Chapter 15. Home and mental ill-health: twenty dimensions

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Abstract

In the context of psychiatric rehabilitation and care, home is often associated with health. In the context of deinstitutionalization, however, home has increasingly become the primary site of psychiatric suffering. Drawing on a two-year ethnographic research project with a drama group for young adult mental healthcare service users living in supported housing facilities, this paper presents twenty dimensions of home through which mental ill-health can be approached as a bodily experienced, and discursively and medically structured form of being in the world. These dimensions are here offered as a framework for further exploration of the social, spatial, temporal, structural and embodied aspects of psychiatric suffering.

Keywords:applied theatre, mental health, housing.

Theoretical background

Inhabiting a place is a human mode of being (Heidegger, 1962/1995). This mode of being is fundamentally affected by mental disturbances and the practices of the psychiatric healthcare services: Illness in general can be experienced as a state of homelessness (Honkasalo, 1998). Psychiatry has the power to remove its subjects from their home worlds (Goffman, 1960). Psychiatric problems contribute to homelessness, and homelessness can contribute to mental disorientation (Tischler, 2007). Social care services often look at the state of the home when assessing especially women's state of mind, and stigmatization leads to mental health care service users facing difficulties finding housing.

Using home to analyse and understand experiences of mental distress enables a reading thata) emphasizes the illness experience and centralizes the humanity of the suffering subject in terms of gender, class, ethics/ethnicity and age, and b) can combine phenomenological understanding of experience as a multi-sensory, bodily relation in/to time and space with the construction of subject positions through discursive and spatial orders (Jäntti, 2012). This is particularly important, as medical models of explanation may reduce e.g. clinician's empathy towards patients (Lebowitz& Woo-kyoung, 2016).

Method / Description of the experience

This project engaged a drama group of around thirty 21-35-year-old participants in a search for the meanings of home in a housing facility in a large Finnish town in 2014-2015. The drama group, although led by a professional theatre director, and part of the participants' weekly programme and thus of their rehabilitation, had no therapeutic aims. We focused on artistic work and shared research on the meanings of home and homelessness. The method used was "devising" (Govan, Nicholson and Normington, 2007) where, without a script, a group explores a chosen topic to produce a performance. To explore the subject, we used drama exercises such as improvisation, but also e.g. writing, drawings, recordings and animation. In addition, I carried out interviews with voluntary participants, and the group interviewed two of its own members. During the production of two performances we discovered the twenty dimensions of home presented below. They are here offered as a tool for further theoretical, theatrical and artistic exploration of the significance of and relationship between psychiatric suffering, housing, and belonging.

Results: Twenty Dimensions of Home

1. *Relationality*. First and foremost, home is an affective relationship between a space and its inhabitant(s) (Johansson and Saarikangas, 2009). Change in either affects this relationship.

2. *CulturalIdea(l)s*. Cultural ideals of health, happiness and well-being are often associated with images of perfect homes in e.g. advertisements and life-style magazines. These cultural representations may comply with or conflict with our own idea(l)s. In any case, they form an interesting, useful, and potentially painful point of comparison to the actual homes of the service users.

3. *Identity*. Homes are intrinsically linked to identity both as points of (dis)identification and as grounds of social identity. How, where and with whom we live places us on a socio-geographical map where nation, region, town, district and neighbourhood all mark our identities. Inviting a friend to a place with the words "rehabilitation home" written on the wall reveals more of one's identity than does an ordinary apartment - and more than is perhaps desired.

4. *Materiality*. Home can be conceptualized as a material extension of one's identity. What distinguishes it from, for example, a hotel room or hospital is that through the everyday acts of living and bodily and material contact a home adapts to one's personal needs, daily routines and routes around one's home. In addition to purely functional objects, a home often includes belongings that represent important memories and attach their owner to a historical continuum (Young, 2005). Taking care of one's home, engaging in the daily chores and deciding how one's daily living environment is designed can be important for recovering one's agency. The widely

recognized, dehumanizing effect of having one's belongings taken away when one is committed to a psychiatric hospital was reported in interviews. Not everyone, however, identifies with their physical environment; some people will find their home in social relations and activities.

5. *Activity*. For people suffering from severe mental health problems, the "self", tormented e.g. by abusive voices, can be an insupportable space. Engagement with activities can help to create an "inner home" (cf. Winnicott, 1973). An inner home is a creative state and can refer to an activity that is so engaging that it enables the subject to forget about him/herself. In our group, table tennis and singing were reported among such activities.

6. *Sociality*. Most interviewees associated home with people. Many also reported that moving into the housing unit had significantly reduced their sense of isolation, and they regarded this as the most important aspect of their current wellbeing. Home can be conceived as a social space - or a social space can count as a home.

7. *Spatiality*. Mental suffering and psychiatric treatments can significantly alter the geographies and spatial patterns of sufferers' daily lives. Depression, for example, can reduce this space to one's bed as in one of participant's drawing of his ordinary day. The maps the participants drew of their typical daily routes showed that recovery, with visits to clinics, healthcare and rehabilitation centres and therapists, often expands these geographies of everyday life.

8. *Multi-sitedness*. Like the important objects within one's home, spaces in one's wider living environment can be marked by important - positive and/or negative - memories or points of identification. Mapping these

spaces can recover one's sense of self and identity. For migrants, they are often transnational and reveal home and identity as layered and multi-sited.

9. *Temporality.* We do not simply inhabit a space, but we carry within us the spaces where we have lived before. Not all dwelling places count as homes. Personal histories narrated through previous homes often draw attention to the childhood home, which our participants often remembered with some nostalgia, though both happy and violent childhoods were recalled. Narratives of past homes can also reveal phases of homelessness in the participants' past.

10. *Homelessness.* The interviews and the discussions around the production of our second performance revealed that homelessness can be experienced as, and analytically broken down to, degrees of homelessness. Psychosis, for example, can be experienced as an existential crisis and the inability to tell whether one is dead or alive, and depression can be experienced as a sense of alienation and nowhere to go. The sense of isolation that often accompanies psychiatric suffering can also be conceived as a form of homelessness. Homelessness can thus refer to a psychological state, existential, spiritual and/or intellectual deprivation, and/or a concrete situation where one is physically deprived of a place to live.

11. *Communality.* The sense of home can be created in/through identification and the sharing of ideas and ideologies. The communities thus created can be found and maintained through various technologies that break down the (imagined) distinction between the private space of the home and the public space outside. The photos the participants took of important objects in their home frequently showed new technologies such as phones and computers. These also played an important role in the improvised scenes. Photos of

books can symbolize both identity and intellectual aspiration. Sharing one's thoughts and receiving positive responses can also take place through books and new technologies.

12. *Spirituality*. Religion or faith can both contribute to and diminish one's sense of safety and belonging. In the Finnish psychiatric context today, however, it is rarely addressed. In our project, religion was manifested both in the interviews and in passing references in the group to religious communities. In the first performance, one participant chose to play a "theologian". Her speech referred to the dual meaning of home in Christianity - heaven as the ultimate home, after life, and the human body as God's dwelling on Earth.

13. *Embodiment.* The body is intrinsically connected to our sense of self. Furthermore, whether we feel at home in our bodies, identify with it or not, as embodied beings we can only relate to the material world through our bodies. The physical aspect of home thus comprises not only the physical building and structure, but the body itself. Certain positions and postures, such as lying on a sofa or the floor, are culturally associated with private spaces and situations. In the rehearsals, we saw a great deal of these postures associated with relaxation and being at ease with ourselves and those around us. Doing nothing or having nothing to do was, however, for many a frustrating aspect of their lives. In their first performance, the participants presented the demand to have not only decent living conditions but also something to do. Home can only become a place for rest if there is somewhere to go in the outside world.

14. *Rhythm*. Home is a space of leaving and return. A space one cannot leave, due to physical or psychological restraint, becomes a prison. Daily routines

and rhythms of coming and going connect the spatiality of home to temporality and embodiment. Depression, for example, can be experienced as feeling out of step with others. In institutional settings it is important to consider whose rhythm is respected and how to reconcile communal functions and individual needs.

15. *Multi-Sensory spaces.* Through sounds, smells and tastes, space also enters us. Auditory hallucinations may invade the soundscape of our minds, and sounds, smells and tastes can help us transcend the spaces our bodies inhabit. Home is often associated with certain foods that are again associated with togetherness. In our performance, one participant associated home with enjoying a steak cooked by his stepmotherwhen he returned from football training.

16. *Language*. Home can be found in language. Language allows us to formulate thoughts and experiences and connect with others. Moreover, through the materiality of its sounds and e.g. prosody it affectively connects us to communities. Rhythm and intonation, social, discursive and dialectal variations, mono- and multilingualism can include or exclude. Through its cultural associations language, or a desire to learn one, can also orient us towards our dreams and desires.

17. *Future*. Home can be conceived of as a space where we orient ourselves towards the future. As recovery has become the expected outcome for most psychiatric conditions, it is important to find ways to explore what counts as home for each of us individually; what will make a place to live that sufficiently supports our agency and being throughout our rehabilitation and recovery. However, many participants found difficult an exercise where

they had to choose pictures cut out from magazines to create their own ideal home.

18. *Autonomy*. Having money and a space of one's own were the two things that Virginia Woolf once defined as essential for women's independence in society. Both are essential for service users' independence as well. At the beginning of the project, keys, doors and thresholds played an important role in the scenes the participants created. An interview revealed that for those living in housing facilities, their rights as residents to decide, for example, if they had to let the staff in, were not always clear.

19. *Economy*. Both national economies and individual circumstances affect where people with psychiatric problems can afford to live. Psychiatric suffering is often accompanied by financial hardship and the encounters with bureaucracy involved in getting housing benefit can significantly contribute to the service users' suffering and lack of agency. Bureaucracies involved in housing benefits are often complex and labour intensive. In our second performance, the national social security office, bureaucratic procedures and endless forms played a significant role. Bureaucratic decisions can be consistent or conflict with rehabilitative needs. In our project, the staff repeatedly recalled an incident where a client, after years of institutionalization, had found somewhere she wanted to live. Paradoxically, however, the apartment did not meet the standards of the welfare office, and despite the staff's efforts, the client had to move to a more modern and expensive flat (!) that, for her, felt less like home.

20. *Architecture*. Apartments, houses, and residential areas are a mesh of architectural trends, socio-economic and political decision-making and the interests of the construction industry. They reflect the family ideologies and

standards of their time; but whether built environments are experienced as alienating or welcoming is affected also by cultural associations, and personal preferences and memories associated with them.

Personal preferences can only be discovered if we keep asking each other and ourselves what constitutes home.

Discussion

Addressing the experience of psychiatric suffering through the notion of home centralizes the humanity of the suffering subject and locates him/her primarily in the context of the home-world. It thus offers a humane approach to experiences that in the current context of increasing medicalization are still imbued with stigmatization and suffering. As a framework, home allows the examination of both the phenomenological orientation and experience as a bodily, spatial and affective relation between a space and its inhabitant(s) and the socio-economic, architectural and bureaucratic structures that shape these experiences. This study addressed this relationship as a culturally, materially, socially, structurally and psychiatrically conditioned form of belonging, and it offers a framework for further exploration of the ways in which different forms of psychiatric suffering are shaped by their local conditions and by individual experiences and desires. To think these issues through the notion of home offers significant tools for understanding the needs and desires of sufferers and can help to enhance both the recovery of service users and housing facilities.

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