Heterotopias of mental health care: the role of space in experiences of distress, madness, and mental health service use.

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Abstract

The change from an institutional to community care model of mental health services can be seen as a fundamental spatial change in the lives of service users (Payne, 1999; Symonds & Kelly, 1998; Wolch & Philo, 2000). It has been argued that little attention has been paid to the experience of the specific sites of mental health care, due to a utopic (idealised and placeless) idea of 'community' present in 'community care' (Symonds, 1998). This project hence explored the role of space in service users' experiences, both of mental health care, and community living. Seventeen 'spatial interviews' with service users, utilising participatory mapping techniques (Gould & White, 1974; Herlihy & Knapp, 2003; Pain & Francis, 2003), plus seven, already published first person narratives of distress (Hornstein, 2009), were analysed using thematic analysis (Braun & Clarke, 2006). Mental health service sites are argued to have been described as heterotopias (Foucault, 1986a) of a 'control society' (Deleuze, 1992), dominated by observation and the administration of risk (Rose, 1998a), which can in turn be seen to make visible (Hetherington, 2011) to service users a passive and stigmatised subject position (Scheff, 1974; 1999). Such visible positioning can be seen to 'modulate' (Deleuze, 1992) participants' experiences in mainstream space. The management of space has hence been argued to be a central issue in the production and management of distress and madness in the community, both in terms of a differential experience of spaces as 'concordant' or 'discordant' with distress, and with movement through space being described as a key mediator of experiences of distress. It is argued that this consideration of space has profound implications for the 'social inclusion' agenda (Spandler, 2007; Wallcraft, 2001).

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Preface

Like many students, I chose to study Psychology due to an ambition to be a Clinical Psychologist. Having studied English Literature at undergraduate level, I wanted to do something more 'concrete', imagining I would learn 'facts' discovered by 'science', which would enable me to be able to 'cure' people of their problems. Of course, I quickly realised that Psychology, and the field of mental health more generally, is a far more complex, contested (and interesting) enterprise than I had envisaged. Where I had expected to find 'facts' there were instead competing, often incompatible theories, supported by varying amounts and kinds of evidence. With no small thanks to some inspiring mental health teaching, I learned that nearly every widely accepted 'truth' I had come into my degree 'knowing' (such as 'schizophrenia is incurable' and 'depression is caused by a lack of serotonin') turned out to be based on little evidence, more a matter of ideology than 'science'. When I learned the wider effects of these 'truths', I became angry, as they included: enforced incarceration; enforced medication, often with devastating side-effects; as well as long-term passivity; higher levels of social exclusion; and poverty. I became fascinated by the alternative accounts of mental health available, from both the service user movement, and the academic literature; I could see that this was an area where theory, far from being only an abstract exercise (as I had often felt when studying English), was a living, breathing, entity, with powerful, often devastating, effects in everyday life. This interest in mental health lead me to my final year project, a study looking at how service users' use of the internet mediates experiences of anxiety. In particular, I was interested in the internet as a potential

route to accessing and disseminating alternative discourses of distress, influenced by post-modernist and social constructionist ideas. Instead, however, it became apparent that the use of the internet was described as an embodied, spatial issue, with my participants describing using the online access as a means to access aspects of 'public' space (particularly, social interaction) from the relative safety of the 'private space' of their homes. Through this project, I discovered the human geography literature on space and subjectivity, building on some excellent teaching looking at the embodied and material turn in social psychology. It was from here that I formulated this PhD project; as space had been such an important issue in my small project of internet use, I wanted to expand this project into a wider look at the role of space in service users' experiences. Here follows an outline of the thesis:

Chapter One sets out the parameters for the project, and reviews the empirical evidence for links between space and mental distress, as well as providing an historical overview of spatial changes in the treatment of distress and madness.

Chapter Two explores theoretical approaches to space and subjectivity, drawing on work from human geography and social psychology. Also, some specific approaches to the spaces of mental health care are explored.

Chapter Three outlines the methodological and analytical approach of the project, locating the methods used in the wider context of service user voices, and power in research. The two data collection methods used, of first person narratives of distress and participatory mapping, are described. The combined dataset was analysed using a Thematic Analysis approach, and the particular analytical parameters used are also outlined.

Chapter Four is the first empirical chapter of the thesis, laying out an analysis of the current landscape of mental health services, and the role of these spaces in the ongoing production of service user subjectivity, both in mental health sites, and community spaces.

Chapter Five concentrates in particular on differential interactions between experiences of distress and spaces, proposing that distress and madness can be understood as 'concordant' or 'discordant' with space; service users' management of these experiences in both the community and mental health service sites is examined.

Chapter Six examines the role of movement through space in participants' experiences of distress and madness. In particular, the role of movement and space in mediating experiences of distress, and of being used by participants' to actively manage their experiences, is explored.

Chapter Seven provides an overall discussion of the findings of the project, as well as a reflection on the process of the research. In addition, the implications of the findings for the current social inclusion agenda in mental health services are discussed.

Chapter One

Space, distress and mental health services

1.1   Community care, space and distress.

Violent, mad ... set free

By MIKE SULLIVAN Crime Editor

A VIOLENT patient stabbed an innocent cyclist to death after being allowed to walk out of a mental hospital, a court heard yesterday. Paranoid schizophrenic John Barrett vanished when doctors let him freely roam the grounds for an hour. The next day he lay in wait in a park for a victim, pulled banker Denis Finnegan, 50, off his bike and killed him. There was outrage last night that Barrett who was hearing voices telling him to kill had not been locked up. The tragedy on September 1 last year follows a string of similar killings by dangerous mental patients freed from hospital under the care in the community system. Campaigners claim the scheme kills up to 40 a year. Barrett, 42, had earlier checked into the Springfield Psychiatric Hospital in Tooting, South West London, admitting he was a danger. He had been conditionally discharged from the same hospital in 2003 even after a conviction for three stabbings on a ward there. (The Sun, 3rd August, 2007)

The above story can be seen to encapsulate a contemporary 'moral panic' (Cohen, 1972) concerning the spatiality of mental health service users. Since the 1990s in Britain, almost all mental health service users have lived 'in the community' for the majority of the time; this change followed the closure of the asylums, forming a relatively sudden conclusion to a longer trend towards community care beginning after the second world war (Goodwin, 1997; Warner, 1985). From being sequestered into large, out of town institutions, often for long periods of years or months, those

diagnosed with mental health problems were hence transferred, in large numbers, into myriad community spaces: individual homes, workplaces, supported housing, community centres, necessitating the daily negotiation of public spaces, such as streets, parks, pubs, cafes and shops. It has been widely noted (Harper, 2004; Moon, 2000; Phelan, Link, Steuve & Pescosolido, 2000; Rose, 1998a; Thornicroft, 2006) that the same period witnessing the relocation of service users from institution to community has also seen a rise in discourses of dangerousness, risk and criminality associated with mental health service users. Such a trend can be seen as exemplified by the above newspaper story; the causation of the murder reported can be seen as linked explicitly to community care, stating that the "scheme kills 40 a year", and in particular to an 'improper' freedom of movement allowed to service users, to the fact that the perpetrator had been allowed to "freely roam the grounds" and been "allowed to walk out" of the institution. The murder can here be seen as presented as emergent from an inappropriate *placing* of those who experience madness, an inevitable consequence of the perpetrator not being "locked up", rather than being a tragic, but rare incident, not reflective of the vast majority of those who have psychotic experiences (Harper, 2004; Moon, 2000). Whilst this can be seen to be an extreme example, it has been argued that such discourses of dangerousness can be seen to inform, and support, both interpersonal and structural forms of discrimination and stigma experienced by service users living in the community (Schulze & Angermeyer, 2003).

Despite the discourse of inadequate confinement (Moon, 2000) seen here to be powerfully perpetuated in media reports, however, contemporary mental health

care can also be seen to be characterised by a further move to place service users in generic community spaces. Over the past ten years, mental health care has been characterised by a move to 'social inclusion' (e.g., O.D.P.M., 2004; D.O.H., 2006; Secker, 2010; Spandler, 2007) as part of the move to a 'recovery model' (Anthony, 1993; Deegan, 1988; D.O.H., 1999; Repper & Perkins, 2003) of mental health services. It has been noted that the social inclusion agenda, as rolled out through services and Government policy, has been individualised (Secker, 2010) and mainly interpreted as a push to paid employment (Campbell & Rose, 2010; see, D.O.H., 2011), ignoring the structural disadvantages and discrimination faced by service users (Secker, 2010; Spandler, 2007; Wallcraft, 2001). A less often discussed outcome of the focus on social inclusion is that in the interests of 'inclusion', many specialist spaces allocated for mental distress, such as day centres, have been shut down (Pilgrim & Ramon, 2009), leaving service users more dependent on negotiating generic community spaces. This pattern can be seen as held in tension (Pilgrim, 2008) with the also prevalent discourse of confinement (Moon, 2000) discussed above.

Space, therefore, can be seen to be a key and constested issue in contemporary mental health care, and hence potentially a crucial aspect of the experiences of service users negotiating community services and living in the community with mental distress. This aspect of mental health theory and practice can however be seen to have been neglected in contemporary psychological and psychiatric research, due perhaps to a mainstream emphasis on individual pathology as opposed to wider social and cultural structures (e.g., see Johnstone, 1989; Kelly,

2006; Smail, 2005; Read, Bentall & Mosher, 2004; Rappaport, 1977), as well as a more general lack of attention paid within Psychology (and other social sciences) to the material context of experience (Bordo, 1998; Brown & Stenner, 2009; Burkitt, 1999; Cromby & Nightingale, 1999; Latour, 2005, Stam, 1998). This introductory chapter will hence briefly examine the historical links between space and mental health service provision, before looking at the evidence for links between space and experiences of mental distress. This will include material from a number of disciplinary backgrounds which have a more spatial focus than Psychology, including geography and urban studies. Before embarking on this review, key terms used in this thesis will first be briefly explored.

1.2   Terminology

Before reviewing the relevant literature on relationships between space and mental distress, it is first important to set out the terminology that will be used throughout this thesis. Whilst it is always crucial to provide clear definitions of terms in academic work, terminology in mental health research is also particularly loaded, with different terms carrying both theoretical and political implications, perhaps due to the contested nature of mental health research (e.g., Hornstein, 2009; Rapley, Moncrieff & Dillon, 2011; Read et al, 2004). The implications of the different available terms will hence be discussed here, and the chosen terminology for this thesis described.

1.2.1 Defining the experience

There exist a plethora of terms to describe and define the experiences examined in this thesis, including 'mental illness', 'mental health problems', 'mental disorders', and 'mental distress'. Each of these terms carries with it differential assumptions of the nature of mental health problems, as well as implications for the social and political positioning of service users.

Mental disorder is the term used in law, defined in the Mental Health Act (2007) as "any disorder or disability of the mind". It thus encompasses learning disabilities and 'personality disorders' as well as psychiatric diagnoses such as schizophrenia. It is the term used by both the ICD-10 (W.H.O., 1992) and the DSM-IV (A.P.A., 1994), the major systems of classification used by mental health professionals worldwide.

Mental illness is defined in the most recent Government strategy on mental health 'No Health Without Mental Health' (D.O.H., 2011), as:

> serious mental health problems that often require treatment by specialist services. Such illnesses include depression and anxiety (which may also be referred to as common mental health problems) as well as schizophrenia and bipolar disorder (also sometimes referred to as severe mental illness). (p. 88)

In other words, a 'mental illness' is here defined in terms of established diagnoses, excluding some of the conditions included under the broader term 'mental disorder', such as learning disabilities.

To some extent, therefore the distinction between terms is here technical, as they describe different experiences. Both 'illness' and 'disorder', however, are also medicalised terms, and hence imply a medical understanding of distress, which has

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been widely contested (e.g., Bracken & Thomas, 2003; Johnstone, 1989; Pilgrim & Bentall, 1999; Read & Reynolds, 1996; Szasz, 1960). As the service user activists Peter Campbell and Diana Rose (2010) note:

> the increasing involvement of service users has seen the rise of non-medical/anti-psychiatric language. There is a tendency to talk about mental distress rather than mental illness […] the de-medicalisation of mental health is seen as advantageous for a number of reasons including the difficulties of stigmatisation and mystification that attend traditional concepts and language. (p. 453)

Mental distress will hence be used in this thesis, within this context of seeking a demedicalised manner of discussing experiences of distress. The terms 'emotional distress' or 'mental distress', have been argued to encompass both "the feelings and perceptions of the people experiencing it, and the symptoms they present to the world" (Read & Reynolds, 1996, p. 1). It is a general term that acknowledges the suffering often involved in the experiences here discussed, without adherence to a medical model, or a diagnostic approach. A further complication arises, however, in considering the issue that not all experiences which might have fallen under the remit of 'mental illness' can perhaps be accurately described as 'distress'. Firstly, it has been demonstrated that the majority of people who hear voices (what would be called 'auditory hallucinations' under a medical model) or who have unusual beliefs (what would be termed 'delusions') are not distressed by these experiences, and do not come into contact with psychiatric services (Romme & Escher, 1993; 2000; 2011; Romme, Escher, Dillon, Corstens & Morris, 2009; Eaton, Romanoski, Anthony, & Nestadt, 1991; Johns & Van Os, 2001; Van Os, Hanssen, Bijl, & Vollebergh, 2000).

Organisations such as the Hearing Voices Network (Romme & Escher, 1993; 2000; Romme et al, 2009; Dillon & Longden, 2011) hence argue for an approach to such experiences which acknowledges that: "hearing voices and unusual beliefs are human variations that need emancipation and freedom of mind" (Romme & Escher, 2011, p. 12), rather than medical 'symptoms' of an underlying disease pathology (Hoffman, 2011) Such approaches stress the meaning of these experiences, rather than seeking to abolish them altogether (Dillon, 2010; Johnstone, 2011a, Romme & Escher, 1993; 2000; Romme et al, 2009). Such experiences would, however, still be of interest in this thesis, in terms of how the production of such experiences interrelates with space. Particular experiences of, for instance, unusual beliefs, hearing voices, or elevated, impulsive mood and action, will therefore in this thesis be known under the term 'madness'. This term is definitively not used in a pejorative manner; indeed some service user groups, such as 'Mad Pride' (Curtis, Deller, Leslie & Watson, 2000) use the term in a political sense with an aim to "reclaiming the experience of madness and the language surrounding it" (p. 7). This term can, therefore, has been chosen as one which does not entail a medical understanding of distress and madness, but instead sees 'mad' experiences as a reaction to life events. As Pete Shaughnessy (2000) eloquently argues:

> I see life as one big swimming pool. Some of us are thrust in the deep end
> and we manage to survive. We make our way down to the shallow end,
> where it's easy, boring. The people there are scared of the deep end, scared
> of the unknown, so they shun people like me and call me MAD. Madness is a
> natural reaction. The worker who abused [my girlfriend] Louise at six years
> old is the killer. (p. 22)

The term 'madness' has therefore been chosen over the increasingly prevalent term 'psychosis', which to some extent has begun to replace 'schizophrenia' in the medical and clinical literature in reaction to the issues raised with the validity of the schizophrenia diagnosis (e.g., Bentall, 2003; 2006; Boyle, 1990; 2007; Cromby, Harper & Reavey, 2012). This term has also been avoided, however, in line with Lucy Johnstone's (2011b) argument that 'psychosis', in the same way as 'schizophrenia' or other diagnoses, relocates 'the problem' in an individual disease process, rather than 'the problem' being located in meaningful, often traumatic, life events and histories. For these reasons, and with an acknowledgement that not all experiences which might fall under psychiatric categorisation are seen as problematic by those who experience them, the terms distress and madness will be used throughout this thesis.

1.2.2   Defining the person

A similar range of terms exist for describing the participants in this study: people who have experienced mental distress and used psychiatric services. The traditional term, 'patient', has been widely criticised as implicitly subscribing to an illness model and positioning 'patients' as powerless and passive (Campbell, 1996a; 2007; Link, Cullen, Struening, Shrout & Dohrenwend, 1989; Scheff, 1974; 1999). There exist a number of alternatives, originating in the service user movemnt, which aim to promote a more equitable position for service users; these include 'consumer', 'service user', and 'survivor'. Campbell & Rose (2010) provide a useful summary of the distinction between the terms:

In the 1980s, talk was often of consumers rather than mental patients but this was often challlenged by activists who denied the usefulness of the term 'consumer' to describe their powerlessness within the system or to recognise that substantial numbers were using services against their will. Some activists identified themselves as recipients rather than consumers to emphasise this powerlessness. Service user has largely replaced consumer in the UK […] But service user is an essentially neutral term and many activists have preferred to use the term 'survivor' which implies a degree of criticism – people are not just using services but are surviving the obstacles they present. (p. 454)

For this thesis, the term 'service user' will be used. The more neutral term (than 'survivor') has been deliberately chosen to not ascribe a political position to participants to which they might not necessarily adhere. As stated by Campbell & Rose (2010), survivor carries definite political, critical implications; although some of the participants in this study would describe themselves thus, this could not be assumed to be the case for all participants.

1.3   Spaces of mental health care: from the asylum to the community

The contemporary picture set out above can be seen as highlighting a potential importance for the consideration of space in experiences of community mental health care. In the following section, this point will be put in context through an exploration of the history of spaces of mental health care, placed in their social and philosophical context. Perhaps the most compelling of these spaces allocated for distress is still the asylum; this section will first discuss the emergence and decline of the asylum, before moving on to explore the establishment of community care.

1.3.1 The asylum

An exploration of the history of mental health care can be also seen as a history of mutating spatial practices that have been part of how distress has been delineated and defined, as well as one of differing theoretical frameworks, and accompanying remedies. Until around 1700, for instance, distress was mainly, as Roy Porter (2004) puts it, "a domestic responsibility" (p. 89). There were exceptions, most notably Bethlem Royal Hospital (or Bedlam), a charitable institution which was established in 1247 and from around 1377 was devoted to the care, or at least incarceration, of people deemed to be 'insane' (Arnold, 2008). The establishment of the asylum system developed at an uneven rate across Europe, with France first experiencing a state initiated 'great confinement' (Foucault, 1965) under Louis XIV in the 1660s, at which point there were 6,000 people confined in the Paris Hopital General. In England, however, it was not until 1845 that the provision of state county asylums was made mandatory and more than half of asylums at this time were still privately run (Porter, 2004). Nevertheless, the point remains that across Europe institutions of various kinds began to spring up based on the idea that separate, specialised and increasingly professionalised spaces were needed for the care, confinement and treatment of distress.

The period in question was one of fundamental social, political and indeed, spatial changes. The power of the feudal system which underlay the organisation of European government began to wane and aristocratic power gave way to state-wide parliamentary democracies and republics as the main models of government. Foucault (1977) analysed these changes in terms of a shift in the nature of

disciplinary power. The established power structures, based on localised adherence to known, named powerful figures in the aristocracy and church he argued were no longer viable when faced with an urbanising and increasingly dense population. Responsibility for the conformity of the population, he argued, therefore shifted to be dispersed through wider structures in society such as the law, government, schools, army and family life. This diffuse threat of punishment was proposed to also have rendered each individual responsible for regulating their own behaviour in order to avoid the 'discipline' of prison or the censure of the family. Hence, as Nikolas Rose (1989; 1998b) has proposed, this period marks the genesis of a rational, self-regulating and individualised self; this model of society is argued to rely on the idea that individuals can understand themselves and control their own behaviour through the application of reason. Foucault (1965) also argued that the emergence of this form of society and self was central to the emergence of the asylum system. This 'Age of Reason' was argued to have rendered 'unreason' as a more profoundly disturbing occurrence, as the presence of such obvious irrationality undermined the concept of the feasibility of a rational, self regulating self. Under this regime, so Foucault argued, European states responded by confining, sequestering and silencing those who displayed such behaviour.

Although there have been many criticisms of Foucault's argument, mainly that he generalised too quickly from the French situation (Shorter, 1997; Porter, 2004), there was certainly an increase across Europe in such sequestered, specialised madhouses at this time, albeit unevenly; in England, for instance, the greatest increase in asylum population took place over the nineteenth century

(Porter, 2004). Richard Warner (1985) has linked these changes to the societal shifts engendered by the Industrial Revolution. Like Foucault, he points to the urbanisation of the population as central to the development of new spaces for the treatment of madness, but rather than positing a shift in the meaning of madness, he instead emphasises the different economic, social and familial structures brought about by a shift from subsistence farming to urban, industrialised communities. The move to a wage economy for instance, acted to exclude those from the labour market who were not able to fully participate while their families were also additionally less able to look after them due to long hours spent working outside the home. To continue to support the burgeoning industrialised economy it was at this point, Warner argues, that the state was required to intervene and provide new spaces to house those who were excluded from the mainstream economy. It is noticeable that these changes are not only economic, social and familial, but also profoundly spatial. Henri Lefebvre (1991) argued that integral to the establishment of capitalism was the division of land into individualised, personal lots; ownership of land passed from the sole control of the feudal lord to being, at least theoretically, obtainable to all through the accumulation of capital. Hence Warner's (1985) analysis of how wage labour acted to exclude those who were previously able to be more easily integrated into the community and economy can perhaps also be seen to be indicative of a change in the access to, and meaning of, space. When ownership of, or at least access to, land is seen as at this time being individualised and tied specifically to the ability to access the labour market then the necessity of creating new spaces for those who are unable to enter this market becomes

apparent. It is also at this time, for instance, that poor houses and prisons began to appear marking a shift in how those at the edges of society were dealt with both politically, and spatially. Industrialisation and capitalism more generally, has been often cited as giving birth to the individualist self (e.g., Rose, 1989; 1998b); here it can also be seen that created at the same time was a more individualised approach to the carving up of space.

As Foucault (1965; 1977) argued, these new, secular spatial and societal forms required new, secular gatekeepers; it is from the Victorian period that the 'psy-disciplines' began to emerge and professionalise. Early asylums were not necessarily run by medical doctors, and indeed some of the most famous (and famously humane) institutions of the moral treatment era such as the York Retreat, were run by lay people (Porter, 2004; Scull, 2010). By the late Victorian period however, asylums were increasingly professionalised and medicalised as the emerging discipline of psychiatry became more influential and the asylum market was increasingly controlled and rationalised. This period is also associated with a rise in biological explanations for madness, many influenced by Darwinism and the idea that madness could be inherited (Porter, 2004). In this climate, it is easy to see how psychiatry, with its emphasis on the physical, medical and biological, was able to expand and consolidate its influence and power.

1.3.2   Community care

Asylum populations continued to grow throughout the nineteenth century, reaching their peak in the early twentieth century (Shorter, 1997). Since the 1940s, however, there has been a steady decline in the population of psychiatric institutions (Warner,

1985) leading in the 1990s to the complete closure of the old asylums and the official establishment of community care. Although psychiatric wards still exist in both specialist and general hospitals, their role is less one of long term 'confinement' than of spaces for short term crises with an aim to swift discharge into the community. In 2007/8, for instance, the mean stay in hospital for those admitted with psychiatric problems was only 7.5 weeks, with the median stay being a mere 16 days (D.O.H., 2009). Rather than being sequestered into single, large scale institutions, often located at the edges of towns, those diagnosed with mental health problems now live in a variety of spaces, including supported housing, private and social housing, homeless shelters, prisons, or the streets. In addition, the services provided by the asylums (as well as some new ones) have also been dispersed throughout myriad health and social services, such as day centres, GP surgeries, and out patient units (see, Goodwin, 1997; Rose, 1998a; Sayce, 2000).

One perspective on the decline of asylum care has argued that an increase in community based care was accompanied by a dissolution of a clear divide between the mad and the sane (Porter, 2008). From the rise of psychoanalysis in the early part of the twentieth century to the normalisation of psychiatric drugs, for instance with the prescription rate of Prozac rising 1300% over the 1990s (Healy, 2002), psychiatric practice has been argued to have seeped into an increasing number of areas of human experience (Healy, 2002; Porter, 2008; Rose, 2006). When, in 1915, Kraepelin established the first categorical system for describing mental health (credited with shaping the diagnostic system of modern psychiatry) his system comprised of only three 'illnesses': manic depression, paranoia and dementia

praecox (see, Bentall, 2003; Boyle, 1990). These could all been seen to describe what are now known as 'severe mental health disorders' and for the first half of the twentieth century there was little psychiatric interest in what are now called 'common mental health disorders', such as anxiety and depression (Porter, 2004; 2008). Since the 1940s, however, there seems to have been an almost exponential growth in the number and scope of psychiatric diagnoses. The Diagnostic and Statistical Manual published by the American Psychiatric Association, for instance has grown from 150 pages in its second incarnation in 1965 to total over 900 pages in its fourth edition published in 1992 (see Bentall, 2003). Over the past 50 years psychiatry has expanded its practice and influence to provide medicalised accounts of an increasingly broad spectrum of human experience. Porter (2004; 2008) argues that, combined with the popularisation of psychoanalysis, this expansion of psychiatric explanation into previously 'normal' human experiences such as sadness and worry has acted to erode any clear distinction between those who are mad and those who are sane. It could be argued that the dissolution of the asylums mirrors this change; as the definition of 'madness' begins to creep into what was previously seen as 'normal' behaviour perhaps also stark spatial demarcation between the mad and sane represented by the asylum also makes less sense. It is in the 1940s, after all, that clinics and facilities begin to appear for 'curable' patients as well as those who were to be institutionalised for long periods (Scull, 2010).

These changes, although beginning in the post war period accelerated during the late 1970s and early 1980s in Britain (Payne, 1999), following a slightly earlier movement to community care in the USA (see, Estroff, 1981). The closing of the

asylums has often been portrayed as a story of liberation; steeped in civil liberties and humanitarian language, these narratives of de-institutionalisation portray the movement to the community as ending an era of abuse and beginning one of modern, humane mental health care (e.g., Bell & Lindley, 2005). It is certainly the case that the move to community based treatment was supported by left-wing civil rights campaigners (Pilgrim, 1997) and the same period of the 1980s and 1990s saw a rapid growth of the role and voice of service users within the mental health system (Campbell, 1996b; Campbell & Rose, 2010), often located within a civil rights framework and linked to other emancipatory movements, particularly those concerned with greater rights for disabled people (e.g., Beresford & Wallcraft, 1996). Nevertheless, it has been pointed out although humanitarian campaigners may have helped to cement the policy of community care, this involved entering into a coalition with the right-wing, neo-liberal politicians of the time (Baldwin, 1993; Pilgrim, 1997; Scull, 2010).

The political climate of the 1980s in both Britain and the USA were characterised by a movement to an individualist, market driven philosophy that emphasised the erosion of state (or indeed any collectivised) control (e.g., see Harvey, 2007; Rea, 1998; Scull, 2010). The resulting approach to society and social justice can be encapsulated in Margaret Thatcher's famous quote:

> they are casting their problems on society and who is society? There is no such thing! There are individual men and women and there are families and no government can do anything except through people and people look to themselves first. (Woman's Own, 31st October, 1987, p. 8)

In this climate, large scale solutions based on social change, which had been central to government policy in many areas during the post-war consensus period of the 1940s to early 1970s (such as the expansion of the welfare state, including the establishment of the NHS in Britain in 1948, and large scale social housing building programmes) became deeply unfashionable. Instead the power of the market and individual responsibility was seen to be key (see, Harvey, 2007). One of the first actions of the Thatcher government, for instance, was enabling social housing tenants to buy their homes (see, Jones & Murie, 2006), eroding the (limited) collective system of allocating living space according to need; in Lefebvre's (1991) terms this space which had been to some extent bracketed off from the individualist system where land ownership is tied to capital, can be seen to have been partially reclaimed. With the abolition of the asylum a similar process can be seen to have happened; a large scale, collective system was replaced with one that partially, but not wholly, devolved responsibility for everyday living, and even treatment, to the individual service user as opposed to the institution. The individualisation of service use, and the spaces which service users are expected to occupy, can also be seen as part of a wider rhetorical shift to a 'consumerist' model of health care provision (emphasising choice), argued to be have been central to New Labour's health policy (Newman & Vidler, 2006), and still prevalent in the current Coalition government's mental health strategy, which presents 'freedom, personalisation and control' as a central theme (D.O.H., 2011).

As touched on in the opening section of this chapter, the *spatial* impact of these tendencies in contemporary mental health care can be seen to be a relocation

of service users from specialised, designated space into a plethora of community spaces within which service users are expected to negotiate their distress and recovery. It has also been argued that limitations of such policies individualising the space of service users has more recently lead to either 'trans-institutionalisation' (Priebe et al, 2005), particularly in the form of an increase of those with diagnosed mental health problems in prison (Fazel & Danesh, 2002; Priebe et al, 2005; Singleton, Meltzer & Gatward, 1999) , or 're-institutionalisation', in the form of an increase in hospital admissions and supported housing (Priebe & Turner, 2003). There has also been an observed increase in homelessness among the mentally distressed (Craig & Timms, 1992; Knowles, 2000a; 2000b). From these patterns, it can be seen that potentially there are issues in simply relocating those with 'problems with living' (Szasz, 1960) into mainstream domestic and productive spaces, with many (although by no means all) ending up in disenfranchised spaces (prison, on the streets).

1.3.3   Experiences of community space, and community mental health care

From this short history of the spaces of mental health care, it can be seen that space has been an integral part of the history of mental health treatment; changes in the spaces allocated for distress can be seen to be central to societal shifts in the understanding of distress (as a domestic or medical problem; a collective or individual responsibility). This macro perspective, however, gives little indication of how space might interpellate into experiences of living in the community with distress.

Several authors, especially from within the field of human geography, have explored the ways in which service users' experience and management of mental health problems in the community can be seen as inherently spatial (e.g., Curtis, 2010; Davidson, 2000a; 2000b; 2001; 2003; Parr, 1997; 1999; 2008; Parr & Philo, 1995; Segrott & Doel, 2005). Segrott and Doel (2005), for instance, highlighted the material nature of the behaviours associated with Obsessive Compulsive Disorder, re-configuring the generally pathologised ritualised ordering of material space and objects associated with the diagnosis, for example by switching light-switches on and off repeatedly, as strategies to ward off feelings of contamination. Joyce Davidson (2000b) also points out that in the case of her female participants diagnosed with agoraphobia, not only were particular highly populated *spaces* the primary trigger for her participants' anxiety but also that they managed their distress spatially, by retreating to their homes and finally their bedrooms. Davidson (2000a) also discusses her participants' reported need to actively practice going outside in order to combat this particular relationship to public space; she explains this in terms of having to "exercise" (p. 652) their ability to function in different spaces in the community, as if they left this unchecked the places which they could go to could become "hopelessly and debilitatingly contracted" (p. 652).

It is interesting to note that while the experiences described by Davidson's (all female) participants are commonly understood in individualised terms as a mental health problem, their retreat to the home reflects what has been argued to be a gendered division of space, between public 'male' 'productive' space, and private 'female' 'reproductive' space (Hanson & Pratt, 1995; McDowell, 1983).

Domestic space, described by Davidson's (2000a) participants as their place of safety, is also the space argued to be allocated as the female 'reproductive' sphere. Such gendered divisions of space can be seen to be compounded by a more general lack of acceptance of the expression of distress in public spaces (Parr, 1997, 2008; Knowles, 2000a; 2000b). Hester Parr (1997) has explored this phenomenon, comparing the reception of 'mad' behaviour in public and specialised (mental health day centre) spaces, arguing that while behaviour associated with distress was received with suspicion and rejection in public spaces, the same behaviour in specialised spaces attracted little negative attention. Parr drew on the work of David Sibley (1995) who has argued that in Western societies public spaces are 'purified' of groups of people who disrupt or challenge social norms.

Indeed, there is evidence that although fewer people diagnosed with mental health problems now spend long periods of time in institutions, community care does mean that people are forced to deal on a more everyday basis with stigma. In a community sample, for instance, Berzens & Petch (2003) found that 41% of service users had experienced harassment in their community, a level twice that of controls. The growing discourse of fear and risk associated with mental distress (Harper, 2004; Moon, 2000; Phelan et al, 2000; Rose, 1998a) can be seen to here be informing and exacerbating negative community views of those in distress. Levels of fear and distrust of people with mental health problems have indeed grown considerably over the same period that has witnessed the closing of institutional care. Comparing the same questions asked in large scale surveys in 1955 and 1996, for instance, Phelan et al (2000) found that people in 1996 were twice as likely to

describe someone with a mental health problem as violent and dangerous even though levels of violent offences committed by those with diagnosed with mental health problems had remained the same. What Parr's (1997; 2008) work perhaps indicates is that these experiences of stigma may not be uniform across the variety of community spaces which services users are asked to negotiate, but instead can be seen as mediated by the particular function of the space in which they are operating. In other words, the service users observed by Parr could be seen to be experiencing differential levels of stigma dependent on the kind of behaviour that was expected or normalised in that particular space. In public space, where, as can be seen above, high levels of hostility and stigma towards mental distress are often present, behaviours associated with distress would be correspondingly treated with more suspicion than in a mental health day centre, which is specifically set up to deal with such experiences.

Indeed, it has been argued elsewhere that community care has only created a new 'Bedlam on the Streets' (Knowles, 2000a), in which those diagnosed with mental health problems are forced to negotiate inherently hostile spaces (McGrath, Reavey & Brown, 2008; Parr, 1997; 2008; Sibley, 1995). Specifically, Knowles looked at people with mental health problems living in homeless hostels and insecure accommodation in Montreal, Canada who had to spend their days on the streets, in public spaces defined by consumption and capitalism from which they were both implicitly and explicitly excluded. She noted, for instance, that truly 'public' spaces were rare in Montreal, with most central areas being designated as shopping or other consumer activities, a phenomenon that has been argued to be increasing in

late capitalist societies (Habermas, 1989; although this has been contested, e.g., Crawford, 1995). Knowles' (2000a) participants were forced to insert themselves into these spaces despite lacking the economic ability to fully participate in the stated function of such places and faced with the constant threat of being moved on. It was observed that service users were often able to remain in certain low-status consumer spaces, generally food courts and fast food restaurants, for long periods of time on the condition that they did not trouble other customers, in other words: "remaining *invisible* is the price of using public space" (Knowles, 2000a, p. 224).

In part, the enforced invisibility observed here by Knowles could be seen as a function of the economic disenfranchisement of her participants, as similar arguments have been made concerning the experiences of homeless people more generally (Hodgetts, Radley, Chamberlain & Hodgetts, 2007; Hodgetts et al, 2008). In her ethnography of an American day centre, however, Sue Estroff (1981) argued that achieving invisibility or looking 'normal' threw up particular challenges for those using community mental health services. Although seemingly living in mainstream community spaces, she argued that clients were nevertheless differentiated from the rest of the community. Very few clients worked, for instance, and so lived to a different temporal pattern to their neighbours. In addition, markers such as unusual dress or the effects of medication (such as twitching, or slowed communication) made the clients' status as mental health service users visible in public, community spaces. Estroff noted how this lead to clients being avoided on the street, excluding them from everyday social interaction. She argued that in asking clients to live in

community spaces while these demarcations existed was in effect asking them "to be insane in sane spaces" (p. 111), and in some ways their spatial integration only acted to help cement a lack of social integration. Despite living in an 'ordinary' neighbourhood, for instance, Estroff found that very few of the clients had successful social relationships that were not either familial related to service use. Similarly, Vanessa Pinfold's (2000) analysis of service users' experiences of negotiating community spaces in Nottingham concluded that service users reported feeling socially isolated, but that they cited the practice of seeking out and routinely visiting particular locations or 'safe havens' in the community as a way of ameliorating the stigma and exclusion experienced in most community spaces. These 'safe havens' included homes, friend's houses, pubs, community groups and sheltered workshops which, as Pinfold argued, offered the opportunity for social participation and the fostering of valued social and community roles without the necessity of engaging in employment. Pinfold emphasised the difficult experiences that service users reported in mainstream workplaces which tended to be unforgiving during episodes of relapse, leading to further feelings of rejection, isolation and failure.

In summary, the spaces allocated for mental health care can hence be seen to be embedded in the social, political and cultural context of mental health care; as conceptualisations of mental health and the role of services/the state change, so do the spaces in which people negotiate and experience mental distress. The changing topology of mental health care can also be seen to impact on the experiences of service users, with the move to community care producing new challenges (Estroff,

1981; Knowles, 2000a; Pinfold, 2000), as well as enabling positive outcomes, such as greater opportunity for collective organisation (Campbell & Rose, 2010).

1.4   Evidence for a relationship between space and distress

Spatiality can hence be seen to be an integral part of how mental distress is dealt with in society, with different ideas and discourses regarding mental health being allied with differential spaces allocated for dealing with distress. The next question to ask is hence what role these shifting spatial patterns play in the development and experience of distress and recovery. In other words, does it matter *where* people are when they develop and deal with their distress, or indeed recover? In fact, there is a large body of evidence spread across disparate disciplines that space, place, and the material environments in which people spend their time, play a highly important role in developing and managing mental distress. Two key facets to this relationship will be explored here: the role that space has been found to play in the development of distress, and in the facilitation of recovery.

1.4.1   Toxic spaces: the development of distress

Perhaps the most straightforward piece of evidence that space plays a role in the development of distress is that mental distress has consistently been found to emerge in particular places more than in others. Higher levels of mental health problems have been found in: England rather than Scotland (Lewis & Booth, 1992); urban compared to rural areas (Paykel, Abbott, Jenkins, Brugha & Meltzer, 2000; Van Os, Hanssen, Bijl & Vollebergh, 2001; Van Os, 2004; Weich, Twigg & Lewis, 2006); and inner city rather than suburban areas (Faris & Dunham, 1939; Lewis,

David, Andréassson & Allebeck, 1992). Of these geographical variations, the most studied has perhaps been the concentration of mental health problems in poor inner city areas. Perhaps the earliest, and highly influential, study to establish pattern was carried out by Faris & Dunham (1939), part of the Chicago School. They observed that the incidence of diagnoses of schizophrenia increased in the more central areas of Chicago and diminished in the suburban areas. Although Faris & Dunham, at the time, explained this phenomenon in terms of the greater social disorganisation found in inner city areas, for much of the twentieth century, as Boydell & McKenzie (2008) note, this pattern was instead explained in terms of either a 'social drift' or 'social residue' hypothesis. It was presumed that the concentration of service users in inner city areas was due to the social exclusion and downwards economic trajectory experienced by those who access psychiatric services, rendering them more likely to be forced to move to poor areas (social drift), or be unable to afford to leave (social residue). More recent research in Sweden (Lewis et al, 1992) and Denmark (Mortensen et al, 1999) has however linked place of birth and residence with psychiatric history, both finding that urbanicity was linked with higher incidence of adult diagnoses of schizophrenia. Mortensen et al (1999), for instance, found that being born in Copenhagen, as opposed to the rural areas included in the study, rendered participants 2.4 times more likely to be later diagnosed with schizophrenia, when controlled for socio-economic status and family history of diagnosed mental health problems; the Swedish study similarly found that incidence of diagnoses of schizophrenia was 1.65 times higher among those brought up in cities. It has also been found that the risk of being diagnosed with

schizophrenia later in life increases with the amount of time spent in urban environments during childhood (Pedersen & Mortensen, 2001).

Multiple features of urban environments have been identified as candidates for explaining these patterns, including poverty (Rogers & Pilgrim, 2003), poor housing (Evans, 2003), social disorganisation (Silver, Mulvey & Monahan, 1999), isolation (Van Os, Driessen, Gunther & Delespaul, 2000; Thornicroft, Bisoffi, De Salvia & Tansella, 1993), experiences of fear (Bentall, 2009), crime and vandalism (Ross, Mirowsky & Pribesh 2001), and inequality (Cromby, 2004a; Cromby & Harper, 2005; Rogers & Pilgrim, 2003). Although each of these factors have been investigated separately in the development of distress, it is important to note that they do not necessarily therefore account for the development of distress as wholly separate variables. Socio-economic status, for instance, while consistently associated with the development of distress (Rogers & Pilgrim, 2003), cannot alone explain the clustering of distress in inner city areas; after all, rural areas have fewer incidences of distress than wealthy urban areas (Paykel et al, 2000; Van Os et al, 2001), while Scotland has a lower incidence of distress than the more affluent England (Lewis & Booth, 1992). It is clear, therefore, that the development of these clusters of mental distress is a more complex process than can be accounted for by a single factor.

Rogers & Pilgrim (2003), indeed, have argued against a single factor approach to looking at neighbourhood effects on distress, instead emphasising the importance of viewing neighbourhoods as a transactional setting, in which these different facets of the environment coalesce to form the particular situation, and

experiences of those living there. An interesting example of this is the observed relationship between proximity to wealth and the impact of poverty; one study in South Africa found that between two communities of comparable levels of deprivation there were higher levels of dissatisfaction and distress in the community which was located on a hill overlooking a particularly rich neighbourhood as opposed to the other area surrounded by neighbourhoods of similar wealth (Rogers & Pilgrim, 2003). The material visibility of inequality can here be seen to mediate the psychological effects of deprivation; in other words, the experience of deprivation, and how this might be part of what produces mental distress, has to be seen as embedded in the particular social and material constitution of the community in question.

1.4.2   Inner city built environments and mental distress

A good place to begin a consideration of a situated view of how material, social and psychological factors might fuse to produce experiences of distress, in particular locations, is perhaps therefore an examination of the material, or built, environment of inner city neighbourhoods. The investigation of the psychological effects of the built environment has been a minority pursuit within Psychology itself, mainly confined to the sub-discipline of Environmental Psychology (e.g., Betchel & Ts'erts'man, 2002; Proshansky, Ittelson & Rivlin, 1976). The work within this area, in combination with a body of (mainly American) urban studies research (e.g., Evans, 2003, Halpern, 1995), does however begin to suggest a compelling picture of the role that material environments can play in producing and mediating experiences of mental distress. Two consistent findings are perhaps particularly pertinent in the

examination of the emergence of distress in poor inner city areas. The first is that 'poor quality' housing, characterised by Evans (2003) as being judged on a combination of structural quality, levels of upkeep, quality of amenities and levels of physical safety, has been consistently found to be associated with increased levels of mental distress independently of socio-economic status (Evans, Wells & Moch, 2003; Freeman, 1984; 2008; Halpern, 1995). Secondly, multiple occupancy dwellings, in particular high-rises, have been found to be more likely to produce mental distress than other forms of housing (Evans, 2003; Fanning, 1967; Freeman, 1984; 2008; Gifford, 2007; McCarthy & Saegert, 1979; Saegert, 1982). Even more strikingly, it has been consistently found that residents on higher floors within high rises have higher levels of mental health (Freeman, 1984; 2008; Mitchell, 1971), and that those who reside in dwellings with open deck access rather than closed corridors have higher levels of depression (Weich, Blanchard, Prince, Burton, Erens & Sprosten, 2002).

These effects have been found to be especially robust in mothers with young children, even more so when those women have low incomes (Evans, 2003; Mitchell, 1971; Freeman, 1984; 2008). The gendered nature of the findings is interesting; Halpern (1995) points out that women are more likely to spend the majority of their time in the home, and this can be seen to be particularly true for mothers of young children. Present here are strong resonances with feminist geographical analyses of the composition of urban space, which have argued that urban and suburban housing structures have served to isolate, oppress and disenfranchise women by removing them from the public and productive spaces of the city and allocating women's 'reproductive' space as atomised, privatised homes,

limiting women's ability to collectivise and form communities (Hanson & Pratt, 1995; McDowell, 1983). Although fewer women are now so completely excluded from public and productive life, with 69% of women in Britain now working (O.N.S., 2009), housewives or mothers of young children could be seen to still perpetuate these spatial divisions by spending a large proportion of their time in domestic space. The practical implications of this division can perhaps be seen to be that this group of women could be particularly vulnerable to the effects of these spaces, and therefore their experiences offer a good picture of how these particular environments shape and mediate social interaction.

High rises have generally been found to be associated with greater social withdrawal and lower levels of social support, compared to low rise developments or houses (Churchman & Ginsberg, 1984; Gifford, 2007; McCarthy & Saegert, 1978). Evans (2003) for instance suggests that in multiple occupancy, high rise dwellings there are few safe communal areas for children to play in and hence children tend to be kept indoors, increasing levels of social isolation and reducing the amount of informal contact between parents living in the same neighbourhood. At the same time as producing more social isolation, high rises are also associated with higher levels of 'uncontrollable' and anonymous social interaction (Churchman & Ginsberg, 1984). Such forms of social interaction have been linked to the development of feelings of helplessness and a lack of control over the environment, experiences which in turn are linked to higher levels of distress (Evans, 2003). It seems, therefore, that the kind of social interaction that is encouraged or produced by the by these particular spaces is not one that is conducive to good mental health. There

is some evidence that this effect is in part due to the detailed arrangement of the built environment itself; an analogous study in student accommodation, for instance, found that those assigned to residential halls with long corridor designs rather than smaller flats were found to register higher levels of helplessness (Baum & Valins, 1977; 1979). This study echoes Weich et al's (2002) study detailed above; in both the more anonymous space that engendered fewer feelings of ownership and control proved more likely to produce distress. Part of the difference between these two arrangements may be the presence of intermediate, more informal spaces that facilitate different levels of interaction in the closed corridor and flat style residences; it has been found that those residences that include a range of different types of spaces, from private to semi-public to public, are associated with increased feelings of control and higher levels of comfort in their residents (Alexander, 1972; Zimring, 1982). In addition, the linear design of long corridors associated with high rises may in themselves inhibit, or at least not promote positive social interaction in their residents. It has been found that social interaction between neighbours was increased when doors to flats were nearer communal areas, or faced each other (Fleming, Baum & Singer, 1985; Moos, 1976).

Another aspect of the environment of inner city living that has been argued to play a role in the development of distress is the paucity of green and open spaces. The literature in this area is perhaps less direct than that detailed above, but environmental psychologists have in general argued that views of, or proximity to, nature plays a role in the 'restoration' of attention and cognitive capacity (Berg, Hartig & Staats, 2007; Cackowski & Nasar, 2003; Kaplan & Kaplan, 1989). There is

empirical evidence to support this claim. It has been found, for instance, that people who have a view of nature from their window recover more quickly from surgery (Ulrich, 1984) and that students who have a view of nature from their window perform better on tests of attention (Tennessen & Cimprich, 1995). Most pertinently for this exploration of the urban environment, Kuo (2001) compared groups of women living in a large high rise housing estate in Chicago, half of whom had trees around their tower block and half of whom did not. This natural experiment found that not only were those women who were living in the 'barren' areas performed worse on measures of attention, but also found related differences in the ways in which these women perceived their life difficulties. Women without immediate access to nature were found to be more likely to procrastinate in addressing major life issues, and reported these issues as more severe and more longstanding. It may be, therefore, that a lack of access to green space renders everyday life stresses more difficult to cope with and hence increases the impact that they have on residents' lives. It is noticeable that this pattern of attribution, of perceiving problems as more long term, or stable, bears some resemblance to the attribution pattern found in people diagnosed with depression (Bentall, 2003). It has in fact been found that those areas of London with less access to private gardens have a higher incidence of depression, independently of socio-economic status (Weich et al, 2002).

What becomes clear from these combined studies is that the detail of how spaces are arranged mediates, shapes and delineates the nature and form of the ongoing social interactions that take place there. How buildings, doors and corridors are

constructed can help to facilitate how people interact, and so influence their relationships and wellbeing. Aspects of the urban environment can also be seen to feed into producing particular emotional and cognitive states that may well be implicated in the development of distress. The above literature has, however, focused on high rises, an obvious candidate for an impoverished environment that would perhaps be expected to produce similarly impoverished social interactions. What is interesting, however, is that these effects are also at times found in less obviously deprived environments. Martin et al (1957; cited in Halpern, 1995) for instance studied the effects on communities of being moved to new suburbs as part of inner city slum clearances in the 1950s. An initial boost in wellbeing was followed by increased reports of distress, particularly manifesting as depression, in the long term. This pattern was, again, particularly prevalent amongst women. Although the new homes were improved on many of the 'poor quality housing' indicators detailed above and so objectively 'better', the women reported finding suburban life isolating and missing the strong community of their previous home. The change in how these women's domestic and community spaces were laid out can be seen to have served to inhibit, or fail to facilitate, the kind of daily interaction with their neighbours that was a part of how their previous community had been built up and sustained. There is a wealth of evidence that both social (e.g. Warner, 2000) and cultural (Bhugra & Jones, 2001; Bhugra, 2004; Bhugra & Arya, 2005; Halpern & Nazroo, 2000) isolation are central to the development of distress; what this research perhaps indicates is that these kinds of experiences are in part produced or mediated by the particular material environments in which social and cultural

relationships take place. This body of research perhaps points to some of the ways in which the social and material collide in order to produce experiences of distress, and how the two can exacerbate and feed into each other.

1.4.3   Therapeutic spaces: the facilitation of recovery

The above evidence can be seen to point to a role of space in the development of distress. Similarly, there is some evidence that the setting in which people experience distress, and exist within for the period of distress and recovery could potentially play a role in the nature of their recovery. One example of this could be seen to be the Soteria project, set up in 1971 by Loren Mosher in California as an alternative to hospital treatment for acute psychosis (Bola & Mosher, 2003; Mosher, 1975; 1999). Inspired by R. D. Laing's (1960; 1967) existential theories of psychosis (see, Bentall, 2009), viewing madness as a meaningful journey through which people needed to be supported rather than prevented from experiencing, Soteria was located in an ordinary suburban house, largely drug-free, and staffed by non-professionals (Bola & Mosher, 2003; Mosher, 1975; 1999). Comparisons with the local psychiatric ward, run on medical grounds, found that while there was no difference in levels of symptomology (e.g., the presence of voices or unusual beliefs) after two years, the Soteria group performed significantly better on a series of psychosocial measures. They were more likely to be in work, to be living independently, and less likely to have accessed mental health services over the two years (Bola & Mosher, 2003; Mosher, 1999). If recovery is understood as a process of "recovering a new sense of self and of purpose within and beyond the limits of the disability" (Deegan, 1988, p. 11), rather than the 'removal' of 'symptoms' (see

Deegan, 1988; Antony, 1993; Repper & Perkins, 2003; 2004), then Soteria can be seen to have succeeded in producing, to some extent, a better outcome for service users. In describing a similar project in Colorado, Cedar House, Richard Warner (2000) describes some benefits of such residential, but non-medicalised, environments:

> People receiving services in a non-institutional setting are called upon to use their own inner resources. They must exercise a degree of self-control and accept responsibility for their actions and for the preservation of their living environment. Consequently, clients retain more of their self-respect, their skills and their sense of mastery. The domestic and non-coercive nature of the alternatives described here makes human contact with the person in crisis easier than in hospital. (p. 61)

Warner (2000) argues that such environments are more conducive to recovery because they are less 'alienating' than hospitals; medicalised hospital environments have been argued to inculcate a passive 'patient role' in service users (Campbell, 1996b; Link et al, 1989; Scheff, 1974, 1999), removing agency through the inherent power inequalities between staff and service users, most clearly defined in, as Warner (2000) points out, the use of enforced restraint and seclusion. There is indeed evidence that this more liberal approach to the control of space in treatment spaces is beneficial for both staff and service users. Bowers et al (2009) found that there were higher levels of self harm and staff-directed violence in psychiatric wards where doors were locked. In general, they concluded that such restrictions put upon service users exacerbated problems of violence rather than contained them.

Perhaps one picture that emerges from this evidence is that those spaces which facilitate a more equal, meaningful and active role for service users can be

seen as, to some extent, more successful in facilitating recovery, when this is taken to mean achieving a recovered place within society rather than the deletion of service users. There is wider evidence to support this idea which can be drawn from cross-cultural comparisons of recovery rates from psychosis-like experiences; it has been consistently found that people in developing countries recover more quickly and completely from psychosis. Perhaps the most sustained investigation of this phenomena are the set of classic World Health Organisation studies comparing incidence and course of schizophrenia across first eleven (W.H.O., 1973; 1979), and then ten (Sartorius et al, 1986; Jablensky et al, 1992) countries. The first set of studies found that, when followed up after 5 years, 27% of participants in the developing countries studied had experienced only one isolated episode of psychosis followed by immediate recovery, while this only described 7% of service users in the developed nations. These findings have been used to provide a critique of the efficacy of Western psychiatry, with authors such as Richard Bentall (2009) pointing out that the larger numbers of psychiatrists there are in a country, the worse the rates of recovery are from mental distress. It has been argued that the characterisation of mental distress as an individual pathology stemming from an underlying and permanent disease mechanism leads to the treatment of those experiencing distress as permanently disabled; where non-psychiatric understandings of madness (such as spirits) prevail, it is argued, experiences such as hearing voices or unusual beliefs are more often seen as a temporary and at times positive phenomenon (Bentall, 2009). Richard Warner (1985) has also analysed these differences in recovery rates in terms of economic inclusion; in non-

industrialised countries, he argues, experiences of mental distress are less likely to lead to exclusion from economic activity, and hence from occupying a valued role within society. As outlined in the first section of this review, he argues that non-industrialised economies leave greater scope for part time participation in economic life in contrast to an individualistic wage based economy. His arguments for the importance of economic inclusion are bolstered by his observation that throughout the twentieth century recovery rates for those diagnosed with schizophrenia in the UK rose and fell in line with employment levels. As more labour was needed, he argues, employment of those labelled mentally ill became more necessary and so more rehabilitative, inclusive mental health services emerged.

Perhaps what Warner's analysis highlights is that the emergence of the conditions, and spaces, which facilitate recovery has to be seen as located in much broader social and material context than the particular ward or project in which service users are placed. In a capitalist society, arguably the major route to active, adult citizenship is economic productivity and in such societies, people who become diagnosed with mental health problems tend to be excluded to a greater or lesser extent from fulfilling this form of productive role in society (e.g., see Boardman, Grove, Perkins & Shepherd, 2003). It was found, for instance, that the days of half of people diagnosed with mental health problems in Colorado consisted of no more than one hour's structured activity (Warner, 2000), while many psychiatric service users complain of boredom (Fromkin, 1985; cited in Warner, 2000) and feelings of purposeless (Robinson & Shaver, 1969). It is important to note however, that the presence of employment in people's lives will not necessarily rid them of these

experiences of boredom and alienation. Indeed, working in low status jobs has been shown to have a detrimental effect on the mental health of workers. In his study of Detroit factory workers, Kornhauser (1965) found that the skill of the job was correlated with the mental health of the worker; the lower status and more repetitive the work became, the higher the levels of distress that were found. Similar correlates have been found with shift work (Parkes, 1999), and within office environments, such as the civil service service (Stansfield, Fuhrer, Shipley & Marmot, 1999). It seems then, that although employment can be seen to be important for recovery, it is also implicated in the development of distress. Perhaps from this it can be concluded that it is the quality and nature of the employment, and the role and status in society it provides access to, that is crucial.

Providing some credence to this position, that it is perhaps social inclusion that is central in successful recovery, is the literature on family relationships. Warner et al (1998) for instance found that service users living in Bolonga, Italy scored better on a range of quality of life measures compared to those living in Colorado, USA and linked this to the fact that those living in Italy were more likely (73% compared to 17%) to be living with their families. While social isolation was a major problem for the service users in the USA, Italian service users were found to be have more daily contact with their families as well as three times more likely to be married or living with a partner. It seems that the Italian culture emphasising family life was helpful in maintaining security and routine, while those who lived alone and independently, a sign of adulthood in the more individualistic USA (see Warner, 2000), in many ways fared worse being less likely to be employed and more likely to

have been accused of a crime. It has been argued that a nuclear family structure offers less flexibility in family roles to include experiences of distress and caring for adults (Hatfield & Lefley, 1987), whereas a more extended family structure such as more commonly found in Italy is more able to 'absorb' the needs of family members experiencing distress. Marit Borg and Larry Davidson (2008), whose qualitative study with service users looked at recovery in everyday life, also emphasised that was highly important to participants to maintain their roles of responsibility within family structures during periods of distress and recovery. She highlights one participant who greatly valued being phoned by her sister whilst on a psychiatric ward to be consulted on birthday presents for the family, while another stressed the importance of continuing to take her children to school every day in facilitating her recovery. Remaining embedded in the social world it seems, in roles and relationships that are not wholly tied up with the position of being a service user is central in the management of distress. This does not mean, however, that proximity to family is always positive; just like with employment, it is the quality and nature of those relationships that need to be considered. Perhaps the most accepted measure of this within psychiatry has been the study of Expressed Emotion (EE), defined as being over-involved and critical (Vaughn & Leff, 1985). Families demonstrating high levels of this communication style have been consistently linked to increased likelihood of relapse (Barrowclough, Tarrier & Johnston, 1996; Butzlaff & Hooley, 1998; Kavanagh, 1992; Vaughn & Leff, 1985); Kavanagh's (1992) meta-analysis covering eleven countries, for instance, found that service users whose family contained a member with demonstrating high EE were twice as likely to relapse as

those whose families demonstrated low EE (66% vs. 29%). It would be possible perhaps to explain these patterns by saying that these patterns of communication emerge from the stress of living with someone with mental health problems, but a fifteen year longitudinal study found that high EE in families preceded the diagnosis of schizophrenia (Goldstein, 1985).

This final point can be seen as indicative of the complexity of creating and sustaining the conditions that are conducive to recovery when living in the community. Projects like Soteria create an enclosed therapeutic milieu which, through careful organisation of the social and material environment, can be seen to help foster the kind of relationships and experiences that can help facilitate recovery. As can be seen above, the set up of such projects in many ways gives clients access to an active, valued role in the community which it may be more difficult for them to achieve through the established means such as work or family life due to the social exclusion of people diagnosed with mental health problems. Residential projects such as Soteria are however extremely rare, and even within the more conventional psychiatric system the experience of staying long term in institutional care is now a minority one. In 2007/8 the mean hospital stay in Britain was 7.5 weeks, with the median stay being only 16 days (D.O.H, 2009); half of service users who were admitted into psychiatric hospital therefore, stayed for two weeks or less. While institutions such as the psychiatric ward and the Soteria project as useful illustrations of which aspects of spaces can be seen to facilitate recovery, they are not indicative of the reality of service users' experiences of modern community care. For the vast majority of service users, distress and recovery are

negotiated not in institutional settings but across disparate community spaces. These spaces can include those covered in the first section which are implicated in the development of distress as well as potentially more positive spaces which could include those which engender experiences more conducive to recovery. The aim of this research is hence to explore the complexity of how these different spaces are experienced, used and managed by service users, and the relationship this holds to their experiences of distress and recovery. Before embarking on the detail of the methodology used to investigate this issue, the next chapter will explore ontological issues, particularly how the concept of 'space' can be understood and its role in experience conceptualised.

Chapter Two

Space, experience, and subjectivity

2.1.   Space: definitions and debates

The evidence outlined in the previous chapter demonstrates a clear role for space in

the experience, development and maintenance of mental distress. Distress can be

seen as more likely to emerge in particular spaces, such as tower blocks with a lack

of green space (Kuo, 2001; Evans, 2003), whereas others, such as the Soteria project,

have been shown to be somewhat more conducive to recovery (Mosher, 1985;

1999; Warner, 2000). The kinds of settings to which those experiencing mental

distress are allocated within society can also be seen as reflecting cultural

understandings of distress, and the position of people experiencing distress (e.g.,

Foucault, 1965; Porter, 2004; Warner, 1987).

It is also apparent from this variety of evidence, however, that 'space' is a

flexible term that can be used to describe physical and social environments on a

number of scales, ranging from the particular arrangement of buildings to the

makeup of people living in a similar area. These examples can be seen to

demonstrate that 'space' is a nebulous concept; in its broadest sense, it can mean

any form of dimensionality (Massey, 1994a), but it is also a term applied across a

number of scales and modalities with similarly varying levels of specificity, from the

general ('urban space'; 'social space') to the specific (a particular psychiatric ward).

It is also a term used metaphorically in terms such as 'head space' or needing 'space'

in a relationship. In addition, the term 'place' is also used, sometimes

interchangeably with space (e.g., Hubbard, Kitchin & Valentine, 2004; Massey & Thrift, 2003; Relph, 1976; Tuan, 1977), to describe locality: again, places can range from a place set at a table up to a particular city, area or landscape (Massey, 1994b). The first task of this chapter, therefore, will be to differentiate and define these terms; the discipline which offers the most thorough explication of these issues, perhaps unsurprisingly, is geography. Following this exploration of insights from geographical theory, this chapter will then move onto a consideration of how space and materiality can be understood within a social psychological framework, in dialogue with social constructionist concepts of the self. Finally, there will be an examination of some theoretical perspectives on the specific spaces of mental health care, drawing on work from Michel Foucault (1986a) and Gilles Deleuze (1992).

2.1.1 Geographical approaches to space and place

Approaches to understanding the nature of space and place are not uniform amongst geographers; the discipline contains as many debates about how space, the object of their study, can be understood, as psychology offers approaches to understanding people. Indeed many of the same issues that divide psychologists along quantitative/qualitative; objective/subjective lines are also present in geographical debates. In geography, the key division that exists is perhaps between physical and human geographers. Hubbard, Kitchin and Valentine (2004) comment that: "physical geography has been relatively untroubled by theoretical debates about the nature of space and place", compared to a more theoretical approach taken in human geography; this difference can be compared to the ontological

silence often attributed to mainstream psychology (Harré, Smith & Van Langenhove, 1995). The litany of theoretical approaches which have been incorporated into human geography will be familiar to social psychologists, as they include post-structuralism (e.g., Gregson & Rose, 2000; Murdoch, 2006; Rose, 1999; cf: e.g., Edwards, 1997; Gergen, 1991; Potter & Wetherell, 1987; Parker, 1992), phenomenology (e.g., Davidson, 2001; cf: e.g., Burr, 1999; Del Busso, 2009; Langdridge, 2007) and actor-network theory (e.g., Bingham, 2000; Murdoch, 1998), as well as echoing contemporary social psychological concerns with embodiment (Teather, 1999; Hall, 2005 cf: e.g., Burkitt, 1999; Cromby & Nightingale, 1999; Gilles et al., 2004; 2005), culture (Crang, 1998; cf: e.g., Squire, 2000), emotion (e.g., Davidson, Bondi & Smith, 2005; cf: e.g., Greco & Stenner, 2008), and affect (e.g., Thrift, 2004; 2008; cf: e.g., Brown & Stenner, 2001; 2009). In addition, human geography has engaged, arguably more completely than social psychology, with political and economic theory, particularly Marxism (e.g., Harvey, 1996; 2001; 2009; Massey, 1984) and questions of globalisation (e.g., Amin, 2002; Brah, Hickman & Mac, 1999). This wide ranging engagement with critical, social and political theory has produced, broadly, a view of space which posits that:

> social, economic and political phenomena are the product of spatial-temporal locality, and that the articulation of inter-relations brings space into being. (Hubbard, Kitchin & Valentine, 2004, p. 2)

Space, or 'spatial-temporal locality' is hence seen as playing a central role in the production of all kinds of social and cultural phenomena, and the process by which space is produced is viewed as both relative and relational. As Massey (1994a; 1999) argues, this is contrasted to a view common in physical geography (and in most

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accounts of space outside the discipline of geography) positing space as 'absolute', a static landscape able to be objectively, definitively mapped. (Again, this debate hence bears some similarity to divisions within psychology over whether psychological phenomenon can be understood as objectively measured, universal phenomenon (e.g., Henriques, Hollway, Urwin, Venn & Walkerdine, 1984; Venn, 1984). Human geographers have been highly critical of a static, cartographical view of space, and offer instead a complex, relational and dynamic view of space which will here be explored.

2.1.2   Space as socially produced and socially productive

A key theorist in the development of the contemporary human geographical perspective has been the Marxist philosopher, Henri Lefebvre. Lefebvre's (1991) major argument was that space was socially produced; defined by relationships. In his major work 'The Production of Space' (1991), Lefebvre acknowledged that: "To speak of 'producing space' sounds bizarre, so great is the sway still held by the idea that empty space is prior to whatever ends up filling it" (p. 15). Lefebvre was hence one of the first theorists to problematise the conception of space argued by Massey (1999) to prevail in physical geography: space as an abstract, static *container* of objects and people, and hence of social processes. Lefebvre described such a view of space as "logico-mathematical space", differentiating this from the "practico-sensory realm of social space" (p. 15). The former, he argued, was an abstraction based on Euclidean geometry, and did not capture how spaces actually operated; a mathematical, objective approach was not able to describe the differences between spaces or understand how they came into being. The theorisation of space, as it

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appears in the world, Lefebvre argued, therefore required an understanding of space as a form of *practice*:

> Everyone knows what is meant when we speak of a 'room' in an apartment the 'corner' of the street, a 'marketplace', a shopping or cultural 'centre', a public 'place' and so on. These terms of everyday discourse serve to distinguish, but not to isolate, particular spaces, and in general to describe a social space. They correspond to a specific use of space, and hence to a spatial practice that they express and constitute. Their interrelationships are ordered in a specific way. (p. 16)

Lefebvre therefore argued that differences between spaces can be understood as differential "spatial practices", and hence are inherently active, productive, and social. The space of a 'marketplace', for instance, can be seen as emergent from the 'practice' of buying and selling, from the relationships between traders and consumers, as well as the traders' location in semi-permanent or permanent stalls; without this 'spatial practice', there would be no marketplace. The 'space' part of the marketplace is hence not seen as separate from the social and economic interactions that make up a market, does not in some way pre-exist the market, but is instead emergent from these very same interrelations.

As the eminent geographer Doreen Massey (1994a) traces, a similarly relational view of space, building on Lefebvre's work, was expounded from the 1970s onwards through the twin development of Marxist and feminist geography:

> the spatial scientists had posited an autonomous sphere of the spatial in which 'spatial relations' and 'spatial processes' produced spatial dimensions. [...] Countering this, the Marxist critique was that all these so-called spatial relations and spatial processes were actually social relations taking a particular geographical form. (p. 254)

The spatial forms of capitalism, it was therefore argued, had to be understood in terms of the social, economic and political processes which produced them; slums and factories were seen as produced, under this view, by capitalist economics. Any study of space, therefore, necessarily required the study of social and political context. Similarly, feminist geographers analysed the composition of urban space in terms of gender. McDowell (1983) for instance outlines the gendered nature of the capitalist division of urban space into a public, productive, male space allocated to the centre of cities, in contrast to a private, reproductive, female space located in the suburbs. Furthermore, McDowell argues that this division of space, allocating women to atomised domestic spaces, served to disempower women, through isolating women, from both each other (hence restricting their potential for collective action), and the public sphere. This second point highlights a second major argument of critical human geography, that space is not only *produced by* social relations (such as here, capitalism and patriarchy) but is also *productive of* social relations (Massey, 1994c; Lefebvre, 1991). The spatial form of urbanised capitalism, once in place, argues McDowell (1983) helped to perpetuate and embed gendered power inequalities.

2.1.3   Space and time to space-time

It is perhaps no co-incidence that the two fields of geography which led the way in proposing a relational and productive view of space were also explicitly political. A concern with the political implications of space perhaps leads more quickly to questioning a conception of space as 'absolute' and static, as it has been argued that such a view positions the spatial as apolitical (Massey, 1994a). In 'Politics and Space-

Time' (1994a), Massey argues that this view of space emerges from a binary construction of space as 'not-time'. While 'time' might be seen as the agent of change, a linear unfolding story of shifting relationships, Massey argues that space is often rendered as the opposite, the static material arrangement of such relations, a slice or snapshot of one particular point in the inexorable, ever-changing progress of time. The arrangement of things in space is hence seen as only an outcome of relationships of objects and people as they shift over time; time is the active agent, space its passive outcome. In this way, Massey argues that space has been depoliticised, that this conception neglects the role of space as an active agent in the creation of experience, events and history.

Massey further argues, as does Lefebvre (1991) that underpinning such a binary view is an adherence to a classic, Newtonian view of physics in which: "both space and time exist in their own right, as do objects. Space is a passive arena, the setting for objects and their interaction" (p. 261). The origin, or at least correlate, of this dualistic tendency can be clearly seen: space, and objects themselves, are seen as inert and passive until compelled into action by an external force. In contrast, Massey points out, post-Einsteinian physics conceptualises space and time very differently. In the Einsteinian universe, time and space are not stable but instead bend and shift: time, for instance, slows as the speed of light is reached, or as a black hole is approached. Under this new paradigm, space and time are not seen as absolutes, nor as absolutely separate, but instead as different attributes of a four dimensional reality: space-time. As Massey says:

> Space is not static, nor time spaceless. Of course spatiality and temporality are different from each other but neither can be conceptualised as the absence of the other. (p. 264)

Furthermore, this four-dimensional reality is seen as being emergent from relations between objects; time slows because of the speed at which an object is travelling or the density of the mass of a black hole. The application of this view of physics hence re-positions relationships, rather than things or objects, as ontologically primary. A dynamic rather than static view of space is also posited; if space is emergent from relationships, located in space-time, then it is also ever shifting along with those relationships that lie at the basis of its formation:

> Space is created out of the vast intricacies, the incredible complexities, of […] the networks of relations at every scale from local to global. What makes a particular view of these social relations specifically spatial is their simultaneity. It is a simultaneity, also, which has extension and configuration. But simultaneity is absolutely not stasis […] There is no choice between flow (time) and a flat surface of instantaneous relations (space). Space is not a 'flat' surface in that sense because the social relations which create it are themselves dynamic by their very nature. (p. 265)

Massey's deconstruction of the space/time binary hence repositions space as active, relational and dynamic, as the dimensional, simultaneous aspects of networks of relationships which are argued to constitute the world. This view, along with the theoretical work of Henri Lefebvre (1991), and wider work in Marxist (e.g., Harvey, 1996; 2001; 2009; Massey, 1984) and feminist (e.g., Bondi, 1990; 1993; Hanson & Pratt, 1995; McDowell, 1983) geography, has been highly influential in shaping contemporary human geographical approaches to space and place. Such work also

brings the human geographical project into close contact with social psychological concerns; particularly, as will be explored below, those approaches which posit relations and practice as central to the production of psychological experience (e.g., Burr, 2003; Henriques et al, 1984; Parker, 1992; Potter & Wetherell, 1987; Gergen, 1994). This synergy between the disciplines of human geography and social psychology will be drawn upon throughout this thesis, in an attempt to fuse the approach to space developed in geography with the highly similar approach to subjectivity developed in psychology.

2.1.4   Space and place

Finally, it is worth outlining the differences that are drawn between the two terms 'space' and 'place' which are often used almost interchangeably. As outlined in the previous sections, 'space' in itself is understood by human geographers, broadly, as a dimensional, located facet of networks of relationships. Space is hence seen as *one* aspect of the dynamic, temporal-spatial production of social and material phenomena. Geography is not only concerned with the abstract definition of space, however, but in the study of particular *places*, often understood as specific incidences of spatial practice:

> For many geographers, place thus represents a distinctive (and more-or-less bounded) type of space that is defined by (and constructed in terms of) the lived experiences of people. (Hubbard, Kitchin & Valentine, p. 5)

The definition of place is hence dependent on, and overlaps with, the definition of space outlined above. Places can be seen as particular, reasonably distinctive, occurrences of social-spatial-temporal practices posited to be more broadly involved

in the production of space; places are grounded and particular, space is the generic dimension. In keeping with the concept of space as fluid, multiple and relational, places too have been argued to consist of complex networks of local and global relationships; located but also porous (e.g., Massey, 1994b; Harvey, 1996; Thrift & Pile, 1995; Hall, 1995). Massey (1994b), for instance, provides an analysis of the north London suburb of Kilburn to illustrate this latter point, a north London suburb. She describes walking down Kilburn high street and encountering: pro-IRA grafitti; adverts for a commemorative event 'Ten Years After the Hunger Strike'; another advert for a Wembley Arena show featuring Bollywood superstars; a shop selling Saris. This place in north London, therefore, can be seen as in part produced by relations with the rest of the world, standing in diasporic relation with the origins of its immigrant communities. Kilburn can hence be seen as a highly particularised place, characterised by a unique set of relations, a specific juxtaposition of people, cultures and material settings, which make it different to other places. At the same time, however, she argues that these unique relations are in part produced and influenced by global links, especially the diasporic links of the residents across the world. Thus places can be seen as specific instances of spatial practice, but as still in part defined and produced by relations with other places and times.

2.2   Social constructionist psychology

As touched on above, the view of space outlined here, prevalent within human geography, shares many parallels with critical social psychological approaches to the production of subjectivity. Social constructionist psychology (e.g., Billig, 1987; Billig et al, 1988; Burman & Parker, 1993; Davies & Harré, 1990; Edwards, 1997; Gergen,

1994; Henriques et al, 1984; Middleton & Edwards, 1990; Parker, 1992; Potter & Wetherell, 1987; Walkerdine, 1985, 2002), for instance, has a similar emphasis on the social production of experience (rather than space), and often has an emphasis on social *practice* (Burr, 2003). Whilst diverse in emphases, and even epistemologies (see, Parker, 1997a), this field of psychological research can be seen as based around four major elements: allocating primacy to social processes, emphasising historical and cultural specificity, understanding knowledge and activity as intertwined, and taking a critical stance towards knowledge (Burr, 2003; Cromby & Nightingale, 1999). Those psychologists who come under the banner of social constructionism tend, therefore, to argue that: "the world we experience and the people we find ourselves to be are first and foremost the product of social processes" (Cromby & Nightingale, 1999, p. 4).

Placing networks of relations, and socio-material practices, as central to the production of space, can therefore be seen to have resonance with social constructionist approaches to subjectivity. Rather than being seen as relatively static, determined by individual differences in genes or personality, people are here conceived as constructed in an ongoing, changing way, by their social environment. Social constructionism hence tends to conceptualise social context as the primary site for the production of experience, and as such, offers a hefty body of work for a consideration of the interplay between the environment and psychological experiences.

Key to the social constructionist argument is that the primary, or indeed sole, medium through which this process is effected is language. Social constructionism

hence draws on post-structuralist theories of language, proposed by writers such as Derrida (1974), as well as being heavily influenced by the work of Michel Foucault (1965; 1970; 1973; 1976; 1977; 1986b; 1986c). Broadly, these arguments have been used to argue that: "language produces regimes of truth which regulate social practices" (Henriques et al, 1984, p. 280). It has, however, been widely argued that some social constructionist work, in focussing on the constructive power of language, has neglected non-discursive elements of experience, such as embodiment and materiality (Brown & Stenner, 2009; Burkitt, 1999; Bordo, 1998; Cromby & Nightingale, 1999; Csordas, 2004; Gillies, et al., 2004; 2005; Hook, 2001; 2007). As will here be explored through an examination of the work of one of the central figures used by social constructionist psychology, Michel Foucault (e.g., Fee, 2000; Parker, 1992; 1997b; 1999; Parker, Georgaca, Harper, McLaughlin & Stowell-Smith, 1996), this can be seen as a limited reading of post-structuralist ideas.

2.2.1   Michel Foucault: power, knowledge and discourse

Michel Foucault's (1965; 1970; 1973; 1976; 1977; 1986b; 1986c) work on the relationship between power, knowledge and discourse has been hugely influential in the development of social constructionist psychology (e.g., Henriques, et al., 1984; Malson, 1998; Parker, 1992; 1997b; 1999; Rapley, 2004; Wetherell, Taylor & Yates, 2001). As touched on in the previous chapter, key to Foucault's (1977) argument was his analysis of the shift in the nature of state power over the period following the Industrial Revolution and Enlightenment, around the end of the nineteenth century. As urbanised and capitalist forms of society replaced feudal structures, Foucault argued, the old forms of sovereign and religious power waned, to be

replaced by more diffuse forms of 'disciplinary' power. Responsibility for the conformity of the population shifted from powerful figures in the aristocracy and the church, located in each community, to be dispersed through wider structures in society such as the law, schools, army, and family life. New institutions of social discipline also emerged, such as the prison, the workhouse and the madhouse. This diffuse threat of punishment rendered each individual responsible for regulating their own behaviour in order to avoid the 'discipline' of prison or the censure of the family.

Inherent in these shifts in power relations and disciplinary structures, Foucault argued, was therefore the production of new discourses and forms of knowledge. Key amongst these, Foucault (1965) argued were the 'psy-disciplines', the new forms of psychiatric and later psychological knowledge which produced new ways of thinking about the person. In 'Changing the Subject', Venn (1984) describes the subject conceived within the 'psy-disciplines' is that of a unified, bounded and rational self, individuated from others and possessing an internally located personality, mind and set of memories that drives and determines behaviour. Venn points out that such a picture of the person is historically specific to the Modernist period identified by Foucault. Nikolas Rose (1989; 1998b) further argues that the individuated subject described by Psychology is necessary for the operation of disciplinary power: people have to understood as rational, bounded individuals in order to be held individually responsible for their actions, and hence subject to the operation of the law, the prison or the madhouse. The body of knowledge produced by the psy-disciplines, with its corresponding discourse of

individualism, can hence be seen as inherent to the operation of the forms of disciplinary power identified by Foucault. This is one example of Foucault's (1977) wider argument that bodies of knowledge are not neutral descriptions of the world but instead reflect, constitute and perpetuate power relationships within the societies that produce them:

> power produces knowledge (and not simply by encouraging it because it serves power or by applying it because it is useful)… power and knowledge directly imply one another… there is no power relation without the correlative constitution of a field of knowledge, nor any knowledge that does not presuppose and constitute at the same time power relations. (Foucault, 1977, p. 27)

Thus Foucault's argument was not just that people who have access to power also have the power to produce knowledge, but that power and knowledge are directly implicated, that they produce each other. When studying a field of knowledge, therefore, it becomes key to study not only the *content* of knowledge, whether for instance, psychiatric research is accurate, but also the *effects* of knowledge; how power relations are constituted through the presence and application of psychiatric knowledge.

In his writing on the establishment of professional psychiatry throughout the nineteenth century, for instance, Foucault (1965; 2006) analysed the effects of the development of psychiatric knowledge in constituting the growth of psychiatric power, consecrated and perpetuated through the institution of the asylum. In a lecture in 1973, published in the volume 'Psychiatric Power' (2006), he commented that: "The essential function of psychiatric power is to be an effective agent of

reality, a sort of intensifier of reality to madness" (p. 143). The relationship between psychiatric knowledge and those in distress, Foucault therefore argued, can be seen as that of the enforcement of one version of reality over another; medically sanctioned 'sanity' over 'madness'. The power of psychiatry, to incarcerate and enforce treatment, therefore can be seen as lying in psychiatric knowledge, in the claim of psychiatry to have specialised, privileged knowledge of both 'reality' and 'madness'. Here, one function of the institution of the asylum is argued to have been to impose this version of 'reality' over 'madness', through a mixture of discursive and material strategies. One particularly striking example of such strategies given by Foucault (2006) is his description of the case of M. Dupre, a patient in an early asylum, around 1830. M. Dupre is described as believing that Paris was, in fact, the town of Langres in disguise. After a walk around Paris itself failed to alter M. Dupre's assertion that the city was an imitation, the psychiatrist Leuret stated: "since he persists in his refusal, he is put in the bath and cold water is poured over his head. Then he agrees to anything one likes" (p. 157). As Foucault points out, the 'success' looked for in this situation is not one of a change in M. Dupre's *perception* of the world, as he still perceives Paris as being Langres, instead:

> what is asked of him – and this is how the statement of the truth becomes effective – is that he avow it […] so the statement of the truth has a performative character in the game of the cure. (p. 159)

The battle being fought here is one of versions of reality, or forms of knowledge, and the psychiatric version here definitively holds the power; disavowing that reality leads directly to punishment for M. Dupre. Psychiatry's power, therefore, Foucault argues, is intertwined with its claims to knowledge (specialised, medical knowledge

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about the 'true' nature of 'reality'). This observation has been highly influential in Psychology (and beyond), leading to critical analyses of the role of psychiatric power/knowledge in the construction of the concept of mental illness itself (particularly diagnoses), mental health services, and service user experience (e.g., Fee, 2000; Parker et al, 1996).

2.2.2 Foucault and the material

Foucault's work has hence generally been applied within Psychology as an underpinning for discursive work, arguing for the productive power of discourse (Brown & Stenner, 2009; Hook, 2001; 2007). It is argued in this thesis, however, that a purely discursive reading of Foucault excludes many of the key aspects of his work. In the above scenario, for instance, the material use of cold water, poured on M. Dupre's head in punishment, is inherent in the assertion of psychiatric 'reality'. Space is also a key part of both M. Dupre's 'delusion' (in that he believes the place of Paris to be in fact Langres), and his 'treatment', which initially takes the form of a walk through the city itself. Language, knowledge and power are important, of course, but to take these as the only elements present in the production of the experiences described seems to leave much of this incident left unexplained. Indeed, in an earlier lecture in the same series, Foucault gives an even more striking example of the central role of materiality in the development of psychiatric practice, in describing the treatment of King George III, who experienced episodes of (it is thought) porphyria (Malcaphine & Hunter, 1966) in the late eighteenth century.

The king was put under the care of Francis Willis, a lay doctor. His 'treatment' included being "consigned to an isolated place" in a room "whose tiled

floor and walls are covered in matting"; he is then told that "he is no longer sovereign, but must be obedient". The text quoted by Foucault, a description by the early psychiatrist Pinel, then relates an act of "madness" by the king where, on the entrance of his doctor, he smears Willis in excrement. Upon this act of rebellion, an accompanying servant grabs the king by his belt, forcibly strips and washes him before "looking at him haughtily" and leaving. Foucault characterises this episode as a "reverse coronation" (p. 20), where the king is subordinated, not only to his doctor, but also to the servants. He argues that this episode can be seen as an assertion of disciplinary power over sovereign power; early psychiatry here trumps the king. Foucault's argument, however, is not that this is a purely discursive practice, as his work has often been read (Brown & Stenner, 2009). Indeed he states:

> And it seems to me that the "matting", which surrounds him and plays [such a big] role both in the setting and the final scene, are important. The matting is both what isolates the king from the outside world, and, as well as preventing him from hearing and seeing the outside world, prevents him from communicating his orders to it; that is to say, all the essential functions of the monarchy are, in the strict sense, bracketed off by the matting. In place of the sceptre, crown and sword, which should make the universal power of the king reigning over his kingdom visible and perceptible to all the spectators, in place of these signs, there is no more than the "matting" which confines him and reduces him, there where he is… to his body. (p. 21)

Removed of all objects representative of his sovereignty, Foucault argues that the king responds with the only "weapons" left to him:

> The only force the king has left is his body reduced to his wild state, and the only weapons he has left are his bodily evacuations, which is precisely what he uses against his doctor. (p. 24)

Crucial to Foucault's argument, therefore, are that both the material context and the king's embodiment participate in the interplay between sovereign and disciplinary power, which he argues is being enacted in this scene. Materiality is argued to be central to the king's position and power; stripped of all material assets, he uses his only remaining object, himself, to resist the treatment laid upon him. Material processes are here described as a constituent part of the relationships, experiences and interactions depicted. As Steven Brown (2001), in his paper 'Psychology and the Art of Living' puts it:

> Discourse is not applied to a pre-formed world, like paint daubed across a canvas, but is rather one aspect of an active process of composition where discursive and non-discursive elements are arranged together. (p. 180)

In this example, the discursive and non-discursive elements of the encounter can indeed be seen as inextricably linked together; involved in the interplay between the king and his keepers, between sovereign and disciplinary power, are both discourse and materiality. Without being materially separated from those objects which can be seen to mediate his sovereign power, the "sceptre, crown and sword" (p. 24), it can be seen that the assertion of disciplinary, psychiatric power might well have been less successful. Brown's quote also encapsulates the approach to the relationship between discourse and materiality which will be taken in this thesis; as two parts of an ongoing mesh of material, social and discursive practices which both structure, and are used by, active agents in the 'composition' of their experience. In taking such a view, this thesis draws on a multiplicity of work in Psychology which has argued for a material, embodied approach to subjectivity, which will be explored in the following section.

2.2.3 Integrating discourse, materiality and embodiment

Over the past 15 years, an increasing body of work has emerged arguing for a more central role of materiality and embodiment than posited by discursive psychology. It has been argued (Burkitt, 1999; Bordo, 1998; Cromby, 2004b; 2007), for instance, that in ignoring embodied experiences, such as the compelling example above, and tending to see the body and materiality as only made real through discourse, social constructionist psychology is guilty of perpetuating Cartesian mind/body dualism. As John Cromby (2004b) comments: "emphasizing the discursive-social at the expense of the embodied-material conceals, rather than addresses, Cartesian dualism" (p. 799). Here, social constructionist psychology is not alone. Donn Welton's (1998) volume 'Bringing Body to Theory' examines different philosophical approaches to the body, including the prevalence and influence of Cartesian ideas. Under Descartes' scheme, the mind and body are conceived of as radically separate, hierarchical entities. An abstract, eternal mind is understood as being in ultimate control of a corporeal, mortal body. Drew Leder (1998) argues that these ideas pervade modern medicine, which conceives of the body as a dead and static object, as opposed to a lived in organism. Susan Bordo (1998) further characterises all academic disciplines as representing extremes of the Cartesian duality, with the interests of the humanities resting in only pure 'disembodied minds', whilst in studying only the physical and material aspects of life, the sciences have created 'mindless bodies'. The tendency in social constructionism to consider only the discursive construction of the body as important can be seen as perpetuating such dualisms; its purely linguistic view of the body ascribes all productive power to

discourse, and hence remains disembodied. Materiality is left to the sciences to dissect.

A second tendency in social constructionist work that has been identified as leading to the exclusion of the non-discursive is the adoption of relativist ontology. As most (although not all, see Parker, 1997a) social constructionist accounts eschew realism, a consideration of the corporeal body and embodied experience has been argued to be avoided due to a fear of invoking an essentialist, naïvely realist body (Bordo, 1998). Similarly, a consideration of material objects can be seen as invoking the idea that there is a stable, 'natural' reality 'out there' which exists beyond discourse (Latour, 1996). These arguments are antithetical to many social constructionist psychologists and theorists. For instance, the philosopher Susan Bordo (1998) describes her frustration at her attempts to raise the issue of the material body with her fellow philosophers in the 1990s, perhaps the height of social constructionist research:

> "You aren't *really* positing *are you*, a body that is unmediated, 'natural', outside of language and discourse, which is not open to a multiplicity of interpretative readings, *are you?"* [...] None of my explanations were able to sufficiently cleanse me of the taint of the retrograde notion of a 'material body'. (p. 88)

Similarly, the seminal social constructionist paper 'Death and Furniture' (Edwards, Ashmore and Potter, 1995) uses examples of materiality (furniture) and corporeality (death) to dismantle realist counter-arguments to a relativist position. They argue that such examples are used by realists to establish a 'line' beyond which constructionist arguments cannot reach, due to the innate 'realness' of material

objects, like furniture, or "rocks, trees and quarks" (p. 28). Their argument is based upon the absorption of these material objects into the discursive realm, in demonstrating the impossibility of escaping discourse:

> rocks are cultural too, in that they are thus categorised, included in the definition of the natural world, classified into sedimentary and igneous, divided into grains of sand, pieces of gravel, pebbles, stones, rocks, boulders, mountains, domesticated in parks and ornamental gardens, protected in wildernesses, cut, bought, used and displayed as 'precious stones', and include as a sub-category "girls' best friends". (p. 30)

The argument employed in 'Death and Furniture' is that as materiality can be seen to be constructed by discourse, that the meanings of material objects are historically and culturally specific rather than 'natural', therefore the discursive is the *only* site of their production. The discursive is held up as inescapable, as to ignore cultural and historical context would be to return to naïve realism. In some ways, this is difficult to argue with. After all, material objects are of course both culturally located and discursively constructed, as amply established by social constructionist work. This work, however, only really establishes that discourse plays a crucial role in constructing culturally specific meanings of material objects (and corporeal bodies); it does not necessarily follow that discourse is their only component.

Ian Burkitt (2003) outlines that a second approach to understanding materiality within social constructionist accounts has been to postulate a "dual-ontology" (p. 322), such as in the work of Rom Harré (1983; 1990; 1998). Burkitt (2003) states that while Harré was one of the early constructionist writers to propose that "social conversation was [...] the primary human reality", he

nevertheless kept to a "realist theory of science when it came to physical reality" (p. 321). The social and the material, hence, were seen as ontologically separate; "two intransigent, imperfectly knowable "realities"" (Harré, 1990, p. 352). As social beings, Harré proposes, we "are located in another world" (p. 352).

2.2.4 Finding a role for materiality

In both of these approaches to settling the question of materiality, social constructionism here seems to adhere to a general problem in the social sciences identified by the sociologist and social theorist Bruno Latour (1996; 2005). In his paper 'On Interobjectivity' (1996), Latour argues that the social sciences have generally avoided engaging with the meaning and role of objects in social life, due to the demarcation of objects and materiality as 'objective' phenomena properly investigated by the natural sciences, based on the assumption of a:

> significant break that separates the objective world from the political world, the exact from the human sciences, nature from culture. As a result of this break, objects cannot irrupt into the social world without denaturing it. And, symmetrically of course, society cannot invade the sciences without corrupting them. (p. 236)

This material/social dualism that pervades academic disciplines has, argues Latour lead to a tendency in the social sciences (he writes particularly about sociology, but the argument is more widely applicable) to simply erase materiality from social scientific accounts:

> Forgetting artifacts (in the sense of things) has meant the creation of that other artifact (in the sense of illusion): a society that has to be held in place with just the social. (p. 236)

Discursive psychology's dismissal of a productive role for materiality can be seen as guilty of just this tendency. Materiality is either gobbled up by discourse, as proposed by Edwards, Ashmore & Potter (1995), or assigned to a separate sphere, outside the purview of social and psychological life, as argued by Harré (1983; 1990). Latour (2005) argues instead that material objects are inherent to human interaction; that objects mediate and transform interactions and hence cannot be seen as either ontologically separate or only made meaningful through discourse. Objects, he instead argues, are 'non-human participants' in interaction; rather than being mere adjuncts to social life, they are part of what produces human experience:

> In addition to 'determining' and 'serving as a backdrop' for human action, things might authorise, allow, afford, encourage, permit, suggest, influence, block, render possible, forbid, and so on. (Latour, 2005, p. 72).

Latour here argues for an active role of objects in creating experiences, for objects to be seen (in a similar argument to Massey's (1994a) deconstruction of space/time) as 'actants' in interaction, rather than merely the passive recipients of human meaning.

Whilst Latour's (1996; 2005) approach to objects is one that has been highly influential in this project, a possible limitation of his argument here is that it can appear to: ''flatten out'' any would-be distinctions between human and non-human entities'' (Stenner, 2008, p. 92); there could be seen to be a lack of differentiation between the human and the material. Positioning materiality as central to the constitution of experience, as has been argued here, hence contains the danger of erasing all differences between humans and non-humans. Whilst this avoids the

problem of Harré's (1983; 1990) dual ontology, separating material and social processes, it nevertheless holds the danger of ending with the opposing, but equally problematic position, to Edwards, Ashmore and Potter's (1995) absorption of materiality into discourse; here, all the complexity of discourse and culture can be 'flattened out' into containing only one form of interaction, the same between objects and people. For this reason, one final insight into the role of materiality in experience which will be included here comes from the work of Michel Serres (1995), the French philosopher. Serres' work provides a possible route to understanding the particular role that objects might play in the production of experience, equally active, but still differentiated from humans.

Serres' arguments centre around the idea that objects used by people can be described as 'quasi-objects', as they are defined by "a luminous tracer of the social bond" (p. 87). He argues:

> Nowhere do I see the sacred without a sacred object, a war or an army without weapons [...] The object is here a quasi-object insofar as it remains a quasi-us. It is more a contract than a thing, it is more a matter of the horde than of the world. (p. 88)

This point can be seen to be a similar one to that made by Foucault (2006), above regarding the significance of the removal of all objects of power from George III's vicinity. These objects (the "scepter, crown and sword" (p. 21)) can be seen as 'quasi-objects', inbued with cultural history and meaning, imbricated with George III's status as king. Furthermore, Serres (1995) also points out that the difference in human and animal societies is in "the emergence of the object" (p. 87), positing that:

Our relationships, social bonds, would be airy as clouds were there only contracts between subjects. In fact the object, specific to the Homindae, slows down the time of our revolutions. For an unstable band of baboons [...] one could characterise their history as unbound, insanely so. The object, for us, makes our history slow. (p. 87)

The specific role objects are proposed to play in mediating relationships, is hence one of slowing down, of anchorage. Objects are here seen to play a central role in the production of experience, to be not just material, but imbued with social and cultural meaning, to be: "multiple in space and mobile in time, unstable and fluctuating like a flame, relational" (p. 90). Serres, therefore, argues that objects contain multiple meanings, developed through the shifting roles they are incorporated into within human culture. He proposes that the very materiality of objects means that the role that they play in producing experience is can be seen as differentiated from, but at the same time wholly integrated into, inseparable from social interaction. Like Latour (1996; 2005), his arguments can be seen as positing the social nature of objects, and the material nature of the social; a lack of a dichotomy between the two. Unlike Latour, however, Serres' (1995) account does not 'flatten out' the human and non-human, but proposes a stabilising, slowing down role for the material objects which humans incorporate into culture, interaction and experience.

Reavey & Brown (2009), in their analysis on the role of objects in memories of child sexual abuse, provide an application of Serres' ideas about objects. They argue that within the memories of abuse recounted by their participants, the objects described can be seen as "invoked to pose ambivalence around incidence and

intention and to subsequently stabilise it in some way' (p. 477). In recalling a door locked by her brother before an episode of abuse, for instance, one participant is argued by Reavey & Brown to 'stabilise' her ambivalence over the episode; whilst considering whether her brother intentionally hurt her, or was just 'curious', the deliberately locked door stands as a material participant in her internal debate:

> The intentions of the actor become translated and stabilised in relation to the door itself. The person who holds the key is the recognisable character who is in charge of the situation. Thus, we are able to say that the stability of the victim/perpetrator binary is produced through the participation of the objects (key, lock, door) that make up the setting. (p. 475)

Although Reavey and Brown are discussing memory, it is easy to see how these arguments could translate into broader studies of psychological experience, such as this one. The objects here described can be understood as preventing and stabilising actions; once the door is locked, escape from the abuse is less likely. The material layout hence limits the possibilities of action, decreases the agency of the victim in this scene.

To return to the geographical literature outlined at the beginning of the chapter, this idea can be seen as similar to an understanding of space as being productive of social relationships, for instance in Massey's (1994c) analysis of the continued existence of communities in post-industrial towns. The comparative stability of materiality, its role in slowing down social relations, can here be seen to be key: the continued presence of the material structures of the town can be seen as an anchoring presence, tying inhabitants to the area even after the activity which produced the spaces in question has desisted. Material objects are here not only

products of human activity, but also limitors and anchors on the range of possible actions available to people, as they engage in embodied, meaningful activity in the world. Hence the material and social can be seen as thoroughly intertwined, as Latour (2005) argues, but also still with particular, and differential roles to play in the composition of experience. It is this approach to the consideration of the specific role of the material which has been taken here; objects have been examined as they are used, interacted with, and help to promote, make salient, and stablise experiences and interactions.

2.2.4   Space and subjectivity: the art of living

As an ending to this section of the chapter, and before considering theoretical approaches to the specific spaces of mental health care, it is worth considering the implications of incorporating the material and discursive into a consideration of subjectivity, as well as into psychological theory and research. For this task, I have drawn on Brown & Stenner's (2009) approach to understanding subjectivity put forward in their book 'Psychology without Foundations'. Drawing on a range of theoretical resources, including Serres, Artaud and Deleuze, they broadly argue for a process-relational ontological approach to understanding subjectivity and experience. Process philosophy, including such writers as Alfred North Whitehead (1929: 1978) and Henri Bergson (1889: 1990), posits that all life and living beings consist of a set of inter-related, ongoing processes, understood as in a constant state of 'becoming' rather than a static state of 'being'. Key to this project, is that no primary ontological division is assumed between humans and objects, but instead humans are seen as more complex organisations of a multitude of ongoing

processes, the most complex of which can be seen to be conscious thought (Rescher, 1997; Stenner, 2007; 2008; Whitehead, 1978). A process approach can be seen to underlie much of the literature outlined above: in seeing space as relational and dynamic (or process, rather than stasis) (Massey, 1994c; Lefebvre, 1991); in understanding objects and humans as participating in mutual processes of interaction, rather than being separate (Latour, 2005). In addition to outlining this ontological position, Brown & Stenner (2009) also suggest a particular approach to subjectivity, drawing on this position of viewing life as a creative, interwoven set of material, social and personal processes. In particular, they use a concept from Foucault's later (1986c) work, the 'art of living' (see also, Brown, 2001; Bendien, Brown & Reavey, 2011).

Brown & Stenner (2009) argue that a key issue with much of critical psychology is that it "has no concept of life" (p. 176). They argue that in the critical turn from the idea of the bounded subject (e.g., Henriques et al, 1984), critical (especially discursive) psychology lost an impetus to investigate: "the creative, dynamic evolution of the modes of existence which make up personal and collective lives together" (p. 176), instead emphasising the ways in which people are subjectifed by discourse. Brown & Stenner (2009) instead argue that Foucault's (1986c) later work, marks a shift to a different way of thinking about subjectivity, through his work on the 'technologies of the self'. In this later work, they outline, Foucault shifts from an idea of subjectivity "as something 'implanted' or 'inscribed' on the body" (Brown & Stenner, 2009, p. 172), to looking at the ongoing practices, including the 'care of the self' (Foucault, 1986c), through which a person builds a

relation with themselves throughout life. These practices could include a variety of ways in which people help produce their particularised subjectivity, or experience of themselves, such as: exercising their bodies; thinking about themselves as an individual; reflecting on their emotions and experiences; identifying (or being identified) as a member of a category (for instance, as: man or woman; service user; parent; teacher; manager; doctor; friend; activist; gay person); communicating feelings and thoughts with others; working in a particular profession; or developing a particular field of knowledge (for instance, medicine; psychology). Such practices are still seen as culturally and historically specific, and hence infused with specific forms of power/knowledge, but here, the focus shifts from how subjects are structured by discourse, to understand the self as: "the shifting form which both contains our sense of self and continuously interacts with and is marked by the forces which sustain living" (p. 172). As outlined in the above section, these 'forces' are here argued to include embodied experiences, material contexts and objects, as well as discourse. As Steven Brown (2001) has argued elsewhere, this can be see to draw attention to how selves actively formulate, or 'stylise' (Brown, 2001), their subjectivity. Under such a view, the self can be seen as:

> a form, a pattern, a type of ongoing relationship that a persona has with herself or himself that is continuously varying – 'not primarily or always identical to itself'. What is more, this form is not singular. It is, Foucault states, variable across the setting where it is seen to matter (e.g. voting, fulfilling one's desires). If it is possible to speak of a subject at all then it must be done with reference to the 'various forms' subjectivity takes and the multiplicity of relationships and connections that pertain to these forms. (p. 168)

To return, again, to the example of George III discussed above, the incident described by Foucault (2006) can be understood as an example of the dismantling of a 'style' or form of life, through the removal of the king's usual 'technologies' of the self; his usual status has been reduced through the ways in which the servants behave towards him (looking 'hauntily'), and the removal of the 'quasi-objects' (Serres, 1995) of sovereignty. The king's 'self', as a powerful sovereign, can be seen as having been distributed through these relationships and objects, as having been composed through an ongoing process of engagement with the world. Yet once the king's self is stripped of its usual mediating factors, its objects of power and relations of respect, he is nevertheless described as using the "only weapons left to him" (Foucault, 2006, p. 21), his bodily evacuations, to re-assert power, to re-make himself within this new setting. Such a view of the self therefore contextual, mediated and distributed through both the material and discursive context, and yet also actively composed, within and through, such settings. Such an approach to the question of the relationship between space and subjectivity thus incorporates a constitutive role for objects and materiality in experience (as argued by Massey, 1994c; Lefebvre, 1991; Latour, 2005; and Serres, 1995), whilst avoiding any potential question of environmental determinacy. It opens up the question of how spaces are lived and experienced, as well as constructed and composed. For this project, therefore, this perspective on the relationship between space, experience and subjectivity will be taken; incorporating the concept of space as a dynamic collection of relations, providing part of the complex 'technologies' and settings for the active construction of subjectivity.

2.3 Theorising mental health care spaces

Following this consideration of the general role of materiality and space in experience and subjectivity, this chapter will now consider some theoretical concepts which will be used to explain and explore the particular role of space in experiences of distress. As outlined in the opening chapter to this thesis, distress, and service use, are now generally negotiated across myriad community and service use sites, in comparison to the large, fixed sites of the asylum system. This section will hence examine how a concept first explicated by Foucault (1986a) in relation to the asylum, the heterotopia, can be understood relevant to a contemporary, distributed system of mental health care. To first consider how the contemporary mental health care system could be understood theoretically, the work of Gilles Deleuze (1992) on the 'control society' will be examined.

2.3.1 Societies of control

Deleuze (1992) argued that Foucault's (1977) analysis of a disciplinary society, whilst powerful as a historical analysis, did not capture the relationship between space, power and subjectivity in more contemporary society. Deleuze (1992) argued that Foucault's analysis of disciplinary power was located in a series of 'enclosures':

> The individual never ceases passing from one closed environment to another, each having its own laws: first the family; then the school ("you are no longer in your family"); then the barracks ("you are no longer at school"); then the factory; from time to time the hospital; possibly the prison, the pre-eminent instance of the enclosed environment. (Deleuze, 1992, p. 3)

It is these enclosures the workings of which Foucault explicates in both Madness and Society (1965) and Discipline and Punish (1977); a key part of this argument was that

such institutions, including the asylum, were part of the establishment of disciplinary power as a replacement of sovereign power; this shift can be seen as exemplified in the treatment of King George III, explored above. Deleuze (1992), therefore, points out that the disciplinary society should be understood as transitory, and located in a particular time period (broadly, the industrial revolution to the mid-twentieth century), in the same way that the "societies of sovereignty" (p. 3) were not permanent:

> But in their turn the disciplines underwent a crisis to the benefit of new forces that were gradually instituted and which accelerated after World War II: a disciplinary society was what we already no longer were, what we had ceased to be. We are in a generalized crisis in relation to all the environments of enclosure--prison, hospital, factory, school, family. […] the *societies of control*, […] are in the process of replacing disciplinary societies. (Deleuze, 1992, p. 3)

In place of time limited, sequestered, located, sites of discipline ('enclosures'), such as the prison, asylum and school, Deleuze (1992) argued that control societies are instead characterised by dissipated, continuous mechanisms of control, not limited to particular sites or periods of time. His evidence for such a change was in shifting practices within these institutions, or more broadly 'systems', themselves:

> In the *prison system*: the attempt to find penalties of "substitution," at least for petty crimes, and the use of electronic collars that force the convicted person to stay at home during certain hours. For the *school system*: continuous forms of control, and the effect on the school of perpetual training […] For the *hospital system*: the new medicine "without doctor or patient" that singles out potential sick people and subjects at risk […] In

the *corporate system*: new ways of handling money, profits, and humans that no longer pass through the old factory form. (Deleuze, 1992, p. 4)

Forms of institutional discipline, whether the prison, school, factory, or most crucially for this thesis, the asylum, are hence argued to have morphed into ongoing forms of control, which are not necessarily site or time specific. Education can hence be seen to have been extended from 'the school' into an ongoing process of 'lifelong learning' enacted across many sites and fashioned as an individual responsibility for constant re-skilling and improvement (Tuschling & Engemann, 2006; Olsson & Petersson, 2008). Similarly, changes in the criminal justice system can be seen to have witnessed a move out from 'the prison' to include practices such as electronic tagging (Jones, 2000), and anti-social behaviour orders (ASBOs), which limit movement in community spaces (for instance, in banning people from entering particular places, or from associating with particular people, with breach carrying the threat of prison) without physical enclosure, and do not have a fixed end point (Flint & Nixon, 2006). These changes can be seen to reflect the similar shift in mental health care, described in the previous chapter, as psychiatry has moved from a location in 'the asylum' to a distributed system of community mental health care across multiple sites (Rose, 1998a); this extension is also argued to have included the extension of the psychiatric gaze into home space, through, for instance, the compulsion of medication regimes in the community (Tucker, 2006). Deleuze (1992) further proposes that these newer forms of practice regulate subjects in a changed way to the disciplinary enclosures:

> Enclosures are *molds*, distinct castings, but controls are a *modulation*, like a self deforming cast that will continuously change from one moment to the other, or like a sieve whose mesh will transmute from point to point. (p. 4)

The kind of 'modulation' talked about here can be seen in the practices detailed above; rather than 'molded', sequestered away in the prison to be disciplined and then returned to the community once made 'docile' (Foucault, 1977), practices like the anti-social behaviour order can be seen be seen to act as a modulation on everyday movement and action, containing the threat of incarceration, but aiming to modulate the risk of criminal behaviour in the first place (Donoghue, 2008).[1] Wise (2002) similarly contends that the move from a 'production' to 'consuming' model of (Western) capitalism (characterised by Deleuze (1992) as a shift from the 'factory' to the 'corporation') has acted, through branding and marketing, to modulate desire and subjectivity, arguing that:

> In that [disciplinary] regime, the subject was defined and generated by institutions (one was spoken by the family, by school, by the factory) which at least provided the subject with a means of protection (at home, you are not subject to the discipline of school). With the crisis of institutions that is characteristic of the society of control, subjectivity is still formed by institutions, but now these institutions follow you everywhere. It is not a different subjectivity, but an intensified subjectivity. (Wise, 2002, p. 40)

A good example of this blurring of boundaries between institutions, and indeed "intensified subjectivity" (p. 40) can be seen in Jessica Ringrose's (2011) work on

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[1] It seems this attempt at modulation has not been entirely successful; ASBOs have fallen out of favour (May, 2010), partly due to the high levels of breaches, totalling 56% of all orders between 1999 and 2009 (H.O., 2009). The point remains, however, that such an attempt can be seen as part of a wider phenomenon identified by Deleuze.

young people's use of social networking sites. Social networking (and therefore the gaze of the school peer group) was found to infiltrate both home and school, blurring the boundaries between the two. Still present in the home, through computer access, off-site social networking interactions were also found to be interpellated into on-site school relationships, through, for instance, bullying resulting from online conversations or pictures posted online. Young people's online negotiation of subjectivity was hence argued to mediate both school and home spaces (and selves) and yet be fully 'enclosed' in neither, in another example of an ongoing, non-site specific, 'modulation' of subjectivity.

The relevance of the concept of the control society for contemporary mental health services is striking; as touched on above, the move from a single site (asylum) to distributed sites of mental health care (ward, outpatient, home, public space), can be seen to follow the model of the 'prison system', 'hospital system' and 'factory system' identified by Deleuze (1992). Service users now live 'in the community', but are monitored, through various mechanisms, such as regular contact with professionals, and regular medication use (Rose, 1998a; Tucker, 2006; 2010a; 2010b). Nikolas Rose (1998a) has indeed argued that most of mental health professionals' time is now spent on the:

> assessment, prediction and the minimisation of risk to the community. The responsibilities of almost all psychiatric professionals have come to be redefined in terms of the assessment of risk. (p. 180)

A concern with risk can, to some extent, be seen to be embedded in the interface between the psychiatric profession and the law; one condition needed under the Mental Health Act (1983) and retained in its amended (2007) form, to forcibly

incarcerate, or 'section' a service user is that: "he ought to be so detained in the interests of his own health or safety or with a view to the protection of other persons" (Mental Health Act, 1983, Sec 2(b)).

As outlined in the first chapter, however, it has been argued that such a concern with risk and safety has significantly intensifed under the move to community care, where the boundaries of 'institution' and 'community' can be seen to have blurred (Quirk, Lelliot & Seale, 2006); it has been argued that such increases in public discourses of violence and safety (Moon, 2000; Phelan et al, 2000) has lead to "a growing pressure on psychiatrists to predict and minimise risk" (R.C.P., 2008, see also, Holmes & Warelow, 2007). This tendency can be seen in policy documents (D.O.H., 2007a; 2007b; Harper, 2004), emphasising the: "principle of empowerment through managing choice and risk" (D.O.H., 2007b, p. 3) and the centrality of risk to psychiatric practise more generally. Contemporary mental health care, therefore, can be seen to bear many of the features of the 'society of control': distributed centres of mental health care through institutional and community spaces (Rose, 1998a; Spandler, 2007), and dominated by a concern for surveillance and the ongoing management of risk (Rose, 1998a), rather than the site-specific 'molding' of service users in the 'enclosure' of the asylum.

What is, however, perhaps missing from this picture, crucially for this project, are the sites and spaces in which control practices and risk assessments are located. There is perhaps a danger, in following the argument that control is not site or time specific, in forgetting that it still is enacted and experienced through specific spaces and at particular times; the interactions and experiences which make up

'community care' are similarly still located in concrete sites, such as particular homes, community buildings, cafes and pubs, even if these sites are more distributed and numerous than the asylum (Symonds, 1998). What is clear from the arguments put forward above, however, is that, to understand the spaces of contemporary mental health care will require a complex picture of how such disparate spaces might relate to one another: be part of the same system, and yet differentiated; be potentially sites of psychiatric modulation, and yet also a part of everyday life. In addition, it needs to be considered how such spaces might play a role in the modulation of the subjectivity of service users. A good candidate for this role, it will be argued here, is Foucault's (1986a) concept of the heterotopia. Whilst this concept was raised by Foucault in relation to the asylum, it will be argued here that it has potential to be extended to help consider the role of space in a contemporary, distributed, form of mental health care.

2.3.2   Heterotopias

This issue, of a potential lack of the consideration of particular sites of mental health care under a distributed community system, has indeed been highlighted by the sociologist Anthea Symonds (1998). In her edited book 'The Social Construction of Community Care', Symonds argued that "community as a site of care does not exist" (p.3), and any attempt to define of the location of community care will lead to a description of: "a hospital, a private home, an institution, a clinic, a community centre, but the phrase 'community' will be revealed as an empty and non-existent site" (p. 3).

Symonds argues that this picture of a placeless 'community care' relies upon an idealised discourse of community, which is "always warm, supportive and secure" (p. 12). She argues that this warm, fuzzy vision of community life is nostalgic and illusory, built on an idealised version of past working class experiences which, she argues, were emergent from the conditions of poverty; those living close together, with few resources to rely on, and no welfare state for protection were forced into a 'mutuality of the oppressed' (Dennis, 1968; cited in Symonds, 1998). The picture of community conjured, through sepia-tinted glasses, by such discourses does not, she argues, represent or reflect lived experience where: "we recognise that conflicts exist, that the neighbours and social networks are not always supportive or friendly" (p. 12). It can hence be argued that kind of 'community' evoked through the discourses of community care can be seen to be utopian. As the geographer Kevin Hetherington (1997) outlines, the word 'utopia' was formed by Thomas More from two Greek words: "*eu-topia* meaning good place and *ou-topia* meaning no-place or nowhere. His Utopia was a good place that existed nowhere, except in the imagination" (p. viii). Symonds' (1998) description of the 'community' assumed in discourses of community care can be seen to fulfil both of these criteria, it is evoked as a good, warm, caring place, and yet it has no particular, fixed location.

It is here that Foucault's (1986a) concept of the heterotopia (translated as 'other' spaces) can be seen as particularly relevant. In a lecture given to a group of architects in 1967, Foucault (1986a) argued that whilst "Utopias are sites with no real place" which "present society itself in a perfected form or else society turned upside down" (p. 24), heterotopias can be seen as analogous spaces which do

actually exist, but: "which are something like counter-sites … in which the real sites, all the other real sites that can be found within the culture, are simultaneously represented, contested, and inverted" (p. 24).

The concept of heterotopia has been widely applied, in geography (e.g., Hetherington, 1997; 2011; Johnson, 2006; Lees, 1997; Lord, 2006; Lou, 2007; Soja, 1996), urban studies (De Cauter & Daheune, 2008), architecture (Chaplin, 2000; McCleod, 1996; Urbach, 1998), and indeed, psychology (Hook, 2001; 2007; Hook & Vrdoljak, 2002); it has also been applied specifically to hospital spaces (Street & Coleman, 2012; White, Hillman & Latimer, 2012). The geographer Kevin Hetherington (1997) has interpreted this concept as meaning: "Places of Otherness, sites constituted in relation to other sites by their difference.. [which] organize a bit of the social world in a way different to that which surrounds them" (p. viii). Heterotopia, therefore, can be understood as spaces, located within a society, which are ordered differently (in terms of both their time and space) to their surrounding spaces, and yet still are held in relation to these other spaces. Contemporary mental health service sites have indeed been argued to be 'ordered differently' to those spaces around them; Hester Parr's (1997) analysis of mental health day centres in Nottingham, for instance, argued that expressions of distress were received differently on the street than in the day centre, inviting less notice and censure in the mental health service site. Such sites, therefore, can here be understood as 'ordered differently' to everyday community spaces, which have been argued to be 'purified' (Sibley, 1995) of expressions of distress (Estroff, 1981; Knowles, 2000a; McGrath, Reavey & Brown, 2008).

Foucault (1986a) gave a number of seemingly disparate spaces as examples of heterotopia, including cemeteries, prisons, museums, ships, brothels, and gardens. All of these spaces can be seen as differentiated and boundaried, and yet as encapsulating and reflecting back the social practices of the societies in which they are located. This relationship, of both difference and reflection, was explored by Foucault through the metaphor of the mirror:

> the mirror is after all, a utopia, since it is a placeless place. In the mirror, I see myself there where I am not, a sort of shadow that gives my own visibility to myself […] But it is also a heterotopia in so far as the mirror does exist in reality, where it exerts a sort of counteraction on the position that I occupy […] The mirror functions as a heterotopia in this respect: it makes this place that I occupy at the moment when I look at myself in the glass at once absolutely real, connected with all the space that surrounds it, and absolutely unreal, since in order to be perceived it has to pass through this virtual point which is over there. (p. 24)

A heterotopia, then, can be seen as a place which both reflects and disrupts a vision, or version, of society, as a place which can be seen as: "reflecting mainstream society's selfness through its otherness" (Saldanha, 2008, p. 2085). In the example given above, the relative ability to express visible distress in a mental health service centre (Parr, 1997; 2008) can be seen as highlighting, through its difference, the invisibility of distress in public spaces, their relative 'purification' (Sibley, 1995). The 'difference' of the day centre can hence be seen to also make visible the necessity of performing a rational, productive self in mainstream space (McGrath et al, 2008; Rose, 1999; Sibley, 1995; Parr, 1997; Walker & Fincham, 2011). In this way, the kind of sites described by Parr (1997), the still present, concrete sites of mental health

care, can be seen to encapsulate and reflect the production of mainstream spaces and subjectivities.

Kevin Hetherington (2011) further explores the relationship between heterotopia and subjectivity in his paper 'Foucault, the museum and the diagram'. Hetherington draws on three further pieces of Foucault's writing, the first of which tackles heterotopia directly, and second two more obliquely. In the preface to 'The Order of Things', for instance, Foucault (1970) discusses heterotopia in linguistic, rather than spatial, terms. He cites as an example an extract from an essay written in 1942 by the Argentinian writer Jorge Luis Borges: '*The analytical language of John Wilkins'*. In this essay, Borges presents a 'Chinese encyclopaedia', which lists classifications of animals such as: "(a) belonging to the Emperor, (b) embalmed, (c) tame, (d) suckling pigs, (e) sirens, (f) fabulous, (g) stray dogs, (h) included in the present classification" (Borges, 1942; cited in Foucault, 1970, p. xv). Foucault argues that this classification system can be understood as a heterotopia of language; just as the space of asylum can be seen to expose disciplinary practices present throughout society, so Borges' classification system, nonsensical as it appears, highlights to the reader the arbitrary nature of classification systems:

> *Heterotopias* are disturbing, probably because they secretly undermine language, because they make it impossible to name this and that, because they shatter or tangle common names, because they destroy syntax in advance, and not only the syntax with which we construct sentences but also that less apparent syntax which causes words and things (next to and also opposite one another) to 'hold together'. This is why utopias permit fables and discourse: they run with the very grain of language and are part of the fundamental dimension of the *fabula*; heterotopias (such as those to be

found so often in Borges) dessicate speech, stop words in their tracks, contest the very possibility of grammar at its source; they dissolve our myths and sterilize the lyricism of our sentences. (Foucault, 1970, p. xviii)

Hetherington (2011) considers this passage in combination with Foucault's (1987) later writing, including an essay about the the writer Maurice Blanchot, which includes a discussion of the 'outside of thought':

His aim in that text was to critique the idea that imaginative thought emerges from the interior subject and located it, instead, within the outside as an emergence of discourse that then acts back on the subject constituting the latter as a subject of the discourse of power. (Hetherington, 2011, p. 7)

This, of course, encapsulates one of the key arguments of poststructuralism, that thought, language and subjectivity are negotiated through publicly available discourses, rather than produced in bounded individual minds (e.g., Billig et al, 1988; Derrida, 1974; Edwards, 1997; Henriques et al, 1984; Potter & Wetherell, 1987). As such it could be seen to run counter to the aims of this thesis, to investigate the role of the material, as well as the discursive, in the production of experience. Hetherington goes on to argue, however, that the role Foucault can be seen to be ascribing to heterotopia, within language, is that of a kind of 'otherness', such as in Borges' encyclopaedia, which exposes, or highlights, the exteriority of discourse. The "disturbing" experience of reading Borges' seemingly arbitrary classification system is argued to *make visible* the workings of classification, which in itself, as Foucault (1965; 1970; 1977) argued at length elsewhere can be seen as a product of power/knowledge. Spatial, rather than linguistic, heterotopia, Hetherington argues, can be seen as similarly making visible, through a differential ordering of space

(rather than language), the workings of subjectification and power. To take one of Foucault's (1986a) examples of a 'heterotopia of deviance', the asylum, its particular spatial ordering, of containment, control and separation, can be seen as having laid bare the processes of disciplinary subjectification which, Foucault (1965; 1977) argued, were central to the production of Western subjectivity from the end of the eighteenth century. The imposition of such practices within these spaces can be seen as making apparent their operation in mainstream spaces; in addition, to the patient, it could be argued, that such space acted to highlight an external locus of subjectivity, through the various psychiatric practices which indicated, in Goffman's (1961) words, that "if he wants to be a person he will have to change" (p. 161). If, as Rose (1996; 1998a) argues, contemporary mental health services can be seen as being characterised by risk, the spaces in which mental health care takes place could similarly be seen to potentially make visible (through, for instance, heightened security and surveillance on still existant psychiatric wards (Bowers et al, 2005; Bowers et al, 2006; Bowers et al, 2009)) practices of a wider 'control society' (Deleuze, 1992). This final point will be explored as part of the analytical chapters later in the thesis, as this concept has not been specifically applied to contemporary mental health care.

2.4   Conclusions

This chapter has set out a variety of theoretical directions which can provide help in understanding the relationship between space, experience, and subjectivity. It is here argued that the human geographical approach, positing that space is emergent from dynamic, situated inter-relations (Lefebvre, 1991; Massey, 1994c), is relatively

easily married with social psychological approaches to the self which propose

relations and practice as similarly central (e.g. Henriques et al, 1984; Brown &

Stenner, 2009). Perhaps the most prevalent of such approaches in social psychology

is social constructionism (Billig, 1987; Billig et al, 1988; Burman & Parker, 1993;

Davies & Harré, 1990; Edwards, 1997; Gergen, 1994; Henriques et al, 1984;

Middleton & Edwards, 1990; Parker, 1992; Potter & Wetherell, 1987; Walkerdine,

1985, 2002). It is here argued, however, that as a counter to the social

constructionist positioning of language as ontologically primary (Brown & Stenner,

2009; Burkitt, 1999; Burr, 1999; Cromby & Nightingale, 1999), a broader reading of

Foucault's work incorporating materiality (e.g., Foucault, 2006) and the 'art of life'

(Brown & Stenner, 2009; Foucault, 1986a) can provide a more integrative

framework for considering the ways in which space, experience and subjectivity

interpellate. Further, to consider the specific role that materiality might play in the

production of situated, actively constructed, experience and subjectivity, and to

avoid 'flattening out' (Stenner, 2008) the human and the material, the work of

Serres (1995) and Latour (1996; 2005) has been here argued to provide a picture of

how objects might 'participate' (Latour, 2005) in experiences by 'slowing down' or

'stablising' (Serres, 1995; Reavey & Brown, 2009) interactions and experiences. The

picture built up here, therefore, can be seen as one of space as produced by a

complex web of ongoing material, social and discursive relations and forms of

practice (e.g. Massey, 1994; Lefebvre, 1991), which in turn can be seen to form part

of the production of experiences (Foucault, 2006; Latour, 2005; Serres, 1995) and

the active composition of subjectivity (Brown & Stenner, 2009). It is with this

approach in mind, that this chapter has also considered of theoretical issues potenitally involved in the specifical production of mental health service sites have been considered, drawing on further work by Foucault (1986a), as well as Deleuze (1992). The following empirical chapters of this thesis will hence explore the specific experiences of service users in mental health services, and living in the community, with such a view of the role of space in mind.

Chapter Three

Methodology

This chapter will explore the major methodological and analytical concerns of this project, following on from the empirical and theoretical parameters that have so far been established. This will include a discussion of ethical and reflexive issues arising from the conduct of this research. The first section of the chapter will outline the general focus of the research and the research questions which guided the development and conduct of the project. Subsequent sections of the chapter divide into two main areas. The first of these is 'Researching service user experiences', which will introduce some of the philosophical aims of the project as well as detailing data collection methods and procedures. This will start with a consideration of the significance of attending to service user voices in mental health research, before detailing the two forms of data that were collected: published first person narratives of distress and 'spatial interviews'. These two data collection methods will be justified and accompanying ethical, procedural and reflexive issues explored. The final section, 'Analysing materiality', focuses on the analytical concerns and processes of the research. Thematic analysis was used to analyse the whole data set, and so ontological and epistemological parameters will be established for the analysis. In addition the particular strategies and procedures used when analysing the data will be detailed.

3.1   Service user voices

> As for a common language there is no such thing; or rather, there is no
> such thing any longer; the constitution of madness as a mental illness,
> at the end of the eighteenth century, affords the evidence of a broken
> dialogue, posits the separation as already effected, and thrusts into
> oblivion all those stammered, imperfect words without fixed syntax in
> which the exchange between reason and madness was made. The
> language of psychiatry, which is a monologue of reason about madness,
> has been established only on the basis of such a silence. (Foucault,
> 1965, p. xii).

As Foucault's famous quote eloquently encapsulates, questions of voice and power are long standing issues when considering service user experiences. Foucault characterises the establishment of a medical understanding of distress at the end of the eighteenth century as also constituting the beginning of a dominance of psychiatric explanations of distress at the expense of alternative voices, most particularly of those who were deemed 'mad' themselves. Where previously had been a 'dialogue' of explanations and accounts of distress between those who experienced 'madness' and those who did not, Foucault argues there stood only a 'monologue' of psychiatric discourse; psychiatry was correspondingly imbued with the power of explaining, defining and controlling 'madness'. The medical model, as numerous authors have discussed at length (e.g., Bentall, 2003; 2009; Cromby, Harper & Reavey, 2012; Johnstone, 1989; Read et al, 2004; Romme & Escher, 1993; 2000; 2011) confers a global irrationality on those who exhibit 'mad' experiences or behaviours such as hearing voices or unusual beliefs, hence, as Foucault argues, discrediting their accounts of experience.

The psychologist Gail Hornstein (2009) explores the history of attempts by service users to record, convey and publish their experiences within this context in her book 'Agnes' Jacket'. The jacket referred to in the title is that of Agnes Richter, an inmate in an Austrian asylum in the late nineteenth century who embroidered fragments of writing documenting her experiences into the inside of her standard issue uniform jacket. The attached label describes this jacket as a 'diary', but the resultant text is nearly impossible to read due to the density of the embroidery and its disjointed composition; only isolated phrases remain decipherable, with one reading, for instance, "today, I am a woman". Hornstein explores the rich symbolism of this jacket as encapsulating both the repression and resilience of service user accounts of distress. Transforming the depersonalised and institutionalised garment of confinement into a richly personal document of experience can be seen as a powerful subversion of the suppression of service user voices described by Foucault (1965). Yet, as Hornstein (2009) points out, interpretation of the jacket is difficult. The fragmentary and elusive nature of the text can be seen as an embodiment of the "stammered imperfect words without fixed syntax" (Foucault, 1965, p. vii) described above; it can be seen as symbolising the difficulties or dangers inherent in the communication of experiences of 'madness'. The positioning of Agnes' text on the inside of her jacket underlines the hidden, oblique nature of her account; it stands a powerful record of her experiences, yet is, perhaps, not meant for public consumption or interpretation. As Hornstein points out, until the 1950s, letters of inmates in asylums were routinely intercepted and read by staff members and

inmates were often banned from having pens and paper; remaining un-understandable may well have been Agnes' only route to expression in this context.

A consideration of service user accounts of distress, therefore, invokes a rich and potent history of both disempowerment and resilience. While underlining the power, or 'monologue', of psychiatric discourse, what also emerges is a hidden, or at least often ignored in academic circles, tradition of experiential publications of distress. The situation described by Foucault, and encapsulated by Agnes Richter's jacket, can be argued to have been ameliorated considerably over the past twenty years, as the service user movement has lead to a well documented increase in the involvement and visibility of service user voices within research, policy and service development (e.g., Campbell, 1996b; Curtis, Deller, Leslie & Watson, 2000; Deegan, 1988; Read & Reynolds, 1996; Rapley, Moncrieff & Dillon, 2011; Sweeney, Beresford, Faulkner, Nettle & Rose, 2009), although it has been questioned the extent to which this increased visibility extended to actual power to enact change within services (Beresford, 2002; Campbell, 2001). Testimony, and the promotion of personal experience as equitable to professional forms of knowledge have, however, been central to this movement (e.g., Dillon, 2010; Dillon & Longden, 2011; Romme et al, 2009). It is now required, for instance, that service users are involved in NHS research, development and service evaluation, and are represented on the boards of all mental health trusts (D. O. H., 1999). In addition, some service user led groups, such as the Hearing Voices Network, specifically privilege direct experience above professional qualifications (e.g., Dillon & Longden, 2011). The acknowledgement of 'experts by experience' at all levels of mental health care can be seen as denoting a

redressing, to some extent, of the 'monologue' of psychiatric discourse in contemporary mental health care, explicitly placing the credibility of first person experience on a par with professional knowledge (Beresford, 2010; Faulkner & Thomas, 2002; Rose, 2009). Also central to the development and promotion of the user movement have been the publication of first person accounts in anthologies (Curtis et al, 2000; Read & Reynolds, 1996; Romme et al, 2009). After historically being 'spoken about' by professionals, many within the service user movement have explicitly aimed to establish the multiple service user explanations of distress and experiences of treatment as legitimate, authoritative forms of knowledge (e.g., Sweeney et al, 2009; Romme et al, 2009).

3.1.1 Power: service user and professional knowledge

These issues, of voice and power, can also be seen to be of particular importance when researching mental distress due to the highly contested nature of the conceptualisation (Bracken & Thomas, 2001; Geekie & Read, 2009; Read et al, 2004; Rapley et al, 2011; Romme & Escher, 1993; 2000; Szasz, 1960), definition (Boyle, 1990; 2007; Bentall, 2003; Hammersley et al, 2008) and treatment (Bentall, 2009; Crossley, 2006; Healy, 2002; Johnstone, 1989; Stanstny & Lehmann, 2007; Mosher, 1999; Moncrieff, 2009; Walker, 2000) of mental health problems. Accounts of mental health vary from individualist medical explanations favoured by mainstream psychiatrists, to spiritual and transcendental explanations, for instance of hearing voices as the manifestation of spirits or demons (e.g., Leudar & Thomas, 2000; Romme & Escher, 1993; 2000; 2011; Romme et al, 2009). The particularly contested nature of mental distress, nevertheless, can perhaps be seen to partly stem from its

conceptual position both within and outside biomedical science. Distress is claimed

as a part of medicine in the West, and yet no definitive biological causes have been

found for mental health problems (Geekie & Read, 2009; Moncrieff, 2009; Szasz,

1960). This can be seen as leaving the biomedical account vulnerable to alternative

explanations, and also arguably more in need of defending against such

explanations. As discussed in the previous chapter, Foucault (1977) argued that

power and knowledge can be seen as intimately bound together:

> power and knowledge directly imply one another […] there is no power
> relation without the correlative constitution of a field of knowledge, nor any
> knowledge that does not presuppose and constitute at the same time power
> relations. (p. 27)

The assertion of a particular form of knowledge, or, here, explanation of mental

distress, therefore, can be seen as intertwined with an assertion of power. A claim

that distress is a medical problem, for instance, supports the need for a medical

solution, and hence supports the power of psychiatry. The prevalence of such claims

can be seen as a reflection of the relative power of psychiatrists within the mental

health system, and medical/scientific forms of knowledge more generally (e.g.,

Beresford, 2010; Parker et al, 1996; Smail, 2005; Szasz, 1994). In the same way,

promoting experiences of distress as equally authentic forms of knowledge also

makes a claim for equal power within the mental health system. When researching

mental health it is therefore essential to acknowledge and consider the relationships

between power, voice, and service user experience, especially in light of the

historical silencing of service user accounts and their lesser (though increasing)

power amongst competing accounts of mental distress (Foucault, 1965; Hornstein,

2009). These concerns infused the overall design of this project, which explicitly aimed to explore service user perspectives and experiences, as will be outlined below.

3.2   Research Design

This project was of qualitative design, utilising two forms of data collection, which were then analysed as one dataset. The succeeding analytical chapters are hence arranged thematically containing data from both sets. Both the overall design of the project, and the data collection methods used, were designed with attention paid to the concerns of voice, power and authorship outlined above. Firstly, qualitative research methods have long been used to address some of the issues in psychological research in just these areas. As has been widely argued, quantitative research, using the hypothetico-deductive method, places power to define the parameters of the research in the hands of the researcher (e.g., see Bannister, Burman, Parker, Taylor & Tindall, 1995; Smith, Harré & Langenhove, 1995; Willig, 2001). As mental health is such a contested area (Hornstein, 2009; Leudar & Thomas, 2000; Rapley, Moncrieff & Dillon, 2011; Read et al, 2004), such a methodology could be seen to have the potential to further reproduce professional/service user power differentials (Faulkner & Thomas, 2002). Qualitative methods instead tend to emphasise the centrality of participant understandings of the subject matter and are open ended and exploratory (e.g., Banister et al, 1995; Harding, 1987; Parker, 2004; Reavey, 2011; Smith et al, 1995; Willig, 2001), arguably leaving more room in the research process for alternative understandings of the subject matter to be explored.

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Secondly, the two data collection methods used both aimed to enable the exploration of service user accounts of space and distress. Firstly, this has been achieved by using already published first person accounts of distress, similar to the testimonies discussed above (Curtis et al, 2000; Read & Reynolds, 1996; Romme et al, 2009) but published as books in their own right. The second method of data collection was the use of participatory visual methods, or 'spatial interviews'. Participatory methods, which start with asking participants to produce accounts (either visual or verbal) of experience, have been argued to empower participants within the research process (Cornwall & Jewkes, 1995; Johnson & Mayoux, 1998; Mayoux & Chambers, 2005); as any interview is based around the participant generated material, this results in a more participant-led outcome than a traditional interview (e.g. Bolton, Pole & Mizen, 2001; Frith & Harcourt, 2007; Kindon, 2003; Knowles, 2000a; McIntyre, 2003; Reavey, 2011; Silver & Reavey, 2010, cf. Kvale, 2006). In these ways, it can be seen that these issues of voice, power and authorship have been central to the design of this project.

3.2.1 Research Questions

This project aimed to explore the spatial aspects of service users' experiences of community mental health care. The main research questions were:

- What role does space play in service users' experiences of community mental health care?
- What role does space play in the negotiation of distress and recovery in the community?
- How are the spaces of mental health care experienced, managed and negotiated by service users?

The aim of the research, therefore, was to explore the role of space in the active management of distress in the community. Methods were hence sought which would enable the exploration of service users' experiences.

3.3   First Person Narratives

The first data set analysed as part of this project was a selection of published first-person narratives of distress. These are defined as accounts of distress and/or experiences of mental health services written from the point of view of those who have experienced them. In the context of mental health discourse, which has historically silenced the point of view of the 'mad' (Hornstein, 2009), such accounts are hence a compelling resource for researchers interested in the experience of mental distress. As Hornstein (2009) details in 'Agnes' Jacket', over 700 first-person narratives of distress have been published in English, although she argues these are seldom explored in academic accounts of mental distress. The oldest of these narratives catalogued by Hornstein is from 1620 and they continued to be published throughout the asylum period with a sharp increase in number published over the past 20-30 years. The era of community care, and the modern service user movement has, in other words, witnessed an explosion in the publication of accounts of distress from the point of view of those who experience it, in line with the greater prevalence of service user voices, discussed above. As a body, these publications encompass a wide variety of experiences, including descriptions of living with different diagnoses and labels (e.g., Adams, 2003; Chisholm, 2002; Jayson, 1937), and of experiencing distress, care and recovery across a variety of situations and settings (e.g., Coyle, 1983; Crowley, 1995). By no means are all of

these publications critical of the mental health system or a medicalised approach to dealing with distress (e.g., Behrman, 2003) although others call for significant changes (e.g., Curtis et al, 2000).

The fact that the growing wealth of published narratives of distress are still largely ignored by academic researchers interested in exploring mental distress (Adame & Hornstein, 2006; Hornstein, 2009) can, however, be seen to underline a continued discrepancy in the assumed credibility of such accounts in academic circles (although this is not universal, see Crossley & Crossley, 2001). This is perhaps surprising as these publications offer a wealth of experiential data, and also their use in research can be seen to sit easily within well established aims of qualitative and participatory research. Firstly, they are detailed accounts of experience produced from the point of view of the service user, and in their own terms, a process which could be seen as fulfilling 'participant-led' principles of qualitative research (Banister et al, 1995; Denzin & Larkin, 1994; Harding, 1987; Letherby, 2003; Parker, 2004; Ratmazanoglu & Holland, 2002; Reavey, 2011; Smith et al, 1995; Willig, 2001). In addition, these accounts are produced outside of the research process, which could be understood as acting to reduce the power differential between the researcher and the researched, as personal dynamics and the potential morphing of accounts to suit the perceived aims of the research are removed from the research process. As detailed above, such issues of power and voice can be seen as particularly important in research with mental health service users (Knowles, 2000a; Sweeney et al, 2009; Rose, 2009), as well as other disempowered groups (Bolton et al, 2001). Such claims for the veracity of this data set for use in qualitative

research must however not be taken as a claim that these narratives are somehow more 'real' or 'authentic' than accounts generated in research. Although these accounts may have been produced outside of either an immediate research or medical context, they have still been produced for a particular purpose, publication, and the events portrayed are still of course open to multiple retellings and alternative accounts in different contexts.

The narrative psychologists Michelle and Nick Crossley (2001) offer a helpful reminder of the fact that first person accounts are still highly contextualised. They compared two anthologies of first person accounts, one produced in the 1950s, 'The Plea for the Silent' and one from the 1990s, 'Speaking Our Minds'. They argued that the accounts contained within the two anthologies differed in their focus, tone and structure in ways that reflected the broader context of the time. Accounts in the first anthology were anonymous, compiled by two psychiatrists, and tended to focus on individual experiences of mental health services. 'Speaking Our Minds', in contrast, was compiled by service users, the contributors were named and had biographies in the front of the volume, and far more often used a collective voice when discussing their experiences. Contributors invoked general social categories such as gender and race to explain their experiences (such as, "like most women I had learned to eat my anger", Read & Reynolds, 1996, p. 7) as well as locating their experiences within the wider survivor movement (such as, "in the past ten years or so we have been finding a voice" (p. 191). Crossley & Crossley argue that these changes reflect the different climates of the times, and different understandings of mental health and status of service users within the mental health system. In the 1950s, there was no survivor

movement (Campbell, 1996b) and so reference to a collective voice resisting the mental health system would have made little sense; hence the experiences described remain individualised. The invocation of race and gender categories, as well as the survivor categories itself, can also be seen as drawing on the identity politics of the 1990s and various 'rights' movements from the 1960s onwards, such as civil rights, gay pride and feminism. First person narratives, like any text, can therefore be seen as always reflecting and drawing on the context of the time in which they are written. Seeing these accounts as somehow 'more authentic' than accounts of distress given in interview or clinical contexts would hence be a mistake.

3.3.1   Descriptions of the narratives

The narratives selected for analysis were taken from Gail Hornstein's bibliography of published first person narratives of distress, available on her personal website: www.gailhornstein.com, and last updated in 2008. This bibliography lists 760 texts published by people with experiences of mental distress and mental health services. In keeping with the experiential focus of the research, those narratives which were primarily factual descriptions of experience were included for selection, rather than those which were either partially fictionalised or political polemic. As the focus of this research is on contemporary British community mental health care, only narratives published in the last ten years, and in the UK, were considered for analysis.

After applying these exclusion criteria, 42 narratives remained from the original list. I noticed that the vast majority (36) had been published by the same specialist mental health publisher, Chipmunka Publishing. This publishing house was

set up in 2002 by Jason Pegler, himself the author of a first person narrative of distress, 'A Can of Madness', also published in 2002. The volume of publications produced by Chipmunka significantly outstrips all other sources identified by Hornstein. When accessed in November 2010, Chipmunka listed 738 e-books as available to buy on its website, 147 of which were listed at being published in 2010 alone. According to the publication procedure set out on the website, books are initially published as e-books and then can later be published as paperbacks; 114 paperbacks are listed as published in 2010 out of a total of 488. These books are mainly written by service users themselves, and include both first person narratives and creative works. Other books are written by family members or professionals. For this project, seven works were selected, from those which were also listed on Hornstein's bibliography, and were narratives of experience rather than fictional or policy orientated works. From the remaining publications, I selected those which were close together in publication date (2007 & 2008, apart from one in 2005, the reason for which is explained below), in order to ensure a similarity of publication context. In addition, I selected publications so that the authors had a range of demographic characteristics, with a balanced gender split, and incorporating middle, working, and upper class narrators. Due to the middle class bias of my interview sample (discussed below), I included a majority of authors from a working class background. It would have been preferable to gain a better ethnic balance, but there was a shortage of narratives published by those from ethnic minorities, hence the reason for including one narrative ('It Happened to Me', with an earlier publication date of 2005). The narratives were:

1. **A Journey into Madness (A. J. I. M.).**

   Author: Alastair McIntyre.

   Published: 2007, Chipmunka Publishing.

   Alastair describes his experience of hearing voices and seeing visions then his subsequent admittance into psychiatric hospital. He does not provide much background information about his life, but states that his first experience of hearing voices was in 1994 on a journey from Bedford, where he had been working, back home to Edinburgh. He describes crossing the border into Scotland and starting to hear a number of voices swearing, which he takes to be spirits. He describes feeling very alert and becoming convinced he is under surveillance, as well as thinking that the radio and television are talking directly to him. He also begins to see lights fluttering and ascending into the sky, which the voices he can hear tell him are souls, as well as lights which surround people and then disappear, which he understands to be their spirit. He is admitted to hospital after going to ask psychiatrist a question about a psychology book he has been reading, and describes his confusion at being admitted. In hospital he meets Tracey, whom he later has a relationship with and moves in with. He describes the following years as including a further admission into hospital plus engagement in a day service when he is released.

2. **Black Magic (B. M.).**

   Author: Suzannah Knight.

   Published: 2007, Chipmunka Publishing.

   Suzannah is a white woman from an upper middle class, affluent family, and spent her early life in England and Holland before moving to Darlington. She was educated privately, including at boarding school. She was born in 1977 and the narrative covers her life up until 2003. The narrative describes her recurring, prolonged 'highs' during which she is convinced she can perform black magic, and becomes increasingly involved in interacting with various spirits and characters who become increasingly real to her, including various

soldiers, serpents, vampires, werewolves and most importantly to her – Piers, a 'James Bond' character whose commands she obeys. She also believes at times that she is a super agent, and the Russian princess Anastasia. These periods of 'high' are described as often being followed by an intense low period, often lasting several months. She also describes her problems with alcohol, including periods of very heavy drinking (all day, every day). Her first period of severe distress was also proceeded by a period of taking large amounts of amphetamines and smoking cannabis daily. Suzannah is hospitalised twice during the period covered by the narrative (1996- 2003), once after the birth of her child. She receives a diagnosis of schizo-affective disorder.

3. **Eyebrows and Other Fish (E. A. O. F.).**

   Author: Antony Scally.

   Published: 2007, Chipmunka Publishing.

   Antony is a white man from a working class background and has lived all his life in Manchester. The narrative covers a period from the early 1990s up until 2004. His narrative begins when he starts work in 1990, in an electronic parts distribution company, before which he describes his lifestyle as being a 'stoner', smoking large amounts of cannabis daily. The narrative details his increasingly all encompassing beliefs that he is being communicated to through advertising, that the different colours, signs and numbers appearing in his everyday life have significant meanings directed at him, and that his interactions with people are scripted and acted. He also discusses the sexual abuse he suffered in care between the ages of 13 and 16 as well as the violence of his father towards his mother. He describes a number of admissions to psychiatric hospital, the first after he catches public lice fuelling his suspicions that his girlfriend is being unfaithful to him. He also describes his involvement in the service user movement and appearances on television in this capacity. He is diagnosed with schizophrenia.

4. **I Thought I Was the King of Scotland (K. O. S.).**

   Author: Jimmy Gilmour.

   Published: 2008, Chipmunka Publishing.

   Jimmy is a white, working class man who was born in Scotland in 1961 before moving to England in 1963. The narrative covers his life from this time, detailing five breakdowns between 1995 and 2005. Jimmy describes his first breakdown as occurring after he is made redundant from his job as a miner. He describes starting to drink heavily and experience periods of feeling very 'high', as well as having problems sleeping and feeling very agitated. When he leaves his wife to go and live with his mother, they contact mental health services and he is admitted into hospital. Out of hospital, he lives on his own and completes his divorce, prompting another admission into hospital when he self harms on receiving his divorce papers. His later experiences include developing the belief that he is the King of Scotland, and that he is being kept under surveillance. Jimmy also describes being given very high doses of tranquillisers in hospital and being kept in seclusion several times. He is diagnosed with bipolar disorder.

5. **It's Happening to Me (I. H. T. M.).**

   Author: Rosealine Allen.

   Published: 2005, Chipmunka Publishing.

   Rose is from a working class background and grew up in a large London council estate. She is of Black Afro-Caribbean origin and was born in 1967. The narrative covers her life from three years old until 2003. At around aged 10, she describes an incident when her brother has sexual intercourse with her. The period covered in the most detail is from the late 1980s to mid 1990s. This includes a description of her time at sixth form, during which she has a relationship with her teacher which ends badly. Most of the narrative focuses on her time at university in Plymouth, where she becomes convinced that people are talking about her and mocking her behind her back, and that her hair is either falling out or uncontrollably greasy. She also describes her

belief that she has a special connection with her university lecturers, and after a while begins to hear the voices of some of them. When her degree does not go well, she describes this as a racist conspiracy against her and complains to the Racial Equality Commission. In the years after university, Rosealine hears increasing numbers of voices (although the lecturer's voice subsides), many of which talk to her about the differences between races and wide reaching theories on the world. She describes her belief that the conspiracy against her is run by the intelligence agencies and the various people in her life whom she comes to describe at the 'Fat Fuckers' or 'FFs'. She describes being admitted into hospital several times and as being diagnosed with paranoid schizophrenia although she completely rejects this explanation of her experiences.

6. **Schizophrenia: One Woman's Story (S. O. W. S.).**

   Author: Tiffany Sutton.

   Published: 2007, Chipmunka Publishing.

   Tiffany is a middle aged mixed race woman, and describes her life from age six months to the present. She details some difficult experiences in childhood, such as considering jumping from the 7th floor of her building aged five after her mother remarries and she has difficulty getting on with her stepfather. She also pinpoints two family moves, at aged 14 and 16, as being disruptive and difficult for her. She describes her first hospital admission as occurring in sixth form, after she starts to hear voices telling her she is not herself; following this she describes how she has been hospitalised 15 times over 20 years. The content of her distress is various, but at times she has believed she was an African princess who married Henry XIII, as well as the painter Monet. During a long (3 year) admission she also describes believing that she was a political prisoner. She is variously diagnosed with schizophrenia and schizoaffective disorder.

7. **Angels, Cleopatra and Psychosis (A. C. P.).**

   Author: Michael Black.

Published: 2008, Chipmunka Publishing.

Michael is a middle aged, middle class man who grew up in Cheshire. By profession, he is an author, and also has a P.h.D in literature. Michael details a sudden onset of visions on a train journey, where he describes being visited by the spirit of Michelangelo. He then details subsequent long-term experiences of encounters with various spirits, including Leonardo da Vinci, Josef Goebbels, a Cardinal, Cleopatra, and an angel, Jana. These spirits are described as being divided into 'good' and 'evil' forces, which often battle against each other. The 'evil' spirits, particularly the Cardinal, are at times associated with Michael's father. He also details several in-patient experiences. Michael details numerous diagnoses, including hypomania, schizophrenia and schizo-affective disorder.

3.4   'Spatial Interviews'

The second form of data used in this project was specially developed 'spatial interviews' conducted with service users. These were designed to explore the spatial and material aspects of service users' experiences of contemporary mental health care and living in the community. To this end, participatory mapping, a method developed in geography (e.g., Gould & White, 1974; Herlihy & Knapp, 2003; Pain & Francis, 2003) and community development research (e.g., Chambers, 1994; Kesby, 2000; 2003; Mascarenhas & Kumar, 1991), was adapted.

Exploring the material aspects of service users' lives presented a particular methodological challenge. As discussed in the previous chapter, the main focus of critical and qualitative psychology since the 1980s has been on the discursive construction of subjectivity (e.g. Edwards, 1997; Henriques et al, 1984; Potter & Wetherell, 1987; Parker, 1992). This has similarly led to the proliferation of

discursively based qualitative methodologies, which take 'texts' of various forms as their data, including already published texts such as the narratives discussed above, but in the main consisting of one to one interviews or group discussions. These 'texts' then tend to be analysed for either discursive (e.g., Burman & Parker, 1993; Parker, 2004; Potter & Wetherell, 1987; Wetherell et al, 2001), or narrative (e.g., Andrews, Squire & Tamboukou, 2008; Crossley & Crossley, 2001) structure. As discussed earlier, such approaches tend to view issues of materiality and space as important only in terms of how they are discursively constructed (Brown & Stenner, 2009; Burkitt, 1999; Cromby & Nightingale, 1999).

The frustration with discursively focused approaches that has lead to recent theoretical interest in issues of embodiment, materiality and space has hence been combined with a search for alternative empirical approaches that enable the exploration of these aspects of experience. In a sense these attempts have drawn on insights gained from discursive psychology following its in-depth analyses of the patterns that people's talk tends to take. A central claim of discursive psychology is that talk is structured by publicly available discourses, meaning that the way in which people represent their experiences is constrained by the discourses already available on a particular subject (e.g., Edwards, 1997; Henriques et al, 1984; Potter & Wetherell, 1987; Parker, 1992; Wetherell et al, 2001). In addition, discursive psychologists have emphasized the normative (Wooffitt, 1992), generalising (Edwards, 1994; 1995) and variable, or context-dependent, (Potter & Wetherell, 1987) tendencies in people's accounts of their experiences. A common discursive practice, for instance, is when asked about a particular experience, to present a

generalized example of that experience, often an amalgamation of several 'real' events, rather than talking about specific instances; Derek Edwards (1994; 1995) refers to this tendency as 'script formulation'. Another tendency explored in detail in discursive psychology is that of people to present their own experiences as normative (e.g., Wooffitt, 1992), a part of which can be using normative or dominant discourses. These kinds of 'practiced', generalized narratives could be argued to be particularly relevant in research work with mental health service users, who are often required to produce accounts of their distress as a part of service use, whether to gain access to services or as part of therapy. Narrative interviews can hence be seen to potentially contain the danger of merely reproducing normalized psychiatric and psychological discourses of mental health, which themselves tend to exclude issues of materiality and space due to the dualistic tendencies discussed in the previous chapter (Brown & Stenner, 2009; Burkitt, 1999; Cromby & Harper, 2008; Latour, 1996; 2005).

It can be seen, therefore, that a traditional narrative interview would be likely to produce accounts of distress which exclude, or at least are not focused on, specific and detailed descriptions of spatial experiences. They are likely to be focused on chronological events, and have a tendency to discuss experience in a generalised manner. As the process-relational ontological position (Brown & Stenner, 2009; Stenner, 2008; Whitehead, 1978) put forward in the previous chapter, argues that discourse is only one of several inter-related processes, which together constitute ongoing lived experience, a methodology was sought in this project which could focus the accounts of participants on the non-discursive facets

of experience. One tactic used by researchers interested in non-discursive aspects of experience, such as embodiment (e.g., Gleeson & Frith, Gilles et al, 2005; Silver & Reavey, 2010), and space (Gabb, 2008; Knowles, 2000a; Radley & Taylor, 2003; Radley, Hodgetts & Cullen, 2005), has been the use of visual methodologies such as drawing (Gilles et al, 2005; Guillemin, 2004), photo elicitation (Bolton, Pole & Mitzen, 2001; Frith & Harcourt, 2007; Radley, Hodgetts & Cullen, 2005; Radley & Taylor, 2003) and video diaries (Kindon, 2003; Holliday, 2004).

3.4.1   Visual methods

Reavey & Johnson (2008; see also Reavey, 2011) argue that visual imagery has long had an important role to play in psychological research, whether through the elicitation of responses in experiments, or pinpointing mental processes through neuroimaging. What has perhaps been less centrally acknowledged in psychological research, is the role of the visual in symbolic meaning making in everyday life (Prosser, 1998; Pink, 2007; Rose, 2001; Reavey, 2011), and hence the potency of harnessing visual imagery in psychological research (Frith, Riley, Archer and Gleeson, 2005). This omission is perhaps surprising when it is considered that it has been argued that contemporary Western society is highly ocularcentric (Jay, 1993), that *seeing* has been argued to now be the primary sense through which we interact with the world; a proliferation of media technologies, such as film, television and photography is been argued to have produced subjects, in late modernity, who comprehend the world first and foremost through visuality.

The visual, then, can be seen as an important modality through which people engage with, understand and represent the world, and hence worthy of interest to

psychology researchers. The next question to ask is what particular benefits can be gained from utilising this vocabulary in research. Visual methods are increasingly used within social science and psychological research (e.g., Knowles & Sweetman, 2004; Harper, 2002; Pink, 2007; Prosser, 1998; Reavey, 2011; Rose, 2001). The visual sociologist Jon Prosser (1998) points out that visual material can be incorporated into research in a number of ways. The first involves the analysis of visual culture already existent in the world, either in terms of widely available visual media, such films, advertisements and television (e.g. Gill, 2011), or personal visual artefacts, such as family photographs (e.g., Majumdar, 2011; Rose, 2003). The second major form of visual methodology is when visual materials are generated as part of the research process itself. Perhaps the most common form of this kind of visual research is photo-elicitation (e.g., Bolton et al, 2001; Del Busso, 2011; Frith & Harcourt, 2007; Lassetter, Mandleco & Roper, 2007; Radley & Taylor, 2003; Radley et al, 2005), where participants are asked to take photographs on a particular theme, which then form the basis for a later interview. Other forms of visual data collection, include drawings (Gillies et al, 2005; Guillemin, 2004; Iantaffi, 2011; Silver & Reavey, 2010), sculpture (Bowes-Catton, Barker & Richards, 2011; Gauntlett, 2007) and video diaries (Kindon, 2003; Holliday, 2004). The common theme in these methods is that the starting point for the research process is that participants are asked to reflect on the particular aspect of their experience under investigation, often for a period of time before an interview, and produce a visual record of that experience. This record then forms the basis for the interview.

The first point to make about such methods is that they are highly participant-led; giving participants the opportunity to reflect on and produce an account of their experience can be seen as helping to reduce the inherent power differential present in the research process (Frith & Harcourt, 2007; Knowles, 2000a; Reavey, 2011). In this way, these methods have much to recommend them for this project, for the reasons detailed earlier in the chapter. Secondly, a common theme throughout these studies which have used visual methods is that such methods are particularly successful in enabling the discussion of the *settings* of participants' experiences (see, Bolton et al, 2001; Gabb, 2009; Knowles, 2000a; 2000b; Knowles & Sweetman, 2004; Majumdar, 2011; Radley & Taylor, 2003; Reavey, 2011). In part, this can be seen as a product of some of the methods used; when taking a photograph, the surrounding 'scene' is necessarily included as well as any people; the material environment is hence made visible in the research process and in participants' accounts by virtue of the medium used. The same can of course be said for video diaries; the immediate context is similarly visible. As such, visual methods can be seen as widening the focus of participants' accounts. As Bruner (1991) points out, verbal narratives are normally organised in terms of time, or chronological life events. As such, issues of space and context are more easily lost. The use of visual materials, which make visible such contexts (e.g., Bolton et al, 2001; Hodgetts et al, 2007; Majumdar, 2011; Radley & Taylor, 2003; Radley et al, 2007), can be seen as highly appropriate for this project, which aims to explore just these spatial, material and contextual aspects of service users' experiences.

The final aspect of visual methods, which renders them particularly useful for this project, is that they have been shown to be useful in exploring aspects of experience which are perhaps less easily accessible, or less tangible, in participants' everyday lives. As detailed above, space is quite an unusual way for people to think about and structure their experiences (Bruner, 1991). In a traditional interview setting, this could lead to a difficulty in asking people to discuss their experiences through this lens. Similar issues have been faced by researchers aiming to investigate embodiment (e.g. Bowes-Catton et al, 2011; Brown et al, 2008; Del Busso, 2009; Gillies et al 2004; 2005); there is very little language available through which to discuss embodied experiences due to the prevalence of dualistic concepts of the body. These researchers have hence experimented with numerous methodologies, particularly visual methods (Del Busso, 2011; Gillies et al, 2005) and Memory Work (Crawford, Kippax, Onyx, Gault & Benton, 1992; Gillies et al, 2004), noting that those methods which focus participants on producing rich accounts of specific and particular experiences have been successful in enabling the exploration of embodied experiences (Brown et al, 2008; Gillies et al, 2004; 2005; Reavey, 2011). Asking participants to produce such accounts, especially using visual modalities, has been argued to 'puncture' (Reavey, 2011) normative accounts of experience, enabling the exploration of these less easily accessible aspects of experience. Participatory visual methods can hence be seen as being particularly relevant for this project; To enable the exploration of the different spaces which service users access and inhabit throughout their everyday lives and when using services, a

particular tradition of representing space visually in research was drawn on: participatory mapping.

3.4.2   Participatory mapping

Participatory mapping is a well-established technique used in geography, planning and community development (e.g., Chambers, 1994; Herlihy & Knapp, 2003; Herlihy, 2003; Lynch, 1960; Rambaldi, Kwaku Kyem, McCall & Weiner, 2006; White & Pettit, 2008; Wright & Fawcett, 2003). Rather than a cartographical approach, where maps represent the physical environment in a literal and accurate manner, participatory maps are subjective representations of spaces or communities. Early work in this area, for instance, was done by the urban planner Kevin Lynch (1960), who created 'mental maps' by asking participants to draw the significant features of the city where they lived, as a route to understanding how the participants organised and cate.g.orised information about their spatial environments. Participatory maps are often used to map community networks and relationships and to help facilitate the communication of how communities understand themselves to outsiders, such as policy makers (Rambaldi et al, 2006). Maps have also been used to understand the impact of environmental changes, such as deforestation, on how people experience their communities (Wright & Fawcett, 2003), as well as to generate located, emic measures of wellbeing (White & Pettit, 2004). These techniques, therefore, have a history of being used to explore people's subjective relationship with their environment, with obvious implications for this project.

Increasingly, maps have also been used to explore aspects of experience that fall more obviously within the remit of psychological enquiry (e.g., Gabb, 2008;

Iantaffi, 2011; Townley, Kloos & Wright, 2009). The community psychologists Townley et al (2009), for instance, used participatory maps with mental health service users, as part of a project looking at service users' levels of community integration. For this project, participants were asked to draw the places that were important to them, then discuss the personal meaning of the places; prompts provided by the investigators included 'which of these places are most important to you?' and 'where do you feel you belong the most?'. The locations identified by participants were then fed into a geographical map and used to calculate the 'activity spaces' of participants, defined as the average area within which participants carried out their daily activities. The authors found that the larger the service users' 'activity space', the more socially included they reported feeling, and that 'home' was the place that the majority of the participants spent the most time, felt was the most important, and in which they had the greatest sense of belonging.

Although partly analysed for their qualitative content, the maps in Townley et al's (2009) study were in the main used as an information generation tool. Other researchers have used mapping to more directly explore emotional and psychological experiences. In her research looking at family relationships, for instance, the sociologist Jackie Gabb (2008), used 'emotion maps' (alongside diaries) to investigate the intricacies of how families related to one another in the home. Participants were given stickers representing members of the family and asked to notate the emotional encounters they had over the period of a week on a plan of their home. This technique has the advantage of specifically locating the emotional encounters described, in both relational and spatial terms. For one participant,

Harriet, Gabb describes how the pleasant emotions associated with friends, for instance, were located entirely in the 'public' areas of the map: the lounge and kitchen. On the other hand, negative interactions with Harriet's teenage daughter were located in the upstairs parts of the house, and particularly occurring when Harriet enters her daughter's private bedroom space; positive interactions between mother and daughter were recorded, but take place in the communal downstairs areas. It can be seen that this methodology is particularly successful in drawing out the spatial aspects of the relationships in the home and drawing out patterns of interactions and experiences in particular parts of the home (intimacy in the parents' bedroom; conflict in the daughter's room; sociability in the communal areas). The complex interactions between relationships, space and emotions can hence be examined in arguably richer detail than enabled by simply asking participants about their experiences. It is noticeable as well that this method also enables the collection of data covering a week in the participants' lives, but that this data is arranged, and can be discussed, spatially rather than temporally (as it would be with a diary method, for instance).

Participatory mapping, therefore, presented itself as particularly suited to the task of exploring the role of space in participants' experiences of mental distress. As can be seen from the example of Jackie Gabb's work, visual representations can be used to discuss specific, located experiences and are well suited to the discussion of emotional and psychological phenomena (Guillemin, 2004; Iantaffi, 2011; Silver & Reavey, 2010; Townley et al, 2009) as well as subjective understandings of community-level phenomena (Chambers, 1994; Herlihy & Knapp, 2003; Herlihy,

2003). Maps are also a normative and readily understandable way to represent space, and it was hence reasoned that participants would find this an understandable way represent the places in their lives and provide a route into discussing the spatial aspects of their experiences.

3.4.3   Spatial Interviews

The procedure for this study used participatory mapping techniques, outlined above, within the context of a qualitative interview; the aim was for the research to be participant led, whilst also focussing directly on issues of space. The interviews were structured in three parts. Firstly, participants were asked to: 'draw a map or representation of the places where you go as part of service use'. Participants were asked to include in the drawing three things: who they saw there, what they did there, and how they felt when they were there. Participants were provided with an A3 pad of paper and a selection of coloured felt tip pens, coloured pencils and lead pencils, giving them a choice of which materials to use. Participants were then asked to describe each place in turn, and then rate the places they had drawn from where they liked being the most to least, and describe the reasons for these rankings. This procedure was then repeated for the second question: 'draw a map or representation of the places you go to in your everyday life which are not a part of service use'. Participants were asked to discuss the same three characteristics of these places: what they did there, who they saw there, and how they felt there. Finally, participants were asked some general questions about the relationship between space and their experiences of distress, such as: 'are there any particular

places you go to when distressed?'. A full interview schedule can be found in Appendix Four.

In practice, this procedure meant that the majority of the interview time was taken up with the discussion of the participants' maps; this structure proved highly successful in focussing the participants' talk on the particular spaces in their lives. Both the ways in which participants interpreted the instructions given and the extent to which participants engaged with the visual aspect of the interview was, however, variable. Some participants drew one map including all of the places they discussed; others drew each place on a separate sheet. Most participants described the places as they drew them; some participants waited until they had completed the drawings before discussing them. One participant did not wish to do any drawing, and so we had a verbal interview instead, covering the same ground. It was noticeable that this interview was less focussed on the specifics of each place than those who did engage with the drawing process, although still providing some useful and informative data. This observation indicates that the mapping technique used was successful in focussing the interview on the spatial aspects of participants' experience. More than one participant commented that they found the drawing useful in organising what they were going to say in the interview, as they could see whether they had missed anything. This point recalls Guillemin's (2004) argument that drawing is both a process and a product; it was useful in both slowing down and focussing participants' talk (as a process), and in acting as a tool for participants to be able to record and monitor their own contribution to the research process (a product).

3.4.4   Participants

Seventeen one-to-one interviews were conducted with service users. The inclusion criteria were that service users be currently be living in the community and accessing community mental health services, as well as be over 18 years old. Diagnostic categories were not adopted as exclusion criteria for this study for two main reasons. Firstly, the boundaries of diagnostic categories have been widely contested as successfully differentiating between the different triggers, experiences and outcomes of mental distress that are experienced by service users (Campbell, 2007a; Bentall, 2003; 2006, 2007; Boyle 1990; 2007; May, 2007). Secondly, many service users have multiple diagnoses, either through 'co-morbidity' (the diagnosis of two conditions at once) or through historical changes to their diagnosis (see, Bentall, 2003; Cromby et al, 2012); indeed, several participants discussed changes that had been made to their diagnoses during the interviews. Considering these two factors, it was not felt that diagnosis would be a useful way of differentiating between potential participants. Instead, the common *spatial* experience of using community mental health services was considered more important in selecting participants considering that the research aimed to focus on this issue.

Participants were aged between 25 and 67 years old, nine were female and eight were male. Much of the recruitment was done online, leading to a variety in participants' locations; six participants lived in the London area, two in Greater Manchester and the remaining nine in Birmingham, Brighton, Exeter, Haywards Heath, Leamington Spa, Reading, Southampton, Worcester, and near Sheffield. Fourteen participants lived in their own home (either owned or rented), two in

mental health supported housing and one in supported housing for physically disabled people. Nine participants lived alone, seven with family and one in a shared house with friends. All participants were white. Participants were not asked explicitly about their sexual identity but two self identified as gay men while six of the women interviewed mentioned current heterosexual partners. Five participants were employed full time, one part time and two on a regular freelance basis; one participant was a full time student, another a full time mother with a child under one. Of the seven remaining participants who were not in paid employment, five engaged in at least part time voluntary work, and one was retired. Although participants were not directly asked for their psychiatric diagnosis, most did reveal this information as part of the interview. Eight were currently diagnosed with Bi-polar Disorder and six with Clinical Depression. Of the three participants who did not reveal their diagnosis two described psychosis-like experiences, one mentioning 'delusions' and another 'having problems with radios'.

3.4.5 Procedure and ethics

This study was carried out in accordance with the ethical guidelines set out in both the London South Bank University Code of Practice for Investigations on Human Participants and the British Psychological Society Ethical Principles for conducting Research with Human Participants. It was approved by the London South Bank University (L.S.B.U.) Ethics Committee before data collection commenced. Below follows a detailed account of how the practical, procedural and ethical issues raised by the study were tackled.

i) Recruitment

Participants were recruited through advertising (13 participants) and snowballing (four participants). Adverts were disseminated through online service user networks, such as the Social Perspectives Network, National Service User Network, Hearing Voices Network and the Critical Mental Health Forum. These adverts were distributed via e-mail, and this was the most successful recruitment avenue, garnering eight participants. Adverts were also placed in various voluntary sector mental health services in and around London (my current location) and Manchester (where I am originally from). These included Mind drop in centres, and church groups. Four participants were recruited through these adverts. Service managers were contacted by telephone or e-mail to ask permission for posters to be displayed, and staff at these services printed off and displayed posters themselves. A copy of the advert can be found in Appendix One. A website advertising the research was also set up, using the same text as the advert (http://www.spaceforrecovery.org.uk), and disseminated through my personal Facebook account. This involved setting up a Facebook group which included a link to the research website; this double step was set up to protect the anonymity of participants. This way, participants could take part in the research without actually joining the group (the membership of which is public) if they wished. Indeed, one participant took this route. The website itself invited participants to fill in descriptions of their experiences of different community spaces, followed by a link to indicate if they were willing to be interviewed. All responses were anonymous, unless participants indicated they wanted to be contacted for interview. Altogether, 62 people joined the Facebook group and two

participants were recruited for interview.

There were some issues with the nature of the participant group recruited. It is noticeable that the majority of participants were recruited through online service user networks; these participants tended to be service user activists, and involved to varying extents in research, advocacy, politics, policy development or teaching about service user issues. This does not of course make their experience any less 'real' or valid (see, Campbell, 2001) but it was noticeable in the interviews that it was often more challenging (though not always) to get these particular participants to describe their own experiences and emotions in detail rather than discuss issues on a broader political or policy level. In addition, their descriptions of services were often (though again, not always) more informational rather than emotional or personal, perhaps due to a greater knowledge of service provision and development. This is not to criticise or invalidate the contributions of these participants, for whose participation I am wholly grateful. It did however highlight a wider self selection bias in the participant group, who were all white, mainly middle class and three of whom had been educated at Oxbridge. In other words, my participant group predictably followed well established patterns of people who are likely to take part in research, particularly volunteer studies (Cannon, Higginbotham & Leung, 1991). The final participant group does, however, raise the question of to what extent the participatory aims of the project can be seen to have been realised.

These limitations to the participant group were perhaps influenced by the recruitment strategy of using voluntary services and service user networks which are to some extent self selecting in themselves. Becoming more involved in a particular

service, rather than relying on participants having the interest and confidence to contact someone they do not know, would also perhaps have been beneficial in attracting a wider range of participants. It is worth noting that in the data set as a whole, some of these issues were ameliorated by the first person narratives also analysed. Although of course again obviously a self selecting group, more of the narratives were written by people from working class (e.g., I Thought I Was the King of Scotland and Eyebrows and Other Fish), and ethnic minority (It's Happening to Me and Schizophrenia: One Woman's Story) backgrounds.

ii)   Securing informed consent

Several steps were put in place to ensure informed consent, from the recruitment stage onwards. Firstly, those participants recruited through advertising volunteered for the study independently which avoided any initial issues of coercion to participate. For those participants recruited through snowballing care was taken to ensure that participants did not feel obliged to take part because of existing relationships. It was emphasised from the earliest stages of contact that participation was entirely voluntary and that participants could withdraw at any time; this was also re-iterated at the data collection stage. In general, it was made clear that participation in the study was entirely voluntary and no monetary incentive was offered to participants.

After participants indicated their interest in the study, they were sent an information sheet containing further details and given up to a week to consider whether they wanted to take part (Appendix Two). This breathing space was given to participants to ensure that participants ensure were able to make an informed

decision about whether or not they wish to take part; in accordance with usual qualitative research proceedings, participants were not deceived in any way as to the nature of the research. Most participants responded more quickly than this to confirm their interest. Formal written consent was secured at the beginning of the interview process. Participants were asked to sign written consent forms, copies of which can be found in Appendix Three. As a part of this procedure it was made clear to participants that they had the right to refuse to answer any questions, and were free to withdraw at any time; these procedures were put in place to ensure that participants were clear that signing the consent form does not tie them to participation in any way.

iii)   Conducting the interviews

Participants were consulted on where they wished the interview to be carried out; they were given the option of conducting the interview in a room at L.S.B.U. but most chose to be interviewed elsewhere. Five participants were interviewed at L.S.B.U., seven in their own homes, three in public cafes, one in a different university department, and one at the participant's workplace. One participant also requested that his partner be present during the interview, which was conducted in a café.

Flexibility in arranging times and places for interview was a key part of ensuring participants felt comfortable in the research process. Finding a place where participants felt comfortable, although normal practice in qualitative research, seemed particularly important considering the nature of the research question. One participant, for instance, explicitly stated that she wanted to come to LSBU to conduct the research, and as part of the interview talked in detail about how much

she disliked her current living arrangements in supported housing. This clearly would have been more problematic as a discussion had the interview been conducted in that living space, especially as one of the issues she talked about was a lack of privacy. Other participants however specifically requested that the interview could be carried out at their home, as this was where they felt most comfortable discussing issues of distress.

Due to the sensitive subject matter of the research there was a risk that participants may have become distressed either during or after the research. To minimise this risk, it was made clear to participants that they were able to withdraw from the research at any time and could refuse to answer any questions that they might find intrusive. One interviewee did become distressed during the interview and nearly started crying, but wanted to carry on. After the interview, I offered to stay with her for a while but the participant instead preferred to leave alone. This particular participant also commented that the interview was less intrusive than she had anticipated as she had not been asked to talk about her past, in constrast to a clinical interview. This comment highlighted an advantage of the participatory design of the interview, that allowed participants more control over the direction of the discussion than in a traditional semi-structured interview (Johnson & Mayoux, 1998; Kindon, 2003; McIntyre, 2003; Pain & Francis, 2003; Reavey, 2011). Most participants commented after the interview that they had enjoyed the process or at least found it interesting.

A final important consideration in conducting the interviews was protecting my safety, considering that seven of the interviews were conducted in participants'

homes and eight required travelling to a different city for the day. To this end, I ensured that someone was always informed of the exact address I was travelling to and my expected finishing time. They were contacted as soon as the interview was over and I had left the participant. There were, however, no issues with safety during the conduct of this research.

iv)   Data storage and confidentiality

All interviews were recorded and then transcribed; audio files were downloaded directly onto either my university computer profile or home laptop, both of which were password protected. Maps were drawn on A3 paper by participants and then scanned on a university scanner and stored on a memory stick which was kept in a locked office at LSBU. Participants were offered access to the full transcripts of their interviews, which two participants requested.

Pseudonyms were used to protect the identity of participants from the transcription stage, and it was made clear to participants that any information revealed in the study would not be passed on to third parties, for instance any mental health professionals, without their express permission. Participants' identifying information was stored separately from the data on my password protected profile on the L.S.B.U. computer system. The maps produced by participants were also anonymised and stored separately from any identifying information about participants. Maps have been kept either in a locked filing cabinet at London South Bank University, or at my home. My supervisors have had access to the raw data in its transcribed (and scanned, in the case of maps) form but only once it had been expunged of identifying information.

The visual nature of the maps presented some particular challenges for securing anonymity; an often cited issue with using images as data (Prosser, 2000; Wiles et al, 2008). as many participants included detailed information about the places where they went, and the people that they saw there, including their real names. One participant indeed contacted me after the interview asking to change part of their map as they were concerned it was not anonymous enough. We met up again and altered the relevant section on the original map, and it was this version that was scanned. All of the scanned maps were imported into Adobe Photoshop on my home laptop, and all names were digitally blurred. The hard copies were then kept at my home.

3.5   Analysing Materiality.

The analytical approach chosen for this research was thematic analysis (Attride-Sterling, 2001; Boyatzis, 1998; Braun & Clarke, 2006; Frith & Gleeson, 2004; Hayes, 1997; Jowett, Peel & Shaw, 2012; Muise, Herold, & Gillis, 2010). Analysing the material aspects of the data collected again threw up a particular challenge, due to the discursive focus of many forms of qualitative methodology. The theoretical emphasis on materiality as jointly constitutive of psychological life (Brown & Stenner, 2009; Burkitt, 1999; Cromby & Nightingale, 1999; Latour, 1996; 2005) can be seen to renders methods developed from a purely discursive stance problematic. As previously discussed, discursive psychology can be seen to view issues of materiality, space and embodiment only through the lens of how they are constructed through discourse (Brown & Stenner, 2009; Burr, 1999; Cromby & Nightingale, 1999). The methods developed within this viewpoint, such as Discourse

Analysis, therefore, similarly focusses analysis on the use and function of language and discourse (e.g., Parker, 2004; Potter & Wetherell, 1987; Willig, 2001; Wetherell et al, 2001). As this project aimed to investigate the role of space and materiality as part of a set of interlocking processes, including discourse, then it was decided that discursive or narrative approaches would be too narrowly focussed for this analysis. In contrast, Braun and Clarke (2006) identify thematic analysis as a methodology which is used from a number of epistemological and ontological positions, used often by qualitative researchers and yet less often explicitly acknowledged. They argue that thematic analysis can be (and is) done from a variety of different theoretical positions and adopting either a realist or constructionist epistemology, providing that these are stated explicitly. The broad applicability of thematic analysis as a methodology lends itself well to the data collected for this project, as it allows for the exploration of the material and spatial aspects of participants' accounts that are less commonly the focus of other analytical approaches.

3.5.1 Thematic Analysis

The multiple uses of thematic analysis means that a clear definition of the form of thematic analysis that is to be conducted needs to be outlined before analysis commences. Braun & Clarke (2006) identify several main components that distinguish different thematic analyses. The first is the specificity of the focus of coding, with different thematic analyses either aiming for a rich description of the entire data set, or to produce themes which focus on one particular aspect of the data. The second distinction they draw is between inductive or theoretically driven analyses. Inductive analyses are those where the themes are seen as emergent from

the data set, without much initial recourse to a theoretical framework. A more theoretically driven analysis, however, would involve a much earlier definition of a theoretical approach, and the themes identified in the analysis would be seen as tied to the theoretical framework of the research. Thirdly, Braun & Clarke distinguish between semantic or latent approaches. Semantic approaches locate the analysis in the explicit meaning of the data: the data is described and then interpreted within the context of previous literature and broader social meanings. Latent approaches, meanwhile, attempt to also examine the underlying assumptions or ideologies that are seen as shaping the data; they look 'beyond' the surface meaning of the data. The development of latent themes, therefore, requires theoretical work at the level of coding, not only interpretation. The final distinction between different forms of thematic analysis that can is drawn is between realist and constructionist epistemologies. A realist approach would see the data as representing a relatively transparent admittance to a stable reality and hence allowing for the straightforward interpretation of motivations and experiences from the data. Constructionist epistemology, however, sees reality and meaning as socially produced, and research data as contingent on its context. As Braun & Clarke point out, descriptive, inductive, semantic and realist approaches tend to cluster together, and specific, theoretical, latent and constructionist approaches tend to also cluster. The first set of characteristics can be seen as sharing qualities with more realist approaches such as Grounded Theory (e.g., Glaser & Strauss, 1967; Kumar, Guite, & Thornicroft, 2001; Ward, 2005), or some versions of I.P.A. (e.g., Smith, Flowers &

Larkin, 2009), while the second set are closer to a discourse analytic approach (e.g.,

Parker, 1994; Potter & Wetherell, 1987, Wetherell et al, 2001).

The analysis conducted for this project broadly falls into the second camp of

thematic approaches identified by Braun & Clarke (2006). The data was coded in

light of the specific question of the role of space in service users' experiences and

this question has in turn been developed within the theoretical context of the

contemporary 'material turn' in critical social psychology (Burkitt, 1999; Brown &

Stenner, 2009; Cromby & Nightingale, 1999; Latour, 2005). Rather than aiming for

an all encompassing description of the data set, therefore, coding from the

beginning of the process of analysis focussed on how space was understood,

constructed and accounted for by the participants. Although based on close reading

and immersion in the data, the specific question of space was at all times the focus

of organising and interpreting the data. Theoretical reading was also central to the

development of the project from the outset, and informed both the development of

the methodology used and the interpretation and understanding of the data. In this

sense, the thematic analysis conducted was theoretical rather than inductive, as all

aspects of the process of the project were explicitly theoretically informed. The data

was interrogated for its theoretical significance from the initial stage of the analysis,

and theoretical work was drawn on in interpreting participants' accounts from the

beginning. This theoretically informed approach therefore also lends itself to a more

latent than semantic approach to interpretation (Braun & Clarke, 2006). Rather than

the meaning of the data being established through thorough semantic coding, then

placed within a theoretical or empirical context, codes are instead here seen as

theoretically driven, and informed by the theoretical or wider contextual implications of the data. This does not amount to a kind of theoretical imperialism over the data set, with inductive meanings being ignored by a strict adherence to a pre-determined theoretical paradigm. Rather, the data has been approached from a particular ontological and epistemological position, and the reading, interpretation and coding of the data has been considered in relation to these theoretical assumptions, and other empirical work in the area, from the beginning of the analysis.

Finally, a constructionist epistemology was adopted. The data was considered as accounts generated for, and contingent on, the context for which it was produced (whether research or publication), rather than representing a stable 'truth' (Banister et al, 1994; Henriques et al, 1984; Parker, 2004; Smith et al, 1995; Wetherell et al, 2001). The analytical approach diverges from a traditional social constructionist approach however, as language is not seen as being ontologically primary. Instead the process-relational ontology (Brown & Stenner, 2009; Whitehead, 1978) outlined in the previous chapter was drawn on in approaching the analysis. Under this view, the material and spatial environment are seen as being part of what produces experience (Latour, 2005; Lefebvre, 1991; Massey, 1994c; Serres, 1995; Whitehead, 1978). In practice, this translates to a shifting of the emphasis of the research from how language is used performatively (Billig, 1987; Billig et al, 1988; Edwards, 1997; Parker, 1992; Potter & Wetherell, 1987) to an interest in the broader context of the experiences described in the data; equal attention was hence be paid to the participation of the material environment in the

accounts of service users. In doing so, two particular aspects of the theorisation of the role of the material environment in the production of social experience outlined in the previous chapter were especially important.

The first of these drew on Latour's (1996; 2005) insistence on the importance of understanding the detail of the roles of the different 'actors' that interact to produce interactions and experiences. These are argued to equally include both human and 'non-human' participants in composing the particularities of 'scenes'. Latour argues that social scientists in general exclude the 'material' half of these actors from their analyses, and also generalise too quickly to broad 'social processes' to construct explanatory models to understand the 'social' half. Instead he argues for a detailed analysis of both the material and social aspects of interactions and experiences. Following these arguments, in the analysis, attention was paid to the detail of the social and material context visible in service users' accounts of their experiences. In other words, the human and non-human actors in each 'scene' or interaction described were identified and considered. In addition, Serres' (1995) work on the role of objects in experience was drawn on. As outlined in the previous chapter, Serres also views objects as being central, not peripheral, to the construction of human relationships and experience. His theorisation that objects slow down and mediate social relationships, providing limitations on the potentials for action and experience, was highly influential in the analysis. Attention was hence paid to how the objects and spaces which appear in service users' accounts mediated, or transposed, the social relations described.

Based on a combination of these epistemological and ontological positions, and drawing on these theoretical assumptions, four 'analytical directives' were used as a guide for approaching the data, and guiding the analysis. These aimed to examine the different material and social aspects of the experiences being described by participants, at both a micro, detailed level and a broader or macro level. The four directives were:

1) What kind of space is being conjured?

    a. The different spaces described across the data set were here examined, with an attendance to the meaning being ascribed to these spaces by participants' accounts. For instance, the ward as a 'blank space'.

2) What are the objects within these spaces contributing to the action, interaction and emotions described?

    a. As well as mapping a picture of the kinds of spaces described by participants, attention was paid to the detail of the objects described, and how they interacted with the experiences described.

3) What else is interacting with space in driving the action described?

    a. In order to avoid a mono-modal analysis that focussed only on 'space', other factors influencing the experiences described were investigated. For instance, how much time participants had to spend in a particular place was described as interacting with their experience of those spaces.

4) How are the experiences described interdependent with space?

    a. Finally, all of these factors can be seen as feeding into an analysis of how the experiences described were interdependent with their context.

3.5.2 Coding and analysis procedure

The entire data set was entered into a single file in Nvivo 8, to enable it to be analysed as a whole. Recordings of the interviews conducted were transcribed and then imported, while the accompanying maps were digitised and also imported. The maps were then linked in Nvivo to the appropriate interviews, and parts of the interviews which discussed the particular drawing. The first person narratives were purchased electronically from Chipmunka Publishing, and so the PDF files could be directly imported into Nvivo. In line with the observations made by Smith & Hesse-Bieber (1996) on the use of computer software in qualitative research, Nvivo was used mainly as an organisational tool during the process of analysis, enabling the intial coding of all parts of the data set at once. Once the initial coding had been completed and the data organised into three broad categories, then relevant quotes were extracted from Nvivo to enable more detailed and theoretically informed analysis.

For the initial (Nvivo based) stage of the analysis, all of the data was first coded under three major categories: 'community services', 'community living' and 'the psychiatric ward'. This structure originated from the structure of the interviews, as the participants were asked to draw, and talk about, the spaces of community care and generic community living separately. It therefore made sense to initially divide up the data into these broad spatial categories, as a way to initially combine the two data sets (narratives and interviews). From conducting and transcribing the interviews, as well as an initial reading of three of the narratives, it also became

clear that there was a large body of data specifically addressing experiences of the psychiatric ward, and so this was coded separately.

Attride-Sterling (2001) presented a model for thematic analysis as progressing from 'basic themes' to 'organising themes' and finally to 'global themes'; basic themes were defined as "lower-order premises evident in the text", organising themes as "categories of basic themes grouped together to summarise more abstract principles", and finally global themes as "super-ordinate themes encapsulating the principal metaphors in the text as a whole" (p. 388). The analysis carried out here to some extent followed such a progression. The first stage of data analysis involved the production of a large number of codes describing the data, under the three spatial categories described above (basic themes). While Braun & Clarke (2006) draw a distinction between inductive and theoretical coding, the procedure carried out here was a combination of the two: codes were inductive in the sense they were grounded in the data, but also theoretical, as coding was driven by the analytical directives laid out above. Several types of codes were simultaneously created: the types of spaces being described, using descriptive headings such as 'blank space', 'surveillance space' and 'deviant space'; the role of the objects described by the participants, for instance coding together all mentions of 'locks' or 'chairs'; other factors interacting with the experiences of space described, for instance 'movement', 'activities', and 'time'; and finally how the experiences described were interdependent with space, such as 'distress in mainstream space' and 'freedom to express emotions'. At the same time I used the 'memo' function in Nvivo to note down thoughts and connections with the

literature, such as linking 'surveillance space' to Gilles Deleuze's (1992) work on control.

The next stage of the analysis, which could be seen as the creation of 'organisational themes' (Attride-Sterling, 2001), involved interorogating the full list of codes for each spatial category, identifying connections and patterns amongst the codes, consolidating similar codes. This was done first internally within each category, and then across the three categories. The four organisational themes created from this process were: located distress (examining the relationship between space and experiences of distress); located subjectivity (examining the relationship between space and subjectivity); and the psychiatric ward. The first two organisational themes combined the data from the 'community services' and 'living in the community' categories, whilst retaining 'the psychiatric ward' as a separate theme. At this stage, I concluded that the two community-based categories were not meaningfully describing separate experiences; the spaces discussed by participants were often both service use and non service use spaces at the same time (for instance, homes, cafes and pubs), and many participants talked about the transitions between operating in these spaces explicitly as a 'service user' and as part of their everyday lives.

The next stage of the process involved returning to these newly organised sets of data to consolidate and further theoretically interrogate the codes which had been formulated, enabling the more detailed analysis of individual quotes and the synthesising of data to form a more coherent narrative. This included further literature searches and theoretical investigation into the identified sub-themes

within the broad organisational themes here identified, for instance, into issues such as 'visibility', the public/private distinction, construction of 'home', service user subjectivities, and the contemporary psychiatric ward. Patterns and repetitions were also looked for between the three organisational themes, to enable the production of more sophisticated and theoretically informed 'global themes'. At this stage, I I became particularly interested in how the experiences of the ward related to those in the community, rather than seeing them as separate, differentiated sets of experiences. It was at these stage, after further reading, that I started to consider Foucault's (1986a) concept of the heterotopia, as a way of thinking about the ongoing relationship between the different spaces described, and their role in the accounts of the production of subjectivity. I used this concept as a way to organise an analysis of the overall organisation of mental health care, and then focussed on two particularly prevalent issues which I had identified across the three previous categories. Each of the final 'global themes' hence incorporate data from all three initial spatial categories, and across the two data sets. Repetitions across the 'organisational themes' were also eliminated. These final themes were:

Heterotopias

Including discussion of both the psychiatric ward and community service buildings as heterotoptias, with a focus on the role of materiality. Also including discussion of resistance to a modulated subjectivity produced through service use in community spaces.

Discordance and concordance

Including discussion of experiences of public/private locations of distress, as well as issues of disclosure within service interactions.

Movement

Discussing the issue of movement within and between service use and community spaces.

These three global themes form the basis for the three analysis chapters which follow. Chapter Four will provide an outline of the concept of heterotopia, and detail its potential application to understanding the accounts of service use and community living gathered during the data collection. Chapters Five and Six will build on this framework for understanding the interrelationships between the spaces and experiences of community mental health care, through discussing two key issues, visibility and movement, in the context of the social inclusion approach (D.O.H., 1999; O.D.P.M., 2004; Repper & Perkins, 2003; Sayce, 2000; Secker, 2010; Spandler, 2007; Wallcraft, 2001) to mental health services.

Chapter Four

Heterotopias of control: space and subjectivity in community mental health care

Community as a site of delivery of care does not exist; this is at the same time its problem and its power. The concept of the community as a place where care can be received does not exist either in the concrete world of everyday practice or in the ideological world of people's lived reality. Try a simple test: ask for a delivery of supplies to be made to 'the community' and the first question will be, 'Where'? This will lead you to name a specific and fixed site which will be another description; that of a hospital, a private home, an institution, a clinic, a community centre, but the phrase 'community' will be revealed as an empty and non-existent site. (Symonds, 1998, p. 3).

4.1   Utopias and heterotopias of community care

As an opening to the analytical chapters of this thesis, it is worth returning to Anthea Symonds' (1998) quote concerning the placeless, utopian construction of community care. As discussed in Chapter Two, Symonds argues that 'the community' is not a place in itself in which mental health care is delivered, or distress experienced, but 'community care' is instead composed of a number of disparate, differently situated sites. People do not live in utopias, but are located in concrete communities and networks, embedded across numerous sites: homes, workplaces, shops, parks, pubs, cafes, and indeed hospitals, community mental health centres and clinics. Experiences of 'community care' therefore, cannot be understood through the utopia of 'community'. Indeed, one participant, Julie,

described this very disjunction between her experience and the idea of community

she described as being perpetuated by mental health services:

> *that's the problem when they talk about care in the community no-one is thinking what is the community y'know and these days with so many people where both people are at work and a lot of grandparents are still working as well y'know I'm a grandparent but a lot of us are still working erm and when you're not working quite often you're looking after grandchildren and things so people are doing a lot because they can't afford to keep a roof over their head and pay the bills otherwise it's not like everybody wants to be at work all the time [I:mmm] it's that you don't have a lot of choice now [I:yeah] houses are so expensive bills are so expensive specially down here water bills and stuff like that are ridiculous so it's like you have to have two incomes all the time just to survive and then you don't see people because you go out they go out most people I don't we don't have a car my son has one but erm so it's like you don't see people cos they get in their car they go to work when they come home it's dark [I:yeah] y'know and and at the weekends they're trying to catch up with everything y'know clean the house do the shopping so you just don't have those kind of community networks [I:mmm] and families are so dispersed as well so it's not like I mean I've got a daughter but she doesn't live close [I:mmm] my family are in Kent my husband's family are in London [I:mmm] and it it's kind of like people move around for job reasons and stuff like that now that you didn't have to [I:yeah] which is like people used to live with whole generations didn't they [I:yeah] and you would pass the children to granny and aunties and all sorts but yeah community like that just does not exist. (Julie, a woman in her late 50s, 637-659)*

Julie here can be seen to be describing the kind of nostalgic idea of community

identified by Symonds (1998), where "you would pass the children to granny and

aunties" (p. 4), as part of a close knit, proximal family, as one which "just does not

exist" (Julie, line 659). Julie instead describes dispersed networks of family and social

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contacts, atomised in individual homes and cars. This can be seen as a description of the arguably more dispersed nature of late capitalist lives, argued to have been in part produced through the explosion in travel and information technology (Castells, 2000), in contrast to the spatially proximal industrial working class lives described by Symonds (1998). Also described here is a considerable amount of toil involved in the production of 'community life', in terms of both paid and domestic work, which Julie contends further desiccates a nostalgic view of community living.

If a utopian idea of 'community' does not, by definition, exist, however, this still leaves open the question of precisely how the spaces of community care can be understood, as well as how they are experienced, used and managed by service users. This chapter will explore these questions, arguing that whilst the 'utopia' of community care clearly cannot exist in the lives of service users, Foucault's (1986a) concept of the 'heterotopia', introduced in Chapter Two, can be illuminating in exploring the configuration of the spaces of contemporary mental health care, as well as the ways in which they are experienced by service users. To recap, Foucault described a heterotopias as places: "which are something like counter-sites ... in which the real sites, all the other real sites that can be found within the culture, are simultaneously represented, contested, and inverted" (p. 24). It is argued here that mental health services, now dispersed across various sites in the community (Rose, 1998a; Symonds, 1998), can be understood as heterotopic; the ways in which wards and community service buildings: "organise a bit of the social world in a way different to that which surrounds them" (Hetherington, 1997, p. viii), will be explored. In addition, an understanding of contemporary mental health services as

operating under a 'control society' (Deleuze, 1992) involving the ongoing modulation of experience, also explored in Chapter Two, will be examined through looking at the modulated experiences of service users operating in community, non-service use space, and yet still under the influence of their positioning as service users. Finally, the ways in which services might also be understood to be heterochronic (Foucault, 1986a) will be explored, paying attention to the impact of the changed time of community services on service users' experiences.

4.2   Heterotopias of the 'control society'

A key feature of the sites of mental health care which was described by participants was an emphasis on control, surveillance and security. Firstly, Bryan, a participant in his mid 60s, described the psychiatric ward as governed by a preoccupation with observation:

> I've found that there's much less interaction [I:mmm] even between patients supporting each other I think go going back twenty years or so people really were interacting more with each other on the acute wards… there was more emphasis on interaction and more more kind of mutual support amongst patients. (Bryan, a man in his sixties, 325 – 331)

> there was nothing going on on the ward at all I mean I went through I think a three week admission where I had one conversation with a nurse literally one conversation […] and I actually tried to spend all as much time as I possible possibly could outside the ward. (Bryan, 359- 366).

> I think there's too much sort of managing patients and um observing patients and nurses actually if there are on the acute er on on in the day room for example if they are actually present in the day room they're not actually doing a great deal… on a couple of occasions I saw nurses sitting in the corner

of da of the day room on their mobile phones well to me that's completely wrong. (Bryan, 377 – 383).

The space of the psychiatric ward is here described as one of control, containment and surveillance, rather than of therapy. The experience of being on the ward itself is described as almost arelational; Bryan describes a lack of peer interaction between service users, as well as between service users and staff members. A lack of interaction on contemporary psychiatric wards has, indeed, been widely noted in studies from the perspective of both service users (Ford, Duncan & Warner, 1998) and nurses (Bowers et al, 2005; Walton, 2000; Whittington & McCauglin, 2000). Julie described a similar experience on the psychiatric ward:

nobody has got five minutes to sit down with you and when I ask staff about it they'll sometimes say yeah but we did talk to so and so when we were making their bed with them well we need more than that [I:laughs] (laughs) how long does it take to make a bed y'know and they're counting minutes whereas people want to have a conversation. (Julie, 892 – 896)

Julie here also describes a similar lack of importance attributed to conversation by nursing staff as seen in Bryan's comment that the nursing staff sit "on their mobile phones" (line 382) rather than engaging with service users. Bryan's description of the ward as a space for "managing patients and um observing patients" (line 377) can be seen to support Nikolas Rose's (1996; 1998a) contention that contemporary mental health care is "less therapeutic than administrative" (1998a, p. 179), based on the control of potential risk rather than the "cure or reform" (1998a, p. 181) of service users. Such a tendency can be seen in Ford et al's (1998) study of practices on the psychiatric ward, which noted the increasing time spent by nurses in the

ward office doing paperwork; administrating the ward, in other words, rather than engaging with service users. The descriptions above of the lack of therapeutic engagement on the psychiatric ward can be seen to support such a view; in these accounts, the ward is described as a reactive space, where staff observe service users passively, only engaging with them if there is 'trouble'. This pattern of behaviour has been observed in other studies of the contemporary psychiatric ward (Alexander & Bowers, 2004; Bowers et al, 2005; S.C.M.H., 1998; Quirk & Lelliot, 2001; Quirk, 2002), arguing that staff roles on the psychiatric ward are increasingly concerned with reacting to, and controlling, 'disruptive' behaviour. This can be seen to support Rose's (1998b) point; service users are described as being engaged with only when they display 'risky' behaviour, which then needs to be managed.

The ward can hence be seen to be here described by Bryan and Julie as epitomising 'control' practices, argued by Deleuze (1992) to characterise a 'control society'. As outlined in Chapter Two, Deleuze argued that the control society had replaced the disciplinary society argued by Foucault (1977) to have characterised Western society since the eighteenth century. It has indeed been argued that contemporary mental health care operates through the enactment of such dissipated mechanisms of control as surveillance, risk management, and enforced medication (Rose 1998a; Tucker, 2010), used to 'modulate' service users' behaviour and experience in the community. If the asylum could be seen to have existed to discipline individuals who deviated from the 'rational' norm (Goffman, 1961; Foucault, 1965; 1977), hence highlighting disciplinary practices operational in wider society (Foucault, 1962; Hetherington, 2011), here the contemporary ward can be

seen to hold a similar heterotopic relationship to a wider 'control society' (Deleuze, 1992), as a space which is described as primarily functioning as a container for 'high risk' individuals. Foucault's (1986a) mirror metaphor is useful here in understanding the ward as a which can be seen to contain, and reflect back, a wider 'control society' of community mental health care (Tucker, 2006; 2010), exemplified by the administrative, observation based risk management practices identified by Rose (1998a).

4.2.1   Making heterotopia visible: materiality on the ward

The concerns of risk, surveillance and observation (Harper, 2004; Moon, 2000; Rose, 1998a) described above as shaping relationships on the psychiatric ward, were also described as being made visible to service users through the material layout of the ward. Several participants described the ward as being characterised by highly visible security measures:

> *this is the hospital and the erm there's like bars everywhere but they're not meant to look like bars so they're in this criss cross pattern. (Lou, a woman in her early 30s, 37-39).*

> *so there are locks on the doors there as well but it's more obvious that there's a big lock [I:mmm] with a pin number on it whereas I can't remember what that lock was like [at private clinic] it could have it could have been that it was a key lock cos well it might actually have been a swipe card type lock so it's a bit more discreet that we're keeping you here and you're not allowed out whereas at the [NHS ward] […] it's a lot more obvious that this is a lock and you don't come in here unless we let you. (Zoë, a woman in her mid-twenties, 276-283)*

Lou and Zoë here describe the space of the ward as being characterised by security

measures, linked to "prison", such as bars and locks. These observations concur with research which has found that psychiatric wards are increasingly likely to be locked, and driven by security concerns (Bowers et al, 2009). Zoë, in particular, comments on the impact of the visibility of such measures, comparing the "discreet" (line 282) locks in a private clinic and the "big lock, with a pin number on it" (line 277) which is described as making more apparent the containment practices of the ward. Hetherington (2011) argued that a key feature of a heterotopia as a space, as constructed through both material and discursive relations in tandem, was that in its materiality, the space of the heterotopia makes visible the practices which it can be seen to invert, reflect and contain. Here, both Zoë and Lou can be seen to be describing the material features of the ward as making their containment visible; making their position as a contained person apparent.

A further feature of the materiality of the ward described by service users was the prevalence of observation and surveillance. Jimmy, the narrator of 'I Thought I was the King of Scotland', described his impressions of the ward:

I would like to explain a bit about the layout of the ward or prison I was now in, as you looked at the building from the outside all the windows were tinted glass so when people walked by they could not see in, as you got to the front entrance there were two double doors which were locked at all times and you had to speak through an intercom to be let in, just inside was a waiting area with another locked door which you had to wait at to be let onto the ward and if you had any visitors they had a little glass hatch with sliding doors were you had to hand over all your belonging [sic] as you were not allowed anything on the ward it was just like visiting someone in prison the only difference was you did get searched before you went on the ward. There were ten members of staff and eight patients [...] the nurses [sic] office was in

the middle of the ward with glass windows which I used to call the goal [sic]
fish bowl, so they could see what the patients were doing […] there was a
door leading out side [sic] to a small courtyard where you could go for fifth
teen [sic] minutes everyday for escorted with a nurse. (K.O.S., p.43).

Rachel, a woman in her 30s, described a particular room that she was placed in on one admission, where she was considered to be "high risk":

it was really near where the nurses were and it was a shared room and it had
a curtain down the middle and the door was a curtain and then here were
windows so they could see in on you um and they were that sort of they were
slightly frosted glass with that that non-smashable type so it wasn't like you
could literally stare in but you felt kind of and then you had a bed either side
and this was a curtain as well and this was basically this was basically near
the kind of near the nurses office as they put me there because they thought I
was high risk and it was so awful and this girl who lived in the other bed
snored all night and I couldn't sleep and then I think the sort of lack of privacy
like I didn't feel like I could change or anything in the room without people
being able to see in very easily. (Rachel, a woman in her early 30s, 249- 259).

It can be seen from both Jimmy and Rachel's accounts that the kind of observation practices described above, and in other studies (Alexander & Bowers, 2004; Bowers et al, 2005; Ford et al, 1998; S.C.M.H., 1998; Quirk & Lelliot, 2001) as typical of contemporary wards can be seen as contained and expressed through the material makeup of the ward. Jimmy describes a central "goal [gold] fish bowl" (p. 43) of an office, in which the nurses are described as spending most of their time (also noted by Ford et al, 1998). Similarly, due to Rachel's categorisation as "high risk" (line 256), the room in which she is placed is described as being designed for ease of staff observation, rather than her comfort or therapeutic benefit. The very walls of the

room have been removed, replaced with "frosted glass" (line 252) and only a "curtain" (line 254) separating Rachel from the other incumbent. To consider the role of these material features of the ward, it worth drawing on Bruno Latour's (2005) statement that: "[material] things might authorise, allow, afford, encourage, permit, suggest, influence, block, render possible, forbid" (p. 72) different actions, experiences and interactions. In Jimmy's account, service users and nurses are described as often separated by the material barrier of the glass walls of the office, which could be seen to "block" embodied interaction, and yet at the same time "allow" observation. At the same time, any interaction with the outside world can be seen as "blocked" by the tinted glass and locked doors. In Rachel's account, the glass and curtain can be seen to be described as participating (Latour, 1996; 2005) in Rachel's feeling of a "lack of privacy" and "the feeling that you were being constantly watched" (line 266). These material aspects of the ward can hence be understood as both containing (Reavey & Brown, 2009) and then reproducing an observer/observed relationship between Rachel and the members of staff, which in itself can be seen as both a product and producer of the centrality of risk in mental health practice (Moon, 2000; Rose 1996; 1998a). Here, the lack of walls in Rachel's 'room', and the transparency of the nurses' office, can again be seen as *making visible* (Hetherington, 2011) the practices of observation described by Bryan and Julie above; Rachel and Jimmy's positioning as 'risky' individuals in need of surveillance is not only produced through relations with the staff, but made visible, materially apparent, through the insubstantiality (translucent rather than solid walls; curtains rather than doors) of the material separation between themselves and the

staff. In Serres' (1995) terms, the materiality of the room be seen to 'stabilise' Rachel and Jimmy's subject positions, meaning that when they enters the particular space of either the ward, or Rachel's room, they are inescapably placed into the position of the observed, the potentially 'risky'. As such, the materiality of the ward can be seen to mirror, reflect back, Rachel and Jimmy's subject position as observed, to themselves, whilst at the same time also reflect out into the community the practices of control and observation which are argued to characterise contemporary community care, but are more hidden, and subtle, in spaces other than the ward.

4.2.2   Community mental health buildings as distributed heterotopias of control

As Rose (1998a) argued, contemporary community care can be seen as distributed across multiple sites, rather than confined to the single 'enclosure' (Deleuze, 1992) of the asylum. Many of the interviewees described the majority of their interactions with services as taking place in such community-based, non-residential service buildings, whilst others described seeing at least some professionals in such spaces. To some extent, the location of service contact seemed to be dependent on profession; whilst several participants discussed meeting their community mental health nurses in non-service use places, such as homes (for instance, Bryan) and public places (most particularly, Julie), contact with psychiatrists or psychologists was mainly described as located in specialist buildings. These varied from distinct community mental health buildings, outpatient units attached to inpatient psychiatric units, to rooms within other healthcare units, such as GP surgeries. Such clinics can be seen to exemplify that the organisation of contemporary spaces of mental health care does not fall neatly into an institution/community binary (Quirk

Lelliot & Searle, 2006), as could be argued to have been the case under the asylum system (Foucault, 1965), but there is instead a greater 'permeability' (Quirk et al, 2006) between the institution and wider community. Whilst being located 'in the community' and generally only accessed for short, defined, periods of time on an appointment basis, and hence differentiated from the sustained stays on the ward, these spaces were nevertheless described as still being partially characterised by the surveillance and risk management practices accounted for as being so intensely experienced on the ward. One key way in which such practices were described as being made visible to service users, as in the ward, was in the preponderance of locks and barriers in community service buildings, as can be seen in the examples from participants' maps below:
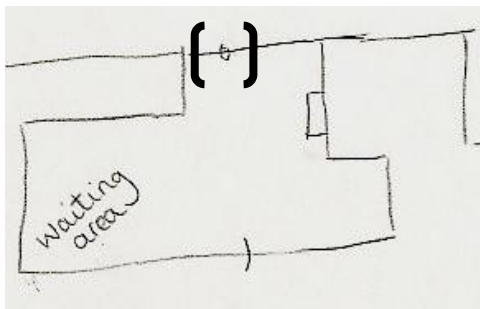
Zoë's picture of her outpatient waiting area with a large lock separating consultation rooms and service users.
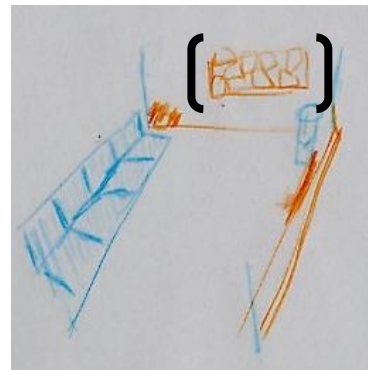
Lou's picture of her waiting area, with a barrier separating service users and reception staff.
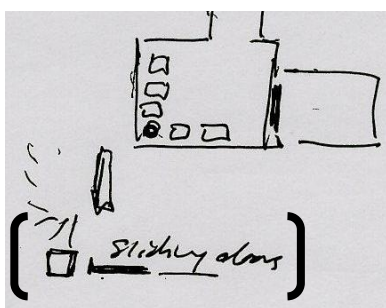
Rachel's picture of her waiting area
with sliding doors as a barrier
to entrance to the building.
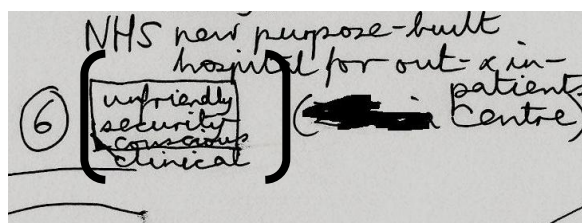
Frank's (a man in his 60s) picture of his
outpatient unit, emphasising the
"unfriendly, security conscious, clinical"
 nature of the space.

Despite their differential status as 'community' mental health service buildings, therefore, all of the units described here could be seen to be characterised in part by a continuation of the security practices of the ward (Bowers et al, 2005; Quirk & Lelliot, 2001), expanded across distributed community service buildings (Rose, 1998a). Whilst service users are not of course confined to outpatient units in the same way as a psychiatric ward, the descriptions of the buildings nevertheless revealed graduated, and visible, controls on access and movement within the buildings which can be seen as echoing the control practices of the ward. Rachel, for instance, whilst describing the décor of her outpatient unit as "quite bright and new and things" (line 51), also described the entrance as an uninviting, unmarked and locked set of sliding doors:

> it's got sliding doors I think um and a buzzer and it's generally you just press the buzzer and nobody ever talks to you but occasionally lets you in. (Rachel, 24 – 26).

I don't think it's a horrible place to go apart from this entrance which I dunno it's hard to describe but when you in it's just a bit bare and concrete with no signage or anything and I kind of think if you didn't if you didn't know where you were going that wouldn't be particularly pleasant and you know it's two floors up so you have to go upstairs. (Rachel, 58 – 60).

The doors and buzzer through which "nobody ever talks to you" (line 26) are here described as constituting a bleak, impersonal barrier which service users have to navigate before they can access the "bright and new" (line 51) space of the service. Rachel also describes this entrance as unmarked, "bare" and "concrete" (line 59), providing a blank face to the outside world; this could be understood as a visible sign of the stigma attached to mental health service use (Dillon, 2010; Link et al, 1989; Sayce, 2000; Scheff, 1974; 1999). Service users faced with this entrance are then also described as dependent on staff to be allowed into the building; here the buzzer can be seen as 'containing' (Reavey & Brown, 2009) a power differential between service users and staff, affording little agency as service users must wait until someone "lets" (line 26) them into the building. On entering the service, therefore, service users can be seen as immediately positioned as passive. The passivity argued to be inherent in a service user subject position (Campbell, 2007; Scheff, 1999; Goffman, 1961; Repper & Perkins, 2003; 2004) can here be seen to be in part produced through the material makeup of the space of the outpatient clinic. Through such features of community mental health service buildings, they can therefore be seen as further heterotopias of a control society (Deleuze, 1992) which, it is argued here, can be seen to define contemporary mental health services. Service users are again here being positioned as observed, passive and

differentiated from staff, in need of observation and management (here, the management of their access to the ward).

4.2.3 Moral management: material positioning of dangerousness

Several participants also described the layout of services, with visible markers of control, as inculcating a stigmatised, 'dangerous' and devalued subject position. Lou, for instance, described her waiting area:

> *it's really quite scary because it's just you know that there's some really disturbed people come into this place and sometimes they're really smelly and and and you know obviously drug user or or a drunks you know erm and it's just quite you just never know what you're going to come across and there's a funny smell there as well and just the way that the other people are barriered you know barred off from you [I:mmm] like you're the plague I dunno I just really dislike it I think it's an awful space to wait um it's just like nobody really cares you know no-one cares it feels really like you know we're not worthy of a decent space you know [I:mmm] it's like this waiting room with these ancient magazines […] and it's kind of a relief when whoever you're waiting to see the psychiatrist or the psychologist or whoever sort of comes in and calls your name and then you get to go behind these big locked doors and go up you know into these tiny little rooms but it's it's just I dunno it's quite a bizarre space I think it's really could be more open [I:mmm] it's so enclosed and lock you're locked away like you're you're… don't know like hmm like you're dangerous or something I guess. (Lou, 324-345)*

Karl similarly discussed the ways in which the waiting area of his mental health building made his feel classified as "dangerous" and a "transgressor":

> *I'm not in my mind you know I'm not one of those people [I:mmm] you know I'm not the transgressor I'm not you know this person being lead away in handcuffs […] you know 'these are the types of people you're forcing me to*

rub shoulders with' he says indignantly [I: (laughs)] you in a mock accent um (sighs) yeah it just you know it really just makes me sit there some days and just go you know here's a person who tried to sexually assault me here's a person who's being led away in handcuffs in the street um you're like you know the jumpsuit and everything (laughs) you know what I'm saying it was just surreal and I'm sitting there going oh it's you know I'm sitting here feeling sorry for myself in the waiting room but this person beside me also looks quite normal and you know normal so I guess it really can affect anyone no it's doesn't affect her except it's her job to look after the guy who's in prison. (Karl, a man in his early 30s, 563 – 577)

Karl here describes an experience of discomfort with being associated with the other people in the waiting area, here accounting for this both in terms of their mental health and also other 'transgressions', particularly criminality. In this incident he describes seeing a woman sitting next to him who looks "normal" (line 575) (here meaning middle class and professional) but rather than her being another service user it transpires that she is there to escort a prisoner using the service. The contemporary association of mental health with risk, dangerousness and criminality (Harper, 2004; Moon, 2000; Phelan, Link, Steuve & Pescosolido, 2000; Rose, 1998a) can here be seen to be participating in the imposition of a 'dangerous' subject position when located the space of community services. Accounted for as co-participating (Latour, 2005) in the production of this experience for service users are the material objects and layout of the space. In Lou's account, for instance, locks and the glass barrier do indeed literally enclose her in the space, dividing the staff (who are able to move freely between the different spaces in the service) from the service users (who are not). Again, this can be seen as affording Lou little agency

within the space, as seen with the barrier in Rachel's account. As described by Lou, these locks and barriers can be seen as contributing to the feeling of being classed as "dangerous" (line 345) due to the association of locks and barriers with criminality and prison. These material aspects of the space can be understood as both social produced and socially productive (Massey, 1994c; Lefebvre, 1991). A barrier between the service users and reception staff can be seen as both having been *produced by* an assumption of difference and dangerousness, and then also helping to *produce* the experiences described as being "classed as one of them", as being a separate type of person to the reception staff. In Serres' (1995) terms, the barrier could be seen as 'stabilising' this distinction; because of its presence, persons entering the space will be placed on one side or another, ordered into either 'service user' or 'staff'. These features of the community mental health buildings described here can hence be seen as heterotopic, as the locks and barriers present can be seen as making *visible* (Hetherington, 2011) to service users the position that they are being placed in; as dangerous other, as those in need of control and surveillance.

Lou's comments on the tattered nature of her waiting room as producing a feeling of being "not worthy of a decent space" (line 336) can also be seen to indicate a moral dimension to the visible positioning of service users here described. Psychiatric labelling has long been argued to contain a moral judgement (Goffman, 1961; Scheff, 1999; Szasz, 1960), designating those labelled as morally inferior, or tainted. Here Lou seems to be describing the shabby nature of her waiting room with "a pile of old magazines in the corner so old they're ancient and there's a watercooler which I just wonder if anyone ever drinks water out of" (320 – 322), as

highlighting, again, making visible (Hetherington, 2011), this moral judgement through the materiality of the space she is assigned as a service user. The blank, sign-less entrance to Rachel's outpatient clinic, described above, can similarly be seen as indicative of a value judgement; the front presented to the outside world is bare, concrete and bleak, making visible the status of the experiences discussed inside. The shabbiness of these buildings also indicates a positioning in the economic order, which could be argued to make visible both the low economic power of many service users (Perkins, 2002; Warner, 1985; 2000), as well as a privileging of the 'productive citizen' (Walker & Fincham, 2011). What all participants here can be seen to be describing is the way in which the materiality of community mental health service buildings help contribute to an experience of being positioned as dangerous, morally suspect and devalued; in other words, subjects in need of control. Community mental health buildings, therefore, can be seen as heterotopic in similar ways to the psychiatric ward; both highlighting, reflecting and making visible the control practices (Deleuze, 1992), risk management (Rose, 1998a) and moral judgements (Goffman, 1961; Scheff, 1999; Szasz, 1960) argued to be inherent in the construction of contemporary mental health care, and indeed, present in wider social practices. In this way it can be seen that the spaces described by participants as comprising contemporary care are produced by their relationships with each other (the ward and the community mental health centre), and extend out into other community spaces.

4.2.4 Modulated subjectivity in the community

The sites which make up community mental health care can hence be seen as constituting a series of heterotopias of control; when in such places, participants describe the inculcation of a particular passive, stigmatised subjectivity, which is in part made visible by the materiality of these sites. A key feature of contemporary service use, however, is that service users are not confined to these official service use places for the majority of their lives. This does not mean, however, that service users can simply leave this subject position 'at the door' of mental health services, instead participants described the complexity of negotiating a residual subjectivity (of passive, stigmatised service user), made visible in service use spaces, across different community spaces. The experiences described by participants could be seen to echo Deleuze's (1992) argument that control societies operate through an ongoing, dissipated modulation of experience and subjectivity:

> Enclosures are *molds*, distinct castings, but controls are a *modulation*, like a self deforming cast that will continuously change from one moment to the other, or like a sieve whose mesh will transmute from point to point. (p. 4)

Extending out from the heterotopias of community mental health care, therefore, can be seen to be an ongoing modulation of service users' subjectivity; rather than being either in an institution, or enclosure, and therefore in need of change, or 'in the community', and therefore deemed sufficiently 'normal', Deleuze's (1992) argument would contend that service users are instead subject to ongoing modulation, assessment and monitoring (Rose 1998a). This extension of control, and a corresponding passive, stigmatised subject position, into the community was not, however, described as uniform across the different spaces which participants

described inhabiting in their everyday lives. Some participants described particular experiences of community spaces which afforded a more active, agentic subject position than that bound up with service use. Karl, for instance, described his experience of playing football:

on the football pitch […] I'm not a patient I'm an active participant [I:mmm] and I'm able to do and I'm able to keep up you know not keep up to excel and to do to do what I used to do and to do what I normally do. (Karl, 941-945)

Similarly, Lou described two spaces which afforded an active subjectivity for her, firstly the gym:

I love the gym I love the gym [...] it's a place where no-one knows who I am [I:mmm] no-one needs to know but I can just sort of be [...] I like I even like using the shower there and that kind of thing because I really hate being at home and anything that I can not do at home [I:mmm] is is really good so I really I like showering there and doing my hair there and you know it sounds really stupid but just you know eating lunch there I just really like the I really like the space … it just feels easier it just [...] it's more comfortable it's it's like I guess this is a space that I don't mind being mine I don't I don't have any issues about being a member of a gym well apart from the fact that I'm really fat but I figure I'm in the gym so you know what can you say but um you know and that's like the that's something I've always had so that's a pre being depressed [I:mmm] it's like it's like I feel normal there I feel like I'm not in an institution I feel like I'm not special. (Lou, 572-598)

As well as her voluntary work in a charity shop:

the charity shop that I work in I really like it … I like the system of it and you know you've got a job to do and you know and and when you're not serving the customers you've gotta be making sure the hangers are all in the right place and that the the size of the so it's really kind of mind numbing work you

know it's not really anything that you have to use your brain for very much but you know you get to be happy with the cust you get to chat with the customers and [I:mmm] you know put on a happy and and feel like you're sort of I don't know contributing to somebody's day without investing too much in it investing too much emotion in it I guess so I do like it and I kind of like there's a lot of people who work there but it's kind of slightly anonymous no-one really knows anything about me there [I:mmm] and I can sort of tell them things or not tell them things so it's kind of like it was kind of like having a clean slate and walking in and I could be anybody to them you know I didn't have to be stupid depressed Lou you know I could be happy Lou. (Lou, 543-563).

Both Karl and Lou explicitly compare the agentic subjectivity produced in these spaces with that afforded by service use, saying "I'm not a patient" (Karl, line 941) and "I didn't have to be stupid depressed Lou" (line 563). These experiences of an active, productive subjectivity are described as being in part produced through the embodied activities performed in these spaces, and also through Lou and Karl invoking the wider meaning of the spaces in question. The geographer Edward Soja (1996) argues that integral to the construction of particular places are 'imagined spaces', the conjured meaning of a space, including its wider social and cultural meaning. A school, for instance, can be seen as made meaningful by a generic idea of what a school is, the broader meaning of education and learning within society, as well as existing as a particular, specific site. Both Lou and Karl here can be seen to be drawing on the 'imagined' qualities of the spaces described in order to enact an agentic subjectivity; the kinds of spaces described here can be seen as associated with activity, normativity and productivity. Exercise, for instance, is widely linked with the production of a functional self and normative appearance (Crawford, 1984;

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Lupton, 1995), whilst engaging sucessfully in workplace productivity has been argued to be the key marker of access to adulthood and citizenship in late capitalist societies (Warner, 2000; Fincham & Walker, 2011). Karl and Lou's descriptions of experiencing a more active subjectivity within these spaces dedicated to these two activities, therefore, can be seen to have a moral dimension; in participating in the embodied activities of sport and work, they can be seen to be accessing a different 'imagined' subject position to that perpetuated through service use, that of an active, productive citizen, in control of their body (Crawford, 1984; Lupton, 1995). Lou's transference of her daily activities, such as showering and eating, to the space of the gym, could be seen as an attempt to extend this experience of subjectivity beyond engagement in exercise activities. Lou specifically states that she does so because "this is a space I don't mind being mine" (line 585), in contrast to her supported housing accomodation; the 'imagined space' of the gym, with a corresponding 'imagined' active subject position, can be seen as one which Lou uses to attempt to (temporarily) dispel the subjectivity afforded by her service use.

It is noticeable, however, that any dismissal of the modulated subjectivity inculcated through service use described by Lou and Karl here, is firstly highly located (confined to particular spaces and activities), and also fragile. Lou, for instance, described an incident when her positive experience of the gym was disrupted:

> *I did start crying when I was at the gym a few weeks ago and that was um because I had to look in a mirror [...] I didn't wanna look in the mirror because I didn't want to look I guess no I guess that's part of it because I didn't wanna see the reality I wanna be this like I could be anybody [I:mmm]*

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while I'm in the gym and and and and I don't have to be sad depressed Lou but when I look in the mirror that's what I see is sad depressed Lou so I I didn't wanna look in the mirror while I was at the gym because you know I'm somebody I I can be somebody else [I:mmm] I feel like I don't have to be this really sad person. (Lou, 613-622).

Here, Lou describes a puncture in the form of subjectivity described as engendered by her active involvement in the gym. She describes looking in the mirror as involving an insertion of "reality" (line 616) into the space of the gym, more specifically of seeing in her reflection "sad depressed Lou" (line 618) while her engagement in the gym is accounted for as enabling her to be "somebody else" (line 621), not "this really sad person" (line 622). Whilst the gym can usually be seen to enable Lou to access an 'imagined' subjectivity of activity and productivity, here the insertion of a visible reminder of her distress, and the kind of subject (and moral) position involved in being a service user, punctures her use of the 'imagined space' of the gym to dispel this devalued subject position from her experience. In a similar way to which the materiality of service use buildings can be seen as making visible to service users their subject position (dangerous, risky, in need of control), here the presence of the mirror can be seen as making Lou's status as a service user visible to herself, puncturing the subjectivity usually afforded by the gym. This can be seen as implying that the successful production of the kinds of active, productive subject positions described by Lou and Karl are in part contingent on the exclusion of distress, and hence the expulsion of their modulated service user subjectivity.

Participants also described a similar use of space to modulate their interactions with services when not in specialised service use sites. Both Zoë and

Janet, for instance, described managing the distribution of service use contact across community spaces:

> *I didn't like it when the CPN come round in fact I used to like cancel all the time in the end I used to be out. (Janet, a woman in her 30s, 160-161).*

> *I put a stop to people coming to the house bec in fact I've never had anybody in my house as in when I first got ill I was living with my mum and dad and there was a home treatment team that were assigned after one probably quite silly episode where something y'know when things had got quite bad and they would come here to mum and dad's house and I hated it because to me that's my space [I:yeah] and it I dunno I just I think that y'know you come home to your own space and to your safe place and to have that intrusion where people are coming in and saying how are you well how I'm not well but I could tell you that in a hospital [I:mmm] where ill people go [I:mmm] ill people aren't at home it's just for me it was always you're either ill or sad when you're at home you just feel a bit sad and when you're at hospital you're ill and the two for me didn't mix. (Zoë, 157-169).*

Both Zoë and Janet here describe excluding service contact from their home spaces, instead choosing to only interact with professionals in designated service use places, primarily the outpatient units described above. Zoë could here be seen to be describing her exclusion of professionals from her home as a protective measure she has taken against the "intrusion" (line 164) of a medicalised 'ill' subjectivity into her home space. In this account, Zoë links the production of two different understandings of her experiences with either her home ("you just feel a bit sad", line 168) or hospital ("where ill people go", line 166). The first is normalised, and implies a transitory experience; everyone gets sad, and it is not permanent. "Ill people" (line 166) on the other hand, is both medicalised, and implies a global

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subjectivity; the whole person is ill, rather than merely experiencing a negative emotion. Medicalised explanations of distress, and psychiatric diagnoses, have indeed been widely argued to confer such a global subjectivity on those who are diagnosed, designating people 'a schizophrenic', for life, rather than someone who has psychotic experiences at some points in their life (e.g., Campbell, 2007b; Bentall, 2003; Rapley et al, 2011; Romme et al, 2010). Being 'mentally ill' rather than 'sad', also, as seen above, also confers a necessity for control, and the kinds of subject position seen above as being made visible in service use spaces, of the stigmatised and morally devalued trangressor. Zoë can be seen to be describing a resistance to the extension of the kind of subjectivity into her home space, and hence being positioned in this way in parts of her life not directly associated with service use.

4.3   Heterochronicity

As well as identifying a heterotopia as a space which encapsulates and reflects back practices in other spaces, Foucault also described heterotopias as places which had a particular, differentiated relationship to time:

> Heterotopias are most often linked to slices in time – which is to say that they open onto what might be termed, for the sake of symmetry, heterochronies. The heterotopia begins to function at full capacity when men [sic] arrive at a sort of absolute break with their traditional time. (Foucault, 1986a, p. 24).

Several participants described the ward as being experienced as a break in ordinary or everyday experiences of time. Heterochronicity, for instance, can be seen to be present in Lou's description of her time on the psychiatric ward:

I didn't need to think anymore it was kind of like someone stopped the world so I could get off you know it it's it was it was I needed that [I:mmm] sort of exclusion from society. (Lou, 357 – 359)

While Suzannah, the author of 'Black Magic' commented that:

People in mental hospitals aren't on an even keel so you can never really make any firm friends, and the friends you do make are a suspension in time. I found I was better off alone and kept myself to myself. (p. 37)

Both Lou and Suzannah here can be seen to be describing their experiences on the ward as detached from their everyday experiences of both relationships, and of time. Both the phrases "stopped the world" (Lou, line 357) and "suspension" (B.M., p. 37) indicate a differentiated, specialised experience of time on the ward. Compare this description of the experience of time as suspended, to the driving, continuous activity and movement described as part of 'community living' in the earlier quote by Julie:

they get in their car they go to work when they come home it's dark [I:yeah] y'know and and at the weekends they're trying to catch up with everything y'know clean the house do the shopping. (Julie, 649 - 651)

This sense of a relentless procession of time and activity described as necessary in the production of a successful community life, stand in contrast to Lou's description of the ordered and managed arrangement of time and activity on the ward:

I didn't have to think about anything or do anything or talk to anyone I just didn't have to think about anything and mealtimes were at a certain time and they'd come and knock on your door and say oh it's time for your dinner or time for lunch or whatever time for medication and you'd line up and get your medication and then you'd go back to your room and it just felt really it felt really like I could shut out the world. (Lou, 110 – 116)

The routine of the ward, with structured mealtimes and medication rounds, is described as (initially at least) being experienced as beneficial. Whilst, as has been widely argued (Goffman, 1961; Mosher, 1999; Warner, 2000) it can be seen that Lou is positioned as passive by these practices, here the regulated, heterochronic organisation of time on the ward is described as being experienced as providing respite from the demands of community living, through not having to "think about anything or do anything or talk to anyone" (Lou, line 110). Indeed several participants, and some narrators, described residence on the ward in this way. Rachel commented:

> it's not like I absolutely hated being an inpatient because in some ways I think it was a bit of a relief. (Rachel, 283-284)

While Ralph also commented that this sense of respite was a key feature of his experience of the asylum he had been admitted to in the past:

> it was outside the stress of life I mean the word asylum taken away innit [I:mmm] so I I think that's a good thing not to have the pressures yeah [I: mmm] yeah [I: so kind of] the pressures lifted off your shoulders yeah. (Ralph, a man in his late 60s, 514-516).

The sense here of the ward as being a "suspension in time", operating as a place and time apart from the rest of participants' lives, can here be seen to have been retained as an experience from, as Ralph comments, an older idea of 'asylum'. This is perhaps in some ways surprising. Contemporary wards tend to be accessed for relatively short periods of time (as noted in Chapter One, the median stay in 2009/10 was only 16 days, D.O.H, 2010), and have been argued to be more 'permeable' (Quirk et al, 2006) than the 'total institution' (Goffman, 1961) of the

asylum, as links are retained to the outside world through frequent visitors and the wider availability of drugs and alcohol on psychiatric wards (Quirk et al, 2006). Nevertheless, as seen above, participants did often describe their time on the ward as experienced as a kind of pause, a suspension in everyday time and relationships. The stated focus of community services is increasingly on 'mainstreaming' and 'social inclusion' (D.O.H., 1999; O.D.P.M., 2004; Repper & Perkins, 2003; Sayce, 2000; Spandler, 2007; Wallcraft, 2001), and so can be seen as pushing service users into activities and relationships which require the kind of ongoing maintenance described in Julie's quote above; this can be seen particularly in the governmental focus on paid work for those diagnosed with mental health problems (Perkins, 2002; Walker & Fincham, 2011). The ward can hence again be seen to be heterotopic in the sense that such a continuous maintenance of relationships and activities, with its corresponding experience of time as driving onwards, is "contested and inverted" (Foucault, 1986a, p. 24): rather than activity-based, the ward is described as a "blank space" (Bryan, line 359), characterised by boredom (Ford et al, 1998; Walton, 2000; Warner, 2000); relationships are similarly described as a "suspension in time" (B.M., p. 37) rather than ongoing; and the experience of time this is described as producing is that of time as "stopped" (Lou, line 358). These heterochronic features of the ward could be seen, again, as an inversion of everyday practices and expectations off the ward. As the occupational therapists Kantartzis & Molineux (2011) comment:

> In Western society, religious, economic, political and other social institutions have combined to construct a daily life that involves the active pursuit of individual goals and an ongoing striving for new experiences and meanings, where work and other productive and goal orientated activities are

particularly valued […] and an important part of self identity […], and where time is a valuable resource to be used appropriately. (p. 4)

The descriptions of the time of the ward can be seen as heterochronic to such experiences of time, as something to be used productively (Carrasco, 2005) in the ongoing achievement of goals. The ward, conversely, is described as a place of little activity and an almost stagnant experience of time, broken off from the ongoing experiences of everyday life.

4.3.1   Heterochronicity of community services

Time was also a key issue discussed by participants in regard to their interactions with community services. Interactions with services in the community were described as taking place in curtailed periods of time, with participants mainly interacting with services during designated appointments (rather than, for instance, using a drop-in day centre, cf., Parr, 1997). Participants often described such interactions as being partially characterised by pressures of time. Bryan, for instance, described the interviews with his psychiatrist as perfunctory:

> *the outpatient clinic certainly in the last couple of years has has bin a question of going in talking to the doctor for a maximum of five minutes and then that's it [I:mmm] so very very basic erm just answering simple questions like are you taking your medication what is your medication and taking erm are you taking your medication are you sleeping are you eating or is your appetite alright that sort of thing so very very basic and quite often the the doctor looks quite bored and is yawning. (Bryan, 78 – 85)*

Whilst James, a man in his 50s, discussed his visits to the psychiatrist as similarly curtailed:

when I go and see the consultant I'm normally quite compos mentos [I:mmm]
and he says how have you been and I say well a couple of weeks or a couple
of months ago I wasn't feeling well th er er then they would ask questions
well in what way weren't you feeling I can't I couldn't remember I feel and er
I can't really describe it so I go away feeling a bit frustrated [I:mmm] not
pinning the problem down but even if I did they the they would just say well
we've offered you medication you're turning it down and I say well do you
blame me I nearly died as a result of the last lot. (James, 237 – 243)

Bryan's account here can be seen as further reflecting the centrality of administration in contemporary services (Rose, 1998a), as Bryan's meeting here can be seen as dominated by an assessment of risk, with the potential of raising medication levels if Bryan is deemed to be too risky. It could be seen that because of this function of the interaction, the time which Bryan is given to discuss his distress with his psychiatrist is reduced to the bare, administrative minimum. James similarly highlights the centrality of medication in his interaction with his psychiatrist, describing an increase in medication as the only outcome for any description of distress. James also accounts for the curtailed, partial nature of his dealings with services as leading to a difficulty in expressing or remembering the particularities of his experiences. The rationed nature of the time described here can be seen as in part a function of the changed landscape of mental health services; compared to the all-encompassing space-time of the asylum (Goffman, 1961), here the distributed nature of the control practices (Deleuze, 1992) of community services can be seen as leading to a shrinkage, and structured apportioning, of the time spent directly interacting with services. The interactions described here are accounted for as centred around the monitoring of potential risk, to be limited through medication,

and hence the space-time allocated for such interactions is described as functional and perfunctory. The interactions described here could be compared to a description by Rachel of how she used the space of a day centre a number of years ago:

> *this room [referring to the lounge] was was really really nice and first thing in the morning when you came in you could just sit in there and I think probably for the first couple of months I went to the day centre that was all that I did I didn't join any of the I didn't like go to any of the groups and I dunno I think I just kind of saw it as a place to get away from pressures of work or [I:mmm] I dunno not that I was incredibly pressurised by work but just to you know get just to relax I suppose and I saw the day centre just as somewhere to do that and [I:mmm] I didn't see any particular use in going to anything like art therapy or woodwork or relaxation but I think once once I'd been there for a while I started going to those things and finding them really helpful but I think the fact that it was a nice place to be anyway meant that I kept going even though I didn't chat with any of the groups and things. (Rachel, 139 – 151)*

Rachel's description of the space-time (Massey, 1994a) of the day centre can here be seen as almost opposite to the accounts given by Bryan and James above. Rachel describes her time in the day centre as unstructured; she describes being able to simply sit in the lounge area and "get away" (line 143) from her everyday experience of space-time ("pressures of work", line 143). The heterchronic qualities of the day centre, similar to those described in the ward above, are here described as enabling an experience of rest and respite, and this as being more valuable to Rachel than the more official 'therapy' available. It is noticeable that this experience was from a service Rachel had attended ten years previously; under the social inclusion and

recovery agenda, day centres are becoming far less common (D.O.H., 2006; Spandler, 2007), and the kind of unstructured, yet heterochronic time (apart from the surging nature of everyday space-time), in services here described far less easily available for service users.

Some participants also discussed certain interactions with services as characterised less by administration and more by the open discussion of distress. Distress and madness are often hidden and privatised, excluded from expression in public spaces (Estroff, 1981; Foucault, 1965; Knowles, 2000a; McGrath et al, 2008; Sibley, 1995; Parr, 1997; 2008). An invisibility of distress was described as reversed in certain therapeutic interactions; this was particularly described as the case for participants who had experiences of psychotherapy, the purpose of which can be seen to be the open discussion of distress. Yet, as noted above, such discussions were also described as limited to the prescribed slice of time allocated for a therapy session. Karl discussed the effect this heterochronic portion of time in his week had on his everyday experiences of distress:

> *say on Thursday when something else had come up again related to er all of this um I was I thought ok I'm feeling anxious about that but I have a place for that you know my Tuesday afternoon [I:mmm] at three o'clock I will go in and that is when I will deal with that so you it it helped me to compartmentalise it or it didn't help and I was avoiding it but instead of falling apart on Thursday evening I was saying ok save that and let's look at that on Tuesday [I:mmm] well I'm y'know so I was pleased to have not a physical space to go to [I:mmm] but a space in my week or a space in my head. (Karl, 266-273)*

Karl here describes the allocation of a specific, structured slice of time during his week as enabling him to "compartmentalise" (line 270) his ongoing distress, to push away experiences of distress during the rest of the week to pour all of his "falling apart" (line 271) into his allocated hour. The time spent interacting with services is hence described as being rationed, and sectioned off from his everyday, ongoing experiences and interactions. This can be seen as another example of the heterochronicity of the spaces of service use; the time spent in his therapy session is described as apart from, and yet related to, his ongoing experiences of distress. The discussion of distress "on Tuesday" (line 272) can also be seen as reflecting back the lack of space for such discussions, or visible experiences of distress, in the rest of Karl's week (Davidson, 2000a; 2000b; Parr, 1997; 2008; Sibley, 1995); the relatively 'hidden' nature of distress (Sibley, 1995; Weintraub, 1997) in the rest of Karl's week, in other words, can be seen as "represented, contested, and inverted" (Foucault, 1986a, p. 27), in the curtailed, apportioned time given to visible distress, in therapy. Karl here accounts for this partioning of time as relatively positive, as it enables him to successfully produce a kind of productive, non-distressed subjectivity for the rest of the week, as all discussion of distress is pooled into his allocated therapeutic hour. Also discussed by participants was the issue of transition, from the exposure and open discussion of distress required in therapeutic interactions, to the production of the kind of subjectivity required in everyday living. Lou, for instance, discussed her experience of psychotherapy:

> *and I just felt like someone was digging into my soul and and pulling up all of this rubbish all this junk that had been festering at the bottom and then just leaving me to deal with it [I:mmm] so bringing it all to the top and sort of this*

big revelation well I really think you don't like yourself in fact I think you hate yourself well I think that I do 'ok that's the end of the session see you next week' and it was just like what am I supposed to do and and it was two weeks until the next session what am I supposed to do with that with those emotions and I go back to this place where I don't like to be and and … e wa and yeah and try and deal with it and it was awful. (Lou, 260-268)

Whilst Karl discussed his ritual for transition between counselling and his everyday life:

in the toilet [...] I say catch my breath I kind of brace myself both before and after um [I:mmm] literally and metaphorically [...] splashing water on my face um and that toilet smells (laughs) just for the record so I can you know I go in there before hand just to that last moment between outside world [I:mmm] London Underground harassed fighting off people in traffic and the person that I am [I:mmm] in the outside world because in in our little counselling room um [therapist] has said to me you know you're too strong you're too guarded you're too this is you know is this how you are in the world [I:mmm] well yes it's how I am in the world because I'm not going to just be a puddle of pudding for [I:mmm] every no-one else needs to see that or wants to see that and it isn't useful or … or you know efficient or effective [I:mmm] how would you live your life if you were just wearing your heart on your sleeve all the time [...] and so that's my kind of um er like the decompression zone [I:mmm] on a space ship I go in I go ah ok look in the mirror and kind of put myself into that space of being able to let this complete stranger [I:mmm] ask me incredibly private questions [...] and then afterwards you know we do the classic thing of well 'I'd really like us to explore this more next time but we've run out of time' right ok I'll just pack everything back up [I:mmm] put it inside zip up the front of me and go back out into the world [...] so my my kind of ritual is that I go in I feel very raw I have my decompression back into the world so I'm not going to cry in the street on the way out [I:mmm] and then I exit I go out I walk past the coffee shop where the staff from the clinic go to

have their coffees [I:mmm] and I walk down the road to the next coffee shop

and I have a coffee and a muffin [...] I need to sit somewhere for half an hour

so what do I do I sit for half an hour with a medium cappuccino [...] and a

muffin and the rest of the world can go to hell and I think about what we've

talked about and I do or don't think about that um and just kind of get myself

back to going out into the rest of the world. (Karl, 352 – 393)

Both Karl and Lou here describe an incompatability between the kind of subjectivity required in therapy and the embodied subjectivity that is described as being expected in everyday community living. Karl describes therapy as necessitating being emotionally "raw" (line 372) and open, describing a corresponding embodied experience of being a soft "pile of pudding" (line 362) with his "heart on my sleeve" (line 363). In his everyday life, in contrast, Karl describes a contained, armoured self consistent with a normative Western, and particularly white, middle class, and male subjectivity (Brannon, 1976; Kilmartin, 2005). As argued by Ian Burkitt (1999), drawing on Elias (1978; 1982; 1985) armourment can be seen as a key experience of the body which emerged in tandem with the privatisation of emotion and sexuality following the Renaissance period:

> these are bodily experiences that are private; they pulsate under layers of clothing, behind the barriers of reserve and are expressed only in private chambers of the household. The barriers of reserve and the restraint on feelings become a body armour, frozen into our movements, gestures, posture and musculature. (Burkitt, 1999, p. 52)

Karl's emphasis on projecting strength, and in particular, a lack of emotional vulnerability, can be seen as indicating a successful production of this kind of normative subjectivity, which can in turn be seen as being at odds with the

heterotopic and heterochronic space of the counselling room. Lou similarly describes her experience of therapy as disrupting her everyday embodied experience, in bringing up "rubbish" (line 262) which she then must deal with alone, in spaces in the community where visible distress can be seen as stigmatised (Estroff, 1981; Knowles, 2000a; Sibley, 1995; Parr, 1997; 2008). The apportioned nature of the time of therapy, pushed up against everyday spaces which require the production of a differential subjectivity, is here described as deeply problematic for participants. The location of mental health services in the middle of ordinary community spaces, despite the highly particular mode of being which is described as being required when engaging in therapy, is described as requiring too sudden a transition from one mode of being to another. The modulation of Lou and Karl's embodied subjectivity (from guarded to emotionally open) which is described as taking place within therapy can be seen as being described as rendering them less able to operate successfully in community spaces. Yet there are no allocated spaces for them to deal with these experiences. Karl is indeed forced into the toilet in his services to manage his transition back into the world, to "pack everything back up" (line 370). Even Karl's transition into the anonymous commercial space of a coffee shop as a breathing space to "get myself back to going into the rest of the world" (line 393) is described as limited by the presence of staff from the mental health service sharing the same, generic community spaces. The partioned and highly structured nature of the space-time of services is hence described as producing a lack of space-time for service users to manage and process the kinds of emotions and changes in embodied subjectivity which are produced during their curtailed

contact with services. The kind of space-time described by Rachel above, of her day

centre simply being a "nice place to be" (line 150) where she could benefit from the

construction of the day centre as a place where distress could be made visible,

without engaging in structured therapy, is glaringly absent from the more recent

descriptions of mental health services.

4.4   Conclusions

This chapter has argued that contemporary mental health service sites can be seen

as operating as heterotopia (Foucault, 1986a) of a control society (Deleuze, 1992),

characterised by observation, surveillance and the administration of risk (Rose,

1998a). Furthermore, it has been argued that a key part of the production of wards,

and community mental health service buildings, as heterotopia can be seen to be

the materiality of the buildings, particularly in the visibility of locks and barriers. In

turn, these spaces are argued to be described as 'modulating' (Deleuze, 1992)

service users' subjectivity, by making visible (Hetherington, 2011) a stigmatised and

morally suspect subject position as service user (Campbell, 1996a; 2007; Haywood &

Bright, 1997; Link et al, 1989; Repper & Perkins, 2003; Sayce, 2000; Scheff, 1974;

1999; Szasz, 1960). Participants described, however, a complex relationship

between their positioning as part of service use and subjectivity as enacted in non-

service use spaces; some participants described particular spaces (the gym; home)

as enabling the production of alternative experiences of subjectivity, such as 'active

citizen' or being 'just sad' rather than 'ill'. Finally, it was argued that time in services

can be seen to have heterochronic (Foucault, 1986a) features, in the sense that

time can be seen to be 'differently ordered' in service use. The 'blank' time of the

ward was described as providing (for some participants, in some circumstances) a respite from community experiences of time and space (Carrasco, 2005; Kantartzis & Molineux, 2011). In addition, the curtailed apportioning of time within community services, under an appointment system, was described as providing a curtailed time for service users to discuss distress, in comparison to a relative silencing of distress in public space (Estroff, 1981; Knowles, 2000a; Sibley, 1995; Parr, 1997; 2008). The movement between these apportioned slices of time, especially in the context of psychotherapy, and the everyday production of subjectivity, was described as complex and often problematic. In light of this overall picture of the landscape of the spaces of mental health care, and the management of service user subjectivity, the succeeding two empirical chapters will explore two key issues arising from this picture of services as playing a role in service users' lives which can be seen to be partial, in terms of space and time, yet still modulate ongoing experiences of subjectivity and distress. Chapter Five will look at the differential experience of distress in spaces in the community, given the context that most of service users' time is now spent in non-service use spaces. Chapter Six will then consider one aspect of service users' experience which has arguably become more salient now most service users are not confined: the role of movement.

Chapter Five

Concordant and discordant experiences: finding a place for distress in community and service use spaces

One of the key consequences of the heterochronic, or time-limited, quality of contemporary mental health services, described in the previous chapter, can be seen to be that service users are now asked to negotiate their distress, and ongoing lives, across a far wider variety of spaces than demanded under the asylum system, as stated in the introduction to the thesis. In addition, it is here argued that such a move to a distributed and heterochronic topology of services can be seen as part of a wider move to a 'control society' (Deleuze, 1992), operating through an ongoing 'modulation' of subjectivity, particularly through the enactment of observation and risk management practices (Rose, 1998a). This chapter will explore one of the impacts described by participants of such a distributed system of mental health care, an inherent complexity in the negotiation of their experiences across such multiple spaces of distress, wellbeing, and the self. Distress, for instance, was described by some participants as being experienced as being more intensely difficult to experience in particular (mainly public) spaces, whilst easier to experience in others (mainly private spaces).

To explore this idea in more detail, the metaphor of personal experiences being 'discordant' or more 'concordant' with the space in question will be used throughout this chapter. This musical metaphor is used here to evoke the idea that spaces are produced through an intertwining of multiple fields of (social, material, personal) practice (Brown & Stenner, 2009; Burkitt, 1999; Lefebvre, 1991; Massey,

1994c), in a similar way to the multiple notes which make up a chord in music. Extending this metaphor, feeling 'discordant' aims to capture feeling that one's own experience, or personal contribution to the space, stands out, jars, like a note played incorrectly in a chord. This chapter will hence examine the accounts of participants describing such discordant and concordant experiences of distress. The characteristics of such spaces (broadly, although not entirely, dividing along public/private boundaries) will be examined, including a discussion of ways in which participants described actively ordering, or 'stylising' (Brown, 2001) spaces to modulate these experiences, particularly at home. The chapter will then conclude with a consideration of how these wider experiences were described as feeding into service use interactions. Within the heterochronic system of contemporary mental health care, where interactions with services are described as being limted pockets of time within which service users are asked to disclose experiences often hidden in everyday life, it will be argued that particular attention needs to be paid to ensuring that the settings of service use interactions are concordant with the disclosure of distress.

5.1   Discordant distress: experiencing distress in public space

Perhaps the key experience of 'discordance' described by participants was that of being distressed in public space, described by several participants as uncomfortable and problematic. Both Janet and Lou, for instance, described their experience of being in public space when feeling "low" (Janet, line 345), or distressed:

> I don't like shops when I'm very low because I get quite agitated because I
> people I need to do anything I start to panic and not be able to breathe I have

to get out there doesn't even need to be that many people [I:mmm] just a normal amount of people and I can't bear it I feel stifled and panicked you know. (Janet, 345 – 349).

if I'm in public it's really quite it's really if I'm somewhere where it's crowded or really exposed it's really uncomfortable when and it almost sort of adds to the panic to the anxiety of the situation. (Lou, 653 - 656)

Lou elsewhere accounted for her reasons for avoiding public space when distressed:

I think part of it is not being judged is being yeah is not being judged so I feel like when I'm crying in public people are thinking like all these things like what is wrong with her like even my friends who don't understand depression don't understand what's wrong with me [I:mmm] and you know I don't even understand it so how can I expect someone else to understand it who's not even in it with me who's not feeling it [...] I think that's that's my problem is that you know I I don't wanna share it with anyone because I don't wanna have to explain why I'm crying non-stop. (Lou, 702 – 709).

Lou and Janet can here be seen to be describing a problematisation of their experiences of distress when in public space. Janet describes her 'symptoms' of 'anxiety', of feeling "panic" and "not be[ing] able to breathe" (line 346) as emergent from her location in public space; she accounts for a separation between her underlying experience of "feeling low" (line 345) and the additional experience of panic and feeling "stifled" (line 348) when in such public spaces. Lou also describes an augmentation of her distress in public places, as 'adding' to the experience of "panic" (line 656), due to not wanting to "share it" (line 708), to invite notice or being asked to provide an explanation of her behaviour. Erving Goffman (1963) in his classic text 'Behaviour in Public Places' argued that public space is ordered by a set of interaction 'rules', and those who invite notice in such spaces tend to be those

who are demonstrating the correct 'involvement' in the space; examples he gives include having an evident purpose in public space, either walking, or if waiting, checking a watch to demonstrate a reason for being in the space. A violation of such rules, of demonstrating the correct 'involvement' in public space, Goffman argued, lead to the kind of sancture and judgement described in Lou's quote above. The arguably more stringent rules of behaviour operating in public space, Goffman argued, can be seen as due to the increased 'co-presence' of strangers, hence requiring, to some extent, more highly regulated modes of interaction. Indeed both Lou and Janet here refer to the 'co-presence' of others, and particularly of strangers, as part of what produces their heightened experiences of distress. They can here be seen to be describing, therefore, a feeling that their experiences of distress, put them at risk of violating, in Goffman's terms, the correct 'involvement', or way of behaving, in public space; in other words, that their experiences are discordant with the practices of public space.

Certainly, it has been widely argued that public spaces are 'purified' (Sibley, 1995) of difference, including those expressing visible distress or madness (such as talking to one's self, or in Lou's example above crying), as well as other stigmatised groups such as the homeless (Hodgetts et al, 2007; Hodgetts et al, 2008), street drinkers (Dixon, Levine & McAuley, 2006) and disabled people (Kitchin, 1998). Hodgetts et al (2007), for instance, discuss the ways in which public space is increasingly designed as hostile to homeless people, through the installation of CCTV cameras as well as: "the design of park benches that people cannot sleep on and the hiring of security guards to remove vagrants from train stations or shopping

districts" (p. 722). The visibility of difference in mainstream space is hence widely argued to be "a matter of public concern", with difference seen to "infect, spoil or taint" (Hodgetts et al, 2007, p. 722) public space, and hence becoming a focus of control and risk management practices, outlined in the previous chapter to be so central to the constitution of contemporary mental health services (Rose, 1998a). Such practices of public space can in turn be seen as part of a wider public/private "grand dichotomy" (Weintraub, 1997, p. xi) differentiating between forms of a wide range of phenomena, including: 'internal' experiences of the self versus 'external' social behaviour; family life versus political and workplace life; and even 'publicly' funded versus 'privately' owned organisations. More 'public' forms of socio-spatial practice (Massey, 1994c; Lefebvre, 1991) hence might entail the presentation of a productive, rational self, capable of work (Foucault, 1965; Rose, 1989; 1998b; Walker & Fincham, 2011) whilst more 'private' forms might include the expression of intimacy, emotion, and sexuality (Mallet, 2004). A key 'hidden', or privatised experience in Western society, has been argued to be those described by Janet and Lou above, that of mental distress (Parr, 1997; 2008). Furthermore, Dixon et al (2006) argue, dislocating behaviour which is seen as properly 'private' into public space can be seen as "transgressing the moral geography of everyday behaviour" (p. 197).

Such a dislocation can be seen to be what is described as here mediating the experiences described above by Lou and Janet. Previous research (Davidson, 2000a; 2000b; 2001; McGrath et al, 2008) has similarly found that women diagnosed with anxiety disorders described their experience of public space as 'hostile' (McGrath et

al, 2008) to their state of distress, and the experience of being in such places as uncomfortable. It is here argued that this 'hostility' experienced in public space can be seen to emerge from a discordance between their experiences of distress and the expected (rational, productive, highly regulated) socio-spatial practices of public space. In addition, it can be seen here that these experiences are not merely uncomfortable; being a distressed person in public space is also here described as promoting additional experiences of distress, emergent from a location in public space.

5.1.2   Visible discordance: attracting control practices

The experiences described above could be interpreted as further 'symptoms' of 'anxiety' or 'depression', under a cognitive model perhaps explained as public spaces being 'triggers' for underlying cognitive deficits, such as catastrophic thinking (see Clark, 1986). Janet and Lou's augmented experiences of distress can, however, be alternatively seen as a 'rational' response, when considered in light of other descriptions by participants and narrators of the potential consequences of displaying distress/madness in public space. In particular, several narrators described instances when displaying distress or madness in public led to the invocation of control practices (Deleuze, 1992) by psychiatric and/or legal services. For instance Suzannah, the narrator of 'Black Magic' described being picked up by the police, and subsequently sectioned, after she:

> *hopped across a fence into the golf course and streaked across it. I saw someone on their mobile phone who must have been phoning the police because the next minute I was hiding in a bush and the next I was being bundled into a police car [...] I was shoved into a cold dungeon.* (B.M., p. 73)

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Of course, Suzannah is here breaking a law, through her public nudity, and might expect to be arrested (if not necessarily, subsequently sectioned). Other narrators, however, described instances when their 'odd' behaviour in public space, or making their belief systems visible within this space, was in itself was enough for incarceration. Michael, the narrator of 'Angels, Cleopatra and Psychosis', for instance, describes being taken, again to the police, after repeatedly asking a taxi driver to take in to the Sistine Chapel in Florence, from Reading:

> *I walked back to the taxi driver complete with my travel bag, and, confident the spirit of Michelangelo was beside me, I opened the taxi passenger door and sat down on the car seat.*
>
>> *"Take me to the Sistine Chapel. Florence. Italy".*
>>
>> *"Listen mate. Get out of my car. I'm taking you nowhere".*
>>
>> *"The Sistine Chapel please".*
>>
>> *"Get out of my fucking car!".*
>>
>> *"I'm not moving, and I'll pay".*
>
> *I had no idea how I would pay by the way anyway, but Michelangelo was sitting on the back seat by now and had his hand on my shoulder. I pressed my case.*
>
>> *"Take me to the Sistine Chapel!"*
>>
>> *"Alright mate", said the taxi driver. "Calm down. I'll take you wherever you want".*
>
> *I think by this point the taxi driver was worried I might have started a fight and won it, which I had no intention of doing, but I seemed to be getting my way, didn't I? Maybe the taxi driver thought I might beat him up and steal his motor. I don't know. But needless to say he didn't take me to the Sistine Chapel. He took me straight to Newark Police station instead. (A.C.P., p. 12-13).*

Michael does not here describe breaking any laws, but instead, through his repeated requests to the taxi driver to take him to the Sistine Chapel, brought on by his vision of Michaelangelo, makes his 'madness' visible in public space; as the taxi driver comments earlier in their reported interaction: '"Listen mate, you've been hanging round this station for four hours going nowhere. Something's wrong with you" (A.C.P., p. 13). Drawing on Goffman's (1963) insights, above, Michael can hence here be seen to be demonstrating a improper 'involvement' in the space of the station, through demonstrably not waiting for, or boarding a train. Such behaviour, brought on through his intense visions of Michaelangelo, has therefore invoked the notice of the taxi-driver. In addition, it can be seen that once Michael reveals his reason for this improper 'involvement', through demanded to be taken to the Sistine Chapel, the response of the taxi-driver is to bring Michael to the attention of the police; in other words, Michael's behaviour in public space here invokes the control practice of incarceration, and eventually, sectioning.

In Michael's case, his experiences of intense visions and voice hearing are described as having emerged very suddenly, in the course of a single train journey. It is worth highlighting, however, that in several of the narratives ('Black Magic'; 'Eyebrows and Other Fish'; and 'It's Happening to Me', in particular), the authors described several months of the development of their 'mad' experiences which incurred little notice or interference from family, friends or mental health services. Others, the onset is more sudden, as with Michael in the quote given above. Nevertheless, a common experience recounted across the narratives was it was when their 'madness' became *visible* (Estroff, 1981; Knowles, 2000a), often through

acting in an 'abnormal' manner in public space, that mental health services were described as intervening. For Antony, the narrator of 'Eyebrows and Other Fish', for instance, his first hospitalisation occurs after he shares his complex belief system with his brother, who takes him to A&E. Rosie, the narrator of 'It's Happening to Me', writes to both her lecturers and the Council for Racial Equality sharing her beliefs, and is subsequently sectioned. It can be seen from these examples that the criteria for admission to psychiatric care is described as often emerging from a disruption in the presentation of a 'rational' self in public (in public space for Suzannah, Michael and Antony; in public discourse for Rosie), or in Dixon el al (1996)'s terms, when they trangress "the moral geography of everyday behaviour" (p. 197). Once distress, or madness, are made public, or visible in public space, this can be seen as making service users the target of moral, clinical and legal intervention, through the involvement of psychiatric services. Within this climate, therefore, the descriptions of augmented, discordant distress given by Lou and Janet in the previous section, can be seen as highly 'rational' reactions to the penalties implicit in revealing distress in public space. The heterotopia (Foucault, 1986a) of the ward, described in the previous chapter, characterised by intense control practices (Deleuze, 1992; Rose, 1998a), can hence be seen to haunt service users' experiences in public space; a threat which can be seen to modulate their experiences of being a person with experiences which are potentially discordant with such spaces.

5.2   Concordant distress: home as a 'safe haven'

In contrast to the difficulties described in public space, several participants (although not all, as will be explored in the next chapter) described their homes as the place in which they felt most comfortable, their "safe haven" (Janet, line 284) and also the place where they felt most able to express their distress. Janet, for instance, described her home as the place she felt most "relaxed":

> *I like being at home it's my sanctuary [I:mmm] it's where I feel safe you know I can have who I want in my house and you know chill out do what I like and feel relaxed in myself you know I like sitting in my garden [I:mmm] it's pretty with all the flowers it's lovely. (Janet, 210-214)*

Whilst both Zoë and Rachel described their homes as the place where they would most like to be when experiencing distress:

> *I have to say I'd much prefer to start feeling really really down and depressed in some ways at home because at least it's my own space and in some ways it's and I can choose who to seek out. (Rachel, 477 – 480)*

> *I suppose at home you're free to feel ever you're free to feel all of your emotions it's fine you can feel anxious and upset and you can feel fantastic all of those anything goes [I:mmm] kind of thing in your own home […] my house sees the extremes [I:mmm] I think of the feeling low erm and I think over time since I've been married and having my own house I think possibly the lows the extremes of the low it's less likely to happen in other places. (Zoë, 376-387)*

> *it's funny because at my house if someone came round and I was really down I probably would have a cry [I:mmm] um but that's because it's my house and I can [I:mmm] and it's not putting anybody out so [I:yeah] if they've come round to see me and I happen to burst into tears well that's tough cos you've*

come to my house so it's alright [I:yes] but if I was going to somebody else's house it's not … to me it's not appropriate. (Zoë, 429-435)

These participants can be seen to be describing an experience of the home as a private realm, identified with the self, emotion (Curtis, 2010; Mallet, 2004; Morley, 2000) and freedom from external surveillance (Saunders & Williams, 1988). As Hareven (1991) argues, such an understanding of the home can be seen to have emerged in the West after the Industrial Revolution, which entailed a clearer separation of home and (paid) work spaces than had existed previously (although this separation has never been quite complete, see Massey, 1994c), and the emergence of the nuclear family as the ideal domestic unit. As Mallet (2004) outlines, a further shift to the individualisation of responsibility in late capitalist, Western governmentality since the 1970s has been argued to further cement the association between "house, home and family" (p. 66), as indicated by an increasing emphasis on home ownership (Madigan, Munro & Smith, 1990). Prevalent conceptions of the meaning of 'home' therefore, can therefore be seen to identify this kind of space as (ideally) a private, domestic space identified with the self and family life. In the extracts above, Zoë, Rachel and Janet can be seen to be describing these meanings attached to home spaces as producing a greater sense of 'freedom' and agency in their home spaces, especially in relation to their distress. Both Zoë and Rachel, for instance, pinpoint the status of the home as personal territory ("it's my house and I can", Zoë, line 432; "I can choose who to seek out", Rachel, line 480) as rendering their home space as the preferable place for the expression of distress. Compared to the greater augmentation of distress described as occurring in public

space, where visible distress can be seen as 'other' to the construction of the space (Knowles, 2000a; Sibley, 1995; Parr, 1997; 2008), here the 'private' nature of the space of the home (Darke, 1994; Mallet, 2004; Saunders & Williams, 1998) can be seen as affording the expression of the similarly 'privatised' experience of distress. Indeed, Zoë accounts for her home space as not only being more comfortable for the expression of distress, but that the experience of such emotions is actually *more likely* to occur within this space, as it sees the "extremes of the low". The private nature of home, and its equation with personal territory (Wise, 2000), freedom from surveillance (Saunders & Williams, 1998) and the private self (Madigan et al, 1990), can be seen to "afford", "encourage", or "allow" (Latour, 2005) both the experience and the expression of "extreme" emotion. When located in the culturally sanctioned space for the expression of emotion and the self, therefore, it can be seen that (some) participants described a release from the discordance and heightened levels of distress described as occurring in public space. Distress at home, as a privatised experience, can be seen as concordant with the "moral geography" (Dixon et. al, 2006, p. 197) argued above to be disrupted by visible displays of difference in public space.

5.2.1   Managing a distressed self: the material ordering of home

It would be simplistic, however, to conceive of the home as a universal "safe haven" that is always characterised by agency and territory (Sibley, 1995; Wright, 1991; Wardaugh, 1999); the sociologist Julia Wardhaugh (1999) points out that such arguments ignore both the violence and abuse that occurs within many homes, as well as implicitly excluding those who do not fit into the 'ideal home' being

conjured, which she argues is assumed to contain a suburban, white, middle-class, heterosexual, nuclear family. David Sibley (1995) has similarly argued that home can be a further potential site for exclusion, complicating a simple division between public and private spaces. Thus, while it is important to not idealise 'the home' as a universal 'safe haven' of domestic bliss, as this is clearly not the case for many people (Wardhaugh, 1999), certain aspects of the practices which create home spaces within Western culture can be seen as here coalescing to render some participants' homes as the place most concordant with the experience of distress, and most conducive to its expression. As Julia Twigg (2000) notes the privacy of the home: "rests on a material affordance… the ability to shut the door on the outside world" (p. 384); in Zoë's account in particular this feature of home space could be seen to be described as enabling the expression of those experiences, including distress, which are privatised and 'hidden' (Weintraub, 1997).

The "material affordance" of home space was however described by participants as more complex than simply shutting out the rest of the world. Several participants described the material production of home as part of the production of their feelings of "comfort", "safety" and agency in their home space, and the detail of their material environments as central to these experiences. Rachel, for instance, described the material arrangement of her home environment as important to producing a "sense of wellbeing" (Rachel, line 389):

> *[it] does make quite a difference to your sense of wellbeing and how you're able to relax at home and things and also just remove yourself from like we've now got a room like a spare room where we can just dump everything that we don't want to see (laughs) [I:(laughs)] like like household bills and all*

of that rather than rather than living with it so yeah absolutely I really like really like my house. (Rachel, 389-394)

Rachel also described her ability to agentically order the objects in her house as helping to produce an environment conducive to sleeping:

I've always had problems with sleeping and things and I was always told you know keep your bedroom clear of things but the problem is you know when you're a student you're just living in one room [I:mmm] and when you're in a shared house you're living in one room pretty much and then even when I moved in with my husband like we were living in such a small flat that you couldn't have the bedroom clear [I:mmm] so they say reserve your bedroom for sleep and make sure you have no other stuff in there but the problem was all of our stuff was in there all of our bills and everything but anyway now we have got somewhere a little bit bigger we just have a bed and wardrobe and hi fi and a chest of drawers and basically I've completely and side tables and the door's there [indicates on map] and I've completely forbidden John my husband from putting any of his work related stuff in there [I:(laughs)] and it's just a real and again we've wallpapered the back the back wall ourselves and painted it and it just feels it feels like um I dunno like I always like I always liked staying in hotels and things because it's like a bit clear. (Rachel, 365-380).

Whilst Bryan similarly described a change in his home environment as engendering an improvement in his general state of wellbeing, and indeed those experiences which could be understood as mental health 'symptoms':

I lived right on a rat run right by a crossroads […] it was quite a scruffy [I:mmm] neighbourhood and lots of people whereas here I live right by the park I mean as you can [I:yeah] you can see I walk out there and I'm in the park and that's made a huge difference to me and seeing people walking in the park as well I get to see far more children dogs all that kind of thing […]

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and erm I'm a lot less anxious [I:mmm] than where I was before I've noticed that I mean I went I had I used to get quite obsessional about things like locking up locking up my flat or whether I'd left the heating on or the cooking on [...] and that by and large has has has erm has gone [I:mmm] and I think that's because I'm living in a much nicer environment and then and then obviously I think having my flat right [I:mmm] is important I mean I really like coming in here and I I like the fact I've got all my books set out exactly how I want them [...] I mean routine is another thing that's important to me I try and keep to routines and that it's when I start losing my routines [I:mmm] that I start getting stressed and having things just right (laughs) and keeping them just right in the flat is is important. (Bryan, 477 – 496)

Rachel and Bryan here both describe the ordering of their home space as an important process in producing feelings of safety and agency in their home environment. Rachel describes the ability, afforded by a spare room, to remove the material reminders of responsibility and stress ("household bills", line 392) from sight, as improving her general sense of wellbeing, and hence being a protective factor in her experiences of distress. Being able to "shut the door" (Twigg, 2000, p. 384) is here firstly described as important in producing a relief from external surveillance (Saunders & Williams, 1998); equally important, howver, can be seen to be the creation of a material, visual separation between the activities of 'relaxing' and those of either domestic or workplace responsibility. The objects she describes as "everything we don't want to see" (line 391), including bills, can here be seen to 'contain' (Reavey & Brown, 2009) responsibilities both beyond and within the home; the walls and doors of the spare room can be seen as affording a separation of these responsibilities from the 'relaxing' and 'safe haven' aspects of the home described above. These objects are described as participating (Latour, 2005) in Rachel's

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experience; the exclusion of all material containers of her responsibilities can be seen here to enable her to relax and sleep, as the room is "clear" (line 366) of these participatory objects. The 'relaxing' 'comfortable' home space described by several participants, therefore, can here be seen to be emergent from ongoing socio-material practices within the home, rather than an inevitable product of an abstract cultural meaning of 'the home'. In a similar way to Rachel, Bryan here describes a change in his home environment as engendering an improvement in his general level of wellbeing, as well as specific 'symptoms' of anxiety, such as "obsessional" monitoring of the safety of his home. These 'symptoms' can be seen here as emergent from the relationship that Bryan describes having with his home space; placed in a chaotic urban environment it might be seen that the safety of Bryan's home could be a 'rational' concern and these "obsessional" (line 482) practices could be seen to be a response to this situation (see, Segrott & Doel, 2005). Furthermore, Bryan describes such 'anxiety', and the practices he uses to manage this anxiety, as being alleviated by his move to a quieter, greener and more family orientated area. This account also, like Rachel's, seems to point to the participation (Latour, 2005) of specific material objects in the production of a 'relaxing' home space. Bryan describes the importance of ordering his home "just right" (line 495) as part of his "routine" (line 493) which helps to stave off experiences of "getting stressed" (line 495). The ownership and agentic ordering of the objects in his home ("I've got all my books set out exactly how I want them", line 487) is described as part of the production of a positive and relaxing home environment. Just as Rachel describes the importance of having "wallpapered the back the back wall ourselves

and painted it" (line 377) in her bedroom, Bryan here seems to be describing the participation of the ordering of material objects as part of the production of the home as a personal space (Darke, 1994; Dupius & Thorns, 1996; Madigan et al, 1990; Mallet, 2004; Morley, 2000). Here, both Rachel and Bryan can be seen to be using their ability to fashion, or 'stylise' (Brown, 2001) the materiality of their home to facilitate 'recovery', or experiences of wellbeing, and distance experiences of distress through the creation of an ordered, calm space. The greater 'concordance' described by (some) participants as experienced in their home spaces can therefore be seen to be in part emergent from this ability to 'stylise' (Brown, 2001) the home in ways which avoid the discordance experienced in public space; the 'safety' of the home (Davidson, 2000a; 2000b; Pinfold, 2000) can be seen as emergent from the possibility of agency, as well as escape from external surveillance, provided by such personal, private spaces, rather than being a 'given' of home space.

5.2.2 Contingencies of home as a "safe haven"

It is, indeed, noticeable that these experiences of the home as an agentic space of safety (Davidson, 2000a; 2000b; Pinfold, 2000) are also described as in part contingent on economic power; Rachel describes being able to shut away her bills because of the economic ability to buy a house big enough to include a spare room, whilst Bryan has had the freedom to move to a quieter area, an option not available to those, for instance, living in social housing. Some other participants did indeed describe a more ambivalent, or openly negative experience of home, which could be seen to be linked to a less secure economic position. Julie, for instance commented that:

"Home yeah I mean home's ok it's my son's working nights at the moment so when I was at home he was actually in bed and I was trying to clean the house [I: ah; laughs] so that was a bit of a problem and the builder's as you might have noticed [I:yeah] are building a porch next door at the same time so yes it was trying to keep the noise levels down and get things done and everything er yeah so that was stressful in that respect erm [...] cos cos it's one room if someone's got the tv on [I:yeah] you can't escape it all you can do is go upstairs to one of the bedrooms and that's not ideal so yeah it's it's ok we downsized so yeah it's ok but people are in in the space so it's not in any way somewhere that you can not now because my husband is 65 now erm he's at home he's not fully retired but he's home quite a bit [I:mmm] so (comic voice) my space is invaded (laughs) he used to work away all the time [I:yeah] so I was used to having my own independence [...] so home is er erm (laughs) (comic voice) other people are in it (laughs) which is nice sometimes but there are lots of times I'd like to have my own space and I don't have that here so I struggle with that. (Julie, 331-349)

James, a male participant in his late 50s, was even more explicitly negative about his home environment:

I don't particularly like it it's a second floor flat in social housing we get a lot of problems with drugs and alcohol in the centre of town it's a very run down area er and er I can't even see out of the windows because they're so high they're er very small erm and that doesn't help my state of mind (James, 267-272).

Julie and James can here be seen to be describing a lack of some of the key aspects of home space which were described by Zoë, Rachel and Bryan as beneficial to the management of their mental health. Julie describes a lack of the ability to materially separate herself from the rest of the family, for instance in completing household tasks without waking her son. Compared to the extra, wholly contained, space of the

spare room Rachel described as enabling the removal of "everything we don't want to see" (line 391), Julie here describes a more cramped living space where there is little ability to differentiate the activities of members of the family ("if someone's got the tv on you can't escape it at all", line 339). The lack of dividing walls in the open plan space of Julie's house can be here seen to participate in the creation of her described feeling of encroachment. James' description of his home is far from the ideal of a 'safe haven' (Pinfold, 2000); instead his home environment is described as worsening his "state of mind" (line 272), due to both the material layout of the flat, and the "run down" nature of the area in which he is located. The material environment he here describes is prison-like, with "high" and "small" (line 271) windows, with no view to the outside. Elsewhere in his interview James described feeling trapped in his current situation, commenting that: "I spend most of my spare time daydreaming about getting away escaping somehow" (336-337). The prison-like nature of his home environment, with high walls and small windows, can be seen as participating in this feeling of entrapment (which has been linked to the development of mental distress, see, Brown & Harris, 1978), as well as his inability to move due his position as a social housing tenant. For both James and Julie, therefore, the particular layout of their home spaces can be seen as removing (or perhaps, not achieving) the key advantages of home space for the management and expression of distress outlined above: privacy, agency and safety.

5.2.3 Spatial modification: using space to mediate experiences of the home

Some participants described their homes as lacking in the ability to "shut the door" (Twigg, 2000; pg. 384) and produce a 'safe haven' (Pinfold, 2000) also described

alternative strategies for modifying or escaping such unsatisfactory experiences of the home. In James' account, for instance, he described a pattern of leaving his home to sit in a nearby public garden:

> *so I walk down there and into the gardens used to be married [I:mmm] got three children from the marriage and they were all born in [place name] thirty-odd years ago I used to take them in their pushchairs into the park to feed the ducks and the squirrels and things and now I sit there and I reflect on my past and I look at the new generations of new parents [I:mmm] pushing their offspring in their ironmongery and I sit there with all of the older men erm yeah it's very nice and you can walk you can walk along the river you walk out into like a country park. (James, 377 – 385)*

Relocating from his flat in a "run-down area" (line 268) to this outside space can be seen as a way of accessing an alternative, and for James, historical experience of the home. The particular gardens he sits in are here accounted for as a place to which he used to take his children when they were young, and is described as still being a place where "new generations of parents" (line, 381) perform this same activity, using the same objects ("pushchairs", line 389; and "ironmongery", line 383). The continuity of these activities within the same space can here be seen to make salient this part of James' past, a time prior to his mental health problems and breakdown of his marriage. In this way, James can be seen to be using the 'imagined space' (Soja, 1996) of the park to bring forth a past version of himself, and arguably, a past home with young children. In this way, James can be seen as using the space to weaken the significance of his current experiences. The material environment and the reoccuring objects and activities within it, can here be seen to 'stabilise' (Serres, 1995; Reavey & Brown, 2009), James' experience of himself in this past time, rather

than the present. As described above, James commented that he spent "most of my spare time daydreaming about getting away escaping somehow" (336-337). Here he can be seen to be "escaping" (line 337) into the past through using the complex 'imagined space' of this park, embedded with personal meaning and history.

Lou also described a dislike of her current living arrangements, and her ordering of the environment of her supported housing unit as central to her management of both her distress, and, like James, her sense of self. She described her reasons for not engaging in any domestic tasks in the supported housing unit, in which she had been living for a few months at the time of the interview:

> *I kind of don't wanna do that in this place I don't wanna cook I just I don't wanna make it my space […] and you know all my kitchen stuff that I've got cos you know I've got quite a lot of really good stuff it's all in boxes and it sits in this corner of my room just in a stack of boxes and um you know and yeah I just I don't want that part of me to settle in this house […] I don't want to be in the kitchen I don't want to make it my space you know and there's this cleaning rota and I just don't want to do it and that's really it sounds really bad it sounds like I'm being really selfish and I'm just really like I don't wanna do but I don't want to clean it I don't want to you know keep it neat and tidy it just doesn't matter to me it's so irrelevant I just don't wanna I don't wanna do anything to it that would make it seem like home [I:mmm] which is a bit I know it sounds weird it's quite a bizarre thing but yeah so I only spend time in my room really and I don't I don't do any cooking I just eat take out which is really bad or go to other people's houses for dinner. (Lou, 190-212)*

Lou can here be seen to be describing a rejection of the kind of ordering and domestic practices described by Rachel and Bryan in the above section as helping to produce a 'safe haven' (Pinfold, 2000) of comparative calm, wellbeing, and

'concordance'. Lou here describes instead not cooking in, or cleaning, the communal areas of her living space. Such behaviour could potentially be seen as further evidence of Lou's 'depression', in withdrawing from others and the communal life of the house. In this account, however, it can be seen that Lou describes a specific resistance to engaging in domestic practices in this particular space as she "doesn't wanna do anything to it that would make it seem like home" (line 209). Lou describes keeping her kitchen equipment in her room, in a box, unused, as a strategy to ensure that she doesn't 'settle' into the house. This extract can be seen to highlight how the arrangement of objects, and engagement in domestic practices (cooking; cleaning), in the home are described here as part of what creates the meaning of home space as personal (Darke, 1994; Dupius & Thorns, 1996; Madigan et al, 1990; Mallet, 2004; Morley, 2000). Lou later described her reasons for resisting making her supported housing unit a 'home', with its associations of permanancy:

> *I need to keep it a temporary thing like I don't want to still be there in two years time I wan to keep it really temporary and therefore I'm not willing to settle in and not really you know I'm not going to unpack my kitchen stuff and use it because I'm only going to be here for a few months you know i it that's kind of my feeling on it although I've been there quite a few months now but yeah I just don't I don't wanna invest any emotion in it because it's it's it's only temporary and it's because it's an institution because somebody has to look after me (Lou, 222-230).*

> *I don't want to make it my home I don't... because that would mean that I'm sort of giving in to it I guess giving into my mental health issues giving into the depression giving in to needing help. (Lou, 240-243)*

Here, Lou can be seen to be describing her rejection of the space of her supported housing as a 'home' as part of a wider rejection of an implied position as a long-term service user. Lou's description of the 'institutional' characteristics of her supported housing can here be seen to reflect some of the heterotopic features of service use buildings outlined in the previous chapter. She comments that "somebody has to look after me" (line 230), which can be read as a feeling of being positioned as a passive, deficient service user (Campbell, 2007; Goffman, 1961; Repper & Perkins, 2003; Scheff, 1999), in a similar way to the experiences of participants in wards and community services outlined in the previous chapter. For Lou, however, such a position is described as embedded in her living space, as she is living in the half home/half institutional space of supported housing. In not engaging with the space as a 'home' (she referred to it elsewhere in the interview as a depersonalised "room, rather than home", line 660) Lou can be seen to be distancing herself from an incorporation of this 'service user position' into her long term sense of self. It could be seen that this process is similar to the one described above by James; both can be seen as using their management of space, and ordering of objects, to resist the implications of the present. Whereas James, in the above extract, can be seen as using space to make his past more salient, her Lou can be seen to be ordering her space in a way that actively resists making her present permanent.

For both Lou and James it can be seen that the association, explored above, between 'home' and 'self' (Dupius & Thorns, 1996; Madigan et al, 1990; Mallet, 2004; Morley, 2000) renders their home space as particularly salient as a key 'technology of the self' (Brown & Stenner, 2009; Foucault, 1986c), or resource in the

construction of their subjectivity. Within the limited resources available to them, therefore, it can be seen that both Lou and James 'stylise' (Brown, 2001) their home space (or their relationship with their home, in James' case) to create a more concordant experience of 'home', even if this is, in James' case, an 'imagined space' (Soja, 1996). Such an active, and complex, relationship between the space of home, the ordering of objects within the home, and the practices which can be seen as producing space as a 'home', can be seen to indicate what Brown & Stenner (2009) call:

> a sort of freedom that remains imbricated within contemporary technologies of self. But this freedom is not some classical version of personal liberation. It is the freedom to make oneself through a continuous exposure – to put some holes in the 'skin' stretched between the various technologies that afford selfhood. (p. 173)

As argued in Chapter Two, one of the key 'technologies' available to service users in the production of their subjectivity, can be argued to be their material environment. These two examples, from Lou and James, can be seen to highlight how even within the context of meagre 'technologies' provided by their relatively bleak home environments, they can be seen to describe a tempering of the meaning of such environments for their ongoing sense of self, through the active management of the settings in which they are placed.

5.3   Disclosure: concordance and discordance in mental health service buildings

The accounts examined above all explore participants' experiences of spaces 'in the community'; whilst experiences in such spaces can be seen as being 'modulated' (Deleuze, 1992) by the heterotopias of mental health services, as explored in the

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section on 'visible discordance', above, to some extent, nevertheless, these sections have explored experiences outside of service use. These same issues, of the complex production of 'discordant' and 'concordant' spaces were, however, described as also playing a key role in participants' experiences of service use interactions. As discussed in the previous chapter, an important feature of contemporary service use interactions, particularly off the ward, can be seen to be their heterochronic (Foucault, 1986a) quality. The accounts of interactions with services described limited parcels of time, the purpose of which was often described was the disclosure of distress, in order to gain access to support, further services or medication, or therapy; from the professionals' point of view, meanwhile, it has been argued that a key function of service use interactions is the assessment of risk management (Rose, 1998a). These two understandings are not necessarily opposed, as it can be seen that in order to assess risk, professionals need service users to disclose their ongoing level of distress. Considering the issues explored above, of the differential 'concordance' of spaces within the variety of settings in the community, some of which participants described also interacting with services, this final section will explore the role of the settings of interactions with services in participants' experiences of disclosure.

The accounts given by participants of their interactions with services, in community service buildings, Zoë, for instance, described her reasons for preferring the room in which she engaged in Cognitive Behaviour Therapy to the consulting room in which she saw her psychiatrist:

at the other end of the building is where you have your CBT and obviously that's always with the same person and that room is smaller its the same rubbishy not very comfortable chairs but its its familiar and its quite a safe room [I:mmm] and going in there and being stressed or just babbling for an hour doesn't feel quite so uncomfortable [I:mmm] so and I I think that is probably down to the fact that the consulting room is really really big and there's quite a lot of windows [I:mmm] and its not I mean its not in a public place so the windows nobody goes past them [I:mmm] but I always feel a bit like I really wish there wasn't six windows in here [I:yeah] because I want to sit here and cry [I:mmm] and tell you that I feel really bad but there's six windows and it feels a bit bare [I:mmm] whereas in the CBT room there's one window you sit with your back to it and there's blinds there [I:yeah] so its a lot more private and I think I always feel a lot more safe it it feels like its safer to be anxious and depressed in a room where other people can't really look at. (Zoë, 124 - 138)

Whereas Rachel described the smoking room in a day centre she attended several years previously to the interview. The experiences she describes hence took place before the July 2007 ban on smoking in enclosed spaces came into effect in England and Wales, which lead to the closure of such spaces:

the smoking room was more closed off so people would chat about things that they wouldn't want to tell the nurses a lot of the nurses came in the smoking room as well or the OTs or whatever but they but because it's a kind of confined space with a closed door if there wasn't a nurse in there I think people would kind of chat more about a lot more about things that were I think I think in this area [indicates lounge] the chat was a bit more sort of generalised whereas in this area [indicates smoking room] there was chat that went on that people wouldn't normally have disclosed in this sort of area [I:mmm] I dunno I suppose examples of things erm I think people would talk more about I dunno things like things that they had I dunno I remember at

one point I was having visual hallucinations and I talked about that with some people in there and I wouldn't really have talked about that in the lounge area [...] I don't think that kind of thing would have necessarily been talked about in the lounge area I think there probably people talked more about the stuff that was in the crappy magazines [I:(laughs)] and things rather than anything particularly intimate and I think and actually yeah it's making me think it's probably where people got most support from other patients [...] I guess the thing is they'd like get nurses would come into the smoking room but they'd come in and have a cigarette and they'd leave most of the time whereas in this area [indicates lounge] I suppose they could be seen to be working in this area [...] whereas activities apart from smoking didn't really go on in the smoking room so I don't think they could really justify their existence [...] even though I think the nurses and OTs who did go in there had more of the trust [I:mmm] of the patients. (Rachel, 161 - 205)

Both Zoë and Rachel can here be seen to be describing a complexity in the production of spaces within services as ones which facilitate the disclosure of distress, or to continue the metaphor used throughout this chapter, are concordant with the experience and expression of distress. Zoë describes the space of the consulting room as one which makes it harder for her to discuss, or make visible, her distress, whilst Rachel describes the smoking room as contrastingly enabling the open discussion of both distress and madness ("visual halluctinations", line 172). It is noticeable that the detail of the materiality of the spaces are described as mediating production of such experiences. Whilst within the ostensibly 'private' space of services, which could be expected to successfully facilitate discussions of distress, considering the accounts above of the relatively 'concordant' nature of private space, Zoë nevertheless describes the "six windows" (line 132) in the

consulting room as participating in producing the feeling of exposure. The windows in the psychiatrist's office can be seen as both 'suggesting' (Latour, 2005) public exposure to Zoë, through showing her the outside world, and 'blocking' (Latour, 2005) the expression of her distress, arguably due to the penalties implicit in public, visible displays of distress (Dixon et. al, 2006; Parr, 1997; 2008; Sibley, 1995). By contrast, both the CBT office in Zoë's account, and the smoking room in Rachel's, are described as enclosed spaces, produced as 'private' as the "closed door" (Rachel, line 165) and "blinds" (Zoe, line 135) block off any external surveillance (Saunders & Williams, 1998). Zoë's embodied positioning in space can be seen as also helping to create the greater level of concordance with the experience of disclosing her distress described in the CBT room (as a space "where people can't really look at", line 138); she describes sitting with her back to the shaded window, 'blocking' any view of the outside world and further 'encouraging' the discussion of her privatised (Weintraub, 1997) experiences of distress. In Rachel's account the space of the smoking room is accounted for as providing a space concordant with the open discussion of distress and madness; the privacy described, afforded in part by the "ability to shut the door" (Twigg, 2000, p. 384) on the rest of the day centre, is described as 'blocking' (Latour, 2005) the surveillance of both mental health professionals as well as providing a shelter from public visibility; the smoking room could be seen to afford a kind of 'double invisibility', from the control practices (Deleuze, 1992) argued above to be a key part of both the public and the psychiatric gaze. Service user groups, such as the Hearing Voices Network, have long argued for the benefit of the kind of mutual, non-judgemental disclosure between service

users, described here by Rachel, as it can be seen as removed from the power dynamic argued to be inherent in service user-professional interactions (e.g., Campbell, 2007; Dillon & Longden, 2011; May, 2007; Repper & Perkins, 2003). The disclosure of the kinds of experiences described as being related by Rachel and her fellow service users in this account, could, for instance, potentially lead to an increase in medication, or even sectioning, as seen in the previously discussed accounts (for instance, of Michael and Suzannah, above) of the consequences of making madness visible. The particular status of the space of the smoking room within the day centre, as contained within the bounds of the centre and yet not an official "working" (line 201) space for professionals, is described by Rachel as producing a lessening of the psychiatric gaze. Whereas in the "working" (line 201) spaces of the day centre staff could be seen as 'working' and service users as 'being treated', with the incumbent power differential implied in that relationship (Campbell, 2007; Goffman, 1961; May, 2007; Repper & Perkins, 2003; Scheff, 1999), in the smoking room staff and service users alike are accounted for as 'just smoking', with any interaction as seemingly secondary to this activity. The activity of smoking, therefore, can here be argued to afford the emergence of more unofficial and (relatively) equal interactions.

5.3   Concordance, discordance and disclosure in community spaces

As discussed in the previous chapter, however, the kind of day centres described by Rachel are becoming increasingly uncommon under the current social inclusion agenda. Indeed some participants described the relocation of their interactions with services into multiple community spaces. One of the common sites described for

meeting professionals in the community was in the home. For some participants, this was described as mediating their interactions with services in a positive way. For instance Bryan commented:

> *the community psychiatric nurse [name] comes for some every erm about every two or three weeks and stays for about um up to half an hour usually usually less than half an hour it depends it depends if it depends very much on what sort of shape I'm in if I want to talk if there's things I want to want to talk to him about if if things are going ok and there's not much to talk about he may only stay for about ten minutes but usually usually he'll be here for about half an hour […] and we have a good conversation [I:mmm] and it's fine erm and it makes a real difference to me that he comes to into my space and talks to me and we kind of have quite an easy conversation and we sometimes talk about books or things that I'm doing and that makes a real difference certainly when I think back to the days b say before 1980 […] there was no support basically I just lived in in the community with an outpatient appointment and […] it's really good that erm I I er I feel comfortable meeting someone here and talking about various […] I've always had a very good relationship with my community psychiatric nurses it's very important part of my care so I kind of feel feel in control of the relationship because it's take because he's coming here er meeting me in meeting me in my own space it makes quite a bit quite a bit of difference. (Bryan, 36 – 56)*

Bryan can here be seen to be describing his interaction with professionals being mediated by the space; in the space of his home, described above as agentic, he similarly describes feeling "in control of the relationship" (line 54). The location of the interaction in 'his' space can also arguably be seen as producing an interaction incorporating Bryan as a holistic person, rather than 'only' a service user; Bryan and his psychiatric nurse are described as discussing "books and things" (line 48), as well

as the 'business' of his mental health. In this way, Bryan can be seen as describing the experience of his home as an agentic and personal space (Mallet, 2004; Wise, 2000) as also being one where discussions of distress are comfortable and productive.

As discussed above, however, several participants discussed more ambivalent experiences of home space than those described by Bryan. Julie, for instance, described being unable to meet professionals in her home, due to a lack of private space, as detailed above. In addition, Julie described an almost complete shut down of dedicated mental health service buildings in her area, meaning that all of her meetings with her community psychiatric nurse were described as taking place in non-specialised, and generally public, sites. These were various, as can be seen from Julie's map below:
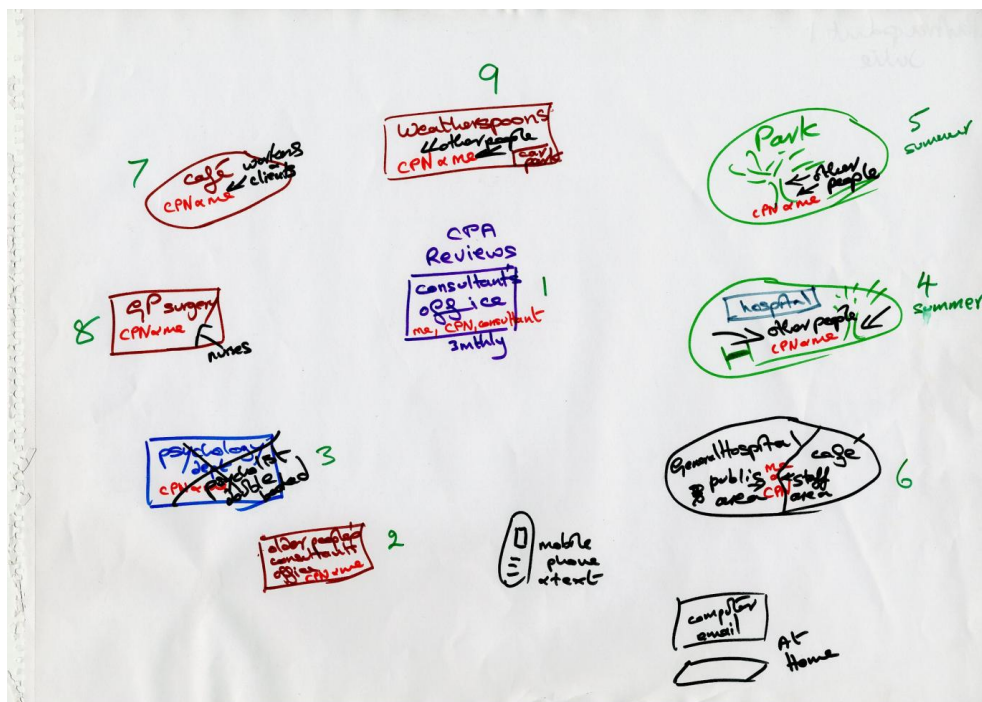
Julie's map, detailing the recent settings of her interactions with services. Apart from the consultant's office, all were places she had met her CPN. The numbers rank the places from Julie's favourite (1) to least favourite (9) place to meet professionals.

Julie, above all other participants interviewed, therefore, was forced to negotiate professional interactions in public spaces. She here describes the experience, for instance, of attempting to discuss her distress with her CPN in a public park:

> *what often happens is you get other people impinging on that space [...] so they gradually start invading and then that little space doesn't become private anymore because obviously as soon as they start hearing you talk about anything remotely interesting you can see the conversation stop. (Julie, 76 – 82)*

As well as a pub:

> *you get somewhere you think's quiet and then it's not because other people think oh that's a quiet little spot and they'll sit there as well [I:yeah] and so that's not ideal the other problem with sitting in a pub of course is that if you get upset about anything [I: yeah] you know you can't really be in tears in a pub without everybody going (whispers) what's going on there [I:mmm] you know so i it you tend to kind of put on your social face [I:mmm] you know how you would if you were going out or something [I:yeah] but you're not going to talk about stuff that really worries you because you don't want to get upset [I:mmm] you don't wanna feel vulnerable because you're in public you're kind of on show. (Julie, 112 – 121)*

Julie can here be seen to be describing an inherent problem with attempting to move discussions of distress from the heterotopic spaces of mental health services, where distress can be seen as being made visible, into 'purified' (Sibley, 1995) public space, which can be seen as discordant with such experiences and expressions of distress. In addition, the comparative fluidity of public space, from which the kinds of closed doors and shaded windows, described above as affording privacy, are absent, can be seen to limit the ability of Julie and her CPN to manage the 'co-

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presence' (Goffman, 1963) of others, and hence the boundaries of their interaction. Strangers are described as unpredictably "impinging" (line 76) on their conversation and listening, which can be seen to act to make Julie's distress, and status as a service user, visible within the public spaces of the park and the pub. Julie accounts for these features of carrying out such interactions in public space as leading to an inhibition of disclosure. It is argued here that service interactions can be understood as heterochronic (Foucault, 1986a), as occupying limited slices of time, dedicated to the assessment (Rose, 1998a) or discussion of experiences of distress. In Julie's account above, such interactions have been moved from a corresponding heterotopia of visible distress, service use spaces, into public space; as discussed in depth above, such spaces can be seen to be exclusionary (Estroff, 1981; Foucault, 1965; Knowles, 2000a; Parr, 1997; Sibley, 1995) and discordant to the very experiences that Julie is here being asked to discuss. Julie describes managing this discrepancy by "put[ting] on your social face" (line 117); by behaving, and presenting herself, in a way which can be seen as more concordant with the requirements of public space. The space can hence here be seen to be thoroughly unsuited to facilitating the kind of interaction necessary, from both Julie and her CPN's point of view; under a system where service users are seen only infrequently and for apportioned periods of time, spaces which are concordant with the expression and discussion of distress can be seen as particularly crucial. Julie elsewhere described a successful social, family, and professional life, in other words an ability to conduct herself, for the most part, in normative social interaction. What

is needed in service use interactions, perhaps, is a space for distress, not a space for the further inactment of her "social face" (line 117).

5.4   Conclusions

In conclusion, therefore, a distributed (Deleuze, 1992; Rose, 1998a) system of mental health care can be seen as leading to a complexity of spaces over which service users are required to negotiate their distress. A key part of this complexity can be seen to be a variation in the concordance and discordance of experiences of distress in relation to these multiple spaces in the community and service use. The necessity of having to negotiate public spaces was described as particularly discordant with experiences of distress, leading to some participants experiencing heightened distress in these spaces. Such augmented experiences of distress were described as particularly likely to occur when service users were in a state of distress themselves, particularly if having depressive or anxious experiences. The previously observed 'concordance' of home space with (again, particularly depressive and anxious) experience of distress (Davidson, 2000a; 2000b), was here argued to be contingent upon an ability to agentically order home space, and create experiences of privacy; to be able to "shut the door" (Twigg, 2000, p. 384), blocking external surveillance (Saunders & Williams, 1998), whilst also ordering the home as a 'calm' space of wellbeing. For those participants who described not having the capacity to 'stylise' (Brown, 2001) their homes in such a way, alternative strategies of modifying their experiences of home were described. Such accounts point to an integral role of space in the experience and management of distress; the experiences of distress, wellbeing and recovery were described as continuously mediated by space, as well

as actively managed through differential engagements with the spatial resources available to service users. Finally, this complex topology of space was described as playing a key role in the production of service use interactions, in private, public and service use spaces. What is here argued to be the heterochronic nature of contemporary services, characterised by time-limited interactions often designed to monitor (Rose, 1998a) the level of 'risk' indicated by service users' current state of distress, can be seen as rendering the context of service use interactions as particularly crucial in facilitating the disclosure of distress. Conducting service use interactions in spaces where the discussion or expression of distress was described as experienced as 'discordant', was here described as particularly poor in terms of facilitating the disclosure of experiences of distress. The current move to 'social inclusion' in British mental health services (D.O.H., 1999; O.D.P.M., 2004; Repper & Perkins, 2003; Sayce, 2000; Secker, 2010; Spandler, 2007; Wallcraft, 2001) can be seen to make such discordant interactions more likely to occur. To draw on the material outlined in the previous chapter, the relocation of service use interactions into public space from the heterotopias of mental health care, which despite the presence of visible control practices, can be seen to at least provide a space for the discussion of distress, holds the danger of preventing service users from disclosing distress during their heterochronic interactions with services.

Chapter Six

Displacement and Movement

6.1 Movement and community care

Implicit in the concept of community care could be argued to be a greater freedom of movement. In moving 'Outside the walls of the asylum' (Bartlett & Wright, 1999) and 'Beyond the water towers' (S.C.M.H., 2005) service users could be argued to be seen to have moved from a position of confinement to one of mobility across normative community spaces. As can be seen from the material presented in the two previous chapters, however, the landscape of community care and the experiences of service users in community spaces reveal a far more complex experience than universal liberty in the community; community care has been widely criticised for in many cases placing service users in positions of exclusion in the community, for instance through regular experiences of stigma and discrimination (Baldwin, 1993; Haywood & Bright, 1997; Spandler, 2007; Symonds & Kelly, 1998). The previous chapter discussed the limited distribution of spaces where the visible expression of distress can be seen as acceptable for service users living in the community, and the consequent penalties often experienced as a result of the heterotopic expression of distress or madness, most particularly in public space (Davidson, 2000a; 2000b; Dixon et al, 2006; Estroff, 1981; Knowles, 2000a; Parr, 1997; Sibley, 1995). A related issue, discussed across both the interviews and the narratives, was that of movement; participants described their movement in the community as in part driven by their experiences of distress and madness, either in

retreating to the 'safety' of private spaces to escape hostile public space, or in moving outside to mediate intense experiences of distress emergent in the enclosed space of the home. This chapter will examine the experiences of participants through the lens of movement and mobility, examining the consequences of such patterns of movement in the community, before examining experiences of movement on the psychiatric ward.

6.2   Self-confinement: retreat into private spaces

As discussed in the previous chapter, public space was described by many participants as problematic when in a state of distress, which can be seen to be due to the emplacement of mental distress as a 'private' experience (Foucault, 1965) and the 'purification' (Sibley, 1995) of public space of difference (Hodgetts et al, 2007; Kitchen, 1998; Parr, 1997; 2008). The set of participants who described, as outlined in the previous chapter, an augmentation of their distress in such spaces, tended to also describe a related pattern of movement: out of public spaces and into the kinds of 'safe havens' (Pinfold, 2000) described in the previous chapter as more conducive to experiences of distress. Lou, for instance, discussed her usual pattern of movement when distressed:

> *I don't like to stray very far from home [I:mmm] I like to stay close to home I I think in case I have to retreat kind of thing [...] so yeah I don't like to go very far especially to like big social gatherings you know if it's somebody's if it's a party or something like that that I feel like I have to go because of the friend that's involved um ye I like I'll go really early [I:mmm] and leave early and so like only stay for about an hour or so um because just in case in case I get stressed um I have to be close to home [...] it matters sort of where you are as well like if you're in an environment [...] where you just feel like you know I*

feel like it wouldn't matter if I had a moment um I I generally am more relaxed so I tend to not get distressed [I:mmm] so so it's sort of I sort of gravitate towards those places I guess cos you know I went through a phase a phase where I just couldn't stop crying [I:mmm] and I was crying all the time and it was really embarrassing to be just sitting on a bus and crying and I just I really want to avoid that now I feel anxious about doing that. (Lou, 656 - 683)

While Zoë similarly discussed her tendency to stay at home, or return home, before becoming "upset", or visibly distressed:

I think from experiencing it [depression] I wouldn't have a problem [I:mmm] with somebody coming round and saying look I feel really down I think you might understand I'm going to cry for an hour [I:mmm] that's fine but I think I couldn't assume that of somebody else [I:mmm] that that would be ok [I:yeah] so I think that's why I have a couple of safe places and the rest of it well we'll just go home before we get upset. (Zoë, 440-445)

Similarly, Janet described limiting her engagement with public space when distressed through the use of her car:

well there was a time when the only time I could go to see Sarah [friend] would be if I drove [I:right] even though I was pretty spaced out on medication I drove there I couldn't get on a train [...] I needed that safe haven of my car [...] it's a safety net thing you know you wouldn't have that on a train there's too many strangers and you know people might speak to you. (Janet, 331 – 341)

All three of these participants describe limiting their engagement with spaces where making their distress visible might invite sancture or notice. It could be seen that described here is a limitation of movement through space (Pinfold, 2000) engendered by the problematisation of visible distress in public space (Sibley, 1995;

Parr, 1997; 2008). Zoë and Lou could here be seen to be describing a curtailment of their freedom of movement, even a form of self-confinement, a shrinking of their engagement with space (Davidson, 2000a). Vanessa Pinfold (2000) observed a similar pattern of movement in her study of service users in Nottingham, finding that her participants tended to have a few 'safe havens' in which they spent the majority of their time, limiting any movement through more hostile public spaces. Indeed, Janet can be seen to be using the space of her car, argued by Michael Bull (2004) to be more generally used as a moveable bubble of private space across the public spaces of the city, as a buffer to enable her to travel between two such 'safe havens': her home and her friend's house.

It is important to note that Janet in particular described this limitation on her movement through space as being state-dependent, stating that: "I'll go pretty much anywhere if I'm feeling ok" (373-374). The curtailment of movement described here, therefore, can be seen as contingent on the experience of distress, and in avoiding its potential visibility in public space. These experiences could be seen to indicate that whilst service users theoretically have greater access to, and freedom of movement across, a range of community spaces, this does not necessarily translate into 'normative' levels of mobility. The 'discordant' experience of distress and its potential visibility is here described as leading to strategies of self-confinement, and limitations on movement through public spaces.

6.2.1 Production of a rational self in the workplace

Participants described a similar pattern of movement when discussing experiences of distress in the workplace. In a similar way to public space, workplaces can be

understood as places that often require the production of a 'rational' and 'productive' self (Putnam & Mumby, 1993; Walker & Fincham, 2011). In particular, it has been argued that involved in the production of a successful workplace self is 'emotional labour' (Grandey, 2000; 2003), in producing the required (often positive and equable) emotions to present as a successful employee. Such aspects of the workplace can hence be seen to potentially render workplaces as similarly exclusionary to distress as public space. Two participants in particular discussed their experiences of feeling distressed at work, both in office environments. Karl described the relative difficulty in maintaining privacy in the workplace:

> *sitting at my desk I've had moments when um I've had a little cry and I think oop we don't want people to see this and it's quite funny because in this space like there's no wall there so this [indicates drawing] is a kitchen counter this is a kitchen counter but there's no like it's just counter height and then there's my desk so all the people who come in to eat and make their lunch whatever are all standing right there w having a chat with me because they're on a* break*. (Karl, 677- 682)*

While Rachel described a resultant pattern of movement she assumed when feeling distressed at work:

> *I went between my desk and the toilet to try and not let anybody in the office know that I was upset and then at lunch time I just went out and chatted to her [a friend working close by] [...] there's one woman who I don't ever want to see me upset not because I don't I just don't want to ever be put in a position where she was asking me particularly [...] so I suppose I tend to hide at work on the whole and get out of there [...] work is kind of its arranged around a kind of massive grass grass bit there's buildings all around here and the entrance of various buildings so sometimes [...] if I've felt really rubbish*

there's picnic tables and stuff I've gone out with sometimes like one of the girls who works in the office and chatted outside. (Rachel, 432-443)

Both Karl and Rachel can here be seen to be describing a necessity to "hide" (Rachel, 337) their distress at work; Karl can be seen to be describing a limitation on his ability to move into, or create, a private space in which he is able to do this, due to the lack of a "material affordance to shut the door" (Twigg, 2000, p. 384) on his colleagues. These accounts could in part be seen to be describing a comparative curtailment of movement within structured office workplaces (Dale & Burrell, 2008). Rachel describes moving "between my desk and the toilet" (line 432) as the two most private spaces in the office, before undertaking as similar strategy to Lou, Zoë and Janet above, and escaping the space of the office to seek 'safe haven' with a friend. It is perhaps telling that Rachel describes using the space of the toilet, also described in Chapter Four by Karl as a space of privacy for managing the visibility of distress after his counselling sessions. Rachel again describes being forced into this 'private' space to manage her distress and maintain its necessary invisibility at work (Putnam & Mumby, 1993; Walker & Fincham, 2011). Arguably the structured organisation of office space, designated as spaces of productivity (Dale & Burrell, 2008), leaves the toilet, arugably produced as 'private' through its usage for privatised bodily functions (Twigg, 2000), as one of the few 'private' spaces within such environments. The reoccurrence of this space as the location for the management of distress can also be seen to underline the moral ordering (Dixon et al, 2006; Szasz, 1960) of experiences of distress; the bodily functions designated to toilets have been argued to be those which are seen to invoke disgust, and as

morally polluting (Twigg, 2000). The emplacement of visible distress in the same space as that designated to the 'dirty work' (Emerson & Pollner, 1976; Twigg, 2000) of toilet functions within the workplace can be seen as perhaps indicating a similar status, or least level of exclusion from the space, assigned to the experiences of distress.

6.3   The drive to be outside: movement as a modulation of distress.

For some participants, however, the kinds of enclosed, private spaces described as 'safe' for the participants in the previous chapter, when in a state of distress, were instead described as conversely increasing their levels of distress, or the intensity of their 'mad' experiences. Indeed, some participants showed an opposite pattern of movement to the one described above; instead of experiences of distress prompting a move to private space, they prompted a move outside. For instance, Julie commented:

> *being in is really not [I:mmm] a good idea you know e especially if you're in the house and that because you you end up coming going into yourself then the voices get worse [I: mmm] and that's normally when I'll overdose as well so mainly in house for me is seriously bad news. (Julie, 450-454)*

Julie described how consequentially, she usually moved into outside space when in a state of crisis, preferring places in the "open air" (line 449). Bryan described a similar pattern of movement:

> *looking back over er over a er period of erm years my tendency is to go out to be walking [I:mmm] to be quite erm to be quite erm feeling I've I've got to be moving and not being erm in one place [I:mmm] as a sort of erm anxiety maybe and a sort of claustrophobia type thing I mean I know I know a few*

years ago erm I was when I was having crises I I would have this very strong feeling that I that er it it say late in the evening that I've got to go out [I:mmm] and at the same time I would kind of know that its not a good cos I'd but this kind of claustrophobic feeling is kind of I've got to I've gotta get out of my flat I've got to go somewhere I've got to do something [I:mmm] um and usually that wins out. (Bryan, 446 – 454)

Both Bryan and Julie here describe a part of their "crises" (Bryan, line 450) as involving a drive to be outside, engaged in embodied motion within open, public spaces rather than remain in the enclosed space of home. It was noticeable that participants who described such experiences tended to do so in the context of experiences of hearing voices, seeing visions, or intensely felt unusual beliefs, rather than the 'anxious' or 'depressive' experiences described by participants in the previous section. For the participants in the previous section, the most crucial feature of their experiences of space could be seen to be the potential judgement faced in public space for visibly expressing distress, and hence they described being prompted to move into private space (Davidson, 2000a; 2000b). This second group of participants, however, tended to describe a more problematic relationship with enclosed, home spaces when in a state of 'madness', and instead were prompted movement out of the house. There were several instances of such experiences described in the narratives. Michael, the narrator of 'Angels, Cleopatra and Psychosis', for instance, described a night when he left his home to wander the streets of York after hellish experiences in his home space:

The next few hours were terrifying and are hard to describe. Darkness somehow fell almost immediately that day or seemed to, and by the evening I knew I was effectively living in Hell. It was still June in 1994, and the lights in

the house still worked of course, but didn't seem to make any difference to how dark it was. So I decided to close all the curtains – I didn't want anyone passing by to look in. The invisible Cardinal's [a malignant spirit] presence was everywhere. I could move around the house, but the spirits of Leonardo da Vinci and Michelangelo [good spirits] were still stuck in my office-bedroom, so I was on my own. (p. 27)

Henry [his dog] was right. I got the feeling he was telling me that going out into York on such a night was at least as safe as staying in the house, and after the experiences I'd been through, I entirely agreed. So that's what I did. I took Henry for a walk round York at 3am. (p. 32)

He then describes walking around York for several hours with his dog, constantly moving:

I also decided not to look backwards as Henry and I walked along a row of terraced houses opposite the railway line because I very quickly realised that I had the Devil on my tail. I could hear his breathing, I could almost hear his footprints. I half wanted to know if he really was red, or whether he glowed in the dark, but there was no way I was going to be so stupid as to look backwards and find out. Henry and I would stay on our walk until the morning came, because I simply assumed that come sunlight my nightmare would be over, at least for one day at least, and then I could talk to Leonardo and Michelangelo again. (p. 33)

Jimmy, the narrator of 'I Thought I was the King of Scotland', also describes his period of elevated, intense mood and energy, and the development of the belief that he is firstly Grant Mitchell and then the King of Scotland, as involving active movement into public spaces:

I got on my bike with my baseball bat down my coat I had no intention of using it but I knew he was my enemy and I just wanted to scare him so he

would leave me alone [...] I got off my bike and made my way through the shop floor with the baseball bat still in my coat. I thought I was Grant Mitchell[2] he was in the canteen I shouted him and let him see the baseball bat [...] He didn't say a word he looked scared and I felt that I had scared him off for good [...] I went and had my haircut really short then went into a shop and brought a suit and an orange tie [...] tried my suit on I thought I was Grant Mitchell. I went out that night to The Boot for a drink I had my new suit, shoes and sunglasses on. I sat on the stool at the bar drinking my pint and my best friend came in [...] he didn't recognise me. I said you have known me for eight years and I kicked his stool and it scared him. I went into the toilets where I saw another one of my close friends and I asked him if he had slept with my key worker [...] I said that I would forgive him and walked out. I felt so good about myself as the highs had started to kick in, so I thought I would go in The Ram for a pint before I went home. I felt like people were whispering about me, I had a game of pool and I don't know what came over me but I through two pool balls behind the bar then left. (p. 30)

At home, Jimmy describes intense experiences:

I was so high there was no way that I was going to sleep. I lay on the bed I had racing thoughts that I was going to be the king of Scotland. If I didn't get out of Ibstock soon a laser gun could kill me. I got it into my head that a limo was going to pick me up at six o'clock in the morning I started ducking and diving under my window. I thought that on the horizon out of my window that there would be a sniper trying to kill me. (p. 31)

In both Michael and Jimmy's accounts, the particular form of the experiences they describe can be seen to change depending on their location in space. Michael describes movement through the streets at night as enabling him to 'escape' the "Devil" and "Cardinal", the figures he sees and hears when in his home

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[2] Grant Mitchell was a prominent character on the BBC Soap 'Eastenders', known for his 'hardman' image and aggressive behaviour.

environment; Michael can hear be seen to be describing the agentic movement through outside space, in comparison to the enclosed space of his home, as producing a changed relationship with his voices and visions, specifically enabling him to escape the power he describes as these visions and voices as having over him when in his home space. Power has been widely argued to be central to the experience of both voice hearing (Birchwood, Meaden, Trower & Gilbert, 2002; Hayward, 2003; Romme & Escher, 1993; 2000; Romme et al, 2009; Vaughan & Fowler, 2004) and unusual beliefs (Bullimore, 2012; Cromby & Harper, 2005; Harper, 2011). Research comparing 'patient' and 'non-patient' voice hearers, for instance, has found that those who do not come to the attention of psychiatric services tend to have a more equal relationship with their voices, to be able to control and reason with them (Romme & Escher, 1993; Haywood, 2003; Jackson, Haywood & Cooke, 2011), leading to therapeutic approaches which engage with the voices service users' hear and aim to develop a more equitable relationship between the voice hearer and voices (Romme & Escher, 2000; Romme et al, 2009; Vaughan & Fowler, 2004). It could be argued that Michael here describes his movement into outside space as producing just such a change; he could be seen to be using agentic movement through outside space, an engagement with the outside world, as a way of reasserting power within his relationship with his voices and visions. It is interesting that Jimmy's experience could be seen in a similar way; in his account, he moves from being (primarily) the powerful figure of the alpha male, Grant Mitchell, when moving actively and agentically through outside space, to being (primarily) the powerless victim of snipers and lasers when in his house. Both accounts hence, to

some extent, locate experiences of victimhood in the home and an experience of empowerment produced through movement in outside space. Although described in less detail, Julie also accounts for her home as a place where "the voices get worse" (line 453) and she is likely to "overdose" (line 454); her movement outside is again accounted for as modulating this experience. Self harm behaviours, including suicide, have indeed been argued to be strategies for managing the intensity of distress (Spandler, 1996; Spandler & Warner, 2007) through redirecting emotional pain into physical pain (Harris, 2000). Julie can here be seen to be describing her movement into outside space as an alternative strategy for managing the intensity of her experiences, avoiding harmful behaviours such as overdosing.

It is worth considering how these different experiences of space, being either stationary and enclosed, or moving through open space, might differently mediate experiences of madness. Firstly it is noticeable that, for Jimmy, his experiences when moving through community spaces can all be seen to consist of him entering into seen as empowering, if aggressive, relations with others: the first man he describes meeting has in the past maliciously spiked Jimmy's drink and so Jimmy intimidates him; he describes his friend in the bar as looking "scared"; when he starts to feel people are whispering about him, he throws snooker balls behind the bar. Compared to his experiences at home, cowering alone on the bed, Jimmy can here be seen to be describing a distribution of his experiences through these relations with others, regaining some power (Birchwood, Meaden, Trower & Gilbert, 2002; Hayward, 2003; Romme & Escher, 1993; Romme et al, 2009; Vaughan & Fowler, 2004); his experiences can be seen to be more easily mediated in this way when not

enclosed in the private space of the home. As Julie comments, at home "you [go] into yourself" (line 451); the enclosed space of the home, which "shut[s] the door on the world" (Twigg, 2000, p. 384), could be seen as participating in 'blocking' (Latour, 2005) any engagement with the outside world and hence enclosing any experiences with voices, visions or beliefs in on the 'private' self. As noted above, there are therapeutic techniques which aim to engage with, and change, the relationship service users' have with voices or other psychotic experiences (Romme & Escher, 2000; 2011; Romme et al, 2009; Vaughan & Fowler, 2004). What is apparent from these accounts, however, is that these relationships between voice and voice hearer; belief and believer are not necessarily static, but mediated through the social, material and relational setting. These settings, moreover, can be seen as being used by Julie, Michael, and Jimmy as a 'technology' (Brown & Stenner, 2009; Foucault, 1986c) to actively mediate their experiences, to widen their relational field by leaving the enclosed space of the home.

6.3.1   Displacement: problematic encounters in public space

Movement into outside space when experiencing madness and/or distress was, however, at times described as a problematic experience. Whilst, as explored above, several participants described such movement as positively mediating their experiences, once in 'purified' (Sibley, 1995) public space, participants described encountering the same issues as those described in the previous chapter, of judgement (Parr, 1997; 2008) and surveillance by the police (Rose, 1996; 1998a). Michael, for instance, described two encounters with the police while walking around York at night:

The night was cool and dry, and I had cigarettes with me too, but for some reason with the Devil on my tail I didn't want to light one when I was still moving. And then a police car arrived with sirens blazing, and I got verbally frisked. What was I doing out at this hour? "Well, walking the dog of course!". Did I know there had been several burglaries that night? No, I did not! Was I sure? Yes, I was positive. And did it look like I was carrying around stolen CD players, officer? (A.C.P., p. 33)

Bryan also described his "drive" to go out walking as having led to a number of admissions to hospital:

and so that part of the reason why I quite often have been picked up by the police in public places because basically that kind of drive to to be out um either early in the morning or sometimes sometimes at night [I:mmm] is part of the erm part of my crisis really I think is this is this sort of claustrophobic feeling whereas I know in actual fact I'd be much safer in a way just to sit to stay at home [I:mmm] that that doesn't seem to be possible and and quite often I lose that kind of battle. (Bryan, 456-461)

Bryan can here be seen to be describing a "battle" between two kinds of safety. Bryan here describes a "battle" between his "drive" to be outside and the "safety" of indoors; as he comments, his drive to be outdoors when distressed has often resulted in psychiatric admission via the police. It is worth noting that he does not comment that he would be less distressed at home, indeed all of the participants discussed in the previous section locate the home as a site of heightened, rather than decreased, distress. As Michael commented in the previous section: "going out [...] was at least as safe as staying in the house [...] after the experiences I'd been through" (A.C.P., p. 32). The 'safety' described by Bryan here can be understood as, in part, safety from the dangers of urban street at night, but also from making his

distress and madness visible (to the wider community, to the police, and to services) through movement into public space (Estroff, 1981; Knowles, 2000a; Parr 1997; 2008). It was noticeable, for instance, that none of the participants discussed in the first section of this chapter, who tended to describe a retreat to the home as a response to heightened distress, described being sectioned via the police. Their pattern of movement out of public space perhaps could be seen to protect them from the control and surveillance practices of public space (Rose, 1998a) which, as argued in the previous chapter, can be seen as exclusionary to expressions of distress or visible madness (Estroff, 1981; Goffman, 1963; Knowles, 2000a; Parr, 1997; 2008; Sibley, 1995).

It could be seen, therefore, that participants who follow this pattern of movement, which can in itself be seen as a strategy to mediate their experiences, can be seen to be placed in a bind within the current landscape of community mental care. Enclosed, inside spaces can be seen as having qualities which can, at times, heighten the intensity of 'mad' experiences, whereas outside spaces which enable agentic movement and engagement with others were described as often leading to problematic encounters, or incarceration. It was noticeable, particularly in the more detailed descriptions of 'crises' in the narratives, how participants seemed to describe being constantly displaced when moving through outside space. Jimmy's account in the previous section, for instance, is one of constant movement from place to place. He also states that he leaves the second pub because "people were whispering about me" (K.O.S., p. 30), prompting him to move back to his home. Several participants described similar experiences. Suzannah, the narrator of 'Black

Magic', for instance, described her experience of a day similar to Jimmy's, of moving from place to place:

> *As I reached the centre of town I saw Ballantynes hotel where I used to work I decided to call in for breakfast. Something stopped me from ordering a brandy; I did at least have some sense left. I ate a full continental breakfast in the plush hotel. The staff were eyeing me up and down with that look in their eyes, they knew something was wrong with me; I was probably talking to myself. […] I paid the bill and continued my walk into town. I really didn't know what I was going to do I had no one to meet and nowhere to go. (B.M., p. 72)*

Alastair, the narrator of 'A Journey into Madness', similarly described his movement through public spaces as being halted by his experience of other people in a pub:

> *I walked from my mum's house in Granton to Newhaven, where I used to play as a child. I wandered all round my favourite childhood haunts: the adventure play ground, the old railway and the harbour. Then I went into one of the local pubs for a pint. As I sat down and started drinking my pint, I couldn't help notice that when people spoke to me they seemed very angry and aggressive. This wasn't how I remembered Newhaven. I decided to drink up and leave. (A.J.I.M., p. 4)*

The encounters described here could be explained as the result of the 'paranoia' of these participants, which could be argued to prompt them to perceive other people as "angry and aggressive" (A.J.I.M., pg. 4) when they are not as, for instance, a defence to low self esteem (e.g., Bentall, Kinderman & Kaney, 1994; Trower & Chadwick, 2006). Whether 'real' or 'imagined', however, the point remains that these participants describe the public spaces in which they attempt to engage as peppered with problematic and exclusionary interactions, and hence as engendering

a continuous displacement from, and between, these kinds of community spaces. Caroline Knowles (2000a) argued that homeless service users were 'moved on' from commercial spaces when they made themselves visible, through shouting or talking. The participants in this study described similar experiences, but also could be seen to describe moving *themselves* on (in a similar way to the self-confinement described above), often in response to interactions which highlighted their madness or distress to others. In a similar way to the participants in the first section of this chapter, therefore, the production of public space as 'rational' and 'productive' (Foucault, 1965; Hanson & Pratt, 1995; McDowell, 1983; Rose, 1999; Sibley, 1995) can be seen as producing an ongoing self-displacement, perhaps more subtle that that which has been described in more uniformly disenfranchised groups such as travellers (Sibley, 1995) or the homeless (Hodgetts et al, 2007). It is also noticeable how time can be seen to intersect with space in these accounts, in driving the interactions; these participants describe acting not only heterotopically (or out-of-space) in displaying visible distress and madness in public space, but also heterochronically (or out-of-time); Suzannah considers drinking alcohol with breakfast, and Michael walks his dog at three in the morning. Marking their behaviour as non-normative, a disruption of the moral or social order (Dixon et al, 2006; Szasz, 1960), is hence the location of their experience in time as well as space, or as Massey (1994a) would argue, in 'space-time'.

Julie gave a particularly interesting description of her solution to the dilemma presented to service users by the subtle and explicit displacement of

distress and madness from public space. She described where she tended to "surface" when distressed:

> *if I'm distressed sometimes I will actually surface in the grounds of the psychiatric hospital [I:mmm] because it's safe because its people I know quite a few of the staff and they help me sometimes because of my workers because I'm around doing things there erm and also because psychiatrists are there [I:mmm] so actually I wouldn't the ward wouldn't feel safe to me at that point it's really unsafe to be even near but actually being in the grounds in sense has a sense of safety in that I know there are people sort of around that understand me which I don't feel like if I went into town I wouldn't feel anything like that but I do that it's its a bit at the same time it's a safer sort of area to be erm the other thing a do is I just go out into the countryside [I:yeah] yeah cos from here I can kind of wander out over the fields and stuff we're right on the edge so I can just be straight out into the countryside [I:mmm] [indecipherable] yeah so I would do that yeah so open air. (Julie, 438 – 451)*

The two spaces which Julie describes as being her most likely destinations when leaving the house can also be seen as the least liable to invoke the kind of penalties potentially present in other public spaces. These are the countryside, where there are very few people, and the grounds (rather than the ward) of the psychiatric hospital where she is both a staff member and service user. In 'surfacing' in the grounds of the hospital, Julie can be seen to be utilising the heterotopia (Foucault, 1986a) of mental health services, as a place where distress is made visible (Parr, 1997), or is more 'concordant', as a place to mediate her experiences. Julie here describes the experience of being in this space as one of relative "safety" (line 444) as there are "people around who sort of understand me" (line 445). Within the

context of a space where distress is expected, and where she has personal relationships with the staff, her expression of distress can be seen as being experienced as 'safe' as it less likely to incur sancture (Pinfold, 2000). Julie's pattern of movement here can be seen as avoiding both the constant displacement of public space and the potential heightening of her distress and madness in the enclosed space of home.

It is worth noting, that in comparison to the spatial landscape of mental health care described by Parr (1997), Julie elsewhere detailed the closure of all community mental health centres in her area, under the current 'social inclusion' agenda (D.O.H., 1999; O.D.P.M., 2004; Repper & Perkins, 2003; Sayce, 2000; Spandler, 2007; Wallcraft, 2001). The hospital, therefore, remained the only space dedicated to the treatment of mental distress within her reach. Considering the potentially dangerous consequences of remaining at home, Julie can here be seen to using this space to escape some of the fiercest intensity of her experiences. It is noticeable that she specifically identifies the ward as: "at that point it's really unsafe to be even near" (line 446); it is the more open, and arguably less coercive, space of the grounds that, relatively, is described as positively mediates her distress. The grounds can be seen as having the advantage of being within the remit of services, and hence carrying less stigma than generic public spaces, whilst avoiding the experience of being enclosed within a ward. Considering the experiences described above of experiencing madness in enclosed spaces, the indoor nature of the ward could here be seen to potentially mediate her distress in a similar way to her home, as well as, as will be explored below, exposing Julie to the control practices (Deleuze,

1992) which were described in Chapter Four as characterising the makeup of the ward.

6.4   Constrained movement in the psychiatric ward

As detailed above, many participants who described such a drive to be outside and engage actively in the world when having intense experiences of madness, often also described being sectioned and placed on a psychiatric ward. In comparison to the accounts of wandering across and between cities, the ward was described, as touched on in previous chapters, as a place of little freedom of movement (Bowers et al, 2006; Bowers et al, 2009). Indeed, some participants who had been previously admitted to asylums commented on the comparatively small spaces allocated to contemporary wards:

> *I think one of the differences is that there was much more space [I:mmm] in the old acute wards than there is now [I:mmm] erm in the old hospitals the acute wards the day rooms were quite large much much larger than they are in most acute war erm units now certainly the day room that I that I just described was probably a third the size of the day room that I used to be in [name] asylum [I:mmm] and then there was also there was a large dining area there was also an area another room a second day room er that in in [asylum] where people played table tennis or [indecipherable] or things so there was much more space [I:mmm] whereas I think in in the unit where I go into now that you really feel that you are confined [I:mmm] I mean one of the things is the roofs are much lower obviously I mean in the old asylums the ceilings not roofs the ceilings were much higher [I:mmm] and the doors I mean you had these enormous doors thick wooden doors but also really tall doors which could be a bit intimidating but it was much more sort there was much more space. (Bryan, 252 – 265).*

it's a lot smaller it's erm it's actually it's in the middle of a housing estate […]
erm the there's very little in the way of grounds in the hospital. (James, 68-
73).

In particular, participants with such experiences commented on the loss of outside
space in most contemporary wards:

[Asylum] was out in the country and you had the er like sitting in a country
garden [I:mmm] and you could sit outside and relax. (Ralph, 512 – 513).

they used to be really nice lawns summer houses places where you could sit
erm and so that aspect of it was quite good if you were if if you were able to
get off the ward and have have the freedom to use the gardens [I:mmm] it
was quite a therapeutic um environment to be in because as I say it was a
beautiful beautiful environment but I mean I remember spending quite a lot
of time when I had the opportunity just sitting in the gardens and and that
was a kind of positive side [I:mmm] and obviously you don't have that
[I:mmm] in many places now because well certainly in London because the un
the units are in the middle of the community you walk out the door and
you're on the street. (Bryan, 240 – 248)

These accounts can be seen to be describing the contemporary psychiatric ward as
providing very little buffer between what is argued here to be the heterotopia
(Foucault, 1986a) of the ward (characterised by visible distress and visible control
practices) and the spatial practices of the community; as Bryan says "you walk out
the door and you're on the street" (line 248). Whilst the old asylums are here
described as having large grounds, described as a "therapeutic" (Bryan, line 243)
space, the smaller spaces of contemporary psychiatric wards, however, have been
argued to be both less isolated and more 'permeable' (Quirk et al, 2006) to the
outside world. This greater level of 'permeability', evidenced by Quirk et al (2006)

through the greater numbers of visitors, as well as drugs and alcohol, on contemporary wards, has also seen an increase in the practice of locking psychiatric wards (Ashmore, 2008; Bowers et al, 2006; Bowers et al, 2009). The changed function of the ward within the distributed system of community care (Rose, 1998a; Bowers et al, 2005), which could be characterised as a shift to being a short term container rather than long term 'enclosure' (Deleuze, 1992), can be seen to be realised through this described shrinking of the ward space.

Bryan's account, for instance, details a reduction in both the size and variety of spaces within and outside the ward, with the day room reduced to a "third of the size" (line 255) and there being little variation of function within the ward, compared to the spaces for activities ("table tennis", line 261) described in the asylum. The 'enclosure' (Deleuze, 1992) of the asylum could, in other words be seen to have incorporated a greater variety of spaces and spatial practices, arguably due to the greater size of the institutions, the longer periods of time spent there, and their greater isolation from mainstream space. This is not to claim that asylums were havens of free and unbounded movement; indeed, in his classic text 'Asylums', Erving Goffman (1961) described asylums as operating a 'privileges and punishments' system, a key part of which was the control of movement. Those who adhered to the rules of the institution, he argued, were granted increasing freedom of movement; one of the highest 'privileges' granted was the ability to leave the ward and use the grounds, whilst one of the most severe 'punishments' was complete curtailment of movement in the form of being placed in a padded cell. Nevertheless, it could be seen that within the shrunken space of the contemporary

ward, described by one participant as a "pressure cooker it's it's a concentration of problems" (James, 168-169), an almost uniform reduction in ease of movement for service users was described.

6.4.1 Patterns of movement on the ward

Within the limited spaces available on the ward, participants tended to describe a further restraint on their patterns of movement, determined by staff. Lou, for instance, described how her preference for spending time in her room was dealt with by staff members:

> *it was mainly yeah you were supposed to I mean I did spend a lot of time in my room and they kept complaining about that saying I should be spending more time in the communal areas. (Lou, 96-98)*

Lou described her preference for being in her room as being in part an avoidance of other service users, as described in the previous chapter, but also due to two particular aspects of the space of her room:

> *I just wanted to be left alone and not have to answer any questions or do anything or speak to anybody and I guess my room just really felt like that was my space. (Lou, 117-118)*

> *my room this window it was like… it had a really amazing view of the outside if you just focussed on the window and looking out the window you could see the clouds and everything and it was summer so it was really nice nice weather. (Lou, 52-55)*

Lou hence describes the retreat to her room as in part an attempt to claim some personal territory on the ward; her movement on the ward could hence be seen as echoing her described pattern of movement in the community, where she describes retreating to private space to deal with her distress (Davidson, 2000a; 2000b,

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Mcgrath et al, 2008; Pinfold, 2000). Lou's retreat to her room can therefore be seen as an active strategy to mediate her distress in the ways she describes as being most 'comfortable' in the community, but which is here curtailed by the staff.

Jimmy, the narrator of the 'I Thought I was the King of Scotland', described a similar, albeit more dramatic, repressive response of staff to his preferred use of space and movement on the ward, when "high" (p. 33):

> *I went into the smoke room and I had never smoked before in my life and I lit up a king [sic] Edward cigar, I felt that this was part of my bi-polar disorder and still felt high. I went for a walk around the courtyard listened to my music which would make me more higher. I was listening to only the strong survive by Billy Paul. I'd do two hundred laps around the courtyard when I returned back onto the ward a nurse pinned me down marched me into seclusion, turned my face down onto the mattress took of my clothes apart from my boxer shorts and then injected me with Accuphase. They slammed the doors behind them.*

> *It was scary being in seclusion for the first time knowing that you cant [sic] get out.*

> *I just covered myself over with the blanket and I had fast racing thoughts in my head and also a sore head, it felt like a giant hangover. I had half hour sleep in there, three hours later the nurses let me out. I had to go and see the doctor again in ward round. I asked him why have I been given Accuphase again? He didn't answer me. He told me that they had to change my medication to four hundred milligrams of Lithium and four hundred milligrams of Quetiapine. Two days later I had an argument with the nurse about my medication they told me that I had taken it, I told them that I hadn't. I kicked him in the leg and then ran out to the courtyard. The nurses wouldn't come out to me, I went back into the medication room started to argue with the nurses again, then a nurses gave me a rugby tackle pinned me*

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down to the floor. There were six to eight of them. They put me into the
seclusion room. They took all my clothes of apart form [sic] my underwear,
lay me flat down on the bed and injected me with Accuphase, they also gave
me another injection I asked them what it was, they said it was Haloperidol.
It calmed me down then they left the room, they kept me in for a good six
hours before they let me out. (K.O.S., p. 33).

In a similar way to Lou, Jimmy can here be seen to be describing a way of dealing with his embodied experience of feeling "high" (pg. 33) through active movement in the outside space of the courtyard, repeating the same pattern of movement described by participants (including Jimmy) in the previous section as a method of mediating the intensity of such experiences. He also describes using his Walkman to create his own private bubble when in the courtyard. This could be seen to be an example of Michael Bull's (2008) argument that personal stereos can be used to mediate experiences of space to limit the impact of the immediate environment and create a sense of personalised social interaction (through the introduction of familiar music). Bull argues that that such devices are often used to modulate the anonymity of the urban environment, but could Jimmy could equally here be seen to be using his Walkman in a similar fashion, to distance himself from his location in the ward.

It is also noticeable that the two spaces Jimmy describes utilising when in this state of intense "high" (pg. 33) are the outside space and the smoking room; within the confines of the ward, these two spaces can be seen as the two spaces characterised by a lessening of the psychiatric gaze, as described by Rachel in the previous chapter (for the smoking room) and Julie in the previous section (for the

grounds), which could be argued to afford Jimmy more agency within these spaces.

Breeze & Repper (1998) have argued that managing 'difficult' service users on the

ward (often those who break rules, as Jimmy does here, or are violent, as he

described being in the community) is often seen as a struggle for 'control' by both

staff and service users, and leading to the use of control practices described here,

such as high levels of medication, and seclusion (see also, Muir-Cochrane, 2006;

Sailas & Wahlbeck, 2005). Such a struggle can be seen in Jimmy's account; he

describes the staff waiting for him to return to the ward from the courtyard before

they "pinned me down marched me to seclusion" (p. 33), which could be seen to

indicate that the more liminal space of the courtyard lies slightly outside staff

territory. In a later incident on the same ward, Jimmy describes running into the

courtyard to avoid another spell in seclusion, and again described the staff as

waiting until he came back into the space of the ward before restraining and

medicating him. Here, the different spaces inside and outside the ward can be seen

to mediate differential power relations between Jimmy and the staff; his location in

the courtyard can be seen to produce a more powerful position, whilst when inside,

the staff seclude and medicate him.

In a similar way to Lou's account above, therefore, Jimmy's movements on

the ward can be seen to replicate his movements in the community, and could be

seen to reflect an active coping strategy for dealing with his experiences of madness.

This coping strategy, however, can be seen as at odds with the practices of the ward;

on behaving in this way, he is heavily medicated and put into seclusion. The

'punishment' (Goffman, 1961) for the visible display of madness, and for disobeying

the movement rules of the ward (where service users were only allowed in the courtyard for fifteen minutes per day, under supervision), is a complete erosion of his freedom to move. The staff and Jimmy (and above, Lou) can hence be seen to be operating with conflicting practices of how to deal with high levels of distress and visible madness, with the patterns of movement described as useful in the community met with an increase of control practices on the ward. On a later admission, when Jimmy had been caught absconding from the ward, he describes a pre-emptive movement into seclusion, in a reversal of his previous, enforced, incarcerations:

> *Not long after I was back on the ward the vampires [staff] came for me I knew what they were going to do, they came from all different wards. I ran into seclusion myself took my clothes of [sic] apart from my underwear and I told them that they better not give me two hundred milligrams [of medication]. At this time I was getting angry I let them give me the injection, I stood back upon to the bed and burst out laughing at them. I told them that they were all wankers; they were all standing around me in a circle. The room was full of vampires I burst out laughing again. They just stood there in amazement then they walked out and closed the door behind them. Six hours later they let me out. (K.O.S., p. 35 – 36)*

Having learnt the outcome of the kinds of patterns of movement he describes engaging in when in the community, Jimmy can here be seen to describe his flight to seclusion as an agentic reversal of power. This account can also be seen to describe a "modulation" (Deleuze, 1992) of Jimmy's patterns of movement engendered through his experiences in the ward. He can be seen to have adopted the ward's prescribed practices for dealing with visible, active expressions of distress or

madness; rather than moving into the garden to partially escape the control of the ward, he instead runs into seclusion and "let[s] them" (pg. 35) give him the medication. It is noticeable that these two officially sanctioned responses to active, visible distress on the ward constitute the opposite of Jimmy's described patterns of movement in the community; rather than moving actively through space, his movement is completely restricted in seclusion, and deadened with medication.

6.4.2   Movement off the ward: compliance and conformity

Several participants described their negotiation of movement off the ward as entailing an adherence to the control practices of the ward. Lou, for instance, describes being put on "one to one" (line 119) observation, a further incursion on her freedom of movement within the space of the ward:

> *but then I got I got put on one to one which meant that I was followed round because I was being naughty and erm so they so I had to have someone following me round and they had to sit in my room and watch me sleep all night because you know I couldn't do I couldn't even go to the toilet on my own [I:mmm] you know they had to come in and watch me and it was [sighs] and that felt like such an intrusion and I was really I mean it really worked because I stopped doing what I was doing that got me put on it because it just was such an intrusion I didn't want it I didn't want them to have to follow me round. (Lou, 119-128)*

Whilst Alistair, the narrator of 'A Journey into Madness' described adherence to medication and staff expectations as a way of ensuring release from the containment of the ward:

> *A few days went past and I had not taken any medication because of the side effects. By now I had had enough and thought: they can't keep me in here*

when there is nothing wrong with me. I had been repeatedly told: you won't get well if you don't take the tablets. So I decided to ask for a diagnosis. I went into the office when a lady psychiatrist was there and asked for one. She said "why do you want a diagnosis?" I explained that they could not hold me there without one. She then said "That's easy; you have schizophrenia." I could not believe it. So I decided to gather as much information as possible on schizophrenia. I disagreed with the psychiatrist after reading the information but could do nothing about it. So I felt trapped and helpless and realised the only way I was going to get out now was to take the tablets which I started to do. (A.J.I.M., p. 11)

Alistair later sees the results of this strategy of compliance:

After being in hospital for approximately two months, I still felt there was nothing wrong with me. I had been taking the medication and obeying all the rules. As a result, the time I was allowed out of the ward had increased from a couple of hours at a time to 9am to 9pm everyday [sic]. I took full advantage of this and only came back to the ward for food and medication at 12pm and 6pm. I felt I had to conform or be confined to the ward. It was around about this time that I was asked by the psychiatrist if I would like to go to my mum's house for the weekend on a pass. I jumped at the chance. Arrangements were made and I was about to have my first real taste of freedom for what seemed like a long time. (A.J.I.M.., p. 15)

Tom, a participant in his mid 30s, similarly described the process of getting off the ward as a "maze" of staff expectations to which he felt he had to conform:

Erm and this a bit more like a maze how to almost about how to get out of it here you've got just a maze [...] just trying to get out really behaving more normally than I would normally [...] so I can get out [...] as long as a I come across as normal (Tom, fragment of a corrupted interview recording).

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Whilst unsanctioned movement *within* the ward, therefore, can be seen as leading to the imposition of further control practices (medication, seclusion and observation), movement *off* the ward was described as necessitating an adherence to such control practices, in conforming to behavioural rules and medication, indicating a similar system of 'privileges and punishments' observed by Goffman (1961) to operate in the asylum system. Whilst the ward can be in some ways seen as a heterotopia of the invisibility of distress, as discussed in the previous chapter, therefore, visible distress, madness, or unsanctioned coping strategies can here be seen as also incurring penalties on service users' freedom of movement within, and possibility of escape from, the ward. These accounts can be seen to encapsulate two seemingly contradictory aspects of the ward environment; that it can be understood as a heterotopia both of visible distress, and of control practices, which in themeselves can be seen as functioning to hide such distress in community spaces. The resultant 'purification' (Sibley, 1995) of public spaces of expressions of distress can be seen as displacing those who display such behaviour (either self imposed, to private spaces, or forcibly, to the ward), as seen in the accounts in the previous sections; those who are displaced to the ward can then be seen as subject to intensified control practices to 'manage' their heterotopic expressions of distress or madness, and only 'released' back into the community once they have demonstrated a willingness or ability to adhere to the control practices which Rose (1998a) argued are distributed throughout community spaces, such as agreeing to adhere to medication regimes. Whilst Goffman (1961) argued that movement within, and out from, the asylum was constrained until the patient adhered to the

rules of the asylum and succumbed to a psychiatric view of themselves, or in Deleuze's (1992) words was "mold[ed]" by the "enclosure" of the asylum, the accounts here of movement within, and out from, the psychiatric ward, can instead be seen to be governed by risk management (Rose, 1998a) and perhaps instead constitute a "modulation" (Deleuze, 1992) of behaviour, and the management of madness and distress.

6.5   Conclusions

This chapter has outlined a potential role for movement in service users' negotiation of distress and madness, both in the community and on the ward. Two patterns of movement have been identified, one as a move inside to escape 'discordant' experiences of public space (Davidson, 2000a; 2000b; Knowles, 2000a; Pinfold, 2000), and a second move into the "open air" (Julie, line 449) to mediate intense experiences in enclosed spaces. The distribution of experiences of madness and distress through engagements with open space, and encounters with other people, has been argued to help mediate power relationships with experiences such as voices, visions, and beliefs (Romme & Escher, 1993; Romme et al, 2009; Romme et al, 2011). The first of these patterns of movement has been identified as a form of 'self-confinement', questioning discourses of community care which present post-institutional lives as ones of freedom of movement (S.C.M.H., 2005; Bartlett & Wright, 1999). Movement outside has also been discussed as potentially leading to experiences of 'displacement', when service users have described acting in ways which can be understood as 'discordant' to the rational production of public space (Foucault, 1965; Knowles 2000a; Sibley, 1995; Parr, 1997). Furthermore, these

patterns of movement, described by participants as helpful strategies to mediate distress and madness in the community, have been argued to be 'punished' (Goffman, 1961) when in the space of the ward, and described as leading to an increased level of practices of control (Deleuze, 1992; Rose, 1996; 1998a), such as medication, seclusion and observation. In conclusion, it can be seen that experiences of distress and madness are here described as distributed, and mediated, through embodied actions in space, rather than simply emergent from individualised, static, internal processes of faulty cognitions or biology (cf., e.g., Bentall, Kinderman & Kaney, 1994; Trower & Chadwick, 2006).

Chapter Seven

Discussion and Conclusions

7.1 Summary of findings

This thesis has examined the role of space in service users' experiences of community mental health care. The three preceding empirical chapters have presented an interpretation of the spatial facets of participants' experience of distress, services, and living in the community. It has been argued that contemporary mental health service sites can be understood as distributed heterotopias (Foucault, 1986a) of control (Deleuze, 1992). The experiences outlined in Chapter Four, of the ward as characterised by observation and risk, made visible thorugh the material structure of the ward, are one example of this point. In line with Foucault's (1986a) argument that heterotopias function as a mirror, that they can be seen as: "reflecting mainstream society's selfness through its otherness" (Saldanha, 2008, p. 2085), it is here argued these features of the ward can be seen to reflect a wider 'control society' (Deleuze, 1992) of contemporary mental health practice (Rose, 1998a). Participants' descriptions of community mental health service sites, as still characterised by the same material 'participants' (Latour, 2005) of locks and barriers as the ward, has here been argued to support this idea, as exemplified by the visual examples in Chapter Four. Again, such material characteristics of these spaces can be seen as making visible, and 'stabilising' (Serres, 1995; Reavey & Brown, 2009) a devalued and stigmatised subject position (Campbell, 1996a; 2007; Haywood & Bright, 1997; Link et al, 1989; Repper & Perkins,

2003; Sayce, 2000; Scheff, 1974; 1999). Further, this subject position is here argued to follow service users out into the community, with contact with services acting, as argued by Deleuze (1992), as a 'modulation', of service users' subjectivity; an ongoing process of subtle modification. In part, this experience of 'modulation' can be seen as emergent from what has here been argued to be the heterochronic (Foucault, 1986a) qualities of service user sites, and service user-professional interactions more generally. To recap, it is argued here that time in mental health services can be understood as heterochronic, as characterised by time organised "in a way different to that which surrounds [it]" (Hetherington, 1997, p. viii); in particular, it is argued that the time spent in services can be seen as set apart to discuss distress, in an inversion of a general silencing of experiences of distress (Foucault, 1965; Hornstein, 2009; Parr, 1997; 2008). In addition, the curtailed nature of these interactions can be seen as producing a problematic transition between the necessary discussion of distress and the presentation of a non-distressed, successful self argued to (often) be required 'in the community', most particularly in normative public spaces (Dixon et al, 2006; Estroff, 1981; Goffman, 1963; Hodgetts et al, 2007; Knowles, 2000; Pinfold, 2000). This point can be seen particularly in the examples from Lou and Karl in Chapter Four, of their experiences of psychotherapy. Deleuze's (1992) argument that control societies operate through 'modulation' was here argued to be present in participants' account of managing and resisting the ongoing production of service user positioning in non-service use spaces; examples from the data include Zoe's resistance of having professionals in her home, as well as Lou and Karl's accounts of spaces of exercise.

This picture of services acting as heterochronic heterotopias, modulating ongoing experiences in the community, through time-limited, risk assessment driven (Rose, 1998a) contact, was argued to have two key impacts on service users' experiences. The first, explored in Chapter Five, was that as service users now negotiate their distress across multiple spaces, and spend most of their time located in non-service use sites, there emerges a complex landscape of spaces which can be seen as more or less 'concordant' with experiences of distress. It has here been argued that, for some participants, public spaces were described as particularly discordant with their distress, often resulting in augmented experiences of distress when in such places, seen particularly in Janet's account of feeling "stifled" (line 348) in public space. This experience of additional distress was linked to an argued increased level of surveillance, and potential threat of sancture, notice, or even incarceration, associated with such spaces (Davidson, 2000b; 2001; Dixon et al, 2006; Hodgetts et al, 2007; McGrath et al, 2008; Parr, 1997; 2008; Sibley, 1995). Experiences of the home, as a potentially more 'concordant' space were also explored in depth, arguing that the experiences describing home as a 'safe haven' (see Pinfold, 2000) can be seen as contingent on agency in the home space (Mallet, 2004; Tucker, 2010; Wise, 2000), rather than being an inevitable feature of home spaces (Sibley, 1995; Wardaugh, 1999). In particular, an ability to "shut the door" (Twigg, 2000, p. 384), creating privacy, and to order home space in a 'concordant' fashion was argued to be important in participants' accounts of creating a 'safe haven' (Pinfold, 2000) in which to experience and express distress. Interactions with services were then examined in light of these issues, of concordance and

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discordance, particularly in the sense that participants described service use interactions in public space which required disclosure as particularly problematic, for instance in Zoe's account of feeling "bare" (line 135) in her psychiatrist's office with many windows, and Julie's description of meeting professionals in public space. This discomfort has been argued to be due to a prevaling production of such spaces as 'discordant' with distress (Davidson, 2000a; 2000b; Estroff, 1981; Knowles, 2000; Parr, 1997; 2008).

Finally, the second impact of the changed landscape of mental health services argued here to be important in the experiences described by service users, was the role of movement in service users' experiences. It was argued that implied in emancipatory discourses of community care (see Symonds, 1998; Pilgrim, 2000) is a greater freedom of movement for service users, unshackled from the confines of the asylum (e.g., Bartlett & Wright, 1999; S.C.M.H., 2005). The complexity of negotiating the landscape outlined in the previous two chapters, of the heterotopias of mental health care, as well as discordant and more concordant spaces in which to experience and manage distress, was however argued to present service users with more subtle forms of confinement and curtailment of movement still present in 'community care'. Retreat to the home as a strategy of safety (Davidson, 2000a; 2000b; McGrath et al, 2008; Pinfold, 2000) was discussed, as well as 'hiding' distress at work to ensure the continued presentation of a rational, productive (Putnam & Mumby, 1993; Rose, 1989; 1998a; Walker & Fincham, 2011) and emotionally appropriate (Grandey, 2000; 2003) self in the workplace. Such strategies were described as being a form of 'self-confinement', avoiding the

experience of discordance described in the preceeding chapter (Davidson, 2000a; 2000b; Pinfold, 2000). In addition, the opposite pattern of movement, a drive to be outside, was described; here, movement into outside and populated spaces was described as, for some participants, an active move to modify experiences of voices, visions and beliefs, in particular their power relationships (Birchwood, Meaden, Trower & Gilbert, 2002; Cromby & Harper, 2004; Harper, 2011; Hayward, 2003; Romme & Escher, 1993; Romme et al, 2009; Vaughan & Fowler, 2004). Jimmy (K.O.S.) and Michael's (A.C.P.) accounts of their movement outside when having 'mad' experiences can be seen as particularly rich examples of the mediation of madness through movement. It was noted that a movement into outside space was often described as leading to experiences of displacement, which again can be seen as linked to the relative 'discordance' of distress and madness (Estroff, 1981; Knowles, 2000; Parr, 1997; 2008), or indeed difference more widely (Dixon et al, 2006; Hodgetts et al, 2007; Sibley, 1995) in public space. In the confined space of the ward, it was argued that these strategies of movement, either through service users spending too much time alone (in particular, Lou), or moving into space which was restricted (in Jimmy's account), were punished as non-conformity and attracted control practices (Deleuze, 1992; Rose, 1998a) of seclusion, medication, or observation (Breeze & Repper, 1998; Muir-Cochrane, 2006; Sailas & Wahlbeck, 2005).

7.1.1 Research questions and key insights

To return to the research questions set out in the methodology chapter:

- What role does space play in service users' experiences of mental health care?

- What role does space play in the negotiation of distress and recovery in the community?

- How are the spaces of mental health care experienced, managed and negotiated by service users?

It can be seen from the summary of findings above that space was described as playing an integral role in service users' experiences of distress, wellbeing, and mental health care. In line with Massey (1994c) and Lefebvre (1991), it can be seen that the relationship described here was not one of merely a container, nor a simplistic determinant of experience; instead, it has here been argued that participants' described a complex, ongoing participation (Latour, 2005) of their material environments in their experiences of distress and wellbeing. In particular, it was argued that material objects, such as locks and barriers in mental health service buildings, could be understood as 'stabilising' (Serres, 1995) particular relations, such as, in this case, a power differential between service users and staff (Bentall, 2003; Campbell, 2007; Goffman, 1961; May, 2007; Scheff, 1999) and 'making visible' (Foucault, 1986a; Hetherington, 2011) an implied subject position (Goffman, 1961; Repper & Perkins, 2003; Scheff, 1999). Furthermore, it was argued that space and objects were used by services as a resource, or 'technology of the self' (Brown & Stenner, 2009; Foucault, 1986c) to actively manage their subjectivity and experience, such as in the examples of active participation in exercise spaces, the ordering of the home to create 'concordance', or movement outside to mediate experiences of unusual beliefs. In this way, it has been argued that space, as a

collection of ongoing, interlocking, and non-deterministic processes (Lefebvre, 1991; Massey, 1994c), intersects with a similar view of the person as in a state of *becoming* (Brown & Stenner, 2009; Whitehead, 1978)*;* experiences are hence understood as embedded in material-social context, and at the same time this material-social context a part of the resource which is used to 'stylise' (Brown, 2001) and construct ongoing experiences of subjectivity. To extend Massey's (1994c) argument that spaces are both socially produced and socially productive, this can be understood as an argument that experiences and subjectivity are mediated and distributed through space, and also that space forms part of the ongoing production of subjectivity. Overall, this position can be seen to fit within a process-ontological position (Brown & Stenner, 2009; Rescher, 1997; Stenner, 2007; 2008; Whitehead, 1978), as experience is viewed as produced by an intersection of multiple processes, spatial, social, and personal, which can be seen as coalescing to produce specific experiences.

This idea has implications for a wider understanding of distress and madness; as stated in the introductory chapters, and noted through some of the analysis, distress is often characterised under a medical model as a fixed, internal property of individuals, an 'illness' which is intrinsic and, particularly in the case of 'schizophrenia', incurable (Antony, 1993; Bentall, 2003; 2009; Deegan, 1988; Dillon, 2010; 2011; Johnstone, 1989; May, 2007; Read et al, 2004; Repper & Perkins, 2003; Sayce, 2000). There have been multiple attempts within mental health theory and practice to redress this balance, through arguing for a role of social and material context in the development and maintenance of distress, as discussed in the

opening chapter to this thesis (e.g., Brown & Harris, 1978; Curtis et al, 2000; Johnstone, 1989; Geekie & Read, 2009; Kelly, 2006; Rappaport, 1977; Romme & Escher, 1993; 2000; 2011; Shaughnessy, 2000; Smail, 2005; Warner, 2000). What is argued here, however, is that the role of context, in particular here, spatial context, can be seen as going beyond being a causation or maintenance factor. The experiences described by participants have here been argued to point to experiences of distress and wellbeing as constantly shifting, thoroughly mediated by, and distributed through, social and material settings. This can be seen, for instance, in the experiences described of states of 'anxiety' being augmented, in public spaces, described in Chapter Four, or the disclosure of distress in service use interactions as mediated by the social and material setting (of public space, of closed or exposed spaces). This can be understood as pointing to experiences of distress as an ongoing process of *becoming* (Brown & Stenner, 2009; Rescher, 1996; Stenner, 2008; Whitehead, 1978) produced through continuous dialogue with the intersecting processes argued to constitute space (Lefebvre, 1991; Massey, 1994c). Experiences of distress and madness are hence re-formulated as dynamic, not static, and specific to the context in which they occur, rather than pre-determined by a set of symptoms, reified from context.

In terms of the second question, of the use of space by service users, it has here been argued that space was used as a resource by service users, as a 'technology of the self' (Brown & Stenner, 2009; Foucault, 1986c) to actively manage and modify their experiences of distress and the spaces which they occupied. Examples in the analysis ranged from from Zoe excluding services from her home

space, and Lou ordering her personal objects in a 'temporary' fashion, both argued to enable the resistance of a global service user identity, to James 'escaping' his unsatisfactory home space by spending time in the park, argued to enable the accessing of a former 'imagined space' (Soja, 1996) of home. In addition, movement within, between and through community and service use spaces has been argued to be a key feature of the production of situated experiences of distress, and part of the agentic management of experiences of distress by participants. This is one place where this research adds to the literature already existent on space, subjectivity and mental health. Whilst work from geography (Davidson, 2000a; 2000b; Parr, 1997; 2008; Pinfold, 2000; Segrott & Doel, 2005) has examined the role of space in mental health services, and service users' experiences, there has perhaps been little sustained engagement with the specific use of material objects and space to modify and modulate experiences of distress.

The final question, looking at the specifics of the spaces of mental health care, has been answered through the use of the concept of heterotopia (Foucault, 1986a). In considering the spaces of contemporary mental health health care, it has here been argued that the move to 'community care' has not meant an end to the importance of attending to the construction of places where mental health care takes place. It is has here been argued that the contemporary, distributed sites of mental health care can be understood as exisiting in relation to the other spaces in the lives of service users, and also informing their activities and relationships in other spaces outside of service use, through the ongoing 'modulation' of their experiences (Deleuze, 1992). It is here that the metaphor of the heterotopia as

mirror (Foucault, 1986a; Hetherington, 1997; 2011) has been utilised, to consider service use spaces as both 'different' places, and yet a part of a complex landscape of service use and community spaces which service users have to occupy and negotiate as part of community care (Symonds, 1998; Rose, 1998a). Whereas, arguably, many of the uses of the concept of heterotopia have been to describe and characterise the makeup of numerous types of places (e.g., Hetherington, 1997; 2011; De Cauter & Daheune, 2008; Hook & Vrdoljak, 2002; Street & Coleman, 2012; White, Hillman & Latimer, 2012), in this project the focus has also been on understanding how such "other spaces" (Foucault, 1986a, p. 3) 'participate' (Latour, 2005) in the prodution of distress, and the subjectivity of service users, both within service use and non-service use spaces. Hence the idea of 'modulation' has been used to describe a potential route for how such 'differently ordered' (Hetherington, 2011) spaces feed into the production of service user subjectivity, and continue to haunt experiences in other spaces, through, for instance, the threat of incarceration (as seen in Chapter Six), or feeling of discordance in public space (as discussed in Chapter Five). Whilst several authors have tackled the relationship between heterotopia and their surrounding spaces, of various forms, such as museums (Hetherington, 2011), hospitals (Street & Coleman, 2012; White, Hillman & Latimer, 2012) and gated communities (Hook & Vrdoljak, 2002), what this project is argued to add to this literature, is an analysis of the *experience* of heterotopia of mental health care, as well as of the role of such spaces in the ongoing process of the production of distress and subjectivity.

7.2   Reflexivity and validity

As Lucy Yardley (1997; 2000; 2008), among others (Banister et al, 1994; Elliot, Fischer & Rennie, 1999) have argued, the assessment of the validity of qualitative research is complex. Whilst some qualitative researchers take a broadly realist approach to validity, such as employing inter-rater reliablility measures in a similar manner to quantitative research, Yardley (2000) points out the relativist epistemology of most qualitative research renders such evaluative techniques pointless, as:

> One of the primary reasons for adopting [qualitative methods] is a recognition that our knowledge and experience of the world cannot consist of an objective appraisal of some external reality, but is profoundly shaped by our subjective and cultural perspective, and by our conversations and activities. (p. 217)

As explored in the methodology chapter, I would concur with this viewpoint, and such a rejection of the possibility of establishing a single 'objective' 'truth' (Banister et al, 1994; Denzin & Lincoln, 1994; Letherby, 2003; Ratmazanoglu & Holland, 2002; Wetherell et al, 2001; Willig, 2001) has indeed been a key part of the reason for adopting qualitative methods in this project. If there is no 'correct' analysis, however, then how is validity and rigour to be established? In answer to this quandary, Yardley (2000; 2008) suggests four key criteria for assessing the quality and validity of qualitative research: sensitivity to context; commitment and rigour, transparency and coherence; as well as impact and importance. A similar set of criteria have been proposed by Elliot et al (1999): disclosure of perspectives; grounding interpretations in the data; and coherence of interpretative framework.

What these criteria share can be seen to share is: firstly, an attendance to the transparency of the research, through the disclosure of perspectives and procedures; and secondly, a rigorous location of the interpretations both in the data, and theoretical literature. The second of these criteria (coherence of interpretative framework, coherence and rigour), are the reasons for the introductory material presented in the first two chapters of this thesis, to provide a coherent empirical and theoretical framework for the interpretation of the data. A crucial part of presenting a transparent research process (the second criteria), including the acknowledgement of the subjectivity involved in the process of data collection and analysis, has been argued to be reflexivity (Denzin & Lincoln, 1994; Banister et al, 1994; Finlay & Gough, 2003; Pillow, 2003; Ratmazanoglu & Holland, 2002; Wilkinson, 1988; Yardley, 1997; 2008). Finlay & Gough (2003) identifies reflexivity as the: "thoughtful, self-aware analysis of the intersubjective dynamics between researcher and researched" (p. ix), an ongoing process by which a researcher reflects on the process of research and the veracity and origins of the particular interpretation of the data. As Finlay (2003) outlines, there are many different forms of reflexivity, ranging from reflexivity as introspection, social critique, or deconstruction. For this project, the approach taken to reflexivity is to first consider the impact of the intersubjective relationships between myself and the participants, considering both my own and the participants' socio-cultural locations (Finlay, 2003; Yardley, 2000), specifically in terms of considering the impact this may have had on the data collected and my interpretations. A part of this consideration of context of the accounts used in this research is a consideration of the context of

the two different forms of data collection employed. Secondly, I have taken a critical look some of the assumptions I brought to the research, specifically, here the role of diagnosis. Finally, in considering the wider impact of the research (Banister et al, 1994; Burman & Parker, 1993; Burman, 1997; Yardley, 2000), this chapter will end with an exploration of the implications of the research for the current social inclusion agenda (D.O.H., 1999; O.D.P.M., 2004; Repper & Perkins, 2003; Sayce, 2000; Spandler, 2007; Wallcraft, 2001) in mental health services.

7.2.1 Participant group: gendered and classed management of distress

As stated in Chapter Three, a clear issue with the participant group of the interviews was that they were almost exclusively middle class, white, and degree educated (as discussed, this was partly ammeliorated by the broader demographic spread of the authors of the narratives examined). Whilst it is not the aim of qualitative research to generalise findings in the same way as quantitative research (Banister et al, 1994; Denzin & Lincoln, 1994; Parker, 2004; Willig, 2001), and so having a 'diverse' participant group can be argued to be less crucial, the largely middle class nature of the participants did produce some issues when starting to analyse the data. In particular, as a white, middle-class, degree-educated woman, I fit into broadly the same demographic as many of my participants. I noticed after my early coding of the data, that I was particularly highlighting experiences which have mainly been covered in Chapter Four of this final thesis, those of discordant and concordant distress. I realised that these experiences most reflected my own experiences of difficult emotional times, when I would be most likely to retreat to my home and room, rather than display such emotions in public. This realisation caused me to

wonder if these experiences were mediated by wider norms of emotional management, which I might share with my participants, such as the privatisation of emotional expression in Western, particularly white, culture (Burkitt, 1999; Elias, 1978; 1982; 1985) and the gendering of private spaces as 'female' (Davidson, 2000a; 2000b; Hanson & Pratt, 1995; McDowell, 1983). Davidson (2000a; 2000b), for instance notes that the diagnosis of agoraphobia, which can be understood as a retreat to the home, is a largely female diagnosis, linking this occurrence to a gendered division of space as public/male and private/female (McDowell, 1983), which could be seen to produce private space as producing a subjective experience of the home as potentially a more 'concordant' sphere for women to experience distress. I considered whether these norms could also feed into my own strategies of emotional management, or if, alternatively or additionally, I was simply honing in on those experiences which most closely matched my own. This realisation led to a re-evaluation of the coding of the data, and in particular, paying closer attention to those opposing experiences, of movement outside when in states of distress.

The potentially wider implications of this tendency in the data, to perhaps be biased towards a particularly middle class mode of coping with distress, could be the over-emphasis of the role of the 'safe haven' (Pinfold, 2000) in the analysis. This was an important point raised by many participants, but it is worth noting that these participants, like myself, tended to be have a level of economic and social power which enabled the ordering of their home space to create a 'concordant' space for the experience of distress. This has been addressed in the analysis, but it is still

worth raising the point that the interview data does come from a relatively 'priviledged' group, as well as one which has been argued to particularly value the creation of territorial home space (Mallet, 2004; Tucker, 2010; Wise, 2000).

7.2.2 Context and accounts of distress

As discussed in the method chapter, these issues were less apparent in the narratives analysed. This was not, however, the only difference between the two forms of data collection. These two different kinds of accounts were collected in very different contexts; one as part of a focussed research interview, an embodied encounter with the participant, whilst the narratives were produced for the public domain, and I did not at any point meet or contact the authors. As well as being produced by people from differing socio-economic backgrounds, it was clear that there were differences in the content and style of the two types of accounts, which I would argue were located in the different contexts in which these acccounts were produced. Most particularly, whilst the narratives contained long, detailed descriptions of the phenomenological experience of distress and madness (such as the long term development of paranoid beliefs, e.g., E.A.N.F.), in the interviews such experiences tended to be described using generalised phrases, such as "crisis" (Bryan, line 78), "if I'm distressed" (Julie, line 438), or "when very I'm low" (Janet, line 316). For the purposes of this project, the interviews provided more focussed descriptions of experiences of particular spaces, but it struck me that these discussions tended to exclude in depth descriptions of the content of the distress being explored. The language of 'crisis' or 'distress' seemed to act as an easily

shared shorthand between the participants and myself, whilst, on reflection, actually sidestepping in-depth descriptions of these experiences.

In part, this probably stems from my own reluctance to firstly unduly upset my participants, and also a desire to differentiate the interview from a therapeutic encounter. Indeed, as mentioned in the methodology chapter, it was directly commented by more than one participant that the fact that the interview did not delve into the specifics of the origins of distress was a relief. The embodied nature of the interview encounter (Del Busso, 2007; Letherby, 2003; Ratmazanoglu & Holland, 2002), which is, of course, an interpersonal relationship shaped by social and cultural context (Letherby, 2003; Fontana & Frey, 2005; Ratmazanoglu & Holland, 2002; Wilkinson, 1988); on reflection, the need to build rapport with participants perhaps lead me to place more importance on demonstrating both sympathy and a shared understanding with participants (in 'knowing what they meant' by terms such as 'crisis') than in pressing for more specific detail. Perhaps in establishing my own credentials as a person with knowledge of mental health, and hence knowing the meaning of such terms, I acutally missed the opportunity to elicit accounts of more specific detail.

The difference in two forms of data collection in the depth of detail provided about experiences of distress perhaps also highlights a more general difference between speaking and writing. The narratives should not be seen as more 'true' because they included such detail, but as produced for a different purpose, and still within a particular context (Crossley & Crossley, 2001; Woods, 2010). It is, therefore, important to consider the context in which these narratives have been

produced, rather than viewing them as providing a simple window into the 'real' experiences of the narrators. Chipmunka, the publishing house which produced all the narratives, has explicitly political, as well as emancipatory and educational, aims, as can be seen by the description given on their website:

> We are a unique social enterprise focused on publishing both factual and creative literature. We want to reduce the humiliation that people with "mental illness" feel by being the main publisher of the mental health literary genre. We give people with mental illness a voice so that they can have the opportunity and positive mindset to lead better lives and hopefully full recoveries or at least a deeper understanding and acceptance of what they have experienced. We also publish people who have learnt to live with their experiences so their books can become inspirational to fellow sufferers. Do not let your children grow up misunderstanding people with mental health issues. Let's improve society so that mental health artists can empower people with mental health issues and be equal in society. Then they can shape their future and help others. (www.chipmunkapublishing.co.uk)

The narratives being analysed hence have to be seen within this context; they have all been written outside of either medical or research contexts, but within this remit of an overarching commitment to using narratives of distress as a way to reduce stigma surrounding mental health. These concerns were noticeable in the structure and tone of the narratives analysed to a lesser or greater extent. Both 'I Thought I Was the King of Scotland' and 'Eyebrows and Other Fish' opened with a preface outlining their intention to contribute to an improved understanding of mental distress:

> *I hope the experiences that I have shared with you will be helpful to fellow service users, professionals and people out in the community. To help with*

the stigma of mental health. I want people to understand more about mental

health problems. (K. O. S., p. 4).

I don't like labels and 'schizophrenic' does not and should not characterise

me, just as diabetic does not personify somebody with diabetes.

Schizophrenia is a 'disease' that is not well understood and is greatly feared,

and most of what people think they know about schizophrenia is wrong.

(E.A.O.F., p. 5).

The other narratives did not contain such explicit statements of intent, yet still

tended to end on a reflective note, considering either their current relationship to

their past distress or the implications of their experiences. In many ways, these kinds

of statements can be seen as responding to pressures described by Angela Woods

(2010) as present in first person narratives published in 'Schizophrenia Bulletin, to

produce 'rational' or understandable accounts to be taken seriously within the

context of a scientific journal. The majority of the narratives analysed did indeed to

some extent conform to a kind of recovery narrative, ending with the narrator

relatively free of experiences of distress, broadly accepting of a medical

understanding of their experiences, and more or less distantly surveying their 'mad'

experiences and self. For instance, the epilogue of 'Black Magic', by Suzannah

Knight, starts:

My mental illness has spanned ten years now and every day I pray I'm alright

tomorrow. I have been misdiagnosed a lot of the time but I think eventually

they have found a drug that suits my illness and I live with schizoid affective

disorder and take Abilify. I now consider myself mentally ill and am very sorry

for the pain I have inflicted upon my parents… I do know I have a good family

and without them I don't know where I would be today. Above all I have

learned it is to respect drugs and alcohol, or don't do them at all. (B.M., p. 77).

This quote can be seen as exemplifying an acceptance of a medical understanding of experiences of distress: "I live with schizoid affective disorder" (p. 77); as well as a reflexive attitude to past experiences of distress: "[I] am very sorry for the pain I have inflicted upon my parents" (p. 77). Similarly, 'A Journey Into Madness', ends with:

> *My mental health is quite good now. I still hear voices occasionally when I'm stressed. I take my tablets regularly, increasing them myself if I feel I'm becoming unwell. I have a much greater control over my mental illness than I thought possible. It took me years to get to this point in my journey into madness, but the future is looking bright. I'm a grandfather and I have a good, stable, loving relationship with my wife, Tracey. I have made many good friends at Safehaven. I also have the support of my family and friends. (p. 48)*

Distress is here presented as mainly something that is in the past, and that has been conquered. These tendencies in the narratives, especially towards the close of the accounts, can be seen as a narrative strategy to present themselves as credible narrators, as argued by Woods (2010). This structure can also be seen to conform to one of the narrative forms identified by Adame & Hornstein (2006) in their analysis of ten narratives of madness, the 'healing narrative', argued to have: "a sense of finality or a resolution to the problems the person dealt with during his or her period of emotional distress" (p. 149). In the context of a publishing house explicitly aiming to create more positive attitudes to mental health, it can be seen that such strategies would be important in establishing both the reality of the accounts

presented and a generally optimistic, positive view of mental health. Despite these pressures, it is however noticeable that this context of a dedicated and specialised publication house for experiences of distress, did seem to offer more room for 'irrationality' than the scientific journal context described by Woods (2010). One of the narratives, 'It's Happening to Me', by Rosealine Allen, for instance, did not adopt a rationalising strategy at all. Here is a quote from the opening paragraph of the final chapter of this narrative:

> *Big Brother (or God) is not only watching us, but controlling our thoughts, feelings and bodily processes to varying extents, anticipating our actions and programming us to behave in certain ways the extent of which I can only guess at. I believe, as far back as secondary school, the FF's have involved various people in a conspiracy around me. (I.H.T.M., p. 89)*

In this narrative, Rosealine did not conform at all to the position of 'rational, recovered' subject surveying past distress, but instead presents her present world view, even though it would be understood under the medical model as indicating schizophrenia. The fact that this perspective has been published un-problematically, perhaps indicates that this particular publication context is able to contain a wider remit of experiences than that described by Angela Woods (2010) in 'Schizophrenia Bulletin', supporting the claim made above that the context of these publications is perhaps more 'independent' of the medical or research contexts in which many accounts of distress are produced. It is interesting to note, for instance, that Suzannah Knight, in addition to the medical, normalised statement of her 'recovered' self outlined above, actually finishes her book with:

Although I try not to think about my illness and the occult that surrounds it I did lately find something very interesting on the Internet…………

BLACK MAGIC, EVIL SPELLS, SUPERNATURAL INFLUENCES

Black Magic, Evil Spells & Curses, Voodoo is the negative use of energies and powers by jealous and malicious beings of Kalyuga, whose main objective is to harm or deprive others of something, control their minds and influence them to do something specific or wrong/negative. (B.M., p. 78)

The description of black magic then continues for three pages. Although on the one hand, Suzannah presents herself as a recovered, reflective and sorrowful narrator, and thus seeming to adhere to the strictures identified by Woods (2010) in presenting as a credible narrator, there also appears to be space here to present parts of her belief system, which could be considered 'irrational'. When considered alongside the content of Rosealine's conclusion, it seems that Chipmunka provides a publishing context which perhaps allows more room for expressions of 'irrationality' within accounts of distress. This is not to claim any special 'freedom' from medical or academic discourse, as all of the authors at least engaged with medicalised understandings of their distress, even if they disagreed with them.

Overall, what these observations perhaps point to is a complexity in making visible, in research, experiences, such as distress, which are often hidden (Foucault, 1965; Parr, 1997; 2008). In the narratives, such experiences can be seen to have been made visible, through writing, within a specifically political context, aiming to raise awareness of experiences of mental health. Several of my interview participants expressed similar motivations for taking part in the research, to raise awareness, or have their voices heard. On reflection, the context of the embodied research interview, especially considering my similarity of experience and social

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position to many of the participants, perhaps lead to an avoidance of a discussion of distress in the terms which did appear in the narratives. Also, this can be seen to point to a general sanitisation of experiences of distress through the language perpetuated in services, of phrases such as 'crisis' and 'distress', which can encapsulate myriad experiences, and yet describe none. This criticism has been more widely levied at diagnostic and psychiatric terms, with Lucy Johnstone (2011a), for instance, arguing that terms like 'psychosis' mask both the context of distress, and the specifics of the person's experience. The use of the, even more normalised terms like 'crisis', 'distress' and 'feeling low' in my interviews can certainly be seen to have potentially performed the same function; perhaps masking a lack of specificity in descriptions of distress and madness.

7.2.3   Diagnosis and the categorisation of experience

When recruiting participants, I did not include any selection criteria on the basis of diagnosis. As discussed in the methodology chapter, this was a deliberate decision, based on my position as a critic of the diagnostic system as one able to meaningfully differentiate between groups of service users (Boyle, 1990; 2007; Bentall, 2003; 2006; 2007; Pilgrim, 2000; Wakefield, 1999), or capture the complexity of experiences of distress and madness (Campbell, 2007; Johnstone & Dallos, 2006; May, 2007). The experience of carrying out this research has not lead to a reversal of this position. It is, however, clear from the subtle patterns which emerged in participants' accounts, that there were some consistent differences in my participants' experiences and their uses of space, and the way in which the two interlinked. Furthermore, in this small sample of participants, these differences

could be seen to be linked to the different forms of distress described. In particular, this could be seen to be the case in the patterns of movement explored in Chapter Six. In general, participants who described 'anxious' or 'depressive' experiences tended to described going home when in a state of distress; those describing more 'manic' or 'psychotic' experiences, on the other hand, tended to describe going out to the "open air" (Julie, line 449). As discussed in Chapter Six, these actions can be seen as strategies to positively mediate situated experiences of distress and madness, either through moving from discordant to more concordant spaces (in the case of the first set of participants), or through seeking a more distributed, and potentially more empowering, experience of voices, visions and unusual beliefs. This is not intended as an argument for diagnostic categories. For a start, these patterns were not described as deterministic; Rachel, for instance, commented that her pattern of movement when distressed had changed over time:

> *my previous way of dealing with being depressed was usually to go out with my friends and drink loads and loads of beer (laughs) [I:(laughs)] and so actually just kind of chilling out usually makes me recover more quickly. (Rachel, 420-423)*

Rachel's retreat to a 'safe haven' (Pinfold, 2000) of her home can therefore be seen as being described as a learnt strategy, rather than simply an outcome of her particular experience. Nevertheless, these patterns in the participants' accounts did lead me to consider the lack of a sufficiently complex, yet specific, language for describing particular forms of distress, and the potential intersection between forms of distress, experiences of space, and patterns of movement. This is a point which has, of course been widely discussed; Richard Bentall's (2003; 2006; 2009)

'complaint' based approach, for instance, is one solution to the insufficiency of diagnostic categories to describe the complexity of experiences of distress. As outlined in Chapter One, he argues for a consideration of individual symptoms, or 'complaints' (such as voices, anxiety, unusual beliefs) as separate, although potentially co-existing, phenomena to be investigating. Whilst this has many advantages over the spurious clustering of experiences into diagnostic categories (Boyle, 1990; Bentall, 2003; 2006; Pilgrim, 2000), the experiences described by participants do not fall into neat 'complaint' boxes either. Overall, the lack of a sufficient language to specify and yet not determine experiences has been a consistent issue throughout this project, and is more generally in mental health theory and practice. The kind of complexity of thinking about how to categorise and describe experiences as is arguably present in the formulation approach (e.g., Johnstone & Dallos, 2006) used by clinical psychologists aims to describe the meaning, potential causes and maintenance of current experiences of distress, can perhaps here be seen to be an important route for thinking about how to describe distress, in terms of specific experiences.

7.3   Critiquing the social inclusion agenda

A consistent underlying theme throughout this thesis has been a critique of current discourses of 'social inclusion' in mental health policy (D.O.H., 1999; O.D.P.M., 2004) and research (Repper & Perkins, 2003; Sayce, 2000), drawing on criticisms raised by Helen Spandler (2007) and Anthea Symonds (1998). When beginning this project, I had, broadly, a (it turns out) naïve idea of the institution as 'bad' and community care as 'good'. Infused with the empancipatory discourse of de-institutionalisation

(Spandler, 2007), I expected to find a set of positive experiences of the community and negative memories of institutions. My growing doubts regarding the simplicity of this position, which had been sown in the reading done in the earlier stages of the research (e.g., Estroff, 1981; Knowles, 2000a), were then confirmed, and re-inforced, when I began interviewing participants. In particular, Julie's map, which appeared in Chapter Five, of the growing number of equally inappropriate places she had met her C.P.N., following her mental heath trust's move to 'social inclusion' perhaps finally banished this cosy idea for me:
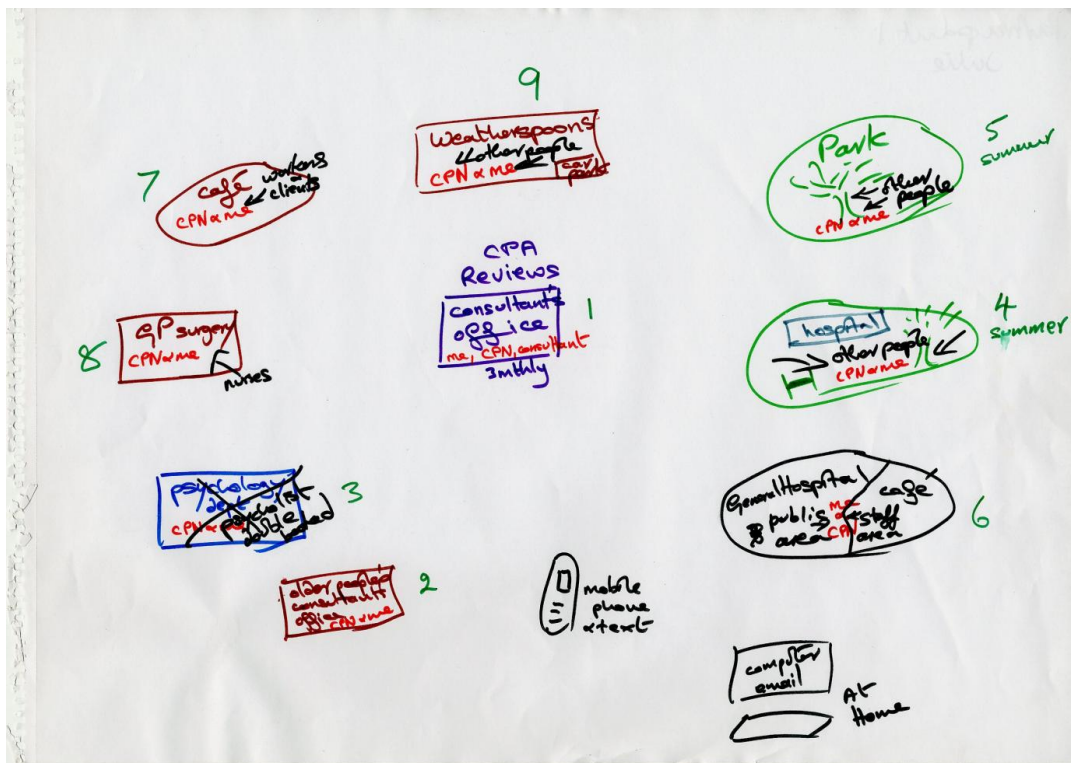
Julie's experience here seemed to indicate a shrinkage of spaces allocated for the experience and discussion of distress, which was still, as discussed earlier, described as discordant to mainstream socio-spatial practices (Foucault, 1965; Knowles, 2000a; Parr, 1997; 2008). As I continued to collect data, from hearing Karl's experiences of 'buffering' himself in the toilet before entering the outside world, or

Rachel's similar experience of hiding in the toilet at work to prevent her colleagues from witnessing her distress, I began to question the very concept of 'social inclusion' as an agenda for mental health services. Yes, many of my (as discussed above, largely middle class and educated) participants did describe complex lives of family, work and friendship responsibilities which would have been impossible if they had been locked away in the asylum. It was also noticeable that for the younger participants, those who had used services under the old system, these 'non-service use' roles and relationships seemed to be more established than some of the more long-term participants. Arguably, the heterochronic (Foucault, 1986a) nature of contemporary services leaves more room for the maintenance of previously existing relationships and roles, which has been a key part of arguments for community care (e.g., Repper & Perkins, 2003; Sayce, 2000). Yet within this context, where service use does not necessarily define the lives of all service users (even if it may, as has been argued in this thesis, 'modulate' (Deleuze, 1992) them), I would argue that the function of services within these more complex, potentially richer, lives needs to be reconsidered. I would also argue, that looking at the social inclusion agenda through the prism of space offers a particularly enlightening perspective on this question.

As argued in Chapter Four, the 'community' in community mental health care can be viewed as a utopian idea, devoid of a consideration of the concrete sites in which service use interactions actually take place (Symonds, 1998). Furthermore, this wider issue with community mental health care, can be seen as having been exacerbated in recent years with the current social inclusion agenda (D.O.H, 1999; D.O.H., 2006; Spandler, 2007). The 2006 Department of Health report, 'From

segregation to inclusion: Commissioning guidance on day services for people with mental health problems', stands as a good example of the discourse of such policies, stating in the section of the report entitled 'Beyond Buildings':

> A day service does not necessarily require a dedicated building or centre. It is the function of day services in maintaining and extending social networks and access to mainstream roles and activities that is critical and there is a need to move from group-based to individualised support. (pg. 17)

It is hence specifically stated, under this particular agenda, that the *places* in which service use interactions take place are unimportant. This, of course, goes precisely against what has been consistently argued throughout this thesis, that the setting of service use interactions are crucial, to the extent that they can prevent or facilitate the disclosure and discussion of distress (see Chapter Five). It is also noticeable that the stated future direction of services is here to 'move from group-based to individualised support'. Mike Chase (2011) has argued that this particular approach to services can be termed a 'bridging' rather than 'bonding' service; service users are encouraged to engage in activities which form 'bridges' into "mainstream roles" (pg. 17) rather than services providing spaces for service users to 'bond' with each other. He argues that:

> the centrally driven version of social inclusion to which the local service provider was contractually obliged to work meant encouraging people away from safe bonding environments towards, arguably, more hostile socially inclusive and mainstream ones. (pg. 17)

This 'bonding' function, argued by groups such as the Hearing Voices Network to be potentially a positive step in recovery (Dillon & Longden, 2011), was also a function

which could be seen to be described in Rachel's description of the smoking room explored in Chapter Five, where she describes sharing experiences of "visual hallucinations" (line 172). The socio-spatial practices of mainstream space, as has been amply argued in this thesis and elsewhere (Dixon et al, 2006; Estroff, 1981; Hodgetts et al, 2007; Knowles, 2000a; Parr, 1997; 2008; Sibley, 1995), can be seen as inherently hostile to distress and difference, leading to the experiences of discordance (Chapter Five) and displacement (Chapter Six) described in earlier chapters. To what extent the emplacement of the kinds of discussions described by Rachel as able to take place in 'bonding' (Chase, 2011) services, located in specialised sites, is a move to 'inclusion' seems highly questionable; I would argue this forcible move of discussion and experiences of distress into mainstream space is in many cases more akin to exclusion than inclusion.

At the same time, however, I would offer caution in considering the terms 'inclusion' and 'exclusion' as a dichotomy; what has been argued throughout this thesis is a need to attend to the complexity and detail of negotiating such spaces, and the shifting relationships described between space, experience and subjectivity. In Hester Parr's (2008) book, 'Mental health and social space: Towards inclusionary geographies', for instance, Parr argued for a potential of particular forms of community 'inclusion' as providing potentially more 'inclusionary geographies' than offered in traditional mental health services: gardening projects, arts projects, and virtual communities. In exploring the potential role of community garden projects Parr argues that:

community gardening offers opportunities through which people with illness might exert their expertise, demonstrate their agency and embody both. (pg.103)

Whilst offering the caveat that:

not all people may easily embody versions of what might be read as active citizenship. As such socially inclusive cities should arguably support a range of spaces. (pg. 103)

This last point can be seen to echo a similar caveat in the Department of Health document outlined above:

It is recognised that there needs to be a range of services available to meet the needs and preferences of all individuals. Commissioners must consider whether there are people with mental health problems who may not wish to participate in mainstream community activities. One approach will not fit all. (D.O.H., 2006, p. 7).

To some extent, Parr here seems to be making a similar claim to one put forward in Chapter Four of this thesis, in discussing Karl and Lou's experiences of active subjectivity in exercise and work spaces. In these extracts, where Karl, for instance, comments on being "not a patient, I'm an active participant" (line 941), he could be seen to be 'demonstrating' and 'embodying' his 'agency', as argued by Parr (2008). I would argue, however, is that such a dichotomy between spaces being either 'exclusionary' or 'inclusionary' and people being either 'able' or 'not able' to be included in mainstream, active citizenship, fails to capture the complexity of the experiences described by service users in negotiating subjectivity within and between different spaces. My participants described being able to "embody… active citizenship" at some points, in some settings, and with certain people, rather than

an either/or of being able or not to 'embody active citizenship', or wishing or not wishing to 'take part in mainstream activities', as characterised in the Department of Health (2006) report. These kind of arguments seem to position a lack of inclusion as a failure of the person, to engage or to be able to embody active participation, a point that has been made by service users (Wallcraft, 2001) and community psychologists (Spandler, 2007). As Helen Spandler (2007) has noted:

> The policy shift to 'inclusion' can make invisible the social structures and divisions which generate and sustain exclusion and create an obsession with the choices and responsibilities of the individual rather than the constraining context in which they live. (pg. 4)

The data presented in this thesis, furthermore, can be seen to paint a more complex picture than this, of an intersection between space and experience which is not necessarily static. As Janet commented in Chapter Five: "I'll go pretty much anywhere if I'm feeling ok" (373-374); similarly, whilst Julie described the intense discordance of attempting to discuss her suicidal thoughts with her C.P.N. in a pub, she elsewhere described an active social life. Neither of these participants, or indeed any of the participants in the study described being *always* included or excluded, and this can perhaps be seen as indicating a simplicity in the idea of space perpetuated by the social inclusion agenda. Rather than there being one version of what space 'is' for people, these experiences point to a need to attend to the function of the interaction of services and the use of spaces which are concordant to that function. If service users are discussing distress, then it seems apparent that a space which is not discordant to that experience is necessary; as Zoe commented "it feels like its safer to be anxious and depressed in a room where other people can't

really look at" (138-139). Within the context of, what has been argued here to be the heterochronic and heterotopic makeup of contemporary services, the provision of such spaces seems a crucial task for services. Considering the complexity of managing distress across the multiplicity of spaces which comprise service users' lives in the community and service use, a space of respite, where distress is allowable and can be discussed, is, I would argue, critical.

Far from needing to move 'Beyond Buildings' (D.O.H., 2006), I would argue there needs to be a consideration of the function of services in the complex landscape of contemporary service users lives, and part of that function requires the return of buildings, of sites and spaces of respite from the potential hostilities of mainstream space. Fleeing too far from the institution, services are perhaps in danger of losing a key part of their function, as a potential place for rest and respite. A surprising finding, personally, in this data was that participants described even the coercive "blank space" (Bryan, line 359) and "pressure cooker" (James, line 168) of the ward to be, at times, "a relief" (Rachel, line 284); this can be seen to indicate the lack of such spaces of respite from experiences of discordance and displacement in mainstream space, which were described as a frequent experience in the negotiation of distress and madness in the community. Simply placing people in mainstream space cannot, I would argue, be seen to solve the problem of the stigmatisation and pathologisation of experiences of distress and madness. As the service user activist and academic Jan Wallcraft says:

> Survivors don't necessarily want to be part of a mainstream society which has rejected them and in which they will never easily fit until society itself redresses its prejudiced attitudes and tunnel vision. Where is the problem

located, in the individual who has dropped out or been excluded, or in society, which tries to force people to fit its stereotypes? 'Social inclusion', if we are not careful, can sound rather like 'normalisation', which appeared to mean making people more normal so they would fit in (Wallcraft 2001; cited in Spandler, 2007, p. 10).

Furthermore, even within the context of many of my participants' lives, who may have counted as 'socially included' or 'normalised', to use Wallcraft's phrase, in many contexts (many, for instance were employed, had families, or both), their experiences of distress and madness, and discussions of these experiences with professionals, can be seen as described as still not 'included' or 'normalised' in the spaces in which they were placed. This is perhaps the key benefit of this analytic of space for considering the social inclusion agenda; whilst these issues often talked about in individualised and static terms, as the person being either 'included' or 'excluded', here it can be seen that particular *experiences* and *interactions*, of distress and madness, which are, of course, what mental health services are designed to deal with, were described as inherently discordant with the kind of mainstream space into which services are currently being re-located (D.O.H., 2006; Spandler, 2007).

7.1.4 Conclusions and future directions

This project has explored the role of space in service users' experiences of mental health care, arguing for a complex, ongoing inter-relationship between space and experience. Experiences of distress and madness have been argued to be thoroughly contextualised, rather than determined by static internal processes, whilst space has also been argued to be used as a resource, or 'technology' (Brown & Stenner, 2009;

Foucault, 1986c) to actively mediate and modulate experiences of distress, madness, and wellbeing.

These conclusions have been drawn from the analysis of a combination of visual and narrative data; overall, this combined dataset can be seen to have provided a useful balance, as discussed in the methodology, of chronologically and spatially ordered data, and the maps proved successful in focussing the interviews on the specifics of the spaces being discussed (see Iantaffi, 2011; Reavey, 2011; Townley et al, 2009). As with most interview techniques, however, the 'spatial interviews' were only based on one encounter, with the attendant problems of being a snapshot, comprising one account of the participant's experience (e.g., Kindon, 2003). Considering the conclusions drawn from this research, of service users' experiences as being ongoing, complex, and understood as produced by a set of inter-related processes (Brown & Stenner, 2009; Massey, 1994c; Stenner, 2008; Whitehead, 1978), it would perhaps be beneficial in the future to extend this study by utilising methods arguably better able to capture ongoing experiences, for instance, diary studies (Latham, 2002; Laurenceau & Bolger, 2005). Considering the relative success of visual methods in eliciting accounts focussed on the settings of participants' experiences (Bolton et al, 2001; Knowles, 2000a; Majumdar, 2011; Radley & Taylor, 2003; Reavey, 2011), a video diary study would be a particularly interesting future direction for studies exploring experiences of space (Kindon, 2003; Holliday, 2004). Specifically, considering the importance raised by participants on the everyday experience of home, and agency within the home (Mallet, 2004; Wise, 2000), and the material presented in the first chapter on the role of inner city

environments in mediating the development of distress (Evans, 2003; Freeman, 1984; 2008; Halpern, 1995) I would be interested in carrying out a project looking at experiences of home in service users living in poor inner city environments. This follow up project would of course also redress some of the issues with the middle class bias of the interview sample in this thesis.

An issue which was not particularly prevalent in the analysis of this particular dataset, but which has been widely raised as crucial in service users' lives in the community, is that of the management of medication regimes (Brown & Tucker, 2010; Carrick, Mitchell, Powell & Lloyd, 2004; Newnes, Holmes & Dunn, 1999; 2001; Tucker, 2006; Rogers et al, 1998). Especially under the changes to the Mental Health Act (1983), which give powers to forcibly medicate in community spaces, this seems an important further issue, which could be seen to mediate service users' embodied engagement with space. Such a project would again lend itself to similar 'ongoing' methods as detailed above.

In general, the relatively broad scope of this project, which looked at the relationship between the various spaces of mental health care, community spaces, and service user subjectivity, opens up a multitude of potential future studies focussing on more specific aspects of service users' experiences. These might include the two outlined above, but also issues like the relationship between space, movement and power in service users' experiences of madness holds a rich potential future vein of research, as well as looking in more detail at the role of 'imagined space' (Soja, 1996) in mediating service users' experiences of distress and subjectivity. Overall, this picture of distress and madness as a contextualised,

ongoing process (Brown & Stenner, 2009; Stenner, 2007; 2008; Whitehead, 1978), mediated by the material and social environment, can be seen as a rich and fruitful lens through which to consider service users' experiences. It is hoped that future research in this area will add to the multitude of academic (Bentall, 2003; Cromby et al, 2012; Johnstone, 1989; Johnstone & Dallos, 2006; Kelly, 2006; Smail, 2005; Rapley et al, 2010; Rogers & Pilgrim, 2003; Romme & Escher, 1993; 2000; Romme et al, 2011), and service user (Dillon, 2010; Dillon & Longden, 2011; Campbell, 1996a; 2007; Campbell & Rose, 2010; Newnes et al, 1999; 2001; Read & Reynolds, 1996; Romme et al, 2009; Sweeney et al, 2010) voices calling for a more contextualised, subtle (and, I would argue, humane) approach to conceptualising experiences of distress and madness than offered by the medical model of distress.

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Appendices

Appendix One: Advert

Are you currently using community mental health services?

Call for Research Participants

My name is Laura McGrath, and I am a PhD student at London South Bank University.

I'm interested in talking about your everyday experience of using mental health services and living in the community. I would like to explore the experiences that you have of the different places in which community mental health care takes place, such as your home, supported housing, public places, hospital, outpatient units, day centres etc.

For instance:

- Does it matter to you where you meet your workers?
- Do you prefer being seen at home? In a medical place? In a public place?
- Does where you want to meet with services change when you are more or less distressed?

Taking part will involve an interview lasting approx 60-90 minutes, at a convenient location. As part of the interview I'll ask you to draw a map of the places where you interact with services and we'll talk about your experiences of each of the places. We also might talk about other places you go to in your daily life.

If you are interested in taking part in this research, then please contact me:
e-mail: mcgratl2@lsbu.ac.uk
telephone: 07903889484.

Appendix Two: Participant Information Sheet

Thank-you for your interest in taking part in this study. This sheet will outline the aims of the study and give you some more information about what your participation will involve.

Purpose of the study

- I am interested in your experiences of the different places where you interact with mental health services (such as your home, GP, hospital, outpatient etc).

- This research will form part of my PhD from London South Bank University. I am in the Department of Psychology and being supervised by Dr Paula Reavey and Dr Phillip Kemp. Paula's main research interests are the psychology of mental health, memory and sexuality while Phillip trained as a mental health nurse and now teaches on the nursing degree as well as carrying out research in the NHS.

Research process

- **What does the study involve?**

  An interview lasting approximately 60-90 minutes. This will take place at a **location of your choice**. A room can be made available at London South Bank University for the interview but it will be up to you whether you would prefer to hold it elsewhere, such as your home or workplace.

  As well as asking **questions** in the interview I will ask you to draw some **maps/pictures** of the places where you have contact with mental health services. The questions asked will then explore the places which you have chosen to represent, as well as asking more generally about your experiences of different places.

- **What will happen to the interview data?**

  The interview will be **recorded and then transcribed** (written down word for word). Identifying information (such as your name) will be changed at this stage so that your interview remains **confidential.** If you wish, **you can also have a copy of the transcript**, and I am happy to remove any part of the interview at your request.

  The **transcripts and drawings will be analysed** and used to write reports and articles about the research. Primarily, this will contribute to my PhD thesis, but I also aim to publish findings from the study in **academic journals and books**, as well use them to **inform services**. I may also at times use the material in my teaching. Everything in these publications will be completely anonymous. If you would like to see final versions of these publications, please let me know and I will be happy to send you copies and hear your feedback.

If you have any questions, please contact me:

Laura McGrath	**e-mail**:	mcgratl2@lsbu.ac.uk
Room E344, Department of Psychology		
London South Bank University	**phone**:	07903889484
103 Borough Road		
London, SE1 0AA		

Appendix Three: Consent Form

Consenting to take part in this research:

Please tick box

I confirm that I understand what this study is about, and have had the opportunity to ask questions.

☐

I understand that my participation is voluntary and that I am free to withdraw at any time, without giving reason.

☐

I agree to take part in the above study.

☐

Please tick box

	Yes	No
I agree to the discussion being audio recorded	☐	☐
I agree to the use of anonymised drawings in publications	☐	☐
I agree to the use of anonymised quotes in publications	☐	☐

Signed ………………………………………………………………………………

Appendix Four: Interview Schedule

1. Please could you tell me a bit about yourself and your relationship to mental health services?

2. Please draw a map, or other representation, of the places which you go to as part of service use. Please include what you do there, who you see there, and how you feel about being there.

    a. Can you talk through each place, telling me about what you have drawn and why.

    b. Please could you rank these places in terms of the place you like being most to being least, and explain why you feel like this.

3. Please now draw a map, or other representation, of the places which you go to as part of your everyday life, not as part of service use. Please do the same, including what you do there, who you see there, and how you feel about being there.

    a. Can you talk through each place, telling me about what you have drawn and why.

    b. Please could you rank these places in terms of the place you like being most to being least, and explain why you feel like this.

4. When you start feeling distressed, what places are you most likely to go to? Why?

5. When you are feeling particularly well, what places are you most likely to go to? Why?

6. In general, how important do you feel that where you are is to your wellbeing?