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Somatic Concerns of Mental Health Service Users: A Specific Tale of Affect

Abstract

Theories of affect have been offered in abundance in recent times as potential remedies for the many theoretical ailments that face the social sciences. Post cognitive theories continue to grapple with new ways of thinking the unrepentantly tricky relation between the psychological and socio-material. This paper will explore some of these avenues, before arguing that theories of affect are required that can speak to specificity in terms of the challenges of embodied states. Drawing on accounts of changing medicated body states of mental health service users the paper will develop a specific empirically rooted notion of affect that sympathises with the pre-personal, relational models of ‘excess’ prominent in affect theory, but that attempts to realise a theory of affect that can speak to the concrete reality of embodied experience. Following a theoretical path that includes Deleuze and Guattari, Brian Massumi, and Michel Serres, I will work towards an empirical engagement with affect that attempts to speak to specificity, rather than generality, as attempts at the latter can often result in over-tasked theories faltering in their explanatory pursuits.

Keywords

Affect, mental health service users, medication, embodiment, Deleuze

Main Text

Recent turns to affect theory have offered interesting potential avenues for thinking about classic ‘problems’ in the social sciences, such as the nature and relationship between individual and society, body and society, body and mind, across disciplines such as cultural studies, human geography, sociology, social psychology, gender and feminist studies. Efforts have been diverse in attempting to offer truly socially relevant and conversant conceptualisations of human experience in ever changing cultural and political landscapes (e.g. Ahmed, 2004; Brown & Stenner, 2001; Clough, 2007; Massumi, 1996; Thrift, 2004). As with any new or re-emerging theoretical arena that promises so much some careful exploration of its potential utility is required. These need to be empirically sensitive, speaking to and for our individual disciplinary concerns.

In this paper I will explore theories of affect with regard to embodiment, and what they may offer for theories of embodiment. Moreover it is a concern with specific bodies that is of interest, namely the psychiatrically medicated bodies of mental health service users (hereafter referred to as ‘service users’). Managing medication, as the primary treatment for mental distress, can be a major part of everyday living as a community mental health service user (given the range of effects it can have on one’s body) (Breggin, 1993; Lacey & Woodward, 1985; Rogers et al., 1993; Tucker, 2006). Additionally medicated bodies are produced through a number of inter-relating forces. Firstly as part of the psychiatric system that has the power to designate that someone

should be treated with medication if deemed appropriate when a person enters the psychiatric system. Additionally biochemical changes that medication effect, and finally how these translate into psychological experience. Service users, whose psychological experiences are bound up in the material activity of their bodies, can face a challenging interpretative task in making sense of their bodies at such times. Theories of affect, posited as valuable ways of conceptualising the complex relations between social, psychological and material forces, are potentially useful ways to explore the medicated bodies of service users. The issue of how we, as social scientists, go about analysing such experiences, is an important question. I will begin with unpicking the most pronounced relationship associated with affect, namely with emotion. Returning to the work of Baruch Spinoza will provide a valuable foundation for gaining insight into future engagements with affect. A theoretical journey will then take in Deleuze and Guattari and Brian Massumi, before working towards an empirical engagement (with some theoretical assistance from Michel Serres) with embodiment that allows a level of specificity to develop that speaks to the concrete reality of living on long-term psychiatric medication.

Affect(s) and/of Spinoza, Deleuze & Guattari, and Massumi

The human body can be affected in many ways, whereby its power of activity is increased or diminished (Spinoza, 1996: 129)

Whereas modern psychology frames affects as forms of emotion, and consequently as cognitively situated internal drivers of action, Spinoza was always concerned with relations between bodies, not affects as cognitively reducible entities. He understood bodies as intrinsically linked to other bodies, and individual bodily actions as produced in concert with the actions of other bodies. Indeed, relations with other bodies either increased or decreased one's own bodily actions. For Spinoza affects refer to the relations between bodies and the 'affects' of these relations. Power is a central constituent of these relations. The effects of bodies on other bodies either increases or decreases their power to act. For example, giving a person a sedative could reduce power to act in one sense, through inducing sleep. But it could increase power in another sense, namely by increasing post-sleep activity levels.

Spinoza's affective model also emphasises movement. In talking about bodies acting on other bodies, he was not pointing to bodies as stable entities, but rather as products of ongoing relations with others; "...the motion and rest of a body must arise from another body" (Spinoza, 1996: 130). A sense of fluidity and dynamism is added to the notion of relational embodiment. Additionally a parallel ongoing set of relations is posited, those referring to 'mindful' as opposed to 'bodily' activities. Whereas modern cognitive psychology has emotions as mental entities, for Spinoza only part of what he believed is emotional was constituted as 'mindful'. Activities of the mind were said to operate in parallel with those of the body. These Spinoza called the 'ideas' of affect, or 'passions'. Although, not all bodily affects had a corresponding idea (a link is seen here with later notions of the 'selectivity' of consciousness that feature for Bergson, and Deleuze and Guattari).

Affect, for Deleuze and Guattari (1987; 1994), was a way of considering the relational production of bodies and spaces. Clearly owing a debt to Spinoza they worked this into a long-standing orientation to conceptualising experience as only in part formed

in and through subjects. Indeed, they were interested in the production of subjects, but only as one part of an ongoing stream of experience (not all reducible to what we take as human activity). In doing this they move from specific discussion of a Spinozist ontology of bodies towards a broader ontology of being. Interestingly they do not often mention the term 'affect' directly, but it operates as a driving force of so much of their ontology of creation. Affect is used by Deleuze and Guattari as a conception of the ongoing fluid flux-like life process of relational being. This is the stage that it enters into and becomes a key part of their creative ontology. They see life as constantly being made and remade, or 'becoming'. Concepts of 'movement', 'process' and 'fluidity' come to the fore. Bodies are seen as products of ongoing relations of force, rather than stable products. Organised through multiple sets of relations between bodies, objects, knowledge and language. Affects, for Deleuze and Guattari, are the means by which possibilities for actions are regulated, increased or diminished, through connections with other bodies.

To focus on medicated bodies of service users at this stage would be to consider their bodies as ongoing products of relational forces that work in ways that regulate somatic activity. This would appear to make some sense, if medication is taken as a 'body', which interacts with service users' physiology in such a way that regulates their ongoing bodily activity (e.g. by decreasing mental distress, or increasing somatic distress through unwanted effects). This would appear a quite straightforward model of bodies controlled by the power of psychiatric services to administer medication and the subsequent effects of it. Indeed, a considerable amount of literature is concerned to point to the multiple power relations emerging from the privileged position of psychiatry over service users' lives (Goffman, 1961; Healy, 1997; Jones, 1993; Laing, 1969; Newnes, Holmes, & Dunn, 1999; Parker, Georgaca, Harper, McLaughlin, & Stowell-Smith, 1995; Rogers, Pilgrim, & Lacey, 1993). What is missed conceptually in such an account is a notion of change, how power relations can alter, reconfigure according to changes in other parts of the object under focus (e.g. nuances of individual medication taking practices). Deleuze and Guattari's philosophy is potentially useful here. They argue that things do not remain as they are, a notion of *virtuality* (or potential for change) is ever present.

Deleuze and Guattari develop their own conceptual thought around creativity. Arising with this ontological framing is a two-form model of experience. Firstly that which we are consciously aware of, relations that form our 'realities'. Secondly, a realm of ineffability, or reserve, from which new previously unrealised (or actualised) relations can be formed. This second form is the realm of difference, which drives experience, and as such incorporates the potential for change. One sees similarities with other dualistic formulations. For instance, Kant's transcendental kinds or Plato's forms. The difference for Deleuze and Guattari is that their second realm does not exist distinctly from the first. It actually exists in parallel with it, as a 'virtual' realm. The notion of virtuality owes much to Bergson, whose own concerns about the problems of memory and time led him to develop theories that espoused the selective and non-linear production of memory and 'duration'. Deleuze was heavily influenced by Bergson (1988) and the notion of virtuality formed a key thread of his creative ontology. Affect, according to this model, is used as the glue that holds the known, or 'actual' realm together with the unknown but potentialised 'virtual'. It is here that affect takes a more leading role in Deleuze-Guattarian ontology than in the places where the production of embodiment is concerned. Affect operates as a driving force, framing

the meeting and parallel existence of two multiplicities, through which experience and life 'flow and become'. Whereas Bergson talked of memory and time, and Spinoza of bodies, affect, for Deleuze and Guattari formed a more central part of their overall ontology.

Affects 'inside' the body

In Cultural Studies Brian Massumi has been pivotal in pulling these ideas together, and drawing out affect as a central strand in the Spinoza-Bergson-Deleuze trajectory. In *Parables for the Virtual* he draws on contemporary neuroscience to evidence the claim as to *excessive* (virtual) experience, or a realm that is *beyond actualisation*. An experiment concerning conscious registering of bodily activity (finger flexing) suggested a half-second gap between bodily activity (the finger flex) and conscious awareness of this. For Massumi this suggests that rather than bodily activity following conscious decision-making (we decide to flex out finger and it subsequently does), consciousness *follows* somatic activity. Not only follows, but is produced through a process of selection. We only become consciously aware of a selection of potential relations/experiences. Massumi states:

...the half second is missed not because it is empty, but because it is overfull, in excess of the actually-performed action and of its ascribed meaning. Will and consciousness are *subtractive*. They are *limitative, derived functions* that reduce a complexity too rich to be functionally expressed (2002: 29)

Here ontology informs epistemology. As ontology of affect as two-sided, with bodies made up of actualised and virtualised formations, and knowledge framed as only possible through actualisation. What come to be known are actualised forms. Moreover, the uploading of somatic information to consciousness, which becomes conscious knowledge, is partial. Certain bodily activity will not register as conscious awareness (e.g. nail growth). Consequently for Massumi, we can only partially know our bodies.

The distinctions that exist between conscious and non-conscious affects, the autonomic somatic responses, like the blink of an eyelid or skin response, belie the existence of autonomic activity that is non-conscious. This 'excessive' model of experience is a technologically derived account of affective activity. One would not be able to make inferences about such autonomic activity without the contemporary technologies available to us. Clough (2007) takes this up in engaging with the biomediated body, in which she is interested in developing a contemporary politically relevant idea of how bodies are produced through complex relations of technology, culture and biology, whilst remaining irreducible to any particular one. Here virtuality exists in the realm of unknowable bodily activity, with affect framed as the link between consciousness and non-consciousness. The question raised is how does this process work in relation to psychiatrically medicated bodies?

With regard to mental health service users taking medication, the relation between service user bodies and medication would only be partial according to Massumi. They may only come to 'know' the formation of certain somatic states. Consequently understanding and analysing service users bodies, and how they come to interpret and

communicate them is difficult. In Spinozist terms service users' bodies are understood as produced through ongoing relations that can both increase and decrease their power to act. A number of relations feature in producing their ongoing activity levels. Primary amongst them is psychiatric medication. This power relation is administered as part of a person entering the psychiatric service system due to experiencing mental distress and subsequently receiving medication as treatment. This happens extensively due to the predominance of medication in psychiatric treatment (Rogers et al., 1998). Through consultation with a psychiatrist the level and type of medication will be decided and administered¹.

Whilst the initial administration of medication can be a relatively straightforward process, the impact it can have on daily bodily activity can be quite complex, and marked. Psychiatric medication can have a series of effects on service users' bodies. One or more of these will be the 'main' effects, aimed at lessening the levels of mental distress. The other effects can be wide-ranging and diverse. For instance, increased appetite, constipation, loss of libido, restlessness, somnolence, infertility, pain, the list could continue. Not everyone will experience these so called 'side effects', and even if experienced the severity and breadth of effects felt will be variable. Nonetheless, for some, living with a medicated body can be a considerable challenge. For social scientists addressing medicated bodies, what remains unclear are the somatic processes through which service users notice and act upon the effects of taking medication. How do some effects come to be associated with medication, and how are such states identified and communicated?

By way of some empirical examples I would now like to consider extracts from interviews with mental health service users about their psychiatric medication regimens, and the kinds of somatic challenges produced therein. The extracts that follow are taken from a project exploring challenges of living on long-term medication for community service users. This project was conducted between 2004-2006 in the East Midlands area of the United Kingdom, and involved semi-structured interviews with community based service users who attended day centres run by a national charity in the UK. Interviews included discussing in detail service users' experiences of psychiatric treatments, particularly medication. This involved talking about the different kinds of medication taken, how frequently and in what dosage, and effects thereof. The following extract is from an interview with Beatrice², a female service user who has experienced several severe psychotic episodes and received medication for a number of years, talks about an episode in which her medication was causing her problems:

Beatrice: so (I: mm) so badly (I: mm) (.) I was (.) restless (.) I couldn't sit still (2) it was awful the pains were in my legs so (.) I thought, I told my key worker (.) and she says "I don't know what it could be" (.) and um the (.) I

¹ This is a slightly simplified account of the process of administration of psychiatric medication for service users. Such processes depend on in-depth ongoing risk assessments, and vary according to whether care is in-patient or community based. Additionally medication can be self-administered (tablet form), or by mental health professional via depot injection. This paper focuses on people living in the community who self-administer tablet forms of medication.

² Pseudonyms are used throughout to protect service users' identities.

think she told my doctor (.) but nothing was happening I (.) so I thought I'm not taking this anymore (.) taking this medication anymore (.) and (.) that's where it all started where (.) I became ill again

In this extract Beatrice is recalling a time in which she stopped taking her medication. The preceding factors that led to her ceasing medication were named as restlessness and pain in her legs. These affective states were not directly visible externally, as other people cannot *see* pain, it is a sensory phenomena, although it can manifest itself in general restlessness that others can observe. Nevertheless it is a term with considerable cultural capital in terms of communicating a problem with one's body. Indeed Beatrice's key worker acknowledges the problem, but is reported as not deciphering the pain in relation to the medication Beatrice was taking. This leads Beatrice to take matters in to her own hands, by ceasing taking her medication, which becomes a problematic strategy as it leads to a reoccurrence of mental distress ("I became ill again").

How to begin to understand how this state is produced, made up of biochemical reactions within Beatrice's body, and how these come to be known and interpreted, and subsequently communicated? A number of factors are involved, all of which potentially reconfigure Beatrice's somatic state at that time. There are the biochemical forces of the medication entering and altering Beatrice's body, the subsequent feelings that enter consciousness, the translating of sensation into language, and communication to the Key Worker. Could we turn to biology to solve these questions? May be a language of biochemistry (e.g. medication reducing dopamine activity in the brain) can explain the multiple somatic productions of medicated bodies. Biophilosophy, for Eugene Thacker (2005), thinks not, and has concerned itself to move away from traditional ideas of thinking what bodies are, or how biological life exists in stable forms, be it genetic and/or biochemical, towards thinking bodies as multiple and dynamic. Rather than think of how bodies are formed, it focuses on changing bodies, creating and inventing new ways of *doing* bodies. As Thacker states:

It abandons the concept of 'life itself' that is forever caught between the poles of nature and culture, biology and technology, human and machine. Instead it develops concepts that always cut across and that form networks: the molecular, multiplicity, becoming-animal, life-resistance (Thacker, 2005)

This Deleuzian take pushes the epistemological activity of philosophy of biology into the realm of ontology (Thacker, 2005). Refiguring bodies as non-boundaried elements of ongoing power relations coheres with what Annmarie Mol (2002) calls the 'enactment' of bodies, where bodies are taken as existing only within the practices through which they are performed. Accordingly, the ongoing production of bodies requires incorporation of the constituent parts of the 'producing network' of the medicated bodies of service users. A useful starting point for such an analysis would be attending to the published 'side effects' of the psychiatric medications taken. This would provide details of the kinds of somatic experience that could occur. However, the reactions, or affects produced by medication taking are variable. One cannot assume service users will experience any or all of the same kinds of reactions. The best that could be hoped for would be a framework of possible affects, somewhere within which individual responses could be mapped. This would be like a form of network mapping, allowing patterns to be developed across a corpus of users. A form

of medication affective map, with patterning of somatic states enacted. Such a factor though would not allow for the relation of possible effects of one medication to be mapped with others. Service users often take several different types of medication. For instance, an anti-psychotic, anticholinergic (to help lessen so called 'side effects' of antipsychotic medication), antidepressants and medication for other non-psychiatric conditions.

A more 'visible' example of the production of a medicated body can be seen in the following extract with Janine:

Janine: Yes, I have tablets, yes, and I had the worst tablets that I have ever had because one of them, I forget which one it was no, used to send my eyes up like that and you are looking up like that and you could not bring your eyes down, it was so embarrassing when you were out anywhere, you know, you would be like this, you know, (laughs).

Janine's account points to a medication that produced a very noticeable somatic state, which was clearly visible to others. She reports that on taking the medication her eyes would roll back in her head, seemingly involuntarily. Such a phenomenon, existing on the perceived boundary between internality and externality (i.e. the surface of the body), was clearly visible to others, which presented quite a problem for Janine ("it was so embarrassing"). Looking back on the occasion brings some humour to the experience for Janine, and she laughs as she recalls the apparent unusualness of that particular somatic information. Here the uploading of sensation into consciousness is somewhat forced. The explicit visibility of the effects of medication is such that conscious awareness follows. In such cases interpretation and communication are reasonably simple.

The extracts of Beatrice and Janine were understood, interpreted and communicated by them reasonably straightforwardly. The formation of medicated bodies can be much more challenging. Particularly tricky for theoretical interpretation are times in which bodily affective states change. Although the notion of affect drawn upon here is one of movement and process, bodies as products of flow, and consequently not continually stable, levels of change are variable. The extent of change and difference varies, in terms of service users' bodies moments of pronounced change can occur when new medication regimens begin. Such changes can occur for a number of reasons. For instance, a change in medication, or amount of specific medication taken, or a new combination of medications. One of the problems facing social scientific theories of affect is how to grasp the slippery ongoing fluid processes that are of interest. Bodies are continually made and remade. Indeed, they are constantly *being* made. Stepping up to try to gain analytic purchase in this 'stream' is difficult. One approach is to draw attention to moments of change, or 'events'. Times when relations deviate from previous patterns and reconfigure, losing connections with previous relations and forming new ones. Additionally we need an approach that is not only a 'social studies of biology' approach (as some recent moves to consider the relation between society and biology have been (Rose, 2007)), but that actually theoretically highlights the coming together and infolding of multiple relations *within* bodies, that in turn, constitute the ontology of the bodies under focus.

One potential way forward with an approach towards conceptualising medicated bodies as informed by affect theory is to consider the body as a system of

communication. This might seem quite a rich metaphor, but here a specific notion of somatic communication, taken from Michel Serres, is formulated. If we follow Massumi's conviction of the actual/virtual model, in which a realm of potential runs alongside, although not ontologically distinct from, that which comes to be, we should consider the body as an open system, or network, of producing inter-relations. How do the constitute parts communicate with one another? Many of the messages bodies send exist outside of conscious awareness. There are many constituent parts of this system of communication; biological, technological (in the form of medication), social, psychological, and their multiple inter-relations. Whilst Massumi points to autonomic affects as those produced by the autonomic system, and not directly accessible to consciousness, the inter-relation of biology and medication can produce affective states that are not directly part of the autonomic nervous system, but nevertheless are not retained or accessible by consciousness.

Learning to be affected

The first part of this process is the registering and deciphering of embodied information. With Beatrice and Janine this was relatively straightforward, through commonly used terms to describe problematic somatic states (i.e. pain), and affective states that are externally visible (i.e. eyes rolling back). It's a question of listening to what our bodies tell us. Or as Serres (1982) puts it, having 'special listening devices' to listen to the noise and signals of the body. For Serres, bodies produce massive amounts of information that are constituted across many levels. He gives the example of a Russian Doll in considering the integrative nature of a set of inter-locking levels, which in bodies, are made up of multiple biochemical and molecular activity. On each level the chemical activity produces background noise, which is produced as excess from the molecular business occurring. Noise is the unwanted interference (such as the crackling of a radio). Neighbouring levels in the hierarchy of levels subsequently receive both the signal of the molecular activity *and* the background noise. The information-noise couplet is loaded up to the next level, and so on, with consequent increased complexity. Serres sees this unwanted interference, partially masking the main signal, as key to understanding bodies. Rather than an undesired extra, it is the most interesting feature. To understand and make sense of this inter-locking system of increased somatic information we need a 'special listening device' for Serres, namely sensation.

Accordingly we can make sense of the mass of somatic information and noise produced by our bodies through sensing (or feeling) it. For Massumi though, not all somato-affective states are sensible. Or at least not all are directly decipherable in consciousness (e.g. autonomic nervous system activity). So, somatic information-noise can exist that is not always consciously perceptible. It is straightforward to imagine that bodies are constantly producing information-noise through their ongoing activity of being-bodies (e.g. digestion, cell regeneration, hair growth). For the most part, this activity is non-conscious, unless a problem is experienced in the system (e.g. food poisoning), when somatic information becomes very 'loud'. For Serres:

We are submerged to our neck, to our eyes, to our hair, in a furiously raging ocean. We are the voice of this hurricane, this thermal howl, and we do not even know it. It exists but it goes unperceived. The attempt to understand this blindness, this deafness, or, as is often said, this unconsciousness thus seems

of value to me. We have eyes in order not to see ourselves, ears in order not to hear ourselves. The observer observes nothing, or almost nothing. (1982: 77)

Analysing the production of medicated bodies requires consideration of the process of 'hearing' our bodies, and how such information may be communicated. Experiencing negative somatic effects from medication can be moments when information becomes very 'loud'. This can occur through both visible and invisible information, where somatic information is observable by others, or only known from 'within'.

Somatic Communication(s)

The earlier extracts of Beatrice and Janine provided examples of quite distinct actualised affective states being produced. They pointed to processes of bodies communicating to their 'owner', and the subsequent communication of negative somatic experience to others (e.g. the key worker). Affect as the link between virtual and actual is reasonable easily communicated. The actualised affect state is pain, a commonly experienced sensation, easily recognised and consequently features as part of the register of conscious knowledge we have about our bodies. Affective states produced by medication were relatively easily translated and captured into actualised communicable meanings, either verbally (reporting the pain) or somatically (eyes rolling back). In the final extract I would like to explore a more protracted period of change between two different medications, and the process of trying to interpret ('know') and communicate such somatic experiences:

Michael:..... I can't remember the first one, I think it might have been the second one I was on Doxyfene for umpteen years and last year, just before I went to the first counselling they said they don't make Doxyfene that was the GP I told you about, I sent in my repeat prescription to the doctors, got to the chemist to pick my stuff up, problem, we have only got a fortnights supply of Doxyfene and this particular doctor was not my usual doctor and he said "when doctor so and so is back from holiday next week, make an appointment to see him so he can prescribe something that is suitable." So luckily I saw the better doctor and he changed me onto so that was a bit scary coming off one, trying to wean off one and go on another as I gradually reduced the dosage I was feeling very weird for that week and then it took about another week or so, ten days for the other medication to start taking effect.

Ian: Can you kind of explain what this kind of weirdness was?

Michael: Well anxiety I think, definitely anxiety and feeling nervous, anxious, scared I suppose is the word and then my eyes were playing a few tricks and things like that, losing my temper, very irritable, blowing up at people, not sleeping, not feeling well, feeling depressed, feeling down. In fact I started taking sleeping tablets that week for the whole week to try and get to sleep to see if it would get better.

With Michael we see the concentration of new affective states being produced, challenges of managing one's body in relation to changes, and the problem of adequately communicating changes. Michael discusses the change from one medication to another as a transition process, which was "quite scary" and made him feel "weird". The use of 'weird' is noteworthy as it suggests some form of non-

specified difference, unusualness, with negative overtones. It also points to the trickiness of capturing changing affective states in actualised socio-linguistic frameworks. It is difficult to make sense of this, and additionally to report on it. Not only to interpret somatic messages that may or may not register in actualised conscious states, but also to attempt to find the language through which to communicate their existence to others. When I ask Michael to expand on what he means by 'weird' we see an array of offerings attempting to capture the changing affective states.

The theoretical approach of Massumi, with the addition of Serres, potentially provides a lens through which to analyse the production of, and challenges of interpretation and communicating the medicated bodies under focus. Whilst in the previous extracts of Beatrice and Janine, in which the progression of information-noise through levels to reach consciousness was quite straightforward, due to the clarity and 'loudness' of the message (eyes rolling back, leg pain), for Michael this is a more complex process. The information and noise is more complicated, as there is more of it. Additionally this points to a transition from actualised state to (re)actualised affective state, with the middle part involving a period in which Michael's body is unmoored and cast off to a virtual period of change. His attempts to get a meaningful foothold in this (re)affecting system are troubled by the mass of 'loud' information, and he casts a wide net in trying to actualise it (anxiety, depression, not sleeping, feeling down, eyes playing tricks). By definition this is a difficult task, due to the production in his body of 'new' affective states, for which he has no past register of actualised experiences to draw upon to name them, for purposes of communication, but also to help him cope during the transition phase.

The transitional features of non-specified visual experiences, temper loss, aggressiveness, depression and somnolence provide a challenge for Michael. On the one hand he faces a shifting array of affective states emerging, changing and disappearing. These make his body at these times a site of uncertainty and fragility. Unsurety as to what may emerge from such a period exacerbates through production of associated depression and anxiety. Michael almost becomes a 'somatic passenger' during that period as his affective state(s) were largely out of his control. Indeed all he could do was attempt some form of intervention to try to gain some controlling purchase in the wave of affective newness by taking some sleeping tablets, in the hope that sleep would improve his physical well being, before the new medication started taking effect (or producing new *affects*).

Moreover, the extracts point to the importance of listening to, however difficult that may be, the 'noise' of the bodies affected by the medication. In psychiatric terms the primary information that should be communicated by medication is a reduction in mental distress (e.g. the experience of hearing voices). For some service users the 'noise' produced by the range of extra effects medication can have (or 'side effects') becomes the primary concern. For Serres noise is not secondary to information, but is actually privileged over it. For service users interpreting, communicating, and managing 'noisy' bodies can be a central feature of everyday life.

The primary source of noise is within the body, whose subliminal murmur our proprioceptive ear sometimes strains to hear: billions of cells dedicated to biochemical reactions, the likes of which should have us fainting from the pressure of their collective hum. As a matter of fact, we do sometimes hear it,

and we call that audibility illness. The hubbub spreads across the nested levels of integration that form a black box full of black boxes – molecules, cells, organs, systems – and gradually, over boundaries and through twists and turns, resolves into information. Through this succession of rectifiers thrown up by the complexity of black boxes, it ends up as a healthy silence, and no doubt also as language (Serres, 2008: 106)

For Serres bodies are systems of noise, although for the most part this noise is inaudible. It is only when problems occur (what Serres calls illness) that the body becomes audible. Although very noisy the biochemical activity of the body goes largely unheard by consciousness for the most part. The process of hearing one's body refers primarily to periods when something changes, a maladaptation. This is similar to Massumi's notion of virtual-actual, in which virtual states remain unconscious and only actualised forms enter conscious knowledge.

Multiple Specificities and Affect

An approach to affect that emphasises the virtual side to experience in relation to embodiment is a valuable resource for exploring medicated bodies. This draws on wider philosophies of embodiment that argue that bodies are formed as processes, not stable entities. We have seen though that in itself, the actual/virtual idea, with affect as the link, cannot speak to the inevitable complexity of specific bodies, namely the medicated bodies seen in the extracts. Virtuality brings with it ineffability, which whilst featuring a realm of potential difference, in terms of embodiment renders certain somatic experience unknowable. Understanding medicated bodies in terms of affect as the communicating element between virtual and actual leaves too much to be explained. For instance, how does the process of virtual to actual occur, how do service users gain knowledge of their bodies, and what are the challenges facing them in doing so? Here Serres' discussion of bodies as communicative systems is a useful aid. The loading of sensory phenomena into consciousness can be framed as occurring through moving through successive levels to consciousness. Moreover, the traditional view of medication as designed to lessen mindful phenomena, is seen as secondary to attempts to manage the 'noise' of the variety of 'extra' somatic effects medication can have. Serres notion that noise precedes information captures this well. The potential utility of Serres' thought in relation to theories of affect has been valuably argued for by Stenner (2004; 2006), particular his concept of the parasite as a means to point to the transformative nature of systems of emotion (i.e. psychological, biological and social), and how emotions work as spaces of communication through which different systems enter and continuously morph, which Stenner terms 'paralogic'. I would like to offer the current paper as a further (specific) offering of a communicating system of affect informed by Serrian philosophy.

Theories of affect, or turns to affect, have proved to be the low-hanging fruits of promise in the social sciences in recent times. Offerings that take as central to theoretical innovation notions of multiplicity and fluidity have much to give to our multiple considerations of bodies and activity in ever changing political and cultural environments. The challenge facing them, as with any emerging theoretical buzzword that borderlines on ubiquity (as 'discourse' has in the past) is that of attempting to offer an over-arching generalised theory attempting to account for the fractured, multiple, and chaotic worlds in which we live. As Serres notes 'the global does not necessarily produce a local equivalent, and the local itself contains a law that does not

always and everywhere reproduce the global' (1982: 75). Theories of affect may take us further down our theoretical journey, but do not in themselves offer some kind of all encompassing conceptual framework which can easily be mapped on to our particular empirical questions. What we need are empirical-theoretical approaches that speak to specificity, not generalisability.

In the case of service users approaching their bodies as complex productions of multiple information and noise can point to the challenges facing them in everyday life. Importantly, it is not *all* service user bodies that are focused on, only particular ones, as the production of different medicated bodies is going to be multiple and diverse. In the examples in this paper, we have seen instances of the deciphering of somatic information, when it is 'loud' and visible or easily captured according to actualised forms of knowledge (e.g. pain). Also, periods of 'virtual' bodies, or transitions of newness when previously inexperienced affective states are produced. These events provide a two-pronged challenge to service users. Firstly, in terms of deciphering affective-somatic information-noise, and secondly attempting to communicate it. Attempts at intervening can be made, but for some, it's more the case of 'riding the wave' of changing bodies during those periods, waiting for more stable (although not necessarily completely stable) affective states to be produced. For social scientists analysing such phenomena we need tailored empirical and theoretical approaches that speak to the multiple specificities of everyday concrete reality.

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