in minimising the experience of mental distress, and in doing so reflected some of the main points of argumentation in the *Time to Change* programme:

The stigma of mental health I think mental health issues of it, it's not kind of seen as a proper like health problems say like you called into work and once you have the flu that's fine, but you call in because you're feeling the depressed, you get laughed at that's not really considered as like an actual illness, probably the stigma behind it. It's not taken as seriously as other kind of health problems. I think that impacts it massively. [AM 11]

3.2. The Artist's Perspective

The interview with Chanje, the artist/performer, made an important contribution to making sense of her development of the ideas in writing the show. Similarly, her reflections also allowed for an exploration of her attempts to depict mental distress and social reactions to it within this dramatic piece. Processes such as opening up to explore sensitive issues using visual arts that draw on personal biography can help people with mental health conditions overcome stigma (Tomlinson et al. 2018).

3.3. Subjective Pride and Acceptance

For Chanje, fostering a sense of pride in the context of being diagnosed with Complex PTSD through the performance was a way for her to positively identify with her experiences:

> I wanted to be able to be myself and have some self-acceptance as a person with a serious mental health diagnosis and also talk about how I'm coping with it. And that was a way for me to be able to exist in the world and actioning and have a voice. And so that was my, you know, so that was just how it came about.

3.4. Humour: A Vehicle for Sense-Making

The process of making sense of mental distress is key to notions of recovery. Making sense of one's mental health crisis has an important impact on how individuals understand and define their own recovery and help place it in a social context. *Plant Fetish* was a way to make experiences of serious mental health problems easier to convey. Humour can challenge the way we think about serious mental distress and trauma. Humour was deployed within *Plant Fetish* to dispel inaccurate stereotypes and provoke thinking or discussion of mental health. *Plant Fetish's* comedy was thus central to the show, allowing engagement with profound and serious concerns, whilst intending not to trigger further untoward upset. In this regard, alertness to the potential for further trauma constituted a reflexive process between the artist and the audience, with regard for mutual sensitivities:

> So, when I was talking about suicidal ideation, I was talking about failed relationships and talking about having emotional flashbacks. I had to dress it in a humorous way, and it made it easy for me to talk about it. It also made it easy for audience to listen to and easy to open up a discussion about it.

Hence, Chanje humorously adorned her experiences to make it easier for her to discuss and the audience to listen. This comedic representation of mental distress could, and did, work to encourage the audience to begin conversations about mental illness. However, humour in a broader context also risks having a negative effect, perhaps reinforcing negative stereotypes of individuals with mental distress, such as "making a fool of themselves" (Coe 2018). Similarly, there may be a risk that humour may adversely affect the seriousness of the message behind anti-stigma campaigns. Such concerns were not, however, evident in our findings, but are worth more considered attention in this context.

3.5. Anti-Stigma Campaigns Inadvertently Reproducing Stigma

Anti-stigma campaigns that are aimed largely at spreading information will inevitably struggle because of the overwhelming majority of stereotyped information and imagery to which the average person is exposed, but a psychosocial rather than bio-genic framing can provoke more positive attitudes (Read and Law 1999; Scheff 1966). In writing the show, an interplay between wider social stigma and the internalised impact was something Chanje was mindful of:

> I think when I was making this show, I was trying to eliminate the internal stigma that I had about my diagnosis and so ... I feel like that was my primary purpose, but it also had some peripheral awareness that I'm not the only person with this diagnosis or that experienced and I do think that there needs to be more visibility around people with mental disabilities and not trust negative things about people with mental health conditions, but some kind of positivity and celebration of it.

When asked about how *Plant Fetish* aligns with current anti-stigma campaigns, Chanje compared her performance to the current Heads Together campaign, which features the involvement of members of the British Royal Family:

> I am not offering any stupid advice ... I'm talking about the real-life experience and I'm making it beautiful and I'm making it funny. And I am not some person from the Royal Family who thinks that they are doing a good thing by telling you to talk to somebody next to you for a minute.

Chanje also called into question some perceived shortcomings of established anti-stigma campaigns, particularly how they apply to aspects of severity. This, the act of beginning a conversation regarding mentally distressing experiences, a key message in the mainstream, though useful for some, can be frightening, especially within BAMME communities:

> The anti-stigma campaigns have got absolutely nothing to do with anybody with a serious mental health condition at all ... I had a friend who was seeing bats and thought she was being chased by a vampire. That's not something you can drop in a conversation. "It's good to talk". Because she was going to get sectioned and obviously being sectioned is frightening and that creates its own stigma.

3.6. Racism and Coercion

A factor in the perceived inadequacies of mainstream anti-stigma campaigns is their relative lack of attention to coercive aspects of services, and the disproportionate application to BAMME communities. The fear of being detained is substantially influential, as BAMME groups are much more likely to be detained under the Mental Health Act as compared to their White counterparts (Gajwani et al. 2016). Service users report fear of coerced treatment as a barrier to seeking help for their mental illness (Swartz et al. 2003).

Psychiatry has a history of pathologising BAMME communities based on definitions of defiance and disorder in opposition to the definition of normalcy and reason. Cultural conflict, social adversity, disadvantage, and racism are factors for the different degrees of mental health service utilisation in individuals from ethnic minority groups. Chanje specifically called attention to White privilege in the context of being denied an opportunity to organise a particular arts-based initiative within services, where she believed her experiences and expertise were overlooked on discriminatory grounds:

> Now … they said no to that project and I am a Black woman and they said yes to a White man who wanted to run a project for White people. They look at me … a Black woman with dreads … they look at the White man who is paranoid schizophrenic and they're like, yeah, go for it. I think your idea is great. I don't mind him getting the money. Let's both get some.

The subjective experience of racism also can intersect with gender discrimination and, for Chanje, realising this in the context of her own experiences provoked an angry response:

> It is because Black women are unimportant and in expendable and they don't give a damn about what I think, what I feel, and they don't have any value for what I can contribute towards my community.

3.7. Family Reactions and Support

A disinclination to seek help for mental distress becomes compounded when individuals are faced with negative attitudes towards mental distress within their families, social context, and communities. For example, for Chanje, there was a familial constraint not to willingly speak about her Complex PTSD experiences:

> So, part of my complex PTSD means that … one of my symptoms is that I have suicidal thoughts, so if I speak to my mum about having suicidal thoughts, she says oh don't think like that. You're so young … and it's like, don't think like that. I don't want to think like that. That's just what's happening and don't think like that is not useful advice. It puts a distance between you because they don't understand how you think or what, what your experience of the world is and there is no way to assimilate with any of their experiences.

Her mother not fully understanding or legitimising Chanje's experiences has had a negative impact on their relationship. Avoiding difficult conversations or seeming to downplay the severity of a person's mental distress may be a highly adjustable and normative approach within the context of stigma. However, it may not always be the responsibility of the family to address the causes of mental distress but rather support the person through their recovery.

3.8. "You Are Having a Laugh": The Intersection of Race, Stigma, and Humour

Extant national level anti-stigma mental health campaigns include an aim to encourage the general public to start conversations about mental health, to reduce the stigma and discrimination experienced by those with mental health issues. Anti-stigma campaigns can be grouped into three broad approaches reflecting aims: to educate and inform; to promote contact and proximity with the stigmatised group and activism; empowering individuals to make their case openly (Corrigan and Gelb 2006). However, these anti-stigma campaigns tend to emphasise normalisation of a concept of mental illness, equating it to physical illness (Taggart and Speed 2019). This approach assumes that taking on board a medical perspective regarding the causes of mental distress, locating these in individual biology, will reduce the possibility for the public to blame people for their mental health problems and any social impact.

On the whole, anti-stigma campaigns are relatively silent on the intersection between race and mental health. Yet, the impact of racial discrimination on mental health is extensive, extending into service anomalies in access and outcome. Therapeutic relations may be complicated or disrupted by intricacies of difference and othering, transacted between staff and service users of different ethnic identities, or the delivery of care and support from within an undoubtedly ethnocentric service system. Indeed, such conjunctures may result in cumulative layers of stigma, with the stigmatised identity of madness adding to an already stigmatised racial identity. Knowledge of this can potentially inform anti-stigma campaigns, although there is little evidence that such ideas have been influential in the mainstream. Successful work in this regard could reduce barriers to care among individuals from BAMME communities and support practitioners within the mental health system to not intentionally or unintentionally disseminate racism in the process of working with individuals from BAMME communities. More specifically, severe mental distress, such as that diagnosed as Complex PTSD, demands perhaps more sophisticated responses, for example, those informed by considerations of trauma.

In relation to the humorous aspects of the show, there is a certain irony of comedy being used by people of colour to express and articulate experiences of stigma, discrimination, and alienation relating to mental distress. In the UK, people of BAMME heritage living through the 1970s and 1980s were often subject to both ridicule and racism expressed in "comedic" forms. Popular television shows presented material that shamefully belittled and humiliated people of colour, who were encouraged to *Love thy Neighbour* and *Mind Your Language*[1]; programmes that targeted, respectively, people of African Caribbean heritage and immigrants from a wide range of nationalities. Likewise, people of South Asian heritage had to endure the weekly humiliating doses of *It Ain't Half Hot Mum*[2], and be 'comically' reminded of how weak, feeble-minded, and incompetent they were, thus legitimating the colonial *civilising* mission of their Masters under the British Empire. Such representations were paralleled in the arena of stand-up comedy, reaching their apotheosis in the overtly racist routines of right-wing 'comedians' such as Bernard Manning and Jim Davidson. Congruent with a brutally distinct post-colonialism, the consolidation of pernicious stereotypes within these popular cultural comedy media helped to demarcate broader social divisions, in a clear delineation of Them and Us; narrative tropes contrasting the savage with the superior civilised European, British English*man* (sic).

Though mass media representations have somewhat improved in this regard over intervening years, imagery that invokes fear of the racialised other has never completely disappeared, re-emerging quite virulently in racist and xenophobic political communications relating to the recent Brexit campaign and thriving in certain corners of social media. It is this backcloth, this context, this daily, grinding, belittling experience that people of colour endure in everyday public, and sometimes private, settings. This provides fertile ground to reinforce the popular misconception that there is a greater propensity, indeed weakness, for non-European people to be more susceptible to experiences of mental distress.

Perversely, or paradoxically, it is this humiliating racism amongst other traumas that can cause the very mental distress, psychological disturbance, and emotional upset that people of colour disproportionately suffer from. Diagnostic processes reify a morphing of experiences of racism, to being labelled as having pathological weakness, to being mentally ill. Once so-labelled, further pernicious effects of stigma kick in at the very intersection of racism and oppression; of being Black and *bonkers*. Mad studies provide a critical perspective that can challenge such intersectional adverse

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[1] These two situation 'comedy' programmes included overtly racist humour that played on every racist negative stereotype, and are latterly considered offensive despite their contemporary popularity.

[2] A similarly offensive yet popular sit-com set in British colonial India.

processes, experiences, and outcomes. Moreover, a mad studies standpoint is open to connections between research, activism, and the creative arts in the furtherance of this critical collision of ideas.

4. Study Limitations

Designed as a case-study, we would not expect findings to be generalisable. The sample of theatre attendees who participated in the post-show discussion was effectively self-selecting, creating a risk of bias. It is thus important to consider how might they have differed from the theatre guests who chose not to stay. We estimated that the gender and ethnic/racial mix was similar. However, for future research of this kind we may, for this and other reasons, consider recording demographic characteristics of the audience. Perhaps a more significant risk of bias in this context might be that the sub-group of the audience remaining for the discussion were more personally attached to the subject matter we were interested in; mental health and stigma. For qualitative researchers, this need not be a major problem, as we may have concentrated participants with strong relevant viewpoints. However, this may also risk missing the views of the general public, perhaps less strongly opinionated, but comprising the population that anti-stigma campaigns must reach. Nevertheless, we might reasonably assume that the wider population were indeed represented within an audience for a show widely advertised in a cultural venue with a loyal audience for shows regardless of specific content. Again, a future project could elicit information from audience members with respect to their prior disposition to mental health issues.

5. Conclusions

Opening up discussions about mental health can be enhanced through performance arts and offer an alternative challenge to stigma. Arguably, performance art offers a means by which previously neglected or discriminated against communities can critically engage with a more complex and nuanced set of representations of mental distress. Furthermore, the impact of racial discrimination on mental health can inform anti-stigma campaigns to diminish barriers to care among individuals from BAMME communities. The utilisation of comedic and dramatic performance may encourage audiences to think more critically about matters such as stigma and its intersection with race, laying the foundations for more meaningful and informed conversations about mental distress, and associated experiences within services and wider society.

Current anti-stigma campaigns tend to use approaches that attempt to normalise notions of mental illness, likening this to physical illness. The public, however, resists and rejects such simplifications. Recognising errors of the "illness like any other illness" mantra, however, is not sufficient on its own. This recognition can lead to *either* stigma and discrimination *or* a more sophisticated engagement with understanding mental distress. A range of alternative perspectives and understandings is necessary to thoroughly tackle such stigma. The mad studies field, with its affinities for mixing survivor narrative, activism, and artistic expression, offers a scholarly standpoint for supporting this challenge. For us, *Plant Fetish* was able to provide a necessary medium to increase awareness of the myriad challenges of living with trauma.

The *Plant Fetish* show typifies how we might represent alternative ways to challenge stigma and discrimination, and how these can relate differently within different groups in society. The writing, performance, and theatre setting provided a space to enable the audience to engage safely with sensitive issues, individually via introspective reflection and collectively via audience discussion and the potential for ongoing conversation beyond the confines of the theatre. This confirms the previous theorising about the positive contribution that art and humour can bring to expressing and sharing thought, feelings, and psychosocial understandings of health and wellbeing. Thus, humour can lift the spirits, make the heart sing, and the soul soar.

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