CONSTRUCTIONS OF MENTAL HEALTH:
MEDIA AND WOMEN'S EVERYDAY LIVES IN THAILAND

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STATEMENT OF ORIGINALITY

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This study explores constructions of mental health in Thailand by employing a bi-modal qualitative research design. In a nine month ethnographic study with 49 Thai women of different life and mental health backgrounds, I observed their day-to-day interactions with, and formulations of, mental health (Group One – the Emergency Home, a hostel for victims of rape, abuse and poverty, Group Two – the Family Link Association, a rehabilitation centre for people living with mental illness and Group Three – the everyday life setting). I also examined 121 mental health related articles in four Thai women’s magazines by employing discourse analysis to explore the system of mass-mediated representations of mental health.

This study responds to the need for complex analysis of mental health. The analysis shows that mental health is socially constructed and contested. In turn, there are a series of interactions, territories, voices and connected discourses behind these constructions. Thai women, this research concludes, are thus co-constructors of mental health in their interactions as media users with the complex representations of mental health in a dispersed media complex environment.

Despite the representations of mental health being inadequate, misleading and biased in women’s magazines (as well as other popular media), the mass media are a key resource of mental health information, blurring the borders between the public and private spheres of women’s interests. Media literacy emerged as an enabling factor in building and generating respondents’ mental health competencies and quality interaction in the recursive connection of mental health. Respondents from Group Two and Group Three drew on higher levels of media literacy in selecting, processing, filtering, criticising and challenging the mass-mediated mental health representations compared with Group One who had limited access to the diversity of mass media.

This study also raises a concern as to the equality in women’s access to different media and the question as to what extent women of different backgrounds can develop the media literacy skills to negotiate and utilise mediated contents to enhance mental health.
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CHAPTER 1

INTRODUCTION

As media cultures, lives and social structures become more fluid (Bauman, 2000), constructions of mental health no longer exist as a stable truth. They are concerned with constant uncertainty, changing lifestyles and a complex process of selection through the connectedness of mediated communication. Living in media cultures (Schmidt, 1992) promotes a sense of connectivity, blurring the distinction between ‘real’ and ‘mediated’ experiences in subtle ways while inviting individuals to join, participate and create their own interpretation.

In today’s world, the contexts of mental health and the media emerge in the quest for wellbeing that has offered different lifestyle patterns for individuals to choose. People with professional titles (e.g., Dr., Professor, M.D.) appear on television, write columns and give advice. People read self-help books and search for information online for the purpose of self-actualisation with the expectation that the information will help them to mitigate risk more effectively in a changing environment. These alternative mental health treatments are highly polycontextual (with multiple contexts that are embedded within one another, cf. Derrida, 2000; Grant, 2007) and readily available in today’s society, a fact that mirrors Giddens’s (1991: 80) notion of “plurality of choice”, which refers to the almost infinite opportunities to create (and to modify) one’s life. As Giddens and Sutton (2009: 396) describe, “we are living in an age where more and more information is available – to draw on in making choices about our lives”. Similarly, Bauman (2000: 63) notes, “the world full of possibilities is like a buffet table set with mouth-watering dishes, too numerous for the keenest of eaters to hope to taste them all”. Media cultures thus offer choice and bring a wide array of information and competing reality construction into our lives, including a number of possibilities to manage mental health problems.

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1 Giddens (1991: 78) describes ‘self-actualisation’ as one key element of self and identity in the present day. He notes, “self-actualisation is understood in terms of a balance between opportunity and risk. Letting go of the past, through the various techniques of becoming free from oppressive emotional habits, generates a multiplicity of opportunities for self-development. The world becomes full of potential ways of being and acting, in terms of experimental involvements which the individual is now able to initiate”.

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Within this context, people are decision makers in the centre of mass-mediated communicative actions that are heavily dependent on the media. Schmidt (1992: 191) uses the term "mediaculture" to describe all human experiences that are mediated by communication. Potter (2011) comments that culture cannot be understood separately from the media because people live in a culture flooded by mediated information. This notion is similar to Bird's (2003: 2-3) view: "we cannot really isolate the role of media in culture because the media are firmly anchored into the web of culture". As Stevenson (2008: 1) explains, the media offer points of cultural references. They are a pervasive presence in our social experience and are recognised as the reproduction of "the experiential content of everyday life".

The current trend in society as described above seems to support Giddens's (1991) viewpoint on the reflexive project of the self 2 in which individuals are responsible for their own selections to manage complexities of environments among the diversification of lifestyle choice in the world that is manufactured by the media. The question of agency has been raised to justify the infinite interactivity and the communication process of subjective and mass-mediated constructions to understand the realities of mental health that "constantly cross the border between the real world and the media world and the border sometimes gets blurred" (Potter, 2011: 126). As Grant (2007: 9-10) describes: "the self is required to manage acute contingencies in communication by coping with the plurality of knowledge systems and their discourses and the risk of too much information". His view reflects the uncertain life in today's world where people need to be ready for complex interaction with the systems of discourses attached to representations of mental health that challenge human agents in a society of global communication.

The topic of mental health in this study is given a fluid definition, built upon a spectrum of related descriptors of mental health in everyday contexts. On the one hand, mental health is an important issue in everyday life that includes the popular interpretation of everyday well-being (McCulloch, 2006). This notion is similar to the WHO's (2001a: 3) view that acknowledges positive mental health as "a crucial interdependent element to the overall wellbeing of individuals, societies and countries". On the other hand, mental health in everyday contexts can

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2 Stevenson (2008: 230) explains the 'reflexivity' concept as "the ability to be able to revise your actions in the light of new information. The argument is often made that information societies are becoming reflexive societies. As the world becomes defined through information overload rather than information society, it is argued, it also becomes increasingly reflexive. This means opening up questions on nature, gender, sexuality, etc. that were repressed in previous historical eras."
also be interpreted as ‘mental illness’, which has been hidden behind a shadow of stigma, exclusion, isolation and discrimination (Armstrong et al., 2002). Millions of people around the world who experience different degrees of mental health problems are victimised because of their illness and, as the WHO (2001a; 2003) indicates, they suffer silently from shame and fear while becoming the target of unfair discrimination. Despite the significance of the media as a social distributor for mental health information (Seale, 2002), previous research shows that the media report myth and misperception of mental health through a high number of disturbing images that reinforce unhelpful stereotypes of mental illness (Byrne, 1997; Wahl, 1992; 1995). These representations, as Dinos et al. (2004: 178) report, “appeared to be a major source of discomfort” for people living with mental illness. Such representations also leave people feeling devalued, discouraged, excluded and mistreated by the public and by the negative framing of mental illness (such as schizophrenia and madness) that the mass media portray.

Mental health is a vital topic in today’s world. The WHO (2001a) estimates that one person in four will suffer from mental health problems at some time in their lives. These figures should prompt global attention and place mental health research as a priority at local, national and international levels. In Thailand, the problem of mental health is prevalent and the Department of Mental Health indicates that women are found to be more at risk of mental and psychiatric illnesses than their male counterparts (Chakrabhand, 2005). This fact is also confirmed by the latest figures in the Annual Thai Mental Health Condition Report (Chamrasrittirong, Prasartkul and Choolert, 2010), which shows that 18.1% of Thai women are at risk of mental health problems compared with 16.3% of Thai men. Different authors also point out that stress is prevalent and is becoming a major problem among Thai women, responsible for increasing levels of alcohol consumption and violence, self-destruction and suicide (Siriwananrangsan, Liknapichitkul and Khandelwah, 2004).

Despite the magnitude of mental health problems, the topic does not capture the attention of the general public and has failed to promote positive images and manage solutions. On the contrary, the repetitive negative stereotype and image of mental illness is still dominant and emphasised in the Thai popular media. Shame and fear of the stigma of mental illness remain and build walls of silence around people living with mental illness. Indeed, what has been represented about mental health in the Thai media seems to fall under the universal category that associates mental health with mental illness or pathology and ‘the dangerous mentally ill’ who tend to commit crimes and even acts of violence (the Department of Mental Health Planning, 2006; Limpanavivit, 2004;
Furthermore, much of the reporting on mental health in Thai newspapers concentrates on news of suicides and is also directly associated with the discourse of psychosis, mental illness and major depressive disorders by using colourful narratives to exaggerate the situation and instead of using the media space to convey constructive information about mental health (Limpanavivit, 2004).

Even in scientific circles, the topic of mental health representation in the mass media does not seem to be a prime concern among most Thai scholars. Despite the growing literature on mental health in Thailand, there has been little analysis of the social and cultural view that examines how mental health is shaped in the everyday context (Burnard, Naiyapatana and Lloyd, 2006; Klunklin and Greenwood, 2005). The majority of studies on mental health are quantitative, based on surveys and scales that aim to measure levels of illness and the epidemiology of mental health. Previous research has been largely confined to seeking an understanding of mental health from the psychiatric viewpoint, for more efficient diagnosis and treatment, while literature has been limited to clinical settings and focused on some selected areas and with sample groups such as psychotic patients or the psychiatric specialists, (Hsu, Davies and Hansen, 2004; Limlomwongse and Liabsuetrakul, 2005; Phanthumchinda et al., 1991). The media-cultural aspect of mental health has been discussed less frequently. While a little research has employed qualitative analysis in the context of mental health and everyday life, as far as I am aware, none has focused on the complexity of mental health construction or attempted to approach women, their different backgrounds and their understandings of mental health through dynamic interaction with the media and the environment. Because of a lack of qualitative research on the understanding of mental health, the interplay of audiences, media and everyday life is yet to be more fully explored.

Because individuals experience mental health differently, any study of people’s understanding of mental health would be incomplete without studying people, their culture and the environment in which mental health is shaped, understood, communicated and circulated. My starting point therefore is to understand the mental health construction of Thai women, particularly those from disadvantaged backgrounds (poor, low literacy, rural dwellers), who have a higher rate of mental health problems and suicides in Thailand. There is an urgent need to focus on women as a particular risk group in order to understand their lives, the causes of their mental health problems, their interactions and their reflections on mental health and its representations. In formulating this research, I adopted the concept of the public sphere as well as audience
reception, genre, convergence culture, and the representations and discourses of mental health in order to investigate women’s interactions as media users and the mediated representations of mental health with the link of recursive analysis between subjective (women) and mass-mediated constructions. These concepts are key components of the thesis, providing an interdisciplinary framework from which to illustrate the complex phenomenon of mental health constructions across the different ranges of communication in the Thai media landscape. ‘Complex’ in this study will refer to the idea of ‘polycontextuality’ (cf. Luhmann, 1995) that implies ‘multiple’ and ‘infinite’ systems where its contexts are not only embedded but also connected to one another, and have no centre of origin (Shapiro, Glinow and Xiao, 2007). This specific set of theoretical concepts is carefully grouped to facilitate the researcher to examine the flow of mental health constructions in Thailand that is a result of the recursive process within the network of communications (Luhmann, 1986). In other words, this process of meaning construction is the understanding of an interconnected relationship between the communication systems of production, reception and reproduction. Not only does this research need a theoretical framework, but it also requires a set of theories to explain the concrete process of mental health construction within the communication network that people engage with their environment. The idea of recursive communication is referred to throughout to explain the endless flow of mental health communications that interconnect women (as media audiences), their actions and the mass media. As Luhmann (2000, cited in Hernes and Bakken, 2003) describes, communications are the basic elements of social systems that are functioned, moved and reproduced through interactions, and should not be understood as linear transmissions from senders to receivers but as creations of polycontextual relations. In other words, this notion of ‘recursivity’ means the infinite possibilities of transmission that cannot exist outside any communication networks:

“Communication should not be understood as mere information transmitted from a sender to a receiver, in the sense that the information is seen as parcels of information that move from one to the other. Instead, information is seen as being created with the receiver through interaction with his/her existing cognitive framework” (Luhmann, 2000, cited in Hernes and Bakken, 2003: 1513).

With this theoretical guidance, I developed this project by asking questions from both the production and reception angles. This study sought to explore how women constructed mental health, what kind of social factors influenced their understandings of mental health, their connection with mental health and the media as well as the options, specified as ‘means’, to help individuals from different backgrounds respond to the mental health experience of mediated representations, risk and uncertainty. I also consider to what extent individuals use the media to
help them cope with and combat personal concerns by examining their dynamic interaction with
the media. From the mass-mediated side, following Giddens (1991: 27), "the media do not
mirror realities but in some part form them" (see also "media as shapers" in Hodkinson, 2011). I
was motivated by the quest to understand the communication systems of mental health and the
ways they 'form' (or confuse) the realities of mental health in a society undergoing a tremendous
increase in media technologies to balance the result from women's subjective views and elicit a
wider system of mental health constructions.

The research design needed a double methodological approach that investigates women's
everyday experiences with mental health and their interaction with the media, while examining
the larger systems of mass-mediated representations of mental health and their implicit
meanings. The study is thus contrastive, aiming to investigate media constructions of mental
health and women's constructions of mental health. As a direct consequence of the theoretical
approach above, the study operates with two main methods: ethnography and discourse analysis.
The dual method of ethnography and discourse analysis is the best choice in view of the
theoretical model of this study and the data, because it enables the researcher to observe and
make sense of mental health systems of constructions across ranges of communications (i.e.,
face-to-face, self-help groups, mass-mediated representations). The use of ethnography alone
involves qualitative audience research that works with small samples while this study needs to
assess wider systems of mental health representations to explicate the meaning construction of
mental health. Ethnography is adopted to capture subjective constructions and women's
relationships with their culture on a day-to-day basis, the question of agency and self. The
project was designed to explore the phenomenon of mental health for those from different
profiles of women, backgrounds, settings and experiences by placing their mental health in a
visible position to be inspected through immersion in their everyday lives. The task is to make
transparent the realities of mental health from the point of view of those involved, in which
mental health is closely interwoven into their way of living, focusing, in particular, on their
media consumption. This approach is adopted from what Hermes (1995: 6) calls "the
theorization of meaning production in everyday contexts", which is applied here to aid
understanding of the holistic process of women making sense of mental health.
As construction is a highly complex concept that involves a multiplicity of competing versions of realities (Brown, 1995), the research seeks to explore mental health mediated representations. This is because people's constructions of self, society and culture are all mediated. Additionally, because people are immersed in a media society, the study of constructions without the examination of media representations would deliver an incomplete picture of the complex process of construction. By engaging women's experiences with everyday life, the mass media take on significance where the meaning of mental health is circulated through the ongoing process of mediation and representation. As Silverstone (2003: 12) argues:

"[The] mediated meanings circulate in primary and secondary texts, through endless intextualities, in parody and pastiche, in constant replay, and in the interminable discourses, both onscreen and ofscreen, in which we as producers and consumers act and interact, urgently seeking to make sense of the world."

Discourse analysis is a particular method that provides a framework to draw "systems of thought or ways of thinking about and discussing the world" (Giddens and Sutton, 2009: 48) and to approach the implicit meanings behind mediated content, which is operated by procedures of exclusion, prohibitions, oppositions, commentaries and author functions. Other methods, such as content analysis, cannot provide a framework for unveiling such questions. To study media representations of mental health, the research contrasts how the mass media frame mental health and construct its reality in women's magazines as special media sites, in order to explore the hidden meanings of mental health mediated content or "texts within discourses [...] that are artificial constructs that seek to control dispersion" (Grant, 2007: 153).

Women's magazines are studied here, with the female audience at the centre of the investigation, as a means of understanding how mental health is constituted in the media and how the media are involved in the continuity of representations. This study views women's magazines as having a special status to empower women (Hermes, 1995) and as offering a contemporary public sphere for women to share their interest in mental health. They are a special genre (comprising sub-genres such as glossy magazines, international magazines, traditional magazines and magazines for the working class) and occupy a special space in the media landscape. They incorporate women's sets of practices and appear to be a reliable way of reaching female

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3 Silverstone (2003: 6) also argues that the mass media "filter and frame everyday realities, through their singular and multiple representations, providing touchstones, references, for the conduct of everyday life, for the production and maintenance of common sense."
audiences by fostering and maintaining ‘a cult of femininity’ (Ferguson, 1983). I was interested in scrutinising the way in which this specific medium communicated the problem of mental health to its readers. This is also because, as Winship (1987) comments, women’s magazines act as agents of socialisation which offer support, encouraging and helping women to overcome their (mental health) problems by focusing on their shared interests into a production package with the inclusive meaning of being a woman that attaches itself to emotions, personal development, health, motherhood, beauty and fashion, love and romance, novels and cookery. An examination of women’s magazines was carried out to help the researcher make sense of the realities of the communicative construction of mental health that are schematised under the order of representations that generates “the general texture of experience” (Silverstone, 2003: 2) formulation, addressed as an essential dimension of contemporary life. The term “schematisation” is described by Luhmann (2000: 109) to mean the “rules for accomplishing operations” or generalisations of meaning that designate “images of the world” (Campos, 2007: 391). When this term is used in the context of mass-mediated representations, it reminds us that, content production in the mass media is a selective process of (re)construction of meanings using a set of binary codes (i.e., acceptance or rejection, right or wrong, normal or abnormal) that Grant (2003: 225) claims, “facilitate connectivity or linkage of communication”. Hodkinson (2011: 5) also suggests that media content often relates to the “manufactured set of representations (or re-representations) of the world”. Not only do the media representations mirror or shape the world, they create a circular model that includes both elements (mirroring and shaping) in certain patterns that therefore fabricate and rule the character of society.

OBJECTIVES OF THE STUDY

The guiding research question in formulating this thesis is to explore how mental health is constructed and connected within the social and individual, mass-mediated context of everyday life in Thailand. In pursuing this intention, the study adopts three overriding objectives.

First, the study attempts to explore and contrast the social and cultural themes and epistemic discourses that frame mental health from women’s subjective viewpoints and from women’s magazines. The aim is to examine the system of mental health discourses and representations that construct mental health in Thailand and to differentiate subjective and mass-mediated constructions while investigating their interplay.
Second, the research focuses on the space and territory of mental health information flow in both subjective and media cultural sphere(s). This question adopts the notion of the public sphere to examine the borders of mental health in the changing Thai media landscape where convergence, diversification and complexity are at the centre of discussion. This research aims to understand the blurred spaces of mental health information between the fluid private and public spheres and seeks the connection between how and to what extent mental health has become a topic of discussion in the publics. In particular, this question aims to identify the sub-systems of communication of mental health which women in this study (viewed as sub-group) gather and exchange their opinions about their shared concerns of mental health.

Third, the research question brings audience reception onto the scene as a useful empirical framework. It seeks to understand the interactivity women have with the media culture. This question is raised to explain the recursion of communications of women, media and their environment. The aim is to illustrate women's role as media users in the age of media communication and technology culture while exploring factor(s) that may enhance women's understandings of mental health and increase their voice in the complex mediated world of Thailand.

**STRUCTURE OF THE THESIS**

This thesis is divided into nine chapters that contextualise the two datasets drawn by the combined method. Chapter 2 establishes the theoretical approach to examining mental health in medical and social contexts and reviews the multiple understandings of mental health discussed in the literature. This chapter places mental health in different transitional scenes, using the theoretical architectures of the public sphere and audience/reception studies. It prepares background concepts such as the definitions of mental health and mental illness, wellbeing, the biomedical model and complementary medicine as well as the key cultural explanatory context of Thailand. It also discusses the Thai media landscape and provides a brief picture of mental health care and research in Thailand. These theoretical concepts feed forward into the discussion of the data, where they are empirically challenged and refined.
Chapter 3 is the methodology chapter, and explains how the research fieldwork was conducted during a nine month ethnographic study to follow Thai women in three settings. It describes the theoretical standpoint of the selected methods and outlines the rational for the chosen methodologies and the use of participant observations and in-depths interviews as my choices of data gathering techniques. This chapter theorises discourse analysis as a method of examining mental health representations in four Thai women’s magazines. The process of sample selection and the relevant concepts of discourse used to investigate the walls of silence that the mass media ignore in their framing of mental health are also discussed.

Chapter 4 explores women’s private experiences with mental health and shows that mental health constructions are highly complex processes that are networked with the series of interactions women have with their mediated environment. The concept of the patriarchal-extended family structure is part of the discourse of ‘Mae See Ruen’ (virtuous women, household grace) that is embedded in the Thai social and cultural context of mental health. This chapter also shows contrasting representations of women and mental health from women’s subjective and mass-mediated constructions while exploring (as well as questioning) the role of women’s magazines as a special genre for women.

Chapter 5 discusses the dominant discourses of the expert, medical system and self-help in the constructions of mental health. I draw on expert systems of mental health that network into women’s everyday lives and at the same time are framed explicitly and implicitly in women’s magazines. This chapter shows how mental health professionals marked their territories with the “expert systems” (Giddens, 1991: 18) that are characterised by the differentiations of modern society. This is particularly clear when examining the representations of the expert’s voice in women’s magazines that medical professionals own an absolute truth of mental health knowledge where titles and institutions are discussed to legitimise such privilege. Despite the strong discourse of the expert, this chapter explores the interactions women have with the expert system and suggests that there are variations in the perception and reception of the respondents, in that they both conform to and reject the expert’s views and knowledge of mental health.

One significant reason that prevents lay people from seeing mental health in a positive way is the strong discourse and myth of the mentally ill, and Chapter 6 classifies the dynamic experiences women have with the mentally ill. This chapter introduces the framing of the mentally ill and explains why the public commonly view people with mental illness as dangerous, violent and
unpredictable, associating them closely with the powerful framings of experts. Despite the strong discourse of 'the dangerous mentally ill' in the constructions of mental health, this chapter suggests that the representations of mental illness are not universal but paradoxical. From a reception standpoint, this chapter maps out different cases to address the role of women as co-constructors of mental health and mental illness. The findings show that the respondents conform but at the same time resist, negotiate and reject the stereotypes (or hegemonic representations) of mental illness. The idea of media literacy is particularly emphasised in this chapter as empirical evidence to illustrate variations of reception and the degree to which women from different backgrounds respond to the mediated constructions of mental health and mental illness.

Chapter 7 sees Buddhism and spiritual health, both prominent in Thailand, as counter-realities of the medical (orthodox) discourse. It explores different aspects to see how spirituality, with an emphasis on Buddhism, comes into women's constructions of mental health. Different scenarios are displayed to illustrate Buddhism as a contrasting discourse to the dominant power of the medical expert. The chapter also shows how different versions of Buddhist principles and practices such as Karma, making merits (doing good deeds), and meditation as represented in the mass media are adopted into women's everyday lives as choices for mental health treatment. Additionally, the chapter illustrates how Dharma (the Buddha's teachings, see Stcherbatsky, 2003) in the mass media is simplified via the process of commercialisation. The chapter suggests that the skill of media literacy is significant in the recursive process in evaluating the mass-mediated text, including spiritual-mental health based construction.

Chapter 8 examines the dynamic interactivity women as media users have with the new media environment in which communication technology and online information are at the centre of social connection. It explores patterns of media consumption by situating women as audiences within the everyday life media context and suggests that the interactivity between women and the mass media is dynamic and recursive (i.e., they create a shift from both sides to generate an infinite circle of connection by feeding information back and forth). Given that Thailand has entered the changing media landscape that deploys multiple communication platforms, this chapter mainly evaluates the role of the mass media as an enabling vehicle for women to have a choice of mental health treatment that also extends nodes of interactivity, regardless of the quality of interaction. Seeing women as diffused, plural and fragmented media users, this chapter investigates women's (Groups Two and Three) online interactions in mental health issues and
sees mass-mediated systems extend the space of mental health interaction. This chapter concludes that media literacy has the potential to be a key skill for media users to engage more effectively with mental health representations in the highly complex systems of mass-mediated communications.

The concluding chapter looks again at the concept of mental health in Thailand that is socially constructed and contested, deeply embedded in personal, social, spiritual and mass-mediated transmissions, reflected by the changing social condition of Thai modernity. The process of mental health constructions can be explained by the complex connection individuals have with mass-mediated representations and their culture in which their relationship is not one-dimensional but an endless loop of polycontextual interactivities among liquid mediated environments. Therefore, the process of construction is a dynamic recursion (Luhmann, 1985) or, as Hodkinson (2011: 6) states, it formulates a “circular model of representation and influence” that he calls “an ongoing process whereby selective media representations constantly feed into and are themselves fed by the make-up and character of society”. This is because the media (and their representations) cannot exist in isolation but depend significantly on their readers and the highly-fluid socio-cultural context. There is a shift on both sides that generates ‘recursivity’ or ‘fluid connectivity’ in any kind of mental health communication. This study identifies media literacy as a key skill in enabling the process of mental health construction in Thai society and in enhancing women’s decision-making processes in selecting mental health mediated information, where mental health in the mass media is driven not only by the systems of discourses but also by material conditions. This thesis finally identifies the issue of equality in women’s access to a range of mass media and the extent to which women from different social backgrounds, and particularly those from disadvantaged groups, possess the media literacy skills necessary to negotiate and utilise mediated mental health content and challenge the complex communicative systems of representation. With different levels of media literacy, the respondents (particularly Groups Two and Three) engaged and generated recursive connections with the media and were capable of securing their voices and mobilising their choice of mental health treatment in the Thai public sphere in which the private and public intersect.
CHAPTER 2

MULTIPLE CONTEXTS OF MENTAL HEALTH IN THAILAND

The topic of mental health is a contemporary issue that has become the focus of analysis in many books (Bury, 2001; Hart, 1985; Marsh et al., 2009; Nettleton, 2006; Rogers and Pilgrim, 2007). It also draws interest in mass media research to examine aspects of the complex system of the mass-mediated representations of mental health and mental illness (Harper, 2005; Philo, 1999; Seale, 2002; Stout, Villegas and Jennings, 2004; Wahl, 1995; 2000). This chapter makes two contributions. First, it provides background for the mental health issue in both general and local context to feed forward into the analysis in the following chapters by reviewing a number of related topics. Second, it discusses the concepts that are used to investigate the systems of mental health constructions (subjective and mass-mediated) in Thailand: ‘audience’ and the ‘public sphere’, to illustrate the theoretical backdrop by reviewing as well as examining competing conceptualisations of mental health.

Understanding mental health is highly context-sensitive, influenced by cultural factors such as class, gender, ethnicity and age (Fernando, 1993; Gu, 2006). As Rogers and Pilgrim (2007) recommend, it is impossible to understand mental health separately without considering a range of social factors and the local context (cf. Maclachlan, 1997). This chapter illustrates the definitions of mental health that exist in the literature while observing the changing context of mental health from the biomedical model to the complementary healing approach which encourages individuals to be an agent of mental health care. It also illustrates the local Thai custom in relation to mental health, provides a brief background on mental health care system in Thailand and discusses how mental illness and the mentally ill are understood by the Thai people. The last section discusses the Thai media landscape and Habermas’s (1989; 2005) version of the public sphere to refer to the same kind of conceptual territory about the media and challenge normative concept of public space. It also addresses the contest of the changing public sphere and audience practices that create a recursive communication system.
2.1 THE SHIFTING TERRITORIES OF MENTAL HEALTH

There have been controversial discussions around the issue of mental health and mental illness (Macklin, 1981). As McCulloch (2006) states, there is a disagreement as to what criteria specify the difference and people are often confused about the relationship between these two terms. This section does not aim to unpack their meanings but to demonstrate their territories and describe how they can be connected. Appel (1954: 391) once differentiated mental health and mental illness, concluding that “mental illness is the opposite side of the coin of mental health” (see also Fernando, 1993). Although there is no global agreement as to how to clearly classify these issues, his comment invites extensive debate.

Keyes (2005) argues that the terms mental health and mental illness cannot be dichotomised because there is no guarantee that the absence of mental illness will lead to good mental health. Although society provides effective treatment to combat mental illness, it does not mean that everyone (without symptoms of mental illness) will enjoy a complete state of mental wellness. This viewpoint is similar to Jahoda’s early (1958) rejection of mental health as the absence of mental illness. Jahoda (1958) clearly states that mental health and mental illness are not at opposite ends but correlate with each other which leads to confusion about their definitions. Where mental health is seen to overlap with mental illness, their territories are hard to discern. Jahoda (1958) interprets mental health in the context of day to day life and expands it to be associated with happiness, quality of life and a positive sense of wellbeing (see also the later studies of Huppert, Baylis and Keverne, 2005; Layard, 2005). For mental illness, Wahl (1995) points out that in addition to the strong link with psychiatric discourse, it can be loosely used to describe a whole range of adverse life circumstances from stress to bereavement that could happen to anyone. Armstrong et al. (2002) found that respondents associate mental health with mental illness even though the question relates to mental health.

Although there are many good reasons to think of health and illness as a continuum, the literature suggests that mental health can be considered as having a particularly close relationship with mental illness. Hence, it is worthwhile taking a brief look at the meaning of mental illness, which mostly refers to a psychiatric pattern related “deviant behavior” (Mechanic, 1962: 66). Previous researchers seem to agree that although mental illness has a vague meaning, this is attached to psychiatric discourse and contributes to the negative interpretations of abnormality. As Albee (1970: 37) describes:
"Ordinarily, we think of mental illness as an unusually persistent pattern of behaviour over which the individual has little or no voluntary control; it differentiates him from his fellows; it incapacitates him; it interferes with his normal participation in life."

Albee (1970) suggests that people with mental illness are generally regarded as ‘abnormal’ and are simply considered in the same way that Foucault (1954: 76) characterised as “alienated madness”⁴. Foucault explains how the public treat the mentally ill: “these men are treated neither entirely as madmen, nor entirely as criminals, nor entirely as witches, nor entirely as ordinary people”. Mental illness in this sense is not a neutral phenomenon but is constructed and evaluated by society (Hayward and Bright, 1997). Rogers and Pilgrim (2007: 25) also comment that “lay people tend to spontaneously view mental illness as being about psychotic or unintelligible behaviour with violent behaviour seen as reflecting mental illness or disorder”. This stereotype of mental illness ignores an individual’s diverse characteristics in a group of people with mental illness and generates a stigma of mental illness that increases prejudice. The stigma (Goffman, 1963) of mental illness plays a significant role in explaining the relationship between mental illness and mental health where the stigmatised person is excluded from their fellows.

Goffman’s (1963) comment on the stigma attached to mental illness reminds the researcher to look closely at the system of ‘representations’ that are manifested in discourse. The reality of mental health is mediated through a network of social interactions and representations (Harper, 2005; Lupton, 1998). As Webb (2009: 2-4) argues, representation is the fundamental element in understanding everyday life: “people practise representation all the time because we live immersed in representation – Humans have no real access to the world itself; our understanding and experience of the world can only be second hand, mediated through systems of representations”. Foucault (1984) clearly explains that representation is not confined to the restricted and highly evaluated meaning of image but goes beyond discourse systems. There is an essential need to understand the system of representations in order to understand the stereotypes of mental health and mental illness that create social stigma for those who are labelled mentally ill. As Dyer (1993: 3) comments, “what is represented in representation is not directly itself but depends on the way it is treated, delineated and enables what people can be in any given society”

⁴ Foucault’s work on Madness and Civilization (2009 [1961]: 61) also discusses an entire population of madness that means “the insane, demented men, individuals of wandering mind and persons who have become completely mad.”
(cf. Hartley and Montgomery, 1985). Hall (1997: 4) introduces the idea of the representational system that involves a complex process of making meaning: "[representation] enters into the field only after things have been fully formed and their meanings constituted". This is to say, representation is a complex meaning construction deeply embedded in culture. Through Hall's representational system, meanings are produced and circulated to individuals' shared understandings. The subject under representational system thus is not a permanent reality but is subject to change depending on who defines, who speaks, and in what circumstances, e.g., where to speak, with or to whom and how. This understanding of representation is explained by discourse systems that are highly codified selections and connected closely to exclusions, oppositions, dichotomisation and multi-voices. Following Foucault (1971; 1980; 1984), discourses regulate how people make sense and see the world. As Danaher, Schirato and Webb (2000: 31) state, discourses are the windows or explanations that "shape our understanding of ourselves, and our capacity to distinguish the valuable from the valueless, the true from the false, and the right from the wrong – because we are not just programmed or driven by instinct, our thoughts and actions are influenced, regulated and to some extent controlled by these different discourses".

The above notion of a representational system has raised awareness in recognising what Morley and Robins (1995: 134) adopt as the Foucaudian reading of power/knowledge and discourse to explain the system of representation that it is always a matter of relationship between power and knowledge, between representing and represented. They noted that "the question is, of course, who are we to represent them? we must always be sure to ask: who speaks? when and where? with or to whom? under what institutional and historical constraints?" This proposition is the epistemic mechanism of communication, the rule of discourse (Foucault, 1980; 1984) and discourse articulates the system of representations including those relating to mental health, particularly in the close observation of popular women's magazines and their framings of mental health that this study attempts to explore.

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5 The concepts of Power/Knowledge and discourse are the key contributions of Michel Foucault's work. Foucault (1972, 1984) identifies that all forms of knowledge are productive of power. Any constructions are constituted by the matter of power and viewed as an object of knowledge that is moved by the rules of discourses.
2.2 CHANGING AGENCY

As many authors argue, mental health has been understood by the dominant Western frame using the scientific approach and the biomedical model that put the emphasis on trained specialists who become the accepted resource in the formal treatment of disease (Fernando, 1993; Fox, 1998). Nettleton (2006: 1) agrees that the understanding of mental health is established through medical discourse that was related directly to an objective science associated with “hospitals, doctors, nurses, drugs and a first aid box”. The biomedical model underlies the authority of the expert (doctor) by identifying power in the doctor-patient relationship (Bury, 2001). This pattern of healing views the patient in the sick role as described by Parsons (1957) to imply that the power of the expert influences patients’ attitudes and behaviours. In the sick role, people agree to become patients until they are healed by relying on the experts’ confirmation of illness.

Hart (1985) summarises five characteristics of the biomedical model of medical knowledge and its practice: a separate account of mind and body; the rejection of magic and religion; the perception of disease according to people and culture; the isolation of the individual; and the identification of treatment space in a medical environment such as a hospital or consulting room. The biomedical model that stresses the dominant power of the medical system has invited much criticism in the discussion of the cultural construction of health. From Giddens and Sutton’s (2009: 394) point of view, medical experts are no longer the only source of health knowledge for the public. They argue that disease is no longer revealed only through scientific explanation but more attention is paid to a human's experience of illness and their relationship with the culture that “listens to the individual interpretations that patients give to their conditions”. This understanding brings people to the treatment centre while directing mental health to be seen under the changing paradigm of complementary/alternative medicine with a

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6 “(1) a dominant concern with the organic appearances of disease combined with a tendency to ignore, if not dismiss, the link between mind and body, between physical and mental well-being. Even psychiatry, the medical specialty devoted to mental illness, predominantly seeks organic causes for the conditions it treats, (2) an orientation towards cure, towards the manipulation of organic symptoms with the intention of affecting their disappearance if at all possible. In this medicine shares certain parallels with magic and religion. All seek to perform their own style of conjuring trick, (3) a perception of disease as an autonomous and potentially manageable entity which threatens personal health in temporary or episodic fashion. Disease is the alien intruder which needs to be expelled. This is in contrast to the view of disease as an integral product of the person/environment relationship, (4) a focus on the isolated individual as the site of disease and the appropriate object of treatment and (5) a belief that the most appropriate place for treatment is a medical environment, a consulting room or a hospital, not the environment where symptoms arise” (Hart, 1985: 12).
whole body treatment, promoting the term ‘wellbeing’ into the lay interpretation of mental health (Beattie et al., 1993). In this current scene, the terms alternative medicine, non-orthodox, complementary treatment (Saks, 1992) and unscientific, holistic, natural, spiritual and sometimes, magical treatment (Lupton, 1994) are used interchangeably in the literature promoting mental health. The popularity of alternative medicine motivates the researcher to recognise mental health in the complex interactions individuals have with their environment. As Beattie et al. (1993: xiii) put it:

“A preoccupation with disease, illness, suffering and discomfort has rendered biomedicine incapable of developing health as a positive concept. In its place they wish to develop a new paradigm of health which recognizes the dynamic interaction between individuals and their environment, and attempts to promote health-enhancing social and material conditions of life and work.”

Using this framework to understand mental health in unscientific terms or lay constructions, Rogers and Pilgrim (2007: 162) point to the idea of a “therapeutic society” that is used to conceptualise mental health as a topic of day-to-day living: “we now live in a therapeutic society in which therapeutic ideas are not confined to clinical and hospital settings but permeate most areas of everyday life”. They state that people have to be more responsible for their health status than in the past because of social change and the natural healing approach of self-help which has become a popular choice for the public in an attempt to resist the power of medical dominance.

Mental health in a therapeutic context recognises the notion of happiness, healthy thinking, emotions, moods, values, reflections, quality of life and the ability to cope with adversities (Jenkins et al., 2002; Layard, 2005; Parker, 1999). It includes people’s ability to fulfill a range of tasks in the context of ‘normal daily living’ and the degree of competency with which individuals can deal with positive and negative feelings. The therapeutic dialogues and self-help narratives are a reminder of Giddens’s (1991: 71) work. He lays out the importance of ‘self-help’ and ‘self-therapy’ as a “means of seeking to live each moment to the full – as a process of growth, and one which has to encompass the major transitions through which a person’s life is likely to pass”. In other words, Giddens (1991: 73) views self-help as a channel to “taking charge of one’s life” by asking the question “what do I want for myself in order to experience the diversity of open possibilities”. He discusses self-help (including self-help books) as materials to produce the reflexive self that providing ways for individuals to become self-forming and become “what we make of ourselves” (Giddens, 1991: 75). Understanding mental health in a self-help context therefore enhances lay understanding of how good mental health is central to
the process to understand ‘self’ and to an individual’s wellbeing (Rogers and Pilgrim, 2007). This is an important shift in the complex construction of mental health that interplays with the conditions of modernity that Giddens (1991) describes.

As Rimke (2000: 67) points out, the aim of self-help is “[to help the individual] to be a responsible citizen means to be responsible for oneself, not others”. From this view self-help, which is an individualised voluntary enterprise, encourages people’s sense of self and responsibility that can be also viewed in the larger economic context of a ‘neo-liberalism’ society where the state interventions in markets are replaced by deregulation and privatisation (cf. Harvey, 2005; 2006). The principle of self-help and the bottomline of neo-liberalism relies exclusively on individuals to be responsible for themselves and presents the key theme of development and personal growth. As Harvey (2005: 145) describes:

“Neo-liberalism is in the first instance a theory of political economic practices which proposes that human well-being can best be advanced by the maximization of entrepreneurial freedoms within an institutional framework characterized by private property rights, individual liberty, free markets and free trade”

Although neo-liberalism is marked as one key understanding of the great empowerment of the individual that allows the turn from state dependency to a regime of personal responsibility, several authors criticise that its concept is limited and therefore grants benefits only to certain social groups. As Harvey (2006: 152) argues, “neoliberalism has been a huge success from the standpoint of the upper classes”. Heron (2008: 98) comments that neo-liberal policies should aim to reduce inequality, exclusion and poverty: “Universalistic neoliberal policies need to be replaced with policies that respect economic and cultural diversity as well as creating policies that seek to reduce social exclusion, marginalization and poverty”. Similarly, Coburn (2000) points out that neo-liberalism on health status carries the vision of individualism that promotes self-responsibility undermining the welfare state and social infrastructures and raising major issues of income inequality and inequality of health status.

Regardless of the concern of equality in viewing therapeutic society through the prism of neo-liberalism, the concepts of self-help (Giddens, 1991; Hazleden, 2003; Rimke, 2000), neo-liberalism (cf. Harvey, 2005) and liquid modernity (Bauman, 2000) share a similar principle in encouraging the individual’s sense of control, autonomy, freedom, responsibility, improvement and empowerment in the ‘reflexive modernity’ (Beck, Giddens and Lash, 1994, see also Giddens, 1991) that conceptualises individuals as being ‘rationale choice makers’. Self-help and
the therapeutic context of mental health lead to the rise of alternative and complementary therapies that offer a sensitive, caring attitude and personal connection with the healers (Lupton, 1994). One principle of alternative therapies is that they encourage individuals to take responsibility for their own health by depicting the body as ‘natural’, ‘balanced’ and ‘in harmony’. They encourage people to participate in the maintenance of their health and seek alternatives to maintain good mental health. The overlap of therapeutic culture, self-help and people’s shifting role from patient to agent, enhances the forms of subjectivity that Advocat and Lindsay (2010) comment on: the role of self-agency is framed under the principles of freedom, choice and empowerment in modernity. Similarly, Coulter and Magee (2003) agree on the role of patients as reflective agents who seek to increase their competency in order to manage their health. This shift could be viewed as the result of the contest between expert power and the medical system which as Bury (2001: 267) notices, starts to move from “treatment and cure to management and care”. This is another interesting faultline in the competing construction of mental health in the age of modernity.

Harden (2005: 220) examines parents of young people with mental health problems and discovers that despite their belief in the expert, parents “engaged in strategies of re-skilling” through the critique of psychiatric knowledge as ‘expert’ and through the acquisition of knowledge”. Through the process of “reskilling” (Giddens, 1991: 7), parents question psychiatric practice, seek knowledge and transform their carer’s role to a more engaging one with the system of treatment. Norreslet et al. (2010) find that patients in their study are sceptical of the expert’s claims and resist conventional treatments by seeking alternative therapies such as self-help and natural treatments. Giddens and Sutton (2009: 396) emphasise: “not only are we able to make choices about the type of practitioners to consult, but we are also demanding more involvement in our own care and treatment”. The changing environment of mental health care encourages people to potentially become agents of their health destiny by means of self-help and natural therapies (Shilling, 2002). As Edgren (2006: 34) argues, people in contemporary society become “health care consumers that no longer want to be passive receivers of treatment and care but they want to be involved”. However, Giddens (1991) argues that the shift from orthodox medical

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7 Giddens (1991: 7) defines “reskilling” – “the reacquisition of knowledge and skills”. He comments that “individuals are likely to reskill themselves in greater depth where consequential transitions in their lives are concerned or fateful decisions are to be made. Reskilling, however, is always partial and liable to be affected by the ‘revisible’ nature of expert knowledge and by interal dissensions between experts”
dependent to self-help and other holistic medicine is just a transfer of faith in the abstract system of modernity. He states that “someone might turn towards holistic medicine after becoming disenchanted with the orthodox medical profession, but of course this is a transfer of faith” (Giddens, 1991: 23). His description implies the strong influences of knowledge environment, power and discourse that exist despite the transformation role of people as reflective agents in a therapeutic culture. Therefore, people in modernity cannot completely shun away from the impact of expert systems and medicine. This provocative view is supported by Rimke (2000: 62) who states that although self-help is an inherent property, it requires external forms of expert knowledge “to learn the tricks of the trade from someone who knows them well” (see also Rose and Miller, 1992).

The idea of viewing patients as agents connects strongly with close interaction with the media to obtain mental health information. Webster (2002) agrees that the arrival of new communication technology such as internet-based information helps people to be more flexible in selecting information related to their mental health concerns and create an opportunity to reduce uncertainty and risk. To understand people, the literature suggests that those who change the mental health environment (orthodox vs. complementary, professional vs. self-help) have to increasingly attach to the rapid growth of the media, information, communication and technology. Livingstone (2005a: 44) comments that audience researchers now encounter a changing media that is “becoming increasingly segmented, globalised, narrowcast and fan-based”. Giles (2003: 25) notes that people interact more with the media due to the development of “dependency relations”. Firstly, the media are closely involved in the construction of realities around us. Secondly, the media provide knowledge and guide lifestyle patterns. Finally, the media give individuals space for play in terms of solitude, relaxation and social interrelations to create their identities. The creation of identities, as Giles (2003) mentions, bears out the concept of reflexivity that Giddens (1984: 3) defines as “the monitored character of the ongoing flow of social life”. A series of explanations on reflexivity are echoed by Bauman’s (2000: 31-39) explanation of the “individualizing process” that there is a growing gap for individuals to “gain control over their fate and make the choices they truly desire”.

With the current trend towards seeing the transformation of patients’ roles to agents and their engagement with the multiplicity of media messages of mental health, concept of the (agentic) audience included in this section to explain the possibility of changing interaction, connection and participation in media use (Hartley, 2007). The review refers to the brief history of audience
research and illustrates the nature of interactivity audiences have with the mass media in the dispersed mass-mediated context of mental health.

2.3 FRAMING AUDIENCE

The study of audiences is important in the rapid change in the media landscape that is marked by a new intensity of connectivity. This does not just rely on the fact that more information is mediated, but that people have highly complex interactions in integrating old and new media technologies into the routine of their lives. As Lewis (1991: 73) illustrates, “doing audience research is a messy and slippery business”. Audience researchers are faced with a diverse target situated within the changing media landscape to become globalised but also segmented and commercialised (Cruz and Lewis, 1994; Jenkins, 2006). Livingstone (2005a: 44) uses the concept “convergence that is mediated by the internet” to explain the merging scenario of information, communication and technologies resulting in individuals’ changing behaviour of reading, viewing, shopping, playing, chatting, downloading and so forth. She employs the terms, media users, to explain the changing audience research paradigm that extends the question of audience reception to one concerning consumption in the consumer culture. Jenkins (2006: 2) describe how people engage more and more with the diverse mediated mode of interaction in the “convergence culture”, provoking rethinking about the audience and their connection with media culture:

“By convergence⁸, I mean the flow of content across multiple media platforms, the cooperation between multiple media industries, and the migratory behaviour of media audiences who will go almost anywhere in search of the kinds of entertainment experiences they want.”

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⁸ Jenkins (2006: 322) continues to illustrate what convergence means “Convergence [is] a word that describes technological, industrial, cultural and social changes in the ways media circulates within our culture. Some common ideas referenced by the term include the flow of content across multiple media platforms, the cooperation between multiple media industries, the search for new structures of media financing that fall at the interstices between old and new media, and the migratory behaviour of media audiences who would go almost anywhere in search of the kind of entertainment experiences they want. Perhaps most broadly, media convergence refers to a situation in which multiple media systems coexist and where media content flows fluidly across them. Convergence is understood here as an ongoing process or series of intersections between different media systems, not a fixed relationship.”
The concept of audience is fundamental to contemporary media culture, while the consumption culture seems to be the point of focus in individual lives. Audiences are highly networked and a question concerned with the interplay of balancing the power of the text and the power of the audience contributes to an analysis in which both areas are constructed and defined (Buckingham, 1998; Curran, 2002). This is because understanding an audience in contemporary society is constantly changing that in many ways illustrates a possible connection with multiple media and publics. McKee (2005: 5) reflects the changing nature of contemporary audience:

"We hear a story on the news and then we talk about it with a friend; we exchange ideas in email groups, down the pub, at the hairdresser's; we telephone a talkback radio station, write a letter to a magazine, etc. This common communication may occur in people's everyday life. The media, therefore, is the channel of public sphere where people find out about the public."

In this study, the word 'reception' is adopted to describe the role of readers as active producers of meanings in their encounters with different kinds of media content. The origin of audience reception is rooted in the theories of literary history where people discuss the content of meaning (Holub, 1984). Eco (1987) points to the importance of readers' interpretation in the communication process, "the unity of a text lies in its destination not its origin" (cited in O’Sullivan, Dutton and Rayner, 1994: 125). Gadamer (1979: 340) explains the meaning created by the audience as "fusion of horizons of understanding", by which he means the meaning of a text is an indefinite process that is made under an individual's frame of reference. As Sandvoss (2007: 28) summarises, "the process of reading, however, is no simple realization of prepacked meanings controlled by the author, but rather an interaction in which the structures and figures of the text collide with the readers' (subjective) knowledge, experiences, and expectations, all in turn formed, we may add, in an intertextual field". The encounter between text and readers is therefore always a fusion of different backgrounds that can be viewed as a "horizon of expectations" (Jauss, 1982).

Iser (1978) explains that although the text is produced by the author; the reader brings the text to life. The dynamic interaction between text and reader in Iser's view gives a relevant framework for this study to examine the connection between women and the media in the constructions of

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9 Wodak (2008: 3) describes "Intertextuality refers to the fact that all texts are linked to other texts, both in the past and in the present. Such links can be established in different ways: through continued reference to a topic or main actors; through reference to the same events; or by the transfer of main arguments from one text into the next. The latter process is also labeled recontextualisation".

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mental health. As Iser (1978) reminds us, the whole process of making meaning is neither direct internalisation, nor one-dimensional but depends on the reader's own experience to evaluate what is being communicated to him/her. Understanding the audience from a reception viewpoint therefore entails the diverse contexts surrounding the relations of audience and content, challenging the conventional view of an active-passive audience and providing insight into the complex process of meaning construction. As Fiske (1987) states, the process of the audience's interpretation involves a subtle negotiation of the audience derived from their everyday experience that they engage with the text. His viewpoint implies that the result of making meaning comes from the extension of the text into the interpreting, communicating activity and skills of the audience, which reinforces them in becoming creators of meanings. This is all the more necessary in highly mediated societies where the 'extension' of connection has changed enormously.

Not only is audience research extended to the technological perspective that poses a challenge to conventional ways of researching audiences, but also to the interpretation of media culture beyond the original act of watching, listening or reading. Ross and Nightingale (2003) state that because the media landscape has expanded dramatically, people are more complex in the range of information to which they are exposed, mixing media, media sources and media activities, compared with the traditional idea of audience where people attend the theatre or a concert (see 'simple audiences' in Abercrombie and Longhurst, 1998). According to Livingstone and Lunt (1994), the mass audience is plural in relation to cultural considerations that require theories of mass communication to adapt to the changes. The changing audience, together with the changing media landscape, requires a re-conceptualisation of audiences in the new media environment, resulting in a conception of communications and constructions of meanings that are motivated by the idea of 'recursivity'. As Luhmann (1985: 6) suggests “communications are possible only within a system of communication and this system cannot escape the form of recursive circularity”. In this case, Grant (2007: 142) interprets Luhmann's concept of recursivity as “implying redundancy in communication, a reference in communication to further communication as opposed to an objective reality”. Recursivity implies an infinite process of communication that cannot exist in isolation between the media and the audience but are the
results of such a connection embedded within the territories of the two. According to this view, an audience is connected closely to recursive communication because it creates feedback which maintains a cycle of meaning constructions. The next part focuses on the audience’s side and briefly discusses the development of audience research. This is clearly divided into a common analysis of phases to illustrate the shift of audience’s role that has been developed from the past that connects audience as part of the recursion which is where the repetition of views, actions and responses of the audience emerges.

The earliest media research sought to investigate the effects that the media had on their audiences, based on the assumption that audience response is predictable as a result of certain media stimuli and focuses on the perception of the media power that Gripsrud (1999: 42) describes as “the era of an almighty media”. This aspect of a (passive) audience is most obviously represented by the tradition of the ‘hypodermic needle’ or the ‘magic bullet’ model of media influence which believes that the media can directly inject values, attitudes and ways of thinking to the audience. Research in this paradigm has been characterised by fear of topics such as sexual content, violence, children, gender and race. Noble (1975) conducted a study in the laboratory and proved that the audience became violent after seeing violent scenes. However, the argument against this result is that the research setting is “an artificial situation wherein it is difficult to discover how things function elsewhere” (Gripsrud, 1999: 39-40). This path of research remained conventional compared with studies of everyday situations where audiences were free to construct their own interpretations of the whole world (cf. Butsch, 2003). Media researchers have shifted their interest from a linear influence informed by the media to explore the relationship between media and audience to a more interdependent approach by seeking to understand the cultural positions of the media content within the setting of ‘everyday life’ (see Ang, 1991; Buckingham, 1998; Gauntlett, 2008; Livingstone, 2005a; Morley, 1980)

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10 There have been debates about audiences with two main broad traditions of audience research. One approach sees the media as powerful and audiences as passive, vulnerable and easily influenced. The other sees audiences as the creators of meanings with major questions of how audiences use and make sense of media content. Much of the early audience research considered audiences as passive recipients and tended to overestimate the power of the media. This concept was challenged by many authors (Abercrombie and Longhurst, 1998; Couldry, 2005; Livingstone, 2005a; Ross and Nightingale, 2003), particularly by making academic turn to the various reception contexts which viewed audiences as highly active recipients. In fact, literary theory (see Iser, 1978; Jauss, 1982) identifies the idea of agents long before media studies.
This path of audience research was formulated by the shift from mass media effects to the promotion of a subtle understanding of mass communication (see ‘uses and gratifications model’ which outlines that different audiences use the same media to meet different psychological needs according to their own wants). The approach of uses and gratifications reverses the impact of the ‘almighty media’ and rejects the view that the relationship of audience and media is onedimensional and predictable. However, debates on the uses and gratifications model assert that it overestimates the power of audiences and implies that the messages are packaged with information that audiences will read in a similar way, ignoring other social factors that may influence an audience’s interpretation (Brunt, 1992; Morley, 1980; O’Sullivan, Dutton and Rayner, 1994).

The next breakthrough in audience research highlights Hall’s (1980) Encoding/Decoding model, which is very influential in examining the relationship between text and audience. He attempts to investigate the process of interpretation where audiences challenge the meaning of the text and argues that audiences’ responses can be different and are related to socio-economic context. Hall proposed three hypothetical positions from which media texts can be decoded using three forms of audience reading strategy: the dominant-hegemonic (preferred); negotiated; and oppositional positions. His conceptualisation explains that there is no guarantee that the audience’s decoding will be consistent with the encoded meaning because the communication is structured in a coded form and is polysemic (with multiple meanings).

Hall’s Encoding/Decoding model provides the foundation for a series of empirical audience research. One breakthrough is Morley’s (1980) study of the ‘Nationwide’ TV programme which confirms Hall’s typology that the media message can be made sense of by receivers who are not necessarily identical. Morley (1980, 1988) further demonstrates that the audience’s response is complex, cross-cutting different features such as class, status, race, occupational positions and gender. He also states that “there is a need to differentiate the moment of comprehension more clearly from the moment of interpretations/evaluation of messages” (Morley, 1999: 140). Later, the contribution of audience research focused on the examination of what audiences did with the media and emphasised human agency in the ethnographic approach of everyday settings that required direct contact with the researched, such as has been earlier cited in Morley’s (1980) work on Nationwide, Ang’s (1985) research on Watching Dallas, Hobson’s (1982) work on Crossroads and Reading the Romance by Radway (1984). The ethnographic approach includes live engagement with the respondents to understand the meanings audiences attach to their
complex interactions with the media (Moores, 1993). As Bertrand and Hughes (2005: 37) explain, "audiences are where mass media research began and where much of it is focused". This phase of audience research is similar to what Iser (1971: 2) reminds us of his reception theory: "it must be pointed out that a text can only come to life when it is read, and if it is to be examined, it must therefore be studied through the eyes of the reader".

The complex media landscape affects our conceptualisation of the interactions that the audience has with the mass media at a time when "the commodification of everyday life pushes critical perspectives to the margins as our cultural lives become subordinate to the dual logics of money and technological reason" (Stevenson, 2008: 224). Some agree that the mass media encourage the bulk distribution of information while enabling the process of commercialisation where many aspects of daily living become commercialised (Grant, 2007; Heron, 2008). The mass media provide a new density of connectivity across human agents that facilitate the individual making their choice from the vast amount of available media content (Margues, 2010). This changing social scene challenges audience studies to understand the process that individuals connect with the media and the way in which they access, evaluate, analyse and communicate media content that generates uncertainty in the communication circle.

To enhance an individual's freedom of choice, communication technologies are in the front line to foster the diversity and degree to which one may participate in the mass media connected culture. Jenkins (2006: 11) points out that freedom could be enhanced if the means of communication are "dispersed, decentralized and easily available". This concern brings the idea of media literacy (Buckingham, 2007; Hobbs, 1997; Livingstone, 2005b, 2007, 2009; Potter, 2005, 2011) into relief and poses questions as to the degree to which individuals, in a developing media landscape, are encouraged to "seek out new information and make connections among dispersed media content" (Jenkins, 2006: 3). Potter (2011: 19) highlights the significance of media literacy and identifies it as an important aspect of understanding people's engagement with the technologically advanced media culture:

"Media literacy is a set of perspectives that we actively use to expose ourselves to the mass media to interpret the meaning of the messages we encounter. We build our perspectives from knowledge structures. To build our knowledge structures, we need tools, raw material, and willingness. The tools are our skills. The raw material is information from the media and from the real world. The willingness comes from our personal locus."

27
The idea of media literacy advances the theory of audience by a rapid rise in communication and technological development. Despite recognising people as audiences or agents of communication, people have a need to take control of mediated information as well as protect themselves from too much information. Potter (2011: 6) uses the term “the challenge of selection” to stand for media literacy as set of skills to help people challenge and make selections “from among the overwhelming number of messages in the constant and increasing flood of information”. As Potter (2011: 6) argues:

“Messages are being delivered to everyone, everywhere, constantly. We are all saturated with information, and each year the media are more aggressive in seeking our attention. It is a hopeless expectation to keep up with all the information available. The most important challenge now lies in making good selections when the media are constantly offering us thousands of messages on any given topic”.

Livingstone (2004b) explains media literacy as the practice of four components; access, analysis, evaluation and content creation which constitute a skill-based approach for the audience’s connection with the mass media. In fact, Livingstone (2007) suggests the use of the term, ‘literacy’ rather than ‘audience’ in the context of today’s media and communication environment that is highly diversified, dispersed and converged. She states: “literacy, more than ‘audiences’ suits a converged environment in which the lines between leisure and learning, public and private, or work and play are increasingly, and productively, blurred” (Livingstone, 2007: 4). Her view endorses the need to extend the discipline of audience study to media literacy that may incorporate other interdisciplinary areas of education, sociology, information science, literatures and policies. In fact, her point can be connected to the idea of recursivity (Luhmann, 2000) that generates the mutual dependency of media and their users as well as their inseparable connection. Media literacy in this research is theoretically and empirically connected with the hybridisation of the public and private where recursivity is generated and circulated.

Therefore, understanding audiences in the present day requires more than one set of theories or rough speculation. Media scholars seek to understand the interrelation between media and audience, particularly the way in which media content are open to multiple interpretations in principle and in practice (Ross and Nightingale, 2003; Dalgren, 2000) as well as the way in which they connect, select and make the best use of the media to benefit their lives.
2.4 THE LOCAL CONTEXT OF MENTAL HEALTH: THAILAND IN FOCUS

This section discusses the specific local context in relation to mental health in Thailand. It includes the cultural concepts of the traditional role of Thai women, the role of Buddhism and mental health care to provide a brief background to how the mental health care system was established. After that, the public sphere and the changing mediascape of Thailand are discussed to provide the framework which examines the dispersed territories of mental health communication.

Geographically about the same size as France, Thailand covers 517,000 sq km. It is bordered by Laos and Cambodia in the north and east, in the west by Myanmar and is connected to the border of Malaysia in the south. In 2005, the population of Thailand was estimated at 62 million people, with up to eight million people living in Bangkok\(^{11}\) and vicinities (cf. Baker and Phongpaichit, 2009). In terms of education, Cooper (2008a) reports that Thai education has improved significantly in recent years with the literacy rate at 95 percent and most Thais complete nine years of schooling.

Family is a key word in Thai culture in which individuals learn obedience, politeness, rules of respect and cultural expectations (Smith, 2005). The ‘extended family structure’ seems to be the suitable term to explain the nature of the Thai family. Cooper (2008a: 56) illustrates the importance of the extended family: “if you are thinking of marrying a Thai, it’s worth knowing that you are marrying a whole family”. Although the Thai family as explained by Vichit-Vadakan (1994) has been deeply influenced by the changes in socio-economic conditions, the extended family system still exists and includes relatives who may be living together such as grandparents, aunts, uncles, cousins and nephews:

“Family provides an individual with support, comfort, a sense of belonging, an identity and a set of expectations that he or she would not have vis-a-vis others in society. In times of need, they seek out the family for assistance before they seek out other persons or institutions.” (Vichit-Vadakan, 1994: 516)

\(^{11}\) Known as “Krungthep” among Thai people. Krungthep means the city of angels. Bindloss (2006) explains that the full proper name for the Thai capital is Krungthepmahanakhon Amornrattanakosin Mahintharayutthaya Mahadilokphop Noppharat Ratchathaniwutirom Udonratchaniwetmahasathan Amonphiman Awatansathit Sakkathattiyawitsanukamprasit. Loosely, it translates as “The city of angels, the great city, the residence of the Emerald Buddha, the impregnable city of the god Indra, the grand capital of the world endowed with nine precious gems, the happy city, abounding in an enormous Royal Palace that resembles the heavenly abode where reigns the reincarnated god, a city given by Indra and built by Vishnukarn” (Bindloss, 2006: 13).
This principle of the collectivistic family model is also described by Sethabouppha and Kane (2005) who found that when Thai people deal with stress, they use three common ways to solve it: (1) consulting family members; (2) relying on religion; and (3) talking with others. These three solutions signal certain cultural influences that affect the Thai way (rural and urban) of living, including people’s coping mechanisms. The cultural concept of living together as a collective unit makes Thai people apply rules of respect and prioritise family matters. However, because of the change in social structure, Pinyuchon and Gray (1997) mark that both urban and rural Thai lives are in transition. Historically, Thai people lived in agricultural villages but with the rapid pace of socio-economic transformation, the Thai family is less agriculturally-oriented and is leaning towards industrialisation, informationalisation and urbanisation. Due to economic factors, the family has had to adjust itself and modify the extended family structure to a nuclear one. According to Chakrabhand (2005), the form and size of the Thai family has changed, evidenced by fewer extended families and an increasing number of single family units. The number of persons in a household is also predicted to fall to 3.09 by 2023.

2.4.1 The Household Role of Thai Women

Thai culture identifies the virtuous women or Mae See Ruen as “proficient and sophisticated in household duties; graceful and pleasant yet unassuming in appearance and social manners; and conservative in her sexuality” (Klunklin and Greenwood, 2005: 49). Thaweesit (2004: 207) states that one of the traditional beliefs that lies firmly in Thai society emphasises “women’s faithfulness and endurance in married life, as well as women’s self sacrifice for the sake of their offspring”. Mae See Ruen is a stereotypical, classical attribute of Thai women that illustrates the gender bias in featuring women with home-keeping characteristics, sexual qualities and with feminine appearance (Phiphitkul, 2001). Mae See Ruen is a cultural process which identifies that Thai women are destined for childrearing, home-making, cooking and caring for the elderly (Cohen and Kennedy, 2000). McKie et al. (1999: 4) argue that Mae See Ruen is an undeniable fact and a significant influence that “home, family and household have over the lives of women regardless of age, social class and experiences of employment”. These notions guarantee the maintenance of Mae See Ruen by praising women who manage household chores well, including mastering exceptional culinary skills, having good manners and ministering to the wants of all family members.
According to Keyes (1984), Thailand is a male-dominated country; its social system operates as a patriarchal structure. This traditional belief lies with the practice of women’s domestic role as the mother-nurturer which has underlined the role of Thai women, conceptualised through the pattern of the Thai family, for centuries (Pinyuchon and Gray, 1997). This custom obviously reflects the historical fact of unequal gender roles that, in the past, explained why Thai boys were sent to study at the temple while Thai girls had to stay at home and learn to do household chores and cooking (Knodel et al., 1999). One traditional literary work well documented by a Thai poet, Sunthorn Phu, who was designated by UNESCO as a Classic Poet of the World in 1986, reflects this custom and describes the duties of a good Thai wife as follows:

“A wife should show her respect to her husband everyday. When the sun sets, she will not go anywhere but prepare the bed for her husband. When the husband goes to bed, she wai him at his feet [by raising the hands pressed together at her chest and prostrating herself at the husband’s feet as a Thai way to show her high respect] every night without fail. If he has aches and pains, massage him then the wife may go to sleep. In the morning, she wakes up before him and prepares water for him to wash while he is eating, sit and watch him nearby so that when he needs something he does not have to raise his voice.” (A Maxim for Ladies by Sunthorn Phu, 1844, cited in Cooper and Cooper, 1986: 45)

What Sunthon Phu (1844) described (see also Kislenko, 2004) was similar to a Thai proverb, which says that the husband is an elephant’s front leg and the wife is the hind leg, which expects women to support and follow (Limanonda, 1995). Pinyuchon and Gray (1997: 214) also state that, the main account of social expectations for a Thai woman is to be a follower who is “to honour and obey her husband”.

Different studies discuss domesticity and the patriarchal system together in which women, viewed as ‘wives’, ‘mothers’ and ‘followers’ are oppressed and have an inferior status compared to men (Barrett, 1980; Hinvimarn, 2001; Oakley, 1974). Marsh et al. (2009) claim that people learn gender appropriate behaviour through the process of social, cultural practice and expectation. Girls learn how to be good women from families, schools, peers and from the media and are shaped to understand their natural differences that women nurture while men go out to work (Connell, 2008). This expectation supports women’s subordinate role in the private sphere while men’s work in the public, is more highly valued (Rosaldo, 1974). Women are culturally represented to reflect qualities that render them unfit for the masculine world, but root them in the private context of the home. One explanation is the cultural expectation of Thai women is embedded within the concept of patriarchy that Walby (1989: 214) defines as “a system of social structures, and practices in which men dominate, oppress and exploit women”. Marsh et al.
(2009) state that this often engenders passivity, oppression, dependence and nurturing characteristics. It can be assumed that Thai women tend to experience overt and covert discrimination in many circumstances and the common cultural practice makes them feel disempowered in which men dominate societies through their roles of heads of households. Walby (1990: 104) points out that the dichotomy of femininities and masculinities is still part of popular cultural practice and the key thing in patriarchal relations is the "differentiations of the discourses of femininities and masculinities, and the valuation of masculinity above those of femininity". This statement signals the unequal power of men over women that shape local patriarchal structures and which in turn have the potential to affect women’s mental health.

However, as Walby (1990) argues, there is a shift in femininity from the private sphere in the contemporary world to the wider space outside the home. This approach is in accordance with what van Zoonen (1989: 227) observes regarding gender and equality enabling women to change and create their own social and political circumstances, including an ability to "re-engage the integration of women in the public sphere". This movement is a starting point to discuss the role of women in contemporary society which positions them as agents, implying an active constructor role in their lives.

The status of Thai women, similar to the Thai traditional notion, has changed dramatically in today’s society (Lhuangsumrit, 2005). Today, Thai women make significant contributions to the arts, education and the political landscape. In higher education, Thai women have also risen to leadership positions and have entered politics as candidates in local and national elections. Despite this transformation, the mother-nurturer role continues to be idealised as the Thai female’s code of conduct. In other words, women work outside the home while continuing their household role. As Hinvimarn (2001) states, a contemporary Thai woman is expected to be a good wife, good mother and good carer while becoming more independent and professional. This notion possibly falls in with a similar account in which Gregory (1999) describes contemporary woman as a ‘home manager’ to mirror the hybrid household role.
This concept of hybridity\(^{12}\) enables us to recognise that identity is fluid and unsettled, subject to shift, change and challenge. As Hall (1990: 235) comments, “identity is a matter of becoming as well as being. It belongs to the future as much as to the past”, and varies by class, ethnicity, gender, age and so on, dependent upon who constructs the meaning.

Women’s magazines are a special site and a specific genre for a specific audience. Women’s magazines occupy a special place in a shifting media landscape. They are a negotiated space for a sub-group (women) to unite, discuss their shared concerns (mental health problems) and re-construct their shared identities. Hermes (1995) describes women’s magazines as a space to share a mutual interest that provides women with a pleasurable way to fill moments of relaxation with columns on knitting, self-made home decorations and cooking tips (Gauntlett, 2008). One assumption is that women’s magazines are a special forum to empower female readers by their systems of representation and encourage them to have a happy life, positioning themselves as a reliable friend (Gauntlett, 2008) who gives useful advice on life problems (Lhuangsumrit, 2005).

Women’s magazines stand out as specialist and generalist. Ferguson (1983: 2, see also Berns, 1999) explains, “specialist in that they are for a single sex, women, yet generalist in that most extend their content appeal across a wide spectrum of feminine concerns”. Previous studies suggest that women’s magazines offer information about how to be a well-rounded women and their useful recommendations are presented in a practical way. Women’s magazines therefore can be viewed as a privileged sphere, inviting female readers to exchange knowledge and information of interest which challenges the male-dominated origin of the public sphere in Habermas’s (1989) model discussed in 2.5.

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\(^{12}\) Stevenson (2008: 228) describes ‘hybridity’ as a “process whereby new cultural forms and identities come into being by combining different cultural elements. This term can be linked to globalisation (the increasing movement of peoples and cultures) and/or media technological implosion whereby different technological elements combine to produce new hardware.”
2.4.2 Buddhism and the Thai People

The spiritual dimension, particularly Buddhism, is highly relevant to any study of mental health in Thailand (Chakrabhand, 2005; Wasi, 2001). In Thailand, there is a belief that mental and spiritual health in Buddhism has an intimate connection with people’s positive attitudes to a good life. Mongkol et al. (2001) reveal that the meaning of mental health is associated with holistic happiness of life satisfaction in the view of the Buddhists. Health in Thailand is re-defined by Wasi (2001) to include a spiritual dimension. He indicates health as the state of wellbeing which derives from the complete balance of one’s physical, mental, social and spiritual health (cf. Chungsatiensap, 1999). There is a strong relation between mental health and the cultural aspect as Chakrabhand (2005) reports and rural people believe that mental illness originates from the power of a supernatural force. This belief often results in local Thai people seeking treatment from local healers instead of asking for help from the mental health care system. Buddhism and spirituality stand out as key themes on which several Thai researchers focus, particularly when investigating how Buddhism and the practice of Dharma (the Buddha’s teachings) help individuals to overcome stress (Burnard, Naiyapatana and Lloyd, 2006; Klunklin and Greenwood, 2005).

The national religion in Thailand is Theravada13 Buddhism and 95% of Thai people consider themselves Buddhists (Klunklin and Greenwood, 2005). In Thailand, religious considerations are important to people across gender, class and groups in shaping the meaning of their lives (Pinyuchon and Gray, 1997). Mulder (2000) uses the term ‘Buddhist culture’ to explain the cultural and religious environment that Buddhism spreads throughout one’s life, including health and wellbeing via religious practices and rituals. Burnard, Naiyapatana and Lloyd (2006) state that Thai people live in a Buddhist culture that believes in spirituality, is deeply rooted in the minds of the Thais and has been a significant part of their cultural background for many centuries (Klunklin and Greenwood, 2005). As Ayal (1992: 131) notes, “the Thai take Buddhism very seriously. It permeates almost all activities and social life”. In Thai society, Buddhism has played an extremely important role in shaping people’s culture, way of thinking and lifestyle (Kapur, 1998). The influence of Buddhist ideologies and beliefs is reflected in the relationship

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13 Theravada or in the other name, Hinayama, is the oldest form of Buddhism. According to Perve and Fontanellaz (2005: 122) “those who follow it are faithful to the Buddha’s teaching. They form the Sangha (community of monks), study the Pali texts and hope to attain Nirvana through renunciation and through correct daily practice which allows escape from suffering.”
Thai people have with the system of Buddhism; The *Wat* (Thai Buddhist temple and monastery), The *Pra* (monk) and The *Dharma* (practices and disciplines).

The Wat is the central venue for Buddhist rituals and ceremonies, and is considered as a sacred place which "shelters the main Buddha image" and in which ordinations take place (Cooper, 2008a: 28). Wat provides a special place of peaceful recreation and acts as a community focal point for social events as much as spiritual centre for Thai people. Thai people go to Wat to worship, shelter, make merit (doing good deeds) and attend the temple fairs (see Smith, 2005).

Seen as one of the *Three Jewels*, the sacred concept in Buddhism, the Buddhist Trinity embodied the lord Buddha, his teaching (Dharma) and the Pra (monkhood). Pra, in the past, was a teacher for Thai boys who provided basic education. Traditionally, a Buddhist monk performed different functions. He lived simply, spending his time in meditation (Vipassana) to uplift his spiritual wellbeing, sought religious knowledge by learning the Pali language (the language of the Buddhist scriptures) and taught children. In today’s society, Cooper (2008a) reports that rural monks continue these traditions by bringing basic education to children in remote areas. In terms of the Buddhist rituals, monks play an important role in chanting and organising sacred and spiritual events, e.g., ordination, new house celebration, wedding rituals and funerals.

The monks have 227 monastic laws to obey in order to follow the Buddha’s path. Perve and Fontanellaz (2005: 133) indicate that “entering into monastic orders is one of the main mechanisms for the transmission of Buddhist values. A young man’s ordination is one of the most solemn and important moments of his life for his entire family”. In Thailand, although women are not allowed to be ordained as monks, they could become Chee (nuns). However, as Klunklin and Greenwood (2005) state, nuns in Thailand have a lower status than monks,

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14 Viewed as a sacred symbol, a Buddha image must be treated with the ultimate respect. As Cooper (2008a: 37) explains, “in the past, severe punishments were handed down to anyone guilty of desecrating an image or scraping the gold leaf from its surface. Today, in spite of restrictions on taking images out of the country, they are openly on sale in tourist shops and even set out disrespectfully by the roadside. Many valuable images have disappeared from the country and turned up in museums in the West.”

15 According to Smith (2005), *Ngan Wat* or Temple Fairs are organized for the purpose of fund-raising for religious activity, combining food festivals and a flea market with other local entertaining shows. One of the biggest, Ngan Wat in Bangkok is called the ‘Golden Mount Fair’ which has never been restricted or closed to any segment of society. As Smith (2005: 192) observes: “modern people to appreciate the Ngan Wat’s many attractions as exotic, rather than mundane. By mixing a diversity of popular culture, the folk fair remains a crucible of cultural change”.

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identified by the nun’s duties of cleaning, cooking and maintaining the temples: they adhere to only eight monastic rules compared with the 227 rules of the monks.

The Dharma (practices and disciplines) in Buddhist philosophy derives from the wisdom of Buddha through insight, meditation and enlightenment. The Buddha’s principal teaching rests on the four principles, the so-called ‘Four Noble Truths’16, which are at the heart of Buddhism to prevent Dukkha (meaning suffering, see Tyson and Pongruengphant, 2007). There are different disciplines and practices that the Buddhists employ. Their religious belief includes the concept of the Three Marks of Human Existence (the state of impermanence, Anijjung, Dukkha, Anutta) as well as the cycle of Karma. They meditate, perform good deeds and maintain the five basic precepts of life, which are “don’t kill, don’t steal, don’t lie, don’t have illicit sexual relations and don’t get drunk” (Perve and Fontanellaz, 2005: 121).

According to Punyasen (2007), Buddhism can be explained in terms of reducing suffering for all living things, while the practice of religion enhances happiness and increases mental strength for a longer life. It is worth noting that, Thailand has various superstitious and magic rituals that link people to nature and the supernatural, which are the cultural product of older Thai traditions. Welty (2009) explains that there are different magic practices, including the use of blessed water, mumbled mantras as well as the common practice of wearing of amulets, putting a talisman in cars, garlands. All these practices demonstrate that rural Thai people have a strong belief in supernatural forces and strongly adhere to and follow the teaching and rituals of the Buddhist faith, while retaining their distinct view of fearing ghosts and spirits. These animistic forces, as Klausner (2000: 148) explains, “were basically, complementary and not contradictory; sometimes merging together” and in the local context, promote a better understanding of the relationship of Thai people with the multiple aspects of Buddhism, spirituality and mental health.

16 The four noble of truths are the Buddhist philosophy, include “Suffering (Dhukka): life is merely suffering, imperfection and struggle. The cause of suffering (Samudaya): suffering is produced by three basic cravings, which are the driving force behind all actions: the desire to create, the desire to control and the desire to destroy. The craving for sensual pleasures (Kamatanha) transmitted by the senses (sight, sound, smell, taste and touch), forces beings to pursue and to create. The craving to control (Bhavatanha) forces beings to possess things and people. The desire to rid one-self of what one does not crave (Vibhavatanha) forces beings to destroy. The end of suffering (Niroda) and the attaining of enlightenment: after death, the purified spirit enters a perfect, timeless state called Nirvana (in Thai, nippaan). The nature of this state cannot be described, because it is beyond the bounds of human experience. The Noble eightfold path: this is the middle way between self-gratification and self-mortification, which eventually leads to enlightenment. The eight principles are: right perception, right resolve, right speech, right action, right existence, right effort, right thinking and right concentration. They can be summed up as charity (Dana), morality (Sila) and the cultivation of the mind (Bhavana)” (Perve and Fontanellaz, 2005: 120-121).
2.4.3 Thai Beliefs and Mental Health, Illness and Care

According to Siriwananrangsan, Liknapichitkul and Khandelwah (2004), the Western view of the bio-medical model was introduced into Thai culture with the establishment of the first hospital in Thailand, Siriraj Hospital, in 1888. Since then, the Western concept of health and illness has been integrated into the lives of most Thai people to seek professional help when they are ill instead of being entirely dependent upon local healers – Mor Meung – local doctor (see Chungsatiensap, 1993). Despite the rapid social acceptance of the bio-medical model, the three concepts of cultural belief (the supernatural, Hinduism and Buddhism) remain important in the Thai’s interpretation of illness, particularly among people in rural areas (Klausner, 2000; Praditsathaporn et al., 2009). As Chungsatiensap (1993) argues, Thai’s traditionally believe in the supernatural force of healing which has a long history and is an effective treatment for both health and mental health.

The formation of mental health care in Thailand could also be traced to 1st November, 1888 when Thailand established the first psychiatric hospital in the reign of King Rama V, the so-called the ‘Baa’ (mad) hospital. This first Baa hospital had different names. It was once called ‘Rok Jit’ (a derogatory form similar to ‘loony bin’) hospital or ‘Red Roof’ hospital because of the very noticeable red roof. In the past, the mentally ill who were labelled ‘Rok Jit’ or ‘Baa’ were discriminated against, rejected, excluded by society and tended to be sent to and confined in this hospital. Popular pictures of mentally ill patients show them in handcuffs, with ropes and chains on their feet. Lay people in rural Thailand still think of the mentally ill in terms of these pictures and refer to them using highly stigmatised terms; ‘Rok Jit’ and ‘Baa’ (Sethabouppha and Kane, 2005). One clear example which illustrates how taboo these terms are in Thai culture is through the reference to ‘Phee Baa’ (mad ghost) which is used in rural areas to stand for the mentally ill who are called “something else” not “a normal human being” (Saroj, 2001: 36).

In 1954, the Baa hospital changed its name to Somdej Chaophraya Hospital. In 2002, the hospital was renamed, Somdej Chaophraya Institute of Psychiatry to reflect the systematic use of diagnosis, treatment, rehabilitation and consultation (see www.somdet.go.th), while establishing itself as a hub for psychiatric research in South East Asia. In 2001, the Department of Public

17 From the history of Somdej Chaophraya Hospital found on http://www.somdet.go.th and as I observed by visiting the hospital museum, the in-patient wards were like a prison with bars. As described in the website, “the patients’ buildings are like jails with bars and without the windows”.

37
Health of Thailand adopted the WHO campaign entitled “Stop Exclusion, Dare to Care” (WHO, 2001b) with a local project to ‘unchain the mentally ill’ (‘Prod Soe Truan’, cf. Saroj, 2001) to call for local recognition and better care for the mentally ill while breaking the image of the mentally ill with chain on their feet.

A further important development in mental health communication and promotion in Thailand was the establishment of the Department of Mental Health in 1994, the national mental health authority under the Ministry of Public Health. Siriwananrangsan, Liknapichitkul and Khandelwah (2004) report that, since then the state care of mental health has concentrated on implementing preventive and palliative care for mental health problems. Some of the interventions are covered by community services, prison services, psychiatric rehabilitation and the use of the media in mental health promotion (Chakrabhand, 2005). However, current mental health and psychiatric provision nationally is still under-performing due to the shortage of personnel, particularly professionals such as psychiatrists and psychiatric nurses (Chamrasrittirong, Prasartkul and Choolert, 2010).

The WHO (2007) reports that one major problem for the mental health system in Thailand is the lack of a systematic database on mental health information. This is because there has been no single agency responsible for the management of a mental health database and thus there is no systematic data management and trend identification. Only one percent of mental health research within the country is published in journals on mental health, as reported by the WHO (2003, 2007). As a result, the existing database lacks rich and meaningful data for a study of mental health services quality, sufficiency and fairness.

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18 As stated in the WHO handbook ‘Stop Exclusion, Dare to Care’ (2001b: 2): “there is no justification in ethics, science or society to exclude persons with a mental illness or a brain disorder from our communities. There is room for everyone”; “don’t fear those experiencing a mental illness. It can happen to anyone. Don’t ignore early warning signs. Dare to challenge the myths and the misconceptions.” (http://www.who.int/world-health-day/previous/2001/files/whd2001_dare_to_care_en.pdf)
2.5 MASS MEDIA AND THE CHANGING PUBLIC SPHERE

The concept of the public sphere developed famously by Habermas in 1962 had a major impact across disciplines (Butsch, 2007; Calhoun, 1992; Fraser, 1992; Stevenson, 2008; McKee, 2005; Gripsrud and Weibull, 2010). The public sphere is the body of ‘private persons’ assembled to discuss matters of ‘public concerns’ through disputation and it is conceptualised as a realm of social life when citizens exercise the right of association, exchange information of common concern and discuss their interests (Habermas, 1989). It is a selection mechanism in which public opinion can be shaped and it is a space where citizens gather and debate issues to reach agreement about ‘matters of general interest’.

In his model Habermas sees the public sphere as a forum where citizens exercise the right of association that formulate rational debate to reach consensus and public opinion as a result of communication. The spread of the public sphere continues with Habermas’s explanation of the ideal bourgeois society in the eighteenth century where he refers to the salon and coffee house as public spaces for the exchange of ideas and information. According to Bohman (2004), the public sphere comprises two mainpoints: a forum or a social space that generates two way communications via face-to-face interaction; and a commitment to freedom and equal participation where members treat each other with mutual respect.

One criticism of Habermas’s (1989) public sphere is that his model is based on the constitution of a bourgeois society from the eighteenth century, where he refers to salon and coffee house as public spaces of association19. His focus on bourgeois society has been criticised for concentrating on the historical context of elite, middle class and educated men, excluding other sub-groups. Poor (2005) explains that Habermas’s public sphere is based on a historical lay-out that is focused on bourgeois origins, ignoring other historical events. Hartley (2007: 192) also states that viewing the public sphere by ignoring group differences it “is possible to offset the reality that participatory privileges are something to be enjoyed only by members of the dominant group”. This point is important as it generates serious challenges from the feminist viewpoint such as Fraser (1992), who argues that Habermas’s public sphere is based upon

19 "The bourgeois public sphere is a category that is typical of an epoch. It cannot be abstracted from the unique developmental history of that ‘civil society’ originating in the European High Middle Ages; nor can it be transferred, ideal typically generalized, to any number of historical situations that represent formally similar constellations" (Habermas, 1989: xvii).
practices of exclusion and that his ideal formation of the public use of reason fails to acknowledge other groups. Fraser (1992) notices that Habermas has ignored sub-groups in society such as women, racial minorities and the poor, while Hohendahl (1995) agrees that the public sphere has left no room for multicultural societies and excludes sub-sections of the public by concentrating only on middle class, white men (see also Dahlgren, 2000). In response to such indifference, many feminists (cf. Fraser, 1992) and non-feminists (Grant, 1995) suggest the idea of sub-publics, multiple publics and competing publics to function in parallel with Habermas's public sphere where sub-groups, sub-cultures and minorities are able to voice their concerns in the shared public space of mutual interest and freedom (see also the concept 'the personal is political' in Benhabib, 1992; 1996; McKee, 2005). In his later essay in Calhoun's collection (1992), 'Further reflections on the public sphere', Habermas acknowledges the class and gender limitations on his bourgeois public sphere by responding to the criticisms of feminists, including a reconsideration of women's role in the public sphere that contributes to the idea of sub-publics20 (i.e., Fraser, 1992) in a diverse society. He notes:

"By now, however, the growing feminist literature has sensitized our awareness to the patriarchal character of the public sphere itself, a public sphere that soon transcended the confines of the reading public (of which women were a constituting part) and assumed political functions [...] The conflict does not merely involve a competition among various parties of loosely associated private people; from the beginning a dominant bourgeois public collides with a plebeian one. From this it follows, especially if one seriously tries to make room for the feminist dynamic of the excluded other, that the model of the contradictory institutionalization of the public sphere in the bourgeois constitutional state is conceived too rigidly. The tensions that come to the fore in the liberal public sphere must be depicted more clearly a spotentials for a self-transformation". (Habermas, 1992: 427-430)

With this revision, Habermas (1992) seems to be more pragmatic in the approach to the conceptual change with empirical question, moderating his more flexible view of the public sphere in his writing in 2006. He notes:

20 Fraser (1992: 115) argues in relation to Habermas (1989) that "the problem is not only that Habermas idealizes the liberal public sphere but also that he fails to examine other, nonliberal, nonbourgeois, competing public spheres. Or rather, it is precisely because he fails to examine these other public spheres that he ends up idealizing the liberal public sphere". She proposes the idea of alternative publics to include members of subordinated social groups such as women, workers, people of colour, gays and lesbians into the constitution of the public sphere: "I propose to call these [alternative publics] subaltern counterpublics in order to signal that they are parallel discursive arenas where members of subordinated social groups invent and circulate counterdiscourses to formulate oppositional interpretations of their identities, interests, and needs." (Fraser, 1992: 123)
"The deliberative paradigm offers as its main empirical point of reference a democratic process, which is supposed to generate legitimacy through a procedure of opinion and will formation that grants (a) publicity and transparency for the deliberative process, (b) inclusion and equal opportunity for participation, and (c) a justified presumption for reasonable outcomes" (Habermas, 2006: 413)

Habermas includes other historical angles and cultural manifestations (such as gender and the media) into his reconstructing analysis which seems to yield a resilient approach. As discussed earlier, he develops a plausible concept of the publics in his later work (1992, 2006) and admits that instead of having one public sphere, the "modern public sphere comprises several arenas" (Habermas, 1992: 430) which implies his agreement to the alternative publics, plural and multiple spheres. This modified concept is particularly fruitful as it provides a flexible framework to examine the mediation of culture in the current complex world. As Dahlgren (2010) convincingly argues, we should view public spheres as plural in the present context. In today's mediated world there are multiple and overlapping social spaces that form various public spheres for different publics. He notes "the major mass media of a society can be seen as creating the dominant public sphere, while smaller media outlets can generate clusters of smaller spheres defined by interests, gender, ethnicity, etc." (Dahlgren, 2010: 21)

Despite the slightly more pragmatic approach (flexible division of private and public, and the notion of the public that includes transparency, participation and inclusion in the lifeworld), it is difficult to deny that his model retains a strong, normative account which gives an uneasy balance between the normative horizon and empirical description (cf. Kellner, 2000). As Morley (2000) argues, Habermas’s reconstructing model of the public sphere privileges certain types of debates with its elitist character in his “rational critical discussion” of the scientific reason (cf. Hodkinson, 2011: 190) that remains to exclude other forms of expressions (i.e., women’s emotions and subjectivity). As Habermas (1992: 428) states clearly: “I investigated how the relationship between public and private spheres changed in the course of the expansion of the democratic right of participation and the social-welfare state’s compensation for class-specific disadvantages”. This view reflects his strong normative description of the private and public sphere as well as cultural forms of reasons that is based on political, economical, and democratic contexts and hierarchical structure with little attention to reflect interests of other groups or cultures (Ku, 2000). Hodkinson (2011) comments: “Notably, there is no place in Habermas’ rationalist vision for emotion, affectivity and subjectivity, all of which are dismissed as commercialized distortions orientated towards the realm of the personal rather than that of the public”. Casteel (2006) also notices, “the private in Habermas’s (modified) work migrates from
the unseen home environment where work is done out of the gaze of the public to another unseen private place within business and out of gaze of the public. Therefore, as Dahlgren (2010: 21) points out, there are ambiguities within the concept: “it is not fully clear whether what Habermas describes is an empirical reality of an historical situation, or whether he is fundamentally presenting the reader with a normative vision”. Although Habermas seems to acknowledge the limitation of his ideal version of the public sphere that is maybe outdated, his reconstructed version of the public sphere still holds its strong normative horizon of private and public division which privileges certain rational voices (such as elites, western, male) in the communicative action of the public sphere.

While Habermas continues with his historical narrative to illustrate the formation of the public sphere, the development of the media and technology (in addition to the use of face-to-face communication, pamphlets and the press) as well as the processes of globalisation, generate debates on changes in the public sphere (Dahlgren, 2010; Stevenson, 2008). To Habermas (1989), the constructive public sphere is generated without the influence of commercial interests. He points out that the shift of the public sphere, with the pursuit of profit as the major intention of media institutions, has diminished the way the public sphere is rationally formed, particularly with the interference of commercialisation, entertainment and trivialisation (McKee, 2005).

Because the rapid change in the media landscape is geared towards the domain of the market and profit maximisation, the public sphere has shifted from the forum of rational debate and the body of ‘private persons’ discussing matters of public concern, to a space of market-driven-commercialisation and a space for media emerge (such as blogs, facebook). For Habermas (1989), the changing public sphere which depends on advanced media technology has raised concerns on the issues of commercialisation that has increased the complexity of society and changed the way the public sphere is formed. In contrast to Habermas’s concern, the advanced development of communication technologies extends the space for interaction that people have with their world. Castells (2000: 406) specifies the importance of new technology in promoting a network society that allows people to build up connections among their networks: “localities become disembodied from their cultural, historical, geographical meaning, and reintegrated into functional networks, or into image collages, inducing a space of flows that substitutes for the space of places”. The advanced mediascape invites people to unite and extend the boundary of the public sphere to include different media use. Dahlgren (2010: 20) illustrates the picture of the contemporary public sphere:
"This space is constituted by both mediated communication and face-to-face interaction. That is, while in the interaction, the ongoing talk between citizens, where the public sphere comes alive, so to speak, and where we find the actual bedrock of democracy. In recent years, of course, such civic interaction also takes place via the newer interactive digital media-public spheres, i.e., in the plural, not only because we are dealing with different European countries but also because within any one country we find an array of distinct, even if overlapping, social spaces that constitute different public spheres, while smaller media outlets can generate clusters of smaller spheres defined by interests, gender, ethnicity, etc. This tendency is certainly growing with the Internet."

Dahlgren reflects the changing nature of the public sphere that is associated directly with the rise of mass media and communication technology. Taking mental health issues into account, it is interesting to examine how the topic of mental health transfers from the private to the public sphere with an overlapping space of personal, social, public and mass-mediated spheres. Although this thesis adopted Habermas's (1989) useful model of the public sphere to explore the spheres of mental health for Thai women to unite, share and discuss their experiences in the changing media landscape that combine multiple forms of media use, his notion needs to be revisited and challenged in two aspects. First, this study sees women's magazines as a blurred border area of mental health private and public space whereas Habermas (1989) argues that these two spaces (public and private) must be kept separate. As he clearly points out, "the line between private and public sphere extended right through the home, the privatized individuals stepped out of the intimacy of their living rooms into the public sphere of the salon" (Habermas, 1989: 45). Even in 2005 he maintained that despite the celebrity culture, there was a separation of public and private in literary, political and scientific debate in which people "turn their backs" on the private (Habermas, 2005: 15). In this study, the theory of the public sphere is valuable as a comprehensive theory (normative and empirical) that generates ideas and debates. The strength of the public sphere is that it is formulated on multi-dimensional perspectives (society, institutional and communicative levels). These perspectives invite the researcher to look at different forms of interaction within spaces of mental health in the blurred frontiers of the private and public spheres (see Benhabib, 1992; Fraser, 1992; McLaughlin, 2004) under the polycontexts of institutions, individuals, technologies and the mass media. The public sphere allows this project to look at the different sets of data in a complex environment and in the different domains of mental health, media and cultural spheres (3 settings, 4 titles of women's magazines and various interactions across the media) where empirical case studies challenge historical and normative description. It is used to understand the sub-publics of women and their interest around mental health in the mass media where women's magazines were selected as the
special unit of examination. In fact, the theory of the public sphere is a conceptualisation of history, institution, individual, media and technology that make it useful as a set of concept and as a architecture in this thesis which looks at the constructions, multiple publics, agencies, institutions, ownerships, etc.

Second, the research will challenge Habermas’s (1989) concern with the public sphere after the revolution in media, communication and technology or in what Dahlgren (2010: 20) describes as “digital media public spheres”. These give emphasis to media power and lessen the value of the idealistic public sphere as a rational forum of debate. Indeed, Habermas seems to contribute his view towards the rise of multiple media platforms that undermines “critical viewers” (cf. Livingstone and Lunt, 1994: 70-76). As Habermas (1989: 437, cited in Grant, 2007: 169) argues, [the mass media] transform the rational salon21 into the realm of publicity that “ended the innocence of the principle of publicity”. In response to such comments, the thesis will bring the idea of recursive communication to examine the connection women as media users have with the media. This approach aims to reduce Habermas’s concern that tends to treat people as “the passive recipient of media messages rather than active agent” (cf. Giddens and Sutton, 2009: 753). This research will also bring the theory of reception (Ang, 1996; Eco, 1987; Iser, 1978) to address the audience as the producer of meanings and examine the “life-world context of media audiences” (Stevenson, 2008: 76). The theories of audience are applied to examine the roles of women as creators of meanings, the concentration that is at heart of the study that views women as active, selective, creative and powerful meaning constructors who are able to make selections of mental health content when the public sphere is constantly shaped and flooded by mediated mental health information (see Gillespie, 2005; Croteau and Hoynes, 2003). This research attempts to draw the complex communication systems from women’s private constructions and the mass-mediated representations of mental health, similar to what Iser (1978: 21) identified as the space between the “two poles”, to refer to the interplay of author’s intentions and reader’s horizons of understanding media constructions in the private and the public sphere:

21 Habermas’s (1989) concept of the public sphere originated in the context of modern Europe in the constitution of bourgeois public sphere in eighteenth century while he refers to salon and coffee house as public spaces for people to gather, exchange ideas, debates and form public opinion.
"The literary work has two poles, which we might call the artistic and the aesthetic: the artistic pole is the author's text and the aesthetic is the realization accomplished by the reader. In view of this polarity, it is clear that the work itself cannot be identical with the text or with the concretization, but must be situated somewhere between the two."

2.6 THE MEDIASCAPER OF THAILAND

This section maps out the media picture in Thailand that is shifting toward the rapid development of communication technology and online information systems. Thailand is a country in transition, where the business of the media has become dynamic and highly competitive. As McCargo (2007) comments, the media environment in present-day Thailand is highly complex in terms of its numbers, classifications and ownerships because globalisation has introduced a new type of social morphology (Castells, 2000), delivering a new form of communication directly into Thai life. The emergence of broadband Internet provision and the launch of the mobile phone in Thailand (with ADSL wired and 3.5G²² wireless) has brought people to what Castells (2000) calls the network society, creating a new phase of mass interaction and allowing all aspects of information, knowledge and entertainment to be integrated. Nowadays, it is common to see Thais carry their laptops and smart phones on public transport, while chatting on msn, facebooking, tweeting, e-mailing or listening to MP3 player, reading magazines and books in the traditional printed form and the i-pad. With this current lifestyle, the convergence media generate a complex interaction with people which is very similar to the global urban landscape. As many argue, we all live in a media culture in which information is mediated (Alasuutaari, 1999; Schmidt, 1992; Silverstone, 2003; Hodkinson, 2011). This changing mediascape challenges the normative public sphere concept that Habermas (1989) described.

The mass media in Thailand are under the broad supervision of the Public Relations Department of the Office of the Prime Minister (Siriyuvasak, 2002). This specific department has an important function, serving as the principal source of news and information about the government's policies. The Thai broadcasting media are entirely owned by the government

²² The National Electronics and Computer Technology Center (NECTEC, 2008) reports that most of the Broadband Internet access in Thailand is transmitted via ADSL technology (Asymmetric Digital Subscriber Line) with speeds up to 7.2 MBit/s on 2100 MHz band by different companies such as TRUE Internet, TOT, CAT Telecom and KSC. For wireless technology, technology 3.5G has been provided by AIS, DTAC, TRUE Internet, TOT, CAT Telecom since December, 2009.
under the regulation of the Radio and Television Act of 1995. As Limpattamapanee and Leveau (2007) report, most channels were leased to private operators either on a short-term contractual basis or long term concession. Newspapers, by contrast, are owned by private companies and several such as the Bangkok Post, Matichon, Post Today and The Nation are listed on the stock market. Some of the leading popular newspapers such as Thairath and Daily News which are sensational (quantitative, popular) publications are in the hands of private family companies (McCargo, 2000, 2007).

Since 2006, Thailand has been constrained politically by the problem of short-lived government cabinets due to the unsolved ongoing conflict and political unrest of the 'anti-Thaksin' movement (cf. McCargo and Pathmanand, 2005; Pye and Schaffar, 2008). The media, as many Thai critics observe, have had to adjust to supplying immediate news from multiple positions, and with a more critical perspective. Kavi Chongkittavorn (2008: 3), the editor of The Nation reflects his view on the current media landscape under the on-going conflicting scene of the Thai political crisis:

"Each media outlet has developed its own niche. For instance, 24-hour cable news channels have become more sophisticated and comprehensive with their coverage. Alternative media, including online news agencies and community radio stations, are publishing and broadcasting up-to-date information, which used to be the mainstream media's turf. Since 2003, they have successfully challenged the so-called elitist views of major media establishments with non-conformist views that are more skeptical. Mass-circulation papers still maintain their best-selling formats undisturbed by these new challenges."

According to Nielsen Media Research Thailand (2007) television is by far the most popular medium in Thailand; newspapers are second, followed by radio, the Internet and magazines. Among the press, the daily newspaper market is very competitive. Despite public ideological expectations of the role of the Thai press, its operating nature as a media business requires it to

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23 McCargo (2000) explains that there were four kinds of Thai newspaper. The first group is a mass circulation paper emphasizing crime stories and sensational news (Thairath, Daily News, Khaosod, Kom Chad Leuk). The second category is a quality newspaper which focuses on politics and economics such as Matichon, Siam Rath. The third group is a business newspaper such as Manager, Post Today. The last group was called vanity papers usually run by wealthy individuals with political interests such as Daily Mirror and Ban Muang.

24 Top Five newspaper readerships in Thailand according to Mindshare (2007) are Thairath, Daily News, Kom Chad Leuk, Khaosod and Matichon. Thairath is the most sensational newspaper that has the largest circulation in the country with a million copies distributed daily. Matichon is the most popular quality newspaper and Bangkok Post is the largest English language newspaper. However, the mainstream print media are represented by Thairath and Daily News, which together account for one half of Thailand's newspaper sales.
maximise ratings and make a profit (Trairat and Chaiwat, 2004). In contrast to newspapers, the Thai broadcast media remain under state control. All television channels are owned by the government or run by semi-government sectors and operated as commercial enterprises (Siriyuvasak, 2002). Television in Thailand is mostly commercialised and generally appeals to popular taste. There are six free television stations in Thailand (Channels 3, 5, 7, 9, 11(NBT) and the recent Thai Public Broadcasting Service – Thai PBS or TV Thai25). Each channel produces its own programmes, ranging from news, documentaries and quiz shows to Thai soaps. Variety and talk shows are among the most popular, with imported series and situation comedies from the US, Taiwan, Korea and Japan (Mindshare, 2007). The Thai broadcast operation market (television and radio) is under the control of major government sectors; the Mass Communications Organisation of Thailand (MCOT), the Public Relations Department of Thailand (PRD) and the Royal Thai Army Radio and Television (RTA).

One breakthrough for the broadcasting business in Thailand was the arrival of the Thai PBS (public service) channel in 2008 that has enabled the Thai media market to be more varied. The morning and evening news programmes have become highly popular and gained high ratings. However, external factors such as increasing oil prices and the violent political scene (see Pye and Schaffar, 2008) resulted in prolonged demonstrations and severe riots in Bangkok and in three provinces in south Thailand, have made the overall media market picture unpredictable in terms of advertising spending and consumer choice.

The radio networks are dominated by the military and the government, which also includes commercial enterprises supervised by government agencies such as MCOT, units of the army and state universities. McCargo (2007) states that state ownership of the radio is a matter of national security but at the same time it is a profitable source of revenue and considered to be the most efficient channel of public communication to reach rural areas. Although radio is the most

25 The newest station since 2008. Established on 14 January 2008, PBS channel or TV THAI was meant to be public television according to the Public Broadcasting Service Act. The station is broadcasting on a frequency formerly held by the privately run channel ITV from the year 2000. After that, the station was taken over by the former Prime Minister, Thaksin Shinnawatra before the ownership was transferred to TEMASEK, a holding company of Singapore in a controversial deal in 2005. Thaksin sold his family’s telecom holdings to this Singaporean company and the deal raised serious questions about conflicts of interest and placed Thaksin under intense political pressure before he was discharged of his position by the military coup d’etat on 19 September 2006. In 2007, ITV was taken back by the government and renamed TITV under the Public Relations Department control. The station has eventually become a complete public service television station in accordance with the government’s decision under the new name Thai PBS (see Siriyuvasak, 2007; Ekachai and Komosevin, 2004; McCargo and Pathmanand, 2005).
pervasive medium, television has gained wide popularity, particularly from 1980 when the cost of television sets became affordable to almost every household (Siriyuvasak and Wiwattanakul, 1988). Wongtes (2000) notes that television has penetrated into almost every Thai household since 2000 and because daily newspapers could not be obtained in remote areas, electronic media (television and radio) have an advantage in providing national coverage.

Magazine sales have been on the increase in the Thai media market. Nielsen Media Research Thailand (2007) reports that there are more than 600 titles published weekly, fortnightly or monthly, to serve different markets. The magazine market is highly competitive with new and international titles. Siriyuvasak (2002) notes that the magazines are mainly aimed at the upper-middle class group, particularly in big cities. Nielsen Media Research Thailand (2007) reports that the top sellers are the national titles, Kwanruen, Kulsatree, Praew, Dichan, Sudsubda and Image, while the international titles, Cosmopolitan, Elle and Lisa have gained popularity among urban female readers. This information is a justification for this research to select women’s magazines (Kwanruen, Dichan, Cosmopolitan and Real Life) to investigate the (sub) public forum of mental health communication for specific target audiences, Thai women living in the Bangkok area.

The emergence of the digital era in the late 1990s signalled a significant change in the Thai media landscape and shaped the Thai media culture into what Jenkins (2006) calls “the convergence culture”. Different media conglomerates came into the market, providing and expanding their ranges of media services. GMM GRAMMY, NATION MULTIMEDIA, MAJOR CINEPLEX, RS PROMOTION, BEC TERO, MANAGER GROUP are key players in the Thai media and entertainment business. These large enterprises combine news with knowledge and information and entertainment by expanding their business across all forms of the media.

Since 2006, Mindshare (2007) reports that the Internet in Thailand has had the fastest growing consumption rate in Asia because of rapid growth in the IT infrastructure. NECTEC (2008) reports the profile of the Thai Internet user as being 20-39 years old, upper middle class income consumers living in Bangkok or urban areas. The Internet reaches about 20% of the population, which is about 13 million. According to NECTEC (2008), the majority of Internet users have university degrees (52%) while the top activities on the Internet are e-mail (27.5%), downloading software (12.3%), playing games (11.5%), reading local news (11.3%), chatting (11%) and
participating in newsgroups and web board (10.3%). The Internet is popular with the business community, those in education and the media and with active citizens (Siriyuvasak, 2007). It also has a huge impact as a search engine allowing people to access global information and borderless resources. The search engine ‘www.google.co.th’ dominates the search while online social networking is a top ranking site with over one million users (Synovate, 2007). According to Chaiyanan and Ramasoota (2007), the Internet is a public platform on which users (who have access to the online media) can play the interactive roles of both sender and receiver while, theoretically, they are able to freely voice their views. Siriyuvasak (2007) agrees, interactive communication invites a wide spectrum of political views as opposed to the private mainstream media and the state electronic media. The changing mediascape of Thailand outlined above, is an essential description that provides a helpful starting point to revisit the notion of the public sphere as it relates to mental health and spaces of interactions. It is used to build up a framework to examine the ‘forums’ that generate the ‘loop of interactivity’ or ‘recursivity’ between audience and the new media landscape where advanced technologies such as the Internet form a much more sophisticated media environment than the past (that concentrates on traditional communication of letters, pamphlets, and face-to-face communications). Despite the growth in Internet traffic in Thailand, Thai women’s magazines still hold their special status, reaching female audiences in higher number, particularly for those who have limited access to the Internet such as women living in the hostel and those from remote Thailand.

CONCLUSION

This chapter has explored mental health in different contexts and suggests that it is a topic involving a polycontextual network of culture, policy and the dynamic interaction that people have with the media. This chapter has established mental health to be a topic of study amongst the contrasting dynamic personal, cultural, spiritual and mass mediated representations. The transformation of media culture in the public sphere to include all forms of communication technologies allows individuals the freedom to choose which media to consume to extend their interactions with mental health. As Hodkinson (2011: 11) points out, “this broader environment, or world, forms an everchanging context within which industry and users – alongside the technologies and content they use, create and distribute – operate”. His perspective reflects the changing architecture of the public sphere in the late-modern world, following McGuigan's
description, "it [the public sphere] includes the various channels and circuits of mass popular culture and entertainment, the routinely mediated aesthetic and emotional reflections on how we live and imagine the good life". This recent view of the public sphere requires revisiting media theories that need to be modified to fit the rapid changes in both the mass media and their audience that Abercrombie and Longhurst (1998: 68) remind us of: "audience is no longer an exceptional event, nor even an everyday event. Rather it is constitutive of everyday lives". Indeed, Morley’s (1992: 13) viewpoint is that in order to understand the complex phenomenon of people and their connection with the media and their culture, "no single method has a monopoly on virtue, but the choice of method, in itself, can neither guarantee nor damn a given study". This insight leads to a discussion of the research methods and design that are employed to investigate the phenomenon of mental health constructions in Thailand.
CHAPTER 3

METHODOLOGY

Mental health is a complex phenomenon which requires the use of more than one technique (Lee, 1993). On the basis of the theoretical framework that is changing audience, changing public sphere, discourses, representations and recursion of constructions, bi-modal methodology recommends itself to this study in examining the data that is complex by allowing the researcher to have a flexible research methods to look at the contestation, the competing mental health constructions of subjective from the everyday experiences of Thai women and from the ways in which women’s magazines represent mental health. A qualitative research methodology was selected because of its distinct character that allows the researcher to investigate details of “lived experiences, behaviours, emotions and feelings” (Strauss and Corbin, 1998: 11). As Goldbart and Hustler (2005) explain, insights through processes and emotions are difficult to understand by quantitative means.

The common practice for a qualitative research design is generally characterised by the fact that there is no single correct method (Flick, Kardorff and Steinke, 2004). Although there is no definite way to decide which methodology is privileged above others, the strength of qualitative research is to allow the researcher to understand the meanings people attach to things in their lives and to study phenomena in a natural setting (Silverman, 2008). Gray (2009) suggests the researcher chooses the methodology by looking at the aim of the study. If the purpose describes the researcher’s intention to explore, explain or discover a situation of interest, qualitative research is appropriate. Lee (1993) notes that fieldwork based on qualitative methods has often been the choice for researching sensitive topics. Mental health is a sensitive issue that may not be explicitly understood but requires a qualitative method in order to understand its meaning constructions in an environment heavily schematised by the media.

To understand the subjective construction by researching people’s life stories, attitudes and experiences, qualitative research is favoured over quantitative research (Hammersley and Atkinson, 2008; O’Reilly, 2005; Silverman, 2008). Denzin and Lincoln (2000) explain that the aim of the qualitative researcher is to reach the depth, breadth and richness of the data that comes from understanding people and their culture by means of ‘strolling’, which Bauman (1992)
describes as the process of listening, observing and experiencing a new perspective to understand those who are being researched. This study employs ethnography to explain the meanings of mental health by concentrating on women’s everyday lives. Two methods were utilised in this ethnographic research: (1) participant observation and (2) in-depth interviewing.

Another way to examine mental health by drawing a wide system of representations is to see how it is constructed in the mass media to complement data from ethnography that works with small samples (49 respondents). Discourse analysis is used to approach social contexts in the construction of social reality and explore how texts are made meaningful via the construction of media production (van Dijk, 1997; Phillips and Brown, 1993). I chose women’s magazines to examine how social meaning, images and stereotypes of mental health are framed because women’s magazines have a special position in women’s media genre that articulate popular language of womanhood today (Gauntlett, 2008; Kim and Ward, 2004). They also entail forums of communications that women can participate in and “gain independence” (Wetschanow, 1999: 6). This study combined methods of ethnography and discourse analysis to facilitate understanding of “the lived border between reality and representation” (Gubrium and Holstein, 2000: 102) the ground to manage the tensions between subjective and mediated representations of mental health. There are two criteria in my research design: the diversity of the samples (women from three different profiles/settings, four Thai women’s magazines’ titles) and the complementarity of the research methods that recursion is used to feed mental health constructions into individuals.

3.1 ETHNOGRAPHIC FIELDWORK

I began my fieldwork with an initial interest in answering the broad question of how Thai women made sense of mental health. Following Malinowski (1922: 9), the researcher should begin the fieldwork with “foreshadowed problems” that are not structurally formulated assumptions and are used to gain rich and in-depth data from the field. In fact, Malinowski paved the way for ethnographic fieldwork with ‘inductive reasoning’ that informs the research question from the field. His method of foreshadowed problems allows the researcher to settle in and begin the work with the researcher’s open mind and as “few preconceptions as possible” (O’Reilly, 2005: 26). As Hammersley and Atkinson (2008: 21) emphasise, ethnographers deal with “producing in-depth explanations of particular situations”, or with “developing theories through systematic
empirical investigation rather than with testing existing hypotheses”. This point is similar to Gray’s (2009: 173), who uses the word “emergent” to characterise knowledge gained in the ethnographic field.

Ethnographers should not enter the field with pre-established theories. Their purpose is to learn and look for a detailed explanation instead of testing any preconceived ideas (Boyle, 1994; Bryman, 1988; Denscombe, 1998). Hammersley and Atkinson (2008) explain that time and in-depth information from the field will help the researcher to refine and transform the direction of the research.

Fieldwork, as explained by many authors (Hammersley and Atkinson, 2008; O’Reilly, 2005, Silverman, 2008) generally requires the researcher to live within a group of people for an extended period of time to study people’s way of life. Denscombe (1998) notes that the benefit of extended fieldwork is to allow detailed explanations of the situation to emerge and make sense of people’s surroundings. In this study, I spent nine months from September 2008 to April 2009 in three different settings to become involved and learn from the people who were being researched.

Researching women whose experiences have been marginalised is never an easy task although “the female researcher may sometimes be accorded privileged access” (Silverman, 2008: 84). Although I am a Thai native woman who speaks the same language as those researched, my perceived advantage raised some restrictions. One barrier was how to be accepted by women who had encountered hardship – for instance, rape, unwanted pregnancy or attempted suicide. This was also the case for women living with mental illness: access to them was difficult. Indeed, this difficulty justified my rationale to employ ethnography allowing me time to get to know the women in the various settings, develop relationships, build mutual trust and encourage rapport (May, 2001) – the hallmark of ethnography.

As my research deals with sensitive events in women’s life experiences, it was most important to carefully select data gathering techniques for successful data collection. Participant observation and in-depth interviews were chosen because these two methods not only allowed direct access to the behaviour being studied, but also gave me access to the hidden and multifaceted aspects of mental health in women’s lives. As Bryman (2008) reminds us, there are two ways to investigate people in the real world. Firstly, through conversations with informants about their routine
actions and secondly, by participant observation which Atkinson and Hammersely (1994) refer to as active engagement with people to view the world through their eyes on a day-to-day basis.

In the fieldwork, I adopted what Denscombe (1998: 150) calls, "shadowing a person or group through normal life, witnessing [their everyday life] first hand and in intimate detail". It was easy to notice women's cues for joy, fun or happiness through observation. However, eliciting women's hidden concerns was more difficult. It is a social, natural practice and the cultural belief that Thai women are generally reserved and traditionally 'inexpressive'. Hence, they tend to keep their feelings of 'unease' within themselves, instead of fully (and freely) expressing how they feel (Doungphummes, 2002). Participant observation fails to guarantee the certainty to explicate hidden thoughts that were embedded in one's mind. As discussed by Briggs (1983: 164), it is "impossible for the researcher to rely exclusively on observation". In-depth interviewing was therefore used to gain deeper insight into how the women felt, thought and explained the ways in which they experienced mental health, and to confirm data gained from participant observation. This agrees with Schweizer (1998: 59), who argues that knowledge obtained using participant observation alone will always be "incomplete and fallible". Therefore, participant observation and in-depth interviews were used together to obtain explicit and implicit details in women's lives.

Although there is no neat systematic research requirement in ethnography, a strategic plan is necessary for conducting studies (O'Reilly, 2005). Emerson et al. (1995) suggest that two phases are involved: first, the researcher enters the field and participates in the daily routines of the people; and second, the researcher records what she/he observes. The first stage refers to participant observation. I applied an overt role where the identity of the researcher is openly recognised in all three settings. The researcher's role, as Becker and Geer (1957: 148) explain, "participates in the daily life of the people under study, observing things that happen, listening to what is said and questioning people, over some length of time". This process allowed me to understand the how, why, and what of women's behaviour of mental health in order to gain insight into their culture (Shaffir, 1999). The second stage refers to the 'noting down' process in which I developed a researcher's field note to record what I noticed as well as my personal reflections.
3.1.1 The Three Research Settings and the Informants

In my preliminary study, I talked to twelve women living in the Bangkok area and asked them to define the term ‘mental health’. The results showed that, for them, mental health had multiple meanings. From the women’s narratives, mental health was in some ways unknown or uncertain. It was associated with a wide range of positive meanings such as ‘happiness’, ‘well-being’, ‘good will’, ‘feeling good’, ‘emotion’, ‘mind’ or with negative meanings such as ‘bad mood’, ‘worry’, ‘stress’, ‘depression’, ‘schizophrenia’, ‘Rok Jit’ (loony bin), ‘psychotic’, ‘mania’ and ‘Baa’ (madness). Hence, I was interested in further examining these multiple understandings of mental health by women from different profiles and with different experiences of mental health, since the results signalled that mental health could contribute to diverse understandings and thereby affect how individuals coped with mental health problems. The results from my preliminary study confirm the point that is mentioned in 2.1 that mental health can be understood differently whereas the confusion between mental health and mental illness is existed. The results also endorse what Iser (1978) reminds us that the process of making meaning depends on individual’s experience, knowledge and expectations. My follow-up investigation was to study women from distinct profiles to see how they understood, dealt and communicated with mental health in their everyday lives. I classified the women in my research into three groups:

1. women with severe life conditions and at high risk of mental health problems;
2. women living with mental illness (carers);
3. women with no direct contact with institutions associating with mental health care. This group was recruited to compare with the other two groups in closed settings whose everyday lives involved mental health institutions and professionals.

The process of recruiting potential women was developed during my second year. After aiming to study women and their mental health experiences, I classified them into three groups by using mental health experiences as the heuristic tool for segmentation. My ethnography is based on 49 women to understand how they experience mental health. Unlike other types of research, ethnography relies on a few key informants who are competent to provide adequate information about the subject being studied, rather than being concerned with a representative sample (Bernard, 1995). In this regard, a typical strategy commonly used in ethnographic studies is what Fetterman (1993: 43) labels, “judgmental sampling” – a technique that allows the researcher to
select informants by using their own judgement. The process of selection did not take place too early. Bernard (1995: 168) suggests that researchers should allow themselves “to go wash in data for a while, and play the field”. This suggestion is valid in my case because it was necessary for me to adjust myself to the settings that I was not familiar with – the hostel and the rehab centre, while getting to know people before the key informants were selected.

3.1.1.1 SETTING ONE: Baan Pak Chook Chern26 (The Emergency Home, The Hostel)

Group One was at risk of mental health problems and mental illness. As my first setting, I chose ‘Baan Pak Chook Chern’ (The Emergency Home), the hostel for women who have had difficult lives. This temporary shelter is run by the Association for the Promotion of the Status of Women (APSW), a non-profit organisation that provided accommodation, food, basic necessities and support to abused women. It was located in the Donmueng District Area of Bangkok.

From 1981 the hostel has been providing temporary accommodation and services for women and children who are victims of forced prostitution, rape, domestic violence HIV/AIDS, unwanted pregnancy, unemployment, abandonment, economic hardship, physical and mental abuse. APSW is partly funded by the World Childhood Foundation of Sweden. The hostel offers women practical assistance such as counseling, child care services, short term vocational training and recreational activities through a 24 hour service.27

26 ‘Baan Pak’ means ‘Temporary house’ and ‘Chook Chern’ means ‘Emergency’ in Thai.

27 The services also include (1) A women’s clinic, which takes care of expectant mothers with unplanned pregnancies who mainly stay at the hostel throughout their pregnancy (2) The children’s home (Baan Dek) looks after children aged two to six years who accompany their mothers sheltering at the hostel as well as children who are victims of violence and abandonment (3) A nursery provides temporary care for infants of the hostel members. The nursery takes care of infants if their mothers decide to put them up for adoption and helps at the initial stage while their mothers are settling into their jobs and their life (4) The rape crisis centre is full equipped with a medical examination room and a close circuit camera to provide sensitive care and assistance to rape victims (5) HIV/AIDS: the hostel provides shelter and care including counselling services, home visits to HIV patients, healthcare and provision of anti-retroviral medication (6) The women’s education and training centre (WE-TRAIN) offer opportunities for the women in the shelter to undergo vocational skills training according to their interests (7) The youth centre provides activities for young people to encourage gender equality, social responsibility and abstinence from drugs and alcohol (8) Gender and Development Research Institute carries out action research on policy issues including advocacy to advance the status of women (information from researcher’s note, APSW library, annual report 2009 and http://apsw-thailand.org/ReportEN.htm, last retrieved 10/07/2010).
According to APSW's annual report (2009), a total of 520 women\(^{28}\) and children sought temporary shelter at the hostel. Assistance was given to 63 pregnant women who were abandoned by their partners or who had been raped by a family member, friend or acquaintance; 52 abused women from domestic violence; 29 rape cases; and 17 HIV/AIDS cases. At the time I conducted my research (September 2008-May 2009), there were about 70 women living in the hostel\(^{29}\).

One of the common characteristics shared by women in Group One was that they came from a rural area of Thailand. The majority of them migrated to Bangkok to earn more money and support poor families that relied mainly on agricultural farming\(^{30}\) for their income. In terms of occupation, they are categorised as 'labourer' and 'unemployed' such as housewives, cleaners, waitresses, factory and construction site workers. Klausner (2000) comments that these careers are classified as the lowest income profession in Thailand. They received the minimum wage of 203 Baht\(^{31}\) per day according to the Ministry of Labour (2008).

In terms of education, primary education is compulsory up to the age of 12 (Grade 6) in Thailand. The majority of women in this group finished compulsory schooling but decided not to continue their education. One woman (out of eighteen) finished Grade 4, and of these, five women passed their Grade 6 and four held Grade 9. The highest education was Grade 12 (five women). Several women chose to leave school to help their families in farming while some of them got pregnant and became full-time wives and mothers. This was partly the result of poverty and a belief that education did not provide them with immediate advantages.

\(^{28}\) This number also includes women seeking help from the telephone counselling (Hot Line) service.

\(^{29}\) Note that many of them work outside the emergency home. Some went to school, some came back to the hostel for rest at night, while many of women lived outside the shelter and returned once or twice a week to visit their babies/children.

\(^{30}\) According to Phiphitkul (2001), Thai women in rural families tend to enter the waged labour force earlier than men because they are less important compared with men for agricultural labour. They also earn two-thirds of what men receive because of their limited skill as well as their unequal value as female workers.

\(^{31}\) 203 Baht equals to £4.06 at the exchange rate of 50 Baht/£1.
3.1.1.2 SETTING TWO: Soon Sai Yai Krobkrua32 (The Thai Family Link Association)

The second group refers to carers at the rehabilitation centre for the mentally ill (classified as suffering from schizophrenia, bi-polar disorder and depression). This is a rehabilitation unit for patients of ‘Sritanya Hospital’, one of the oldest and biggest state psychiatric hospitals in Thailand. The centre provides different treatments including one-to-one counselling, training for carers as well as other recreational activities that prepare recovering patients to return to the community. ‘Soon Sai yai Krobkrua’ is located in the Physical Treatment building of Sritanya Hospital, Nontaburi Province, a suburb of Bangkok.

Known as the rehabilitation centre, Soon Sai Yai Krobkrua was established in 2003. The centre operates Monday to Friday, from 8.00am to 5.00pm. The majority of patients are mentally ill and are accompanied by those who care for them. Several members are in-patients and come to the centre for a daily treatment programme. This centre is the community network to support people living with mental illness. It is partially sponsored by the government, as well as the pharmaceutical company, Johnson and Johnson Janssen-Cilag Thailand and Indochina.

The centre devotes itself to increasing awareness of understanding mental illness and supporting those suffering from mental diseases and their families. The records showed that the average of educational background for Group Two was a bachelor degree (six women) while five had earned a master’s degree. One out of thirteen attended vocational school and received an accounting diploma. One woman completed Grade 6.

This centre provided rehabilitation activities for patients living with mental illness. I recruited 13 carers of patients which included women who were mothers, daughters, sisters or volunteers at the centre. Some of them came together with the patients. Others I met during an eight week ‘mental illness educational programme’ offered by the centre during March-April 2009. Most of them came routinely to the centre for special counselling sessions with the centre’s senior volunteer, ‘Khun Kusuma’33, known among the members as ‘Mae Ku’ (‘Mae’ means ‘mother’

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33 ‘Khun’ is a polite prefix used to call one’s name. It applies to both men and women and is a polite and formal form.
and 'Ku’ is Kusuma’s nickname\(^\text{34}\)). Among 13 carers, three were recovering patients who had become volunteers at the centre. I usually spent time after work with them, meeting for ice-cream and sometimes dinner. These activities allowed me extra time to observe and learn how they coped with their life in addition to my observations at the centre.

The women in Group Two are carers of patients with mental illness. More than half of my respondents (eight out of thirteen) resigned or retired from their job and became full-time carers. The others were college students and employers. Three of them were hired by the centre as carers.

### 3.1.1.3 SETTING THREE: Women without Direct Contact with Mental Health Institutions

The women in this category were experiencing everyday mental health problems, i.e., worries and stress (cf. Kranz and Long, 2002). My research was conducted in Bangkok and my aim was to move around to different places in order to meet, talk and spend time with women as individuals. Women from my social networks were recruited to understand how Thai women without direct contact with mental health institutions communicate mental health in their everyday lives. The respondents in this group were selected by means of non-probability sampling – opportunity sampling, the sampling strategy that is used in qualitative research “when time constraints and cost force the researcher to make compromises” (Lewin, 2005: 219). In particular, it is used to recruit a group of people that the researcher has established a relationship with and those who agreed to be part of the study. However, because this opportunity sampling is purposive, “it is important to acknowledge the undoubted biases that will occur from this approach” (Lewin, 2005: 219). It is, however, one of several methods used in the research project and there is thus mitigation.

My informants aged between 20-40 were living in Bangkok. This particular age group was identified as a critical age exposed to the risk of experiencing mental illness, according to the Department of Mental Health Planning, Thailand (2006). Eighteen women were approached

\(^{34}\) In Thailand, people use their nickname for informal correspondence, for instance they use nicknames for families and friends as well as colleagues. Using a nickname is one way to show a level of intimacy with someone.
using different strategies. Those I had known previously were told about my research and asked if they wished to be part of this study. Others were recruited in different ways. I took advantage of new communication technologies to expand the opportunity to develop a relationship with women by using mobile phones, texts, e-mails, msn chats, hi5.com and facebook.com as women connected with the world via these communication tools in their everyday lives. This fact strengthened what Dahlgren's (2010: 20) challenge of the 'public sphere' (Habermas, 1989) that its normative model has been transformed to “digital media public spheres” which are plural, dispersed and hybrid.

Among Group Three, nine were employed, four women were business owners and freelancers, three were students and two were housewives. For those who were employed, their salaries ranged between 10,000-80,000 Baht (£200-£1,600) monthly. This salary range allowed the majority of the women to have a good quality of life. Those who were unemployed also enjoyed a financially secure life as they received support from their families. Despite the fact that I recruited women from different occupations, educational backgrounds and marital status, I am aware of the limitations of my research. The nature of small-scaled research of ethnography meant that my selection could not cover other groups/sub-groups. There is a tendency to omit voices and opinions of others who are not part of a network of friends and acquaintances of the researcher. However, as Bryman (2008) points out, the researcher needs to ensure they gain access to wide range of individuals, while the selection of choices is based on the research question. The intention of recruiting this group was to specifically understand women without direct contact with mental health institutions who may have common mental health conditions compared with those living in the hostel or seeking help from the rehab centre. In addition, as O’Reilly (2005: 39) suggests, the choice and the size of sampling in ethnographic study should be made “on the basis of practical limitations” which refer to accessibility, time and financial constraint in my case.

Women in Group Three had a higher educational background when compared with the other two groups. Eleven women had their bachelor degree, five had a master degree and one had been awarded a Ph.D. in Education. As a result, these women with better opportunities to have secure and lucrative jobs in Bangkok such as business, government, lecturing and employment in multi-national companies. The intention to recruit women from different socio-economic profile will give extensive picture of the cases (Thai women living in urban Bangkok) ‘within cases’ (or sub-cases - women living in the hostel, the rehabilitation centre and women with no direct
contact with institutions associating with mental health care). As Hammersley and Atkinson (2008: 35) describe, ethnographers select people under research not only by the particular cases relating to research problems but also “usually sampling from the data available in the case”. This is because “no setting will prove socially homogeneous in all relevant respects, and the adequate representation of the people involved in a particular case will normally require some sampling” (Hammersley and Atkinson, 2008: 37). Recruiting Thai women from different backgrounds thus allowed this study to have a wider relevance (O’Reilly, 2005) in observing Thai women (with different socio-economic profiles) in their meaning constructions of mental health.

3.1.2 The Challenge of Gaining Access

Any initial journey into fieldwork begins when the researcher enters into social settings that are relevant to the research problem in which s(he) gets to know people by to listening to and hearing what they think and say about their own experiences (Rubin and Rubin, 1995). However, this process is one of the most complex and difficult stages. As Hammersley and Atkinson (2008: 41) note:

“Gaining access is a thoroughly practical matter ... achieving access is not merely a practical concern. Not only does its achievement depend upon theoretical understanding, often disguised as ‘native wit’, but also the discovery of obstacles to access, and perhaps of effective means to overcome them, itself provides insights into the social organization of the setting or the orientations of the people being researched.”

In my practice, I experienced difficulties in what Feldman, Bell and Berger (2003) call, ‘a rude surprise’, where the researcher is advised to expect the unexpected before gaining access, particularly when getting into the hostel and the rehabilitation centre which are considered ‘closed settings’. My role in the field followed an overt route that clearly identified my intention to be an open (overt) researcher. Overt research, as explained by O’Reilly (2005: 60), is “conducted openly with the researcher’s identity being known to all participants”. This role was seen to be a means of access which allows the researcher to learn about people through empathy and experience. I chose to perform a “participant-as-observer” role (Bryman, 2008: 410) where the researcher engages in regular interaction with people and participates in their daily lives. In my practice, I realised that the researcher’s role and identity should not be limited to one role and may need to be developed over the course of fieldwork. I saw that being only an observer in the
field seemed not to confer permission to develop relationships and build up trust with the women. Instead, I performed various roles in the setting, e.g., researcher, volunteer and teacher. Because ethnography involves interaction with people, the researcher’s role has to be flexible and changeable. Marvasti (2004: 52) gives an example from his own fieldwork:

“I might have begun a day with the peripheral role or just listening to the clients’ conversations in the parking lot. I could then go on to the more active role of a volunteer. The day could have ended with me assuming the completely participant role of the shelter’s night manager.”

3.1.2.1 Gaining Access to the Hostel

After I chose to study women’s experience of hardship and to learn how they dealt with difficulties, I started to search for potential hostels on the Internet. The result discouraged me as there were so few and the information was not up to date. However, I found UNIFEM35, a website suggesting organisations in Bangkok that helped women who were victims of violence, abuse and poverty. Among these, the Emergency Home (Baan Pak Chook Chern) was cited repeatedly. I called and tried to gain access, although I anticipated that it would not be easy for strangers to get in. After being referred to a couple of people, I was fortunate to have a formal meeting with APSW Director, Methinee Pongvej, who granted me later permission to conduct my research in this hostel.

I later gained access into this closed setting via ‘top management and senior executives’, the means that Bryman (2008) indicates as one way to help the researcher get into closed settings. Later, the Director introduced me to Korawin, the Team Leader in the Social Work Department; the Baan Pak Chook Chern hostel was the major function operated by the department. She was a central point of contact and became my ‘gatekeeper’. A gatekeeper is one of the most important people in an ethnographic study with “controls over key sources and avenues of opportunity” (Hammersley and Atkinson, 2008: 27). In this case, the hostel is a private setting where boundaries are marked and may be not easily penetrated without the helping hand of gatekeepers. Korawin, known as ‘Pa Tui’ (‘Pa’ means aunt and ‘Tui’ is Korawin’s Nickname),

introduced me as ‘Pi Pam’ to her staff and the members in the hostel. (‘Pam’ is my nickname in Thai).

In the hostel, I was allowed to use the office facilities and was invited to join in the free meal for staff. I usually had lunch at the hostel and socialised with staff. Talking with them provided me with a basic (sometimes insightful) background of the hostel. During my first two weeks, I noticed that there were some foreign volunteers around the hostel. Their presence inspired my idea to do voluntary work parallel with my researcher role and expand the opportunity of making contacts with women. Pa Tui was pleased with me and allowed me to shadow her staff. Another task I was assigned, was to help teachers at the Children Home. Being a volunteer was not only my strategic approach to get closer to the women, but also allowed me to give something in return to the organisation (for the fact that I regularly used its facilities and had a free meal, see debates about exploitative potential of ethnographic research in Hammersley and Atkinson, 2008: 217-218).

I started my fieldwork in September 2008, feeling awkward and insecure during the first few weeks. I started my work by observing how women performed their everyday tasks (how they fed their babies, played with children, chatted in groups, cooked, cleaned, took a walk, read comics, read magazines), while I helped staff with some administrative tasks in the office such as filing, typing documents, and conducting the hostel’s tours for visitors. I was also assigned and permitted by APSW to help translate some documents into English and helped as a translator when foreigners needed to interview members. These tasks allowed me to slowly learn about their backgrounds.

I spent time with the women early in the morning and late afternoon when they were free from their routine work and observed them when they usually got into groups and sat on benches outside and in the corridors. Many times, I overheard their discussions about their hardships. Although I met them everyday, it was not easy to initiate the conversation. Indeed, it was rather uncomfortable because I did not know what topic I should bring up. This situation made me realise that time is an important factor in ethnography that helps people settle in and become

36 ‘Pi’ is a Thai kin term for siblings. This word is not differentiated by sex but age. ‘Pi’ is used for an elder sister or brother and applied in close and informal relationships. The seniority system also dictates that Thais calls older people ‘Pi’ and younger people as ‘Nong’ (younger sisters/brothers). These terms can also be used to develop into family. ‘Pi’ and ‘Nong’ can include those connected biologically and socially. With this system, it can easily develop friendships and relationships and such intimacy could turn a stranger into a family member later on.
familiar with the researcher and vice versa. As O'Reilly (2005: 93) makes clear, the researcher needs time in the setting: "when you have hung around long enough, you become part of the setting, part of the background that others take for granted".

However, this difficulty was lessened after I spent long time in the field and participated in various activities with the women. The problem was also helped by my second role at the Children's Home, the place where members called me "Kru Pam". This Children's Home was the support function for women who had children. It was a small centre inside the hostel area that acted relatively like a day care centre for children aged two to six. Mothers who were members of the hostel dropped off their children in the morning and came to pick them up in the afternoon. My role was to help teachers take care of children and meet their mothers. Using the advantage of knowing the children to initiate talks was a tactic that helped me to open conversations with their mothers. Over the course of the research, I had many more stories to generate discussions with members of the hostel.

My relationships with the women and staff at the hostel had deepened through increasing familiarity. I started to engage in many activities and chatted with the women while my observation continued. I spent three to four days a week, including some weekends, at the hostel. The weekends were a form of quality time when the women were free from work and had more time for themselves and relaxation. I used this opportunity to mingle, observe, and learn about their leisure activities. Sometimes I chatted with the women for the whole afternoon while they breast-fed their babies, watched television, played with their children, or I let them teach me how to paint nails or prepare meals with them at the children's home. These were routine activities but extremely important in establishing conversations and building up relationships.

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37 'Kru' stands for teacher, particularly used for lower education (Grade 1-12).

38 Note that I went to the hostel early in the morning and went back in the evening as I was not allowed to stay overnight at the hostel. There was only one small room for night shift staff.
3.1.2.2 Gaining Access to the Rehab Centre

I firstly anticipated that it would be difficult to gain access this group because of the particularly sensitive ethical nature of mental health practice. However, my previous background as a PR staff member from the Department of Mental Health gave me an advantage to connect with my old colleagues who were on the psychiatric staff and advised me of the best approach to access the setting. As Bryman (2008) describes, one tactic to gain access is to use friends, contacts and colleagues to help. I made phone calls and appointments with people from my network and asked them if they recommended any places to observe the everyday life of people living with mental illness. Several people suggested visiting the Thai Family Link Association (Soon Sai Yai Krob Krua), which is a rehabilitation centre for psychiatric patients, located at Sritanya Psychiatric Hospital.

Gaining access to this rehab centre involved many restrictions that required a long pre-approval process. My first approach was through one of my previous colleagues, a psychiatric nurse who had been my co-host in one radio counselling programme from 2005. She introduced me to another person in charge of the Research Department and we discussed my intentions to observe at the centre. I learnt that the hospital had a highly strict ethical protocol for researchers to follow in conducting a study inside Sritanya Psychiatric Hospital. The researcher had to deliver an oral presentation to the committee about her/his project to get permission for access from the hospital’s ethics committee. The formal confirmation letter from the committee was an important document that allowed me access to the centre.

At the centre, I was introduced to Mae Ku, a senior care-taker who ran the rehabilitation activities section. Mae Ku had been a volunteer since 2003 when two of her sons were diagnosed with schizophrenia and she retired from her work to take care of them. She has devoted herself to this centre and worked as a full-time volunteer. She introduced me to the staff, patients and carers as “Pi Pam – she is a student. She came here to learn from us”. I personally liked this introduction as it emphasised the goal of the ethnographer in entering a setting to learn from people and their culture.

With a similar approach to the hostel, I also worked as a volunteer in this rehab centre. It was Mae Ku who needed my help in running the rehab handicraft activities and my days were filled with everyday challenges. Although the patients who came for service were not classified as having acute symptoms, dealing with psychiatric patients and their families was extremely
difficult. In doing so, I needed to understand the nature of mental illness for better observation (to understand that schizophrenia patients heard ‘voices’, that they always spoke to themselves, that they had hallucinations, that depression disorder patients sit silently without eye contact, and that bi-polar patients had extreme joy during their ‘mania rising’ stage). It is one of the most important aspects in ethnography in Silverman’s (2008) view that the researcher seeks to see things in context and learns about the environment of the people being researched.

After a couple of weeks of observation, I realised that my background knowledge of mental illness was not enough to help me to understand the setting. I quickly learned about mental illness through frequent chats with staff at the centre and searched the Internet. I also registered on the eight week mental illness educational programme (Saiyai Workshop) run by the centre for new carers. The course ran every Saturday in March-April 2009 at Sritanya Hospital between 9:00-12:00am with a 200 baht registration fee. I found this course useful because it enhanced my understanding of mental illness, its causes, symptoms, treatments and medicine. Attending this course was another opportunity to build up a network and meet carers of the mentally ill. Not only did this course gave me chance to observe carers, it also allowed me to speak the same language as the people in this centre (I understood better when people discussed their psychiatrists, prescriptions, symptoms, generic and specific name of the medicines).

I spent three to four days a week at the centre. Most members came late morning. Some of them were accompanied by their carers to attend different activities, i.e., ceramics works, English conversation, yoga, music, karaoke, and Norn Tua Lek (Reading and Writing Club). I went to the centre at around 8am, socialising with staff and helping them with administration, i.e., typing reports, filing records. When members arrived later in the morning, I participated in activities with them. I helped Mae Ku to facilitate talks and comfort the carers. My role was to listen and take notes of conversations about patients’ histories. This duty allowed me to closely observe them while listening to their illness experiences from the carers’ own narrations.
3.1.2.3 Gaining Access to Women in Group Three

My third site is relatively different in nature from the first two settings. In this third setting, I did not have to seek permission from people in authority to gain entry. I approached this group as individuals. The focus was on how to recruit them and to what extent I would be able to be involved in their everyday activities. Because the nature of this setting did not allow me to do observation with a number of respondents at the same time, I had to divide my time and adjust myself to the informants.

For this group, time management was the main concern. The difficulty came from how to spend quality time with them as individuals while I was committed to observing the other two settings. I therefore shared my weekdays with the first two settings. However, my timetable was flexible and I adjusted my weekly schedule depending on situations and special events.

The majority of the women in Group Three were occupied with their office work on weekdays. However, I exchanged this limitation of time by sometimes going to have lunch with them near their offices. Sometimes, I met them after work, joining them for shopping, exercise, or coffee or dinner. These casual appointments were helpful in entering their private sphere and learning about their lifestyle patterns. In addition to ‘hanging out’, I developed a rapport with them by means of new technology. I exploited the use of mobile phone, mobile texts, electronic mail, msn chats, hi5 and facebook to create a sense of everyday chats with them. Hi5.com and Facebook.com were the personal webpages where people on the ‘friends list’ were able to surf through their personal profiles, journals, photo albums or any other notes they shared with the public. New technology allowed me to talk and observe women beyond the limitation of space and time. It was also a gateway to establishing a relationship with them before the focused conversation took place.

However, adjusting my timetable to fit their schedule seemed to be a complex task. I found it rather difficult to roam around Bangkok and met my respondents in different places while my concern was to find time to take notes on what I had just observed. As suggested by Denscombe (1998: 151), “field notes are urgent business and the ideal practice is to write during actual observation”. However, I realised that this was not always possible in my case. I usually went through the note-taking process at night before going to bed when I could give full concentration to my notebook.
I encountered many obstacles as well as dealing with a tight schedule when researching three groups of women. Due to the fact that I had nine months in the field, it was most important to be prepared and flexible in my schedule to maximise the contacts with women. However, what I received in return was the data that helped me to gain a better understanding about women's lives and their perception of mental health. The richness of data refers to the depth and fullness of details or, what Clifford Geertz (1973) described as ‘thick description’, another trademark of ethnography.

3.1.3 Participant Observation: From a Stranger to an ‘Insider’

Participant observation characterises most ethnographic research and is central to effective fieldwork – in particular, to generating data from the field (O'Reilly, 2005). The researcher needs to enter the social situation, not only for engaging in activities, but also to recording their observations while they interacting with people in the setting. As Bernard (1995: 137) explains:

“Participant observation involves establishing rapport in a new community; learning to act so that people go about their business as usual when you show up; and removing yourself everyday from cultural immersion so you can intellectualize what you’ve learned, put it into perspective, and write about it convincingly.”

The term participant observation refers to research in which participation is necessary. It helps researchers to obtain acceptance into a setting, record data while maintaining a professional distance. Participant observation enhances the quality of data obtaining from the setting in all aspects of people’s lives in what Gunter (2000: 52) calls an “in-depth study of the whole individual”. However, conducting participant observation is unavoidably problematic to the extent that it relies solely on the researcher’s own judgment that makes the study very subjective (Bernard, 1995). There is also a dilemma when researchers and the researched become familiar and have many things in common such as lifestyle and taste that the researcher will take events and behaviours for granted, leaving important data unnoticed and unrecorded (Fetterman, 1993).

I began my observations from the moment I started the fieldwork and learned about the communities and women by collecting a range of data about their everyday activities. As Spradley (1980: 33) notes, the types of observation will change during the course of fieldwork. It will begin “by making broad descriptive observations, trying to get an overview of the social situation and what goes on there”. For women in Groups One and Two, my additional role as a
volunteer helped me to have more contact with them. Gradually, they became comfortable with my daily presence. At the hostel, when women saw me, they smiled, called my name or came by to say ‘hello’ before they resumed their daily activities. The longer I spent time in the field, the more I got used to the settings. I could observe women’s daily lives and learn about their lifestyles. By adapting myself, I learned to knit and do handicraft work as women in the hostel practised this for modest payment. I started to read the magazines they liked to familiarise myself with the content in their favourite periodicals and to understand their topics of interests. I searched the Internet for trivia on the TV stars they admired (the media consumption patterns of the three groups is discussed in Chapter 8) and recall the details from my search to initiate conversations with my respondents. In the rehabilitation centre, I learned how to sing their songs and danced with them in the music room. I also started to learn yoga and exposed myself to different cultural traditions which helped me generate additional topics of conversation with the women in Group Three.

The process of becoming accepted was developed through engaging in these everyday activities. Soon, some women started to share their personal stories. The nine-month observation allowed me to witness many incidents that happened in a women’s life (i.e., from early pregnancy until childbirth, the senior year student who became a new graduate and then employee). However, as a Thai researcher in Thailand, maintaining a professional distance and complete objectivity proved to be difficult. The concern of the researcher’s subjectivity is also discussed by Malinowski (1922), namely that there is a high level of doubt about claims to objectivity in ethnography. This is because writing ethnography is the product of “creative work in its own right” (Denscombe, 1998: 73) that reflects the reality of the situations from the experiences of the researcher. This is why the methodological complementarily provided by discourse analysis offers a counterbalance in my examination of mental health constructions that I will discuss in the next section. It is important, in the complexity of mental health construction, to remain sensitive to the interplay of mediated and private constructions.

In my case, I had engaged in women’s unfortunate lives and secrets. When trust was gained, the role of the researcher was transformed to a more intimate level and women tended to be more open. It would be difficult in my practice not to show sympathy when they shared their stories. I also found it emotionally difficult to leave them at the end of my fieldwork. This is accepted as the dilemma of ethnography when the researcher is immersed in the life of people under research for a certain time period. It has been argued that it is critical to maintain distance from the
researched in order to secure the objectivity of the researcher based on the principles of positivism (Elliott, 1971; Hammersley and Atkinson, 2008). I also realised that the distinction of ethnography is that the researcher is allowed to enter into the territory of people's lives and to see the world from their individual point of view. Therefore, it is a matter of some controversy as to whether the researcher can be truly objective in ethnographic research. Goffman (1961, cited in Fielding, 2008: 269) expresses his belief that one way to understand different cultures is not to be too objective: the researcher needs to get close to people and look inside their world:

"Any group of persons-prisoners, primitives, pilots or patients – develop a life of their own that becomes meaningful, reasonable and normal once you get close to it. And... a good way to learn about any of these world is to submit oneself in the company of the members to ... [their] daily round."

This recommendation encourages ethnographers to appreciate the world of others while they are in their settings and realise that they are part of the world that they study (Silverman, 2008). Indeed, I am convinced that knowledge could be obtained from the subjective immersion while there is no way of understanding people without being part of their lives. I am also aware that this is an aspect of ethnographic research that probably remains impossible to resolve. In turn, I started to feel that the close relationship and the difficulties of detachment encouraged me, as a researcher, to complete this research to articulate the women’s voices. In a response to this concern, I also adopt the complementary method of discourse analysis to balance the results from subjective constructions and to draw wider systems of meaning constructions of mental health. Discourse analysis is used in this study to elicit the meanings of mental health constructions embedded in the mediated representations.

Participant observation not only allowed the researcher to become accepted but also helped in the selection of informants. This method also helped me justify the kinds of questions to be asked in the different groups, who should be selected and helped me to decide when to interview each woman.
3.1.4 In-Depth Interview: Trust and Ethical Considerations

The in-depth interview is one of the main data collection tools in qualitative research because of its flexibility in discovering new realms of meaning from people's point of views. This technique allows people to freely explain and express their hidden thoughts (Fetterman, 1993). The open-ended character of conversation is a preferable technique which can be regarded as "license for the interviewees simply to talk about an issue in any way they choose" (May, 2001: 124). As Punch (2005) notes, the in-depth interview is a good way of enabling better understanding of people's perceptions, meanings, definition of situations and constructions of reality in their terms.

This method is considered a supplementary technique to participant observation and is used as part of comprehensive methodological framework alongside discourse analysis. Berstrand and Hughes (2005) illustrate that it allows interviewees to express themselves at their own pace and through their own words. In this study, in-depth interviews were useful by using 'informal' and 'unstandardised' patterns. This provides quality depth of data by allowing women to elaborate their experiences and "respond in a leisurely way" (O'Reilly, 2005: 116). The casual conversation is the strength of this method as it eliminates the sense of discomfort which usually occurs during other interviewing techniques such as formal or structured interviews. The use of in-depth interviews is an efficient way of probe women about their feelings. As May (2001: 120) points out, this method allows the researcher to "get rich insights into people's experiences, opinions, values, aspirations, attitudes and feelings".

In-depth interviewing allowed me to observe the non-verbal cues which could provide an emotional signal where an eye for detail is paramount. Mental health is a sensitive topic that involves people's feelings and life context. It is important to see how women react when the topic of mental health is raised and how they express their feelings in telling of concerns and hardships. The in-depth interviews can also help researchers to ensure the validity of data gained from participant observation. This point of strength is useful because it helps to clarify unclear information, cross-examine previous findings and collect opinions towards mental health issues.

Despite the fact that in-depth interviews offer the most natural situations for data collection, there are difficulties in conducting them. Because the character of 'free' conversations means that the interviewees can talk about anything, the researcher can be distracted from the topic they wish to study (Gray, 2009). Another situation may occur if the researcher dominates the talk and
leads answers in the direction of their hypothesis. On the contrary, the role of researcher is to encourage respondents to elaborate and express things and also listen carefully to the words in order to picking the meanings and interpretations behind them. This pragmatic (i.e., interactional) technique also articulates with the method of discourse analysis that is designed to explicate the unseen meanings, evaluation, frames and schematisation that are embedded in the mass media.

In my research, when the women became familiar with my presence after several months, I started to conduct in-depth interviews. O'Reilly (2005: 123) commented, “in-depth or focused interviews often take place after a period of participant observation has sensitized the ethnographer to the setting”. I started to shape the analysis by reviewing my notes in detail about impressions and reactions to certain events. After gaining some insight from the field, the employment of in-depth interviews was necessary as a ‘one-on-one’ tool to explore deeply the details of the researched topic. It also became clear to me to see how participant observation and in-depth interviewing began to merge at this stage of my fieldwork.

Trust was the main component for me as a researcher in order to obtain sufficient rich and deep information. When trust was developed, the women seemed to gradually reveal the secrets of their lives particularly, when the in-depth interview occurred. At this point, I applied the “guarantee of confidentiality” (Hammersley and Atkinson, 2008: 110) by making sure that no one else could know which informant had said what that would be attributable. To cover their identities, I changed their names and retained anonymity for them throughout the thesis. However, for the purpose of better referencing between their alias names and the groups that they belong, I changed their names to new ones with one, two and three syllables according to their groups – for instance, ‘Pin’, ‘Joy’ – Group One, ‘Malee’, ‘Sandy’– Group Two, ‘Kinnaree’, ‘Jintana’ – Group Three.

Trust was essential in building relationships, particularly in the case of Pin (39, raped and abused). I would like to underline her story and discuss my ethical concerns in conducting this ethnography. I interviewed her one afternoon in November, 2008 after our frequent contact for three months. Our conversation took place in what is described as a ‘free flow atmosphere’ that gradually allowed me to enter into her private sphere. She told me that it was a time of great suffering for her when she discovered that her husband raped her daughters (note that she has
two daughters, 16 years and 3 years and both of them were raped by their father). In her life, she had been under stress because of violence and sexual abuse from him.

After this conversation, I remembered that it was one day in April 2009, the time of my last month at the hostel. Pin came to sit beside me with tears. I sensed that something was wrong. I listened carefully to what she was going to explain. I softly touched her shoulder and we stayed silent for a long time. Without looking at me, she whispered that there was a reason in the past that made Pin thought of suicide and it was because she was raped when she was nine. This wound was a trauma that she had had to live with for 30 years without telling anyone.

I could not deny that I felt emotionally engaged and depressed to learn her secret. When this part of her life was revealed, I felt strongly empathetic while having an uncertain feeling to what extent I should share her experience in this study from the professional standpoint. Seeing the paradox of professional-emotional engagement as well as practices from the balance of trust, disclosure and degree of confidentiality carries critical ethical aspects. It reminded me to re-think the ethical dilemma and the authorial position of the researcher that (s)he is in the position to make choices in what to study, interpret and communicate (Goldbart and Hustler, 2005). There is a serious concern for the researcher of sensitive topics such as mental health because it involves the process of "making public things that we are said or done in private" (Hammersley and Atkinson, 2008: 212) while the respect for one’s privacy should be another concern to be remembered. Researchers have to be aware of their role by “becoming more thoughtful, more informed, more reflexive, and more critical in their own actions, perspectives and responsibility” (O’Reilly, 2005: 59). As Cooper (2008b: 19) reminds us, reflexivity is used to build up a more critical sensitivity towards social research that asks a researcher to be aware of their role “whether we are justified in doing it”.

In Pin’s case, I was aware that the only possible reason why she revealed her story was because she trusted me (that I would not tell anyone her story). Thus, sharing her piece of life in this research could be seen as an abuse or a manipulation of trust and this dilemma has become my significant concern in this ethnographic report despite the fact that I employed alias name together with her verbal consent to be part of my research. Pin’s secret brings me to acknowledge what Cooper (2008b: 18) suggests that field researchers should consider a process of “questioning ourselves” on our role. In my ethnography, a number of ‘personal stories’ were revealed after trust had been developed while I felt I must be responsible for what I wrote about
Pin (and other respondents). The story of Pin is one among several examples that convinced me to rethink the implications of ethnography and to balance the effects of the researcher on the study. What I mean by ‘balance’, following Hammersley and Atkinson (2008: 15), is the recognition of reflexivity that carries a critical consideration in ethics. As they argue, all ethical considerations cannot be completely resolved by appeal to guidelines or rules but serve as reminders that “the exclusive, immediate goal of all research is, and must remain, the production of knowledge”. While the ethical dilemma about the level of disclosure and confidentiality as well as the intensity of the human struggle to make sense of traumatic experience remain, I used Pin’s voice to demonstrate the implication of trust in this report by trying to minimise her narrative as less descriptive as possible. I decided to reveal part of her story based on what Goldbart and Hustler (2005: 16) suggest, the purpose of ethnography is to “tell the story and let the voices be heard of less fortunate or marginal members or less visible members, within society”. Pin’s case was the lesson-learned about ethical consideration of author’s role in the research that allows the ethnographer to think, rethink and decide how to enable the voice of the respondents from marginal groups to be amplified in ways which are less likely to be interpreted as the manipulation of trust. Researchers have to prepare themselves for any possible challenge which results from the research. As O’Reilly (2005: 211) suggests, researchers need to think about “what we read, what we write and acknowledge that we are part of the world we study”. After that, Fielding (2008: 269) makes clear, the role of researcher is “stepping back to make a more detached assessment” and seeing the world in more neutral ways in order to transfer what (s)he found with the most possible view of objectivity.

3.2 DISCOURSE ANALYSIS: THEORY AND PRACTICE

Although there is no absolute consensus on the definitions of discourse analysis, it can be said that discourse analysis is a qualitative research method that offers ways of challenging our thinking about many aspects of mental health particularly when it is mediated (Cheek, 2004; Harper, 1995). While its origins are rooted in the field of linguistics, the method has been widely applied within media and cultural studies, and is best understood as a field of research rather than a stand-alone analysis (Punch, 2005). Despite its popularity in many disciplines, there is diversity
and persistent confusion within the nature of the term ‘discourse analysis’\textsuperscript{39}. My goal in this section is not to unpack it because I believe that it is stored with a multi-perspectival approach from interdisciplinary frameworks. Therefore, there will be more than a single set of rules to make use of it. For this study, I will employ discourse analysis to deconstruct discourses in the mass-mediated representations of mental health and draw wide systems of representations in four selected women’s magazines to complement ethnography in the understanding of mental health constructions from the mass-mediated side. In the contexts of mental illness and stigmatisation, in particular, my research aims to address questions of framing, silencing, dichotomising, opposition and exclusion. In contrast to other text analyses (such as content analysis that is focused on quantitative explanation), discourse analysis has its value in observing the ways in which reality is framed by the manifestation and formulation of “texts within discourses” (Grant, 2007: 153). This methodology helps to explain the epistemic force (and thus power relations) of communication (Foucault, 1971) that is ruled by procedures of exclusion. This characteristic places discourse analysis in a different light to other methods that also examine media texts.

As Cowan and McLeod (2004) state, discourse analysis is also an effective method of understanding the complex phenomena in the health disciplines. This includes the systems of communication as to what constructs ‘truth’ and ‘reality’ about health in the way the textual or content analysis could not. This is because “reality is seen as the object of constructing practice that involves with the network of power” (Breheny and Stephens, 2003: 171). When power comes into consideration, as Hare-Mustin (1994: 21) explains, it brings a “network of practices, institutions and technologies that sustain dominance and subordination”. Discourse analysis is a way of understanding the system of exclusions, of voices and groups at the margins of society that may be difficult to recognise. It has a high sensitivity towards often implicit epistemic framings.

\textsuperscript{39} The confusion of the terms used in discourse analysis creates critique for utilising the terms “discourse/text/narrative/theme/story as if they are interchangeable” (Cheek, 2004: 1146).
3.2.1 Discourse and Texts

The term 'discourse' has various meanings and uses. Fairclough (1995: 2) identifies two main uses of the term. The first, very general, is more focused on the use of linguistic units such as language, grammar, syntax, and sees discourse based upon "the assumption that language is an irreducible part of social life, so that social analysis and research always has to take account of language". The second use of the concept of discourse is more closely associated with the work of Foucault (1971: 18) that is less associated with the linguistic features of the text but focuses on discourse as a construction of reality, based on the mechanism of epistemic order, dichotomisation, opposition and exclusion: "discourse as a social construction of reality, a form of knowledge". In this study, I tend to adopt the latter route, following Foucault (1984), seeing discourse as an epistemic order that organises, classifies and allocates things to one another which, as a result, determines how people make sense or refer to things that they take for granted. As Cheek (2004: 1142) illustrates the meaning of discourse, "[it]consists of a set of common assumptions that sometimes, indeed often, may be so taken for granted as to be invisible or assumed". Lyons (2000: 349) proposes three arguments of approaching media representations with the use of discourses:

"(1) Individuals are socially located and gain their beliefs about health and illness from the discourses and constructions that are available to them; (2) media representations of health, illness and disease reproduce meaning concerning health and illness, for lay people and professionals alike; and (3) media representations mediate individuals' lived experiences."

I focus less on the technical use of language, but rather use discourse as a comprehensive tool to approach mental health in their mediated meanings through text and subtexts in women's magazines. The approach of my discourse analysis is to explore the connections between 'content' as a 'product' from discursive practice exercised in social and cultural processes, partly from power and knowledge, that operates within the understanding of mental health as a form of making meaning. Discourse in this study is involved with the dynamic processes, systems of representations and the repertoire of mental health interpretations that construct mental health to understand how the episteme of mental health is ordered or framed (see Danaher, Schirato and Webb, 2002; Chimombo and Roseberry, 1998).

To discuss 'text' (a sub-category of discourse) as the articulation of discousal practice, contemporary social science has been widely influenced by the claim that "the world is socially constructed and emphasises the role of the texts in the construction of the social world"
(Fairclough, 2003: 8). Even though texts can be seen to have different meanings, I use ‘texts’ in this study to refer to written and printed materials in 121 related mental health articles in four Thai women’s magazines. Texts, in this study can be organised according to several criteria, the text type and genre, as well as the content and theme represented.

As Fairclough (2003: 3) points out, ‘text’ and ‘discourse’ are closely related to each other. He states that:

“Any analysis of texts which aims to be significant in social scientific terms has to connect with theoretical questions about discourse. Indeed, no real understanding of the social effects of discourse is possible without looking closely at what happens when people talk or write.”

This notion is similar to that of Talbot (2007: 10), “text is part of the process of discourse and it is pointless to study it in isolation”. However, as Hartley (2007: 74-75) reminds us, discourses are not the same as texts – texts (and textual analysis) can be used to follow the moves of discousal practice “by showing how particular texts take up elements of different discourses and articulate them (that is, ‘knit them together’)”. He states, “although discourses may be traced in texts, and although texts may be the means by which discursive knowledge are circulated, established or suppressed, discourses are not themselves textual” (Hartley, 2007: 75). Therefore, while discourse is perceived as a process, text is understood as an observable product. Garrett and Bell (2005) also point out that when a researcher is discussing discourse analysis, it may refer to the interpretation of text to understand the processes of the social meaning-making.

2.2.2 Representations and Exclusions

Foucault’s discourse concept is fundamental. From Foucault’s (1980; 1984) view, certain discourses will operate in some ways to marginalise or exclude others, which frames the effect of power relations in representations. As Punch (2005: 222) emphasises, “the concept of power is vital to discourse analysis by way of the theoretical connection between the production of discourses and the exercise of power”. Foucault clearly describes in his book, The Order of Discourse40 (1984), procedures of exclusion operating in discourse which lead to discourse being reproduced. The first one is the taboo of the subject, which is a distinctive form of prohibition

40 The original version is 1970.
that makes it difficult to speak on topics such as sexuality and madness. The second exclusion is that of rejection as people view the mentally ill as 'mad' or 'insane' and are therefore treated as unimportant and ineffective (see Foucault, 2009[1961]). The last principle is the system of exclusions between true and false which gives legitimate power to those who are seen to be 'experts' and can speak of the 'truth'. Truth, from experts, is deeply characterised by social practices of which Mills (2003: 58) gives examples: "universities, government departments, publishing houses, scientific bodies and so on". Foucault’s approach to representation focuses on the meaning and production of knowledge through the practice of discourse and to the way language works to organise knowledge, power and practice41 (cf. Hall, 2001; Mills, 2003; Sheridan, 1980). His approach is inclined to be historically specific and sees different forms of 'power and knowledge' as always originating in certain contexts and social meanings. Analysis of discourse is an alternative angle to help equalise the power relationship and free individuals to have more resilience to control their own lives. In addition, as Breheny and Stephens (2003: 171) argue, the understanding of discourses is vital to any examination of mental health: "it [discourse] involves appreciation of the way in which attributions do not simply reflect objectively real causes of symptoms but actively construct individual responsibility for health".

Fairclough (1995: 26) describes, "representation as a clearly a discourse matter, as we can distinguish different discourses, which may represent the same area of the world from different perspectives or positions". In other words, discourses and representations are ways of constructing aspects of the world: "the processes, relations and structures of the material world, the mental world of thoughts, feelings, beliefs and so forth" (Fairclough, 1995: 124). Through representation, more than one discourse, viewed as a cluster of themes and ideas that are used together to frame particular constructions (Breheny and Stephens, 2003), can be projected, which may complement, compete and dominate one another. Analysing media texts in this direction is a representational point of view that Fairclough (2003) describes as the emphasis on the inclusion and exclusion of elements in the events. Silverman (2008: 223) points out, discourse analysis studies how "inequalities are constructed, made factual and justified". It will also be interesting to see how today's media grant authoritative power of representation to create their social

41 Foucault's works illustrate discourse concerning mental illness which constructs people's concepts and perceptions of what mentally ill persons are like, including their symptoms, behaviours and the way they should be treated. In his view, discourse has become a solid framework for the "justification for the power of practitioners concerned with the mentally ill and for their treatment regimes." (Bryman, 2008: 499)
judgment on the process of selection and de-selection to observe the major circulation of social shared meaning (Talbot, 2007).

Discourse analysis involves seeing and analysing meaning from the text that embedded mental health which Luhmann (2000) calls – schematisation. Fairclough (1995) describes the usefulness of this method of approaching media texts to see the assumption behind the texts that relate closely to the construction of the episteme and reality from Foucault’s (1971) viewpoint. As Fairclough (1995: 5) reminds us, “representations, identities and relations are key themes and assumptions that structure the text and will be simultaneously representing, setting up identities and setting up relations”. Discourse analysis thereby allows the researcher to look at the way texts are organised and analyse how things are said. However, it also prompts the researcher to read beyond the text by searching for silences or gaps to find alternative accounts which are excluded by omission in the organisation of a discourse that serves a particular purpose (Toynbee and Gillespie, 2006). With this advantage of discourse analysis it allows the researcher to assess the mass-mediated systems of representations to draw wider as well as embedded meaning constructions of mental health.

2.2.2.1 The Selection of Thai Women’s Magazines

As in all qualitative methods, the researcher has to have a reasonable and systematic process of how the data in the study is selected. For a discourse analytical approach, it is crucial to provide such explanation. As Cheek (2004: 1147) suggests, the selection of choices needs to contain detail about “which texts were analysed, why they were chosen, and how they were generated. In other words, there must be a rationale given for the choices of texts and it must stand up to scrutiny”.

In this study, four women’s magazines were chosen to examine how they represent women’s mental health. In order to select those four women’s magazines, I developed a “women’s magazines survey” (see Appendix C), a short list to examine which magazines were the preferred choices of my informants. This tool was used to explore how ‘their women’s magazines’ talk about mental health. In doing so, I asked each informant to identify her most favourite magazines from the top fifteen magazines titles as ranked by Mindshare (2007). The results were as follows:
The result directed me to see the relationship between women's magazines and the profiles of their readers. I chose three women’s magazines which were rated as the first choices from each group (Group One – Real Life, Group Two – Kwanruen and Group Three – Dichan). In addition to these three main titles, I also selected Cosmopolitan (the Thai Edition) to examine how mental health was framed in a glossy international title. The brief background of each title is described as follows:

1. **Dichan Magazine**: Dichan means ‘I’ in Thai. It is the pronoun used for a woman. Dichan is a glossy magazine, printed on high quality paper and was ranked number one among my informants without direct contact with mental health institutions and professionals.

2. **Kwanruen Magazine**: Kwanruen means ‘Household Grace’, see Mae See Ruen in the previous chapter. Kwanruen is one of oldest women’s magazines in Thailand and has the highest circulation. It was ranked number one among my informants in the rehab centre.

3. **Cheewitjing Magazine**: Cheewitjing means ‘Real Life’. This magazine was printed with non quality paper and was ranked number one among women in the hostel.

4. **Cosmopolitan Magazine**: An international title which inspires with information on relationships and romance, fashion and beauty, health and well-being. It was ranked second among my informants in Group Three.
A total of 48 magazines across four titles – *Dichan* (monthly) 6 issues, *Cosmopolitan* (monthly) 6 issues, *Kwanreun* (fortnightly) 12 issues and *Real Life* (weekly) 24 issues was collected over 6 months from November 2008 to April 2009. The reason for choosing this particular period was because of my need to extend my observation after the fieldwork started in September 2008 to confirm the titles women read in their everyday lives (observation from women’s everyday life) and to secure the reliability of the selection. I made use of the advantages of ethnography to “draw on the direct evidence of the eye to witness events” (Denscombe, 1998: 139). In this case, I observed the magazines women read before the selection of titles. I verified my observation by developing a ‘women’s magazines survey’ to confirm women’s choices. This process was called ‘a methodological triangulation’ where the researcher employs different data gathering tools to confirm verification and research reliability (Denzin, 1998; Strauss and Corbin, 1998). It ensured that there was a good correspondence between my findings on women’s choices over the course of my observational study. After that, I asked them to confirm their preferences by “respondent validation” (Bryman, 2008: 377) during my routine conversation with them.

### 3.2.2.2 The Selections of Mental Health Articles

I chose four Thai women’s magazines to investigate the way in which the media present mental health. I selected mental health related pages by using the specific key words drawn from the multiple meanings of mental health that the respondents defined, both in the preliminary and the follow-up studies such as (1) happiness [Sukha]; (2) unhappiness, [Dukkha]; stress [Kriet]; depression [Sao]; (3) mind [Jai]; emotion [Arom]; good spirit [Sabai Jai] and (4) mental illness [Rok Jit]; mad [Baa]. However, I am aware that by relying on certain key words, there is a possibility that I could omit other terms related to mental health that can be interpreted by other social groups outside this research. During my fieldwork, I selected every column in which one of these words was appeared; I then collected and filed them for analysis. The next section explains how the two sets of data were managed as well as how they were coded and analysed during my analysis phase.
3.3 DATA MANAGEMENT, CODING AND ANALYSIS

My ethnography contains two sets of data – the field-notes (observation notes and personal reflection) and the interview transcripts. From the field-notes, I spent time at night recording my recollections. I began to set up an interview schedule with my informants during the days from December 2008 after four months in the field. Interviews were recorded on an MP3 player, a handy digital device to record voices and I asked each woman if she felt comfortable with me using this recorder. Although, the respondents all agreed to the recording, there was one woman from the hostel who I sensed was not comfortable with me using this recording device. The hint was through her non-verbal cues; she made frequent pauses and kept looking at the MP3 player when she was about to tell me something very personal. For this particular interview, I stopped recording and changed to note-taking. However, I admit that the free flow conversations without concerns about writing gave me more chance to use eye-contact, engage and ask follow-up questions with my respondents in more in-depth ways.

The interviews were digitally-recorded and later transcribed verbatim, by myself and coded in NVivo8 with my series of researcher field-notes in one file. The reason I decided to transcribe all the interviews myself instead of seeking an assistant was because, as I transcribed, I recalled the non-verbal cues each respondent gave me such as their silence, sighs, eye contact that had significant meaning in qualitative research. NVivo8 is one qualitative data analysis software that aids the researcher for ‘code-based theory building’ (Lewins, 2009). Nvivo8 assisted me mainly in organising data and identifying recurrent themes emerging from the transcription. This process was done partly while I was in Thailand. Transcribing as soon as possible after the interviews while my memory was still fresh gave me some advantage. It allowed me to retrieve certain non-verbal cues from the interview when I listened to the women’s voices, and I was also be able to review my researcher notes and reshape my questions for my next interviews if I saw some prominent theme issuing from the data. This process guided me to realise that this was the set-up stage of my initial analysis while I was collecting data from the fields. Boulton and Hammersley (1996: 290) suggest that:

"The process [of ethnographic and participant observation work] is not confined to a particular stage of the research; it begins at the start of data collection and continues in more or less formal ways through the completion of the research report."

82
I realised that coding was an ongoing process. It could be said that coding is the heart of any qualitative analysis labelling data that Punch (2005: 199) identifies as "the specific and concrete activity which starts the analysis". In the coding process, Strauss and Corbin (1998: 3) refer to "an analytic processes through which data are fractured, conceptualized and integrated to form theory". According to Ryan and Bernard (2000: 780), there are multiple tasks in the coding process which include "sampling, identifying themes, building codebooks, marking texts, constructing models and testing these models against empirical data". Similar to the qualitative data analysis that Ritchie, Spencer and Bryman (1994: 176) describe, is an essential step about "detection and the tasks of defining, categorizing, theorizing, explaining, exploring and mapping" which come from the research questions that the researcher has been asking.

In doing my first analysis while I was in Thailand, I applied the thematic analysis by coding via Nvivo8 and this process continued throughout my analysis after I returned to the UK. As Ritchie, Spencer and Bryman (1994) note, thematic analysis is the familiarisation stage for the researcher to begin the procedure of abstraction and conceptualisation and an attempt to identify the key themes from the set of data that were examined. At this stage, I realised that "analysis and data collection are interlinked" (O'Reilly, 2005: 180, see also Bryman and Burgess, 1994) that allowed the researcher to build up ideas and make links while collecting and coding data. Through the system of 'nodes' in Nvivo8, I was able to identify the references and the specific themes of the document I had coded such as domesticity, spirituality and Buddhism, self-help and expert help, connections with the mass media, stigma of Rok Jit and Baa. At the end of the analysis, I translated women's testimonies into English and selected extracts are presented in this thesis.

For the media texts, I analysed 121 articles using discourse analysis to draw a system of representations by which women's magazines constructed mental health. In doing so, I read through every page of each title and made a list of keywords and phrases that related to what my informants described in their understandings of mental health. I clipped each article, labelled it and developed the coding sheet (see Appendix B), a document to draw understanding of mediated representation of mental health in a format similar to the traditional content analysis.

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42 Nodes are the specific term used in Nvivo8 software. Nodes are basically mean themes units, concepts, etc. They are "the route by which coding is undertaken and is defined in the latest release as "a collection of references about a specific theme, place, person or other area of interest. When the document has been coded, the node will incorporate references to those portions of documents in which the code appears." (Bryman, 2008: 570)
As Potter and Wetherell (1994: 55) comment, discourse analysis is “a craft skill”, there was no single instruction on how to conduct this analysis. I used the coding sheet as a preliminary approach to understand the media representation as Potter and Wetherell (1994) suggest, the coding file made the task of discourse analysis more manageable. I drew certain themes from the representations and stereotypes through the process of trying to ‘make sense’ of how women’s magazines framed mental health by identifying what was presented and what was not there through the subtexts and the silences that motivated the representations. In this process, as Bryman (2008: 499) explains, the discourse formulates a version of reality through the variation of the text “that is constitutive of the social world that is a focus of interest or concern”.

3.4 SOME CRITIQUES OF QUALITATIVE RESEARCH METHODS

There are critical debates on conducting qualitative research. The first criticism questions the role of the researcher over the researched in qualitative methodology and that qualitative research is not scientific because the methodology is only based upon the subjective impressions and reflexivity of the researcher. The second debate is about small-scale research and emphasises the problem that its findings fail to extend to the wider population.

The first critique leads to the issue of power relations between the researcher and the researched. Focusing on ethnography, there is a tension in trying to avoid the sensitivity of power relations in qualitative research; there is a difficulty in maintaining an equal power relationship with the subjects. This was the case in this study, where many of my researcher’s roles are exercised. The nature of some roles, such as teacher (Kru, Ajarn), is highly involved with different degrees of power in Thai culture. One solution is to follow Goldbard and Hustler’s (2005: 17) suggestion that instead of being too conscious about the power of the researcher, s/he should “enable participants’ voices to be heard in ways which are not too strongly filtered through the researcher’s lens” by listening to their voice with care. This is because there is no definite way to avoid contact between the researcher and the respondents in qualitative research, because the researcher aims to become closely involved in people’s lives to gain insight into the unfamiliar culture. However, I was also aware of a single dimensional of the results drawn from women’s subjective views and experiences. I, hence, employed the use of discourse analysis to examine the mass-mediated representations of mental health in this research, as a complementary method to my ethnographic design which highly emphasised women, their voices and viewpoints.
Discourse analysis tends to involve analysis with the notion of 'inclusion/exclusion', 'selection/de-selection' and 'foreground/background'. It is difficult to avoid the fact that discourse analysis may fail to offer a completely objective account of a given text. This is because interpretation is a process that entails multifaceted aspects as there is no standard formality. As Fairclough, (1995) notes, part of interpretation process comes from understanding, judgement and the evaluation of the interpreter. Therefore, the researcher has to be aware of this limitation and consider that "analysts are not only readers but also producers of discourse" (Parker and Burman, 1993: 159) who also bring a certain understanding by their subjective framing. I also mitigate the risk by cross-referencing and within texts and looking at narrative coherence in this study.

One controversy centred around the role of qualitative researcher is the problem of subjectivity. Denscombe (1998: 73) points out that qualitative researchers "are conscious of the way in which their account of particular lifestyles or beliefs is a construction based upon the researchers' interpretation of events". One concern comes from the fact that qualitative research attempts to examine the phenomenon by relying crucially on the researcher's human instrument to gather information which tends to remain unknown (Goldbart and Hustler, 2005; Walsh, 2004). Denscombe (1998: 79) describes this limitation as "tensions within the approach", by which he means that the tension stems from the double concerns of:

"Realist aspirations to provide full and detailed descriptions of events or cultures as they naturally exist, and a relativist awareness of the reflexive nature of social knowledge and the inevitable influence of the researcher's 'self' on the whole research endeavor."

Fielding (2008: 276) argues that "objective observation is impossible". This is because the goal of the researcher is to gain insight by attachment, not a detached relationship with the researched group. It therefore depends on the individual judgement of the researcher to position her/himself. However, following O'Reilly (2005: 27) comments that "research design should be a reflexive process which operates throughout every stage of a project". This reflexive turn is the strategy that helps the researcher to locate and examine her/his role in writing up the research honestly.

The second criticism is on the limitation of small-scale research. However, I am not convinced that this is a problem in qualitative research especially where multi-modal methods are used. I believe that, to conduct rich, multifaceted research, the researcher needs to narrow the analysis by dealing with small data sets emerging from specific social meanings with the aim of
“constructing understandings of reality rather than describing the reality” (Cheek, 2004: 1147).

For ethnography, it is most important for the researcher to gain insight into people and their culture: the researcher has to become involved in all aspects of people’s lives which include the public and private realms of the individual. The approach can be achieved when trust has been established and a relationship between the researcher and those being researched has developed. It cannot succeed either by isolating the researchers from the subjects being researched or by covering the vast scale of socio-economic background of people which the quantitative researcher commonly conducts in which human connection, relationship, time and trust are not the prerequisites in designing the research.

Following on from the limitation of small-scale research, there is also extensive debate over not representing the whole population of the society because the field researcher focuses on a few groups or small samples. This leads to the view that the findings in qualitative research cannot be extended to wider populations with the same degree of certainty that quantitative analyses offer. I believe that doing social research is not a competition (or a comparison) between qualitative or quantitative means since they share similar intentions in wanting to better understand the world and improve the quality of life. The difference is the aim of qualitative research which is to discover and “create new and theoretically expressed understandings’ of the people and culture” (Strauss and Corbin, 1998: 8) instead of the quest for measurement and generalisability but even in qualitative research, quantification exists in frequencies and repetitions. I also relied on Bryman’s (2008) argument that qualitative research is guided by theoretical logic and not a statistical one that aims for generalising to populations of the universe. However, as Seale (1999: 225) suggests, although the researcher encounters representativeness of sampling, “it would be worthwhile to think about whether we can generalise in some way, at least to a similar group or similar settings”. He suggests that the qualitative researcher can ‘transfer’ what she/he has learnt to wider populations by passing on their findings. As Silverman (2008: 351) states, “qualitative researchers seek to answer ‘how’ and ‘what’ questions and then pass on their findings so that the causes and outputs of the phenomena identified (‘why’ questions) can be studied by their quantitative colleagues”. These arguments remind us about the differentiation of inductive and deductive research. Following Malinowski (1922), inductive reasoning is the qualitative research approach that allows the flow of data while informing the research question. As Hyde (2000: 82) states, inductive reasoning “commences with observation of specific instances and seeks to establish generalizations” which is in contrast to quantitative research of deductive reasoning that
“starts with generalizations apply to specific instances”. Because the arguments against qualitative research design that had been discussed are logical, I accept that the researchers need to be aware of the limitations of their research in many ways. They should also welcome criticism as well as challenges over qualitative research in order to be reflexive while finding ways to aid the validation of the study. As Cheek’s (2004: 1147) concludes, “once we become certain about anything [in qualitative research], then we are probably in danger of oversimplification and creating orthodoxy”. Complementary methods in this study thus are designed to balance one-sidedness in the following chapters.

Chapters 4, 5, 6, 7 and 8 are the analyses of the two datasets combining ethnography and discourse analysis discussed in this chapter. I draw five key themes embedded in the findings: (1) Private context – Mae See Ruen; (2) Expert systems and self-help; (3) Myths of mental illness – Rok Jit/Baa; (4) Buddhism and spirituality; and (5) Media, user and convergence culture to illustrate the systems of representations and constructions of mental health in Thailand. These themes will answer the research questions of complexities of representations, formations of mental health space for interaction and changing roles of women as mental health mediated users. Chapters 4-8 examine the polycontexts of mental health constructions that reflect different features of modernity by drawing analyses from women’s experiences and women’s magazines’ representations according to the theme specified in the context of theoretical debates. The analyses demonstrate the connection of the respondents (women in the three settings) with the media (women’s magazines and other media with which women interacted) while complementing, comparing and contrast the results from the two datasets as a recursive process structured in my methodology and returning to the questions of the public sphere and the changing audience.
CHAPTER 4

CONTRASTING REPRESENTATIONS OF THE PRIVATE CONTEXT OF MENTAL HEALTH

As different authors note (Bury, 2001; Siriwananransan, Liknapichitkul and Khandelwah, 2004), mental health is a ‘private’ issue that involves personal territories, privacy and secrecy which thus, already, challenge the view of the public sphere as non-hybrid. The analysis in this chapter includes the private scope of the constructions of mental health. I refer to ‘private’ in two dimensions which overlap in meaning i.e. ‘personal’ and ‘domestic’. The term ‘domestic’ means women’s activities in the home rather than work outside (see ‘domesticity within the family’ in Oakley, 1974: 60-70; ‘homework and housework’ in Johnson and Lloyd, 2004: 90-94) while ‘personal’ refers to women’s feelings, interests and issues about their concerns inside and outside the household.

Following the methodological steps above, this chapter seeks to document the lived experience of the private context of mental health in contrast to mass-mediated representations. It examines how mental health is made meaningful in women’s experiences and links this to women’s role in households embedded within the Thai patriarchal, extended family system compared with the mass-mediated representations. The first section of the chapter details the definitions of mental health and shows that mental health is not a single dimension but can be understood and communicated in different ways. The second part illustrates the characteristics of the three groups to provide an essential life background of the researched groups related to their private experience and mental health status. The third and fourth sections discuss Thai women’s domestic roles and link them to the traditional discourse of ‘Mae See Ruen’ (household grace, virtuous women, see 2.3.1) while drawing on the multiple representations of women and their private context as represented in Thai women’s magazines. The last section discusses the popular representation of ‘easy-fix’ techniques, framed by women’s magazines as a treatment for women’s problems, and connects them to the ideas of agency and self-actualisation while examining the recursion of these easy-fix recommendations to questioning the dichotomisation of passive and active audience.
This chapter is centred around three key arguments embedded within the theme – private context constructions of mental health. First, mental health representations of women’s private context in women’s magazines were contrastive to women’s subjective experiences. Despite the subtlety of Thai women’s life experiences in the extended patriarchal family structure, women’s magazines simplify women’s problems as ‘easy-fix’ driven by the consumption culture. Second, although women’s magazines endorse the strong discourse of ‘Mae See Ruen’, they are venues of contestation and hybridisation of women’s identities by a series of representations that reconstruct women’s roles towards self-modification and autonomy. Women’s magazines are the sub-public system of communication for female audiences that challenges the normative notion of the ‘public sphere’ by blurring private with public, extending the space of interaction for their readers. Third, taking the idea of recursion in this analysis, the respondents are co-constructors in their identity construction as well as in their attitudes and actions towards the easy-fix tips advised as solutions to women’s stress in women’s magazines.

4.1 PLURAL DEFINITIONS OF MENTAL HEALTH

To examine mental health constructions from women’s viewpoints, it is important to understand how they define mental health. As reviewed in Chapter One, mental health can be understood differently resulting in no clear agreement on its definition and no adequate specification of a workable distinction (George et al., 2000; Hill et al., 2000). My study found that women’s mental health and mental illness were intensely personal matters associated with women’s experiences in different contexts of mind, emotion, wellness, happiness, stress, depression and spirituality in which contexts often overlapped. The results from the interviews demonstrated that mental health and mental illness are not polar opposites but are located somewhere along the same continuum. At one end, there is the positive meaning of mental health that locates the holistic meaning of happiness and wellbeing which is quite close to the WHO’s (2003: 7) definition of mental health:

“Concepts of mental health include subjective wellbeing, perceived self-efficacy, autonomy, competence, intergenerational dependence and recognition of the ability to realize one’s intellectual and emotional potential. It has also been defined as a state of wellbeing whereby individuals recognise their abilities, are able to cope with the normal stresses of life, work productively and fruitfully and make a contribution to their communities.”
At the opposite end of the continuum respondents highlighted mental illness (Rok Jit, Baa) in a psychiatric context, which Rogers and Pilgrim (2007) identify as a dominant discourse that sees individuals as sick patients. Table 4.1 shows the diverse understanding of mental health that the respondents across the three groups in the hostel (Group One), the rehab centre (Group Two) and the open setting (Group Three) described in their own words.

<table>
<thead>
<tr>
<th>Mental Health Definitions from Women’s Self</th>
<th>Group One (18)</th>
<th>Group Two (13)</th>
<th>Group Three (18)</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Happiness, Wellbeing, Positive thinking, Strength of mind, Feeling Good</td>
<td>1</td>
<td>3</td>
<td>3</td>
<td>7</td>
</tr>
<tr>
<td>Dukkha, Karma, Buddhism</td>
<td>2</td>
<td>4</td>
<td>3</td>
<td>9</td>
</tr>
<tr>
<td>Stress, Sadness, Feeling unhappy, Depression from unsolved life problems (i.e., rape, abuse)</td>
<td>11</td>
<td>6</td>
<td>6</td>
<td>23</td>
</tr>
<tr>
<td>Mental illness, Rok Jit, Baa</td>
<td>4</td>
<td>0</td>
<td>6</td>
<td>10</td>
</tr>
</tbody>
</table>

Table 4.1 Mental Health Definition from Women’s Perspectives

The table shows that the women in Group One (the hostel) significantly understood mental health as stress and depression arising from unsolved life problems (11 out of 18) while four of them associated mental health with mental illness. Two women described mental health using principles of Dukkha (suffering) and Karma, and one defined mental health as happiness. Three women in Group Two viewed mental health as happiness while four related mental health to Buddhist concepts. In Group Three, three women defined mental health as happiness, while four referred to it as stress and unsolved life problems. Six women viewed mental health as being similar to mental illness and three of them associated Buddhist practices with their explanations of mental health.

The understanding of mental health from women’s points of view can be grouped into several main themes. The first theme saw mental health as happiness and wellbeing. Seven out of 49 respondents related their understanding of mental health to happiness, positive thinking and strength of mind, for example:

“Mental health means my ability to continue my life happily. It means doing good deeds for others to be happy. I will be happier if I can help suffering people.” (Kanda, 55, Carer, University degree, Group 2)

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43 This woman was about to leave the hostel at the time I asked her to define mental health and after her life problem was resolved.
"To me, mental health is a state of happiness. It’s the feeling that I am happy with my life." (Ravivan, 34, Business owner, Master’s degree, Group3)

Another description of mental health was related to stress caused by unsolved life problems (23 women). The majority of Group One narrated their adverse life incidents to describe their mental health status while six women in Group Three referred to mental health as everyday stress from work and relationships:

“I don’t know exactly what mental health means. It could be the tension that I am now having. I feel exhausted. I can’t find hope in my future. Sometimes, I cry at night.” (Cat, 26, Dancer – unwanted pregnancy, Grade 9, Group1)

“It could be stress and feeling discouraged, I don’t know. I think of myself as having problems with my boss and I just don’t know what to do. I can’t talk about it to anyone.” (Kanyanat, 25, Employee, University degree, Group3)

The findings showed that ten women from Groups One and Three associated mental health with mental illness by explaining their understanding of mental health in the context of the stigma of mental illness, using strong words such as ‘Baa’ (mad) and ‘Rok Jit’ (loony bin):

“I think it [mental health] means Baa. It’s the same feeling when you lose control over your life. You may feel invisible and worthless.” (Golf, 19, Student – Unwanted pregnancy, Grade 9, Group1)

“I think of Rok Jit people when thinking of mental health. They have severe mental problems and they just can’t live with people.” (Pimpimol, 33, Bank officer, Master’s degree, Group3)

Seven women in Group Two related mental health to the holistic meaning of wellbeing and Buddhist concepts such as Dukkha (suffering) and Karma, which reflected the same Buddhist belief and practice found in women in Group Three:

“Mental health is the same thing as Dukkha. It’s a circle of Karma and individual action.” (Somjai, 50, Housewife-Carer of schizophrenic son, Grade 6, Group2)

“I think of Buddhism when I think of my mental health. The Buddhist practices are the way to good mental health” (Pimchanok, 22, Employee, University degree, Group3)

The narratives showed that the definitions of mental health from women’s point of views were varied, the respondents tending to associate their understandings of mental health with their experiences. This result could be explained by McCulloch’s suggestion (2006: 4) that the understanding of mental health in the contemporary world is usually linked to the context of ‘normal daily living’. Not only did the respondents associate mental health with happiness as
defined by the WHO (2003), they (across the three groups) also connected mental health with stress, Dukkha and mental illness in equal proportion with greater stress, depression and unsolved life problems. In contrast to women’s magazines, it was clear that the glossy magazines in particular, (Dichan and Cosmopolitan) represented mental health more in the context of ‘happiness’, ‘wellbeing’ and/or ‘stress release techniques’ (102 articles) while there was only one article in Dichan and one in Cosmopolitan that discussed women’s severe life problems (rape, abuse). Only two articles in Cosmopolitan talked about women’s suffering from living with mental illness. In fact, those issues should be represented as ‘serious’ concerns for women that cause mental health problems in a way similar to that seen in women in Group One (Baan Pak Chook Chern) and Group Two (carers of the mentally ill). This representational gap is connected with the idea that women’s concerns, described as a private issue, should be recognised under the principle that every member of society is part of the public discussion.

4.2 THE SILENCE OF MENTAL HEALTH IN EVERYDAY LIFE

This section explores the characteristics and life backgrounds of women and their personal problems in three groups with varying experiences of mental health. The first group (women in the Hostel) is composed of disadvantaged women living in poverty, with basic education and adverse life experiences in the first group. Everyone’s housing, education and employment is subject to some limitations. The second group (women in the Rehabilitation Centre) includes women who are carers of people living with mental illness. They suffer from the double burden of being carers and the social stigma attached to the social perception of mental illness. The majority of Group Three is committed to the dual tasks of unpaid household work and paid work as career women. Several are students and housewives (see Appendix A).

4.2.1 The Invisible Wounds: Women in Violent Relationships

Previous studies have confirmed that common mental health problems such as stress, anxiety, and depression are associated with people in the lower socio-economic groups with a poorer education and fewer work opportunities (Muntaner et al., 2004; Patel, et al., 1999; Payne, 2006). This claim is true among women in the hostel. Their main shared problem is poverty, which is often associated with increased risk of physical, sexual and mental violence and abuse from their
partners or strangers. The consequences of violence have caused significant damage to their mental well-being through visible physical injuries, unwanted pregnancies, severe stress, depression, mental trauma, self-harm and suicide attempts. Their problems can be broadly identified with three causes that reflect this group’s poor level of mental health. The three testimonies below demonstrate Group One’s shared life problems of domestic violence, rape and unwanted pregnancy that affected their mental wellbeing. In many cases, the women in Group One were confronted with multiple adverse life scenarios such as Bee (26, Waitress, Grade 6) who was beaten by her husband and got pregnant before she sought help from the hostel, Aim (26, Cleaner, Grade 6) was raped by her father and was also abused by her husband.

**Problem One: Domestic Violence**

“I lived with my boyfriend for three years. At first, he was such a nice man. I don’t know what made him change. He started to beat me and kicked me without reason. I was so scared. I would have died if I had stayed with him longer. This time, it was the worst [pointed to the wound on her head, covered by a white long top bandage]. My blood was all over the place. This was just beyond my control.” (Joy, 26, Clerk)

**Problem Two: Rape**

“I was so stressed and had no idea how to continue with my life. I almost went mad and was close to committing suicide. I remembered someone tied up my hands with rope and sent me to Rok Jit hospital. I was conscious but couldn’t communicate with anyone.” (Chom, 35, Hairdresser)

**Problem Three: Unintended Pregnancy**

“I was hit by my baby’s father. I was shocked and hurt. I had 12 stitches on my head. Why didn’t he think of the baby when he beat me. After he knew I got pregnant, he gave me money to have an illegal abortion. What kind of the man was he?.” (Bee, 26, Waitress)

Violence seemed to be the main cause of trauma that affected Group One’s quality of life including intimate sexual assault, marital rape, forced sex and other forms of sexual violation caused by their relationships with fathers, husbands, partners and strangers. The narratives illustrated that (domestic) violence created physical trauma as visibly evidenced in the respondents’ injuries and the mental trauma that became an invisible wound, leaving them sad, stressed and distressed. As Ali and Toner (2000) explain, women in violent relationships are more at risk of stress, low self-esteem, loss of confidence, exclusion, self-blame and silence. Many studies also point out that violence against women creates negative effects on emotional consequences such as depression, post traumatic stress disorder (PTSD), sexual dysfunction, self-harm and suicide attempts (Fischbach and Herbert, 1997). As Hawton (2000) indicates,
poverty, deprivation and a feeling of social exclusion may substantially increase the risk of suicidal thought and, as the WHO (2001a) points out, women living in violent relationships are more likely to commit suicide. In this study, self-harm and suicide attempts have also been interpreted by several women in Group One as their solution to overcome severe stress. Five women used sharp knives and cigarettes on their palms, arms and inner thighs. I noticed the scars on their bodies during my observation in the hostel. One woman was about to commit suicide by jumping out of the window and several others reported that they thought of suicide at some point during their life crisis.

4.2.2 Double Illness: Women in a Stigmatised World

Group Two was composed of women who were carers of psychiatric patients in the Rehabilitation Centre (Soon Sai Yai Krob Krua). In addition to caring for the mentally ill who suffered from recurrent hallucinations, anxiety and mood swings, they also became frustrated because of the social stigma of mental illness that the public had toward their family members. This scene is the situation that Rusch, Angermeyer and Corrigan (2005: 529) describe as a “double problem” to refer to the condition that “not only mental illness results in the difficulties arising from the symptoms of the disease but also in disadvantages through society’s reactions”.

Their life problems also arose from factors such as the complexities of performing their domestic roles as ‘mothers’, ‘wives’ or ‘daughters’. Group Two reported the problem that forced them to take responsibility for caring for sick family members. This section articulates Group Two’s voices to explain their frustrations and share the difficulties they had encountered. As suggested by Wahl (1999), the technique of listening to and providing space for people living with mental illness to express their stories is an enhancing strategy for increasing their self-esteem and rebalancing their quality of life. The following are narratives of carers’ reflections of their life problems.

Problem One: Suffering from the Carer’s Role and Household Role

“In the past, I caught my husband having an affair. I still live with him but there are no good memories left. Now, my daughter is addicted to drugs. She has taken ‘Ya E’ [Ecstasy drug], ‘Heroin’ and ‘Ya Baa’ [Amphetamines]. I am scared that one day she will become Baa. Her father did nothing. I have to fight with all of this mess alone.” (Anong, 45, Soldier – Carer of schizophrenic son, Master’s degree)
Problem Two: Suffering from the Carer’s Role and the Public Stigma of Mental Illness

"After the doctor said my son had schizophrenia, I was so stressed. At home, I had to do everything, take care of him, do the housework, cook for everyone while my husband played cards. Don't ask me about happiness, I don’t know what it is like after age 30. This maybe the result of bad Karma. I tell very few people. If many of them knew, the news would spread further with no control. I don't want to hear someone call my son Rok Jit and treat him like a criminal.” (Somjai, 50, Housewife – Carer of schizophrenic son, Grade 6)

These two testimonies reflect what women in Group Two have been confronted with as carers of psychiatric patients. In addition to the burden of being carers and household responsibilities, they encounter the second illness, the stigma of mental illness, that created the social codification of shame, secrecy and exclusion. As seen in the second citation, the respondent said she tried to hide the fact that her son had schizophrenia because of the stigma of the terms ‘Rok Jit’ with which her neighbours labelled her son (as she described, her son was treated “like a criminal”).

In this case, Philo (1999) explains that mental illness stereotypes can have harmful effects on the lives of both sufferers and their families, particularly of extreme rejection and stigmatisation. On a social level, the narratives describe how women living with mental illness were excluded. In Thailand, the terms Baa and Rok Jit have strong negative associations when used to label mental illness symptoms and those who have been identified as having mental illness. As also seen in different interviews, the carers expressed that they felt ‘excluded’, ‘discouraged’, ‘guilty’ and ‘hurt’ at being carers of the mentally ill:

“What else could I do, if I didn’t work here as a volunteer. I don’t think I will be hired anywhere else. Here [the rehab centre] is the only place that welcomes me.” (Racha, 32, Carer at the centre, University degree)

“Some people call my sister Baa. This is very humiliating. She can’t harm anyone, they are scared of her unstable emotion.” (Tina, 28, Government officer – Carer of depressed sister, University degree)

Stigma is a matter of great concern that causes people living with mental illness to feel excluded and discriminated against. Green et al. (2003: 225) notice that stigma can emerge from three potential conditions; “overt discrimination, perception and fear of discrimination and internalization of social stigma”. They state that the strongest source is overt discrimination resulting in those stigmatised being socially disadvantaged or excluded from mainstream activities. One proposition that previous studies put forward is that the public stigma of the mentally ill is derived from the myth that the mentally ill are dangerous (Knight, Wykes and Hayward, 2003; Link and Cullen, 1986; Nunnally, 1961). However, there is a growing body of
literature shows social subjects resisting and rejecting media representations from the reception viewpoint (Abercrombie and Longhurst, 1998; Blackman, 2004; Gunter, 2000; Iser, 1971; Wilson et al., 1999). This “critical viewer” (Livingstone and Lunt, 1994: 72) implies the transforming view of seeing people changing from the position of “mindless viewers to one of active, selective and informed viewers”. This point leads to the challenge of the dichotomy view of active and passive audience and the belief that readers of the texts are homogeneous which will be discussed in the following sections.

4.2.3 Women’s Multiple Roles

Mental health and wellbeing were viewed as issues of everyday life that could create serious difficulties for women and to a certain degree, affect their quality of life (Payne, 2006). Siriwananrangsan, Liknapichitkul and Khandelwah (2004) reveal that stress is prevalent and is becoming a more common problem for Thai women. The majority of women in Group Three, like the other two groups, performed the socially expected roles of wife and mother, while working outside the household as professional women. These multiple roles often caused those in Group Three stress at some point in their lives. Women demonstrated the shared life problems that were the causes of their stress and unhappiness.

Problem One: Economic Recession

“I have to limit my budget by taking the bus to work because it’s the easiest way to save money. My mum is the one who pays the bills, cleans the house, takes care of my Alzheimer grandma and supports my aunts who live in our house. I don’t understand why everyone has to depend on her.” (Pimchanok, 22, New employee, University degree)

Problem Two: Love and Relationship

“I broke up with my boyfriend last year. I don’t know what happened but one day he told me he wanted to break-up. I felt as if I had been kicked off a cliff. Then what was next? He treated me like I was one of his objects [-crying–].” (Wirongrong, 33, Air crew, University degree)
Problem Three: Domestic Burden

"I work for my husband’s business. We run the resort in Chieng Rai. It’s hard work but I have no choice. This is his business so I have to work hard to keep this resort going. I take care of the house, his parents, my mother and my aunt who live with me. It’s difficult being a wife, an in-law and a daughter at the same time. The most difficult aspect is to keep everything in balance. There are only 24 hours in my day, too.”

(Kinnaree, 36, Hotel owner, University degree)

Group Three shared the experience of working outside the home and the domestic work that they said they felt ‘responsible for’. The vast majority of women were full-time employees and at the same time they cared for their husbands, children, the elderly and the ill, together with additional domestic chores. Several women in Group Three (three single women) reported their unhappiness was caused by relationships with men where they were cheated on and unfavourably treated. Most of this section has tried to illustrate the diversification of women’s experiences across the three groups. They had different personal concerns that differentiated patterns of their mental health problems described as stress, discomfort, worthlessness, feeling of exclusion and wishes to commit suicide.

4.3 WOMEN’S SHARED STRESS AND HOUSEHOLD ROLES

Although women from the three settings had different socio-demographic and life backgrounds, one shared mental health problem was household responsibilities and caring for other family members. In 4.2, respondents’ life experiences were illustrated pointing to their shared stress to the degree in which they engaged with their household role. The narratives demonstrated a close connection between the informants and their household commitment that implied the Thai traditional idea of Mae See Ruen which expected women to be ‘good women’ (good wives, good cooks, good carers and good followers, discussed in Chapter Two). Housework, as described by Mederer (1993: 135) was "an integral part of the gender definition of wife". As Davies and Carrier (2001) indicated, these household tasks are situated in the domestic sphere related closely to patriarchy or in Walby’s (1990: 128) term, "patriarchal social structures". Several women, particularly Group One, expressed their experiences:

44 A province in northern Thailand. Chieng Rai is a destination place for tourists. This province has a unique culture, mild weather and authentic Thai northern food.
“My husband is free to do anything he wants anywhere while I spend my time in the house, doing all the housework.” (Bee, 26, Waitress – Domestic violence, Grade 6, Group1)

“He is not responsible for anything. What he likes to do is have fun with young girls at the bars or karaoke clubs. Me? I can’t have fun. What I have to do is to raise my child.” (Chom, 35, Hairdresser – Domestic violence, Grade12, Group1)

Although it was clear that the respondents in Group One seemed to adopt the cultural code of Mae See Ruen more strongly than Groups Two and Three, an interesting point was to discover that Group One, viewed as vulnerable subjects, resisted such convention. The testimonies illustrating the variations by which abused and poor women tended to conform to such cultural codifications resisted that power, showed their contrasting views and dialogical multi-voices:

“My final decision was to poison him. I put strong sleeping pills into the instant noodles, waited until he fell asleep, then I ran away with my son. Now, I won’t be beaten by that drunken husband anymore.” (Mek, 36, Unemployed – Domestic violence, Grade12, Group1)

“I choose not to go back to live with him. It was too much. After leaving here, I will go back to my hometown and stay with my parents.” (Joy, 26, Clerk – Domestic violence, Grade12, Group1)

“I decided to leave him because he treated me like a slave. He forced me to do everything, all the housework while he did nothing. Why did I have to follow his orders, I was the one who was working. I paid the bills, too.” (Petch, 27, Sex worker – Unwanted pregnancy, Grade 6, Group1)

Although previous literature such as Cooper (2008a) has suggested that Thailand fits into a patriarchal system, a specific cultural concept that is defined as “a form of social organization in which men dominate, oppress and exploit women” (Macionis and Plumer, 2008: 887), there were other stakeholders who influenced Thai women’s mental wellbeing. Other people involved in the respondents’ lives included mothers-in-law, spouses’ families as well as the members of the women’s and their husband’s extended families who took up a superior role and framed the respondents as oppressed family members. As some respondents across the three groups expressed:

“What made me feel so depressed was his family, especially his mother and sister. I did everything I could but it was never good enough.” (Pin, 39, Maid – Domestic violence, Grade 6, Group1)

“I have to do everything in the house and to take care of his disabled mother. Instead of showing her appreciation, she always complains that I am not good enough.” (Somjai, 50, Housewife – Carer of schizophrenic son, Grade 6, Group2)
"How could I expect others to help. It's my responsibility to take care of the house and keep it tidy for them to enjoy." (Adchara, 36, Housewife, Master's degree, Group3)

Regardless of educational and life background, the testimonies illustrate the double power of the patriarchal structure that combines with the account of the extended family unit. The testimonies show the link between the respondents and their extended family system that affected women's wellbeing. This result explains the latest survey figures as reported by Gray, Tongthai and Suwannoppakao (2010) that family is the most influential factor, 50.3% compared with the economic factor (36.9%) and health (8%), affecting the happiness of Thai women aged 20-39. It is still common for Thai, married couples to live with their families in the same house (Gray, Tongthai and Suwannoppakao, 2010; Vichit-Vadakan, 1994). Although, the nuclear family, viewed as the central social unit in modern life, has transformed this conventional settlement, the extended family system retains its importance, in various degrees, to the respondents' lifestyles. A number of women across the three groups reported that they lived either with their parents or with their spouse's parents in order to take care of them (such as preparing meals, accompanying them to the doctors). One woman from the hostel illustrated that what she meant by family was not limited to a picture of 'father-mother-child' but included siblings and relatives:

"I want my family back. I have a dream to reunite my parents, grandma, uncle and aunt, my sister and my nieces. I want to see my baby grow up among them." (Aim, 26, Cleaner - Domestic violence, Grade 6, Group1)

Almost all respondents from Groups Two and Three also shared similar viewpoints in valuing the extended family system:

"I'll do my best to support my family. I will be proud to take care of my parents and my relatives." (Malee, 58, Business owner - Carer of depressed son, Diploma, Group2)

"Family is a powerful word. It makes me a better person. Now I live with my mother, my aunt and my niece. I am happy to be the one who earns money and supports them." (Tonghatai, 30, Employee, Master's degree, Group3)

Cultural diversity plays an important role in understanding women's mental health. Previous research has revealed that among Asian families, close family ties provide effective support in dealing with psychological problems (Uba, 1994). This is the case for the majority of the respondents who identified their close connection with their extended family members. Cooper (2008a) describes the family as the first and safe world for Thai people. Women in the three groups revealed that they shared their stress, frustrations and sometimes secrets with people such as...
as mothers and close siblings. The result revealed that in women’s consultations with family members, the respondents did not aim for recommendations or solutions. Instead, they just needed the feeling of support from the people they trusted while they preferred to get over their problems by themselves. In fact, the narratives echoed Bauman (2000) who characterised contemporary society as the individualised society where individuals are directed to take responsibility for their lives, both for their accomplishments and the unpleasant consequences. He explains, “worries are private and so are the means to fight them off” (Bauman, 2000: 65).

Several women reflected this notion:

“When I got stressed, I called my mum. When I heard her voice, every problem seemed disappear. I told her about my work. I knew she couldn’t help me but knowing that she cared was the most important.”
(Wirongrong, 33, Air crew, University degree, Group3)

“If I can choose one person to share things with it would be my sisters. It’s nice to have friendly ears to listen, but I don’t want any suggestions from them. I’d rather fix my problem myself.”
(Golf, 19, Student – Unwanted pregnancy, Grade 9, Group1)

“I liked to go back home and hug my grandmother when I got into a fight at school. I didn’t want any moralising from her, I just felt safe when I was with her”
(Mala, 20, Student – Carer of Schizophrenic father, University Degree, Group2)

These testimonies not only stressed the importance of the extended family system in Thailand, but also displayed women’s sense of positive empowerment and responsibility in dealing with mental health problems. The respondents revealed that they mostly resolved their own problems, but they expected emotional and moral supports from the people they trusted.

My point was therefore to demonstrate that being a member of the extended family in Thailand was paradoxical. It could be positive as a psychological shelter that the respondents may seek when confronted with stress and worries and in their narratives the women tended to demonstrate the positive effect of being part of it. However, having an extended family also implied increased household responsibilities for Thai women which often accounted for additional stress in caring for a larger family unit. The significant majority of the respondents across the three groups explained that they felt obliged to take care of their houses, spouses and children, relatives and the everyday life of everyone in the house, while cleaning, cooking and caring were their routine tasks. Indeed, these three characteristics were strong features of ‘Mae See Ruen’ characteristics that implied domestic accounts of being good women, who were referred to as housekeepers, child raisers and carers of sick family members. Despite the shared stress and frustrations from
household responsibilities several women revealed a contrasting view which stated that, although they were exhausted, it was a pleasure to serve their family members. As they put it:

“I am happy when I stay home and manage my house without anyone saying I am not good enough to keep things tidy.” (Ton, 20, Housewife – Economic hardship, Grade 6, Group1)

“Although I am so exhausted from my office work, I cook for my parents and I am proud to be the person who takes care of them.” (Patty, 25, Employee – Carer of depressed mother, Master’s degree, Group2)

“It has to be me who knows where everything is in the house. I know where my husband’s socks are and I know what exactly my son likes to eat. I want to be a good wife and good mother.” (Adchara, 36, Housewife, Master’s degree, Group3)

These testimonies showed the imbrications of women’s household space – Mae See Ruen role, the extended, patriarchal family structure and the ability to manage housework. These accounts combined to imply women’s restructured role of ‘home manager’ (Gregory, 1999) or as Oakley (1974: 7) describes, “manager(s) of the domestic environment” that suggested the hybrid role of Thai women in modern social structures. Mederer (1993: 133) re-conceptualised household work by stating that it was better considered as “the creation of a household in which family members are cared for. It involved not only accomplishing tasks, but defining them as necessary, creating standards for their performance, and making sure that they are done in an acceptable manner”. This theme was centred on the discussion within the discourse of ‘household’ that shaped domesticity and household values, which according to McKie et al. (1999: 6), it “involves[s] with family, relationships and the desire to create and live in a home”.

In the next section I will analyse the representations of women and their mental health in women’s magazines in order to compare and contrast two points. I observe that in their special role to provide space for women to share their mental health experience, women’s magazines generally reduce the complexity of women’s lives by simply constructing women’s problems to be universal, uncomplicated and trivial driven by the force of the consumption culture. Second, despite women’s magazines offering a confusing set of images, they are considered venues of contestation and hybridisation of women’s identities which blur private with public to extend the sub-public communication of mental health for their female readers.
4.4 THE DYNAMIC IMAGES OF THAI WOMEN

Previous studies indicate that women’s magazines have a special position in women’s public space that represents female’s shared interests (Ballaster et al., 1991; Winship, 1987). Although a working class magazine such as Real Life took an obvious stance to represent the ‘voices’ of poor females, this magazine reserved little room to empower its readers and reproduced the stereotypical images of women as passive subordinates, dependent and victims of relationships. Women’s images in Real Life were restricted to the domestic role of the ‘private-woman’, attaching women’s territory to the household roles of cooking, cleaning and child care in relation to working class women, their hardship, poverty and unsolved relationship problems. The following extracts represent disadvantaged women’s profiles while reinforcing women’s images as unemployed housewives with restricted public life:

“These days, my husband is the one who works. I just stay home, cook for everyone and raise my kids.”
(A voice from one reader in Column “Free Your Mind”, 983/31: 38)

“I am so stressed because my husband is having an affair. I did my best to be his wife. I prepare meals and do everything for him. I don’t know what has made him change. What should I do?” (A voice from one reader in column “Talk to the editor”, 980/31: 28)

In Real Life, images of passive women were portrayed frequently (17 out of 24 articles). It also pointed out women’s domestic role through the shared image of poor-powerless females from rural Thailand. Other testimonies similarly represented women having unfortunate life experiences:

“I come from a very poor family. I quit school and have worked since I was teenager at a construction site. It was such a tough life. I have never known what happiness is.” (A voice from one reader who wrote to the author of Column “Free your Mind”, 985/31: 21)

“I first came to Bangkok to find a job in a sewing factory. I got 500 baht/month and sent my salary to my mum. I also earned some petty cash washing clothes for my neighbor and I got 20 baht/basket.” (A voice from one reader who wrote to share her story in Column “Soul Mate”, 976/31: 18)

The representations of women as subordinate and ‘failed-females’ were framed through the magazine stories of unpleasant relationships such as abuse, abortion and cheating, mostly in the genre of intense ‘dramatic portrayal’ (Lupton, 1998). Women’s stories in Real Life were described in a tragic tone, using a language that called for sympathy such as “she is a hopeless poor girl” (980/31), “please don’t hurt me, I beg you” (977/31), “naïve girl and her bad-boy
boyfriend: rape, video-clip and threat” (975/31), “my life is in the hands of satan” (977/31). These narratives implied women’s images as passive and fragile while framing them as victims of destiny without a motivation to change to a better life:

“I got stressed after I got pregnant with a married man. It was getting worse when he told me this baby didn’t belong to him, then he hit me! Please, don’t hurt me, I begged him a thousand times. I thought of having an abortion to end the problem. I couldn’t sleep at night.” (From ‘If you don’t love me, Please don’t hurt me no more’, Column “Story from Real Life”, 977/31: 99)

“My husband threatens me. When I told him I wanted to find a job, he was angry and beat me. He just wants me to stay at home, raise our kids and do the housework. What should I do? I don’t want to stay with satan anymore.” (A voice from a reader in column “Free Your Mind”, 977/31: 39)

Despite the high frequency of representing women as victims of the relationship, a few columns in Real Life offered a contrasting image of independent and assertive women (5 out of 24 articles). The magazine encouraged readers to make a choice in their unfortunate relationship by advising them to leave their husband or ask for a divorce. In this scenario, women’s magazines were venues of the sub-system of communication for female readers described as ‘sub-public’ (Fraser, 1992) that had the potential to be a space of contestation on women’s images:

“Being a widow is not that bad. I wasted 20 years just being his wife. Now I am happy. If you suffer because of your husband, think twice. You do have a choice to make. Don’t care what people think.” (Column “Free Your Mind”, 985: 39)

“Don’t stay depressed, stand up, fight and change yourself with hope.” (Column “Is Thai Right”, 975/31: 46)

“You have to be strong and carry on with your life. Don’t live in silence.” (Column “The Emergency Home”, 975/31: 82)

“Special Report” was a column in Real Life that attempted to deconstruct the image of powerless working class women as survivors of hardship. One article reported a story of an ordinary woman who had suffered in life but who later became rich and successful due to her determination and hard work. Interestingly, women’s success and happiness as framed in Real Life, is not easily obtained but needs to be ‘fought for’ through hard work so that they can earn a good income and buy luxurious goods and services (that made them happy):
"We have to fight for it. My life had been totally changed because of 'Pla Ra' business. I was once a poor woman from Mahasarakam, I had no money to buy food. I worked as a labourer for the lowest wage, but now I can eat whatever I want. I bought a house and a truck. Now I am happy. It's a gift from heaven. This year, I will be touring Europe, my dreamland." ("Special Report", 970/31: 15)

The concept of the 'fight for happiness' was also found in several columns in Real Life to encourage readers where the emphasis was on the representation of struggling rural women, particularly those in subordinate relationships. It was represented under different headings; "Fighting widow stands up with pride after her husband left her" (Real Life, 970/30); "Fight for the good life, You can do it" (Real Life, 976/31).

While Real Life generally represented a passive female image which was quite close to the profiles of Group One, Kwanruen, Dichan and Cosmopolitan seemed to reverse the representations with less reference to women as subordinates. The life of women in modern Thai society as represented in these three glossy magazines was filled with diversity and challenge. Women's status was not limited to the strict context of the domestic space but extended into the public space (workplace, abroad) where women were represented as 'smart', 'independent' and 'assertive' – "Celebrating your happy new year without being with a guy" (Cosmopolitan, 143/13), "An interview with a happy lady: life is easy with positive thinking" (Dichan, 766), "The secret from a successful working woman" (Dichan, 771), "Ways to twist your pessimistic thinking: hot tips for women of the present" (Kwanruen, 887). These headlines represented the images of independent women who do not confine themselves to the home, but seek success in work and relationships as well as happiness and personal pleasure.

Instead of representing women as victims of relationships (such as in Real Life), the contrasting image of women as relationship managers was offered in the glossy magazines, predominantly read by Groups Two and Three. The magazines de-constructed women's passive role in the relationships to these of agents able to control the situation. For instance, one article from Cosmopolitan used the headline "How to manage your angry boyfriend" (142/13) to show

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45 The traditional food for Northeastern Thai and Laos, so called, 'pickled mud fish'. It had been fermented for a certain period of time. 'Pla Ra' is heated on stove with toasted rice and mix with different ingredients such as chilli and spices. It usually has a strong smell. 'Pla Ra' is eaten with fresh vegetables and is sold in a jar or a plastic box.

46 A province in a north-eastern part of Thailand, a region that is considered the poorest part of the country.
women’s potential to control their relationships and break the patriarchal frame. Another two extracts highlighted a similar point:

“Married life is not like a dream that will have a happy end. If you decide to divorce, it’s important that you need to think of money management but it’s more important that you plan to manage your properties. Whatever your new status is, please be happy with it.” (Column “Money Money Money”, Dichan, 767: 88)

“A soul mate is a fairy tale that every women dreams of. However, you are the one who can design your love life and decide who can be your soul mate. You don’t need to wait for angels to help you.” (How to construct your soul mate, in Column “Mirror your life with happiness”, Dichan, 773: 270)

Despite the significant frequency of representing women as independent, assertive and sophisticated, several columns in glossy magazines still had an embedded representation of ‘Mae See Ruen’ that increased the visibility of women’s private values by representing the image of domestic women, but less so than in Real Life. Kwanruen, Cosmopolitan and Dichan reproduced the Mae See Ruen attribute while offering new images of professionals and independent women which were close to the profile of women in Group Three. While they tried to show women’s images of women as professional and independent, their ideal role as framed by glossy magazines was that women needed to be good at housekeeping, cooking and caring. This trend was evidenced in several columns that offered the readers traditional recipes, techniques for food preparation, tips for tidying the home, guidelines for pleasing husbands, knitting patterns, sewing, home decorating with ‘Do-It-Yourself – DIY tips’ such as handmade curtains, quilt blankets, painted vases. These representations implied that the discourse of Mae See Ruen was really strong in the Thai mass-mediated context, while the findings drew a hybrid set of representations of women’s images as a result of contestation between Mae See Ruen and independent women’s discourses. The following extracts showed how Mae See Ruen was embedded in the glossy magazines:

“When Valentine’s Day comes, it’s time to think of something special for your loved one. We have ‘feeling good’ ideas for you. One of the nicest activities is to invite him to your house for a very fine home cooked dinner. Show him how good your culinary skills are.” (Column “Miscellaneous” by the editorial staff, Kwanruen, 894: 70)

“100% of men fall in love with women because of their beauty. However, my ideal woman is the one with a good combination of beauty, professionalism and Mae See Ruen who can manage my house.” (Column “His Point of View”, Cosmopolitan, 145/12: 110)
This hybridisation of women's representations combined at least two schematisations between the traditional domestic role and the reconstructed image of women with independence and public achievement (cf. Gough-Yates, 2003). As Blackman (2004: 224) suggests, the contrasting image of “traditional women” and “no-needs modern women” is the key representation in today’s women’s magazines. With an emphasis on the latter, the challenging concept of ‘independent women’ stresses a stronger discourse of greater self-determination and improvement, which could be viewed as a substantial characteristic of positive mental health that enhances women’s self actualisation (Chamrasrittrirong, Prasartkul and Choolert, 2010).

Likewise, Gough-Yates (2003: 1) asserts that with the editorial shift to promote a new image of women as independent and assertive, magazines try to construct new readerships by reinforcing the representations of “new women” as “sharp and trendy”, “stylish and curious”, images which were the patterns that this study also found representing Thai women in the glossy magazines. It can be thus said that women’s magazines are venues for guiding women’s identities and the modified role of Mae See Ruen towards the context of ‘choice’ that offers women the consolidation of schematisations and the ongoing cycle of change of hybridisation.

Mental health problems (and life problems) as represented in Dichan, Cosmopolitan and Kwanruen were quite similar to common problems that were reported by Group Three, such as stress from relationships, work and the economic crisis while omitting the representations of the shared frustration of domestic obligations. While the glossy magazines ignored the visibility of women’s shared stress, they mediated women’s problems as ‘simple’ (non-serious) and ‘superficial’ for which the magazines had patterns of treatment to offer. Women’s magazines constructed women’s problems as easily solved issues that could be fixed by techniques such as “having ten minute massage”, “having one scoop of ice-cream”, “using scented candle” (Cosmopolitan, 144/12), “changing your lipstick colour” (Kwanruen, 894), “having a gourmet dinner”, “having a cup of coffee” (Cosmopolitan, 146/12), “fancy your new dress” (Dichan, 771), “going to the spa”, “a warm bath”, “shopping” (Dichan, 772), “doing manicure with your close buddy” and “watching funny clip on youtube” (Cosmopolitan, 142/13). These tips were packaged and communicated as simple solutions to reduce women’s stress and were constructed with the commercial purpose of attracting female readers. These series of representations was found across Dichan, Kwanruen, Cosmopolitan in significant numbers, the authors offering tips, steps or guidelines to make the techniques accessible and friendly to remember.
Women's problems were communicated as non-serious problems while the representations of quick-fix techniques which were a simplistic schematisation to reduce stress were also offered. 'Shopping', 'changing a hairstyle' or 'buying things' were put forward as solutions based on the assumption that happiness (and good feeling) could be bought and achieved by the power of consumption (Margues, 2010). As McRobbie (1999: 46) reminds us, glossy magazines convey their readers into the consumer culture based on the simple solution that money can help them reduce their problems:

"The glossy advertisement did nothing but convince readers of their own inadequacies while drawing them into consumer culture on the promise that they could buy their way out of bodily dissatisfactions and low self-esteem."

To see simple solutions as suggested by women's magazines in terms of space, it was noticed that most of the activities required readers to apply them in the home (aromatherapy, a warm bath, reading books in the bedroom, a spa at home). Sometimes they could occur outside the home but obviously required action in close or private settings (hair salon, massage room, dress shop) that are considered places restricted to women. This recalls the critique of Habermas's (1989) model of the public sphere and his dichotomised view of private and public. As van Zoonen (1989: 227) comments, women's roles and problems are primarily embedded in the private sphere of household life and are publicly rejected: "women's roles are primarily acted out in the private sphere of family life, men's role in the public sphere of paid work and politics". Women's matters are constructed by women's magazines in this study as 'insignificant' issues; their concerns such as rape, abuse and frustrations with household commitments were not worthy of bringing into public discussion. Fraser (1992, see also Gardiner, 2004; McLaughlin, 2004) argued against Habermas's (1989) distinct opposition to the view that gender is constructed through systems of differentiation where women are represented and isolated from a male public. This perspective limited women to the private context of the home while devaluing female experiences and undermining women's equality in public discussion:

"The view that women were excluded from the public sphere turns out to be ideological; it rests on a class and gender-biased notion of publicity, one which accepts at face value the bourgeois public's claim to be the public." (Fraser, 1990: 61)

Although women's magazines were framed in an initial assumption as a special media genre and a special site of the 'public sphere' that generated a sub-system of communication to empower women readers, this study has signalled the subtle representations of women's images and their
private concerns. This analysis invited me to evaluate women’s magazines in the ambiguous positions of both empowering and disempowering women. For the empowered role, women’s magazines provided a sub-public communication system for a sub-group (women), merged private with public and extended the space of talk in the discussion of their mutual concerns.

However, within the representations of their private concerns, women’s magazines also disempowered women. First, the glossy magazines omitted the voices of women with severe life problems and burdens of domestic accounts and second, they trivialised their problems into easily solvable issues that can be determined by superficial treatment (shopping, dressing, massaging). Magazines for the working class, such as Real Life, also disempowered women from underprivileged backgrounds by reinforcing the images of passive women as victims of relationships and ‘failed self’ but implied that ‘money’ was a means to a happier life. In these four titles of Thai women’s magazines, it could also be said that they refused to listen to the multiplicity of women’s voices while they were “in danger of failing to recognise the important values that home can represent” (Johnson and Lloyd, 2004: 160).

Despite the confusing set of representations on women’s images and their mental health, previous research has indicated that the glossy magazines are a special mass-mediated site that speaks the language of ‘power women’ highlighting a positive self-image – confident, assertive and demanding the right to control their lives (Gough-Yates, 2003; McRobbie, 1999). One example was in Kwanruen, where readers were advised to reflect on their roles and believe in their power: “You are what you think. You are in full power to choose if you want to be happy or sad” (Column “Trendy Woman”, 895). Another interview from the column “Fun&Fearless Female” in Cosmopolitan used the headline, “Listen to My Heart” (142/13) to direct readers to appreciate the importance of the ‘self’. These examples illustrated the idea of women’s empowerment which women’s magazines recommended their readers to choose for a ‘good life’. This notion of a good life brings women’s issues such as domestic management, health, education and relationships into the limelight, directing the message that women’s lives as well as their concerns are significant and political (Ryan, 1992). This idea of ‘personal is political’ is duplicated by many authors whose concern is that women’s private issues, ranging from homemaking, child rearing, beauty and health together with personal problems of domestic violence, rape and abuse, deserve a prominent space in the public sphere (Benhabib, 1996; Fraser, 1992; McKee, 2005; Young, 1990). In this scenario, women’s magazines recommended themselves as
a female sub-public by mediatising what counted as ‘women’s private topics’ into public recognition that could become a “socially relevant topic” (Wetschanow, 1999: 7).

The idea of a ‘life of their own’ (McRobbie, 2004) or emancipation (Bauman, 2000) was also found to be a significant theme in the self-actualisation frame in Thai women’s magazines. Instead of echoing adverse life events, the magazines represented the happiness women deserved. The notion of ‘DIY happiness’ and the ‘easy happy moment’ were broadly represented across Dichan, Cosmopolitan and Kwanruen and were packaged in an easy-fix tips format. One title in Cosmopolitan used the headline, “It’s very easy if you want to be happier” (144/12) to encourage women to use their competence to solve problems by themselves while another column in Dichan wrote, “Let’s create your own happiness: ten easy ways to heal your soul” (769) to recommend ten simple happy techniques. Unlike Real Life where happiness was communicated as being out of reach, happiness in the glossy magazines could be easily achieved by following easy-fix guidelines – simple and practical solutions that advised positive attitude with an embedded interpretation that happiness could be bought:

“Happiness is everything around. It depends on how you view it. You should be satisfied and happy with who you are and what you have got. Collecting rare pictures could be an aesthetic source of happiness” (Column, “Art Collection”, Dichan, 766: 185)

“You can create your own easy moments, even in your house. Let’s start with finding your favourite scented candle from your nearby department store and use it in your bedroom with a sip of Chardonnay, dim the light while playing mellow jazz music.” (“Column, Miscellaneous”, Cosmopolitan, 145112: 192)

The recommended easy-fix techniques in Dichan, Cosmopolitan and Kwanruen implied that women’s concerns that may cause mental health problems could be resolved by consumption. In a response to such representation, the respondents from Group Two and Group Three illustrated their critical views toward the media motive of easy-fix that linked happiness to money and material environments. The narratives showed how they evaluated the media by questioning certain mediated contents. This set of findings was revealing because it signalled how media literacy was processed in the recursive relationship between the respondents and the mass-mediated representations of easy-fix which was schematised in women’s magazines as a simple solution to women’s stress:
"I read women’s magazines only when I want to know new make-up trend. A lot of make-up brands are in the ads such as MAC, BOBBY BROWN, ESTEE." (Valley, 30, Government officer – Carer of schizophrenic mother, University degree, Group2)

“If you pick up one magazine, you will notice more than 50% of advertisement [-smile-], but I read it anyway because some are interesting and I like to read the columns that interview successful women.” (Jintara, 33, Novelist, Master’s degree, Group3)

“They just want to sell their products. There is no need to think about anything deeper. Do you really think you will have a good skin like the celebrities if you use the same cosmetics? No way, they must use so many retouch programmes like photoshop to make the presenter’s skin look as healthy as appeared on women’s magazines.” (Adchara, 36, Housewife, Master’s degree, Group3)

Easy-fix techniques, from the respondents’ point of views, were therefore part of the consumption culture offered to women who could afford to buy this lifestyle. Interestingly, although there is a strong narrative of autonomy in which individuals “gain control over their fate and make the choices they truly desire” (Bauman, 2000:39), this point reminded us of Giddens’ (1991: 5-6) notion of modernity that people at the margins “are more or less excluded from the possibility of making lifestyle choice”. If lifestyle can be acquired by material drive, underprivileged groups such as those in the hostel would be left behind in the promotion of commodified consumption culture. The schematisation that framed women’s concerns as easily solved problems (using a scented candle, cosmetics) seemed to grant privilege to affluent groups such as women in Group Three. As Luhmann (1995) explains, complexity generates selectivity while the formation of systems and discourses seek to reduce the complexity by schematisation that is less complex than their reality. Questions of mental health, stress and easy-fix in women’s magazines are therefore inherently material and political in nature.

47 Leading international cosmetics brands.
4.5 READERS, WOMEN'S MAGAZINES AND RECURRENCES

Women in the three groups revealed that apart from their work (in and outside the home), they spent their free time with different kinds of media. A significant number of respondents indicated that they used mass media including women’s magazines for relaxation. As they put it:

“I love the moment that I am alone, watching TV, surfing the internet, listening to the music, laying on my bed and read *Cosmo*.” (Tina, 28, Carer of depressed sister, University degree, Group2)

“I prefer to be alone, especially during weekends that I am free from my office work. I like to watch TV, see DVD and read good novels and women’s magazines at home. They give me the feeling of freedom.” (Piyada, 24, PR staff, University degree, Group3)

“I like the moment when I am alone with my favourite magazine while listening to the MP3. There is no one else but me. I don't need to think of anything. This is my world although I am surrounded by many people.” (Yupaporn, 25, Restaurant owner, University degree, Group3)

These narratives linked Hermes’s (1995) study to this research. She investigated how the readers made sense of women’s magazines and found that they increased women’s pleasure by filling the gap of relaxation because the magazines were ‘easy to pick up’ (i.e. that they could be read anytime). Women magazines in Hermes’s work were an alternative bridge of leisure and pleasure that provided readers with a personal recreational space through anti-stress materials such as beauty, travelling, wedding preparation, home decoration, dream bachelors, as well as an opportunity for women to fantasize in their ‘safe world’ construction. One woman from the hostel gave an example:

“I am happy when I read ‘Gossip’ and ‘STAR’. They are fun and don't require too much of thinking. I love novels in the magazines too. I read it before going to bed and imagine myself to be the main character [laughing].” (Cat, 26, Dancer – Unwanted pregnancy, Grade 9, Group1)

Women’s magazines are a specific media genre through which women shared their experience of consumption (Gough-Yates, 2003; Hermes, 1995, Winship, 1987). Although the women in the three groups had diverse profiles and life experiences, they seemed to have common interest that reflected the shared cult of femininity (Ferguson, 1983). Several respondents across the three groups revealed that they liked the media content that provided them, “a moment of pleasure”, “a feeling of relaxation” and “whatever entertains me”. As one respondent described, “I want to read anything that is not stressful but brings me a quiet moment after my long day” (Maleewan, 28, Teacher, University degree). Other informants defined their interests in different entertaining
topics while indicating beauty, fashion, novels, gossips and horoscopes as the main topics they looked for:

“I like to read romantic fiction in women’s magazines before going to bed.” (Chom, 35, Hairdresser-Domestic violence, Grade 12, Group1)

“I usually spend sometimes at women’s magazines’ kiosks and skim through the fashion direction and make-up trend.” (Valley, 30, Carer of schizophrenic mother, University degree, Group2)

“Where could I find new cooking recipes and home decoration tips, if I don’t read magazines.” (Adchara, 36, Housewife, Master’s degree, Group3)

As discussed above, women’s magazines provided the shared space for women (viewed as sub-group) to widen their domestic interests of housework, health, mental health, beauty and cookery. Women’s magazines used problem pages, interviews, letters to the editor/columnists to promote mutual understanding that assumed a shared experience between readers. Inside the women’s magazines, there were different columns offering advice on solving women problems about work, love and relationships that one respondent explained as “you will never understand if you are not woman” (Petch, 27, Sex worker - Unwanted pregnancy, Grade 6, Group1).

The readers of women’s magazines enjoy the companionship of their choice of women’s magazines: “many times learn bits and pieces for ideas on how to look or behave, as well as more straightforward information about health, popular culture or social issues” (Gauntlett, 2008: 206). As described earlier, women’s magazines blurred the borders between women’s private interests and the public realm of sharing, provided a special forum for women to discuss their mutual interests, share experiences and intensify their voices in the public awareness. Several respondents reflected similar viewpoints:

“I love reading columns in Real Life. Women write to share their personal tragedies and what they experienced and these are lessons I have learned from.” (Cat, 26, Dancer, Unintended pregnancy, Grade 9, Group1)

“What I got from the magazines is support. Whenever I read other stories, I see alternative perspectives. Sometimes, they are very useful and write about things I had never thought about before.” (Wirongrong, 33, Air crew, University degree, Group3)

In these scenarios, women’s magazines were venues of the sub-public place as a forum for women to exchange thoughts on their private matters, challenging the normative model of the public sphere (Habermas, 1989). The respondents across the three groups disclosed that they
were interested in women's magazines because of the topics that were close to their lives along with the simple techniques to improve life that usually guided them to be more independent:

“I like Kwanruen. It provides me useful information about becoming a successful mum.” (Kaew, 38, Factory worker – Economic hardship, Grade 4, Group1)

“I like what they [women's magazines] taught me how to be smart new employee.” (Piyada, 25, PR, University degree, Group3)

“I learn a lot from Cosmo. Many columns guide me how to be myself in stressful situation. It all depends on my attitude, not others.” (Benya, 36, Business owner – Carer of depressed mother, Master’s degree, Group2)

Another carer (Pornpan, 40, Carer of bipolar son, Master’s degree) revealed that when she wanted to read about life guidelines, she went to the glossy magazines and found a number of stories that represented “how to be a confident person or how to develop my self-esteem”. This result was similar to Gauntlett’s (2008: 205) who explains that women's magazines offer women positive self-image and confidence that “speak the language of popular feminism-assertive, seeking success in work and relationships, demanding the right to both equality and pleasure”. Several respondents in Groups Two and Three also revealed that as a result of reading women's magazines, they were able to anticipate what the magazines were about to say before they actually read or bought them:

“I can expect what I’ll get in magazines ... health stories, cooking, sewing, beauty. All about women’s stuff.” (Sandy, 34, Carer of the mentally ill, University degree, Group2)

“There are many interesting columns in women’s magazines such as how to live healthy and happily, seven shortcuts to good health, ten tips of being happy single person. Every magazine gives you similar content.” (Kinnaree, 36, Hotel owner, University degree, Group3)

At this point, the feature of genre ( Berger, 1992; Lacey, 2000; Mittell, 2001) becomes relevant and establishes the relationship between text producer (magazines) and audience (readers) with mutual agreement on the content (beauty, cooking, health, pleasures) and forms (letters, bullet tips, interviews) (Fairclough, 2003). As Hodge and Kress (1988: 7) comment, despite the fluidity of genres, they constitute a tacit contract between authors and readers: “genres link kinds of producer, consumer, topic, medium, manner and occasion and add that they control the behaviour of producers of such texts and the expectations of potential consumers".
The testimonies also implied women’s need to gain access to information about the “direction of living” (Gauntlett, 2008: 223). Women’s magazines offered their readers a pattern to happiness by extending the use of easy-fix recommendations into wider therapeutic discourse, such as “Raise your hands if you love yourself” (Dichan, 767) and “Empowering yourself with five easy happy moments” (Cosmopolitan, 146/12). Gauntlett (2008) notes that women’s magazines are a special site of today’s self-help cliché, described as popular psychology, to relay the messages of choice and freedom to their readers. The representations of women’s problems with the suggestions of easy-fixed techniques create a sense of feminine connection (of mutual concern between female readers) that are mostly focused on self-improvement and self-actualisation. These self-related treatments are described as “a balance between opportunity and risk” in Giddens’s (1991: 78) observation and are recognised as techniques to empower women in order to promote independence. One advantage is that women’s magazines have been credited with providing a path of escapism through fantasies, recommendations and personal confessions (Hermes, 1995), prompting readers to rethink their own lives, aspirations, desires and self-development under the discourse of empowerment (Blackman, 2004). This point is highly important as it shows how women’s magazines display themselves as a specific media genre through which women shared their experiences (Ferguson, 1983; Gough-Yates, 2003; Hermes, 1995, Winship, 1987). Ferguson (1983) agrees that women’s magazines provide the reader with wellbeing information which can be viewed as the basic ingredient of a happy life and good mental health. One article showed how women’s magazines offered a new form of selfhood under the theme ‘self-love’. It was an extract from an interview with the director of an advertising company. She shared information as to how she solved her personal life situation:

“It’s important to value myself. There are many good things waiting for me. However, it’s most important thing that I love myself. I always think that I am the one and I can design my own happiness. I know what is best in me.” (“Open Heart”, Dichan, 767: 269)

Within the context of easy-fixed tips under the broad theme of self-help, women’s magazines also encouraged their readers to be expressive in their relationships instead of staying quiet:

“I love myself and I am happy in what I am. I know what I want. I wouldn’t do a stupid thing like commit suicide. My life is valuable. Be honest in what you really want.” (“He said, She said”, Dichan, 767: 200)

“It’s important that you know how to love yourself. You need to balance your life and bring a happiness moment to replace your sadness. If we see a black spot in our life, we have to turn it to white or grey.” (“Cosmo Interview”, Cosmopolitan, 143/13: 43)
Interestingly, women’s magazines constructed these techniques as a smart choice by endorsing representations of Thai celebrities which were another form of legitimisation. ‘Celebrity’ is the concept that is defined as “a system of valorizing meaning and communication which confers on the person a certain discursive power within society, the celebrity is a voice above others, a voice that is channelled into the media systems as being legitimately significant” (Marshall, 2004: x):

A clear example was drawn from one column in *Cosmopolitan* that used celebrity to introduce the ‘love yourself’ techniques.

“I encouraged myself when I got stressed. I stood in front of the mirror and told myself ‘nobody loves you like I do’. It’s like you separate yourself into another person, and the one you see in the mirror is another ‘you’ that listens to you everyday. For me, I believe I can be happy in my own way. Admit to your problem and fix it. Don’t be silly by blaming yourself” (“Cosmo News Interview” with Patcharasri Benchamas, *Cosmopolitan*, 141/12: 42-45)

In addition, several testimonies described how the respondents across the three groups liked to read columns associated with celebrities:

“I like interviews with celebrities. What I like is reading their real lives and learning how they deal with their personal crises. I also learn how they develop their positive thinking.” (Patty, 25, Carer of depressed mother, Master’s degree, Group2)

“My most favourite page on the magazine is the ‘Celebrities Gossip’. It’s entertaining. I want to know who dates who.” (Benya, 36, Carer of depressed mother, University degree, Group2)

“The fashion set in *Praew* is spectacular. The clothes look beautiful on the young popular models but they may look totally different if we wear them. [-laugh-]” (Bussaba, 32, Lecturer, Ph.D, Group3)

The use of celebrities in women’s magazines was beneficial to the processes of legitimisation and product endorsement. As Cashmore (2006: 3) states “the celebrities have become products themselves – they are new commodities in the sense that they’ve become articles of trade that can be bought and sold in a marketplace. Obviously, you can’t buy them, but you can buy their representations, their sounds and the products with which they are associated”. Indeed, the

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48 Marshall (2004: x) defines celebrity as “public individual who participates openly as a marketable commodity serves as a powerful type of legitimization of the political economic model of exchange and value – the basic of capitalism – and extends that model to include the individual.”

49 As Thai people called her by her nickname ‘Kalamare’, Patcharasri Benchamas is a celebrity in Thai society. She is a popular television reporter, actress and author of many books.
representations of celebrities in the mass media (such as in women’s magazines) reflect the changing contemporary culture where celebrities are commodified by the mass media to offer inspirations and choices for people. Poder (2008: 101) interprets what Bauman said: “contemporary people are more into stars that can be read as inspirational examples of ways to enjoy life”.

Blackman (2004: 222) comments that women’s magazines “present generalized statements about new forms of selfhood – as being subject to one’s own efforts to constantly reinvent and transform oneself”. This trend of representation of self-love (as well as self-help) was also found to be a coping mechanism from the respondents’ views that enhanced the notion of self-agency to overcome their mental health problems as practical guides of living. Women from all three groups with an emphasis on Groups Two and Three overcame their stress by encouraging themselves with certain phrases such as “I talked to myself, if no one loved me, I knew at least I loved myself” (Pimchanok, 22, New employee, University degree, Group3), “I told myself when I got stressed that everything was going to be ok” (Pornpan, 40, Employee – Carer of bipolar son, Master’s degree, Group2) or “It must be better” (Jintara, 33, Novelist, University degree, Group3). These testimonies identified the therapeutic language that was also found in different headlines across four women’s magazines and in self-help books (Gauntlett, 2008), reflecting the media’s role in providing lifestyle choice for individuals to choose and act “who to be” (Giddens, 1991: 81). The connection of the use of therapeutic language was where the recursion expressed itself. A majority of women in Groups Two and Three who used the self-help phrases above (such as “I love myself”, “It is going to be ok”) admitted that they liked to read about self-help in the media to solve their personal problems and to maintain good spirits. Several of them admitted that they adopted the knowledge of self-help from the media in their personal lives. This set of findings confirmed the work of Luhmann (2000) where he establishes the link of systems of communication in which recursivity constructs the network of communication that implies feedback and redundancy. As Grant (2007: 170) describes, meaning is constructed by a recursive process that formulates self and culture reference:

“Similarly, there must be a recursive loop social between, for example, reality TV shows, feeding forward into everyday face-to-face interactions, forming part of a communications environment in which public and private are blurred. For popular media environments are very much part of the everyday and offer points of cultural reference for millions worldwide”
However, the findings also revealed a contrasting result showing that the subjective constructions are dispersed. Several women in Groups Two and Three criticised the easy-fix techniques as unsuitable guidelines. As a result, they declined the recommendations of these techniques:

“I read many How-To columns in women’s magazines but I feel bored. Their tips just don’t work.” (Kanda, 55, Carer at the centre, University degree, Group2)

“One columnist suggested the readers to do bathing to release stress [laughing]. How would it work for me, it’s too hot to have hot bath and I don’t have a bath-tub. Another one suggests readers to visit their parents, I don’t need it because I live with them.” (Maleewan, 28, Teacher, Master’s degree, Group3)

With these two set of findings – 1. follow or conform and 2. reject easy-fix tips of the media – the data from women’s experiences also showed a third view that combined both recognition and rejection of easy-fix representations. While the respondents who were frequent readers of glossy magazines (Groups Two and Three) disclosed that easy-fix content was useful, they criticised it for being “irrelevant to them”, “too trivial”, “too superficial”, “doesn’t work, I don’t buy it”. These findings suggested that readers of women’s magazines are not universal and could not easily (or directly) be absorbed or affected by the texts that are represented by the media. However, their critical view could not guarantee that “they would never be influenced by [the mediated] content” (Gauntlett, 2008: 191). Their subjective constructions are dispersed in the following ways:

“I tried to follow different advice given in the magazines, most of them didn’t work but some of them did. Meditation, yes ... I think it works quite well to release stress in my case.” (Wirongrong, 33, airline staff, University degree, Group3)

“I used to do home spa just as I read in Marie Claire. Although it’s not a workable solution to kill stress, it helps in a certain way.” (Patty, 36, Employee, Master’s degree, Group2)

“I think these advices are trashy but it’s useful to see how other people cope with their problems. Not all tips are junk. A few of them make sense.” (Kinnaree, 36, Hotel owner, University degree, Group3)

In summary, this section demonstrated that the readers’ reactions to easy-fix content in women’s magazines were very diverse. While the magazines may speculate that their general readership would enjoy the flow of the easy-fix content presented in this particular pattern, the readers of women’s magazines co-constructed their own meanings by recognising them (they adopted certain techniques) but at the same time critically engaged in the view that the selection of
mental health treatment, as offered by the mass media, was impractical. The wider scope of self-help in relation to women's magazines' representations, women's choice and systems of experts will continue to be discussed in the next chapter.

CONCLUSION

The research has shown that mental health has multiple definitions. It is an intensely personal matter that involves different social processes and individual strategies, as illustrated in women's domestic experiences of mental health in contrast with the representations of women's images and their experiences in women's magazines. Drawing from the three different profiles (the poor/and the abused, the carers of the mentally ill, women without direct contact with mental health care institutions), the respondents experienced different mental health problems caused by distinct factors, resulting in their diverse interpretations of mental health. Despite the nature of their different mental health problems, the respondents shared the stress imposed upon them in performing the household roles. This role framed Thai women with the mother-nurturer attribution that followed the rule of the extended patriarchal family structure. The household discourse, described as Mae See Ruen is a normative code of conduct for Thai women that expects "women's faithfulness and endurance in married life, as well as women's self sacrifice for the sake of their offspring" (Thaweesit, 2004: 207). Although Thai women were living under the patriarchal, extended family structure where inequalities of power exist, the results showed the varying degree to which they recognised and challenged the traditional view of Mae See Ruen.

The results showed that women's magazines, particularly the glossy magazines (Dichan and Cosmopolitan, Kwanruen), provided a confusing set of women's images that reflected a multiplicity of discourses of femininity, such as the contrasting images of independent professionals with the household role of traditional Mae See Ruen. They drew upon the pre-established discourses in society and endorsed the power of the dominant group by reproducing the image and stereotype of women as victims and subordinates such as in Real Life. In the more up-market magazines (Dichan and Cosmopolitan), the contemporary image of femininity was packaged with certain characteristics in a promotion of self-agency of independent, assertive, successful professionals able to control their own lives while the analysis pointed out the way in which the discourse of Mae See Ruen was still embedded and hybridised within those
representations. There were dynamic representations of women's profiles that omitted the sense of framing women as poor, rural working class, whose lives were over-shadowed by dramatic and tragic narratives. In addition, it was clear from the findings that the glossy magazines reflected the narrative of middle class women's lives (which was close to the profiles of women in Group Three) and excluded the voice of other social groups, such as the working class, by ignoring women's diverse experiences and shared frustrations of housework commitment that deserved public recognition.

In the representations of women's private problems, the glossy magazines placed less emphasis on the discussion of women's severe life problems such as domestic violence while framing their problems as ones which could easily be solved. They simplified women's problems into a series of easy-fix problems and offered simple and superficial techniques for solving women's stress and other mental health problems through shopping, massaging, using scented candles, changing nail colour and lipstick. These recommendations were the embedded elements that connected women's magazines to a consumption culture that offered lifestyle choices by means of advertising, according privilege to affluent groups and classes. Women's magazines (glossy magazines in particular) thus had the potential to ignore certain social groups who could not afford these lifestyle choices as part of their stress reduction process.

Despite the ambiguous roles of women's magazines, they re-constructed women's roles and enabled women to be active in the creation of their destiny via the discourse of self-actualisation, self-improvement and empowerment that reflected modern life where individuals are motivated to become agents of their own happiness (see self-help and neoliberal modes of governance in Rimke, 2000). The private constructions of mental health in both women's subjective and mass-mediated views were therefore complex with a different set of representations, which offered women as media readers to recognise, negotiate and hence, reflexively, select their own imagery for a co-construction of mental health that fits their experiences and expectations.
CHAPTER 5
THE DISCOURSES OF THE MENTAL HEALTH EXPERT

Related to the polycontexts and public sphere of mental health described in previous chapters, ‘system of expert’ identifies mental health experts’ voices that have constructed mental health from subjective and mass-mediated views. The expert system refers to the self-referential process of communicative interaction in which medical professionals engage with people in examining, identifying symptoms, prescribing remedies, as well as to the mass media. As Giddens (1991) describes, the experts establish their professional position by conveying advice that is highly influential in many aspects of the ‘knowledge environment’ in everyday life. This chapter explores how the informants and women’s magazines respond to these influential voices by examining the communication system of the expert in relation to mental health from two perspectives – the subjective constructions of the informants and mass-mediated representations. In this chapter, the concepts of power, knowledge and discourse are exercised within interactions and relationships that explain how the system of experts is maintained and reproduced by the truth of mental health knowledge from experts’ views and voices. Expert systems, as part of abstract systems (Giddens, 1991) reflect the social landscape of modernity where trust is the key feature that merges the knowledge environment with a taken-for-granted confidence that individuals have with others.

This chapter argues that discourses of mental health experts are very strong and embedded with the polycontextual features of expertise and medicine systems, trust, self-help, gender, media, power relations, etc. However, women as a lay audience, challenge the expert power by developing their self-help skills while carers of the mentally ill participate in self-help groups – the hybrid forums (i.e., they encourage people to share their private experience and give public space for sub-social groups to gather and discuss the shared concern) that challenge the normative model of ‘the public sphere’. Self-help groups emphasise the possibility for women (with mental health problems) to share their personal experiences, exchange views and co-construct their mental health with others that have similar interests. In the context of expert systems, women’s magazines as channels of communicative action reproduce the power of experts through the endorsement of their titles, opinions and affiliations that undermine the complexity of others’ experiences, views and voices.
The first section of this chapter illustrates how women in the three groups interact with mental health experts in their everyday experiences. The second discusses how the media construct expertise by examining the way in which experts’ voices are represented in the magazines and observes how the expert system integrates itself in the everyday narrative of self-help referring to risks and opportunities for agency in Thailand. The third section introduces the therapeutic scene of mental health that emphasises the idea of self-help as an influential trend in which women are invited to manage their own mental health and wellbeing. This operation of self-help is an expansion of a reflexive project that illustrates a “distinctive connection between abstract systems and the self [that] is to be found in the rise of modes of therapy and counselling of all kinds” (Giddens, 1991: 33).

5.1 EXPERTS AND WOMEN’S EVERYDAY LIFE

The expert systems could be assessed as a form of power that is influential not only in areas of technological expertise but also in human relations and their connections with the world (Giddens, 1991). In this study, the ‘expert’ refers to medical professionals in the mental health discipline including psychiatrists, counsellors, therapists, nurses and social workers. As Giddens (1991) explains, these professions are central to the expert systems of modernity. Knowledge and expertise are essential elements for the circulation of the power of experts who are authorised to speak the truth about mental health. This authorisation is based on scientific medical knowledge that “became the most influential set of ideas, shaping our beliefs about functioning of the human body in sickness and in health” (Seale, Pattison and Davey, 2001: 44). The medical power included the legitimisation of implicit value judgements and factual statements in the diagnosis, remedy and treatment of mental health. Medical knowledge is thus created as a discourse or epistemic code in the way in which specialists make sense of the world. This act reproduces ‘the truth’ claims of mental health knowledge and reinforces the power of the expert when the topic of mental health is discussed.

The following analysis includes women’s perceptions and experiences of experts, based on the responses of 49 subjects. There were various communication opportunities for mental health professionals to convey their knowledge and expertise to the lives of the respondents and through different forms of contact:
1. Psychiatrist-patient interactions in clinical settings (Groups One, Two and Three in the case that they decided to see the specialist for mental health treatment);

2. One-to-One counselling with a social worker or psychologist (Groups One and Two where individual counselling was part of the rehab programme for the respondents);

3. Self-help groups (Groups One and Two attended self-help group organised by the hostel and the rehab centre);

4. Mass mediated representations and interactions that mediated expertise (Groups One, Two and Three interacted with mental health experts through the mass mediated representations).

The results showed that women interacted closely with the medical experts while the expert systems intruded into many aspects of people's everyday lives (e.g., in the mediated medical advice programme, self-help groups and clinical consultations). Every respondent associated themselves in one way or another with these four patterns but with differing views toward the experts.

5.1.1 GROUP ONE: Experts and Vulnerable Women

In Group One women contacted the experts through one-to-one counselling and weekly self-help sessions run by the hostel. As Nettleton (2006) describes, the aim of the self-help group is for people with mutual concerns to share, exchange and get support while empowering them to think positively in coping with their life incidents. At the outset the idea of 'self-help' in this research is an ambiguous concept. On the one hand, it is a self-strategy “for enlisting subjects in the pursuit of self-improvement and autonomy” (Rimke, 2000: 61) and is a reflexivity of modernity. On the other, self-help may be viewed as Giddens (1991: 23) describes “a transfer of faith” which is a result of the impact of systems of expert and medicine. Rose and Miller (1992) describe that self-help projects engage with external forms of authority and expert knowledge. As Rimke (2000: 62) argues, self-help has an ambiguous role in modernity – "self-help lessons appear to teach a subject to rely exclusively on oneself, simultaneously to rely exclusively on an expert other, and then also to become an expert in some aspect of one's selfhood".
Different activities were initiated and included in self-help discussions as a means for relaxation such as drawing, singing, yoga and meditation. Several respondents admitted that they once thought that their problems could not be resolved and they usually ended up stressed and frustrated. With self-help groups, the majority of Group One stated that they were inspired to live and learn different ways of dealing with stress after the effects of unfortunate lives.

“They [therapists] suggested that I need to be strong and encouraged me to find a job instead of being so depressed. Sooner or later, I will be out of this place. I have to fight for my life.” (Jan, 21, Sex worker - Unwanted pregnancy, Grade 6, Group 1)

“I learn how to talk to myself. If no one loves me, I know at least I love myself. I found my strength after opening my heart in the self-help group.” (Ton, 20, Unemployed, Grade 6, Group 1)

The self-help groups offered an additional opportunity for women to communicate their feelings and thoughts from the inside (the self) to the outside. The majority of respondents in this group disclosed that they had learned techniques that helped them to adjust their attitudes and become stronger women from self-help groups. These findings were similar to Jorm (2000: 397) who includes self-help skills in mental health interventions as a priority for people to manage their emotions:

“Self-help skills are of great importance. When the public were asked to rate a range of interventions for likely helpfulness, self-help interventions were found to be at the top of the list in both Australia and the UK. Among the most popular self-help interventions are seeking support from family and friends, engaging in pleasurable activities, taking up new activities and physical exercise.”

In addition to the regular self-help groups, the psychologists and social workers who worked at the hostel also ran a counselling session. By means of one-to-one counselling, every member had a chance to meet a professional to talk about their lives and ask for advice. Two respondents expressed how they liked to talk to their counsellor:

“I like to talk to ‘Pi Ice’ [her social worker]. She asks me to write a journal and hand it in to her before we meet.” (Aim, 26, Cleaner - Domestic violence, Grade 6, Group 1)

“It is an invisible wound inside me. No one could notice, no one else could heal it. It has to be myself. I am the one who needs to get on with my life. This is what she taught me. I felt better after talking to her” (Chom, 35, Hairdresser - Domestic violence, Grade 12, Group 1)
The narrative showed that the respondents treated their problem as a personal matter while identifying their willingness to share it with an expert they trusted. As Giddens (1991: 244) indicates, trust is a vital component in the expert systems that lies on the baseline of a “leap into faith which brackets ignorance or lack of information”. In addition, by asking the respondent to write their thoughts in a journal, as mentioned by Aim, the expert has access to a respondent’s feelings and thoughts. The staff of the hostel usually asked women to write a diary to describe their feelings. As one social worker shared with me, “I usually ask them to write whatever they want to write about their feelings. Sometimes they draw. I learn many things that I miss out from our face-to-face interactions”. Writing a diary in this scenario was a form of the narration of the self which Giddens (1991: 243) defines as “the story or stories by means of which self-identity is reflexively understood, both by the individual concerned and by others”. However, the activity of writing the diary was a manifestation of an ambiguous role of self-help that was a reflexive project of the self while its process was an intrinsic aspect of expert systems. In the hostel, writing a diary was combined with other activities such as yoga, art therapy and meditation to assist women in maintaining a positive attitude towards their life crisis. Regular self-help activities, counselling and writing a diary joined the system of expert in guiding women to adjust their attitudes towards positive mental health. These combined self-help activities run by the experts demonstrated how strong medical discourse was both in principle and in the practical use of mental health care and treatment in the hostel.

Each month, there was a staff meeting at the hostel in the form of a ‘Case Conference’ where the staff shared, discussed and found solutions together for the women who sought help from the hostel. APSW invited a senior psychiatrist who was the retired director of a leading medical school in Thailand to chair the meeting. Her role was to advise staff and provide a medical explanation for the women’s risk behaviours. For example, in January 2009, a woman who had just given birth from an unwanted pregnancy was brought into the conference. The woman (a teenager) was depressed after the delivery and tried to commit suicide by jumping out of the window. The assumption was that this woman may be mentally ill and in need of medical help and therefore the advisor suggested that she be sent for mental examination at a psychiatric hospital. In this scenario, the psychiatric hospital formed a structured system of curing abnormal conditions by using scientific test results to confirm the value judgement of trained experts. The expert’s voice (the senior psychiatrist in this case) became a very powerful truth that had to lead, evaluate and judge her mental health symptoms as to whether or not she was ill. The
psychiatrist’s judgement was complemented by the scientific tests from the specialised institution (psychiatric hospital). Hardey (1998) explains how expert systems connect with lay people in that people expect medical experts to provide them with a consultation which leads to diagnosis, prescription and treatment. Their ‘authorised’ and ‘respectful’ knowledge is, in fact, socially and culturally constructed and privileged, specifically when their expertise is used in combination with technical language and medication. The expert’s voice seems to legitimise what counts as ‘sick’ and lay people who want to be healed accept and do not challenge their comments but simply take them for granted. In fact, these legitimisations of expert knowledge are intrinsic to the whole system of modernity that places trust at the centre of interaction with the abstract systems (Giddens, 1991).

When mental health was discussed in the hostel, trust was found to be key for respondents to share their stories with others. The ‘taken-for-granted confidence’ with the experts, was the way in which trust was established to alleviate the “potential threats and dangers that even the most mundane activities of day-to-day life contain” (Giddens, 1991: 3). Several informants expressed their trust to certain staff and the therapist, Ajarn Daeng, a lecturer in psychology who conducted self-help groups for women at the hostel:

“I like Ajarn Daeng very much. Last time she taught me many things. Every time I talked to her, I felt warmth and I look forward to talking to her again.” (Noi, 32, Cafe singer – Domestic Violence, Grade 6, Group I)

“I trust Ajarn Daeng. She is the one who changed my mind not to give my baby away. She brought a doll for me and asked me to hold it. Then she asked me to pretend that the doll was my baby. She asked what would I want to tell it and how would I want to apologise? I cried suddenly. After that, I decided to raise the baby by myself.” (Cat, 26, Dancer – Unwanted pregnancy, Grade 9, Group I)

“I used to think that my life was the worst. My husband abused me and raped my two daughters. It was a shameful life. His family was just too much to handle but I must have a strong heart. Ajarn Daeng taught me that if others can survive, I can survive, too.” (Pin, 39, Maid – Domestic violence, Grade 6, Group I)

The findings also demonstrated the polycontextuality of trust from Group One’s point of view that the gender of the experts played an essential role in forming women’s trust with them, particularly for those who had been raped or were domestically abused. Although they admitted that doctors were highly skilled medical specialists, the narrative below showed that women in Group One were reluctant to consult and accept treatment from male experts:
"I know they [doctors] are all good because they have a degree, but for me, the person I want to talk has to be someone I feel comfortable to talk to. I wouldn’t want to share anything if I don’t know them. I don’t like it when the hostel sends me to see male doctors. I have the feeling that they don’t listen to me. Besides, I don’t think they could help me.” (Pin, 39, Maid – Domestic violence, Grade 6, Group1)

"How could you feel completely comfortable describing how you have been abused by someone? I always asked for a female doctor.” (Chom, 35, Hairdresser – Domestic violence, Grade 12, Group1)

Trust, at this point was similar to the notion of trust that Giddens (1991) defines in two ways, namely the reliability of a person or system and the technical knowledge itself. As he notes, “trust may be defined as a confidence in the reliability of a person or system, regarding a given set of outcomes or events, where that confidence expresses a faith in the probity or love of another, or in the correctness of abstract principles and technical knowledge” (Giddens, 1990: 34). The narratives above further illustrate what Giddens (1990) refers to as a ‘reliable person’. In this study, regardless of the expert’s knowledge and expertise, gender was an influential factor in creating trust in the women from Group One as they revealed that they felt emotionally closer to female professionals. In their cases, the relationships that the respondents developed with Ajarn Daeng (psychologist) and Pi Ice (social worker) were examples which support such an observation.

5.1.2 GROUP TWO: Experts and Patients

Mental health professionals also unsurprisingly played an essential role in the lives of carers. The experts’ practices of diagnosis, treatment and prescription were also found to be significant for women in the rehab centre. Knowledge, particularly about symptoms of mental illness, treatment and medication were important for members in this group. They relied heavily on information and scientific knowledge related to the symptoms of mental illness and revealed that regardless of the gender of the expert, they trusted their psychiatrists in a certain way:

“My doctor told me that my depression disorder is now bipolar. He explained that the symptoms were hidden inside me for too long. I used to question my unstable symptoms and wondered why I always had mood swings. I understand now what bipolar disorder is and its symptoms after the doctor explained them to me.” (Sandy, 34, Carer at the centre, University degree, Group2)

“I learned from a psychiatric nurse that mental illness can’t be completely cured but needs long term treatment to adjust chemical substances in the brain. Patients just need to take prescribed medicine throughout their lives.” (Valley, 30, Carer of schizophrenic mother, University degree, Group2)
The testimonies reinforced how knowledge about mental illness was owned by the medical expert. The information about symptoms and remedies was conveyed to Sandy and Valley by their psychiatrist and nurse. These examples were common in doctor-patient relationships where the power of the doctor was obviously seen as a ‘professional role’ while the patient was seen as having a ‘sick role’ (Parsons, 1957) who seeks medical advice and cooperates with the trained practitioners. Experts were obliged to help patients regain the balance of their mental health by applying a high degree of skill, expertise and technical knowledge to cure patients. Hart (1985: 96) clarifies the connection between doctor and patient as “the means of transmitting the biomechanical model of disease to everyday life. Through the routine contact of doctors and patients in hospitals, medical ideology penetrates the subjective experience of illness and herein lies the scope for social control”.

On-going medication and regular consultations were the typical interactions with experts and carers. As observed in the rehab centre, women relied heavily on the prescription from their psychiatrists and were dependent upon the expert’s opinions, paying great attention to the regular meetings with their psychiatrists. Their regular appointments were the time when psychiatrists made decisions to retain, adjust or change the combination of their medicine and these decisions were an important process during the patient’s life-long course of mental health treatment and rehabilitation. Two carers explained their relationships with the experts:

“He prescribes medicine for my father. He is supposed to know everything about the symptoms and is able to adjust the medication. What has happened to my father was beyond the normal case, I need his [psychiatrist] help.” (Mala, 20, Student – Carer of schizophrenic father, University degree, Group2)

“My psychiatrist gives advice. He tells me that I should adjust the medicine to better control the chemical substances in my brain. Sometimes, I get scared that my body might react negatively to a new prescription. My doctor tells me not to worry, the reaction is normal. What I need to do is take the medicine for life.” (Kanda, 55, Carer at the centre, University degree, Group2)

One of the most interesting scenes that guided me to understand how the system of experts, medication, medical knowledge and the self-help group worked, was relevant to Group Two’s experience, was the eight week training for carers of the psychiatric patients’ programme (Sai Yai workshop). This training was designed for carers of mentally ill patients to help them understand the nature of the condition (focusing primarily on three key illnesses; depression, schizophrenia and bi-polar disorder). The training was conducted in the form of a self-help group, where members met on a weekly basis at the Family Link Association, learned new
lessons and shared their direct experience of being carers. Lupton (1994: 128) describes the benefit of the self-help group: “it offered an opportunity for people who feel isolated and alienated from others because of their illness to join together with like sufferers”. This training was organised by skilled carers, some of whom were staff at the rehab centre. The programme was meant to create a friendly community for people living with mental illness to gather, learn and exchange opinions, ideas and experiences in their lives of caring for the mentally ill. The course also indirectly created a network for future dependency among members of the community and promoted a ‘you are not alone’ atmosphere to participants.50

This course provided practical information for carers through weekly lessons. It covered eight different topics on the cause and classification of mental illness, how to manage a crisis, communicating mental illness, the right medicine, stress reduction techniques for carers, leading a happy life with mental illness, empowering carers, legal perspectives and mental illness advocacy. The programme helped members to obtain essential resources and to develop coping skills by providing means of strengthening members’ self-concept and lessening the stigma of mental disability. The overall message seemed to encourage carers to be optimistic about mental illness. The moderators in self-help groups for carers emphasised that the best way to alleviate carers’ sufferings was through regular attendance at self-help groups, while appropriate medication such as anti-depressant treatment was an essential factor in the patients’ recovery. At this point, it must be noted that a multi-national medicine company had sponsored this training and partially funded the Family Link Association. A small engraved plaque on the wall before entering to the corridor indicated that the centre was sponsored by a multi-national pharmaceutical company.

The carers’ self-help session run by the rehabilitation centre had two intentions. The first was to create a space for carers to share their mutual concerns. The second intention was not too explicit, but the fact that a multi-national pharmaceutical company had sponsored the course was

50 The description was identified as the main objective to launch this programme in 2004. The description was found in the programme’s handbook (2009) as well as on the website of the Family Link Association. “This curriculum is designed for a group of learners who are living with mental illness in a form of self help group, provide knowledge and assist them to understand their problems as well as to encourage members to find ways for better living with the mentally ill through the eight week programme” (http://www.thaifamilylink.net).
unnoticed and resulted in the programme including a series of talks by a pharmacist emphasising the use of medicine. It also implied a close connection between experts (pharmacist), medications and institutions (Sritanya Hospital, Family Link Association and a Pharmaceutical company) that are crucial variables in maintaining the expert discourses in a circle of expertise, medical and self-help practices, (implicit) advertising and commercialisation.

Although it was difficult to deny that women in the rehabilitation centre engaged closely with mental health experts on various occasions and seemed heavily dependent on their knowledge and expertise, several women in Group Two resisted the expert’s treatment and opinions. Some of them questioned the experts’ expertise, their decisions on treatments and the medicine they prescribed. Several carers changed the psychiatrist/hospital or found alternative treatment that better suited their needs and expectations:

“Our problem is unlike diabetes or cancer when your doctor can tell what kind of medicine would help you. Nobody knows except yourself. I don’t mean to be rude but the psychiatrists, may have a degree without having actual experience like we do. Sometimes, I feel that they don’t understand us. What they did was to prescribe the medicine. For me, I prefer to have this session [self help talk]. We can share our experiences and I can find way out in the way that the doctor can’t give us.” (Sandy, 34, Carer at the centre, University degree, Group2)

“It really took time for me to find the right person to treat my son. Bi-polar disorder is very difficult to distinguish and unexperienced psychiatrists have a tendency to misdiagnose it. I had been with my previous doctor many years but the symptoms didn’t get better. I decided to change the doctor and move all of his records here.” (Pornpan, 40, Employee – Carer of bipolar son, Master’s degree, Group2)

“I first went to another hospital, but it didn’t work well. The psychiatrist didn’t know much about my case. I didn’t want to waste my time so I changed the hospital. I wanted to be healed.” (Racha, 32, Carer at the centre, University degree, Group2)

The testimonies addressed the women’s views towards their psychiatrist and medication. Although, they expressed their trust in the practitioners, they were also critical (cf. Schulze and Angermeyer, 2003). The narratives explain various ways the carers resisted the experts. A few carers changed expert and looked for an alternative or complementary way of healing (self-help, holistic therapy). Instead of complete dependence on professionals in the hospital system, the majority of carers discussed their feelings with their peers in self-help groups. The space of self-help group in this scenario was a sphere of emotional and self-experience exchange. It was a form of therapy which was the reflexive project of the self that Giddens (1991: 34) refers to as “a phenomenon which, on the level of individual, like the broader institutions of modernity,
balances opportunity and potential catastrophe in equal measure”. These findings led me to see the diversification of space for carers to talk in the shared forum of concern where members were united and empowered by having the opportunity to express their thoughts. The result of seeing self-help groups as a social space for communication among the carers (as well as women in the hostel) in sharing their personal experiences and private concerns challenges the normative model of the ‘public sphere’ of Habermas (1989) that is non-fragmented, non-hybrid and privileged to the dominant groups. Self-help groups widen opportunities for carers (and other interest groups) with different kinds of mental health problems to elaborate their experiences and hardships. These forms of communicative action appreciate ‘minority voices’ and celebrate the diversity of experiences.

Despite its embedded operation in the systems of experts, self-help groups offer emotional support and open a new (and extended) arena for people to share their experience of medical treatments, emotions and mental health concerns (Herzlich and Pierret, 1987). Although there was no formation of consensus as a result of their coming together, the self-help group in this study has a special position to be a sub-public of ‘emotional connection’ that is not limited to the hegemonic, political elite described in Habermas’s formulation of the public sphere in 1989 or the revised versions of his modified public sphere in 1992 and 2006. Self-help groups provided a sub-public communication system for social groups at the margins (such as carers of the mentally ill) and became a negotiated space to combat the stigma of mental illness and connected with carers’ ‘inner selves’ to communicate their feelings with others who shared mutual trust and concerns.

Although it is difficult to deny that expert systems play a crucial role in people’s lives in the age of modernity, this may be undergoing change. Giddens (1991) observes that people are becoming more active about their health and generate the lay re-skilling which is the process of making decisions about risk. The re-skilling process requires people to seek new knowledge and develop their skills (such as self-help) to challenge the power of experts. This developing skill could be enhanced by the rapid change of the media technologies that disseminate medical information and offer choices for people, inviting them to seek what they believe is the most suitable treatment. Shilling (2002: 630) comments that the more information people have, the greater the opportunity to ‘shop around’ for health care and second opinions. Different carers disclosed that in addition to gaining knowledge from self-help groups, they obtained information
about mental illness and medical information from different mass-mediated channels, including the Internet:

"At first, my doctor said I had depression. I didn’t know what he really meant. I started to search for information about it on the Internet. I went to www.thaimental.com and its web-page was informative. I found out that this centre offered an eight-week training programme, I applied for membership online and attended the class." (Kanda, 55, Carer at the centre, University degree, Group2)

"Living with patients with schizophrenia is difficult if you don’t have enough information about how to take care of them. I read a lot of books and spent so much time on the Internet to search for everything about its symptoms, treatment and care." (Jitdee, 40, Business owner – Carer of schizophrenic sister, Master’s degree, Group2)

The concept of ‘media literacy’ appeared at this stage and connected closely to this changing picture (that the respondents challenged the authoritative position of the experts by seeking mental health information from the mass media). Several respondents from Groups Two and Three revealed how they made decisions in relation to mental health treatment based on the information that they had:

"If I had any doubts about the medication, I would search the Internet or find a second opinion. This is just to confirm that you are getting the right treatment.” (Benya, 36, Business owner – Carer of depressed mother, University degree, Group2)

"Why should I waste my time and pay a lot just to talk to the doctor. There are so many books that can help you solve your problems. If they are not too serious, you can learn from them." (Bussaba, 32, Lecturer, Ph.D, Group3)

Thus, there is the interplay of lay-experts, media and the public sphere where experts are now being challenged as the exclusive group which has the solution to illness. In this scenario, public access to the mass media provides carers with the opportunity to develop their knowledge, to become skillful in mental health experience and to challenge the existing power of expertise (cf. Livingstone and Lunt, 1994). This study also revealed a unique Thai cultural form of seeing spiritual resources as local mental health experts, supporting the point that mental health experts were socially constructed and therefore had multiple interpretations. Respondents across the three groups reflected their trust in ‘Pra’ (monk), and ‘Chee’ (nun) when they needed emotional support. This result signalled something about trust in modern-lay experts: Thai women can shift their trust from medical experts and turn to other authorities that they believe could assist them regain balance in their lives. Giddens (1991: 142) explains clearly how decisions about patterns
of living could return to traditional accounts such as faith in spirituality (and spiritual resources such as Pra) – one form of an infinite pluralism of expertise:

"Religious fundamentalism, for example, provides clear-cult answers as to what to do in an era which has abandoned final authorities: those final authorities can be conjured up again by appeal to the age-old formulae of religion. The more ‘enclosing’ a given religious order is, the more it ‘resolves’ the problem of how to live in a world of multiple options”.

The role of spiritual health in Thai life became more subtle when the issue of mental health was a concern for Thai women. Several women across the three groups revealed that they relied on Pra and Buddha’s teachings as their practical source of mental health treatment:

“When I got stressed, I listen to Pra’s lessons on radio. He recommends how to let go of things. It helps me a lot in dealing with my stress.” (Tina, 28, Government officer – Carer of depressed sister, University degree, Group2)

“I like to go to Sathira-dhammasatharn\footnote{Sathira-dhammasatharn acts more or less like a temple but it is run by a nun, Mae Chee Sunsanee, and is open to the public to participate in many activities such as meditation retreat session. As stated on the website, “Sathira-dhammasathan, a learning community, where the members learn to live peacefully. We believe that human beings, through practice, possess the potential to develop our lives, so that we can soar through suffering and oppressiveness. Therefore, the way of life at Sathira-Dhammasathan has been designed in such a way that it is conducive for us to deliberate on our lives, both physically and mentally. In both ways, we must learn to go forward, with steps of wisdom. We need to be able to live without being affected, so that we can keep calm and peaceful within ourselves and not create suffering or harmfulness to others.” (http://www.sdsweb.org/)}. I was pregnant at that time and Chee [nun] showed me how to do walk meditation. It was amazing. I felt calmer. I wish I could go there again.” (Cat, 26, Dancer-Unwanted pregnancy, Grade 9, Group1)

“To regain good mental health is similar to what Buddha taught. I think his lesson is an absolute answer for all problems. For me, I trust ‘Tan Wor Wachiramatee’\footnote{Tan Wor Wachiramatee is a Pra who wrote many books on applied Buddhism. He relays Buddha’s lessons into simple and accessible language and links them to people’s everyday lives. Examples of his books are ‘Dharma Before Bed’, ‘Relaxing Dharma’, ‘Love Management’, ‘Anger Management’.}. He writes so many good books and delivers the Buddha’s lessons to our lives.” (Jintara, 33, novelist, Master’s degree, Group3)

Spirituality in mental health was the emerging theme that reflected the unique aspect of Thai culture in relation to mental health. In one way, spiritual resources are one form of local mental health expert that the respondents trusted. As Giddens (1991: 19) describes, religious belief is “directly connected to the psychological security of individuals and groups”. On the other hand, spiritual practices challenged the epistemic frame of scientific reason. Women adopted different
spiritual practices into their everyday treatment of stress and life problems. Spirituality (and the role of Buddhism) in Thailand played a vital role in the process of social fragmentation that described a polycontextuality of mental health constructions or a ‘recontextualised’ modernity in the Thai context. The analysis of spirituality and mental health is explored further in Chapter Seven.

5.1.3 GROUP THREE: Women and Stereotypical Psychiatrists

Group Three had relatively less direct contact with mental health experts compared with Groups One and Two. Their everyday mental health problem, as reported in 4.1, was common stress as a result of the burden of their household roles and problems such as economic recession, relationships and work. Instead of contacting the specialists, they had their own ways of dealing with stress: “I phone my close friend” (Yupaporn, 25, Cloth shop owner), “I talk to my mum or sister” (Maleewan, 28, Teacher), “I read a magazine” (Kinnaree, 36, Hotel owner), “I just stay alone” (Darika, 33, Employee), “I go to the temple, tumboon [making a merit, doing good deeds], “I pray and meditate” (Kessara, 28, Employee) and “I plan a trip” (Jintara, 33, Novelist).

The majority of participants in Group Three thought of mental health professionals, and psychiatrists in particular, as people unrelated to their lives. They described psychiatrists as experts who dealt with ‘extreme’ cases of mental sickness such as people with ‘severe stress’, ‘the deeply depressed’ or ‘those thinking of suicide’. A number of them referred to the psychiatrists in association with the terms Rok Jit (a loony bin) and Baa (mad). These two words implied social and personal links in women’s negative perceptions toward mental illness and the mentally ill:

“My life has nothing to do with them [psychiatrists]. I don’t know why I have to see them. They only deal with Baa or Rok Jit people.” (Piyada, 24, PR officer, University degree, Group3)

“I don’t need their help. I’m just stressed but I am not sick! If someone goes to see psychiatrist, that means they are Rok Jit. They must be uncontrollable or think of committing suicide or are deeply depressed.” (Maleewan, 28, Teacher, University degree, Group3)

“If someone wants to see a psychiatrist, that means she is out of control and it’s maybe too late for her to be cured. It would not happen to me, I wouldn’t go to Sritanya Hospital for sure.” (Pimpimol, 33, Bank officer, Master’s degree, Group3)
The narratives showed that women in Group Three mostly had negative attitudes toward mental illness. They excluded themselves from the circle of mental illness treatment and viewed the mentally ill as people who were closely connected with mental care institutions. Because this group had less direct contact with mental health professionals, when they were asked to describe psychiatrists, several respondents illustrated their characteristics by referring to different movies:

“He [the psychiatrist] is an old guy with thick eye glasses and wears a neat suit. His personality is like a general doctor, calm and gentle. He talks and makes notes. I have never met one but I thought of many movies. He has a couch in his clinic where the patients sit and talk.” (Kinnaree, 36, Hotel owner, Group3)

“The scene I did remember well was the mentally ill person freaked out and a guy wearing a doctor’s gown gave him an injection, then he was tied up by several male nurses.” (Maleewan, 28, Teacher, Group3)

Two women described the characteristics of the psychiatrist and differentiated types of psychiatrists. They derived their perception of Western specialists from the images encountered in the mass media, while the Thai psychiatrists in their opinions dealt with Rok Jit (a loony bin), associated with an extreme sense of mental ‘sickness’. This result could explain why the majority of respondents in Group Three had tried to isolate themselves from connections with the mental health specialists, the mentally ill and the mental care institutions. As they put it:

“He [a psychiatrist] might ask us to lay down on a comfy sofa, speak softly and gently. I have seen this scene in many Hollywood films, the leading character has her own psychiatrist to complain about her love life. It’s different from Thai psychiatrists, people just don’t want to see them.” (Adchara, 36, Housewife, Master’s degree, Group3)

“It’s probably common to go to see a psychiatrist in the Western culture. I have seen this in films, if people have relationship problems, they go to see the shrink. The doctor will give them recommendations. I think he may make our life easier, but this is not going to be the case in our country. Going to see psychiatrist is another story. They cure Rok Jit people.” (Wassana, 33, Bank officer, Master’s degree, Group3)

The testimonies implied that different cultural contexts may play an essential role in Thai women’s attitudes towards psychiatrists (and other mental health specialists). Although visiting the psychiatrists could be a common choice for people seeking mental health treatment in the West (Roberts, 2007), lay people (such as women in Groups One and Three) viewed psychiatrists as specialist doctors for people who were mad or for those who had severe (and abnormal) mental health problems. One barrier was the problem of accessibility to mental health care and resources in Thailand. One woman (Pannarai, 24, editorial staff, University degree, Group3) commented that “getting access to the psychiatrists is very difficult”, echoing the
mental health survey indicating 0.8 psychiatrist for the total population of 100,000 (Chamrasrittirong, Prasartkul and Choolert, 2010). With limited direct experience of mental health professionals, a significant number of women in Group Three relied on mass-mediated images in their perceptions of psychiatrists including self-help routes. This point illustrated what Giddens (1991: 27) reinforced as the characteristic of the mediated experience that introduces the remote experience and external events into everyday activity while producing “the feelings of reality inversion”. Potter (2011: 133) shares a similar view, “the border between our real world and the media world is becoming harder to discern.”

The next section examines how women’s magazine’s representations of experts are constructed. The result showed that by emphasising extensively experts’ titles and their institutions, the magazines were the voices for the experts to disseminate their powerful position of being owners of mental health discipline.

5.2 CONSTRUCTIONS OF EXPERTISE IN WOMEN’S MAGAZINES

This section complements the ethnography approach above by focusing on four Thai women’s magazines and examines who the ‘speaker’ of mental health was and what was said/was not said when the knowledge was circulated. Mental health was represented in women’s magazines as relating to women’s personal, family and social contexts that were mostly referred to the experts and their recommendations. As Lupton (1992; 1994) explains, mental health is socially constructed to be the language of the medical expert and expertise. The shared dominant voice found across four magazines contributes to similar patterns of seeing the direct link between mental health information and the reference to mental health professionals. One pattern showed that the magazine gave regular space (pages, columns) for experts (doctors or other kinds of experts with official credentials) to communicate about mental health with their readers.

Table 5.1 illustrates the classifications of mental health experts as represented in women’s magazines whose names appeared as psychiatrists/doctors, nurses, scientists, academics and therapists (music, sleep, sex, hypnosis, life coach). Mental health experts in Thai women’s magazines also included spiritual and religious resources such as Pra (monk) by recognising them as a local type of mental health expert.
### Table 5.1: Representations of Expert Voices in Thai Women's Magazines

The magazines referred to experts' voices by citing their names, titles and listing medical institutions and health organisations in the body of the text, such as “College of Medicine, Cornell University”, Kwanruen, 893, “Doctor Erick Robinson, Professor from Psychiatric Department, University of Toronto”, Cosmopolitan, 141, “Doctor Mark Cornstan, Professor in Psychiatry from University of Virginia”, Cosmopolitan, 141, “Journal of Personality and Social Psychology”, Cosmopolitan, 143. The use of these titles was the authorisation strategies in the discourses of the mass media that women's magazines may assume that their readers will respect and trust the expert's voices, opinions and titles.

With the heavy use of experts' voices listed with their titles and credible institutions in women's magazines, it was interesting to see how women in this study responded to these representations. Women across the three groups showed certain belief towards mental health information carried by knowledgeable persons with titles such as 'Doctor', 'Professor', 'M.D.'. Several women in Group Three said although they had never contacted mental health experts, they believed in what experts suggested in the media:

- “The author holds the title ‘Professor Doctor’, so he must be knowledgeable. His comments are surely credible. I read what he recommends in the magazine.” (Kessara, 28, Employee, Master's degree, Group3)

- “I like to read the column in which the doctor answers reader's questions. He gives good advice. He has a lot of experience.” (Kanyanat, 25, Employee, University degree, Group3)

The carers' (Group Two) views toward the experts in the mass media also seemed to recognise the authority of the experts:
“It’s interesting to read what the doctors explain about different symptoms in different columns. They are useful and give us more awareness in our lives.” (Sandy, 34, Carer at the centre, University degree, Group2)

“When I go to the bookstores, I first go to the health section. I like to buy books written by experienced doctors who share their experiences with various patients. I learn a lot from the books.” (Patty, 36, Employee – Carer of depressed mother, Master’s degree, Group2)

Findings from women in Group One had the same results as from the other groups in that they believed in what doctors said in the media:

“I thought about seeing him [a psychiatrist, an author of the column that she read] and taking an examination that he mentioned in his article. I don’t know, maybe I would fail the test. What if I don’t pass? He won’t allow me to bring up my baby.” (Jan, 21, Sex worker – Unwanted pregnancy, Grade 6, Group1)

“I like Dr. Punn when he gives recommendations to readers who write to him. His advice is useful.” (Golf, 19, Student – Unwanted pregnancy, Grade 9, Group1)

Titles (of experts) seemed to have a significant influence on the construction of expert, both from subjective and mass-mediated viewpoints. The use of experts’ titles was an obvious form of strengthening their voices and reproducing their opinions. Women’s magazines in this scenario allowed a continual flow of the ‘authorised’ voice while endorsing the experts’ ownership of mental health discipline to appear in the mass circulation.

The dominant use of experts and their titles in mental health columns can be explained by Foucault (1972). His discourse and power concepts imply an epistemic privileging of expert views that are publicly circulated. The authority to perform such actions lies in the dichotomisation to legitimise the medical view and at the same time to exclude (or indirectly reject) other views. In this respect, medical discourse and mediated medical discourse were constructed by mental health experts via their expertise. When concern about mental health was raised, women in all three groups reflected their trust and faith in the expert systems, including the experts’ views, their medical examination and tests, while women’s magazines reproduced such representations of mental health professionals in their columns. This connection describes Gidden’s view on the attitudes of trust: the intense representations of expert and their titles on the media reflect the role of expert system where trust is a primary feature that is “directly connected to the psychological security of individuals and groups” (Giddens, 1991: 91). Without knowing
the experts (as represented in the mass media), the respondents believed in what the experts said with a taken-for-granted confidence that can be referred to ‘abstract systems’ of modernity.

This section illustrates how the power of the expert is maintained by the connecting nodes of scientific examination, expert knowledge, credibility and institution. In fact, these scenarios follow Giddens's (1991) view that expert systems are examples of an abstract system that reflects the nature of modern life and connects how society is organised and managed. Expert knowledge is the key element in the expert system that shows how people respect the power of authority and institutionalised knowledge. Different narratives reflected a certain level of trust in the medical experts concerning mental health and implied that trust bridges the space and gap of uncertainty while constructing a ‘take it for granted’ view of people’s faith in the expertise of professionals. People heavily depended on this social order but had little understanding of how the process actually worked.

The media in this scenario allocated space for mental health experts to deliver their expertise and knowledge by “becoming familiar with the discourses and texts that they provide commentary on” (Danaher, Schirato and Webb, 2002: 22). It was through this communication pattern, via comments from the professionals, that the readers trusted the information given. The media indirectly mediated expert power by using their full names, titles, degrees and affiliations. This was because they predicted that these attributes had a privileged place in the mental health discipline and that the experts were legitimised to talk about the specific context of mental health. This mediated endorsement of expert power was seen in several articles in which the magazines suggested to readers that seeing the doctors was the best solution to their mental health problem. These articles often omitted to offer other possible choices of mental health treatment to the readers:

“From what you have said in your letter, I suggest you come to see the doctor. This is the best way of curing your stress so that you can resume a happy life.” (Column “Unhappy Marriage”, Real Life, Q&A by Dr.Punn Paramee, 982/31: 42-43)

“If you got PMDD [Premenstrual Dysphoric Disorder], it’s necessary to consult your doctor. You need to take prescribed medicine. Before going to see your doctor, observe yourself and note down your symptoms if you have a headache, gained weight, insomnia, etc.” (Column “Cosmo Health Alert”, Cosmopolitan, 146/12: 146)
These findings signalled how women’s magazines placed their readers as receivers of knowledge while filtering expertise in lay understandings, separating expertise and scientific rationality from everyday thinking. This observation could be explained by Livingstone and Lunt’s (1994: 92-97) comment on a “crisis in legitimation of expertise” because the expert (including their knowledge and expertise) is separated from everyday thinking, “they can only be legitimated through claims to authority”. Livingstone and Lunt (1994) identify two processes by which the dissemination of expert knowledge can be filtered by the media: they are “through journalists and through popularizing scientists”. Using a significant number of expert titles with reference to their institutions legitimised experts’ views and voices as owners of mental health knowledge by the journalists (editorial staff in women’s magazines). The power of the expert is maintained by the mass media that constructed how the experts could be regarded. This representation legitimised their columns/voices/arguments/advice by having professionals and their titles endorse what the magazines wanted to communicate. It is interesting to note that a number of articles that cited a Thai expert’s voice in women’s magazines, signalled a gender bias and the superior role of the Thai male mental health expert over that of the female expert. There were 10 columns out of 14 where middle-aged males were introduced as ‘psychiatrists’ who ran columns in the Thai women’s magazines (Dr. Vittaya Nakwatchara in Dichan, Dr. Pun Paramee in Real Life) while Thai female specialists were credited as nurses, social workers and therapists without descriptions of their detailed opinions and without columns under their own names. These findings encouraged me to critically examine the role of women’s magazines as to whether they had special status to empower women’s voices (including female experts’ voices). Not only had women’s magazines provided an unequal space for female authors, they framed women as female specialists (such as nurses) with less expertise and lower professional status than male doctors. This discursive practice was executed by obscuring the voice of female experts while representing male doctors in a more obvious way. Therefore, while trust (of experts) is inherent in abstract systems of modernity, gender bias appeared to be a condition that affected the representations of mental health experts in Thai women’s magazines. As explained by Foucault (1984), discourse explains how society (human and mass media) under discursive formations regulates the way we make sense of mental health. It operates in a binary system that explains the mechanism of exclusions between the notions of true and false which in this case, may give legitimate power to those (male) experts to speak what is believed to be the ‘truth’ (Foucault, 1972) about mental health. Therefore expert system is an embedded discourse in the Thai
understanding of mental health, seen as both subjective and mass-mediated framings of expertise.

The previous chapter discusses self-help (and other alternative treatments) as a site for self-control, freedom of choice and increased levels of autonomy that challenge experts and their orthodox healing system (Peterson, 1997). However, because self-help is a concept that is embedded with the discourses of expert, the results from this research gave a complex and contradictory impression. Rimke (2000: 62) makes a convincing argument that self-help is not an independent process because it requires dependency on oneself while acknowledging the conventional belief of the experts: “self-help is thus an individualized voluntary enterprise, an undertaking to alter, reform or transform the self, or some intrinsic aspect of it, which is contingent upon a person’s seeking some external form of authoritative assistance”. As Advocat and Lindsay (2010: 491) argue, people are not simply autonomous consumers who can be easily freed from experts. They are still dependent upon the professionals, which is “a central feature of the illness experience and the medical encounter in simplistic consumerist constructions”. Although previous research seems to agree that modernity creates the environment that encourages people to be responsible in making choices in their own lives, it is still hard for Thai women to be totally free from the discourses of the expert (as found that the social workers/psychologists organised self-help groups, self-help sessions at the rehab centre were sponsored by a pharmaceutical enterprise, doctors wrote columns about mental health and recommend (self) treatment in women’s magazines). Giddens (1991: 23) describes it as difficult “to escape altogether from the impact of systems of medicine and medical research, since these influences many aspects of the ‘knowledge environment’ as well as concrete elements of day-to-day life”. This section observes the connections between expert and self-help in women’s magazines and shows how expert systems interact with self-help in today’s narratives of wellbeing.

Needless to say, mental health professionals are the key agents in producing and disseminating knowledge and ‘truth’ related to mental health. Experts have an authority to rationalise what constitutes sick, judge who is mentally well or unwell and decide how individuals should be treated. They seemed to be authorised persons for disseminating what counts as mental health knowledge in people’s everyday thinking. Not only did experts relay technical knowledge about mental health, they also transformed scientific theories of mental health into everyday practices
that “filter into the existing stock of common sense knowledge about mental ill-health” (Morant, 2006: 819).

‘Mental health everyday practices’ as referred to by Morant (2006) imply that mental health may no longer be limited by the clinical discourse that provides technical language or allows the authority of experts to be fully exercised. The literature suggests that there is a gradual transformation of mental health as pathology and medical intervention to mental health in everyday-therapeutic atmosphere to include holistic health (Advocat and Lindsay, 2010; Rogers and Pilgrim, 2007). This result showed that mental health experts adjusted themselves to this transformation, extending their expertise (including their recommendations) into the current realm of self-help, alternative and holistic therapy by recommending unscientific healing methods in their columns with the use of informal/non-technical language. This transfer of knowledge (from pure scientific mental health knowledge to the everyday narrative of holistic talk) identified the process of ‘popularizing scientists’ “by which expertise filters into ordinary understandings” (Livingstone and Lunt, 1994: 96). Although the process of popularisation of mental health knowledge by the use of less scientific terms may result in a “loss of expertise” (de Certeau, 1984, cited in Livingstone and Lunt, 1994: 6), Thai women’s magazines reversed this restriction. They maintained the production of expert power by the endorsement of their titles to legitimise status and to maintain their expert position as a source of credibility in mental health columns.

In this study, several authors (who were medical experts) suggested new ways of dealing with stress and tension. In one example, a psychiatrist wrote in Dichan’s column, “Mirror your life with happiness”. He invented a new technique combining meditation with hypnosis and renamed it “Modified Positive Meditation & Self Hypnosis” to recommend how to deal with negative thinking. Another author, who was a doctor, used the word ‘alternative and integrative medicine’ to include acupuncture, hypnosis and Chi [Chinese healing technique] into his methods of healing everyday stress. Another expert introduced the complementary therapies of ‘imagination therapy’ as a good practice for people to believe in themselves, think positively and become happier. This hybridisation of representations reflected the shifting direction of the Thai experts from being the owners of scientific knowledge of mental health to embracing unscientific treatments (such as alternative medicine) into their body of recommendations.
A significant majority of the experts in women’s magazines included easy-fix techniques into their total package of recommendations. They used a specific writing pattern by numbering and bullet points to make their stories easier to read and more accessible. This genre of representation was often used in women’s magazines to provide readers with quick and accessible solutions to problems (Gauntlett, 2008). An example in Dichan was the author (a psychiatrist) who provided readers with an explanation as to why women feel bad about themselves. The author engaged his readers with an introduction of the topic and introduced his techniques to ‘fix’ the problem. He wrote:

“Feeling is something that comes from your inner emotion and has nothing to do with reasons and facts. Having bad feeling is normal and it usually comes from feeling hopeless, stressed, a pessimistic personality, etc. However, you can easily fix this bad feeling by 1. Free your heart from hatred, 2. Free your mind from worries, 3. Live simply, 4. Learn to give more, and 5. Expect less.” (Column “Mirror Your Life with Happiness”, 768: 275)

This specific extract shows that the author, who was a psychiatrist, modified scientific information into popular language. He used accessible language and genre (bullet points and short words) for his medical explanation of ‘feeling’ by formatting his suggestions into numbered points. These findings show how the author (expert) uses numbers/bullet points as easy-fix tips combined with scientific explanation to resolve everyday problems of concern to women. They demonstrated the pattern of how professionals employed the discourse of self-help in popular women’s magazines. One could say with Luhmann (1995) that the expert system increasingly intersects with the media system. Indeed, mediation in this sense is inescapable but it does not imply that the experts and their voice remain completely unchallenged by both the media and the audiences.

Most of the mental health content as represented in women’s magazines was simplified and digested to be an accessible piece of information for mass circulation. Here the medical content is tailored to women’s magazines to make the columns reader-friendly and accessible by modifying the genre (bullet points and informal language). In this process, the experts also transcend the borders of orthodox and non-orthodox treatment by blurring their professional recommendations with easy-fix, self-help and complementary health treatments while extending their territory of recommendations to include unorthodox methods. Mental health professionals, self-help and therapy are therefore part of the expert system in order to secure the mental health professionals’ position of being the ‘experts in this field’.
Despite the strong discourse of the expert, there are challenges and rejections that the respondents had with the experts. Women across the three groups showed recognition and resistance to the experts’ opinions both in their face-to-face interactions and the mass-mediated representations. As earlier noted, carers resisted (and rejected) the power of experts by deciding to change practitioners or find alternative treatment. Several readers in Group Three challenged the experts’ views (particularly their recommendations on easy-fix tips) in the glossy magazines by criticising their advice as “too broad, don’t work” (Chalida, 24, Reporter, University degree, Group3) and “irrelevant to my life” (Darika, 33, Employee, Master’s degree, Group3)

5.3 SELF-HELP, USERS AND THE MASS MEDIA

Findings suggest that there was a common use of therapeutic language with heavy emphasis on easy-fix and self-help recommendations in the columns related to mental health across a range of different magazines. This trend suggested that the orthodox view of medical care described in the biomedical model is now being challenged in a therapeutic culture. In Thailand, Chakrapand (2005) reports that mental health is now widely understood from a holistic point of view\(^3\) which is “an approach to health care that emphasises prevention of illness and takes account of a person’s entire physical and social environment” (Macionis and Plummer, 2008: 684). Chungsatiensap (1993, 1999) also indicates that the prevalent use of natural therapies (such as chakra, yoga, chi and cheewajit that focus on the relationship between body and mind) is gaining popularity among Thai people. Such treatment also includes different forms of self-help practices that encourage them to be more involved in their health and well-being.

Hazleden (2003) argues that self-help texts are the most visible popular manifestation of therapeutic discourse. Previous studies about self-help texts identify a trend which presents self-help in terms of individual choice. The topics of self-help are vast with repetitive themes associated closely with happiness (Rimke, 2000), self-development (Blackman, 2004), improving aspects of relationships, loving yourself and secrets of success (Gauntlett, 2008).

\(^3\) “A whole approach to medicine involves combining current conventional treatment with alternative medicine and unorthodox therapies to treat whole systems, rather than focusing on parts in isolation. The application of holistic methods avoids the supremacy of the doctor as healer and the passive acquiescence of the patient, instead promoting an interaction between them that takes account of the total experience and circumstances of the patient” (Thorne, 1993: 16)
They suggest readers should overcome their adverse life moments in order to be happier and more productive. Giddens (1991) uses the term, 'recovery texts' to explain a consistent set of self-help messages that enhance happiness through the acquisition of self-belief.

At least three key authors address the rise of self-help in their discussion on the complexities of modernity that link interdisciplinary contexts related to reflexivity: (Giddens, 1991 – the ideas of trust, re-skilling and abstract systems; Bauman, 2000 – autonomy, freedom in liquid modernity; and Gauntlett, 2008 – self-help literatures and the pursuit of a happy identity). These authors provide an account for explaining the dynamic phase of social change and lifestyle understood as 'reflexive modernisation' (cf. Beck, Giddens and Lash, 1994) in which individuals have choice to write their lives. Choice in this context lies within the popular discourse of self-improvement. McRobbie (2004: 261) states that "the individual is compelled to be the kind of subject who can make the right choices". The concept of self-help may enhance the sense of autonomy and freedom of choice to enable people to plan 'a life of their own' (McRobbie, 2004). However, the notion of self-help can also truncate the self (Grant, 2007) from the wider social community. Giddens (1991: 180) claims that forms of therapy can be an "indulgence", a self-practice that focuses on the meaning of self. Several women, particularly in Group Three, tended to reflect this contrast:

"I think it’s all about attitudes, once you know the trick that they [problems] can be solved by shifting your thinking, you will no longer need your friends or anyone else to listen to your complaints." (Pannarai, 24, Editorial staff, University degree, Group3)

"I take holidays whenever I get stressed. I think it’s a good self-help technique that makes you feel you are competent to manage your problems. It’s good to be alone and go far away, away from anyone I know." (Bussaba, 32, Lecturer, Ph.D, Group3)

To reduce stress, the respondents across the three groups revealed that they often practised self-help techniques. Women in the hostel mostly learnt about self-help through their participation in self-help groups while a few of them read self-help books. Women in Groups Two and Three learnt about self-help techniques by themselves, mostly by reading self-help materials in the mass media:

"I had a depressive disorder but I am now a volunteer carer and this job makes me proud of myself. I have to thank the Family Link Association website that guided me how to think positively in my life." (Benya, 36, Business owner – Carer of depressed mother, Master’s degree, Group2)
"Why do I have to care about him? I still have so many good things in my life. I read one book, The Secret, it taught me to think positively and bring my soul out from any unhappiness moments." (Kinnaree, 36, Hotel owner, University degree, Group3)

"Whenever I need support, I read women’s magazines. Lots of encouraging contents are in there." (Sandy, 34, Carer at the centre, University degree, Group2)

In addition to reading, other respondents watched some television programmes that invited the doctor to give comments on health issues or they searched the Internet. Several women discussed their mediated experience of self-help:

"I like to read books that give me guidance to cope with my problem better. Sometimes I watched TV and the doctor talked about stress and how to detect our sad mood. It was an interesting live programme. At the end of the programme the host asked the home viewers to call and exchange their experiences of stress. Learning about what others feel and how they manage their stress was very helpful." (Racha, 32, Carer at the centre, University degree, Group2)

"I like to read How-To books, like self improvement books. I read Passion to Success, it’s an American book but translated into Thai. This is a good book because it answers many of my questions. I also like to watch one TV programme, Arokaya [-wellness-], that invites different celebrities to the show and share their health experiences. This show is entertaining as well as educational." (Bussaba, 32, Lecturer, Ph.D, Group3)

The belief of the strong influence of the media in disseminating an expert’s knowledge, offering the laity the passive position to absorb the ready-existing knowledge of the expert is arguably changing. Racha and Bussaba mentioned the two Thai TV programmes that emphasised (and appreciated) the lay experiences of health and mental health. These programmes were a reminder of the study of television audience discussion programmes that Livingstone and Lunt (1994: 178) argue “cut across various symbolic oppositions which have traditionally been encoded in the mass media as representations and legitimations of the social order”. In their study, audience discussion programmes reposition the roles of laity and experts by constructing their new relationship to have equal opportunity to talk about what they know in different ways (such as storytelling). The TV programmes that Racha and Bussaba mentioned can be viewed not only as channels for the dissemination of mental health knowledge. They can be direct invitations for lay audiences to ‘share’, ‘exchange’ and ‘celebrate’ their ordinary (everyday) experiences, creating the changing form of interaction between lay and expert and blurring the boundaries of private stories with the public sphere while at the same time reinforcing the idea of the public sphere
where the media generate “clusters of smaller spheres defined by interests, gender, ethnicity, etc.” (Dahlgren, 2010: 21).

In fact, what also emerged from these narratives was the reflection and interpretation of choice with which the media (television, books, website and women’s magazines) provided the respondents. More importantly, the women from the three groups were able to evaluate, adopt and reject the mediated recommendations. These findings were significant as they signal the importance of gaining ‘access’ to the media as a source of mental health information as well as the density of media interaction that give individuals more opportunity to contact the mass media and use their mediated information to reduce uncertainty and risk (Webster, 2002). They also implied skills and competency that women (as media users) from different profiles required to make effective judgements on the mediated content of mental health. The issues of ‘access’ and ‘media literacy’ are the key requirements in this development process that are discussed further in the following chapters.

CONCLUSION

The analysis clearly shows that mental health experts and their medical knowledge are influential factors in framing mental health constructions (subjective and mass-mediated). This chapter illustrates how mental health is framed by an expert system and its dominant discourse in the Thai context and is embedded within abstract systems of modernity. It supports the assumption that the distribution of expert knowledge is pervasive and is part of modern life and that scientific knowledge is the key feature in the construction of the expert system of mental health. The experts (psychiatrists, psychologists, psychiatric nurses, social workers and therapists) are at the centre of knowledge circulation which can be achieved by diverse forms of relationship: the doctor-patient relationship that usually takes place in the clinic or hospital which is naturally found in the experience of carers; through the experts in self-help groups; in counselling sessions; and in the mass media. However, the findings revealed an interesting result in that there was recursion where women across the three groups recognised but challenged (by rejection) the system of experts, cueing the variations of the crisis in legitimation of expertise. This research indicates the self-help group – a forum for members in a sub-social group to raise their voice and exchange their matters of interest – as one form of communicative action that blurs private with public. Self-help groups (partly viewed as embedded features in expert system) are a way to
celebrate the diversity of women's experiences of mental health in the public. Self-help groups and their significance in this study are similar to the nature of TV audience discussion programmes that allow personal stories and expressions to emerge through 'story-telling' and 'debate' genres. As Livingstone and Lunt (1994: 180) argue, “the public/private dimension may also be collapsed, in both the system and the life-world, through the processes of story-telling and accountability. Members of the public are invited to tell their private stories in public, undermining the distinction between private and public in the life-world”. This analysis strengthens the point indicated earlier that 'public sphere' is hybrid, challenging the normative model of Habermas (1989) that public sphere is dichotomised by the domains of private versus public.

One way to see how discourse connects to knowledge and power is to observe closely the system of experts in the media. The dominant representation of experts offers a particular construction of mental health through medical professionals who have access to medical language while others are excluded. This creates epistemic privilege. Medical discourse constructs medical knowledge and circulates it as the professional culture which is then taken-for-granted. Not only do particular discourses gain prominence over other discourses and establish knowledge in their operational systems, such knowledge also constitutes truth status, which is the rule of a discourse (Cheek and Rudge, 1993: 275). The power of the expert is constructed by expertise that lies in the value of accuracy, reliability and credibility (Turner, 1987). The magazines legitimise expertise by the use of experts’ titles while constructing experts to have the authority to speak of the truth about mental health. However, the role of the expert is being challenged. The respondents, particularly the carers, obtained a wider choice through the dissemination of mental health information in the mass media. They started to resist the power of experts by developing a critical distance toward their practitioners and mental health treatment. Despite the importance of mental health experts in social constructions of mental health, the respondents started to question their expertise and find alternatives (by attending self-help groups, searching information on the media, consulting monks) to fill the gaps in their knowledge related to illness. Although the respondents found the concept of self-help useful, they rejected some self-help advice both from direct contact and mass-mediated contact. Therefore women are co-constructors in their belief about the experts as well as the practice of self-help. In fact, the theme of self-help in this study is a paradoxical concept. In one way, it promotes self-responsibility and an ability to cope with problems, extending the diversity of sphere to gather individuals (living at the margins) with
mutual concerns to share (emotional) experience and exchange moral support. It is deeply embedded in the reflexive project of the self that allows individuals to choose their lifestyle and to take charge of their lives. On the other, self-help depends highly upon expert systems (self-help groups led by therapists at the hostel and the Family Link Association, self-help content as advised by the experts in women's magazines) that finally became an essential feature of expert systems filtering through abstract systems in modern social life.
CHAPTER 6

MYTHS RELATING TO MENTAL HEALTH AND MENTAL ILLNESS

The theme of ‘mental illness’ emerged from the foregoing analysis as an important variable that creates a negative response in the understanding of mental health both in the media and in subjective constructions. As previous studies describe, lay people often confuse mental health with mental illness and assume that there is a very close relationship between them (Armstrong et al., 2002; McCulloch, 2006). The result of this confusion is the stigmatisation of people who are mentally ill and the creation of a negative stereotype that such people are dangerous and violent (WHO, 2003). As the narratives from 4.2.2 demonstrated, carers of the mentally ill experienced ‘double illness’, from mental illness itself and from the stigma attached to it.

This chapter investigates how mental illness is constructed from women’s subjective viewpoints and examines their diverse experiences with the mentally ill. The key concepts of stereotyping and stigmatisation of the mentally ill are used to explain why negative characteristics, such as being dangerous, are found in both women’s perceptions and mass-mediated representations of the mentally ill. According to Rogers and Pilgrim (2007), stereotyping is always narrow, rigid and misleading. It is a form of social typing that ignores individual variability within social groups and involves a multiplicity of biases. This chapter illustrates the respondents’ constructions of mental illness from their experiences to highlight different scenarios in which women interacted with the mentally ill. The findings suggest that although the representation of the ‘mentally ill’ as dangerous was strong, both respondents and women’s magazines offer nuanced constructions. This chapter argues that there is interplay of the multiple constructions of mental illness cross-functioned in receptions of the topic and that there are some reproductions of and challenges to the popular image of mental illness. The analysis leads to the understanding of the recursion of communication (Luhmann, 2000) between the media and subjective construction, while media literacy emerges as a skill to extend the quality of that recursive connection between the media and its users. This chapter also sheds light on the complexity of the mass-mediated representations of mental illness and the fact that the discourses of both experts and class inequality have a major influence on the social framing of the mentally ill.
6.1 MEDIA FRAMING OF THE MENTALLY ILL AS DANGEROUS

Research into media representations of mental illness delivers consistent findings about the negative image of mental illness and its assumed link to violence and dangerous behaviours (Philo, 1994; Sieff, 2003; Stuart, 2003; Wahl, 1995; 2003). The mass media are the most common sources of public information and understanding of mental health and mental illness (Wahl, 1995; Nunnally, 1961), but at the same time they are accused of representing negative stories of mental illness which contribute to the stigma of mental illness due to the schematised images they portray (Philo, 1994; Salter and Byrne, 2000). In a study from the 1950s, Taylor (1957) investigates newspaper, magazine and television representations of the mentally ill and finds that the media construct them differently from ‘normal people’ and describe them by using words such as ‘dangerous’, ‘dirty’ and ‘unintelligent’. Thornton and Wahl (1996: 18) also find that “dangerous, aggressive and irrational” are the specific terms used to label the mentally ill. Similarly, Wilson et al. (1999: 442) point out that the mentally ill are defined as “stereotypically and blatantly negative and served as objects of amusement, derision or fear”. These findings correspond with Wahl’s (1995) conclusion that the media play a major role in constructing the stigma of mental illness through the images they represent – such as ‘the mentally ill are dangerous’ – thus delivering negative stereotypes to the mass audience. Heather (2006: 99) maintains that entertainment and news media “provide overwhelmingly dramatic and distorted images of mental illness that emphasise dangerousness, criminality and unpredictability”. Therefore, regardless of time, little has changed in how the public and the media view the mentally ill.

Link and Cullen (1986) assume that because people in society lack first-hand experience with the mentally ill, they depend upon the media as a primary resource in understanding mental illness. Through mediated representation, people construct their realities about mental health and mental illness from popular imagery and representation (Olstead, 2002). As Peterson (1994: 127) comments, “we have become increasingly dependent on ever-changing media information and images for providing our reference points for understanding what it means to be a ‘normal’ human being”. The media consistently associate mental illness with negative stereotypes, which may lead to the assumption that the mentally ill are dangerous, unlikeable and should be avoided. These views produce a strong connection between the negative mass-mediated representation of mental illness and negative public attitudes toward the mentally ill (Coverdale, Nairn and Classen, 2002; Haywood et al., 2002; Knight, Wykes and Hayward, 2003; Stout, Villegas and
The negative stereotypes, to some extent, generate what the Glasgow University Media Group describes as "the climate of fear" (Philo, 1999: 57, see also Angermeyer and Schulze, 2001; Wilson et al., 1999) that surrounds the subject of mental illness and contributes to negative beliefs in members of the public, which in turn is constructed by the media.

The results of my study support previous findings that people in society seem to be trapped in the negative stereotyping of mental illness. However, the findings demonstrate that the respondents' understanding of mental illness was varied across the three groups. On one hand, women used the terms 'Rok Jit' (the loony bin) and 'Baa' (mad) metaphorically in referring to people with what many of them called 'abnormal' or 'dangerous' behaviours. The women also described the characteristics of the mentally ill in ways close to mass media representations. On the other hand, the understanding of mental illness was not always affected by the media's construction of the mentally ill as violent and dangerous. One woman in Group Three criticised the media's misrepresentation of the mentally ill as follows:

"The media always blame the mentally ill, accusing them of committing the crimes and telling others that they are dangerous. I don't think they are all harmful" (Ravivan, 34, Business owner, Master's degree, Group 3).

This narrative was one among a number of examples that showed how the speaker rejected the mediated (mis)representation of the mentally ill, signalling that the reception was not homogeneous. This provides a starting point in this chapter for examining the multiple understandings of mental illness, the audience's constructions of mental illness and their recursive communication with the media.

6.1.1 Variations in the Stigmatisation of Mental Illness

A number of studies frequently draw on Goffman's (1963) work and his notion of 'deep discredit' that generates discrimination against the stigmatised person (Byrne, 2000; Green et al., 2003). Goffman (1963) explained that stigma is a dual interaction between the 'normal' and the 'stigmatised'. It is a process of social construction in which the stigmatised persons are isolated, and the social distance between the labeller and the labelled, which generates the negative consequences such as rejection, exclusion and discrimination, is increased (Hayward and Bright, 1997). One finding in the current study was that the respondents in Groups Two and Three used
terms such as ‘abnormal’, ‘unpredictable’, ‘dangerous’ and ‘incommunicable’ to describe mentally ill subjects:

“Baa means crazy or losing your mind. There are so many of them out there, yeah ... I am scared of them. You never know what they’re thinking.” (Kessara, 28, Employee, Master’s degree, Group3)

“Rok Jit people are abnormal. They love violence and destroying things.” (Bee, 26, Domestic violence, Grade 6, Group1)

Philo (1999) states that these traits (dangerous, abnormal, unpredictable) are the primary attributes mentioned when members of the public refer to stereotypes of the mentally ill. Goffman (1963: 11) describes mental illness as the stigmatised feature associated with the negative perception of the mentally ill to be rejected and discriminated against while generating particular forms of disapproval, devaluation and exclusion:

“[stigma refers to] bodily signs designed to expose something usual and bad about the moral status of the signifier. The signs were cut or burnt into the body and advertised that the bearer was a slave, a criminal, a traitor, a blemished person, ritually polluted, to be avoided, especially in public places.”

Not only are Baa and Rok Jit the stigmatised terms that generally influenced the respondents, fear of the mentally ill and other negative perceptions may prevent them from seeking the medical treatment offered by specialised psychiatric institutions. In this study, the name ‘Sritanya Hospital’, one of the biggest mental hospitals in Thailand, also created the feeling of rejection in seeking help from this institution. Some informants revealed that they refused to be treated at this mental hospital because of their fear and shame of being labelled as a mentally ill patient in Rok Jit hospital:

“I don’t want other people to know I was treated at Sritanya Hospital. I don’t want them to think I am Baa.” (Mai, 19, Unwanted pregnancy, Grade 12, Group1)

“When I first got medication from Sritanya, I had to hide it. I don’t want my relatives to find out that their niece was being treated in a psychiatric hospital.” (Racha, 32, Carer at the centre, University degree, Group2)

“I would be embarrassed if one of my family members was a patient at Sritanya Hospital. I don’t want people to feel bad about us. I will have to keep this a secret.” (Adchara, 36, Housewife, Master’s degree, Group3)
Stout, Villegas and Jennings (2004) explained that fear of being stigmatised and embarrassment over having to receive mental health treatment are common in many countries, and this has an impact on the experience of illness. As Star (1957) states, the idea of seeking help from psychiatrists enjoyed little public endorsement because of people’s fear and shame, and this can result in the rejection of the institution. ‘Mae Ku’, a senior carer at the rehabilitation centre (The Family Link Association) put forward her view that the subject of mental illness in Thailand has been kept in the dark, and is considered shameful, and thus there is a risk that mentally ill patients will end up outside the official treatment system:

“Talking about mental disease is a taboo subject in Thai society. Potential patients lack the opportunity to be cured and cared for because their symptoms are a family secret. Their relatives are embarrassed and in many cases, reject the nature of the disease. Thai people are too ashamed to talk about it.”

By comparison, women in Group One and Group Three generally viewed people with mental illness in similar ways, leaning towards the negative stereotypes found in previous research. Some of them described people with mental illness as being ‘dangerous’, ‘violent’, ‘aggressive’, ‘unpredictable’, ‘uncontrollable’, ‘abnormal’, ‘dirty’, ‘manic’, ‘crazy’, ‘without morals’ or ‘living in their own world’ and ‘unable to communicate with other people’. Several respondents associated the mentally ill with sexual acts and crimes by labelling them as ‘rapists’, ‘sadists’, ‘lecherous people’, ‘sexual convicts’, ‘underwear stealers’ and ‘obsessed with sex’. A few respondents from Group One, who were impoverished women from rural areas, referred to the mentally ill as being possessed by spirits or being cursed, which reflected the cultural connection of spirituality, magical rituals and mental illness that exist in Thai rural beliefs. This point is explained by Chungsatiensap (1993: 2) who explains that health and illness in Thailand are rooted in three multi-dimensional cultural frames of “ghosts, Hindus and Buddhism”.

The majority in Groups One and Three also described the mentally ill using expression such as “wearing torn clothes”, “a man with dark skin”, “a dangerous man”, “wearing excessive make-up”, “staying naked”, “shouting out loud in public” or “serial killer”. These negative perceptions mean people with mental illness are viewed with shame, disgrace or disapproval (WHO, 2001b), resulting in an afflicted individual being rejected by others. These findings are the key consequence of the stigma of mental illness, which Harper (2005: 468) describes as “a great myth” that has been hidden in society and in popularly mediated representations. The myth of mental illness causes discrimination that Sholl, Korkie and Harper (2010) consider a significant barrier to the social inclusion of individuals with mental health problems. These negative
stereotypes of mental illness can have damaging effects on the lives of sufferers and their families, as this study demonstrates in Group Two’s (carers) narratives of their life experiences.

In comparison with Groups One and Three, a number of carers gave different descriptions of the mentally ill. They demonstrated their understanding towards the patients with mental illness for whom they cared and with whom they empathised:

“If you get toothache, it can be cured if you visit the dentist, but depression is something different. It’s suffering. It’s like waking up with no will to live. I understand depressed patients very well when they explain to me how they feel.” (Malee, 58, Carer of depressed son, Diploma, Group2)

“The public has limited knowledge about mental illness. It’s also difficult to detect if someone is sick. Unlike the disabled person, whose disability you may see, the illness of psychiatric patient is often not visible. How could they say that they had visions? Their medicine is expensive. They hear voices? Who would understand? Others might think they must be Baa.” (Sandy, 34, Carer at the centre, University degree, Group2)

To justify the stigma of mental illness, some carers employed scientific reasoning to explain its causes. Several carers explained that the symptoms of mental illness came from “unbalanced chemical substances in the brain” or “acute stress”. One carer, who had also suffered from depression, put it as follows:

“When I took cabs and told drivers to take me to Sritanya, they usually gave me a puzzled look and asked if I was not scared. I asked the drivers every time what I should be scared of. Mental illness is caused by malfunctioning of the brain; it is all about chemical substances that are not properly balanced.” (Racha, 32, Carer, University degree, Group2)

Racha (and a number of carers) seemed to describe the mentally ill and the symptoms of mental illness in neutral narrations and sympathetic descriptions, without the use of the stigmatised terms such as Rok Jit. However, there were several cases in which the carers also fell into the myths of mental illness, particularly when they described the unknown mentally ill whom they met randomly on the streets. More than half of the carers reported that they had been frightened of a mentally ill person in the past (or even in the present day if they met people whom they thought had mental illness in public places). This result was noteworthy because it showed how strong the stigma of mental illness was, while demonstrating that the mentally ill can be schematised into different categories. Despite their direct experience as carers of the mentally ill and the large volume of information they had gained about mental illness, Group Two also shared the the everyday negative perceptions that the mentally ill are dangerous. This occurred
specifically when the women referred to the mentally ill ‘roaming the streets’ and to those who committed crimes featuring the news:

“I used to get scared of Baa patients, I was afraid that they could harm me. When I read about them in the paper, I was worried and felt unsafe whenever I walked back home. Now, I understand better how they feel and I am sorry for their illness.” (Tina, 28, Government officer – Carer of depressed sister, University degree, Group2)

“Of course, I am afraid of the real Rok Jit. On the streets, if I see some suspicious man who looks dirty and nervous, I’ll walk away. I don’t want to risk being hurt.” (Mala, 20, Student – Carer of schizophrenic father, University degree, Group2)

Women in Groups One and Three did not always demonstrate the negative perception that the mentally ill were dangerous or describe them as having disturbing characteristics. Although it could be assumed that lay people tended to have an immediate view of mental illness as psychotic, dangerous, unpredictable and violent because of the myth of mental illness, this view was not universal. Several women particularly in Group Three put their opinions differently:

“I feel sorry for them knowing that they were arrested and sent to jail. Many crimes occur because people get addicted to drugs, not because they are Baa.” (Pimpimol, 33, Bank officer, Master’s degree, Group3)

“Not all of them [mentally ill] harm people. The reason could be because they were abused when they were young. It could be an undeletable scar for them.” (Wirongrong, 33, Air crew, University degree, Group3)

This section illustrated that there were variations in the respondents’ understanding of mental illness. There were complexities of external and internal contradictions that contrast and parallel within the same group or between the groups. For instance, Mala used the term “real Rok Jit” (the mentally ill person whom she met on the street and identified as a violent and dangerous man) to differentiate from her schizophrenic father who had already been treated by a psychiatrist, and the term “the cured psychiatric patient” to label the mentally ill individual for whom she cared. The mentally ill thus can be classified in different, and sometimes contradictory, ways in a single individual’s construction. The next section continues to draw on the women’s self-evidence of their experiences with the mentally ill and of the various scenarios in which they had learnt about mental illness in their intricate cultural contexts, in order to demonstrate that subjective constructions are diverse.
6.2 EXPERIENCING THE MENTALLY ILL IN EVERYDAY LIFE

Self-evidence (direct experience as described in women's own narrations) or life experience was the key factor that affected how the respondents constructed their understandings of mental health and mental illness. The following section examines three different scenarios of contact, driven by the data to ascertain how the women interacted with the mentally ill. The different scenarios are: (1) Immediate Experiences; (2) Casual (Random) Experiences; and (3) Mediated Experiences. The use of the term 'experience' is adopted to provide a particular framework for the respondents in this study, dealing with each experience. There is a hybridisation of experience overlapping among the women as groups and as individuals, which shows the women's dynamic understanding of mental illness. This hybridisation relates to the recursion of communication from media to subject to media that creates a 'loop of connection', which in turn emerges as a key result in the examination of mental health constructions and describes the dependent relationship between the media and their audience.

6.2.1 Immediate Experience

This first classification covers the experiences that involve women's direct, close and frequent contact with the patients of mental illness. It is the situation specifically described by the carers (Group Two) who cared for the psychiatric patients in Sritanya Hospital and the rehabilitation centre (the Family Link Association). The respondents developed their understanding about mental illness through their everyday experience as carers as well as from the knowledge they gained from specialists in the mental health care system. Women with immediate experience of the mentally ill on the whole showed less fear of the patients compared with the other two groups. In fact, they showed their understanding of how it may feel to be a psychiatric patient:

"If you ask me about mental illness, I think of my mum. She is now being treated for depression. In her case, she lost my brother and it is now more than ten years that she has had to cope with the loss. I will do anything to help her." (Patty, 36, Employee, Carer of depressed mother, Master's degree, Group2)

"I am so sorry for my son. When the symptoms recur, he is out of control. It's a tough situation for all of us. Although, he behaves strangely, he has never harmed anyone. One day, he knelt in the garden and prayed to invisible angels. I thought he had had a vision." (Somjai, 50, Housewife - Carer of schizophrenic son, Grade 6, Group2)
Most carers described their understanding of mental illness in terms of chemistry, medicine and biomedical explanations rather than identifying symptoms in a social context with associations of violence and dangerous behaviour, as usually described by the women in Group One and Group Three. As discussed in section 6.1, the carers’ understanding of the nature of illness relied mostly on scientific explanation, and the belief that mental illness can be cured through systematic medical treatment and care in a specialised mental institution. At this stage there was an interface between experts, mental institutions and scientific explanation bound up with the expert systems discussed in Chapter Five that influenced women’s understanding of mental illness. Sritanya Psychiatric Hospital has become a special institution whose role lies between that of an asylum and “professionalisation of medicine” (Giddens, 1991: 161) that Giddens describes as “a setting where medical technology can be concentrated and medical expertise fostered” Giddens (1991: 161). Sritanya and the Family Link Association became the settings of technical correction that produced scientific knowledge on mental health and mental illness that affected how the carers constructed their knowledge of mental illness.

6.2.2 Casual Experience

This classification refers to the random situation in which women met the mentally ill at some point in their daily lives. This type of experience was frequently mentioned by women in all three groups. The respondents reported that they met unknown mentally ill people in various public places such as ‘bus stops’, ‘soi’ (small streets), ‘phone booths’, the ‘market’ and ‘under the bridges’. They characterised the mentally ill using negative terms such as ‘dirty’, ‘dangerous’, ‘worthless’, ‘violent’, ‘funny’ and ‘unpredictable’. Such terms are similar to popular depictions of mental illness in the media to which previous studies on mental health representations in Thailand refer (Limpanavivit, 2004; Pattarawanich, Tantipiwanasakul and Poomsaitong, 2010). This casual experience strengthened women’s negative perceptions of the mentally ill. For example, they used the terms Baa and Rok Jit, to symbolise the mentally ill person whom they met:

“Yes, I am scared of Rok Jit people. They are abnormal. They could hurt me. I sometimes meet them on the streets or at bus-stops. I can’t predict what they have on their minds.” (Joy, 26, Clerk, Domestic violence, Grade 12, Group 1)
“There are so many Rok Jit in Bangkok. People who like to hide cameras in the ladies and enjoy seeing women naked. They are abnormal.” (Kanyanat, 25, Employee, University degree, Group3)

“I met Baa people many times in my life, on the streets, soi or at bus-stops. The Baa man wore dirty clothes, mumbled or shouted. He slept on the footpath. I didn’t know what he was thinking. I was just afraid that he would come after me. It was quite a scary experience.” (Piyada, 24, PR staff, University degree, Group3)

The negative portrayal of the unknown mentally ill person as being dangerous and violent seems to correspond closely to the descriptions and profiles of ‘poor’ and ‘homeless’ people. With this general association to such profiles, women did not provide clear information about the background of the mentally ill individual, such as age, social status and occupation. Regardless of whether the homeless people to whom the women referred were actually mentally ill or not, women from different groups labelled them with negative attributes, describing them as ‘dirty’, ‘disgusting’, ‘smelly’, ‘dangerous’, ‘untrustworthy’ and ‘highly drugged’. These descriptions also linked the mentally ill to an unidentified underclass:

“Who knows what he is thinking? He might be Baa or drunk. He looks homeless, he is dirty and wears torn clothes. If you come closer to him, who knows what might happen? He may rape you or kill you. No, better to stay away. It’s too risky.” (Mekla, 36, Domestic violence, Grade 12, Group2)

“There are so many Rok Jit on the streets. They are like homeless people. I meet them all the time on the pier. When I am 100 m away, I already feel insecure.” (Kessara, 28, Employee, Master’s degree, Group3)

These narratives show how casual experience shaped the women’s perceptions toward the mentally ill. Roger and Pilgrims (2007) note that if members of the public see people acting in a different or strange manner, such people run the risk of being labelled as ‘a nutter’, ‘a loony’, ‘crazy’, a ‘freak’, ‘scary’ and ‘violent’, which are prefigured notions of mental illness. The results suggested that people with mental illness were viewed with multiple characteristics in the same way that Rogers and Pilgrim (2007) review negative stereotypes of the mentally ill in the press by the heavy use of the titles Rok Jit and Baa. They suggest that apart from violence, the mentally ill may be depicted as being naively cheerful, childlike and quirky, leading to their social incompetence and the perceptions of dependency and lack of intelligence. Such figures could become “the butt of humour” (Roger and Pilgrims, 2007: 36), another image in cartoon depictions and advertising where ‘nuts’ are used to create humour about human failings. In addition to ‘violence’, ‘dangerous’, ‘crazy’ and ‘childlike’ (Roger and Pilgrims, 2007: 36), the mentally ill can also be labelled as ‘funny’, ‘weird’ or ‘like a clown’. All of these traits are
accompanied by negative stereotypes that caused social rejection of and discrimination against those suffering from mental illness. In the respondents’ minds, this is socially embedded.

6.2.3 Mass Mediated Experience

The central aspect of the stigmatisation of people with mental illness is that they are dangerous and unpredictable (Heather, 2006; Wahl, 1995). This perception may result from two major factors. As explained by Penn and Wykes (2003), people who misunderstand the nature of mental illness because they lack direct experience of the mentally ill tend to absorb the negative stereotype of severe mental illness that is repetitively framed by the mass media. As Lyons (2000: 356) comments, “meanings developed in the media often become so embedded in society that is it difficult for individual women or men to resist them”. Although this is a widespread view that may be not true in all cases, several respondents shared how they learned about mental illness from the media:

“I can imagine what the mentally ill looks like from TV representations such as in Thai drama series. Oh! but I have seen Rok Jit in the market. I would rather stay away. They may be dangerous.” (Jintara, 33, Novelist, Master’s degree, Group3)

“In a drama on Channel Five, there was a scene in which a mentally ill mother held a baby in her arms and screamed like crazy. I remember this scene vividly. For me, I am not afraid of Baa people, but I wouldn’t let you leave me alone with them [laugh]. What if they come to wring my neck? How can you predict when are they going to freak out?” (Kinnaree, 36, Hotel owner, University degree, Group3)

In these narratives the mass media have become a major source of public knowledge about mental illness and have helped formulate people’s understanding of Rok Jit and Baa, particularly for the women in Groups One and Three who had less direct contact with the mentally ill. These testimonies confirmed that certain representations (such as the mentally ill being dangerous) were rather strong while people’s perceptions that the mentally ill are dangerous could be based on the experiences they gained from the media (Seaman, 1992). For the carers, more than half of them reported that they also had held a negative attitude towards the mentally ill in the past before they became carers:
"In my childhood, I watched one TV drama and remembered a scene with a person threatening a child. He was dirty, had messy hair and unfriendly eyes. But it was a long time ago. Now if I see a man like that, I want to take him to the hospital for proper treatment." (Patty, 36, Employee – Carer of depressed mother, Master's degree, Group2)

"In the past, I was afraid of these patients. I was scared that they might harm me, like in Chitlada’s case in the newspaper. I started to keep my distance from these people when I walked in the streets, as I thought they were weird. But since I became a carer, I am not afraid of them anymore." (Valley, 30, Government officer – Carer of schizophrenic mother, University degree, Group2)

A number of studies into the depiction of mental illness in the media have been paid much attention by the press. Over the past decade, research has indicated growing attention to images of mental illness in both the press and popular magazines (Nairn, Coverdale and Classen, 2001; Wahl et al., 2002; Wahl, 2000; Williams and Taylor, 1995). The respondents across the three groups confirmed that the negative portrayal of mental illness in the mass media had a direct effect on them, causing them to fear the mentally ill to a certain extent. This result became clear when women in Groups One and Three referred to the representations of mental illness in certain films. For example, the women made mention of scenes showing a schizophrenic killer committing a crime:

"Rok Jit people must be violent like in many films I have watched. He handcuffed and hit his wife before having sex with her." (Tan, 39, Maid, Unwanted pregnancy, Grade 9, Group1)

"Rok Jit is Baa. They just can’t communicate and are uncontrollable. Sometimes, they may look depressed like those we see in the movies but suddenly they kill people." (Kinnaree, 36, Hotel owner, University degree, Group3)

The study of the Glasgow University Media Group (Philo, 1994, 1999) explains that the mentally ill had been affected by overwhelmingly negative and inaccurate representations (misinformation, inaccurate use of psychiatric terms, the use of negative stereotypes). Media representations, therefore, were a critical element in forming and influencing people's attitudes, while the media’s stereotyping of mental illness can distort the truth and may create the stigma of

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54 ‘Chitlada’ was a psychiatric patient whose story hit the front page headlines of every Thai newspaper in 2005 during her trial. She was accused of entering a school and stabbing a schoolgirl without reason. After the court investigation, Ms. Chitlada Tantiwanitchayasuk was diagnosed as schizophrenic by the Department of Mental Health. She was ordered to spend 4 years in prison followed by mandatory release into the care of the ‘Galaya Rajanagarindra Mental Institute’ where she will remain until the authorities believe she is no longer a threat to society. Her progress will be reported to the court every 6 months (see news archives on The National News Bureau of Thailand, Public Relations Department, http://www.prd.go.th).
mental illness in women's perception of mental health. However, this notion was not universal. Not every woman in the study conformed to such ideas. Women across the three groups with a higher frequency in Groups Two and Three challenged the mass-mediated representations by providing explanations of the media intention or questioning the media. The next section focuses on the developing strategies the respondents adopted to filter the mass-mediated content of mental illness. These strategies challenge linear models of communication and support the view that constructions are recursive.

6.3 MENTAL ILLNESS, REPRESENTATIONS AND MEDIA LITERACY

People experience the world outside themselves through media representations in various ways (Webb, 2009). When it comes to the subject of mental illness, previous literature indicates that the mass media prompt prejudice and reinforce public fears of mental illness. They distort truth and emphasise stigma by exaggerating social stereotypes that associate the mentally ill with violence, unpredictability and dangerous crimes (Wahl, 1995). Although the result in this study tends to demonstrate the direct connection between women's perceptions of the mentally ill and the mass-mediated representation that they are dangerous, not every respondent conformed to such a frame. Women, particularly in Groups Two and Three, criticised and rejected these representations while several of them questioned the media or engaged with different media sources to confirm the information they had received. These findings signal that women's understanding of the mentally ill is not uniform but is fragmented and hybrid.

The informants disclosed that they had struggled to get the information they wanted about mental health, because a less positive mental health content was represented. In addition, they found a number of negative representations of mental health and mental illness in the media. Several respondents shared their views on the difficulty of finding positive mental health information in the press, while another working woman described the films that perpetuate the negative stereotypes of the mentally ill:

"There is no way of getting positive information about mental illness from newspapers. How could I believe what Thairath said? The paper always cover too many dramatic stories about the mentally ill who have committed a crime. If I want to know what the symptoms of mental illness are like, I go to specific websites or I read books." (Jitdee, 40, Business owner, Carer of schizophrenic sister, Master's degree, Group2)
"Many films about mental illness are all about violence, serial killers and crimes, such as in the Anthony Hopkins series ‘Silence of the Lambs’, ‘Hannibal’ and ‘The Orphans’ or ‘Psycho.’" (Wirongrong, 33, Air crew, University degree, Group3)

Some women in Group Three revealed that they understood the driving force behind popular newspapers and television is the need to increase circulation figures. They also understood that the media are businesses that have to survive in a highly competitive market:

“If newspapers don’t strike the headlines, how can they sell their news? I noticed that the same stories were reported differently in three papers I read. Sometimes they lied, but it was fun to read.” (Pimchanok, 22, Employee, University degree, Group3)

“The media in our country exaggerate. They have the power to make an ordinary man look like a prince or a devil. They just want a sales margin. We consume what they offer but we need to evaluate if it’s true or not. What they present may not be an absolute fact. We need good judgement to deal with them.” (Tonghatai, 30, Employee, Master’s degree, Group3)

The understanding of the media as a business force was the foundation of media literacy. Media literacy is described by Potter (2005) as the media user’s knowledge of media content and industries. Livingstone and Lunt (1994: 70) comment that members of the audience are “critical viewers” who “are ever more experienced, critical and sophisticated in their reception of the media as they become increasingly familiar with its forms and production process”. The ability to understand and identify accurate content requires “a set of skills or competencies” (Buckingham, 2007: 44) or the essence that Potter (2005: 22) refers to as the tools and skills of media literacy. He explains that the media user needs to have the ability to access, analyse, evaluate and create the media message:

“Media literacy is a set of perspectives that we actively use to expose ourselves to the media to interpret the meaning of the messages we encounter. We build our perspectives from knowledge structures. To build our knowledge structures, we need tools and raw material. These tools are our skills. The raw material is information from the media and from the real world. Active use means that we are aware of the messages and are consciously interacting with them.”

In fact, the findings reveal various aspects related to the respondents’ understandings of mental illness, including their ability to describe the symptoms, their experience with the mentally ill, and the opportunity to seek knowledge about mental illness. These ideas can be described as ‘mental health literacy’ (Jorm et al., 1997) to include different features related to people’s capacity to understand mental health. For instance, several respondents were able to recognise
psychological symptoms, know how to seek information and professional help and could identify risk factors and self-treatments. A number of the respondents were able to compare and contrast the mass-mediated information of mental health from different media channels. According to the concept of media literacy, users who are media literate are “consciously processing the information and screening it out, then keeping the useful information and building a strong knowledge structure” (Potter, 2005: 292). As McRobbie and Thornton (1995) point out, audiences may or may not be influenced by the media, but they understand the financial need of journalistic practice to guarantee the emotional involvement that keeps the interest of the public and increases media ratings. This awareness could protect audiences from the influence of the media and enable them to better select, consume and criticise what the media say. This notion is also explained by Buckingham (2007: 53) who describes the essential characteristics of media literacy that require multiple literacies in constitution of a “whole range of contemporary forms of communication”. He states that media audiences “need to be able to evaluate the material they encounter, for example, by assessing the motivations of those who created it and by comparing it with other sources, including their own direct experience” (Buckingham, 2007: 48).

The testimonies showed that women seemed to have made rational decisions about how to select and use the media they consume. The result was in accordance with Abercrombie (1996: 140), who argues that “audiences are not blank sheets of paper on which media messages can be written” (cf. Iser, 1971, 1978). Women across the three groups (with a higher frequency in Groups Two and Three) showed their understanding of the fact that the media are in the business of conveying information, are highly competitive and driven by a need to commercialise. Mass media, in this case, respond to market forces by writing what will attract a mass readership. One secure way to boost sales, particularly newspaper sales, is to use sensational headlines with emotionally charged words and to connect mental illness with violence and crimes to catch the attention of the public (Thornton and Wahl, 1996). As seen in Thai sensational newspapers, the mentally ill are referred to in front page headlines relating to crime. Such headlines employ colourful and emotionally-charged language. For example:

“Rok Jit charged by local cops for stealing women’s underwear at condo.” (Thairath, 9 January 2008)

“Sick lesbian committed suicide because of stress from unfulfilled love.” (Baan Muang, 11 February 2008)

55 Headline examples during the time of my preliminary study (January-February 2008).

Byrne (2000) states that the motivation of the press is the newsworthiness\(^6\) which is superior to a worthy story and that explains why the images of madness and distress attract public attention and increase ratings. The respondents, particularly in Groups Two and Three, often rejected the negative media representations of the mentally ill and displayed disbelief at how the media repeatedly associated criminal news with the mentally ill:

"I don't like the way the media talk about Rok Jit people. In Chidlada's case, the media tried to say that she stabbed that kid without any human feeling. On television, they always make people with mental illness look so stupid or like they are too dangerous and need to be avoided." (Racha, 32, Carer at the centre, University degree, Group2)

"When I read the front pages of newspapers, they are all about sick psychopaths, serial killers, the insane, the Rok Jit who committed crimes. I don't want to wake up and read this kind of news. Newspapers exaggerate. There is no need to make this scenario worse." (Chalida, 24, Reporter, University degree, Group3)

From the narratives, the media, and newspapers in particular, can be seen as social structures for emphasising the stigma of mental illness, creating an environment which views the mentally ill as a threat or as being capable of violence towards others (Philo, 1999). The testimonies highlighted misrepresentation of mental illness in the media that focuses on the idea of the homicidal madman who behaves violently, erratically and inexplicably (Foucault, 1967). However, the informants, particularly Groups Two and Three, refused to allow the media to be a wholly 'brainwashing' vehicle that consistently misinformed them. In this scenario, media audiences were capable of dealing with the media: they became more selective in choosing what to consume and justified their own interpretation of mental illness via their reception of the media content. These findings demonstrate the breakthrough of audience research, in contrast to traditional mass communications research, by placing more emphasis on people, their reception and their recursive connection with the media culture. Furthermore, media content is not fixed,

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\(^6\) Richardson (2007: 91) lists news values that are “the criteria employed by journalists to measure and therefore to judge the newsworthiness of events”. He cites different authors who attempt to provide lists of qualities that they believe a news story should possess (cf. Galtung and Ruge, 1965; Hetherington, 1985). The basic news values include: frequency, threshold, lack of ambiguity, meaningfulness, unexpectedness, continuity and negativity. Harcup and O’Neil (2001) restructure the list of news values and argue that the conventional classification is the way that journalists construct news rather than the characteristics that an event needs in order to be reported. They add several elements such as references to the power elite, celebrities, tragedy or accident, surprise and entertainment.
but acquires meaning at the moment the content is viewed, read or listened to. In fact, what the findings suggest is the extended mode of reception from the audience’s standpoint that generates feedback and redundancy to the circle of communication, creating a recursion of connections between audience, the media and their environments. According to Luhmann (2000: 98), communication is the “dual structure of reproduction and information”, which he refers to as the flow of an infinite interactivity or a recursivity in a network in which communication takes place (cf. Grant, 2007).

The analysis suggested that the majority of the respondents in Group Three and most carers in Group Two were able to criticise and question the negative representations of the mentally ill, and frequently suggested that these representations were exaggerated. These women, as media users, created the recursive connections by proposing that the media should perform a better role in educating the public and representing the mentally ill in a more accurate fashion. Several of the women stated that they stopped buying certain newspapers that exaggerated news about violence. A few of them even posted their views about newspapers’ negative reporting on the Internet. These connections displayed how media literacy has become a skill in assessing the media and extending the quality of feedback while creating the circle of communication. Not only did the respondents criticise the representations, they also took actions (for example, ceasing to buy newspapers) that may shift the balance in the production-reception process of recursivity. The results below show the media literacy skills respondents exercised, when engaging with media content on mental illness. Ang (1996: 13) comments on the changing role of the audience, as being “more semiotically skilled, more sophisticated or educated in their meaning making abilities”. Several informants reflected the (media literacy) skills that Ang (1996) refers to:

“The media should educate the public by offering more accurate information about mental illness and not keep representing news on Rok Jit and crimes. Many films also reinforce the negative depiction of the patients. I haven’t seen any movies that end their stories with the hope of recovery for the mentally ill. All of them finish their stories with the characters becoming Baa and being admitted to hospital, or disappearing somewhere, or being ignored.” (Jitdee, 40, Business owner – Carer of schizophrenic sister, Group2)
“I don’t like reading news about mental illness, like the guy who got high on drugs and threatened a kid. This kind of news doesn’t give anything to society. I always ask a question when I read the news: why do the media keep presenting this kind of story? How can we beg for society to view them in a more positive way if the media don’t change how they view the mentally ill? I ended up not reading that paper.” (Pannarai, 24, Editorial staff, University degree, Group3)

Despite media literacy, it is difficult to deny that in many situations the negative portrayal of mental illness informed the respondents’ understanding of the mentally ill. Many carers who were close to the mentally ill had negative views of those whom they met on the streets while a high number of women who showed media literacy skills in their narratives (Group Three) disclosed that they understood the real motivation of the media in reporting the crimes committed by the mentally ill. However, they were generally frightened when they saw patients with mental illness or people displaying what they described as ‘abnormal’ behaviour such as the homeless talking to themselves or dirty and smelly men on the streets. According to Iser (1978), the process of making meaning is not a direct internalisation or a single dimension but depends on dynamic contexts such as gender, economic background and life experience, which extend nodes of meaning construction. The analysis suggests that there was an interplay in people’s everyday life experiences and the mediated experience where individuals viewed the mentally ill and their world with a hybridisation of the construction. Therefore, the women’s understanding of mental illness through mediated representation could not be predetermined. The interpretation can have a number of possible meanings because communication is a process of interaction that is polysemic. What the dynamic narratives could explain was the interplay between text, context, and women’s interpretation by which of mental illness (and mental health) are generated. As Gillespie (2005: 226) comments, although audiences are active meaning creators, the researcher of the audience should not underestimate their complex thinking, since they can recognise dominant representations that are used to maintain social inequalities:

“The dynamic between compliance and resistance is not always an adequate way of understanding how people engage with media texts, not least because dominant meanings are in any case sometimes hard to identify or pin down, especially in richly polysemic texts”.

Concluding this section it is important to note that women’s understandings of mental illness were connected with social, cultural and mass-mediated experiences. At some levels, women were selective media users in choosing the media content. However, because communication of mental health and mental illness is a highly recursive and polycontextual process, while the
discourses and representations of mental illness were very strong, women could give the result in the opposite direction or in a rather unpredictable way.

6.4 MENTAL ILLNESS IN WOMEN'S MAGAZINES

Among the samples of 121 mental health articles, there were eight pieces related directly to mental illness with the titles 'Rok Jit' and 'Baa' that referred to people with unusual behaviours or stood for patients with mental illness. Although the number was very small, these pieces cannot be easily ignored. This small number was significant because of the quality of the framing, which is in contrast to the dominant framing of mental health in women's magazines that generally deal with how to be happy as discussed in earlier chapters. The small number of articles indicates how women's magazines virtually ignore the issue of mental illness, which certain groups of women felt was significant. The observation of this small number of columns also enabled the researcher to see that magazines assume 'mental health' automatically means 'mental illness' and follow the negative stereotypes attached to it. The use of discourse analysis was beneficial in this chapter as a tool to see how women's magazines established the dualistic mental health representations (happiness–treatable, easy-fix, self-help and Rok Jit – hopeless, dangerous, insane, vulnerable) and an exclusion of voice. The results showed that the magazines endorsed the voice of mental health experts to convey mental health information while omitting other voices such as the people who suffered from mental illness and their carers.

Women's magazines also associated mental illness with expert discourses where medical practitioners were incorporated into the text and took a major role in the treatment and rehabilitation process. For instance, *Cosmopolitan* represented the expert (a psychologist for sex offenders) and her authorised voice to diagnose the illness. *Kwanruen* located schizophrenia and depression to the expert systems (psychiatrists, medical institutions, rehab-centres and anti-depressant pills). Problems related to mental health and mental illness in women's magazines were also frequently constructed in clinical discourse and the issues for medical experts that were tied closely to their affiliates, titles and specialised treatment were seen as the only solution to mental illness. One example can be found in *Real Life* (977: 99): a reader claimed “I got very stressed and almost become completely mad because of him”. The columnist, who was also the editor of the magazine suggested this reader “go see the doctor and let him help you with your illness”. This message assumed that the symptom 'very stressed' that made this woman 'almost
become completely Baa’ was a sign of mental illness that needed specialist care. The magazine legitimised the role of the medical doctor as a helper of the mentally ill. It also portrayed the doctor as being specialised in diagnosis and the mental health care system where trust (in the medical expert) merges with the abstract system that “coexists with a taken-for-granted confidence in others” (Giddens, 1991: 23). This representation strengthened the social belief as discussed in Chapter Five that medical experts are highly important in the system of mental health treatment and in abstract systems of modernity. The expert in this scenario was constructed by the media to derive power from representing the mental health knowledge of which they claimed to be the owners. Foucault (2009: 61[1961]) explained the influence of medical power in judging one’s illness:

“We have to leave it to medical archaeology to determine whether or not a man was sick, criminal, or insane who was admitted to the hospital for ‘derangement of morals’ or because he had ‘mistreated his wife’ and tried several times to kill himself.”

Not only did the magazines construct the image of mental health professionals as ‘powerful’ and ‘life savers’, in *Cosmopolitan* (142/13: 104), people with mental illness were portrayed as ‘incapable’ and ‘powerless’. One article in *Cosmopolitan* presented a half-page title to emphasise the voice of a psychologist, illustrated with the caption on the first page: “I am a helper of these psychiatric patients”.

This story was covered with a full page picture of a foreign psychologist sitting in her clinic talking to her patient. The caption of this picture reproduces the social stigma of mental illness by selecting “Shoshanna [the name of the presented psychologist] to conduct one-to-one therapy with a mentally ill subject.” (*Cosmopolitan*, 142/13: 104). Not only had the article put a mental health expert in the centre of communication, this story also implied the exclusion of the mentally ill person. There was not a single sentence in the six page article that quoted the mentally ill person’s thoughts, feelings and concerns. In turn, the column focused only on the psychologist’s life, her motivation and her career. The magazine thus ignored the visibility of the mentally ill while displaying an unequal power between the medical expert and people with mental illness. At the end of the interview, the magazine emphasised the psychologist’s belief that, “it is the most important job for the therapist like me to protect them [the mentally ill] not to turn their heads to re-commit the crimes” (*Cosmopolitan*, “Real-Life Reads”, 142/13: 109). This last phrase showed that this psychologist believed that her specialised skill would be able to heal and stop her psychotic patients from re-committing crimes. This representation also reproduced
the popular schematisation of the media that frames the mentally ill as dangerous and violent (and that it is normal for them to commit crime).

How the media represented mental illness in women's magazines was not one-dimensional. Mental illness was also represented in a negative tone to suggest that the mentally ill were violent, dangerous and abnormal by linking people with mental illness to extreme expressions such as "screamed like crazy" (Kwanruen, 894), "scary Rok Jit" (Real Life, 980), and "madly stressed before committing suicide" (Cosmopolitan, 143/13). Conversely, they also reversed the assumption that the mentally ill are scary, crazy and dangerous by framing them as victims and vulnerable patients. Kwanruen (894: 274) printed a letter from a reader who wrote to share her experience of having a mother who was being abused by her step-father and who was living with depression:

"It was like living in hell. She was videotaped while sitting on the chair, tied up and was beaten with a leather belt. Her body can't function very well. She speaks very slowly and she has had a miserable life for forty years."

The narrative indicates the high level of sympathy of the writer with the mentally ill person rather than expressing her fear and embarrassment. This coincides with Olstead's view (2002) that mental illness can be represented in different schemes in the media. He uses discourse analysis to examine a Canadian newspaper and found that while psychopaths and violence seem to be the predominant concerns of the media in representing the mentally ill, they are also framed in terms of "passive patient portrayal" that implies "helpless, disempowered and pathetic dependency" (Olstead, 2002: 634).

A further point to discuss is the observation of the images of the mentally ill that were associated with the factor of class. The results showed that the mentally ill tended be framed in women's magazines as vulnerable patients who needed love and care if they were from the middle class and had a close connection with the authors, for example, family members of the women who wrote the Cosmopolitan, column "If someone you love committed suicide" (Cosmopolitan, 143/13) and "The ocean of sadness" (Kwanruen, 894). On the other hand, harmful depictions of the mentally ill could be framed as representing more 'deviant' or 'abnormal' perpetrators of sexual misconduct such as "a convict of sexual crime, sex offender" (Cosmopolitan, 142/13) or "a sex call from Rok Jit" (Real Life, 980/31). The representations of the mentally ill as poor, dangerous, violent and harmful were similar to the women's subjective constructions referring to
the mentally ill they met on streets, describing them as the ‘dangerous’, ‘dirty homeless man’ or the ‘real Rok Jit’ as discussed in 6.2.

CONCLUSION

This chapter shows that mediated, subjective and recursive constructions of mental illness are not stable. The women in the study constructed mental illness from the various experiences (immediate, casual and mass-mediated) they had had with mentally ill people, and this experience informed how they made sense of mental illness. Despite subtle variations and differences, everyday life experiences, certain stereotypes, such as the fact that the mentally ill were seen as dangerous, abnormal and violent, remained dominant. The results highlight the complexity of the constructions and the interplay of the subjective and mass-mediated view with a variation of representations and constructions. The analysis pointed out the recursive communication between women as media users and the media with the idea of media literacy that extended the quality connection in the communication circle of mental health. Women showed their ability (particularly Groups Two and Three) to criticise and reject the mass mediated (mis)representation of mental illness, giving an uncertain result in communication and unpredictable connection with the mass-mediated representations of mental illness.

In analysing the representation of mental illness in women’s magazines, a small but significant number of articles discussed mental illness. This small number implied that women’s magazines did not place mental illness as a priority but pointed to the classic Foucauldian dichotomisation that framed mental health and mental illness as completely different. Compared to the earlier chapters, where mental health was represented positively as ‘happiness’, ‘self-help’ and ‘cosmetics’, this chapter illustrates that mental health could be represented as ‘dangerous’, ‘abnormal’ and ‘mad’ while ‘passivity’ and ‘vulnerability’ were also schematised to represent the (middle class) mentally ill in women’s magazines. This chapter emphasises the strength of expert discourse, and how it dominated and was embedded within the representations of mental illness in women’s magazines. In addition, in the examples used there, there was also a scheme of class difference that worked behind the process of mass mediated construction. This corresponded to the women’s subjective construction of the mentally ill, whom they described as ‘the dirty homeless’. In fact, there is no clear signal from the findings that women’s magazines were motivated to provide a space for those living with mental illness. It does not seem that
women's magazines intended to empower sub-groups by echoing their real voices of thinking, feeling and concern. In turn, women's magazines reproduced popular representations of the mentally ill as dangerous while securing space for the medical experts to proclaim their status as the owners of mental health/illness knowledge in a taken-for-granted manner.
CHAPTER 7

SPIRITUALITY AND MENTAL HEALTH

This chapter introduces a spiritual perspective into the association of mental health and mental illness, both in media representations and in women’s constructions. It explores the meanings of mental health contextualised in spirituality, which is a dominant discourse embedded in Thai society. The theme ‘spirituality’ in this study comprises two features – spiritual resources and spiritual practices. Spiritual resources such as Pra (monk) and Chee (nun) are introduced as local forms of mental health expert in abstract systems (Giddens, 1991) that reflect living conditions in modernity. On the other hand, spiritual practices (e.g., meditation, doing good deeds) could be viewed as local self-help knowledge that is part of the reflexive project of the self. These two approaches to the examination of spirituality strengthen the existence of expert systems while the use of spiritual techniques contests medical treatments and challenges scientific knowledge, providing a lifestyle choice for the respondents to maintain good mental health.

The first section illustrates the interface between religious faith and wellbeing in Thailand, where Buddhism is the mainstream religion\(^5\) (Burnard, Naiyapatana and Lloyd, 2006; Visalo, 2003). The second section discusses the supernatural force that is considered an important aspect for those who believe in the spirit world. The supernatural force explains how the power of the spirit, ghosts or other animistic elements help to form the respondents’ subjective construction of mental health and mental illness. The third section demonstrates the link between religious practice as a spiritual path and wellbeing from the respondents’ viewpoints. The fourth section illustrates the complex representations of spiritual mental health in the magazines where the representations of Dharma, (the teachings of the Buddha) were examined. The last section looks at spiritual health and mental health in the public debate among the dispersed media platforms of Thailand. This chapter argues that the notion of Buddhism, which can be understood in terms of dynamism of the institutions of modernity, is a unique characteristic of Thai culture that provides

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\(^5\) Ninety-seven percent of the population in Thailand claims to be Buddhist. There are over 30,000 temples situated in the country with more than 200,000 monks.
narratives of ‘hope’ and ‘choice’ for good mental health in the systems of constructions of mental health in Thailand.

7.1 FAITH AND SPIRITUALITY

Previous literature suggests that faith in spirituality can have an intimate connection with hope, optimism, life satisfaction, happiness and wellbeing (Beit-Hallahmi and Argyle, 2007; Ekachai, 2000; Hackney and Sanders, 2003; Koenig and Larson, 2001), self-actualisation (Ariyabuddhiphongs, 2009; Eckersley, 2007) and a feeling of vitality (Joshi, Kumari and Jain, 2008). The majority of respondents, regardless of status, class and group, attached themselves to different religious practices (mostly Buddhism\(^{58}\)), which they described as a source of peace of mind, a mechanism to cope with stress and a self-access gateway to explore the real meaning of life:

"I thought of an ordination after that crisis [she was sexually abused by a stranger]. Dharma is the only thing that can heal me.” (Chom, 35, Hairdresser, Domestic violence, Grade 12, Group1)

"After my mum passed away, I started to rely on the three jewels of Buddhism\(^{59}\). I don't know much about them and I am not sure if they can help me with what I am suffering.” (Racha, 32, Carer at the centre, University degree, Group2)

"I don’t expect things. Everything has its own way to grow and decline. I pay respect to the ‘Quan Yin’ [a Chinese goddess figure] and I chant ‘Chinnabanchara’ every night. I hope that good things will come to me.” (Darika, 33, Employee, Master’s degree, Group3)

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\(^{58}\) Two of the forty-nine respondents reported a different religion to Buddhism. One of them is Muslim and the other is Christian. However, the results were similar: spiritual belief played a significant role in promoting their wellbeing and at the same time, was also a solution to their stress.

\(^{59}\) The three jewels of Buddhism, also known as ‘the three refuges’ or ‘the triple gems’ mean the Buddhist trinity, comprising three objects of veneration: 1. the Lord Buddha (the teacher or awakened one), 2. his scripture or teaching (Dharma), and 3. the monkhood, who follow Buddha. Today, these three elements are symbolic of wisdom, truth and virtue among Buddhists.
One informant from Group Three who did not identify herself as religious spoke of her faith in religion:

"I am not a religious person, but deep down in my heart, I know Dharma\textsuperscript{60} could heal me. I think of Dharma and pray every time I lose my confidence." (Kinnaree, 36, Hotel owner, University degree, Group3)

This testimony reveals a special conviction that faith is a sacred inner belief that is connected to a sense of positive thinking and a good life while faith, as described by Giddens (1991: 196), lies "almost by definition on trust". Even where faith is not explicit, Dharma seems to claim a special position in the respondents' testimonies. Eckesley (2007: 54) notes that "spiritual faith is a deeply intuitive, but not always a consciously expressed, sense of connectedness to the world in which we live". Through different spiritual activities, faith is associated with positive outcomes of 'hope', 'security' and 'miracles'. As several respondents describe:

"I believe in Allah. He is definitely the centre of everything in my life. If I read Al-Qur'an and pray, good things will come to my life and I feel secure." (Yupaporn, 25, Restaurant owner, University degree – Yupaporn is a Muslim, Group3)

"What I want is just to be with my children again. I pray for it. I don’t want anything else, I am just waiting for a miracle to happen." (Mek, 36, Domestic violence, Grade 12, Group1)

Forty-seven respondents who identified themselves as Buddhists reported that they applied the Buddha’s teachings as a stress reduction technique to regain their peace of mind. The respondents adopted different concepts such as ‘Mindfulness’, the ‘Four Nobles of Truth’ (Dukkha, its origin, and ways to end it) and the ‘Three Marks of Human Existence’ (Anijjung, Dukkha, Anutta; the state of impermanence) to alleviate their worries, to understand suffering and to explore the more profound aspects of life:

"I rely on what Buddha taught. When I feel depressed, I try to capture what is in my mind. I tell myself that suffering is natural. This feeling of struggle can’t be with me forever. It comes and goes." (Kanda, 55, Carer at the centre, University degree, Group2)

\textsuperscript{60} I use Dharma throughout this chapter to refer to the collective teachings of the Buddha. The essence of Dharma is the impermanent nature of all life. The term is used to imply the laws of nature. Thai people try to realise the true meaning of the Dharma by different religious practices, such as insight meditation (Vipassana) and ordination (Stcherbatsky, 2003 and Macy, 1991).
Several carers reported that through the practice of Dharma they experienced a feeling of ‘deep peace’ when they felt demotivated through caring for the mentally ill. Many carers adopted different religious techniques such as prayer, making merits (doing good deeds), meditation, putting food offerings in the monks’ alms bowls, donating money to the temple or the poor and discussing Dharma with a monk to reduce stress and sufferings:

“When I think of someone who could heal my mental suffering, I think of Pra. Pra brings Dharma of the Buddha to us in a way that doctors and nurses can’t. Medical people know how to cure the body, but not the soul.” (Mala, 20, Carer of schizophrenic father, University degree, Group2)

“I used to take sleeping pills when I couldn’t sleep, but my brother suggested I meditate and pray. I started to learn how to meditate and it worked. The only person who could free you from Dukkha is yourself. I rely on Dharma and meditation and I go to the temple and talk to the monk.” (Benya, 36, Business owner, carer of depressed mother, Master’s degree, Group2)

In these cases, spiritual practices and resources represented hope and a chance of recovery for the sufferers of mental illness and mental health problems. As Dane (2000: 5) suggests, spiritual techniques are a way of deeply examining oneself “within the spirit of self-inquiry, self-understanding, and healing”. People may seek alternative medical services because they have lost belief in the power of orthodox medicine to relieve stress and anxiety. As previous studies (Joshi, Kumari and Jain, 2008; Kalkstein and Tower, 2009) suggest, belief in spirituality and its practice can have a positive effect on mental wellbeing, reducing suffering and enhancing positive emotions.

Women from different groups reported that they overcame their stress by using religious resources, such as talking to the monks or meditating. This supports the findings of previous literature that spirituality appears to be strongly connected with aspects of wellbeing, and that people want to be treated holistically where physical, emotional and spiritual dimensions have an intimate connection. Nakasone (2007: 652) suggests that body and mind should be considered a single unit because “illness of the body impacts mental health; and mental illness directly affects physical wellbeing”. Pra (monk) in Thai mental health scenarios combines people’s faith with a spiritual experience involving trust, described by Giddens (1991: 244) as “the vesting of confidence in persons or in abstract systems, made on the basis of a leap into faith which brackets ignorance or lack of information”. Trust in Pra is comparable to the trust that Giddens (1991: 19) describes, as “directly connected to the psychological security of individuals and groups”. Giddens states that traditional authority (such as religion) exists in modernity and
becomes part of “an indefinite pluralism of expertise” (Giddens, 1991: 195). Although Pras are religious figures who have little to do with the scientific or technical knowledge of medicine or clinical care, the respondents considered them ‘experts in the spiritual world’. Pra delivered the truth of the law of nature (such as Karma) on a spiritual level that not only attempts to achieve happiness but also wisdom from self-realisation: in Buddhism, the source of ultimate happiness is to understand suffering. As Munindo (2005: 193-194) states:

“When we learn to experience suffering so that we don’t believe in the way it appears to be, and we endure in the way that we need to endure – with here-and-now judgement-free awareness – sooner or later we will experience a letting-go, bringing relief and joy. This is the happiness that comes from seeing through suffering and this is the happiness that strengthens our faith. Faith that is discovered like this doesn’t get us into arguments or lead to contention. This is a personally verified form of faith and is what can give us bearings in life. Even though at times we might find ourselves without light or any outer signs that we are heading in the right direction, we can feel secure in an inner sense of trusting that comes from our heart’s orientation towards truth”

7.2 SUPERNATURAL FORCES AND MENTAL HEALTH

This section explores an aspect of animistic elements (magic, spirits and ghosts), which at some point affected how the respondents constructed their understandings of mental health. The results show that the conventional belief that ghosts and demons and the main cause of mental illness still exists strongly in the perception of women in Group One (hostel). There was clearly a willingness to consider mental illness as having supernatural elements. Klausner (2000: 360) discovers that for people who believe that the mentally ill are possessed by evil spirits, the solution is simply to ask a spirit doctor or an animist practitioner to “exorcise the wicked intruder and the usual method of exorcism involves beating the patient with specially treated branches while chanting magical formulas”. This view is relevant, since about half of rural women in the hostel associated their belief in supernatural forces with the treatment of mental illness. In the present study, the examination of mental health in relation to ghosts and supernatural powers helped to provide a deeper understanding of how the respondents from rural areas made sense of many aspects of mental health, mental illness and spirituality:

“I know one Rok Jit who lived around my neighbourhood. He behaved very strangely. He acted like the medium of a spirit. Maybe a ghost had possessed his spirit. Perhaps this was the main cause of his illness.”
(Noi, 28, Housewife, Domestic violence, Grade 6, Group1)

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Burnard, Naiyapatana and Lloyd (2006) point out that although the contemporary view of mental health healing tends to be more 'modern', rejecting traditional belief and practice, healing is sometimes supplemented with a traditional method using supernatural power to overcome mental illness. In their research on Thai culture, the authors cite the story of a man who takes a sick family member to see a 'ghost monk' in the hope that he can release a spirit from inside the body. The spirit is believed to be the cause of the sick person's mental illness. A similar case was also identified when the research at the hostel took place. One pregnant woman (22, Grade 6, Farmer) was suffering from depression because of her unwanted pregnancy. She isolated herself in her bedroom, hardly spoke to anyone and always cried. She attempted to commit suicide twice during the time the fieldwork for this study was being carried out. The hostel staff called her mother in southern Thailand and informed her that her daughter was being sent to the Sritanya Hospital for examination. Two days later, the mother showed up at the hostel and took her daughter back to their hometown. The mother did not believe that her daughter had depression (as diagnosed by the psychiatrist) but was convinced that her daughter was possessed by an evil spirit that needed to be released by a local shaman rather than depending on a systematic treatment at the psychiatric hospital. This finding illustrates that the belief that mental illness is caused by supernatural forces and requires traditional healing is still common in rural Thailand. While there was no tangible evidence to confirm the effectiveness of spiritual faith as curative, the findings provide empirical support for the fact that spiritual belief (by using spiritual healing to cure the mentally ill) provided hope and reduced the women's worries about illness. The superstitious ritual in this scenario reinforced mental stability, emotional consistency and psychological security, particularly among women from remote regions such as the women living in the hostel in this study.

Different testimonies from women in Group One explained how the belief in the magical helped form their understanding of mental health. For instance, Aim (26, Cleaner, Domestic violence, Grade 6) believed that a spell had been put on her father, which had caused him to become a cruel, immoral and aggressive person (note that Aim was raped by her father when she was young):

"I am sure that my stepmom must have done something to my dad and it must be something to do with a spell. My dad used to be a very kind person. It was her fault. She was the one who ruined my family."
Another example was a story of one pregnant woman who decided not to have an abortion because she believed in 'kuman thong' (golden baby ghost, a little spirit that died with the pregnant mother, see Klausner, 2000) and that the dead baby would come after her for revenge.

"When I knew I was pregnant, I wanted to have an abortion, but my friends warned me not to. They said the baby might become 'kuman thong' and come after me for revenge." (Nuan, 32, Masseuse, Unwanted pregnancy, Grade 12, Group1)

While the majority of women in Group One believed in ghosts and magic, Groups Two (carers) and Three (everyday life) did not seem to admit to those views, particularly if such concepts were represented in the press. Many women in Groups Two and Three rejected the mass-mediated representations that associated magical belief and animistic elements with mental illness.

"Thailand reported on the 'Dr. Prakitpao's case', and said it was because he was bewitched by his affair. I didn't believe what the media said. It was impossible." (Malee, 58, Carer of depressed son, Diploma, Group2)

"I felt hopeless about the news report. I remembered there was a story of a boy who committed suicide by hanging himself with a stocking while wearing a skirt. The press said it was because he was transsexual and some papers even reported that he was cursed and possessed by the ghost of 'Tani' [specific term for the female ghost living in Thai banana trees]." (Pompan, 40, Employee – Carer of bipolar son, Master's degree, Group2)

The narratives illustrate that the women's interpretation of media content (particularly Groups Two and Three) is polysemic. They create different meanings, and polysemic texts have a distinct meaning for each respondent. Sandvoss (2005: 124) notes: "the fundamental assumption that (popular) texts are open, open to different interpretations and to different meanings constructed in the process of reading and by different readers has rarely been challenged". In this study, the majority of women in Groups Two and Three rejected the suggestion in the mass media that mental illness is rooted in the supernatural and magic, while women in Group One

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Dr. Prakitpao Tomtitchong was the owner of a famous physics tutorial institute in Bangkok. He had a vision, made up stories and spent a large amount of money buying cars. His story was presented on the front page of a Thai newspaper. The newspaper reported Miss Premika's accusation [one of his ex-students who claimed to have had an affair with him] that she used black magic on Dr. Prakitpao. However, after the official diagnosis took place, the psychiatrists agreed that he had bi-polar disorder and needed treatment and rehabilitation in a psychiatric hospital.

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confirmed their strong beliefs about the link between mental illness and different forms of animistic influences.

Spirituality, including superstition, is one way of understanding how mental health and mental illness are constructed in the local Thai context. As several authors point out (Cooper, 2008a; Pinyuchon and Gray, 1997), there is no way of understanding mental health in Thailand without reference to cultural elements, particularly in the study of people for whom spirituality marks its importance through religious rituals and the spiritual practices of everyday lives, an aspect addressed in the following section.

7.3 SPIRITUAL HEALTH AND EVERYDAY LIFE

Religious practices provided different rewards for the respondents such as comfort, relaxation, peace of mind and security, which Ozorak (1996) identifies as positive feelings that help individuals to be happy. Religion in this study as confirmed by other research was seen as a source of comfort and a means of coping with stress and frustration (Chen and Koenig, 2006; Tyson and Pongruengphant, 2007). Women across the three groups adopted different spiritual practices and Dharma lessons (Buddha’s teachings) in dealing with their unhappiness. When it came to the issues of mind and emotion, religion became a means of healing uncomfortable feelings such as stress, worries, sadness, loss of will power and feelings of worthlessness. The informants applied Buddhist practices by referring to activities such as ‘Suad Mon’ (praying, chanting), ‘Sai Bard’ (elm offering) and ‘Tum Boon’ (sharing merit, doing good deeds) as their everyday stress reduction techniques. These Buddhist practices were also referred to in the presentation of mental health treatment in women’s magazines. Several women practised Buddhism in greater depth by adopting the ‘three marks of existence’ and belief in Karma (see 2.3.2). Many of those in Groups Two and Three read Dharma books and searched for Dharma online during their leisure time to seek peaceful moments. This point was highly important as it signals the role of the mass media as a source of information on spiritual mental health for those who had access to such media:

“I rely on the Buddha’s way of living. He taught people to admit the nature of ‘dhukha’ which exists for a certain time and then dissolves. When I am sad, I ask myself to notice this. Maybe later in the afternoon, I won’t feel as bad as I feel in the morning.” (Kanda, 55, Carer at the centre, University degree, Group2)
“I used to let things go. I believed that all bad things arose because they meant to happen that way. I read Dharma books and ‘Suad Mon’ at the time my boyfriend left me. I practiced them for three months. It was a miracle. I got over it and have my life back.” (Kessara, 28, Employee, Master’s degree, Group3)

The following narratives also describe how spiritual elements were naturally associated with women’s lives across the three groups and show how women adopted spiritual techniques to cope with their problems:

“Buddhism and happiness are the same thing to me. When we suffer, Dharma can heal.” (Chom, 35, Hairdresser, Domestic violence, Grade 12, Group1)

“Mental health and Dharma go together very well. If you get stressed, the monk will teach you how to let things go. I think Dharma is an alternative solution for people who seek happiness.” (Tina, 28, Government officer – Carer of depressed sister, University degree, Group2)

“I believe that every problem can be fixed with the principle of breathing. This is the Buddha’s way of teaching people to be mindful of everything. I follow the Buddha’s oath of detachment that nothing is permanent.” (Maleewan, 28, Teacher, University degree, Group3)

Women across different profiles carried out various spiritual activities in their everyday lives. A high number of them went to the temple when they were stressed and felt the need to find a peaceful moment. Others performed different kinds of good deeds, such as putting food offerings in a monk’s alms bowl, freeing fish and birds and paying respect to the symbol of the Buddha (Wai Pra62). The Buddhist concepts such as the belief in Karma, Meditation and Merit Accumulation were mostly referred to by different respondents across the three groups as their everyday stress-coping mechanisms. These findings are interesting because they gave insight into how the respondents dealt with mental health problems to regain balance and improve their way of life.

62 Cooper (2008a) explains that Wai Pra “is not rigidly fixed and is essentially a private action between the individual and the Buddha. Usually, a candle is lit first and placed among the other candles in a row set in front of the image. The flowers are placed in water. Then the incense sticks are lit from the candle and held between the palms in a gesture of wai (hands on the chest), sitting quietly in the respectful position. People then recite some set phrases in Pali (the language of the Buddhist scriptures) praising the Buddha, his teachings and the other monks that the Buddha created. This would normally be followed by a wish, expressed mentally in Thai. Then the incense sticks are stuck into the container of sand provided, a square of gold leaf is pressed onto Buddha’s image, and the individual concludes with the triple obeisance. People are quite free to follow this procedure or may prefer simply to sit in silent communion with the Buddha. Following the simple ritual of ‘wai pra’, it is normal to donate some money into the box provided” (Cooper, 2008a: 34-35).
7.3.1 Belief in Karma

Religion has a great impact on Thai people’s everyday life. Pinyuchon and Gray (1997: 210) state that “Thai for the most part are Buddhists who believe that one’s life does not begin with birth and end with death. Each life is conditioned by volitional acts (Karma) committed in a previous existence. The concept of Karma is explained in terms of the law of cause and effect”. With this explanation, Karma in Buddhism opens up different interpretations that can refer to active and passive actions, describing how people follow ‘the law of cause and effect’. The passive aspect of Karma means that people must follow the consequences of their previous actions and therefore they cannot change their destined Karma (that was previously designated such as the experience of an adverse life circumstance). A high number of informants from Group One accepted this idea:

“My unhappiness was caused by previous Karma. I perhaps collected too few ‘Boon’ [religious merit] in my past life and that is why I have suffered in this life.” (Aim, 26, Cleaner, Domestic violence, Grade 6, Group 1)

“I believe it’s all about Karma [long pause]. I insisted on doing it [abortion]. If I had not taken drugs, it would not be like this. I felt really guilty and it was a high price to pay.” (Cat, 26, Dancer, Unwanted pregnancy, Grade 9, Group 1)

Aim and Cat’s narratives show that the unfortunate incidents in their lives were meant to happen, caused by bad actions in their past. This belief allowed them to accept their fate, but they reported that they felt discouraged to move on with their lives. The opposite meaning of Karma is the action of the present moment. This action has a positive intention that affects future aspects of living. This latter route follows the direction of active Karma, in which people have free will to choose what kind of action they want to undertake. Sucitto’s (2008: 2) definition is helpful:

“The teaching of Karma therefore encourages a sense of responsibility for action; the responsibility to give attention to the many conscious and half-conscious choices we make in terms of what we do. What this means is that in this present moment we do have a choice as to how the future pans out: whether we will feel joyful and at ease with ourselves, or anxious and depressed depends on our actions now. And similarly, through our actions now, we can be liberated from the past, present and future. That’s what Awakening to Karma brings about.”

Considering Karma in this light was found to be much more influential for the rest of the women in this study (particularly Groups Two and Three). Positive Karma motivates the notion of the Active Buddhist that leads people to realise that their happiness depends on the way they act at
the present time. Karma is the key component associated with the lives of Buddhists. It allows people to have a positive effect on the world in which they live and influences how they act. Several women from Groups Two and Three described their Buddhist role through an understanding of active Karma:

"Dukkha derives from Karma. I don't believe in destiny. It has to be me who creates my own life. I can't depend on anyone. The only solution is to find the cause of my problem and fix it." (Sandy, 34, Carer at the centre, University degree, Group2)

"I believe in Karma. It has to be something that we did before and it influences our present status. I believe that we need to accumulate merits in this present life to have a good life in the future. It's our choice to do good things." (Ravivan, 34, Business owner, Master's degree, Group3)

Active Karma strengthens people's sense of responsibility and control of their actions, which implies that they can make a choice to create happy lives. As Pinyuchon and Gray (1997: 210) state, "belief in Karma is very powerful and affects the Thais' values, behaviour patterns and attitudes toward life". Seeing Karma in this way encourages women to choose their actions (by a creation of positive Karma) and influence their future.

7.3.2 Meditation Practice

One of the everyday spiritual practices that the respondents across the three groups frequently mentioned was 'meditation' (Samatha) or 'insight meditation' (Vipassana). Meditation, as Dane (2000) describes, is an inner resource that one adopts to find the meaning of life, including hope, comfort and peace, and to cope with suffering. Barker's (2008: 37) explanation on meditation is helpful: "meditation entails two key elements: concentration and insight".

63 Meditation in Buddhism designates two kinds of practices. The first one is called 'Samatha' and the second is 'Vipassana'. Samatha meditation is one of concentrating the mind on an object, rather than letting it wander off to other things. As Sumedho (1987) explains, one may choose an object such as the sensation of breathing, and then pay full attention to inhaling and exhaling. Eventually, people who practice it become tranquil. Vipassana or insight meditation is a mindfulness practice that does not choose any particular object on which to concentrate but observes things as they are. Everything that people see, hear, smell, taste, touch and all mental conditions including feeling, memories and thought are changing conditions of the mind that rise and fall. Vipassana is the path to understanding the state of impermanence. There are also other forms of meditation practices. Dooley (2009) gives examples of Transcendental Meditation (TM), Indian Yoga, Zen meditation and Vipassana to describe the methods of meditation that have been adopted in western countries.
"The practice involves developing the capacity to place attention on one single point. This is commonly the in-and-out movement of the breath. As concentration is strengthened, the mind settles, we become more peaceful, and understanding grows."

The respondents revealed that meditation produced a number of benefits for maintaining a positive outlook and alleviating negative attitudes. This is because, as Thich Naht Hahn (1975) teaches, meditation with concentration on mindfulness brings our conscious attention to the present without any attempt to change it. Meditation is the practice that teaches people to be mindful of the present and focus on immediate experience:

"I believe that meditation can relieve my stress. I feel refreshed after a short course of meditation and have restful sleep afterwards." (Anong, 45, Soldier, Carer of schizophrenic daughter, Master’s degree, Group2)

"I was so shocked at the time my boyfriend dumped me. It was my brother who suggested that I do meditation. Before that, my mind was always wandering around with thoughts of the past that were discouraging. I started to do meditation and it helped me to stay with the present." (Chalida, 24, Reporter, University degree, Group3)

Almost all of the women were familiar with meditation practice through having attended one form or another of meditation training, normally the Vipassana Course or the Meditation Retreat64, organised by different religious groups, associations and temples, including Baan Pak Chook Chern and Soon Sai Yai Krokruea:

"I hit a dead-end and didn’t know what to do. I decided to go to the temple and stayed there for a month. It was the only thing that worked for me. I practised meditation and it was helpful." (Chom, 35, Hairdresser, Domestic violence, Rape, Grade 12, Group1)

"Last month, the staff took us to ‘Sathira Dharmasathan’. The Chee (nun) taught us how to do walking meditation. I felt really good. I learnt that I should not attach myself to sufferings. I wish I could go back there some day.” (Cat, 26, Dancer, Unwanted pregnancy, Grade 9, Group1)

"I just got back from the meditation retreat at ‘Sathira Dharmasathan’. It made me realise that I don’t want to be rich but I need a peaceful life. That’s happiness, don’t aim too high and don’t attach yourself to anyone or anything.” (Patty, 36, Employee, Carer of depressed mother, Master’s degree, Group2)

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64 Usually the course is organized by different religious organisations. It could be a one/three/five/seven or fifteen day programme, depending on the preference of the attendees and the availability of the venue. In the course, they mainly practise meditation (sitting and walking), following the Buddha’s five precepts which are 1. To refrain from killing living creatures, 2. To refrain from taking what is not given, 3. To refrain from sexual misconduct, 4. To refrain from harsh and false speech and 5. To refrain from taking intoxicating liquor and drugs.
The role of Sathira Dharmasathan (as well as other temples) mentioned in the testimonies was significant as a sanctuary in which to practise meditation. Attending a meditation course with Chee (nun) was one activity provided for the members of the hostel and members of the Family Link Association. Several women in Group Three also disclosed their regular visits and reported that they relied on meditation when they became stressed.

Meditation is adopted as a form of alternative healing and, sometimes, as a technique to complement an orthodox treatment for people with mental problems such as stress and depression (Davidson et al., 2003; Tepper et al., 2002), or physical sickness such as cancer and HIV/AIDS (Sungsing, Hatthakit and Aphichato, 2007; Kongkaew, Thaniwattanon and Chailungka, 2007; Dane, 200065). Different studies report that meditation is used to reduce tension, fear, frustration, inferior feelings and to soothe unstable emotions (Benson, 1996; Carlson et al., 2003). Dane (2000:16) comments that "meditation is a salient component of positive coping. Meditation appeared to be a strategy for resistance in the face of suffering". Meditation as well as other religious practices could be considered as choices of natural or spiritual therapy that were clearly identified by the respondents as sources of peace of mind. They gave the women the opportunity to work through things themselves using self-healing and self-understanding (Dane, 2000; Macy, 1991). These practices enhanced positive thinking, living and wellbeing by connecting body and mind, and were beneficial to those who practised them.

7.3.3 Merit Accumulation

Merit making or merit accumulation is a Buddhist concept that leads people to believe in creating good Karma in order to have a peaceful life. As Ariyabuddhiphongs (2009) describes, the Buddhist belief in merit mediates the correlation of Buddhist religiousness and satisfaction with life. The idea of accumulating merit is relevant to the concept of Karma, which Kirsch (1977: 247) explains as the Buddhist belief in the power of merit. Buddhism encourages the

65 Sungsing, Hatthakit and Aphichato (2007) found that Thai patients with cancer applied meditation for three purposes: as energy to help improve immunity and repair injuries, as a balancing agent of the body and mind and as a method of developing wisdom to understand things as they really are. This story yields a similar result and reveals that patients with HIV/AIDS in Songkla Hospital (Southern Thailand) practise meditation with the aim of purifying their minds (Kongkaew, Thaniwattanon and Chailungka, 2007). A similar study was also conducted with HIV/AIDS patients in Chiang Mai (Northern Thailand) and gave the same result. The author reports that meditation technique works for HIV/AIDS patients who "search for alternative ways from conventional medical treatment to lower their stress, regain control of their health, attain some peace of mind and hope to prolong their survival" (Dane, 2000: 7).
individual to “participate in situations productive of merit, the ritual complex of merit-making activities such as almsgiving, ordination or insight meditation”:

“Since the causes of suffering are located in the world, the aim of the Buddhist is to free himself from desire and attachment, to escape from the world, to gain nirvana and this process is done through the path of merit-making or merit accumulation which seems be the shared belief among Thai people.”

Merit-making rituals are common daily religious activities. They could be viewed as symbolic exercises and the process of accumulating good deeds. Burnard, Naiyapatana and Lloyd (2006) explain that there are two functions that constitute the concept of merit making. First, merit-making is a demonstration of the principle of living a good life. It is a worthy thing to do something positive for its own sake. Secondly, it is viewed as a way to free oneself from the effects of bad Karma that can accumulate from present and past lives. The narratives below represent women’s different ways of collecting merits.

“I pray, meditate and give away my things to poor people. I don’t know how much they help me in reality but they do give me mental power. It’s hard to expect the consequences right away, but it’s a feeling inside telling me that I want to make a merit.” (Wirongrong, 33, Air crew, University degree, Group3)

“After I wake up in the morning, I watch news on TV, have a cup of coffee, take a shower, pray, meditate and go to work. In the evening I come back, and pray before going to bed. Nothing much but I am happy, and at least I have time for gaining merit via praying and meditating.” (Kanda, 55, Carer at the centre, University degree, Group2)

“Before I came here [the hostel], I usually went to the temple to feed the monks. Once in a while I helped Chee clean the temple in my hometown.” (Chom, 35, Hairdresser, Domestic violence, Grade 12, Group1)

The Buddhist way of living permeates many aspects of everyday life among Thai people and the status of the spiritual is distinctive and powerful in helping people to cope with mental health across different parts of the Thai population. The narratives illustrate that there are many ways to accumulate merits, including prayer, meditation, doing good deeds by offering alms to monks, the children and the poor, visiting and donating money to the temples. According to Praditsathaporn et al. (2009), performing good deeds in merit can influence the balance of one’s mind and this belief leads people to become creators of their own Karma. With their belief and religious practice, the respondents had options to connect body and mind, to reconsider the meaning of their lives and to enhance their overall wellbeing which could be seen as a “reflexive project of the self” (Giddens, 1991: 9). Besecke (2001: 367) explains that to be reflexive means
to ‘step back mentally from people’s own perspective and recognise it as situated in an array of other possible perspectives’.

7.4 BRIDGING DHARMA AND SELF-HELP IN WOMEN’S MAGAZINES

This section examines a key result from the analysis of mental health related articles from the four Thai women’s magazines whose content particularly represented the spiritual point of view of Dharma (the Buddha’s teachings) in relation to women’s mental health. There is a strong sense that these magazines ‘privilege’ the spiritual as a technique for self-help. The results show that women’s magazines provided a space for women to share their religious experiences in relation to their happiness and unhappiness. Spirituality emphasises the religious benefit of increasing an individual’s happiness and decreasing suffering through subjective constructions such as meditation, mindfulness and doing good deeds. There were two main relevant themes from the findings that will be discussed in this section. The first point emphasises the representation of Dharma as a common stress coping mechanism that the magazines usually frame as a treatment option and a self-help solution. Spiritual self-help, as suggested in the magazines, particularly Dichan and Cosmopolitan encourage readers to have more freedom over their lives by adopting religious techniques. The second point analyses the use of Dharma practices within the representation of ‘professional help’. The results show that the columnists, including the medical professionals, tend to adopt the essence of Dharma in their package of expert’ advice and link this to commercialisation.

7.4.1 Spiritual Self-Help

In 34 (out of 121) articles, Dharma of the Buddha was framed as a spiritual path to happiness and as a stress coping mechanism in all Thai women’s magazines. Some articles mentioned different ways of collecting merit as a means of happiness, such as “feeding disabled children” (Kwanruen), “going to the temple” (Kwanruen), “reading a Dharma book” (Dichan; Kwanruen; Cosmopolitan), “understanding the Three Marks of Human Existence” (Dichan; Kwanruen) and “meditating” (Kwanruen; Real Life; Dichan). Several articles in Dichan suggested ‘praying’ in front of a sacred symbol for readers under stress and also recommended that readers perform good deeds by applying the ‘Five Precepts’, Buddha’s rule, in their daily life. Several articles
discussed Karma as a Buddhist’s principle to explain why individuals experienced different life circumstances \(\text{(Dichan, Real Life)}\).

Regardless of the titles, all Thai women’s magazines connected mental health with spiritual health and suggested Dharma as an efficient way of reducing stress, discomfort and adverse life events. The magazines used different genres (letters, interviews and narratives of life experiences) for presenting advice and for inviting readers to write to the magazines about their life problems. The columnists suggested various spiritual techniques to their readers such as the understanding of the law of Karma, Sati (mindfulness) and the Three Marks of Existence (Anijjung, Dukkha, Anutta), the foundation concepts of Buddhism:

“It’s good to know what love is but don’t let yourself feel overwhelmed by love. You need to be aware that everything is subject to change. Nothing is permanent. This way of thinking is the path of the Buddha. He taught people to learn how to love, how to detach themselves from love and understand the state of impermanency.” (Column “Trendy Women”, \textit{Kwanruen}, 893: 148)

“The death of my mother has given me constant sadness. I tried to understand the nature of life – as Buddha said, ‘everything is subject to change’. It’s all about Anutta.” (“Letter to the Editor”, \textit{Kwanruen}, 893: 29)

Several articles across the four magazines emphasised the use of Sati (mindfulness) as a vital element to achieve happiness in everyday life, while a number of articles mentioned meditation as means of overcoming the feeling of everyday loss and discomfort:

“It’s most important that you have Sati. Dharma can help you with all your sorrows.” (“Cosmo Interview”, \textit{Cosmopolitan}, 141/12: 45).

“I was so depressed after having arguments with my boss. After that, I found the Dharma book of Ajarn Jarun\textsuperscript{66}. I read his book and went to meditation every Sunday at the temple near my house.” (“Letter to the Editor”, \textit{Kwanruen}, 892: 29)

“I was in debt and was discouraged at that time. Buddhism helped me out from that situation. I went to the temple for meditation for six months. With the power of the merit, I found a kind man who gave me a chance to build up my own business.” (“Special Report”, \textit{Real Life}, 977/31: 14)

\textsuperscript{66} A well-known monk among Thai people. His reputation is based on a meditation course on how to do insight meditation.
The result was similar to that found in the fieldwork. The magazines incorporated the use of Dharma in their advice while the respondents across the three groups also applied different religious practices when confronting mental health problems. Women's magazines offered recommendations to help readers cope with their problems by suggesting Dharma techniques. Dharma practices were used as an individual's self-treatment when women were stressed, which several respondents referred to as a 'simple' and 'natural' technique that led to a 'worry-free' feeling (Patty, 36, Employee) and a 'feeling of freedom' (Ravivan, 34, Business owner). Dharma techniques were combined with self-help techniques in the glossy magazines such as Dichan and Cosmopolitan while self-help was linked to Dharma practices that encouraged people to find the real (and deep) meaning of life and permanent happiness:

"Dharma can help you. It's an absolute solution to everyone's life problems." (Interview Kalamare, popular TV moderator and news anchor, “Cosmo Interview”, Cosmopolitan, 141/12: 41)

"I find my life is meaningful through the practice of meditation. It's true happiness. It's most important for everyone to be mindful in every action of their lives. It's the rule of nature.” (Interview Thitinart, popular author of a bestselling book, “The Law of the Navigator”, Kwanruen, 893: 242)

"Other people might find it difficult to cope with a problem like mine [divorce]. By practising Buddhism I felt it was not too difficult, for it taught me how to be strong. I have read Dharma books since I was young, I learned how to forgive and forget. It's not easy and needs constant practice.” (Interview with Nut Meria, popular singer, Dichan, 767: 51)

The findings reflected the use of Dharma with self-help to assist readers in understanding the nature of suffering. Dharma practice was constructed by women's magazines as a local choice of healing and spiritual treatment that gave readers a sense of self-esteem, control and freedom. These representations enhanced the individuals' responsibility to take control over their lives where individuals (readers) were positioned as active and responsible citizen.

The result shows that the representations of professional help and spiritual self-help were closely connected. This section aims to test the salience of spirituality in the discussion of professional help and self-help under the holistic frame of wellbeing. Spiritual practices are suggested by different authors as techniques to manage everyday stress. The medical experts, who were also the authors, re-contextualised the use of spiritual techniques in their advice. Instead of seeing spiritual health as a non-orthodox technique that contrasted with scientific reason and knowledge, spiritual healing became a local feature embedded in experts' advice represented in Thai women's magazines.
For instance, Dr. Vittaya Nakwatchara, a psychiatrist, who wrote the column “Mirror the Life” in *Dichan*, integrated Dharma into his discussion of mental health. He advised one woman who was cheated on by her boyfriend to undertake Ubekka (state of neutrality or disregard for stimuli, one of the four principles of virtuous existence). On a different occasion the same author suggested readers should understand the law of Karma and do good things by merit accumulation to lessen their feeling of loss.

Because of its popular appeal, the medical experts re-contextualised Dharma in their medical discussion of mental health, using women’s magazines as a public (mass-mediated) site to secure their territory of being the owners of the mental health discipline. Instead of treating spiritual health as a separate issue and a counter to scientific treatment such as Gall et al. (2005) suggest, arguing that spirituality violates the scientific bottom line of medicine and health care (see debate in Ellis, 1980 and Bergin, 1980), the Thai medical experts incorporated Dharma into their body of advice. They re-contextualised the scientific explanation of mental health treatment with the religious viewpoint and combined them into the total package of their views and recommendations. This local model of representation of self-help (Buddhist practices as means of self-help guided by the experts) demonstrated the process of social fragmentation that put a great burden on the individual while bringing the meaning of spirituality into individuals’ lives in what Besecke (2001: 366) describes as “reflexive spirituality”. He notes that reflexive spirituality is “a way individuals relate to religious symbols and practices in their efforts to gain personal meaning from religion”.

### 7.4.2 Commercialising Dharma

With a popular belief in Buddhism, religion was read as ‘news value’ in the Thai context. Bringing religious perspectives into the articles on ‘mental health’ and the ‘mind’ was assumed to be a strategic way to attract audience by bringing the meaning of Buddhism into readers’ spiritual outlook. This point emphasised how the magazines and their columnists (including the medical experts) selected the topics to be discussed when spiritual mental health became a popular topic in women’s magazines. The topic of mental health, the use of meditation and other forms of complementary healing, with an emphasis on holistic wellness, were attractive to the readers of women’s magazines across this study. A high number of respondents in Groups Two and Three stated how they like to read Dharma in women’s magazines (and other mass media):
"Women’s magazines and pocket books are useful sources of Dharma. You get the core of Buddha’s teachings without reading his original difficult language." (Tina, 28, Government officer – Carer of depressed sister, University degree, Group2)

“I like to read easy Dharma in women’s magazines. They show that Pra can teach you how to control your mind and understand the essence of living.” (Maleewan, 28, Teacher, University degree, Group3)

“Secret magazine is different from the others. They have a lot of Dharma stories that helpful and practical. Dharma is the main reason why I renew my subscription with this magazine.” (Patty, 36, Employee, Carer of schizophrenic mother, Master’s degree, Group2)

These narratives demonstrated the connections that the respondents had with the media and mental health while showing how the recursion worked between user and media institution. Patty, in particular, revealed that the reason she re-subscribed to the magazine, Secret, was because it offered a number of Dharma stories that she liked to read. This showed that the connection Patty had with Secret magazine did not end at the moment she read it. She maintained interaction (by renewing her membership) between herself as a reader and Secret magazine as a media institution while the magazine recycled what their target readership expected to see (Dharma stories). In this case, the process of communication between readers and women’s magazines was recursive. This example demonstrates that since media, society and culture are very complex, it is impossible to conceptualise the media without the audience’s attitudes and behaviours in current media cultures.

The results also show that women’s magazines linked Dharma to happiness and wellbeing through commercialisation. As seen in Dichan, Kwanruen and Cosmopolitan, the hybrid genre of the ‘advertorial’ (advertising and information) was introduced to give information about wellbeing by combining physical health and mental health. In a different column, the embedded intention of the columnists was to sell products, such as scented candles, by introducing them as wellbeing merchandise. These columns were informative and beneficial to several respondents who believed in holistic, natural healthy living. However, these advertorials were created to sell the products or services in the women’s magazines.

The ‘holistic lifestyle’ has become a popular theme with the rise of (mental) health commercialisation in women’s magazines. Readers are viewed by the magazines as targets of the healthy lifestyle market with the use of advertorials (and infomercial material). As different authors describe, the boundaries between genres are shifting and becoming more fluid: they are easy to recognise but difficult to define because they transform and mix journalistic features to
become a hybridised genre (Abercrombie, 1996; Chandler, 1997, see also Fairclough, 2003). Turner (1993: 38) comments, "genres continually change, modulate and redefine themselves". The intertextualisation of genres reflects the challenge from the producer's point of view to attract new audiences (see the concept of 'intergenre' in Livingstone and Lunt, 1994). As Abercrombie (1996) reminds us, the trick for the media producer is to offer a variation on a generic formula that can keep the existing audience while attracting new consumers.

One example can be seen in an article, "Lemon Farm, the rural sanctuary for your holistic wellbeing" (Dichan, 763: 216-220) which aimed to promote a new supermarket. The author discussed happiness and connected people's wellbeing to nature by suggesting that readers could maintain good health and wellbeing by thinking well and eating well. Instead of saying that Lemon Farm is now open as a supermarket, please become our customer, the magazines introduced this commercial enterprise with the expression "your rural sanctuary" to stand for supermarket, giving a natural holistic sense it was assumed would match readers' interests in having holistic and spiritual wellness. This article also included various quotes from medical experts giving information about healthy living, such as a scientific explanation of the benefits of eating organic food (available at the Lemon Farm supermarket) and the spiritual benefit of meditation and thinking positively. The author (a member of the editorial staff, no gender specified) intended to advertise the products from this supermarket by blurring commercialisation with information and scientific knowledge (cf. Gabe, 2003). Instead of buying advertising space to publicise this new supermarket, the author made the article more accessible by using the reader's belief in the medical expert's scientific information and spiritual health to endorse and justify the benefits of the organic products (sold at this supermarket). The authors emphasised the products from a merchandising angle, rather than informing or educating their readers. In this scenario, communication between the audience and the media is the process of recursion where the change of their interaction depends on the shift of both sides. The more the audience became engaged with the media and showed their reluctance to read commercialised content, the more the media needed to hybridise, both in format and genre, to maintain the audience's attention. Therefore, it was a critical point for readers, as consumers of mental health products, to be aware of the hidden intention of the advertorial as well as the use of a mixed (inter, hybrid) genre aimed at commercialisation. This awareness was to make the best use of the information the women were given and to be cautious of what the media intended to communicate and convince them of.
At this stage, the analysis shows the interplay between spirituality and commercialisation with media literacy through the prism of an individualising model that promotes individual agency and responsibility with self-help ideas. Crawshaw (2007: 1614) argues that although self-help offers individuals a model for taking control of their lives and experiences through a critical reflexivity, such an individualising model is “in turn linked to the rise of consumerism [...] self-help literature positions the individual as a consumer who buys into particular discourses and adopts strategies for the creation of an appropriate identity”. Not only did the example of the Lemon Farm supermarket that sold organic products demonstrate that in the project of modernity individuals’ lives are changing through abstract systems (experts, knowledge, trust), it also showed that routine consumption (food shopping, eating) could become commodified by the new narrative of ‘eat well’ (with organic food). Individuals were encouraged to adopt such a trend as a means of achieving good health. Such a model of dissemination in the mass media (i.e., advertorials, infomercials) aims to enhance the pursuit of wellbeing to match people’s interest with commercialisation. The greater the diverse representations of mental health (expert, spirituality, wellbeing, commodity), the greater the individual needs skills of media literacy to become familiar with forms, intentions and productions of the media. The idea of media literacy is required at a time when consumption culture is at the centre of social change at the level of the individual, the spiritual, the media and the culture.

7.5 LOCATING SPIRITUAL MENTAL HEALTH IN OTHER MEDIA GENRES

The findings from the analysis of women’s magazines and women’s experiences from the fieldwork strongly support the fact that spirituality plays an important role in Thai culture. Regardless of how religious they were, the respondents adopted multiple aspects of Buddhist practices into their everyday lives, mainly to serve as a buffer when experiencing a stressful life.

In women’s magazines, different Dharma and various spiritual perspectives were simplified and packaged to provide readers with an alternative viewpoint of mental health treatment. In addition to women’s magazines, the topic of spiritual health in various mass media was discussed. There were two key media platforms that the respondents revealed that they often looked at: ‘Dharma Blog’ and the ‘Pocket Book of Popular Dharma’. These two sources were the media sub-genre mostly cited by the respondents’ as the source of their mental health information. The integration of spiritual health information into the mass media provided those respondents who had access to
such media with a wider choice of mental health treatments to help them deal with their concerns in relation to mental health problems.

Certain informants mentioned several books that simplified the Dharma essence and made it accessible, unlike the original version in the ‘Pali’ language, which Kanyanat (25, Employee, University degree) reported as being “too hard Dharma that is too difficult to understand”. Dharma books have grown in popularity among Thai people. A series of books by different authors (including Pra (monk) and non-Pra) are displayed on the ‘suggested reading’ shelves in bookshops and recommended as a feel-good and self-help resource. The vast majority of Dharma pocket books in the mass market are well designed, with attractive covers. The Dharma/Self-help materials offer individuals guidelines and practices for good living and positive thinking on health, wellbeing, lifestyle and relationships (Crawshaw, 2007; Giddens, 1991; Rimke, 2000). Crawshaw (2007: 1613) notes that the language of self-help manuals (including those relating to spiritual health) draws on popular psychology: “the implication is that individuals can manage their own identities, regardless of social or discursive influences. In this ways, the self can be transformed and a new narrative written”.

Women in Groups Two and Three revealed that reading Dharma books was one of the treatments they chose to deal with stress:

“IT hurt me when I thought about why he left me. I tried to do everything to overcome my distress, ‘Sai Bard’ (offering food into the monk’s alms bowl), praying and reading Dharma books. The books taught me to let things go and to become a new person who pays attention to the present, not the past.” (Kessara, 28, Employee, Master’s degree, Group3)

“When I have free time, I love to read books about Dharma. It has become a habit. Dharma helps me to live my life with precaution. My mother said that I look calmer and more mature.” (Anong, 40, Soldier – Carer of schizophrenic daughter, Master’s degree, Group2)

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67 Weekly observation of the recommended bookshelves of several leading bookstores in Bangkok during September-December 2008.
Women's magazines used Dharma to draw the reader's attention to their columns. *Kwanruen* discussed love and happiness by quoting the venerable Ajarn Mitsuo Gavesako's Dharma pocket book "Essential of Life is Love and Metta":

"The venerable Ajarn Mitsuo wrote in his book 'The Essentials of Life are Love and Metta' that 'if the seed of love which is Metta has grown in your mind, you will consider what love means to you. Everyone, every animal in this world loves their lives. The power of Metta will bring peace to every single life. Buddhism teaches us how to love with detachment and we learn that everything can be changed.' (Column "Trendy Women", *Kwanruen*, 893: 148)

This book, written by Ajarn Mitsuo was mentioned by a significant number of informants in Group Three. They read this book (and other books in series by the same author) and reported that they obtained useful Dharma ideas and applied it to their own situation:

"I like to read Ajarn Mitsuo's book. It's a good source of food for thought. Money means nothing if we aren't happy. True happiness is to give, not to get. What else do we want as human beings? Dharma completes my life. I also love Dharma tales in this book." (Bussaba, 32, Lecturer, Ph.D, Group 3)

"The content of applied Dharma was so accessible that I could apply it to my life right away. I read the tiny ten baht book of Ajarn Mitsuo and I liked it very much." (Maleewan, 28, Teacher, University degree, Group 3)

These narratives imply the recursivity, intertextuality and connection that Ajarn Mitsuo's book had with the readers and other media. There was a reproduction of his work by *Kwanruen* and the reception of Dharma's content by the readers to demonstrate how the system of mediated representations, spirituality and audience reception maintained communication which was interactional in nature.

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68 Popular Japanese priest, living in Thailand. He wrote a series of Dharma books that aimed to teach the masses the 'easy-to-read' thoughts of Dharma in everyday life. He simplified difficult the Dharma language (Pali) into an accessible form. He is a very well-known religious figure who wrote many books of applied Dharma in Thailand.  
69 Metta means kindheartedness, compassion, mercy.
In addition to Dharma books, ‘weblog’\textsuperscript{70} represents the popular Dharma and has become a source of knowledge for those respondents who have access to the Internet. It was interesting to see how the spiritual aspect of Internet use was integrated into the women’s everyday life as a means of obtaining peace of mind. Women in Group Three and several carers revealed that they ‘browsed’ the Internet when seeking information about stress reduction techniques or searching for ‘How-To’ tips for fixing life’s problems. Several said they randomly searched for information about symptoms and treatment of mental illness. The findings supported Nettleton and Hanlon’s view (2006) that, with the rise of information and communication technology, people became more knowledgeable about (mental) health care issues, had the opportunity to share their everyday experiences with the world and had the opportunity to gain access to local and global information about mental health.

Women who had access to the Internet mentioned the websites they used regularly to read Dharma articles, and the blogs they used to share Dharma experiences:

"I like to read stories that represent Dharma perspectives. I go to www.landham.net to read Dharma articles. It’s free and you can read whenever you want to. This website was easy to find. It contained the truth of living that helped me reconsider how to live my life happily." (Kanda, 55, Former patient – Carer at the centre, University degree, Group2)

"I always go to www.ybat.com to search for a meditation programme. This website belongs to the Young Buddhists Association of Thailand Under the Royal Patronage. They always provide good Dharma articles. Sometimes they use cartoons to tell stories." (Patty, 36, Employee – Carer of schizophrenic mother, Group2)

The role of the Internet in providing an extended space in which to discuss various aspects of mental health, including spirituality, was important particularly for women in Group Two, as it allowed them to find information and share their experience of being carers. In this case, the media opened an extended, intertextual space about an individual’s value of life to become a public mutual interest by means of sharing their private concerns and experience of Dharma.

\textsuperscript{70} Marsh et al. (2009: 696) explains, “blogs provided links to other websites and enabled bloggers to swap information about sites of shared interest. In 1998 Jorn Barger first used the term ‘weblog’ to describe the interaction between these early sites and this became shortened to ‘blog’ As the Internet grew and the systems became more user-friendly, the number of ‘link-driven sites’ mushroomed and within a decade the community of bloggers could post their personal details and ideas and converse with one another’. See also the development of the world wide web in the discussion on ‘the Media.’ (Giddens and Sutton, 2009: 725-777)
CONCLUSION

Throughout this chapter, a series of connections between spirituality and mental health in different dimensions was explored. It can be concluded that the issue of spiritual mental health can be understood not only from a private, personal perspective; it can also be explained by social and cultural perspectives that are interactional and recursive in nature. The study shows that there was a connection between Buddhism and mental health via Dharma practices in women’s lives and different forms of religious faith, supernatural power, media representations and everyday practices. All aspects were combined to give an ultimate meaning of spiritual health and holistic wellbeing to people who believed in them. Dharma was used as a stress coping mechanism that encouraged the women to take responsibility and have freedom in their lives by following the footsteps of Buddha, who taught people to ‘design their destiny’ through the gateway of good ‘Karma’, ‘Merit Accumulation’ and ‘Meditation’. Dharma in the local Thai scene is well linked to the idea of reflexivity (Giddens, 1991) that asks people to be responsible for their own lives. The respondents who had access to multiple media modes, gained more opportunities to combat stress and other everyday mental health problems by obtaining spiritual mental health information, from Dharma books, women’s magazines and websites.

Buddhism was used as a complementary healing path and was sometimes placed in a role that challenged the dominant discourse of medical experts. As many authors point out, the concept of alternative therapy (and complementary healing) is rapidly gaining popularity in society (Chakrabhand, 2005; Klausner, 2000; Mongkol et al., 2001). Spiritual health that has an emphasis on local self-help techniques has become a cultural aspect embedded within mental health constructions that explains the relationship of the ‘sacred life’ with the meaning of health, mental health, happiness and wellbeing (Ekachai, 2000). However, the connection of spirituality and mental health has two aspects. On the one hand, it promotes a sense of self, empowerment and self-actualisation through a reflexive process. On the other hand, faith (and trust) in spirituality as well as Pra (monk) is simply a manifestation of the expert systems that were part of the everyday life of Thai women. This reflects the complex living in modernity that Giddens (1991) describes.

In women’s magazines, the representations of Dharma were simplified via the process of popularisation and commercialisation in order to attract mass readership by means of hybrid (mixed) genres. The findings emphasised the concept of the advertorial, which has been used in communicating commercialised content, even content related to spirituality, self-help,
professional help and mental health. As Fursich (2007) points out, the hybrid genre emerged because of the influence of commodification that obscured the boundaries between information and entertainment in the media-saturated age. It was also a result of the changing and shifting positions of audience and media in their circle of communication.

Although the respondents admitted that spiritual mental health content as represented in the women's magazines was useful, the way that such content was constructed tended to be commercially-driven. This point could extend the analysis to consider media literacy as a natural extension of all other communication literacies that come from an audience's engagement with their environment. Because the respondents were living in a changing environment heavily dominated by the media, certain skills were needed to filter and evaluate the mass-mediated content to make the best use of spiritual material. The next chapter continues to illustrate how media literacy has contextualised itself into the recursion of mental health communication. Although the most sophisticated media landscape has been constantly and speedily changing in diverse ways, it has at the same time transformed in a highly converged fashion (cf. Jenkins, 2006), and this affects the way in which spiritual mental health is constructed in modern Thailand.
CHAPTER 8

MENTAL HEALTH AND CONVERGENCE CULTURE

This chapter examines the connections that the respondents as media users had with the mass media and identifies the space of communication in which they exchange their mutual concerns about mental health. It illustrates the changing nature of the media landscape in Thailand (discussed in 2.6) which is similar to Jenkins’s (2006: 3) explanation of a convergence culture, a paradigm for media change: it “represents a cultural shift as consumers are encouraged to seek out new information and make connections among dispersed media content”. In fact, the idea of a convergence culture seems to outline the nature of ‘a diffused audience’ (Abercrombie and Longhurst, 1998) in which people become an audience all the time and engage intensively with media forms that are dispersed and plural but connected at different levels – private and public consumption, production and reception. The respondents extended their interactions with mental health by means of a new and complex media environment that increases specularisation of the social world. The respondents become highly diffused and individualised while the new media structures allow them to go almost anywhere to “seek out new information and make connections among dispersed media content” (Jenkins, 2006: 3) in which technology, industry, activities and society merges.

The first section of this chapter illustrates how women became ‘diffused’ audiences in their dynamic media consumption, allowing them to engage with the information flow across different media environment and channels. The second section shows how women’s concerns are transferred across the blurred boundaries of the private and public spheres that create the subsystem of mental health communication for the respondents and challenge Habermas’s normative description of the public sphere. The third section analyses the role of the media in providing mental health information, knowledge and a choice of mental health treatment while the expansion of communication technology in the media systems extends the user’s connection with their mental health communication.

This chapter argues that the changing mediascape of Thailand into a highly mediated culture, changes the way mental health is constructed in two scenarios. Firstly, mental health communications between private and public become fragmented and blurred in terms of topics of
interest, patterns of interaction and space of encounter. Secondly, the ideas of ‘audiencing’ and ‘performing’ (cf. Abercrombie and Longhurst, 1998) intersect the way in which women have become users, producers, performers and consumers of mental health through the two processes of convergence culture and media literacy. However, new forms of audience-media connections (such as online forms) also create new forms of inequality that make experiences of convergence uneven. Certain social groups (such as impoverished people without access to the Internet) are excluded from developing media/communication networks, thus truncating their potential recursion with the media culture.

8.1 DIFFUSION IN CONNECTIONS

Although women in each of the groups had different patterns of media consumption, they engaged enormously with different kinds of media in their daily lives. They become more connected (participation, production and creation) with the expansion and change of media systems through technology, society, space and experience (Couldry, 2005; cf. Grant, 2007 in ‘truncated self’).

To understand an audience in the contemporary world, it is worth revisiting the features of a diffused audience. Abercrombie and Longhurst (1998: 69) use this term for the dual process of interaction: “people simultaneously feel members of an audience and that they are performers; they are simultaneously watchers and being watched”. Abercrombie and Longhurst (1998) map a trajectory of audiences from ‘simple’, ‘mass’ to ‘diffused audience’ that co-exist in people’s everyday media interactions based on the argument of the ‘Spectacle Performance Paradigm’ (SPP), which describes the changing audiences in their conceptualisations. The concept of diffused audiences combines simple and mass audiences to explain the nature of modern audiences where “the difference between audience and performer becomes unclear, because performance in society is so widespread that a difference is imperceptible” (Gulnar, Balci and

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71 I developed the ‘media diary’ sheet (Appendix D) and distribute to 49 respondents to record their media consumption over a period of two weeks in November, 2008. This data collection technique was used to help the researcher to capture the media experiences of the subjects and to get comprehensive information regarding the types, duration, genres and purposes of media use. Vandewater and Lee (2009) also use the terms, ‘viewing logs’ and ‘media logs’ in their study to mean a similar kind of media diary. They note that this process is “designed to capture media use of respondents during a particular period. Media diaries are a modified form of a time diary, focused on a particular activity, namely, media use” (Vandewater and Lee, 2009: 1161, see also Kent, 1993).
Cakir, 2010: 165). This concept describes the multiple operating processes that the individual has with the media, constituted through everyday consumption blurring the line between private and public, audiences and producers, performers and consumers. Couldry (2005: 186) comments on the diffused audience by emphasising the use of new media, which “is almost permanently connected to one electronic medium or another, across almost every activity of social and private life”. The concept of diffused audiences reflects the modern culture that features the audience experiences that everyone is an audience all the time (Abercrombie and Longhurst, 1998), particularly when researching audience after the advent of a multiplicity of Internet-based technology that Jenkins (2006: 19) comments on, in which an audience will become “visible, noisy and public”.

Abercrombie and Longhurst (1998) use the expression ‘a diffused audience’ to refer to an audience characterised by ‘the Internet connection’, explaining the development of people to become an audience with no fixed settings. In this study, a diffused audience is a useful concept in understanding the nature of any audience behavior that is unfixed and uncertain. Despite the efficient notion that ‘diffused audience’ describes people’s changing relationship with the new media environment that connects the audience with producer, consumer and performer, the concept seems to be inadequate in explaining some phenomena based upon control of access (such as describing women without access to the diversification of new media – the women in the hostel). In fact, access and the use of new communication technology such as the Internet were the key differences in the respondents’ media consumption. Women in Group One (hostel) were the only group that had limited access to online media. The reasons for this limitation were: (1) Internet illiteracy – all of them (from working class and disadvantaged backgrounds) revealed that they did not know how to use the Internet or computers, and (2) restrictions to the Internet infrastructure – the hostel is a self-funded NGO and has limited resources for accessing high-speed Internet². In comparison, the women in Groups Two and Three had quite close patterns of media exposure. They mainly received information from television and print media. They made intensive use of the Internet and other IT gadgets such as, i-phones, i-pods and MP3 players and had more flexible opportunities to access various media than the women in Group One.

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² During the period of observation, there were only two computers connected to the Internet at the hostel. One PC was situated in the office and the other was in the printing room. Members (informants) were not allowed to use office supplies and facilities without authorisation.
8.1.1 Pattern of the Media Consumption: Group One

The informants usually spent their free time with the print media (magazines and books were available at the hostel, while they were able to watch television after dinner in the common area). The titles of magazines they read were Real Life, Kwanruen, celebrity and gossip magazines (TV POOL, GOSSIP, STAR). In the evening, eight women in Group One watched soaps, variety shows, quiz shows and sit-coms on television. Seven women read the front pages of popular daily newspapers (Thai Rath and Daily News) as well as stories covering crime and celebrity news. Seven of them read comics, novels and pocket books that they borrowed from the small library at the APSW. Five women liked music and listened to their favourite songs on the radio:

"I like to read information in Kwanruen about how to prepare to be a mum. Another thing I like to do is listen to music while reading. I feel relaxed and don’t need to think too much about my life." (Aim, 26, Cleaner – Domestic violence, Grade 6, Group 1)

"I like watching TV like ‘TEE SIP’ [popular Thai variety talk programme], ‘Reality TV’ and quiz shows. I also like to read comics. They are entertaining. I read Kwanruen and Real Life. My favourite columns are the interview pages. They are good source of information on how to overcome a crisis." (Mai, 19, Unemployed – Rape, Unwanted pregnancy, Grade 12, Group 1)

8.1.2 Pattern of Media Consumption: Group Two

Carers of the mentally ill reported that they mostly watched television, read women’s magazines and pocket books and used the Internet. Almost all of them used the Internet on a daily basis. They searched websites such as google.com and pantip.com, for information and news updates. Their favourite women’s magazine titles were Kwanruen, Cheewajit, Secret and glossy magazines such as Cosmopolitan and Dichan. Nine of them watched TV every morning for news programmes, and they watched soaps and quiz shows in the evening. Seven of them said they read pocket books when they had time and were alone. The books they read were particularly

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73 The findings about the women’s magazine preferences are taken from the survey I developed during my research to see which magazines women as a group and as individuals preferred to read. The titles of the magazines were also crosschecked while having casual conversations with each woman as well as with my observation as part of the ethnographic work.
applied Dharma and biographies/diaries of recovering patients. One book, entitled *The Journey Out of Baa* was frequently mentioned among the carers at the rehab centre:

“My happiest time is when I can be myself. I stay at home, turn on the TV, open my computer, listen music and search for things. I like to read tips for living in *Cosmo*. I usually read them before going to bed. Another of my favourite books is *The Journey Out of Baa*. It was exceptionally good and encouraged me to fight mental illness.” (Sandy, 34, Former patient-Carer at the centre, University degree, Group2)

“Everyday I sing, listen to music and read books. I like to read applied Dharma or applied psychology books that guide readers on how to create a secure life. One book written by Dr. Terdsak is very interesting. Another book, *The Journey out of Baa* is also useful. The staff at the hostel recommended this book to me.” (Racha, 32, Carer at the centre, University degree, Group2)

### 8.1.3 Pattern of Media Consumption: Group Three

Almost all women in Group Three used the Internet daily. They not only used the broadband Internet in their offices or on their personal computers at home, but were also connected to it on their wireless notebooks and mobile phones. They performed different activities on the Internet such as chatting on *msn*, updating their status on *Facebook*, writing a diary on *Blogspot*, browsing websites, visiting chatrooms, listening to music, and watching TV programmes that they had missed on *Youtube*. More than half of them revealed that they spent a large amount of time in front of the computer. They also liked to watch TV programmes such as news, drama, Thai soaps, American series (*CSI, Desperate Housewives*), variety shows, *HBO* (The Home Box Office), *Discovery Channel*, *MTV*, *Channel V* (music) Thailand, *BBC* and *CNN*.

Twelve women in Group Three read both the print and online versions of popular women’s magazines. The titles they particularly liked were *Dichan, Cosmopolitan, Secret, Cleo* and *Health and Cuisine*. Six women were also interested in reading news magazines: *Businessweek, The Economist* and *Matichon Weekly*. They expressed an interest in reading pocket books such

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74 Translated version of original book, *The Quiet Room: A Journey out of the Torment of Madness*, written by Lori Schiller, a former schizophrenia patient. This book was important and was mostly mentioned among the carers as a source of their will to live. It was translated into Thai by a novice translator who was also a recovered psychiatric patient of Sritanya Hospital and a member of the Family Link Association, one of the three sites in this research. Every carer in this study knew about this book and praised it as “an inspired text” because as they said, the book gave them hope and faith in recovery. The book described how a psychiatric patient (schizophrenia with hearing voices) felt, how the symptoms developed, how the illness was handled, how the patient was treated and how Lori recovered and was able to return to her family and community.

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as novels, biographies and self-help books. Dharma books also grew in popularity with the group. Nine of them referred to different book titles:

"I usually watch news on TV, soaps and MTV. It all depends on my mood. I watch UBC Sports Channel, HBO or use the Internet to search for information I need. I like to read books such as 'The Top Secret' and Dharma books." (Pomchanok, 22, New employee, University degree, Group3)

"I log into my computer to check e-mails first thing in the morning. On my mobile phone, I receive daily news updates about IT, stock markets and currency exchange rates. I spend most of my free time in front of my computer, playing on Google and Youtube." (Tonghatai, 30, Employee, University degree, Group3)

The findings show that the respondents connected themselves closely with multiple media platforms with flexible time and settings. The mass media merged with all aspects of women’s daily lives and the respondents could not detach themselves from them. The women’s connections with the media, particularly Groups Two and Three can also be explained by Castells’s (2000: 501) notion of network society, whereby the media and new technologies transform human relations and interactions by a series of connected nodes. He states, “A network is a set of interconnected nodes. A node is the point at which a curve intersects itself”. His abstract definition implies the interconnection of social life by linking complex informational networks where the communication nodes are generated by people and the richness of communication in a media saturated environment (Stalder, 2006).

As computer-based technologies have expanded, people enable the processing of the flow of communication and interaction flexibly in a shorter time and wider space. Castells (2000: 6) writes, “with new information and communication technology, the network is, at the same time, centralized and decentralized. It can be co-ordinated without a centre”. For example, women in Groups Two and Three learned convenient new ways of connecting with the world by using web-based communication in their own time and place, and creating a communication link with their network. Through using electronic mail and different social network sites such as msn, facebook.com, twitter.com, hi5.com, myspace.com, pantip.com, youtube.com, Groups Two and Three became diffused audiences in network society, using new technologies to gain and exchange information, creating a borderless sphere of participation and social interaction from one to many almost all the time. When it came to the discussion of mental health, the new media environment extended the mode of interaction people had with the media and allowed them to access information, inviting them to create a connection in the online forums (Cline and Haynes, 2001; Webster, 2002). This transformation expanded the pattern of mental health interaction to
unlimited connections and invited people to observe the flow of information within and beyond the frontiers of the private and public spheres. The results also show that similar mental health content in convergence scenarios can be obtained with no fixed genre. For examples, several respondents shared how they interacted with the media to select information that interested them, including the information on Dharma and alternative healings:

“The concept of ‘Anutta’ is really useful. It helped me a lot to overcome my stress. It became a habit to read Dharma books before going to sleep. Whenever I feel depressed, I come back to the rule of Anutta that teaches me that nothing is permanent. It happens and it will be soon be gone. In the past, I read Dharma in magazines and books but once I got high-speed Internet at home, I mostly searched for everything online.” (Kanda, 55, Carer at the centre, University degree, Group2)

“I can find whatever topic I want on the Internet. Let’s say Cosmo may have good reports about yoga, but I can also find similar stories in Cosmo online as well as searching Google for alternative sites that talk about yoga too. There are millions of them and it’s more convenient for me to go through the Internet than going to the bookstore.” (Yupaporn, 25, Restaurant owner, University degree, Group3)

The concept of the blurred genre now merges in the analysis when the new technology provides a new platform for local and global access of information. The narratives above show that women were flexible in combining the use of different mass media to search for the content they wanted. This scene signals the changing interaction between the media and their users. The respondents seemed to focus on ‘content’ rather than format and genre (Yupaporn showed that, to obtain information about yoga, she shifted her interaction with the media from reading Cosmopolitan to browsing Google). According to Iser (1978), the two poles (audience and media institution) cannot exist in isolation and the modification of interaction comes from a shift from both sides. As Livingstone (2004a: 81) points out, the media need to re-define themselves in terms of combined genres and changing form to cater to the audience’s taste:

“In the new media environment, it seems that people increasingly engage with content more than forms or channels – favourite bands, soap operas or football teams, wherever they are to be found, in whatever medium or platform.”

The respondents’ feedback creates a recursive impact on how the media are represented, while the media need to adjust to provide for users’ preferences and lifestyles. For example, because of high reader demand, Dichan published a nine-page interview with Nut Meria (a popular singer in Thailand) in issue 767. As the writer states clearly in the introduction to Meria’s long interview: “I received numerous letters from readers, saying that they wanted to know more about her
attitudes towards unhappy marriage and how she survived being labelled a widow” (Dichan, 767: 276, column “Open Heart”). Another example from Kwanruen shows how recursion is maintained between the audience and media. In the column “Letter to the Editor” in issue 893, the editor highlights key stories. In the first paragraph, she introduces Thitinart Na Patalung, the author of ‘Navigating Your Life’, voted most popular book by Kwanruen’s readers:

“If I have to mention one book that gives the most inspiration according to your votes in our project ‘The Most Inspiring Book that Makes You Feel Better’, it has to be ‘Navigating Your Life’, written by Thitinart Na Patalung, the best-selling book with a circulation of 640,000. Because this book was voted number one in our popular list, this issue will bring Thitinart to our coffee table to talk about her book in detail.” (Kwanruen, 893:242, column “Letter to the Editor”).

The extracts from Dichan and Kwanruen illustrate that the relationship between media and their audiences is not linear but a dynamic connection in which both parts of the social-open systems that communication was built upon their interactions. Media and women as users are closely connected and interdependent. As different authors (Castells, 2000; Jenkins, 2006) explain, the extended media landscape contains the new morphology of social change, which is polycontextual, polycentric and has multiple nodes of connection (Grant, 2007). It creates connectivity and shifts, which is an invitation to maintain a fast, dispersed, dynamic communication loop. This view is similar to that of Giddens and Sutton (2009: 724), who describe how the changing media landscape has made an impact on the production, distribution and consumption of information:

“Newspapers can be read online, mobile telephone use is exploding, and digital television and satellite broadcasting services allow an unprecedented diversity of choice for viewing audiences. With the expansion of technologies such as voice recognition, broadband transmission, webcasting and cable links, the Internet threatens to erase the distinctions between traditional forms of media and to become the primary conduit for the delivery of information, entertainment, advertising and commerce to media audiences.”

However, the changing pattern of media consumption has become more dispersed and mobilised, and the concept of diffused audience, which describes the significant use of new media and technologies was insufficient when examining the everyday media consumption of women in Group One (hostel). As shown in 8.1.1, they relied heavily on conventional media such as magazines, radio and television and did not have access to online technologies. They revealed that they had never used the Internet in their lives:

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"I heard people talk about ‘the net, the net’, but I don’t really know what it is? I don’t know anything about computers." (Chom, 35, Hairdresser, Domestic violence, Grade 12, Group1)

"Using the computer is too complicated. I can’t type and I don’t understand how the Internet works. How can I make use of it? It’s so expensive.” (Noi, 32, Singer, Domestic violence, Grade 6, Group1)

"The Internet and the computer? No, I don’t have them. I have no idea about them but I would like to learn how to use them some day.” (Jan, 21, Dancer, Unwanted pregnancy, Grade 9, Group1)

Not only do the narratives demonstrate that women in the hostel did not have access to online media, they also imply the absence of the skills required to use the Internet ("I can’t type”, “I don’t know anything about the computers”). These testimonies signal the interface concepts of audience, online interaction and media literacy in a convergence culture that Livingstone (2007) refers to as ‘competence’, ‘capability’ and multiple communication ‘skills’, which are central to any examinations of complex media and communications environments. As Livingstone (2009: 186) states:

“Using the internet is clearly not as simple as turning on the computer and checking email or clicking on Google [...] Accessing the internet is far more demanding than turning on the television, going to the cinema or opening a book. Expanding the conception of access beyond hardware to encompass accessing information and communication further increases the literacy requirements on users, for they must navigate complex portals, databases and other information sources effectively and efficiently if they are truly to ‘access the internet’. Lastly, the access dimension of literacy includes the skills required to avoid undesired contents, thus managing one’s exposure to content and contact risks, whether through technical means or social practices.”

In contrast, the women in Groups Two and Three who had access to use the Internet reflected on their ability to use it and described the Internet as a useful source of mental health information:

“I use the Internet to search for everything I want. I don’t need to go to the library anymore. I just stay relaxed in my room, turn on my music, browse the web and msn with my friends.” (Mala, 20, Student-Carer of schizophrenic father, University degree, Group2)

“Often, when I am stressed, I use the Internet to find ways to resolve it. I like to read stories about how people cope with their life problems. The Internet is a shortcut to learn how to get over whatever worries you.” (Pannarai, 24, Editorial staff, University degree, Group3)

These narratives suggest that the use of new communication technologies has the potential to enhance people’s opportunities to gain information to combat stress and concerns allowing them to gain a wider range of information for self-treatment and extend their interactions with the
world. The respondents connected themselves with the media in multiple settings and carried out a variety of activities at the same time (such as Mala using the Internet while listening to the music and chatting on MSN). However, opportunities to extend access to local and global resources do not always guarantee quality of information, and also increase uncertainty and risks of “misinformation”, “inappropriate influence” and “exploitation” (Livingstone, 2009: 173, see also ‘Risk Society’ in Beck, 1992).

The convergence environment as described in the rapid change of the new media scenario echoes Habermas’s (1989) notion of the public sphere, particularly when he was criticised by different authors for only paying attention to face-to-face interaction and being inflexible in new communication platforms with the potential to generate new forms of participation (Dahlgren, 2000; Downey and Fenton, 2003; Grant, 2007; Kellner, 2000; Stevenson, 2008). Although his earlier work seems to view the development of the mass media as a threat to the formation of the public sphere, Habermas’s later articles seem to develop a less pessimistic view of modern media. He revises his notion of the public sphere as a “complex networks that branches out into a multitude of overlapping international, national, regional, local and sub-cultural arenas” (Habermas, 1996: 373). This statement reflects his belief in accepting the media as the chief institution of public discussion and his intention to modify the concept of the public sphere in a less restricted way. In this scenario, Habermas’s normative condition of the bourgeois public sphere that relies on face-to-face encounters in salons or coffee houses is no longer valid (Goodnight, 1992). The public sphere of mental health within the online environment is extended and becomes dispersed, intertextual and polycontextual, i.e, the face-to-face forum is extended to virtual communication where people can meet and exchange views at anytime. The topics of discussions are varied and the boundaries between private topics versus public concerns are blurred. The following sections continue to illustrate these changing conditions of the public sphere in the Thai convergence culture.

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75 Habermas (1989: 41) views the development of periodicals as a breakthrough (in the bourgeois period) in providing a medium for private views appearing in public opinion. He notes: “soon the periodical (handwritten correspondence at first, then the weekly or monthly printed form) became the publicist instrument of this criticism”.

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8.2 EXTENDED COMMUNICATIONS: MEDIA USERS AND MENTAL HEALTH

According to Horgan and Sweeney (2010), people experience difficulties in accessing mental health information in the mainstream media because mental health and mental illness are so stigmatised they rarely appear in the mass media. This statement explains why fewer reports about positive mental health have been published, which coincides with the finding in Chapter Six (Myth of Mental Illness) that very few (eight) articles refer to particular types of mental illness.

Because the mass media usually associate mental health with negative images, such as stereotypes of the mentally ill, the respondents revealed that they had to search for mental health related content in other media sources to answer their queries. The respondents, particularly those who used media intensively (Groups Two and Three), seemed to agree that what was missing from the current overwhelming media culture was content to help them reduce their everyday stress and, at the same time, suggest motivations for living.

The respondents, particularly those who had mental health problems, identified their interest in content such as self-help texts and Dharma stories. They revealed that they found what they wanted to know about mental health in pocket books, magazines and from the Internet. They also described the content they were looking for as 'Sabai Jai (Feel Good) content'. The words 'Sabai Jai' or 'feel good' are used interchangeably in this analysis to stand for the mental health related content that the respondents used as a self-healing ways measure to relieve their unhappy moments (such as suffering, stress, and discomfort):

“I like to buy pocket books written by recovering patients and learn how they dealt with their sickness. The books are useful sources of information on instructing me how to manage my life with my mentally ill father.” (Mala, 20, Student – Carer of schizophrenic father, University degree, Group2)

“When I go to SE-ED [a popular bookstore in Thailand], I buy self-help pocket books about what to do if your kids use drugs. They are relevant to my life and I want to know how best to care for my children.” (Anong, 45, Soldier – Carer of schizophrenic daughter, Master’s degree, Group2)

“I found one interesting book about Dharma, ‘The Gift of Peace’. It’s an inspiring book. I remember one quote that said, you are what you think. Think that you are a being of peace and peace will become your new personality.” (Jintara, 33, Novelist, Master’s degree, Group3)

Sabai Jai is a common term Thai people use in their everyday lives to mean a 'state of happiness'. Sabai means 'happiness, comfort, warmth' while Jai literally means 'heart', but can be interpreted as 'mind' or 'feeling'.

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‘Sabai Jai’ information in this scenario encouraged women to have a greater sense of self and suggested ways in which they could retain power and control of their own lives. The informants, frequently cited Dharma as their source of feel good texts, where the authors simplified its essence into an accessible format for everyday use (see Chapter Seven). Women in Groups Two and Three also referred to self-help features in different media genres as sources of motivation and self-improvement.

The analysis also shows that the respondents shared what they read about feel good materials with their families, colleagues and friends via face-to-face communication or with self-help groups to which they belonged:

“The useful information I read from books and magazines I always share with my parents. I want them to get good tips for a good life, too.” (Pimchanok, 22, New employee, University degree, Group3)

“I like to come here for the self-help group with Mae Ku [senior carer in the Family Link Association]. She always motivated us with her ‘Sabai Jai’ words. Many times she brought good books to our group. They were inspiring.” (Racha, 32, Carer at the centre, University degree, Group2)

In this scenario, ‘feel good’ material created interactions for women as media users by formulating potential networks for multiple communities (Hongladarom, 1999). The respondents created recursivity by initiating a new circle of mental health communication with their local networks, to allow them to discuss their concerns about mental health. This recursive process was generated by creating, reproducing, and circulating the content in an intertextual way (reproducing, cross-referencing and modifying). Women who used the Internet exchanged ‘forwarded e-mails’ about good quotes/stories with their friends, and several of them wrote personal blogs (Kanyanat, 25, Employee, University degree, used myspace.com, Pannarai, 24, Editorial staff, University degree, used blogspot.com), while the majority of them used Facebook. They posted and re-wrote Feel Good stories (such as Dharma content and inspiring quotes) on their personal pages, and invited others to read, leave comments and create continuous connections:

“I collect many good quotes and good stories and post them on my blog. I usually post good Dharma and good quote from Kahlil Gibran77 to share with my friends. It gives you a sense of motivation.” (Pannarai, 24, Editorial staff, University degree, Group3)

77 A well-known Lebanese poet.
"I like to spend time on Facebook and roam around my friends' walls, leave them my comments or share nice stories on my wall. New good thoughts usually come from talking to people." (Adchara, 36, Housewife, Master’s degree, Group3)

The Internet in this case went beyond simply being one source of information on mental health but extended the connection between the women and their networks with 'small-scale social conversation' (cf. Hodkinson, 2007: 631) while facilitating creation and recursion. Borrowing Jenkins's (2006) idea of a convergence culture, the changing media landscape is an enabler that allows women to have greater access to information and provides them with a plurality of choice in dealing with mental health in the connected culture. It extends the audience's role from being receivers of the media message to being users and performers, who convey their interest to the wider public. This creates the participatory sphere of debates, discussions and recursion of mental health through means of online forums. In other words, the Internet provides a sub-forum for women to raise and share their interest in mental health, which could be seen as being similar to women's magazines providing a shared public space to appreciate women's everyday experience and make their voice heard (seen in columns such as “letter to the editor” in Dichan, Kwanruen and “Real Life” in Real Life). The logic of ‘sharing’ what we know, what we experience and what we are interested in recalls Jenkins’s (2006) idea of “collective intelligence”, which sees the media as platforms for people to form “knowledge communities” around mutual interests: “no one knows everything, everyone knows something, all knowledge resides in humanity” (Pierre Lévy, cited in Jenkins, 2006: 26-27). In other words, this collective process enables new forms of participation to emerge on the basis of the idea that “each person has something to contribute” (Jenkins, 2006: 53). With this idea, individuals have a wide range of information to contribute, from everyday mundane experiences to intellectual/sophisticated and technical aspects. This is an example of collective intelligence in knowledge communities, which brings the expertise of each member into the centre of communication where “knowledge becomes power in the age of media convergence”78 (Jenkins, 2006: 21). This point also explains the embedded connections of knowledge and expertise in abstract systems of modernity.

Members of today’s society have the potential to extend their interactions with the world via mediated experiences. In particular, because the Internet allows women as media users to meet at the same point regardless of space and time, the cyberworld has become a point of contact for

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women in the e-community. In this extended communication model, the respondents in Groups Two and Three were able to engage with the new opportunities to participate in the information society. Those who used the Internet became users in multiple contexts of communication and had multiple engagements in the cybersphere such as sending/forwarding e-mails, browsing information, writing a diary on line, posting comments on blogs, and chatting on social network sites. The web is thus more than just an information source but is also a junction of information exchange for connection and recursion. In other words, it is a new kind of density of information, the dissemination of the information and a potential for articulation that is blogging, facebooking or tweeting. Different narratives illustrated how the respondents interacted with different online activities which indicated the different forms of social communication:

“I read news online by going to matichon.co.th and click on the news that interests me. I like to read headlines and columns about lifestyles and cultures.” (Piyada, 24, PR staff, University degree, Group3)

“I always go into pantip.com and read news update. I view updates of celebrity scandals on the Chalermthai chatroom and enjoy posting comments, too.” (Valley, 30, Government officer – Carer of schizophrenic mother, University degree, Group3)

“I like to update my diary online. It’s an activity that allows me to be myself when I am alone. It was fun to decorate my pages.” (Sandy, 34, Carer at the center, University degree, Group3)

The interactions described by respondents such as Valley – “I view updates of celebrity scandals and enjoying posting comments” and Sandy – “it was fun to decorate my pages [personal blog]” demonstrate that the respondents create performances in accordance with Abercrombie and Longhurst’s (1998) ‘Spectacle Performance Paradigm’. According to this paradigm, the boundaries between audiences become fluid and blurred with performers in which the respondents created their performer’s role. For example, in the case of Sandy, the way she wrote and decorated her blog can be seen as a contemporary form of ‘self-expression’ (Hodkinson, 2007). Sandy constructed her own image and identity in the way she wanted to be perceived in sharing her everyday details with the world.

79 A quality newspaper – see 2.6.
80 A popular online forum in Thailand that invites users to come and exchange information about their interests – see 2.6.
The multiple interactions of media users described by the respondents linked mental health to the essential topic of women’s concern which was similar to Robinson et al.’s (1998: 1264) illustration of the interactive health communicator in the Internet. It implies two-way communication in accessing and transmitting the health content:

“The interaction of an individual — consumer, patient, caregiver or professional — with or through an electronic device or communication technology to access or transmit health information or to receive guidance and support on a health-related issue.”

Williams and Calnan (1996) state that the development of electronic media changes the way people engage with everyday medical information whereby virtual spheres connect people to basic medical advice. A number of recent related studies confirm that the Internet has become a popular choice in searching for mental health information (Cline and Haynes, 2001; Edgren, 2006; Gallagher, Doherty and Moral, 2008; Renahy, Parizot and Chauvin, 2008). Horgan and Sweeney (2010: 118) agree that websites are the new mental health care outlet for “those who have received a new diagnosis and those who want to help others cope with mental health related problems”. The advantage of the Internet in the mental health care system is also described by Cline and Haynes (2001): individuals may access sensitive topics they are reluctant talk about in face-to-face interaction. As discussed earlier, the Internet seems to be a new platform that provides additional space for sub-groups (in this scenario, women and/or those living with mental health problems) to search for and exchange information and thoughts about mental health. It is, in fact, the central idea of the sub-public where subgroups and subcultures are gathered to voice their concern (mental health) in shared diverse societies (Fraser, 1992) which challenges Habermas’s normative view (1989; 2006). The Internet is therefore a new opportunity and new form of social interaction that creates a series of sub-systems of mental health communication between women and their world in highly complex, intertextual and polycontextual fields with the multiple use of media technologies. Although the Internet can be used to extend a circle of mental health discussion, access to it among the 49 women was not equal. At this point, it is worth considering Patelis’s (2000) comment about discussing the findings carefully with an awareness of unequal accessibility.

The results show that online discussion provided the forum for women with the same problems for the purpose of sharing information. Carers in Group Two used the Internet to access information on mental illness, seek advice, express their feelings and call for support. What the informants experienced seemed to support the findings of Horgan and Sweeney (2010) who
suggest that the Internet opens up a digital public sphere that mobilises people to construct a new culture of information technologies in their social life. Their view is similar to that of Schmidt (2001), who describes the possibility of media technologies maximising opportunities of seeing the world through interactions that transcend space and time. When it comes to mental health queries, Horgan and Sweeney (2010: 118) state that mental health information online may be more advantageous than other media because it enables the user to “remain anonymous and share feelings on a more intimate level while feeling less stigmatized for gaining mental health information and support” (see also Johnsen, Rosenvinge and Gammon, 2002; Shaw, McTavish and Hawkins, 2000). Wallace (2001: 236), also points out the benefit of using the Internet for anonymity and uses the phrase “a perfect place for conspiracies” to mean the anonymous atmosphere found in the newsgroup for people suffering from social stigmatisation. She states that “the relative anonymity of the net offers people a chance to talk about their problems to others who share them, without all the complications of face-to-face relationships” (Wallace, 2001: 205)

These statements from different scholars explain why particular carers in this study admitted that they were comfortable discussing their mental health problems in chat rooms: nobody could identify who they were because they used ‘aliases’ and ‘nicknames’81. They also disclosed that they felt safer discussing their problems about mental health and mental illness on the Internet:

“You can talk freely on the Internet. I can say whatever I want and nobody knows who am I.” (Sandy, 34, Former patient – Carer at the centre, University degree, Group2)

“I like to visit the mental health chatroom in pantip.com, read and leave my question. I don’t feel anything because no one is interested in who you are. Everyone is equal in the cyber world.” (Tina, 28, Government officer-Carer of depressed sister, University degree, Group2)

“I feel totally safe in front of the computer. Sometimes, you just don’t feel the same when you talk about your problems to someone you know very well. I am not sure they could accept what I have been through.” (Racha, 32, Carer at the centre, University degree, Group2)

81 The informants who used weblogs or chat rooms on the Internet used many nicknames instead of their real names. Some of them gave examples of using common nicknames in Thai such as ‘Ying’, ‘Jib’, ‘Nok’ as well as names that explained the state of their emotions or symptoms so that no-one would recognise who they were. Women revealed they used the aliases: ‘depressed girl’, ‘poor mum’, ‘waiting for real love girl’.
Feeling 'safe' and relatively anonymous enables carers to disclose more about their problems. Walther (1996) describes the situation in which people feel anonymous, safe and distant, and therefore motivated to reveal more emotions, as 'hyperpersonal'. Wallace (2001: 206) agrees that the anonymous environment of the Internet “is especially well-suited for Internet support groups involving stigmas that are easy to hide, and that could be highly embarrassing if they came to light”.

The testimonies also give a positive view of the online forum as an extended space in which to share mental health concerns, which generates the recursive loop of mental health communication similar to the way in which Giddens and Sutton (2009: 728) describe the significance of the Internet that allows a new type of relationship to emerge. They state, “anonymous online users can meet in chat rooms and discuss topics of mutual interest – many Internet users become part of lively online communities that are qualitatively different from those they inhabit in the physical world”. Bringing the theoretical abstraction of the public sphere into this section provides a useful counterfactual framework in understanding women and their sphere of mutual interest in mental health. Grant (2007: 60) explains how the fluid public sphere is reconstructed by the process of mediatisations. He notes that “the public sphere is constituted by mediatisations which introduce turbulence, generate challenge and renew reality levels with an almost simultaneous speed and intensity”. His view reflects the fundamental and flexible adaptation from face-to-face interaction to the new form of communication that expands the space for discussion and even challenges the public sphere by changing “complex communication networks” across multiple contexts (Grant, 2007: 4). If the essence of Habermas’s public sphere is to create an interactional space in the form of the old bourgeois ‘salon’ for people to express their opinions and interests, the mass media, including the Internet in contemporary society, may arrange a centre for information exchange. The mass media can invite people to join and generate public discussion in a much more intertextual (transformation of text, genre and cross-referencing) and polycontextual way (plural, dispersed and uncertain). However, this observation also shows that the Internet may truncate interactions to a certain extent (Grant, 2007). A few carers and several women in Group Three disclosed that they did not like to connect with people online because the relationship on the Internet that they experienced was highly superficial and often fictional. As they stated:
“You never know who is who on the Internet. How can you be so sure that you will obtain real friendship with people you have never met? I don’t reveal any deep information about my life on any webboards.” (Jitdee, 40, Business owner – Carer of schizophrenic sister, Master’s degree, Group2)

“What we say on Facebook is so superficial. How would you create a real connection by typing one or two lines on the walls? For me, it’s just a public mailbox to say hello and how are you. Many times, I don’t know what to say to some of my high school’s friends. We have not seen each other for ages! And I don’t want to share my life with them.” (Bussaba, 32, Lecturer, Ph.D, Group3)

The Internet therefore has the potential to extend our connections but can also cut interactions, turning human communication into a surface phenomenon. It could be said that the Internet in mental health can be understood as a sub-social system that extends interaction, creates a complex space for sharing and giving support and allows people access to unlimited information to help construct their identities, communities, social practices and mental wellbeing. However, such an extension could become too vast to allow the establishment of close connections and rich relationships. As Grant (2007) comments, people become so polycontextual across so many different systems that they may end up becoming fragmented, dispersed and intertextual but also truncated which is a result of the multiplicity of media environments.

The following section demonstrates the performance of audiences as users of mental health information and examines their connections with online information on mental health. It explores how informants engaged with the Internet in two activities – searching Google and sharing concerns by writing on blogs. Khan and Kellner (2005) point out that the World Wide Web constitutes a global information network, while blogs are dynamic networks that maintain an ongoing dialogue to integrate and disseminate interactions on a dispersed level.
8.3 CRITICAL USERS

The emergence of the website Google.com\textsuperscript{82}, allowed Internet users to access world information easily. The use of Google and the web gears the world towards a knowledge culture in which the boundaries of ‘knowing’ and ‘not knowing’ become fluid and blurred.\textsuperscript{83} Wallace (2001: 4) notes:

"[It is] a kind of library/magazine rack/yellow pages, and also a self-publisher – most people say they can find what they were looking for in at least half the time. They know where they are going and wisely wrote down the address, because a simple keyword search can bring up hundreds of thousands of hits."

In this study, the informants who used the Internet revealed their heavy use of Google to browse for the information they wanted such as Thai celebrity gossip, international songs, popular books, self-help information and content on health and mental illnesses (severe stress, schizophrenia and depression). The arrival of Google has gradually changed the way users of the Internet obtained information. One woman in Group Three, the mother of a nine-year-old boy, explained her changing interaction with this technology:

"I can use the Internet when my son goes to school and my husband is at work. Usually I surf around, playing hi5 and facebook. I use Google to help my son with his homework, too. The world is changing. Unlike in the past when we went to the school library and spent weeks searching indexes and books, nowadays what children need to know is how to search for information on the Internet." (Adchara, 36, Housewife, Master’s degree, Group3)

As discussed earlier, mental health problems in Thai society have traditionally been kept secret and people are reluctant to talk about them freely in public (Cooper, 2008a). When they need to learn more about mental health, a Google search seems to be a shortcut for the Internet user to obtain information. The following narratives described how the respondents explored their topics of interest by using Google as an entry point to reach information on mental health and mental illness:

\textsuperscript{82} The search engine service founded by former graduate students of Stanford University in 1998 – see The Search: How Google and Its Rivals Rewrote the Rules of Business and Transformed our Culture by John Battelle (2005). Google.com is described by Larry Page, one of Google’s founders, as “a reference librarian with complete mastery of the entire corpus of human knowledge" (Battelle, 2005:252)

\textsuperscript{83} See the concepts of ‘Intelligence Agent’, Battelle (2005) and ‘Intelligence Agency’, Jenkins (2006).
"I went back home and searched the Internet after my doctor told me that I had depression. I used Google and typed ‘depression’ in the search box. There were a lot of self-tests. My feelings matched many of items listed such as feeling worthless, having no will power, and thinking of suicide.” (Sandy, 34, Carer at the centre, University degree, Group2)

"At first, I didn’t know much about schizophrenia. I rely on books and search on Google by typing the word ‘schizophrenia’ to see what it is all about.” (Jitdee, 40, Business owner – Carer of schizophrenic sister, Master’s degree, Group2)

"I basically got information about hot yoga from the Internet. I first knew that there was a hot yoga course in Bangkok from my friend and she said she felt so relaxed after a one-hour course. I was interested in this treatment so I searched for it on Google.” (Yupaporn, 25, Restaurant owner, University degree, Group3)

The respondents also revealed that there were a number of easy-fix tips in relation to their searches for stress reduction techniques. They referred to self-help information as a popular topic that they searched for online (Gallagher, 1999). One woman used Google to search for a solution when she was stressed by typing the phrase ‘solutions to stress’ into the search box (Darika, 33, Employee, University degree). She explained that there were ‘millions of websites’ about simple, self-help techniques such as ‘calming yourself’ or ‘a good massage’. These findings agreed with previous literature, which describes the Internet as “speculative, comprised of basic ‘How To’ representations, with little empirical research” (Cline and Haynes, 2001: 671). Although Darika did not think the suggestions on the Internet worked well for her, she enjoyed reading what the websites suggested:

“It’s fun to read easy tips on stress on the Internet even though I don’t think they are suitable for me.” (Darika, 33, Employee, Master’s degree, Group3)

Although the Internet offers widespread anonymous access to mental health information, interdependent interaction and content tailoring, the informants seemed to agree with critics about the quality of online information (Cline and Haynes, 2001). They were aware of a number of websites that were advertising and selling products. The respondents claimed that their search was not completely reliable because the mediated content that they read was highly commercialised:
"I searched about aromatherapy on Google and found one interesting website. It talked about the history of aroma treatment and classified which scent matched which sickness such as lavender for relaxation, vanilla for pleasure, and lemon for better breathing. But you know, when I scrolled down to the bottom of the page, it said that this page was supported by one company that wanted to sell its products, which were scented oils and aroma kits. How can we trust a website like this?" (Chalida, 24, Reporter, University degree, Group3)

"I have never used the Internet to search for ways to solve my problems. I tried it once by typing in the words ‘stress, solution, happy’. The results were junk pages promoting McDonald's happy meals, advertising travel agents, commercial stress-free workshops and yoga courses." (Benya, 36, Business owner – Carer of depressed mother, University degree, Group2)

Several respondents in Group Three mentioned that when they searched online for information about happiness, their searches returned – “websites about diet pills, slimming pills and beauty pills”. As Bussaba (32, Lecturer, Ph.D) explained: “These websites just wanted to sell their pills for weight control by making false claims. They have no legal certification from the food and drug administration. These misleading advertisements are very dangerous”. This result is very important as it reveals the tension between opportunities to gain information online and the risks of misinformation. Giddens (1991: 109) explains that “to live in the universe of high modernity is to live in an environment of chance and risk”. Livingstone’s (2009) work on children and the Internet also captures the theme of ‘Risk and Harm’ in children’s use of the Internet. She describes the nature of risk in the online environment, stating that “the inextricable linking of opportunities and risks also characterizes the everyday experiences of individuals, for risks emerge from everyday social relations and processes of our (society’s) own making” (Livingstone, 2009: 170).

One point to discuss from the findings is the connection of seeing how diffused audience activity and mental health content merges consumption culture that Abercrombie and Longhurst (1998) describe as the circuit of spectacle and performance, which is rooted in industrial capitalism. In this context, the respondents seemed to speak from a consumer’s point of view, and expressed their thought toward online mental health related content, see narratives above – Chalida (aromatherapy products), Benya (McDonald’s Happy Meal) and Bussaba (pills for weight control). The process of audiencing starts from their enthusiasm to search for information to improve their (mental) health by searching for information on the Internet. However, as Jenkins (2006: 27) describes, “the emergent knowledge culture will never fully escape the influence of
commodity culture”. Audiences cannot escape from the circuit of consumption where the issue of mental health flows into such claim, moving toward material conditions.

However, the majority in Groups Two and Three criticised the easy-fix materials found on websites as being ‘too simple’, ‘very commercialised’ and ‘impractical’:

“Many self-help techniques that the media suggested didn’t apply to my situation. When I read them on the Internet, I needed to filter the information and see which one worked for me. Sometimes, their tips are so superficial and I think, they just don’t work.” (Yupaporn, 25, Restaurant owner, University degree, Group3)

“Its website is very commercialised. I want to read information about self-therapy on insomnia, not advertisements that pop up every time I open the pages.” (Rattana, 33, Novelist, Master’s degree, Group3)

“I don’t read How-To columns. I know what I need to do if I get stressed. What the authors suggest wouldn’t fit into my lifestyle.” (Patty, 36, Employee, Carer of depressed mother, Master’s degree, Group2)

In response to the point that the Internet was a useful source of mental health information but at the same time was rather unreliable, women Groups Two and Three searched for a second source to justify, reject or confirm the information they found on the Internet:

“It’s ok to search for information on the Internet but I prefer to look in more reliable sources such as books. On the Internet, it’s hard to find references. Anyone can say anything. It could be true or false. If you don’t do a cross-check, you may get incorrect information.” (Jitdee, 40, Business owner – Carer of schizophrenic sister, University degree, Group2)

“The Internet is a very useful source of information. You can find anything you want on the Internet..but to tell the truth, I don’t count on it. Most of the information is rubbish. A number of websites I’ve found are usually sponsored by commercial products. You need to compare what you’ve found with other people or other sources” (Kinnaree, 36, Hotel owner, University degree, Group3)

What can be seen in this set of findings is the series of skills the respondents used to counter any risk in their interactions with the Internet. They were able to question, judge and confirm the validity of the media content by cross checking the references. In fact, this result follows Livingstone’s (2004b: 5, see also Potter, 2011) discussion about media literacy that poses a challenge as to how users of the “fast-changing production context” are able to question the authority, objectivity or quality of mediated knowledge in the overwhelming media culture. Such skills enable the audience to access, analyse, evaluate and create media content instead of “simply being passive sponges soaking up whatever comes their way” (Giddens and Sutton,
This is the traditional view of media power, which has resulted in wide-ranging debates in the long development of audience studies.

8.4 BLOGS AND SUB-SYSTEM OF MENTAL HEALTH CONNECTION

In the online world, women Groups Two and Three performed various activities on the computer. One key finding is that the women used blogs to seek mental health information, share experiences and generate connectivity. Jenkins (2006: 320) describes the term blogging as:

"A technological platform that allowed for easy and rapid updating of web content. Increasingly, it has come to refer to a mode of publication of grassroots origin that responds to information circulated either by other bloggers or by the mainstream media."

In this study, the informants mentioned several websites that provided them with mental health information: thaimental.com, thaifamilylink.net, dmh.go.th, pantip.com, tobenumberone.com. These sites had dedicated spaces for users to communicate in the form of blogs, web-board or chat rooms. Women in Groups Two and Three revealed that they enjoyed reading updated information on blogs, and participating in the virtual community by asking questions, posting comments and exchanging views. As discussed earlier, the Internet is not just a source of information about mental health but also an invitation to experience new quality interactions in a mediated cultural world. These forms of interactions are similar to Cudmore and Bobrowski's views (2003) that suggest that the mental health care consumer today becomes knowledgeable in mastering the Internet by actively asking questions online or making appointments with their doctors. Some informants explained how they participated in weblogs:

"Another good source of information is pantip.com. There is a chat room about psychology where people, including recovering patients, gather and talk to the psychologist. I like to see what other people think and how they take care of their sick family members." (Valley, 30, Government officer – Carer of schizophrenic mother, University degree, Group2)

"I was so depressed and lost 3 kilos in 3 weeks. I checked for information on www.thaimental.com, the web-board for mental health. I left my concerns about being mentally sick. I think it was the psychiatric nurse who suggested I go see a shrink." (Kanda, 55, Carer at the centre, University degree, Group2)
"In pantip, there is a special blog for office girls to share their problems at work. It’s really useful because we all usually have the same problems with bosses and clients. I like to read other’s posts and see how they deal with the same situation. I sometimes share what I think, too.” (Kanyanat, 25, Employee, University degree, Group3)

The respondents connected themselves with the online community by blogging. They were able to broadcast what they thought, creating a community with similar concerns, initiating talk and exchanging views in order to solve an individual’s problems. The online community was a special space for women to have a mutual sense of unity in sharing problems. One carer expressed her positive feeling of visiting a mental health blog:

“I don’t know anybody who has a situation like mine [taking care of her sick father], but reading this blog [pantip.com] helps me to feel that I am not alone. At least, there are many people out there experiencing the same problem.” (Mala, 20, Student-Carer of schizophrenic father, University degree, Group2)

Sharing people’s personal stories in weblogs, exchanging views and seeking solutions were the activities that blurred the distinction between personal and public space, which endorses the idea of multiple publics (cf. Dahlgren, 2010; Fraser, 1992; Grant, 2007). This virtual communication encouraged people to leave their private zones and freely engage in discussions with those who had similar concerns. If Castells (2000: 410) is right in saying that “space is the expression of society”, participating in such a space is therefore the extension of the self, in that people (carers in this scenario) join and establish the network of sharing “the same communication codes” (Castells, 2000: 470) for people having mutual concerns. According to Stevenson (2008), literature on the Internet influences change in the communication landscape by reducing public space and giving more interaction in a horizontal direction rather than in a vertical structure. One carer (Kanda, 55, University degree) said that when she posed her question on one website, thaifamilylink.net, to ask about the best treatment for depression, she received comments from many people suggesting different healings techniques. In this scenario, this blog created multiple dialogues and potential interactions, which enhance the multiplicity of choice of mental health treatment. The virtual space on the blog gave this carer “possible interaction in a horizontal direction” (Stevenson’s, 2008: 184) that can be viewed as an empowered communication channel for women living with mental health problems and the mentally ill, allowing them to multiply their voices and share what they really think or need with a larger public. In fact, communications on blogs (as well as online journals) draw a ‘sub-network’ that has “facilitated the attachment of individuals to substantive groupings” (Hodkinson, 2007: 626), which in this study may refer to people living with mental illness and those with mental health concerns.
The relationship between women as media users is complex and there may not be an obvious line between the producers of texts (in the Internet sphere) and the audience who read such texts. Wallace (2001: 12) explains that “we have more power to influence this environment [the Internet culture] than we ever had for television or telephone because we can be creators, producers and users at the same time”. Access to the large scope of the media and new communication technologies seemed to be the key to increasing the respondents’ chances of exploring choices of living that relate to their mental health and wellbeing. However, because greater access may not always mean quality of information, it is therefore critical from an audience’s standpoint to have media literacy skills (access, analysis, evaluation, creation and participation) to understand people’s complex connection with the media (Livingstone, 2007). In addition to the paradox of Internet access and its quality of content, this chapter points to the basic problem that those from underprivileged backgrounds do not enjoy the same opportunities to obtain mental health information. Without access to the new media (or the ability to perform different kinds of literacies – writing, reading, typing, and using the Internet), women in Group One (hostel) were automatically excluded from mental health mass-mediated resources and the extended circle of mental health communication. They have been excluded from the chance to improve their quality of life in the rapid rise of the interactive communication opportunities that the other two Groups have benefited from and enjoyed.

CONCLUSION

Convergence culture marks a shift from the conventional paradigm of media and audience to diffused media and audience scenario that creates news form of connections (Jenkins, 2006). The expansion of new communication technology provides a changing media environment that extends the connection of mental health communication in Thai society. Mass media facilitated communications and interactions encouraged women to become media users who are diffused, diverse, and interactive in new ways. The mass media have provided a particular space for women who experienced similar mental health problem to gather and discuss their concerns. The new phase of communication using the Internet enables users to have access to a wider range of global and local mental health information in the changing landscape of the info-sphere (see ‘informational city’ in Castells, 2000: 398-410), which is diverse and intertextual but at the same time can cause risk and uncertainty.

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Following Abercrombie and Longhurst’s (1998) notion of a diffused audience, the women in this study mobilised the flow of complex communication and interaction. This is particularly the case for those respondents from Group Two and Group Three who engaged with different types of media. They became not only active recipients of mental health content, but also interactive and intertextual agents, able to create the discussion and recursion of mental health in multiple ways by exchanging their viewpoints on online forums, chat rooms and weblogs. Such interactivities are a response to the developing process of media literacy, which Potter (2011: 12-13) describes as: “being skilled at assessing the meaning in any kind of message, organizing that meaning so that it is useful, and then constructing messages to convey that meaning to others”.

This chapter shows that women who had access to the diverse aspects of the media had more opportunity to obtain, use and create the mental health information they needed. The mental health information that they received from the media reshaped their mental health knowledge and skills, while giving them choices of mental health treatment (such as in the case of Feel Good (Sabai Jai) texts in women’s magazines, books, forums, chat rooms and weblogs on the Internet). In other words, the communication scenario to include the Internet offers the individual access to ‘the possible alternatives’ (Giddens, 1991: 83) to deal with their mental health problems by providing the plurality of choice for them to choose and adopt. In these scenarios, convergence culture is the provider of a reflexive process that invites individuals to understand their needs, modify their self-identity and organise the relationship between the net (and the mass media) and the self (Castells, 2000).

Despite the opportunity they had to access the world of information about mental health, the respondents in Groups Two and Group Three revealed that the mental health content on the Internet was commercially based and mostly unreliable. However, they seemed to understand that the underlying motivation of media institutions is to commercialise, but they challenged media representations by searching for confirmation and crosschecking information. Their actions demonstrated the multiple media literacy skills to access, filter and evaluate the mediated content. Media literacy skills enhanced the women’s competencies to become creators of meaning in dealing with the mass-mediated content and facilitating the development of quality recursion that women had with the media culture. Following Livingstone’s (2007) comment, media literacy seemed to work as a useful (theoretical and practical) concept in the study of audience and their interactions in converging media, technologies and in the polycontextual sphere of communications. This chapter pinpoints the concern about unequal access to the media.
and online development. It is clear from the findings that women in Group One were excluded from the development of a convergence culture where the media, including the Internet, create an infinite horizon of interaction that invites users to get connected to the world of information. This concern enables the gap of opportunity to be reduced by bringing media literacy into the development process in order to enhance women’s good mental health without other concerns about technological, institutional or social obstructions.
CHAPTER 9

CONCLUSION

This body of research starts with three questions and their answers are refined to stand out as the conclusion to this study. The aims of this research are: (1) to examine the social and cultural systems and epistemic discourses that construct mental health; (2) to explore the territories of mental health in the private and public spheres of the Thai convergence culture; and (3) to investigate the role of Thai women as media users and their recursive connection with media cultures. This research also seeks to identify the potential factors that enhance women’s competencies to make heard their voice of mental health.

In terms of question one, the thesis is explained by the notion of polycontextual communication that manifests across the analysis. It covers different themes embedded in this study: the private, the public, the professional, self-help, trust, spirituality and Buddhism, classical (Mae See Ruen) and popular images of women, empowerment, disempowerment, Rok Jit, Baa, production, reception, participation, consumption, commercialisation, passive, active, single meaning, plural meaning, hybridisation and the multiplicity of modes of media and communications. Section 9.1 illustrates that questions of mental health are not only about the personal dimension, but also the social and cultural that are interactional and recursive in nature. These features not only constitute endless connections between women and their media culture, but also interconnect and reflect the Thai landscape of modernity that leaves mental health exposed to multiple formations and interpretations.

In terms of question two, the research has identified the blurred public sphere in the mediated world that has changed the Thai mediascape into a highly commercial, convergent and intertextual site for communication exchange. It challenges Habermas’s notion of the public sphere by exploring mental health ‘territories’ (or sub-spheres) in the blurring of private and public dimensions (in terms of participation, space and diversity of content). To follow previous studies (Berns, 1999, Hermes, 1995; Kim and Ward, 2004; Lhuangsumrit, 2005), this study discusses women’s magazines as special public venues for guiding women’s identities, sharing mutual concerns and making their voices heard. However, because the findings from Thai
women’s magazines are very dispersed and contradictory, the research questions the extent to which these magazines represent the real voice of women and their mental health.

In terms of question three, the research has concluded that in women’s connections with the media and mental health, they become agents who co-construct, explore and make sense of a world that is increasingly media-cultural in two aspects. First, the term co-construction implies the interplay between women and mental health discourses and representations. The results from women’s reception are varied and challenge the dichotomy of an active-passive audience, arguing that the interpretation of media texts does not adhere to the fixed categories of the dominant or oppositional reading (Hall, 1980). Because media and audience are both part of media systems and human systems, there is a tendency for the systems to merge, reverse or break out with no clear pattern. Luhmann (1995), in developing his comprehensive view to reflect that society is non-linear and polycontextual, states that the world is connected by flexible networks embedded in dynamic social phenomena.

Second, not only does my study discuss women’s ability to challenge the mass-mediated representations, the analysis also explains women’s competencies to co-construct a role in which they are highly engaged with the media (see ‘audiences’ as ‘performers’ and ‘spectators’ in Abercrombie and Longhurst, 1998). Media literacy, as seen from the analysis, relates closely to the recursion produced by the media and users forming a recursive circle. Following Livingstone (2005a: 44), I use the term ‘user’ to stand for the complex modes of audience actions — “playing, surfing, searching, chatting and downloading” — that go beyond the conventional acts of a ‘simple audience’, moving towards ‘Spectacle Performance Paradigm’ (Abercrombie and Longhurst, 1998). The term ‘fluid connectivity’, refers to the recursion between women and their media culture that is changing on a daily basis and in which the passive/active dichotomy is abandoned by the features of ‘users’ and ‘media literacy’.

This research identifies not only potential media literacy — the set of skills that feed forward into the cycle of effective recursion — but also clear evidence of dynamic variations that call for equal access to the media and competency to use them to create and maintain recursion with mental health: for instance, women in Groups Two and Three draw on higher levels of media literacy. It shows that they can be informed users who have a better chance of connecting to the world in order to express themselves and to make their voice heard.
9.1 CONSTRUCTIONAL VARIATION OF MENTAL HEALTH

Drawing on a bi-modal methodology of a nine month ethnographic study with women and a discourse analysis of Thai women’s magazines, this study of mental health constructions reflects fundamentally a complex version of living in Thailand that is characterised by different features of modernity. The term ‘fluid construction’ is chosen as a description of the dynamism and the polycontextual connections of mental health that are easily ‘leaked’, ‘flooded’ and ‘melted’ in Bauman’s (2000) description of liquid modernity. On the one hand, mental health can be understood as a changing social structure that has been transformed into ‘commercialisation’, ‘consumption’, ‘social marginality’, ‘technological encroachment’, ‘incomprehensible abstract and expert systems’ (cf. Schumaker, 2001). On the other hand, it can be interpreted at an individual level as the reflexivity to understand not only “what we are, but what we make of ourselves” (Giddens, 1991: 75), based upon notions such as choice, self-actualisation and self-help. This formation of self enhances individual freedom to choose a lifestyle and encourages responsibility for complex choices of living.

The mediation of experience has become a major part of modern living and making sense of mental health. Giddens (1991: 24) makes clear that “the development and expansion of modern institutions were directly bound up with the tremendous increase in the mediation of experience which these communication forms brought in their train”. There is a series of interactions, territories, voices and the connectedness of discourses creating an ‘epistemic order’ (Foucault, 1984) that are drawn from this examination of mental health constructions. These epistemes formulate mental health to become abstract phenomena and designate the way women make sense of the world in a ‘take-it-for-granted manner’ (see “familiar schema” in Luhmann, 2000: 36-37). This research illustrates a different set of mental health representations and shows that they are paralleled, reinforced and challenged by each other. My results agree with different authors who argue that (mental health) constructions are socially defined and are a never-ending process (Hall, 1997; Hayward and Bright, 1997; Lupton, 1992; 1994; Olstead, 2002) while representational variation is the manifestation of such complex constructions.

The discourse of experts is one example that describes the complex constructions of mental health where abstract systems, self-help, trust and spirituality are interconnected. This study develops a series of scenarios, showing that experts are the key players in the social construction of mental health and endorses the way Foucault (1984) uses the term, ‘power and knowledge’ to emphasise the systems of exclusion, a prevailing social and cultural codes and norms. Experts in
this study hold the power over the practice of healing from the biomedical model's perspective that links medical doctors, hospitals, medication, consulting sessions and systematic treatment (Fox, 1998; Hart, 1985; Nettleton, 2006). As different authors argue, the uses of medical authority and commentary by medical experts are ubiquitous and so shape beliefs of mental health and mental illness in our lives (Crowe, 2000; Kutchin and Kirk, 1997).

In women's magazines, medical experts are framed as the producers of the knowledge that is legitimated to disseminate the truth about mental health. This legitimisation is processed by referring expert's titles and medical affiliations. Thai women's magazines articulate the voice of experts (with a high frequency of male voices) as if they were the only authority to speak on mental health issues, excluding other related voices such as the patients, the mentally ill, the carers and the voices of female experts. Experts and their knowledge produce 'difference, exclusion and marginalisation' that relate closely to power and representations, while 'trust' (of the expert) has become a crucial link to maintain the power of expertise. Giddens (1991: 138) notes that "doctors and many other types of professional expert derive power from the knowledge-claims which their codes of practice incorporate".

The theme of 'self-help' appeared to be a key attribution in the construction of mental health from both subjective and mass-mediated views in this study. Following Giddens's idea of the trajectory of the self, self-help (and other forms of self-therapies) is a process of growth for one to 'take charge of one's life' where individuals are responsible for their choice of living. On the one hand, self-help can be viewed as part of 'reflexive project of the self (Giddens, 1991: 5) that "consists in the sustaining of coherent, yet continuously revised, biographical narratives, takes place in the context of multiple choice". On the other hand, self-help operates within the expert/abstract systems (as seen among different scenarios, e.g., self-help groups run by Ajarn Daeng and a pharmacist; women in Group One were asked by the social workers to write diaries to reflect their feelings; different experts wrote self-help columns and appeared on TV to guide viewers on how to maintain good health). These self-help scenes depended heavily on the experts and required the role of authority and expert knowledge to 'act at a distance' as part of self-development (Crawshaw, 2007; Rimke, 2000).

Despite the strong connection of the discourses of experts, spirituality was identified in this research as both a contrasting (Hart, 1985) and complementary discourse. Spiritual disciplines and practices (the belief in Karma, insight meditation, doing good deeds) among the Buddhists
were the cultural means for women to cope with mental health problems and a reflection of reflexive process. Sethabouppha and Kane (2005) agree that religious practice is a priority when Thai people think of mental health treatment. This is because many Thais live in a ‘Buddhist Culture’ (Chungsatiensap, 1993; Mulder, 2000; Puntasen, 2007; Wasi, 2001) where Buddhism has an internal meaning with people’s faith and positive attitudes that enhances their wellbeing (Almeida, Neto and Koenig, 2006; Beit-Hallahmi and Argyle, 2007; Koenig and Larson, 2001). The belief in Buddhism has been a significant part of Thai cultural background through the sacred meanings of the Wat (temple, monastery), the Dharma (practices and disciplines) and the Pra (monk), which are intimately associated with the Buddhist’s way of living (Cooper, 2008a).

Schumaker’s (2001: 3) description of mental health in Asian countries is useful. He observes the phenomenon of mental health in Asia and defines it as a pathway to modernity that reflects the unique values of the East such as family ties (or collective identity), religious heritage and respect for authority. He notes:

“Asian countries have modernized in ways that reflect their own values, traditions and cultural heritages. Easternization has been able to retain a certain degree of collective identity, cooperative endeavour, and respect for authority”

Many themes drawn from this study described what Schumaker (2001) illustrates as distinct cultural features of Asian countries that constitute how mental health is constructed. They include ‘family ties’ (extended patriarchal family structure in Chapter 4 and the way in which the respondents consulted their family members when they were stressed), ‘religious heritage’ (the belief and faith of Buddhism as the sacred path to happiness in Chapter 7) and ‘respect for authority’ (expert systems in relation to abstract systems in Chapter 5 as well as the extension of authority to include Pra (monk) and Chee (nun) as spiritual experts who can be consulted on mental health treatment). On many occasions, Dharma practices are selected by the respondents as their everyday self-help that challenges the power of medical experts (several respondents follow the Buddha’s teachings as a stress-coping mechanism instead of seeing a specialist). Spiritual treatments (such as meditation, merit accumulation) emerged as self-practice local treatments to enhance women’s ability to deal with problems while Dharma empowered women to make use of local resources and develop their local knowledge as an alternative means of achieving a good life. Spiritual self-help in this scenario not only offers women an alternative to manage stress but also provides a lifestyle choice as to who they want to be at a time when the traditional legacy of Buddhism intersects scientific knowledge and abstract systems (seen in the
representations of spiritual techniques that contextualised the expert’s advices in Thai women’s magazines). In this view, local spiritual resources such as ‘pra’ blurred into abstract systems where the account of ‘trust’ cut across an individual’s fateful moments. Instead of pursuing arguments about whether modernity weakens the hold of religious explanations and diminishes the role of spirituality in society (cf. Flew, 2002; Hervieu-Léger, 1990), I agree with Giddens (1991: 142) that the role of religion reclaims a place as a local form of knowledge that “offer[s] significant support in shaping significant life decisions”. He notes:

“In modern times some forms of traditional authority continue to exist, including, of course, religion. Indeed, for reasons that are to do precisely with the connections between modernity and doubt, religion not only refused to disappear but undergoes a resurgence.” (Giddens, 1991: 195)

Modernity challenges the existing religious influences and can be seen as a developing process to organise the environment of reflexivity — a process through which “social practices are constantly examined and reformed in the light of incoming information about those very practices, thus constitutively altering their character” (Giddens, 1991: 38). As discussed earlier, a significant majority of women across the three groups turned their beliefs to traditional authority when they sought for peaceful moments practising Buddhist self-techniques (i.e., meditation, doing good deeds, belief in Karma) in their routine engagement with mental health. The concepts of spiritual self-help, holistic treatment and re-skilling appear to correspond directly to a different set of findings, encouraging respondents to work towards good mental health as a reflexive path to a happy identity and to plan a life of their own where personal power is marked as an inherent property (Gauntlett, 2008; McRobbie, 2004; Rimke, 2000; Shilling, 2002). Not only does this scenario illustrate the co-existence of spirituality and self-help (cf. Repstad, 1996), it demonstrates how they are networked in a unique local form in the ongoing development of mental health and modernity in Thailand.

This study also demonstrates that questions of mental health constructions are not only questions of representations and discourses that were posed initially in formulating this research, but inherently material in nature. Mental health in Thailand connects its representations strongly with the logic of consumption while placing the key feature of self-help in a context of lifestyle choice. Giddens (1991: 196) explains that the project of the self is a result of modern conditions that strongly influence by “standardising effects of commodity capitalism”, which also influences consumption patterns of advertising. Seen in magazines’ representations, good mental health, lifestyles and happiness can be purchased. The magazines offered a consumption package
of good mental health with easy-fix techniques that lay within material and consumption culture (such as shopping, travelling, massaging, changing hairstyle). Giddens (1991: 198) describes: "the project of the self becomes translated into one of the possession of desired goods and the pursuit of artificially framed styles of life".

If the narrative of mental health is generated through the process of consumption in the mass media that gives alternatives of choice, individuals (regardless of class, social status and gender) are thus confronted with the possibility that they need to be more competent in choosing what is best for their lives. Bauman (2000) states that individuals have full responsibility to take charge of their lives and can blame no one for unsatisfied outcomes. Bauman (2000: 74) uses the term "shopping list" to stand for the individual's search for "skills needed to earn for living", for "ways to drawing attention and ways to hide from scrutiny" and "for ways to earn the love of the beloved". These requirements enhance the notion of 'individual choice' that Giddens (1991: 197) describes "individualism becomes extended to the sphere of consumption, the designation of individual wants becoming basic to the continuity of the system. Market-governed freedom of individual choice becomes an enveloping framework of individual self-expression".

This setting of self-help transforming the individual to be responsible for their choice (of mental health) can also be explained by "the potential of newer neo-liberal discourses of health care to position responsibility for the management of well-being with the individual" (Crawshaw, 2007: 1606). The trend of women's magazines in their representations of commercialised mental health (such as easy fix techniques, DIY happiness, celebrity and expert endorsements, commodified spirituality) guided me to see how the media constructed their readers as responsible and self-regulating citizens, which reflected the neo-liberal model (cf. Harvey, 2005; 2006) of mental health care. Crawshaw (2007: 1613) states that "the individual is required to be a self-promoting health-seeking citizen, willing and able to manage and regulate their own behaviours under the guidance of experts". However, use of the neo-liberal model that maximises 'entrepreneurial freedoms' (Harvey, 2005) through reflexive engagement (by withdrawing any forms of state interference) seems to have limitations. Several authors comment that it privileges upper classes who have better finances and does not cover certain social groups (i.e., the rural, the impoverished) from the development of free market ideology that disregards unequal opportunities among people from different profiles (Harvey, 2006; Heron, 2008).
One example would be the results in this study where the rise of consumerism framed mental health, self-help and happiness to be commercial products that individuals can purchase. This premise is based upon the claim of free trade where markets are allowed to serve all economic needs without restraints (Wacquant, 2009). This idea automatically excludes certain individuals such as those with disadvantaged profiles who do not have such affluent backgrounds from the free market system — "everyone can become whoever they want to be, that identities can be purchased, and that total happiness, new lives and destiny's can be forged through the power of consumption" (Margues, 2010: 325). In addition, the development of media and the digital divide that has become the primary venue of mental health knowledge also obstructs certain social groups such as lower class (e.g., women in the hostel) with limited access to and literacy of new forms of media interactions (e.g., blogging, facebooking, emailing) which in fact should be available to all individuals regardless of their profiles and economic backgrounds.

9.2 THE BLURRED PUBLIC SPHERE

With the expansion of communication technology and without the concern of unequal access, the mass media distribute a wide range of information to be sought in a variety of sources (Jenkins, 2006). As Smith and Gunter (2005: 350) suggest:

"The disciplinary knowledge now called expertise is loosened from its institutional moorings by media, interest groups and social movements that transmit their particular versions of truth with the speed of the electronic signal, the digital pulse, and the ubiquitous newspaper, magazine, pamphlet and book to the private imaginations of readers, viewers and listeners."

The change in the Thai media landscape with advanced technology innovation, transforms the way people interact with mental health information (Webster, 2002). The results illustrate the changing behaviour of women in managing their mental health, particularly when communication technology encourages the use of easily accessible global information. Borrowing Bauman's (2000) term, in the context of liquid life, it motivates people to confront constant uncertainty and provides multiple spaces to connect with mental health information in a highly mediated environment. This changing media environment builds up the infinite connectivity between people and the media and offers an invitation to a recursion in which the term 'fluid connectivity' is used to refer to the nature of that interaction.

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Habermas (1989: 389) defines the public sphere as “a domain of our social life in which such a thing as public opinion can be formed”. Indeed, the logic of this study had nothing to do with the rational political consensus described as the essence of the public sphere or with unifying reason as a result of gathering. What the public sphere has provided for this study is a comprehensive theory to assess different set of findings in the complex space of discourse and the formation of mental health space for sub-groups (such as women and carers of the mentally ill). In fact, emotion and women’s experiences of mental health are areas that Habermas does not include in his model of the public sphere either in his normative version 1989(1962) or the later restructured writing (2005, 2006) where he embraces his flexible and empirical view of plural spheres as a response to feminists’ critics that Habermas ignores women and their private lives such as child-rearing and household responsibilities (Benhabib, 1992; Ryan, 1992).

Several aspects relate this study to the centre of criticism of the public sphere in relation to women’s magazines and mental health. The theory of the public sphere has given this study a valuable entrance to look at the media empirically in terms of its formation, role and operation. The public sphere is particularly fruitful to this study to extend an understanding of mental health constructions in terms of space (private and public), diversifications of content (personal interest and shared concern) and participation (the mediation between social actors, who have the power to speak but to what degree and to what purpose). However, the analyses across this thesis illustrate clearly the emergence of new forms of public engagement with the blurred borders of mental health discussion that directly challenge Habermas’s dichotomisation between the private and the public sphere that is based upon his political description as well as his exclusion of certain ‘subsections’ (as discussed in 2.5). Following Fraser’s (1992) argument, Habermasian public sphere is ruled by elites, e.g. educated, middle class men. She points out that “the discriminatory notion of Habermas’s public sphere could not accommodate people of all categories and tended to be gender blinded and ignored other sub-groups and minorities who were living in the same society” (Fraser, 1992: 115). This argument applies forcefully to women, and with even greater force, to women living with mental health problems which in this study referred to disadvantaged women, such as the poor, the abused and those living with mental illness.

In one way, women’s magazines offer public space for women’s business, while representing women as individuals to express their personal experiences through letters to the editors/columnists. The examples of sharing women’s personal concerns, such as stress at work,
uncertainty in relationships and home care management blur the private sphere with the public that many feminists (Fraser, 1992; McLaughlin, 1994; van Zoonen, 1989) discuss in their critique of Habermas’s (1989) blindspot on gender sensitivity based on the idea that ‘the personal is political’. This idea forms a sub-public system of communication with women and minorities in parallel to the Habermasian bourgeois public sphere. These general observations are similar to Lhuangsumrit’s (2005: 4) who points out that women’s magazines (glossy magazines in her study) are the site of mutual trust among Thai female readers where the borders between personal matters and public concerns are difficult to discern:

“The personal matter is not a personal one anymore. We could share our experiences and resolve our problems together, then we could empower our groups to get stronger and know about our true voices and selves to make a good relationship with all people.”

The model of sub-forum of mental health communication can also found in the respondents’ participation in self-help groups (Groups One and Two) and their use of blogs (Groups Two and Three) where women’s experiences were focused and valued. Specifically in women’s magazines, they could become not only a sub-system of communication among women to raise their voices and introduce their problems in more detail than in other media (Berns, 1999), they could also become ‘a negotiated sphere’, a modified version of the public sphere that extends women’s visibility by appreciating their diverse experiences of everyday life. Instead of aiming for consensus, the public sphere is evaluated to the extent to which it opens up to dynamic expressions and voice. This point is described by Livingstone and Lunt (1994: 34-35) who claim that the public sphere can be assessed by two approaches. The first is to consider Habermas’s ideal form of public debate that generates political consensus and public opinion. The other is to understand the public sphere and the media as platforms of expression “of diverse political and social interests in order to form a working compromise between negotiated positions”. This study sees women’s magazines as creating potential space for negotiation and re-formation of women’s identities that should not be marginalised or limited by the voice of dominant groups (such as middle-class, urban women, professionals). This analysis challenges the ideal description of the public sphere that is not universal but “fragmented into a mass of competing interest groups” (Fraser, 1992: 59). Seeing women’s magazines (as well as self-help groups and weblogs) as different public spheres of mental health, discussion in this study is similar to the point suggested by Dahlgren (2010), that different media outlets can create clusters or different set of diverse spheres that are constituted to serve interests for different publics. In fact, Habermas (1992,
2006) admits that his normative model of the public sphere has limitations in a response to the feminists’ debates (cf. Fraser, 1992) by accepting the alternative ideas of plural and multiple spheres. However, as discussed in 2.5 there is a tension in his modified description of the public sphere (and private sphere) that it still emphasises certain cultural forms of rationalities (i.e., politics and economics) in elites’ contexts, silencing other voices and non-political interests (cf. Dahlgren, 2010; Hodkinson, 2011; Kellner, 2000; Ku, 2000; Morley, 2000). Therefore, in applying the theory of the public sphere to the analysis, I agree with Habermas to the point that he conceptualises public sphere as a comprehensive tool to understand the public space(s) which are not about institution, but also individual, agency, history, technology and communicative action that are networked in a polycontextual formation. His flexible description of plural spheres (cf. Habermas, 1992; 2006) contributes to better understanding in viewing the topic of mental health as women’s interest in diverse form of space, construction and discussion. However, within the tension in his explanation of the modified public sphere that seems to be “inspired by the vision of a robust public sphere serving a well-functioning democracy” (Dahlgren, 2010: 21), is his strong normative view to privilege certain types of rational discussion in elite, western, masculine and political characters that fail to include marginalising voices and their concerns. Hodkinson (2011: 190) notes:

“the ideal of fully inclusive, equal and informed participation may sound laudable, such critics argue, but, in practice, the rationalist version of public culture called for by Habermas privileges a very particular elite set of cultural ideas while excluding other forms of culture and expression”.

To look at the issue of women’s shared interests such as domestic management, relationships and health (cf. Benhabib, 1996), this study highlighted women’s magazines as women’s shared space that literally extended women’s worlds into the public domain. Women’s magazines in this study provided the negotiated sphere to break and challenge the cultural code of the ‘Mae See Ruen’ domestic role that expects Thai women to be good housekeepers, followers and supporters (Cohen and Kennedy, 2000; Keyes, 1984; Limanonda, 1995; Pinyuchon and Gray, 1997). Cosmopolitan, Kwanruen and Dichan suggest women should become more assertive, independent and professional while adopting independence, freedom and self-help to reconstruct women’s household role to accord with Gregory’s (1999) argument that sees women as home managers. This hybridisation of women’s role, in fact, results from the negotiation that women’s magazines de-construct the ‘Mae See Ruen’ role and re-construct women’s images (independent and professional roles) in the popular discourse. As Castells (2000: 2) reminds us, the media in
the transformation of social change are "a contested domain, rather than a sphere of cultural reproduction" (cf. Phiphitkul, 2001).

However, my concern is to justify to what extent women's magazines are a special media genre and social forum for women (Fergusson, 1983, Kim and Ward, 2004) that represents the voices of diverse groups, supports the difference in women’s experiences and reflects women’s real problems with mental health. While the issues of equal access and diversification of experience remain priorities, women’s magazines should be assessed according to how well they support the diversity of women’s voices and encourage women’s participation in sharing simple versus complex concerns or hidden versus open interests where public and private issues merge in both the life world and the mediated world. This study observes the dynamic representations of stress-coping mechanisms in which women’s problems are presented as trivial, superficial and simple by women’s magazines. Titles in women’s magazines show a similar trend: authors assume women’s life problems as non-serious matters that can easily be solved by adopting very simple solutions such as shopping, using a scented candle, buying cosmetics and having a ten minute massage. Although these easy-fix tips were defined as popular self-help techniques, they were framed and reproduced as a universal treatment that underestimated the variance of Thai women’s experiences across social groups, classes and locations. *Cosmopolitan* and *Dichan* represented women’s lives in a number of articles but they seemed to limit their representations to the narratives of middle-class-urban women, such as strategies for worries of (office) work or solutions to reduce stress by learning yoga or affording luxurious goods and services. These suggested tips intrinsically assumed the way of life in Bangkok (and other big cities) rather than essential concerns shared and raised among women across different profiles (such as stress from household work, domestic violence). These findings imply that women’s magazines ignore the multiplicity of women’s voices and experiences and that the representations in this scenario are used to reduce the complexity of reality in a ‘taken-for-granted-manner’. Without a signal to show that mental health is a serious issue that threatens women’s wellbeing, it is represented as a superficial problem that does not require serious discussion or long term planning for its solution. Indeed, it is constructed to be a commercial topic driven by consumption culture, where women’s magazines have already prepared packages of treatment to solve women’s problems with different kinds of merchandise.

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As stated, Thai women’s magazines do not take seriously problems that affect the quality of life of women. They disregard the problems of certain sub-groups such as the poor, those who have been raped, those suffering from domestic violence and by silencing women’s shared stress related to household burdens. Although they do so to a certain extent in *Real Life*, the magazine represents women as passive and as victims of bad relationships. Magazines exploit dramatic narrations (sensational lead, colourful and strong description) to describe women’s miserable lives of abuse, rape, cheating and unwanted pregnancies written by battered working class women or exaggerated by the editors. In these texts, women’s magazines disempowered readers in a double sense. Not only do women’s magazines represent women as the passive actors of the incidents, they discourage women to resist such unequal power by excluding the recommendation of break-ups, reporting to the police or calling for help while silencing the abuser’s responsibility in their stories. As Berns (1999: 105) comments in her research:

“As long as these magazines continue to locate the victims’ experiences within a discourse that silences the role of the abuser and of society, individuals will continue to not ask why does he hit her?, why does he get away with hitting her? and why doesn’t she leave?”

The results from women’s magazines, therefore, seem to conform to Shevelow’s (1989: 192) comment that “they were instrumental in shaping the traditional hierarchy of men and women, and reformulating women’s social role as equal in name, however subordinate in custom and in law”. The reason behind such representation also points to the motivation of women’s magazines as media businesses that tend to popularise women’s stories (such as abuse, worries) as objects for commercial purposes. For instance, the rise of self-help with the commercial success of women’s magazines constructs mental health into a ‘wellbeing business’ driven by the assumption that good mental health can be purchased (by shopping, massaging, watching movies). The mass media in this account are the public sphere of commercialisation that transform mental health into a mere commodity for wellbeing and connect consumer culture with self-help dialogues and advertising. These findings can also be addressed by Margues’s (2010: 325) explanation of the rise of consumption culture in modernity that “total happiness, new lives and destiny can be forged through the power of consumption”. As a result, the discourse of self-help (including spiritual health) is a consumption industry with a commercial agenda which is controversial. On the one hand, it is sold in women’s magazines to empower the readers to build up women’s self-actualisation and self-improvement. The emerging phenomenon of self-help (and DIY happiness) expands the space of self agency and personal choice that is framed under
the discourses of freedom and empowerment (Advocat and Lindsay, 2010). Various self-help
scenes, including the role of Buddhism, encourage an individual’s inner sense of control,
enhance autonomy, freedom, personal responsibility and empowerment. This fits with the
principles of ‘liquid modernity’ (Bauman, 2000) and the ideas of ‘self’, ‘reflexive self’ and
‘reflexive modernity’ (Giddens, 1991; Beck et al., 1994), constructing each individual to be
capable of being the author of her/his life. On the other hand, self-help could be something
totally different. Women’s magazines may assume that women do not want to (or cannot)
actively resolve their problems. They position themselves as a special female media that
commercialises women’s concerns by selling quick solutions to happiness that can be achieved
by buying wellbeing products that are endorsed by medical experts.

In Thailand, the complex media business environment in terms of numbers, classifications and
ownerships (as discussed in Chapter 2.6) also raises a major concern for the rational public
sphere and the functioning of consumer culture that “today’s industry is geared increasingly to
the production of attractions and temptations” (Bauman, 2000: 78). The real motivation of the
media may not be to disseminate rational, useful mental health information to the public. Instead,
they articulate such information to legitimise the intention to sell products or services that are
difficult to distinguish from information and commercialisation or simply to maintain normality
and to maintain their status within the communication system.

The operation of consumption and consumer culture shapes my second discussion regarding the
Habermasian notion that the ideal public sphere requires the media to be immune to commerce.
From Habermas’s (1989: 171) viewpoint, the integration of mass media and consumption culture
has transformed his ideal model of the public sphere to be merely a marketable site for revenues:

“In as much as the mass media today strip away the literary husks from the kind of bourgeois self-
interpretation and utilize them as marketable forms for the public services provided in a culture of
consumers, the original meaning is reversed.”

For Habermas, the issue of ‘what sells’ rather than ‘what informs’ comes into contention and
spoils the idealisation of the public sphere. This is because the real intention in his view of the
media, is to transform the public sphere into a space of market-driven-commercialisation more
than pursuing a commitment for free debate. With the clear purpose of making profits, the
commercialised public sphere may prompt readers (such as of women’s magazines) to become
victims of a consumer culture by being trapped into the mediated mental health content of
commercialisation (such as the representations of mixed genre – advertorial, infomercial and the use of professional titles to endorse the advertised products). Habermas (cited in Kellner, 2000: 265) implies his discontent in observing this commercialised public sphere which makes people become passive consumers; “who absorb passively entertainment and information provided by the commercial media which seeks to attract, entertain and pacify its audience while selling commercial goods and ideology”. This statement raises the dilemmas which result from the increasing growth of the media landscape, while reflecting Habermas’s underestimated impression of people as potential media-literate users. Kellner (2000) states that the public sphere, for Habermas, is violated by media organisations and is altered to be a realm of spectacle in which people become objects of news, implying a passive audience. This point is similar to Abercrombie and Longhurst’s (1998) contrasting notions of spectacle that forms ‘diffused audience’ and performances. The concept of spectacle under the Spectacle Performance Paradigm claims that audiences cannot be totally passive. They perform different roles based on their interaction with the media and everyday life; audiences are “socially constructed and reconstructed (rather than being determined or structured)” (Longhurst et al., 2004: 106). As Abercrombie and Longhurst (1998: 75) state:

“People simultaneously feel members of an audience and that they are performers; they are simultaneously watchers and being watched […] Since people are simultaneously performers and audience members, culture consumers become culture producers and vice versa”

The original concept of a normative (rational) public sphere simplifies the complex media practices that are unfit and seem to move contrastively with the rapid development of the new media industry (Crossley and Roberts, 2004) as well as the changing nature of audiences where the interaction between spectacle and performance is the focus of interest. Rather than seeing the public sphere as an ideal small scale media formation without a motivation for marketing, this study sees this change as a challenge for audiences and a natural development of social transformation to correspond with the new media environment that is “a fundamental alteration from first hand interaction to a mediated one” (Grant, 2000: 80). As McGuigan (2010: 15) implies, the changing public sphere is a diverse platform of performances where individuals can play with their imagination of good life:

“In the late modern world, the public sphere is not confined to a republic of letters. Rather, it includes the various channels and circuits of mass popular culture and entertainment, the routinely mediated aesthetic and emotional reflections on how we live and imagine the good life.”
In a response to Habermas's criticism of the commercialised public sphere, the results of this study alleviate his concern by demonstrating women's skills of media literacy that are presently formulated beyond the simple dichotomy of a 'passive' or 'active audience' of "socially diversified (rather than mass), technologically converged (rather than distinct) and interactive (rather than one-to-many, which producer and receiver separate)" (Livingstone, 2004b: 4). This counter-movement extends my discussion to bring audience reception, recursion and media literacy into consideration. I argue that, while the respondents are seen as co-constructors of mental health, media literacy is an enabler to extend their quality connection with the media and to support women (as active meaning creators) to participate in the public sphere (despite the commercialisation) in order to express their voice about mental health.

9.3 THE RECURSIVITY OF THE CO-CONSTRUCTION

No discussion of media representation or misrepresentation is complete without consideration of the interplay with audiences. This is because users and the media cannot exist in isolation or cannot be observed as stand-alone concepts. They are connected in rather a fluid way by creating the shift in the recursive interactivity from both sides. The term co-constructors is defined to imply a mostly pattern-free process of making sense that audiences have with the media which represent mental health in a stereotypical fashion. As Seale (2002: 31) comments:

"The life of the media text depends on pre-existing frames, templates, stereotypes or common construction between producers and audiences, which involves a process of active construction of meaning by audiences, though usually within the confines of dominant scripts."

This study identifies women as co-constructors of mental health in two aspects. First, it shows a conflicting result that women conform to, but also reject, the dominant representations in their reception with the large system of mental health mass-mediated representations. Second, the co-construction is evaluated by the extended interaction women have with the media. Women are encouraged to participate with the media to exchange their opinions while selecting the mediated messages to co-construct good mental health.
9.3.1 Reception and Co-Construction

Through a series of interactions, not only with the mass media but also with their environment, the respondents developed their understandings of mental health that allowed the hybrid construction of mental health to emerge. This hybridisation was the product of recursion mixing women's everyday experiences with the cultural categories of dominant discourses as illustrated in Chapter 4, 5, 6, 7 and 8. The constructions of meaning of mental health from both subjective and mass-mediated contexts in this study challenge the oversimplification of an active audience notion while strengthening individuals' ability to create the meaning from their own constructions. Again, this point supports the idea of seeing audiences as spectators or performers (Abercrombie and Longhurst, 1998) where audiences perceive themselves as both audiences and performers in which they are cultural producers.

Although the respondents manifested differences in their criticism of mental health representations, the way in which they interpreted mental health content demonstrated clearly that they were not a passive audience easily influenced by the mass media. As Livingstone (2005a: 42) points out:

"Media power is a two-way interactive process, even though many of the cards remain in the hands of the media producers and even though audiences are more constrained by their own circumstances than free to read anything they like into text -- and also the myth of direct media effects and of passive vulnerable audiences should be laid to rest at last."

The respondents construct their understandings of mental health in a variety of individual mass-mediated and non-mediated experiences. Women interpreted mental health content in ways that made sense of their interests and experiences that did not correspond precisely with the dominant representations of the media. For instance, several women criticised and rejected the negative stereotype of the mentally ill that the press represent as dangerous, violent and aggressive. A number of respondents challenged the representations of easy-fix tips in women's magazines that were too simple and impractical. The results show that women (particularly those in Groups Two and Three), tended to understand the motive of the media behind representations such as their aim to sell, advertise and attract mass interest. They became more interactive and critical in seeking information and rationalising what they consumed (e.g. they crosschecked information from different media, questioned the representations or judged the media). Several women crosschecked the news with different newspapers or searched additional information on the Internet, questioned and challenged the existing knowledge power of the expert.

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The analysis of women's receptions also led me to revisit the principle of reception theory that "the text can only come to life when it is read and if it is to be examined, it must therefore be studied through the eyes of the reader" (Iser, 1971: 2, see also Berstrand and Hughes, 2005; Iser, 1978; Ross and Nightingale, 2003). Building on this, Abercrombie (1996: 140) argues, "audiences are not blank sheets of paper on which media messages can be written". These theoretical frames of seeing women as creators of meaning led me to understand, as Iser (1978) said, that the process of meaning construction is not a direct internalisation. Rather, it is a complex and indefinite process that challenges the conventional views of the powerful text and powerful audience. This connects 9.1 to the way in which this research argues that the process of meaning constructions of mental health is always polycontextual. People create meanings by the reading of discourses and feed their subjective interpretations to the media through the recursive process.

Although this study identifies women as creators of meanings, it cannot reject that certain discourses in relation to mental health constructions were very strong and difficult to challenge. As Webb (2009: 26) points out, "representation defines reality: it tells us what it is. But it does much more than that; it also makes and shapes our understanding of reality. We can know and access the world only through language, or representation". This analysis reflects Silverstone's (2003: 6) viewpoint that mediated representation(s) filter, frame and circulate everyday realities while providing references "for the production and maintenance of commonsense". One clear example was the understanding of the terms 'Rok Jit' and 'Baa' that were used predominantly to refer to the mentally ill as dangerous and to be avoided, in both women's face-to-face references and in women's magazines' representations. A majority of the respondents across the three groups used these terms to label the mentally ill they met casually in public places, and disclosed that they learned from the media such as newspapers, films and dramas, that the mentally ill (described as dirty, homeless) were dangerous (Chapter 6). These results imply that the mentally ill in Thailand are constructed without media and people awareness in their diverse characteristics while they are stereotyped in negative perceptions as being psychotic, unintelligent and violent (Rogers and Pilgrims, 2007). It is also interesting to see a series of findings that illustrate the layers of representations of mental illness linking the mentally ill to criminality and poverty, but at the same time as vulnerable patients who need special attention and care. Constructions of mental illness are therefore not a neutral phenomenon but socially and mass-mediatedly constructed, judged and (re)produced by society. With these variations of
representations, I agree with Olstead (2002: 624) that mental illness is not to be seen as an illness "but rather as a form or suffering related to social, economic or political circumstances" Like Hall (1997: 3), he suggests, "it can be assumed that the subject under a representational system is not an eternal truth but can be fluidly constructed and communicated depending on who defines, who speaks, and in what circumstances" 

These findings confirm Foucault's (1954) concept of alienated madness, the product of a discursive practice of stereotypes of the mentally ill that enlarges prejudice against persons labelled as the mentally ill. The mentally ill (including their carers and family members) are, hence, socially excluded from public acceptance and are rejected and disempowered by their fellows (see Goffman's (1963) notion of deep discrediting). In this scenario, the mass-mediated experience generates social distance and exclusion while bringing what Giddens (1991: 27) describes as "the intrusion of distant events into everyday consciousness" and "the reality inversion" so that the rare experience in daily life (such as socialising with the mentally ill) could become a regular confrontation in media representation, exposed in and across the media content (see Giddens, 1991, the case of death and dying). Understanding their relationships therefore is a complex task which suggests that individuals cannot be evaluated as simply passive or active readers of representations. As this study illustrates, women are co-constructors of concepts of mental health with the potential to absorb the dominant schematisation and able to challenge the mediated representations of mental health depending upon the contexts to which they are being applied and experienced. Williams and Calnan (1996: 1619) state that "people are not simply passive or active, dependent or independent, believers or skeptics, rather they are a complex mixture of all these things".

9.3.2 Participation and Co-Construction

The expansion of media and communication technology has provided new ways of obtaining mental health knowledge. People are granted further opportunity from the fast-growing information society to make choices in their lives by being informed and educated (Giddens, 1991; 2009; Jenkins, 2006). For instance, the carers (Group Two) brought mental health information from the mass media (books, weblog, Google) to discuss with their doctors such matters as the symptoms, choices of medication and treatments and became highly involved in the process of diagnosis and treatment. Several of them found solutions to their concerns from
their use of Google and interactive participation with mental health online forums. Women in Groups Two and Three disclosed that they learnt different stress-coping mechanisms (Sabai Jai content such as Dharma, self-improvement) from the Internet while participating in several online forums to exchange ideas and information about mental health and mental illness. The findings agree with Norreslet et al. (2010) who report that the patients in their study use the media to contest orthodox treatment and replace their routine of seeking help from the professionals with self-help. These new forms of interaction included the ways in which women shared what they knew by spreading, reproducing, circulating or even challenging and rejecting the mediated mental health information with their network in different communication settings (such as in self-help sessions, online forums and face-to-face interaction). They also created their own communication circle by reproducing mental health content in online and offline conversations. Jenkins (2006) stated that the convergence culture illustrates the cultural shift that assists audiences to become information seekers, making their own sense and connecting to the network of local and global information and creating recursion of mental health communication. To follow Luhmann (2000: 66) in this scenario, the mass media not only convey information, they also “make available background knowledge and carry on writing it as a starting point of communication”.

Hence, the key difference when examining the interactions women of different profiles have with the large scope of media environment is how well women access, obtain and benefit from the mediated information on mental health. Women in Group Two and Group Three who have greater access to diverse media platforms, including the Internet, were significantly more able to use the media to identify mental health treatment options compared with those in Group One (the hostel). They also displayed their highly interactive capability with electronic media to seek information and participate in virtual discussions, exchange views and find solutions for their concerns (i.e., they posted comments, wrote personal blogs and engaged in e-forums).

With these findings, the respondents develop their co-constructors’ roles which are shaped beyond the original act of reception by extending their interaction with participation and recursion in the media sphere. The emergence of online media (such as weblogs, chatrooms) creates a sub-system of communication that invites women to convene and raise their voices about mental health in a heterarchical way. The Internet forum in this scenario is not just a public source of mental health information but an extended space that invited recursion in a way that could be viewed as a contemporary e-salon or e-coffee house in Habermas’s (1989) term.
Women, with their online interaction, were both audiences and content producers who initiate the talk, disseminate the news, provide feedback and maintain interaction in the Thai public sphere that has diverse, intertextual and polycontextual conditions. This point reflects Abercrombie and Longhurst’s (1998: 75) idea that the roles between audience and media producer are blurred: “people are simultaneously performers and audience members”. Couldry (2005: 193) also makes the point that, “the social distinction between the two [media performer and audience] is falling away”. Their views agree with a current study in Thailand that the online culture eases users to play a double role of sender and receiver (Chaiyanan and Ramasoota, 2007). Clearly, this process is observed to be part of the larger co-constructing process in the complex communication network that may be beneficial exclusively to elite groups (educated, urban) and the individuals who have access to the media (as well as the skills to utilise them). As Jenkins (2006: 11) reminds us, “freedom is fostered when the means of communication are dispersed, decentralized and easily available”.

Although the concept of convergence culture seems to allow open access to greater information (Jenkins, 2006), there is clearly unequal opportunity for women from different groups, profiles and backgrounds in obtaining mental health information from the media. The question is also raised as to what degree women were able to ‘assess’, ‘screen’ and ‘challenge’ systems of representations, able to use the media to address their concerns and make their voice heard for the benefit of their mental health. In fact, these skills are rooted in the concept of media literacy which is “a multidimensional skill to protect ourselves from the flood of media messages we constantly encounter” (Potter, 2005: 2).

The results of seeing women’s complex process of co-construction particularly from the second viewpoint (participation and creation of quality connection) leads to an immediate discussion about access to convergence culture and the extent to which women from different social backgrounds are capable of using the media for the benefit of their mental health. Although the convergence culture extends modes of interaction to invite individuals to exchange views about mental health, this transaction cannot be done if people are unable to gain access. This research thus raises a concern of unequal media access among women’s different profiles, particularly for those recognised as marginal who have limited opportunities in their lives and whose voices have not yet been properly addressed. This exclusion involves the members living in the hostel and people living with mental illness outside the circle of mass media connections. However, as Buckingham (2007) argues, access is not an absolute answer to human complex interaction with
the media. "It [also] means developing a much broader critical understanding which addresses the textual characteristics of media alongside their social, economic and cultural implications" (Buckingham, 2007: 48-49). This argument is a reminder of Castells's (2000: 32) explanation of the network society that "new information technologies are not simply tools to be applied, but processes to be developed. Users and doers may become the same". His point immediately endorses the process in developing users' competencies to better confront the complex media scenario.

9.4 MENTAL HEALTH AND MEDIA LITERACY

The more intense the pressure of the social economic need for social change, the greater the tendency towards fragmentation and the greater need for self-dependency that puts a great burden on the self. I conclude my examination by emphasising the factor that enables a new quality in women's co-construction of mental health which is in accordance with the shift of social fragmentation towards freedom, autonomy and agency. I argue that in a complex communication network, media literacy emerges as an enabling vehicle to help women in co-constructing their competencies of mental health by maintaining a recursive connection with the media. Potter (2011: 134) stresses the importance of media literacy in a mediated culture:

"This is why being media literate is so important. Media messages are not always the way they seem. There are often many layers of meaning - the more you are aware of the layers of meaning in messages, the more you can control the selection of which meanings you want. Being more analytical is the first step toward controlling how the media affect you. If you are unaware of the meanings, then the media stay in control of how you perceive the world."

The findings illustrate the development of women's skills in their interactions with the current media landscape where the pace of hybridisation (mixing different media programmes, forms, genres and contents), diversification (selections of multiple media programmes, forms and contents) and convergence (concentration of media ownership; the changes of media technology, space, society and interactions; combined forms of information services such as personal computer, mobile phone with the Internet) was captured.

As discussed in the previous section, my concern is that convergence culture may not provide equal freedom for everyone with an ideal concept of access for all. As the results clearly suggest, certain groups of Thai women (the disadvantaged, poor, women with less formal education who
are kept silently in the hostel, e.g., in Baan Pak Chook Chern) have been largely excluded from the development of the *knowledge communities* and *collective intelligence* (Jenkins, 2006, see also Hongladarom, 1999) and the *network society* (Castells, 2000) where certain social groups are excluded from the circle of mental health communication. Jenkins (2006) explains Lévy’s idea of collective intelligence: “none of us can know everything; each of us knows something; and we can put the pieces together if we pool our resources and combine our skills” (Jenkins, 2006: 4). This process cannot be developed if there is no accessible forum for sharing what they (women) know such as their experiences of being carers of the mentally ill and their voice on mental health.

Media literacy stands out as a variable associated directly to the factor of social class in which women with higher education (average university degree, middle class such as Group Three) have access and (know how to) make use of the media to voice their views compared with women in the hostel (working class with lower degree of education, average Grade 6). This view is similar to Buckingham (2007: 51) who comments that the issue of socio-economic status in a fast developing environment of technologies can generate a gap in ‘physical access’. As a consequence, individuals with a low educational background will be alienated from the development of social structure. Certain social groups will be excluded from access to and capacity to deal, manage and master the media in the digital phase that formulates the ‘knowledge communities’, ‘collective intelligence’ and the ‘network society’.

Since there is a need to ensure that women are firstly provided with basic access as a developing stage of building media literacy, the changing mediascape that includes online technology could become unattainable for those without access and basic literacy in the new media. This includes women in Group One (the poor, the rural, the abused and the disadvantaged) and other women in violent circles outside this research, carers and people labelled as mentally ill outside the mental health care system. In other words, if the previous studies confirm that the media is a popular source of mental health information that helps individuals to handle risk and uncertainty (Webster, 2002; Williams and Clanan, 1996), the fundamental necessity for media audiences is the basic convergent literacy to access, process, evaluate, and analyse the mediated information. In this scenario, the use of media literacy could not be successfully implemented unless there are some interventions to reduce this gap by supporting equality to media (physical) access. Livingstone (2007: 6) states that literacy is an interdependent and multi-social process in the triangulation of individual, society and the state:
“It is widely incorporated into processes of governance, being built into educational curricula, part of the skills required for a competitive labour market, co-opted as part of the legitimization of neo-liberal market deregulation and contributing to the discourse that excludes certain segments of society as well as that which includes, and further privileges, the already-information rich.”

Because media literacy could be a natural extension of all other communication literacies in dealing with mental health, access is not only the requirement to help women to become fully engaged in their interaction with the media including the Internet. Media literacy also requires standard communication skills such as reading, writing, computer literacy and Internet literacy for a person to be fully integrated into the large-scale media environment. This ‘set of skills’ (Buckingham, 2007) facilitates managing the mediated content when the lines of genres, the function of the media and the changing shape of the public sphere are difficult to discern. The call for media literacy prompts the state to re-think what could be improved inside and outside the Thai education system to prepare different social groups to have access to and be capable of using mediated mental health information. These uses, as Livingstone (2009: 186) elaborates, depend on “the abilities to access, analysis, evaluate and create and each of these is, further, part of a dynamic and mutually supporting process of engagement and learning”.

This study suggests media literacy as one possibility of increasing women’s choices in dealing with mental health information in the complex media environment. ‘Choice’ in this sense derives from women’s flexibility and access to old and new media, to select types of care and treatment, as well as choices of information to help women make decisions about mental health in their lives. Media literacy has become an enabling tool in the development of an ‘individualising process’, giving women the competency to self-manage their mental health, helping them to “gain control over their fate and make the choice they truly desire” (Bauman, 2000: 31).

Therefore, Thai women, particularly the vulnerable groups, lower classes and those who have restricted exposure to the mass media, are entitled to have access and skills of media literacy to engage effectively with the media systems. As Livingstone (2009: 187) summarising Buckingham (2007) notes that media literacy enables users to understand that representations are selective and motivated, “while also marginalizing other voices; here arise crucial questions of authority, authorship, ex/inclusion, reliability and bias”. Potter (2011) also agrees, media literacy can help people to “better appreciate media content”: 248
"The key to media literacy is to be flexible and aware. Being flexible means being willing to traverse the entire spectrum of messages and being willing to enjoy the full range of messages. Being aware means thinking about where you are in the spectrum and knowing the different standards of appreciation to apply to different places on the spectrum of reality. By being both flexible and aware, you can much better enjoy the enormous variety of messages in the media and at the same time, control the effects of those messages so that you avoid the negative ones that usually come from automatic exposure and instead more intensely enjoy the positive effects that can result from any media message." (Potter, 2011: 134)

The concept of media literacy also enables Thai women to be more visible, particularly women with lower mobility, with less sense of control and with limited access to media, knowledge and information. At the same time, it empowers women to appreciate their autonomy while guiding them to a greater sense of freedom in making life choices and enabling them to reflexively ‘write their lives’. Giddens (1991: 68) explains that “we are not what we are, but what we make of ourselves” and as Bauman (2000: 216) reminds us, the prime concern for sociology in liquid modernity is to promote autonomy and freedom: “the job of sociology is to see to it that the choices are genuinely free, and that they remain so, increasingly so, for the duration of humanity”.

This study justifies my intention to conduct this research by examining Thai women and their mental health from different profiles to, as it were, ‘speak freely for themselves’ and by assessing women’s magazines to understand how the episteme of mental health is constructed through explicit and implicit forms of “difference, exclusion and marginalisation” (Giddens, 1991: 6). As I attempt to illustrate throughout, mental health is not an eternal truth but socially constructed and contested in a complex media environment. It involves polycontextual features of personal, social, cultural and mass-mediated factors which are networked in the dynamic communication process embedded within systems of discourses and representations in and across the media system. This research suggests media literacy is an empowering force for Thai women, especially for those from disadvantaged groups who were “excluded, feared and pushed to the margins of society” (Margues, 2010: 326), to extend their connection with the system of mental health construction as a challenge in the changing media culture of Thailand. This closing paragraph opens up the possibility for change and making “difference which make[s] difference” (Bauman, 2000: 8) to improve Thai women’s mental health, particularly for those whose voice has been preserved in silence, liberating individuals to have more ability to control their lives where the explicit and implicit forms of “difference, exclusion and marginalisation” (Giddens, 1991: 6) are generated, re-circulated and passed on in modern Thailand.
I began my research with a review of Habermas’s (1989) work on the public sphere while familiarising myself with different concepts in relation to the social and mass-mediated contexts of mental health, such as the historical development of audience research, representations, reception theory, genres and discourses. After four years’ experience, this study has provided me with empirical evidence that demonstrates the polycontextual connections between media and audience that link different findings to the project of modernity (such as self-help, abstract systems, experts, trust, reflexivity, spirituality, liquid identity, risk and choice). The results confirm that in the study of constructions the researcher cannot conceptualise media complexity without at the same time conceptualising users’ complexity including their media literacy, the skill that maintains the users’ connection with the media culture that is flooded with opportunities and risks. The review of the literature during my first year encouraged me to conduct qualitative research to understand mental health in the social, cultural and mass-mediated contexts which seem only to be discussed marginally in studies of mental health in Thailand. As suggested by previous studies (Chungsatiensap, 1993; Dane, 2000; Wasi, 2001), most of the research focused on medical settings, ignoring the cultural connections that explain the system of belief and diverse experiences people have with health, mental health, illness and treatment. As Chungsatiensap (1993: 3) critically notes:

"The understanding of health and mental health concepts in Thailand is limited to the discourse of advanced medical technology and ignores the value and context of people and Thai cultural values. Therefore there has been a gap in understanding between doctors and patients. This is because the medical professionals do not have a clear understanding of the patient’s cultural background, and they tend to give ‘orders’ instead of ‘listening’ to the needs of individuals."

This project is the first of its kind to adopt the qualitative means of ethnography and discourse analysis to understand mental health constructions in contemporary Thailand. This study also pays detailed attention to marginalised women living in a hostel and the rehabilitation centre, comparing them with women who have less contact with mental health care institutions. It also seeks to make theory operational by connecting it empirically.
This project was a challenging journey to learn about the constructions of mental health. Although the literature prepared me to see the variations in the findings, I realised that it was extremely difficult to unpack the discourses and representations that constructed mental health. This is because, as I discuss in my conclusion, mental health is a fluid phenomenon. Its representations and discourses are networked and interwoven but have no definitive pattern; they are subject to flow and merge, challenge and change for multiple interpretations. Identities are fluid, as so too are constructions of mental health. Convergence culture merges itself into the structure of modernity and facilitates the increasingly complex flow of texts, representations and narratives across media, blurring boundaries between private versus public, professionals and producers versus audiences and performers, fact versus fiction and mediated world versus real life.

In conducting this study, I found that my research was composed of many abstract and complex ideas that have long been developed in academia. Many of the concepts used in this study tend to be dichotomised by a set of binary oppositions, such as private and public sphere, passive and active audience, mental health and mental illness, normal and abnormal, ‘Mae See Ruen’ and independent women, medical treatment and natural healing, professional help and self-help, rationalisation and commercialisation. However, what I maintain at this stage is that the boundaries of mental health, representations, media and audience cannot be categorised into these simple differentiations. Indeed, we are immersed in a reality that undergoes almost permanent reconstruction by the systems of constructions and representations. Mental health is thus deeply embedded in diverse constructions in a variety of individual and mass-mediated interests and experiences. I see mental health constructions as one clear example which reflects living conditions in modernity. The analysis of embedded representations, co-constructions, blurred public sphere and multiple voices encouraged me to revisit Bauman (2000) and Giddens (1991), particularly their works about the conditions of modernity. They provide a useful conceptual backdrop to understanding the nature of the social constructions of mental health that are networked with polycontextual features (self, media, culture). They ‘bend’, ‘leak’ and ‘flow’, to use Bauman’s (2000) metaphors of ‘liquid modernity’.

This project was an academic exercise that invited me to observe social change through the phenomenon of mental health. Ethnography allowed me to reflect on the world of mental health through the eyes of 49 women who welcomed me into their lives while I gradually learned to listen, respect and carefully echo their voices. Being with women in the three settings for nine
months was an aesthetic experience and a joyful journey of discovery. It enhanced the opportunity to learn from people and see the world from their perspective, while discourse analysis gave me an alternative way of understanding the mass-mediated frames of mental health. Not only did this study give me the opportunity to conduct systematic, scientific, and creative research, I was also inspired by Thai women to find ways to articulate their mental health experiences and to identify enabling factors to help them withstand mental health risk and uncertainty. This research is an initial exploration; it requires further debate and academic engagement to reflect the voice of other sub-groups in Thai society.

However, because the constructions of meaning are so complex, the results could have been different if I had used a different set of theoretical frameworks together with larger samples and had varied the social groups, gender and generations, or had investigated mental health in other media genres. Despite the usefulness of discourse analysis to draw on an implicit meaning from the media text, I was aware that this method was highly subjective on the limit samples. As a result of the small scale focus, my research may obscure other related themes found in women’s magazines which could give a more comprehensive picture of how the magazines frame mental health (such as their constructions of commercial beauty products, explicit and implicit sexual language and the construction of masculinity in women’s magazines). I thus recommend future research use discourse analysis as a potential method to understand the complex network of constructions of mental health in other media genres (Thai film, TV drama, newspapers, self-help and Dharma books) and other sub-genres of the magazines (magazines for teenagers, LGBT – lesbian, gay, bisexual, transgender), to see how mental health is represented.

A future study could include a cross-cultural analysis to compare and contrast mental health from an intercultural perspective, while the key related messages of Mae See Ruen, Rok Jit, Baa and Buddhism may reveal interesting differences. Other future work on the media and audiences in Thailand could possibly move into online-social network spaces, adopting discourse analysis to examine users’ identity of their status updates on Facebook and Twitter. In fact, these updates are people’s direct and personal creation of their own identities, which in many ways reflect their voices on mental health and concerns, particularly after 2006, when Thai people lived through an intense political crisis (see Limpapatamapanee and Leveau, 2007). Moreover, social networks sites may be a new territory to examine how mental health knowledge and information ‘leak’, ‘flow’ and ‘flood’ in the public sphere of modernity. This social scene invites people to stand out
clearly as reflexive media users, performers and spectators who create, spread, circulate and reproduce mental health content in their recursive connections with their new publics.

This project has helped me to realise my continuing interest in researching mental health and the mass media in different settings and to bring theoretical and methodological frameworks into various media situations. Because understanding the polysemic nature of mental health from the audience's point of view was far more complicated than the direct effect model or the polarity of active and passive audience classified, further investigation of audience reception combined with the concept of media literacy should therefore continue to address the understanding of the blurred, intertextual and negotiated space between the two poles of audience and producer (cf. Iser, 1978) as well as the connections that generate the endless communication of mental health.

Bird (2003: 2-3) reminds us that "audience is everywhere and nowhere". I learned from conducting reception research as part of my analysis that the concept of audience cannot be viewed as uniform and the study of audience therefore cannot be limited to one particular media genre at any point in time. In turn, these studies should include consideration of everyday life in order to understand the dynamic role of the audience (media user, spectator, self-healer, active Buddhist) and its multi-voice (internal contrasting perceptions of the mediated representations) in the media culture, particularly at a time when we are witnessing the expansion of communication flow as well as borderless online networks raising the possibility of a new dimension of connection. Another important aspect is to understand both the diffused audience and the diffused nature of the current media landscape (cf. Couldry, 2005) in order to explore their polycontextual connection in the process of meaning constructions of mental health. Alasuutaari (1999: 6) summarises his idea about the next generation of audience research, stating that "the main focus is not restricted to finding out about the receptions or "reading" of a programme by a particular audience. Rather, the objective is to get a grasp of our contemporary media culture". Although his statement was made 12 years ago, my study reveals that this approach has remained significant in the study of mental health construction where people, the media and their culture are inseparable ways of thinking about the audience (cf. Abercrombie and Longhurst, 1998 – "Diffused Audience", 'Spectacle Performance Paradigm). In fact, this notion is similar to what McLuhan and Fiore (1967: 26) indicate about the importance of the media and their intertwined relationships that result in complex media culture.
“All media work us over completely. They are so pervasive in their personal, political, economic, aesthetic, psychological, moral, ethical, and social consequences that they leave no part of us untouched, unaffected, unaltered. Any understanding of social and cultural change is impossible without knowledge of the way media work as environments.”

Future research into mental health construction in Thailand should also continue to give space to marginal voices, particularly those viewed socially as victims of the stigma of mental health and mental illness, such as the mentally ill (in and out of the medical system), female prisoners, homeless people, slum inhabitants, juvenile delinquents and orphans, while maintaining the ethical concerns about the subjects’ anonymity, confidentiality and privacy. Furthermore the researcher’s reflexivity and safety should be a major consideration in any future work on mental health constructions. With the emphasis on multiple voices in a contextual study of multiple constructions, the qualitative method of ‘balancing text and audience’, I believe, should be one of the most efficient ways of preventing critics from oversimplifying the power of the media (e.g., Habermas, 1989) by observing and giving more space to talk, particularly for those living on the margins, while not overestimating a powerful active audience. In order to understand audience, the question of power and domination should become less central and move to an interpretation of the complex interactions that audiences from distinct profiles have with the media. Opportunities for future study involving ‘media literacy’ include exploring further the extent to which people from different social groups/sub-groups could use the media and challenge the system of media representations in the media-saturated age. Not only should questions be asked about the skills in engaging with the media, the investigation should include critical questions relating to the rapid growth of information, communication and technologies. Livingstone (2009: 3) recommends that the researcher should extend their examinations to ask “whether these [media literacy skills] enable them to engage with their society in all its manifestations – local and global, public and private, serious and playful, enchanting and dangerous”. She suggests that the media researcher should shift the focus from questions of access to explore “new opportunities for information, communication, entertainment or even, more grandly, ‘empower’ them in relation to identity, community, participation, creativity and democracy” (Livingstone, 2009: 4). Future research on mental health communication thus, could pull together the meso and macro picture of state and mental health policy, and the public mental health care promotion and prevention system, in addition to the broader analysis of social structure and the public sphere to emphasise people’s creativity, participation and empowerment on mental health issues. The public sphere of mental health also should be examined closely to
trace the development of participatory democracy and investigate how the public sphere formulates political debate and structures of governance while re-framing audiences as political citizens within the larger model of liberal governance, self-help, responsible citizenship, neoliberalism and “freedom of autonomous selves” (Rimke, 2000: 72).

Lastly, it is necessary to continue to investigate the space of negotiations between the two agencies (audience and the media) by taking into account the production process, which should also mark the dual voices of the producers (who are also the media audience). Indeed, it is my personal criticism of my own work that I am ignorant of the real voice of media producers (columnists of women’s magazines, journalists of sensational news and film producers) and their potential to be media users. Although beyond my limit of my research, approaching media producers could be another way to understand meaning constructions of mental health and the recursive views from the production side.

In the end, my study constitutes an initial attempt to reconsider the complex realities of mental health from multiple perspectives (theoretical, methodological and cultural). Although a clear path of understanding mental health constructions in modern Thailand from a qualitative point of view is far from complete, it is hoped that this research will provide a point of reference from which to approach mental health in an interpretative way. As this study implies, researching mental health constructions with the notion of media literacy is simply an indication which may help to realise the potential of the ‘self’. I also hope this research will generate enthusiasm for future studies into finding ways to create easier lives and remake and reward people’s sense of identity (Giddens, 1991). This task is to follow the pursuit of liberation to help individuals design their mental health and their lives by “gain[ing] control over their fate and make the choices they truly desire” (Bauman, 2000: 39).


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# APPENDIX A: BIOGRAPHICAL CHARACTERISTICS OF THE RESPONDENTS

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<thead>
<tr>
<th>GR</th>
<th>Alias Name</th>
<th>Age</th>
<th>Occupation</th>
<th>Income (Baht)</th>
<th>Status</th>
<th>Education</th>
<th>Problem encountered as reported by themselves</th>
<th>Remarks</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Pin</td>
<td>39</td>
<td>Housemaid</td>
<td>150/day</td>
<td>Separated</td>
<td>GRADE 6</td>
<td>Domestic violence/Raped by acquaintances</td>
<td>Thought of suicide,</td>
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<tr>
<td>2</td>
<td>Bee</td>
<td>26</td>
<td>None (Waitress)</td>
<td>(4000)</td>
<td>Single mum</td>
<td>GRADE 6</td>
<td>Domestic violence, Unwanted pregnancy</td>
<td>Cut herself</td>
</tr>
<tr>
<td>3</td>
<td>Joy</td>
<td>26</td>
<td>None</td>
<td>None</td>
<td>Single</td>
<td>GRADE 12</td>
<td>Domestic violence</td>
<td>Boyfriend stabbed by using a cutter</td>
</tr>
<tr>
<td>4</td>
<td>Chom</td>
<td>35</td>
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<td>(5,000)</td>
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<td>GRADE 12</td>
<td>Domestic violence</td>
<td></td>
</tr>
<tr>
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<td>Mek</td>
<td>36</td>
<td>None</td>
<td>None</td>
<td>Separated</td>
<td>GRADE 12</td>
<td>Domestic violence</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Noi</td>
<td>32</td>
<td>None (Café singer)</td>
<td>None</td>
<td>Single mum</td>
<td>GRADE 6</td>
<td>Domestic violence, Having conflict with mother-in-law</td>
<td>Cut herself</td>
</tr>
<tr>
<td>7</td>
<td>Aim</td>
<td>26</td>
<td>None (Cleaner)</td>
<td>None</td>
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<td>GRADE 6</td>
<td>Raped by her father and a monk</td>
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</tr>
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<td>None</td>
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<td>GRADE 9</td>
<td>Group raped by her boyfriend and his friends</td>
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<tr>
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<td>Mai</td>
<td>19</td>
<td>None</td>
<td>Single mum</td>
<td>GRADE 12</td>
<td></td>
<td>Raped by her uncle's worker</td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>Cat</td>
<td>26</td>
<td>None (Dancer)</td>
<td>6,000</td>
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<td>Unwanted pregnancy with her boyfriend</td>
<td>Cut herself, Abortion</td>
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<td>Jan</td>
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<td>None (Sex worker)</td>
<td>None</td>
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<td>Unwanted pregnancy, Baby is retard, Philippines</td>
<td>Attempted abortion</td>
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<td>Massager</td>
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<td>Unwanted pregnancy with boyfriend</td>
<td>Attempted abortion</td>
</tr>
<tr>
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<td>Golf</td>
<td>19</td>
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<td>Single mum</td>
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<td>Unwanted pregnancy</td>
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<td>14</td>
<td>Ton</td>
<td>20</td>
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<td>GRADE 6</td>
<td></td>
<td>Economic hardship, Having conflict with mother-in-law</td>
<td></td>
</tr>
<tr>
<td>15</td>
<td>Tan</td>
<td>39</td>
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<td>Single mum</td>
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<td></td>
<td>Economic hardship, Unwanted pregnancy, thought of suicide</td>
<td>Put away baby for adoption</td>
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<td>Prang</td>
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<td>Economic Hardship</td>
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<td>38</td>
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<td></td>
<td>Economic Hardship</td>
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<td>Economic Hardship</td>
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<td>Depression-schizophrenia</td>
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<td>Depression</td>
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<td>College</td>
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<td>Brother-depression and committed suicide</td>
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<td>Father's Depress</td>
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<td>Master's</td>
<td>Stress</td>
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<td>40000</td>
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<td>Master's</td>
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Remarks
1. Currency Exchange £1=50 Baht
2. Age given as of the date of interview (November 2008-May 2009)
EH – The Emergency Home
FL – The Family Link Association
# APPENDIX B: WOMEN'S MAGAZINES CODING SHEET

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<th>No. of Pages</th>
<th>Author(s)</th>
<th>Title</th>
<th>Topic Discussed</th>
<th>Mental Health Theme (Happiness, Stress, Mental Illness, Spirituality, etc.)</th>
<th>Remarks/Observations</th>
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<tr>
<td>No.</td>
<td>Column/Issues</td>
<td>Relevant Actors</td>
<td>Genre</td>
<td>Introduction</td>
<td>Body</td>
<td>Conclusion</td>
<td>Remarks/Observations</td>
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</tbody>
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APPENDIX C: WOMEN'S MAGAZINES SURVEY

Informant (W) ............... (NO.) ............... (GROUP) ...............  

<table>
<thead>
<tr>
<th>TITLE</th>
<th>Tick if the respondent has ever read this magazine</th>
<th>Remarks</th>
</tr>
</thead>
<tbody>
<tr>
<td>KWANRUEN</td>
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<tr>
<td>KULSATREE</td>
<td></td>
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<td>KOOSANG-KOOSOM</td>
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<td>CHEEWITJING</td>
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<td>DICHAN</td>
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<td>PLOYKAMPETCH</td>
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<td>PREAW</td>
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<td>SUDSUPDA</td>
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<td>IMAGE</td>
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<tr>
<td>COSMOPOLITAN</td>
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<td>ELLE</td>
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<tr>
<td>MARIE CLAIRE</td>
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<td>CLEO</td>
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<td>LISA</td>
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<td>CHEEWAJIT</td>
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<tr>
<td>KRAIMOR</td>
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<td></td>
</tr>
<tr>
<td>MORCHAOAABAN</td>
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<tr>
<td>OTHERS</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

What content the respondents have mentioned that they would like to read in women’s magazines?

- [ ] Fashion and beauty
- [ ] News and technology
- [ ] Opinions, political knowledge, international affairs
- [ ] Physical health, mental health and well-being
- [ ] Relationship and sex
- [ ] Cookery, knitting and household cares
- [ ] Short stories, novels
- [ ] Real Life, interview
- [ ] Others, please specify .........................................
APPENDIX D: MEDIA DIARY SHEET

Name: ............................................................................................................

Date: ..............................................................................................................

(Please circle today's date)

<table>
<thead>
<tr>
<th>Monday</th>
<th>Tuesday</th>
<th>Wednesday</th>
<th>Thursday</th>
<th>Friday</th>
<th>Saturday</th>
<th>Sunday</th>
</tr>
</thead>
<tbody>
<tr>
<td>Media Genres</td>
<td>Titles, Channels, Frequencies</td>
<td>List of Columns/Programmes/WWW</td>
<td>Duration (Minutes)</td>
<td>Time of Exposure</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Newspaper
1. 1.
2. 2.
3. 3.

Magazines
1. 1.
2. 2.
3. 3.

Books
1. 1.
2. 2.
3. 3.

TV
1. 1.
2. 2.
3. 3.

Radio
1. 1.
2. 2.
3. 3.

Internet
1. 1.
2. 2.
3. 3.

Others (please specify)
1. 1.
2. 2.
3. 3.
APPENDIX E: INTERVIEW GUIDELINE

Respondent’s Name: ................ (Alias Name) ........ (Group) ........ (Code of Digital File in MP3 player) V ........

Date of the Interview: ..................... Venue: ...................... Time: ......................

Women’s Mental Health

1. What/who has made you feel happy/stress/unhappy (please describe)?
2. What would you do to make your life better/to feel happier?
3. How do you plan your future?, What is your dream?
4. What did you do when you got stressed or had feeling of discomfort, Who do you feel comfortable to talk to?
5. What brings you to the hostel? (question for women Group One)
6. How do you feel being a carer? How do you manage your life as a carer of the mentally ill?, What is the most difficult task of being a carer (question for women Group Two), etc.

Note

______________________________________________________________________________

Understandings of Mental Health

1. Please explain ‘mental health’ and ‘mental health problems’ in your opinion?
2. What are the differences between mental health and mental illness in your opinion?
3. If I mention the word ‘mental health’, what is your first thought?, Will you be thinking of what, who and why? Is there any particular situation that you can think of?
4. Please describe the terms ‘Baa’, ‘Rok Jit’?, What could make people to become ‘Baa’ and ‘Rok Jit’ in your opinion? How do you feel about them and why you feel that way?
5. Have you ever met, socialised with people with mental illness in your lives?, How often do you meet them, and Where do you usually meet them or hear about them?
6. What do you think about psychiatrists, mental health professionals, and psychiatric hospitals? Have you ever seek for their service (or think of using their services)? In what case you think you will go to see specialists?
7. Who and where will you go to if you want to know about mental health related information?, Why you think of those people/organisations?, etc.

Note

______________________________________________________________________________

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Media and the Everyday Life

(1) What are your favourite media genres/channels?, What are your favourite programmes, shows, stations, newspapers, magazines, books?, describe how do you like them?

(2) How do you read/listen/watch the news, When and Where do you use the media?

(3) Have you ever read/listen/watch the news, stories, films, dramas about ‘Baa’, ‘Rok Jit’?, How frequent do you read/listen/watch them, How do you feel about these representations?, please describe the news/programmes and scenes that you remember they represent Baa and Rok Jit

(4) What is(are) your favourite women’s magazine(s) titles? How often do you read them? Why you like (them) and What columns you like to read, Why?, What are the content that you like to read?

(5) Have you ever read, watch or find anything about mental health information in the media/women’s magazines? Please describe. What do you think about them?, etc.

(6) Please describe your interaction with the new technologies (such as the Internet). How often you use them and in what purpose? What do you think about using them? How do you like them?

Note

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
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Note from observations and Remarks

________________________________________________________________________
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