Chapter One

"Every moment in life is a step in a random walk".
(Massumi, 1992, p. 23)

1.1 Introducing the thesis

As a body of work, this thesis is exploring the narratives elaborating on diagnostic identity, performance and spatial production of mental health service users'[1] everyday lives. The major aim of this thesis is to unpack the experiential accounts of people suffering with enduring mental health distress[2] and their interactions in day to day spaces. The primary focus is on service users aged fifty years and over with an emphasis on having been in contact with formal psychiatric provisions for at least five years (see Chapter Three for a more detailed discussion on why this particular age range was chosen for this thesis).

Nevertheless it would be worthwhile briefly discussing the academic rationale behind the choice of participants. Advancing age and enduring mental health distress were deemed as important criteria to include within this thesis because this particular community can be largely ignored in terms of research, societal recognition and governmental funding (McCulloch, 2006). For example, the recent advances in providing psychological therapies via the governmental funding of programmes such as 'Improving Access to Psychological Therapies' (IAPT) are aimed mainly at younger service users or those with low/moderate levels of depression and anxiety (Kelvin, 2011). Consequently, older people who have psychiatric diagnoses such as paranoid schizophrenia, borderline personality disorder and bi-polar affective disorder can be largely ignored (Mellow, 2003). This may well be a result of the ways in which we construct old age and psychological distress with the cultural focus resting within the spectrum of degenerative disorders such as dementia and the lessening of cognitive function, i.e. memory loss (Reynolds et al., 2000). With this in mind, an abundance of literature focuses on dementia (Brooker, 2005; Wattis, Hobson, & Barker, 1992) and cognitive degradation, such as memory loss (Lebowitz & Niederehe, 1992; Moscovitch & Winocur, 1992). In brief, this particular community of older service users who live with enduring mental health distress remains largely ignored within the wider research literature.

[1] The terms 'mental health service user' and 'service user' are used within this work. The term 'service user' refers to 'mental health service user' only and does not refer to other communities who share the same label.
[2] By using the term 'enduring mental health distress' I am referring to service users who have been using formal psychiatric provisions over a period of five years or more. Degenerative mental health distress such as dementia, are not included within this research project.

Secondly, this body of work is concerned with how older service users negotiate and seek to (re)produce their narratives of space. These narratives are not abstract, empty accounts of 'just simply going to the shops', 'just simply visiting the day centre' or 'simply staying at home'. They are experiential accounts of spatial production inextricably bound up with the codings of mental health distress and are anchored by the use of spatial landmarks and objects (a brief synopsis discussing the development of material culture theory namely, Actor Network Theory is discussed in Chapter Six). There is a body of research literature exploring the complexities of mental health geographies (notably, Painter & Philo, 1995; Parr, Philo & Burns, 2006) and the ways in which service users access (or not) and move within community spaces such as shops, parks and restaurants. My aim is to add to this literature by exploring the complexities of receiving and experiencing a diagnostic psychiatric identity and the various impacts this can have on the spatial production of everyday service user life. In this way, I am looking at the continuity of identity, movement, change and difference rather than positioning space and performance as static empirical areas awaiting analysis. The main focus of this work is therefore framed around mental health distress and the ontological realms of creativity, potentiality and becoming within and through daily spaces[3].

1.2 The move to space[4]

"Space is the everywhere of modern thought"

(Crang & Thrift, 2000, p. 1)

Space is traditionally thought of as the sole domain of physical geographers and has been defined using quantitative, geometric measurements whilst at times negating the human and social aspect of space (Urry, 2005). More contemporary positions now incorporate the theoretical and empirical debates within human geographies. Human geography is a distinct move away from the geological and fixed cartographies of space, instead focussing on the differential uses of space within the social world, with a particular emphasis on conflicts and inequalities of space (Werlen, 1993). Taking space and mental health distress into account, the inequalities of access to community spaces can be an important area to discuss further.

[3] It should be noted that this thesis does not follow the conventional route of listing a statement of aims and objectives. This is due to the overall framing and theoretical thrust of this thesis as being an exploration into daily service user life which does not seek to ask or answer questions as such. As will be seen on further reading, this thesis is located in the 'middle' of service user life in that there is no beginning or conclusion, rather this thesis is interested in gaining an understanding of the on-going potentials which may or may not be actualised within daily service user life

[4] Whilst there is some research work undertaken within the psychological literature (e.g. McGrath, Reavey & Brown, 2008; Tucker, 2010) exploring (re)productions of space, the majority of literature in this area is still located within the field of critical human geography

1.2.1 Inequalities of community space

Carter Park & Radford (1999) draw from the historical discourses of deviancy, unpredictability and the threat of potential violence associated with some forms of mental health distress (such as psychosis). Thereby drawing attention to how such negative discourses subsequently became absorbed within societal practices and the containment of the 'insane' within purpose-built asylums ensued (Foucault, 1965). These sets of discourses resulted in a kind of closing off and demarcation of space specifically allocated for madness, a space set apart from the wider society. These boundaries are still relevant in today's society whereby spaces such as the modern psychiatric institution, the day centres and residential structures form important elements of spatial access within the contemporary 'care in the community' programme (Conradson, 2003b; Parr, Philo, & Burns, 2005). Consequently, service users can still reside on the outer boundaries of wider communal spatialities due to the cultural framing of diagnosis, erratic behaviours and social unpredictability (Painter & Philo, 1995). At some level, this line of exclusionary representation makes sense, when one takes into account that mental health is still widely recognised as being stigmatised, especially within the diagnostic spectrum of schizophrenia (Canning, 2006).

Painter & Philo (1995, p. 114) take this position forward by emphasizing that access to space can be a result of segregating (even if the rhetoric is of non-intentionality) political and social processes thus; *"…people who might be present in the spaces of citizenship (within the place or territory, even allowed to stroll through the public spaces of civic decision making) but who remain in effect spatially invisible non-citizens"*. In this particular quotation, there is an emphasis on socially/culturally disengaged individuals, such as mental health service users for example, which can override the rhetoric of unconditional occupation within public spaces.

Parr (1997) elaborates further on the ways in which marginalised groups such as service users interacted within urban public spaces, with a focus on the relational aspects between the collective and individual service user. Parr discusses how service users engaged within, what she terms 'insane places', where unconventional behaviours were displayed. Such spaces consisted of the park, a pavement or a café. She concludes that the variants of bodily capabilities, physical appearance and social behaviours could be key factors whereby socially unconventional physical markers were not readily tolerated by the collective. This kind of intolerance, she notes, resides within mental health whereas physical disabilities receive more

political and social support in terms of introducing reforms and improving access to certain spaces.

Whilst these positions are useful in offering a broad framework from which to explore the spatial production of public spaces and mental health, there is no element of affective components, of the event or encounter. What is meant here by the term affective are those feelings which are both emotional and sensual, as Blackman & Cromby (2007, p 5) summarise; *"that which is in the background, often unnoticed, or that exists beyond our capacity for conscious deliberation"*, i.e. they go beyond cognition alone. Instead, there is a tendency to rely on the largely negative cultural and more concrete frameworks of madness as mapping in fragmented ways onto the cartographies of collective space. Sibley (1995) however, does acknowledge that such notions of exclusionary spaces (such as a day centre) are more complex and diffuse than the somewhat reductionist binarisms of *them/us, sane/insane* etc., may claim (Cloke & Johnston, 2005). It is this move away from the creation of dichotomized representations of madness and space which is of interest in this thesis.

1.3 Spaces of interest

The spaces within Chapters Four, Five, Six and Seven are concerned with long-term psychiatric institutions, charitable mental health day centres and the home. In the case of psychiatric institutions, two participants have emerged from the historical regimens of continuous hospitalisation into the current 'care in the community programme'. All other participants had spent fairly long periods of time (i.e. one year and more) within modern psychiatric institutions on a cyclical basis, or as often termed were part of the 'revolving door syndrome'. These kinds of concerns are also linked in with the legal ramifications of entering into acute psychiatric services under Section 3 of the Mental Health Act (1983)[5] under 'compulsory' or 'voluntary' detention due to psychological distress. Consequently, for all participants, the process (and the perpetual potential) of admission and spatial residency within psychiatric wards were valuable themes to explore further.

Day centres have become dedicated micro spaces allocated for service users within the community (Parr, 1997; Conradson, 2003b). In terms of aging, there is an abundance of gerontological literature claiming that with advancing age, social networks within the community can become markedly reduced due to physical (e.g. a lessening of physical mobility) and psychological (e.g. degenerative memory loss) degradation (Birren, Sloane, &

[5] The Mental Health Act (1983) has now been superseded by the Mental Health Act (2007)

Cohen, 1992; Gearing, Johnson, & Heller, 1988; Lebowitz & Niederehe, 1992). These factors can be exacerbated further when mental health distress is included within this social equation as many service users are reliant upon state benefits to aid mobility and for some there is the constant (real or imagined) fear of stigmatisation and harassment within community settings. These feelings of anxiety can stem from the vulnerabilities associated with the physical ageing of bodies and also from those associated with the negative cultural assumptions of enduring mental health distress whereby service users can be verbally taunted within the neighbourhood.

Taking these issues together, research has indicated that service users can be subsequently marginalised within their immediate neighbourhood communities and the day centre may then become the focal meeting space to maintain social relationships (Painter & Philo, 1995; Parr, 2008; Parr & Philo, 2003). These positions would largely appear to endorse the day centre as a space allocated for service users to engage in mutually inclusive inter-personal relations away from the 'gaze' of the immediate neighbourhood. Nevertheless, some research has indicated that day centres do not necessarily function as unproblematic spatialities and discuss how some service users are excluded both spatially and socially due to exhibiting unconventional bodily behaviours (Parr, 2000; Parr & Philo, 2005). Consequently, there is an exploration within this work on the myriad ways in which the spaces of mental health day centres are woven into participant's narratives of daily life.

Finally, in terms of service users, the spaces of home are where the majority of daily time can be spent (Tucker, 2010a, 2010e). For the research participants within this body of work, this includes supported, semi-supported (warden controlled) and independent modes of living. All three residential contexts are imbued with divergent accounts, for example, issues of privacy, lack of autonomy, loneliness and vulnerability. This an area which has been left largely unexplored within the research literature and it is therefore a valuable space to include in this thesis.

To summarise this section, Massey (2004) suggests that human geographies facilitate the formation of transitional identities through defined practices of interaction and in this case, the practices of psychiatry. Taking this notion forward, this thesis draws from some theoretical ideas from human geographies to provide an understanding of the psychology of mental health distress within various contexts. To reiterate this point, it is this question of how service users (re)construct and (re)position their own identity within terms of specific

geographical spaces that is of interest. Consequently, this thesis will explore the interactional relationships between shifting identities, performances and space as a way of untangling transformation and potentiality. The purpose of this approach is to unravel the heterogeneity of individual service user life as opposed to positioning this particular community as a homogenous group who can seemingly share the same kinds of daily experiences within some of the research literature. In this way, service users within this research thesis offer differing experiential accounts of spatial production, emotional and sensual aspirations and ways of playing out day to day life when living with a long-term psychiatric diagnosis.

1.4 Introduction to the theoretical framework

Theoretically, this thesis will draw from the approaches emanating from post-structuralist schools of thought. Within structuralism the focus is on social mechanisms such as marriage, school, mental health diagnoses and psychiatric interventions rather than the human as a social and active agent within these apparatus (Murdoch, 2006). Foucault (1986) argues that the umbrella of structuralism seeks to provide an established set of relational elements which are inextricably linked, in that they are presented as a type of formalised arrangement. For example the gendered relations of wife as responsible for domesticity and located in the home and husband as hunter gatherer located out in the workplace. This approach is limited by neglecting to explore the ways in which people have many varied identities which correspond to particular spatial social contexts encountered in everyday life (Brown & Lunt, 2002).

Drawing from the 'tool box' of theoretical concepts offered up by (Deleuze & Guattari, 2004) the key areas of this thesis will utilise some ideas from the variety of *'free'* and *'open networks'* presented within their influential set of texts; *'A Thousand Plateaus'* (ATP) (Bonta & Protevi, 2004, p. 4). On first reading, Deleuze & Guattari present a somewhat bewildering array of ideas which seem to bounce around the mind – at times, they may briefly appear to tie in neatly but this is then interrupted by another series of complexities to contend with (Brown & Lunt, 2002; Semetsky, 2003).

But this is not the point of their work, they are not seeking to present a rigid doctrine of social performance and spatial stratification (whereby individuals are seen to act in specific ways within certain social parameters), rather they are interested in the divergent trajectories, the multitude of pathways and flows of performance – of ontological creativity (Thrift, 2006). With this in mind, ATP can be likened to being faced with an array of confectionary on a

'Pick and Mix' counter. Within the selection of sweets chosen, there will always be those that are preferable to others, the sweets that both look and taste better. The favoured confectionary will be eaten first and bought again in the future. There may be some we reject altogether. It is all a matter of taste. Likewise with Deleuze & Guattari's concepts, one is presented with an armoury of ideas where they both actively encourage the reader to engage with those creative trajectories which suit the purpose in hand in favour of other concepts.

As this thesis is primarily interested in the differential and changing experiential accounts of everyday service user life, a theoretical framework which offers more fluid ways of exploring the plasticity of spatial experiences, performance and identity would seem appropriate. In this way, this thesis draws on particular concepts offered by Deleuze & Guattari as a valuable aid to analyse the research data to enable a more heterogeneous positioning of participant's narratives.

As Massumi (1992, p. 54) notes when discussing ATP;

> *"…we have a slew of concepts. They do not fit together in a neat system. This is not a package deal. They are offered as a repertory to pick and choose from, to recombine and refashion, in the hopes that they may be found useful in understanding processes of structuration: the integration of separate elements not more or less regulation stratified formations…"*

Even on further reading – this work remains challenging and complex not more so because it goes against our internalised Western way of thinking. As a body of texts, it seeks to destabilise the penchant we can have to stratify (via categorisation and codings) groups of people and subsequently 'freeze' spatial experiences and social performances as having particular stable qualities related to an assigned social identity (Brown & Lunt, 2002; Conradson, 2005). ATP is concerned with the concepts of variance as opposed to the positions of fixity (Tucker, 2011).

In this way, rather than discussing space as an *'a priori'*, an empty mass of matter just waiting for performances to be executed, this work will explore *'space is(as) a social product'* (Lefebvre, 1999, p. 26). It is the social performance that makes space tangible, such as shopping in a supermarket, without consumers the supermarket would be an empty, static void. It is the weekly shopper who creates space (Crang, 2005).

Such complexities and theoretical ambiguity of the Deleuze-Guattari flows and creativity have been criticised as too obscure, with too much attention given to the continuity of flows upon flows – elements not philosophically relevant to every day human life (Harman, 2008). However, Deleuze and Guattari's work is far more nuanced than this. The ontological thrust of their work is one imbued with flows and stoppages. It is not simply a process framework of moving from one flow to another flow within a largely unproblematic horizontal diagram, there are blockages and obstacles (Graham & Thrift, 2007). Much like human and non-human (Deleuze predominantly refers to animal behaviours to explain concepts) daily life, movement and space do not operate on a level continuum but more so there are elements of strategic negotiation. They are in a constant changing state of flux and diversion (Doel, 2000).

Another critique is around the Deleuze-Guattari concepts of process and becoming encompassing the actual and the virtual or the myriad set of potentials that may or may not happen. Badiou (2007) disputes these notions by arguing that beings are not productive as part of a system of a multiplicity of flows but are more so representational as a materialised self-identity. Here Badiou (2007) argues that rather than Deleuze & Guattari offering a 'tool box' of heterogeneous multiplicity their positions always return to the 'one'. For example, Badiou (2007) refutes the 'event' as being part of a process of virtual continuity from one set of multiplicities to another set of multiplicities as the 'event' is neither constituted by the past or the present but is more so bound within the singular present (here multiplicity is erased whereby the variety of potentialities are irrelevant). The 'event' for Badiou is bound up with a definitive breaking away from the past to create and form a new beginning, there is no tangible connection between the past and the future; *"The event is neither past nor future. It makes us present to the present"* (Badiou, 2007, p. 39).

Hallward (2006) argues that Deleuze & Guattari's philosophical concepts are both ambiguous and abstract with little bearing on the grounded ways of everyday living. In this way, it is contended that Deleuze & Guattari neglect to state exactly how changes and potentialities are evaluated – their ambiguous theoretical framework lacks depth and material clarity by focusing on the virtual or the *'extra wordly'* (the things we cannot tangibly perceive) (Hallward, 2006, p 3). For Hallward (2006, p. 162), their works are based on spirituality and offer; *"little more than utopian distraction"*. They have little relevance within the real and material world in which we live (Curtis, 2008).

Nevertheless, this body of work is seeking to explore the multiplicity of fluctuating movement and potentiality and the spatial production of service users' daily lives. Consequently, the heterogeneous and myriad conceptual processes of spatial and identity movement between flows or plateaus [6] (although problematic to fix in terms of discourses alone) are theoretically valuable when analysing these mutable areas as opposed to making distinctions between the virtual activity and the fixity of the actual (Curtis, 2008; Protevi, 2007). For Seigworth (2007), the argument presented by Hallward referring to the abstraction of Deleuze & Guattari's concepts neglects the importance of creativity in their work and our own ontological creativity. In this way, Seigworth (2007) claims that Hallward and other like-minded critics attempt to anchor Deleuze & Guattari's philosophical thoughts and concepts as opposed to allowing a more nuanced, gradual and fluid position on human and non-human relational movement and transformation. In terms of analysing these elements within this thesis, rather than lacking evaluative depth, Deleuze & Guattari offer up a relational set of analytical concepts to explore these elements, namely non-discursivity (Brown, 2001). Non-discursivity as an analytical tool is discussed further in this Chapter and throughout the thesis.

1.4.1 Performativity

Within this work the elements of social performance will draw from Judith Butler's concepts of performativity. Butler (1990) discusses the ways in which gendered identities and subsequent social interactions are moulded by a process of iteration. Iterative performances focus on the ways in which people continuously rehearse certain behaviours which either conform to the wider discourses of gender identification or indeed, can repudiate such performances. Here she argues that performance, even within mundane routines such as shopping or walking are linked with the social constructions of expectation such as being a 'typical feminine woman'. Social performance is therefore entwined with one's discursive repertoire (i.e. what it is to be a 'normative' feminine body) whereby some performances can be embodied whilst other performances can be rejected (those performances that constructed as typically masculine for example) (Butler, 1993). This notion of performativity is also relevant to the wider discursive positions around mental health distress and more particularly the more 'extreme' diagnoses such as schizophrenia whereby service users either internalise a psychiatric diagnosis or indeed disembody the cultural framework from which they derive and

[6] Plateaus refers to the myriad conceptual layers and possible connecting intersections within Deleuze & Guattari's approach to philosophical readings

create alternative social identities linked with more 'normative' social performances (Hacking, 1999).

1.4.2 Some analytical concerns

Taking the above theoretical positions offered by Deleuze & Guattari forward analysing the concepts of continuous movement and change is wrought with difficulty. By this I mean the divergence of ways in which life is spatially played out in everyday spaces. It might seem that the spaces we inhabit on a regular basis are static and fixed – there is no element of creativity and change invoked here. However, if we take an example of being part of a spatial microcosm within a train carriage on a daily journey to work, there can be many different performances of the real and of the imaginary. As a way of alleviating the boredom of the journey, one might start to create alternative lives for other passengers and one might assume them in a variety of different social and spatial situations. At this point, we are seemingly not moving in the bodily sense but we are using our imagination in creating a continuously changing set of processes of spatial performances for people we don't even know. We might even feel some somatic sensations when considering certain roles and activities we place these people in. These thoughts are fleeting and soon forgotten because as our journey draws to an end we turn our attention to getting off the train and getting to work. Our performance at this point can then become one of material focus as we endeavour to get to the work place on time along with everybody else on the platform. What is meant here is that rather than daily life as necessarily being played out in ways which have a direct material basis on daily life (e.g. Hallward, 2006), we can and do use our spatial creativity to create flows and plateaus of fantasy which will possibly never have a direct impact on our everyday relations.

Nevertheless, writing around such social spatial performances effectively makes fluctuations and nuances redundant and all we can provide is a freeze-frame of change or transformation. Let me briefly unpack this further. With particular relevance to this thesis, taking the aforementioned geographical positions that service users are marginalised within wider society (e.g. Painter & Philo, 1995) we can discursively situate service users as 'the other'. This notion of displacement informs the way in which the analysis is undertaken in that the factors of primary importance here are the discourses of mental health distress. In this way, analysis can be drawn from the parameters of psychiatry and all the implications this can have on service user life. Of course, these are important issues they are of upmost importance to

the participants within this research project – from my experience, mental health distress forms the crux of their accounts of everyday life[7].

However, as Brown & Tucker (2010. pp. 6, 10) point out; *"When subjectivities are understood as more-or-less clearly defined positions within a semiotic field, all flow and transformation is erased…Analysis become re-description"*. Here, change and transformation whether temporal or eternal become problematic to analyse – the analysis will by its own method render movement as a static phenomenon – all I can offer is a snap-shot of performance which has subsequently been through an interpretative process using my own thoughts and words.

To briefly summarise, at times, the theoretical concepts used to analyse the spatial production of mental health will not provide a neat and tidy fit (Crang & Thrift, 2000; Massumi, 1992). That is not, however, the intention of this work. I am as much interested in leaks and cracks whereby experiential accounts do not always fit like snug pieces of a full jigsaw puzzle to the theoretical framework but like an uncompleted puzzle, can give one a sense of a particular picture of daily service user life.

1.5 What's in a name?

It would be useful to discuss the use of some problematic terminology within this work. For example, the term 'madness' will be used intermittently within this thesis and it would seem pertinent to discuss the reasons why the use of such evocative language can be important in trying to unravel the complexities of mental health. Porter (1997) argues that the term 'madness' can be seen as an unscientific choice of language (i.e. this term is not used within evidence-based research) when discussing the neatly coded and categorized Western bio-medical models (such as the Diagnostic & Statistical Manual-DSM) which dominate mental illness in post-industrialised societies. In pursuit of destabilising the aforementioned medical models, Porter (1991, p.1) asks: *"What is reason? What is madness? Where lie the dividing lines?"* This line of questioning by Porter goes some way in highlighting the fragile and somewhat ambiguous position of what actually constitutes normality and, conversely, abnormality. In this way, 'madness' is a term used to denote this sense of moral and medical confusion and elasticity surrounding rationality and, conversely, irrationality[8].

[7] Whilst it is appreciated that service users can tap into other discourses as well (such as gender identity for example), from my own observations and conversations with participants, mental health seemed to be the dominating area within their daily lives.

[8] There are other arguments that the diagnostic criteria/symptomologies around schizophrenia lacks scientific validity and reliability e.g. Mary Boyle's work; 'Schizophrenia: A Scientific Delusion?'

Madness is word wrapped up in a performance to question the categorical ways in which Westernised societies seek to code phenomena such as mental health distress. Therefore, by presenting a discrete set of symptomologies, there is a negation of the creativity and fluidity which form service user's accounts of living with and living through such diagnostic criteria ((Greenhalgh & Hurwitz, 1999). Perhaps this is why madness is a term of choice often used in many seminal, critical psychiatric texts, notably by Foucault (1965), Porter (1987), Scull (1979), Laing (1965) and Szasz (1971, 1974). Consequently, the use of this style of linguistic term within this thesis is not meant to be a derogatory way of expressing mental health distress, nor I am suggesting that forms of mental health distress do not exist. Moreover, a fundamental thrust of this thesis is to explore the mutable ways in which diagnostic criteria impact upon the playing out of everyday service user life.

'Madness' as a term of describing mental health distress is not the only potentially contentious way in which the language within this area can cause debate – the diagnostic label of 'schizophrenia' also has negative connotations. The term 'schizophrenia' will also be present within some data extracts, analysis and discussion of theoretical concepts. This particular diagnostic label is one that has been and remains, culturally and social contentious largely due to the ways in which this particular medical diagnostic term can create negative impacts for those in receipt of such a diagnosis. In response to these ramifications, the term schizophrenia is being replaced (albeit slowly) by utilising the expression 'psychosis'. Maybe there is a suggested lessening of the stigma attached to the label of psychosis because it forms part of a wider spectrum of disorders and is therefore more diagnostically ambiguous. Nonetheless, I would also point out that taking my research experience into account, psychosis is a term used in academia and within professional psychiatric services – schizophrenia is a term used in day centres by service users. Therefore, the use of the term schizophrenia will be used intermittently throughout this work.

1.6 Madness as a tangible entity

The contemporary discourses of mental health can be varied in terms of content and meaning as briefly discussed above. Subsequently, there are various ways in which we seek to linguistically frame this phenomenon which ultimately reifies mental health distress as a tangible entity, one which is accessible to grasp from an intellectual front, if not experienced personally.

However, to look at the present, we must firstly look to the past, to gain a sense of how discursive practices have evolved to establish the social stratum of the post-industrialised service user. By providing a historical context, I will elaborate further on the multifarious macro-aspects that combine to stratify and subsequently, socially position members of society with long-term, mental health distress. Rose (1998, p. 41) draws attention to the importance of history when considering areas such as psychology, thus; *"…history disturbs and fragments, it reveals the fragility of that which seems solid…Its aim is not to predetermine judgment, but to make judgment possible"*.

1.6.1 The historical emergence of madness

There are many interpretations of the history surrounding the social construction of mental health, psychiatry and that of a service user (Foucault, 1965; Rogers & Pilgrim, 2005). For example, Scull (1979) claims that Medieval England maintained a flexible approach with regards to the care and responsibility of those with mental health problems. Many were left to their own devices whilst others were reliant upon familial support. Those afflicted, without any family to provide maintenance and categorised as 'too deviant' to reside in mainstream society, were placed within small, general hospitals. At this time, only Bethlem[9] existed as a specialised mental health institution, this solitary building with very few occupants consisted of both the insane and sane (Porter, 1987; Scull, 1979).

In spite of this, Medieval England still sought to persecute those who were categorised as 'demoniac' with their resultant insanity supposedly emanating from connections with intangible satanic forces (Sedgewick, 1982). Witches became the prime target of retribution, their physical being and soul, the very antithesis of all that was Godly and Holy in a cultural and social world dominated by Christianity (Jones, 1993). Supportively, Szasz (1974, p. 199) states; *"Witches…recruited from the ranks of the poor and oppressed, played the role of scapegoats"*. The social norms of 'deviancy' were therefore based on the immorality of those who sought to usurp the dominance of theological beliefs[10]. Resemblance (whether physical or psychological[11]) of socially constructed definitions of depravity became the fundamental

[9] Also known as 'Bedlam'
[10] This historical social construction is refuted by Zilboorg (1935)
[11] The social construction of witches is both gendered and age oriented in that all that was demonic was female with a particular focus on older women (Porter, 1987)

pathologies that permeated notions of madness at that particular period in time (Scull, 1979, p. 13)[12].

Nonetheless, the multiplicity of methods regarding the treatment of those with mental health difficulties remained fluid and indeterminate during this epoch. Scull (1979) states, at the outset of the mid-eighteenth century, the mad were still not largely isolated within the confines of institutions affiliated with abnormality. Rather those with mental health distress were grouped together with the classes of the *"morally disreputable, the poor, and the impotent, a group which also included vagrants, minor criminals and the physically handicapped"* (Scull, 1979, p. 13).

Furthermore, Porter (1987) claims that examinations undertaken during this period to test mental capacity were of a simplistic, practical nature to assess the levels of efficacy of how a subject was able to deal with day-to-day activities, i.e. "Can you tell me your name?" These historical renditions would suggest that classicist, medicalised notions relating to mental illness remained dormant at this time.

Nevertheless, the initial steps of formalising categorical data of the aetiologies, which were deemed to be contributory to abnormal behaviour and presentation was in progression. Listed below is an indicative list of the causal factors of a group of patients admitted to Bethlem in the early 19th century.

A Table of the Causes of Insanity of about one third of the patients admitted into Bedlam by William Black (1810, in Porter, 1987, pgs 33-34):-

Misfortunes, Troubles, Disappointments, Grief	206
Religion and Methodism	90
Love	74
Jealousy	9
Pride	8
Study	15
Fright	51
Drink and Intoxication	58
Fevers	110
Childbed	79
Obstruction	10
Family and Heredity	115
Contusions and Fractures of the Skull	12
Venereal	14

[12] It would be reasonable to suggest, for example, that Szasz and Foucault would claim that this position is still 'true' within developed, post-industrialised societies

Small pox	7
Ulcers and Scabs dried up	5

This table illustrates the eclectic mix of trajectories relating to the underlying factors that cause mental distress. Some origins relate to the personality traits of the individual, such as pride whereas those organic symptoms such as small pox, ulcers and fevers are also prevalent (Porter, 1987). Subsequently, aetiologies relating to mental health distress were documented as multifarious indicating that no one decisive factor could be cited as attributable to the consequent admission to Bethlem.

Although positioned as socially undesirable and residing on the marginal boundaries of reciprocal integration, the physical segregation of those deemed mad was not used in earnest until the mid-nineteenth century and onwards (Scull, 1979). However, the cultural and social representations and treatment of the 'insane' versus the 'sane' was soon to irrevocably shift. Based on the higher echelons of scientific and rational ethos, the enforced incarceration of the service user was soon set to dominate the psychopathological landscape.

1.7 'Abnormality' personified

> *"They called me mad, and I called them mad, and damn them, they outvoted me"*
>
> Nathanial Lee in (Porter, 1991, p. 88)

The above extract on madness would serve to imply that deviation from the norm is not easily recognised as an easily definable phenomenon and reinforces the notion that normative behaviour is socially and culturally bound. Nevertheless, how did we get to the point whereby pathological labels of madness could be reliably assigned on an individualistic basis? Indeed, how were the notions of idiosyncratic and deviant behaviours reified into a standardised format that could be easily determined and identified? These are not simplistic questions that can be answered adequately within this thesis alone but moreover they serve to reiterate the concrete implications of post-industrialised man's fascination with explaining all strands of human nature whereby cultural diversity can be forsaken in the name of scientific endeavours. This course of events needs to be unpacked further in order to shed some light on the intervention of the human subject as a tangible entity.

Drawing from Foucault's (1965) postulations that following on from the Enlightenment came a period of rationality, surveillance and discipline, madness became the new contagious

disease to replace that of leprosy. For Foucault, the leper[13] was 'the other' of the medieval world, *"a prime source of contamination which was to be treated with respectful fear"* (Boyne, 1990, p. 6) . Within historical terms, the Enlightenment was an evolutional period during the 18th Century whereby scientific analysis replaced theological beliefs and hence all societal behaviours, conditions and factions could now be rationalised accordingly. Therefore, creating an order of knowledge based upon emergent practices and assessments to ensure that 'power' could be maintained by those 'experts' who held authoritative control through the means of economic and cognitive superiority (e.g. Foucault, 1965; 1970; Scull 1979). Subsequently, classicism embraced the production of identity through the means of difference, measurement and order (e.g. Foucault, 1965, 1970; Scull, 1979) whereby binary positions would emanate and 'the other' was the end creation from the seeds sown of empiricism (e.g. Foucault, 1970, 1977; Gilman, 1985; Rose, 1998).

As a result mental illness was seen as both politically and socially reliant upon authoritative and expert bodies not only within the realms of governmental policy but more importantly, at that time medicine was to become the dominant factor within the development of this phenomenon. *"…insanity came to be exclusively defined as an illness, a condition within the sole jurisdiction of the medical profession"* (Scull, 1979, p. 16).

The genesis of psychiatry and the necessity to treat madness as a medical category emerged from the ashes of this transformation of the insane to be treated as a separate distinction from all other deviant (whether physical or social) classes of groups. The resultant discursive practices positioned those with mental health difficulties as needing to be segregated from mainstream society to isolate this 'medical problem' and confinement within asylums followed (Foucault, 1965; Goffman, 1961; Porter, 1987).

1.8 The shifting of the spatial domains of madness

For Scull (1979, p. 25) ; *"Their (asylums) primary importance lay in the fact that they helped to legitimate the notion of institutionalisation as a response to the problems posed by the presence of mentally disturbed individuals in the community"*. Boyne (1990, p. 32) reaffirms this position by claiming, *"The asylum, legitimated in the languages of psychiatric and medical science and strengthened by the powerful discourse of humanism, focuses its energy on madness - the weak seam in the fabric of reason, the place where difference might break through - and welds that seam tight shut"*. Mental health now clearly resided as an

[13] For Szasz (1971) witches were the 'other' in medieval society

individualistic phenomenon, one of dissimilarity and one that should be removed from all societal dimensions.

As one would expect, there are criticisms of Foucault's influential accounts of the reification of 'madness' and the resultant subjection of the service user. Sedgewick (1982) infers that Foucault's historical record of madness is driven by the post-structuralist position advocated by Foucault rather than an accurate record of the historical shift of the benign to the malevolent treatment of all those afflicted by mental health distress. Additionally, Sedgewick (1982) disputes the chronological accuracy of Foucault's account of abnormality, claiming that Foucault ignored certain historical facts to strengthen his own theoretical position. Furthermore, these arguments postulate that those with mental health difficulties were not indeed seen as an entity consisting of 'the other' but rather an enhanced humanitarian ethos evolved from the Enlightenment period. Sedgewick (1982) further supports this position by drawing attention to the beneficial advancement of the evolution of psychiatry, which sought to eradicate the targeting of indiscriminate retribution, such as those of witches. However, whilst these contentions may achieve a viable critique of Foucault's work it is the embracement of rationalisation and assessment of the socially defined normal human being that is particularly of interest at this point.

1.9 Categorising mental health distress

With the implementation of 'care in the community' during the 1960's and 1970's which resulted in the closure of designated psychiatric institutions, the emergent discourses of rehabilitation and integration back into mainstream society came to the fore (e.g. Parr, 1997). This physical shift was inextricably bound within the discourses and discursive practices of medication (Rogers & Pilgrim, 2005). For example, the dominant use of measuring and ranking divergent human behaviour such as those contained within The Diagnostic and Statistical Manual-IV (DSM-IV, 1995) is arguably an end product from the classical school of thought. Whilst commonly used within mental health practice, this manual remains a bone of contention characterised by the conflicting and ongoing tensions which exist between the biological and experiential discourses of mental health (Harrari, 1999).

Biologically, it could be argued that the prevailing use of clinical, diagnostic criteria such as the DSM[14], which seeks to position trajectories associated with various mental disorders as

[14] The DSM was first published in its entirety in 1952 (Kutchins & Kirk, 1997)

universally identifiable and standardised categories (Bentall, 1990; Bentall, Jackson & Pilgrim, 1988; Cooper, 2005; Foucault, 2008) is the mainstream understanding of all that is mental illness. Thereby positioning mental health as a verifiable medical condition alongside physical illnesses such as cancer, diabetes and arthritis (Lynch, 2004). This formalisation of mental health distress into neat, identifiable compounds provides a shorthand frame of reference which is common to all mental health professionals (Tyrer & Steinberg, 1993). This process, in turn, facilitates an efficient and reliable nosology to aid the professional detection and treatment of mental disorders by medically pathologising certain deviant behaviours and firmly placing these abnormalities within defined parameters.

In direct contention to the biomedical approach, Elizabeth Rowe clearly states her case that the DSM explicitly precludes any sense of humanism by labeling and coding mental health patients as units of diagnostic criterion.

> *"The Diagnostic and Statistical Manual is an American invention for use by American psychiatrists. Why should it concern us here in Britain? It should concern us greatly because, like MacDonalds and Microsoft, it's here and affecting our way of life…The use of the DSM…reflects a growing tendency in our society to medicalize problems that are not medical, to find pathology where there is only pathos, and to pretend to understand phenomena by merely giving them a label and code number"*
>
> (Rowe, 1997, p. ix)

It is worth noting at this point that this thesis does not seek to position the psychiatrist as an *"agent of repression and of power"* (Clare, 1980, p. 2) but aims to critique the dominant hypotheses and systems prevalent within psychiatry. For example, if one solely adhered to the biomedical model and placed mental health disorders as purely malfunctions of the brain, a result of misfiring neurons and neurotransmitters failing to produce chemicals in the correct proportions then how is the suggested increase in depression accounted for? The World Health Organisation (2008) predicts that by the year 2020, depression will become the second largest factor within the global burden of disease. If the causality of depression is accounted for by a chemical imbalance alone does this rise indicate that the structure and function of the human brain is evolving to become less efficient?

Moncrieff (2003) supports the above positions and argues that categorising mental health as a discrete biological event, created by a chemical imbalance not only serves to increase the social and economic power of the pharmaceutical industry but negates factors such as social deprivation and poverty. This argument is further progressed by Bracken & Thomas (2001) who contest that modern day psychiatric practices need to include the social, political and cultural realities encountered by service users by engaging in forms of hermeneutic enquiry alongside the biological approaches most commonly used. These critiques of psychiatric practice propose instead that a more holistic approach should be taken by adopting a biopsychosocial model as the preferred framework from which to understand mental health distress (e.g. Double, 2002; Smail, 2007).

The DSM has also come under much criticism when extraneous variables such as cultural changes are evaluated together with the diagnostic criterion, which remains the life-blood of this publication. It has been argued that whilst the invention of most DSM categories have managed to survive the test of time, there are some that have disappeared altogether as a result in the change of consensual values. For example, the descriptive definition of an anxiety-based disorder has changed three times since 1979 alone (Kutchins & Kirk). This fluidity of categorical modification has led Kutchins & Kirk (1997, p. 24) to surmise that the *"DSM is a compendium of constructs and like a large and popular fund, DSM's holdings are constantly changing, as the managers' estimates and beliefs about the values of those holdings change"*.

Whilst the constant revision of a dominant medical model such as the DSM[15] (Brown & Tucker, 2010) might seem to indicate the dynamic nature of aggressive 'medical' research and its subsequent absorption, there is one particular category that can only be reasonably positioned as socially bound within a particular period of time. Emulating social norms prevalent during the medieval period, it is claimed that the DSM was directly influenced by Christian theology which prohibits same-sex sexual activity (Szasz, 1971)[16]. As a direct consequence, homosexuality was diagnosed as a mental disorder in the 1968 version of the DSM which some posit was influenced by Freud's 'Oedipus Complex', whereby homosexuality was the result of a child's dysfunctional parental relationship. Thereby, postulating that the DSM's classification of homosexuality was inspired by the prevalence of the psychoanalytic movement in the United States of America at that time (Kutchins & Kirk, 1997). Nonetheless, homosexuality was eventually discarded as a medical illness from the DSM in 1987 (Bowker & Star, 1999; Kutchins & Kirk, 1997).

[15] It should be noted that currently a new revision of the DSM is under review for future publication
[16] For Szasz, this treatment is akin to that of the persecution of witches during the medieval period

The above positions would seem to suggest that not only is mental health distress culturally defined but is also susceptible to wider social norms that seek to control and contain those who do not conform to acceptable social practices. This isolation of those with mental health difficulties can be further compounded if their identity is already politically located on the boundaries of normative ideologies (Rattansi & Phoenix, 2008).

1.10 Social identity as a 'natural kind'

In terms of identity, social psychology has offered varying theoretical concepts of self and social identity and the ways in which people behave within specific spatial locations. Prominent examples include social representations theory (Moscovici, 1981) and social identity theory (Tajfel, 1981). These concepts can be broken down further by exploring areas such as attitude-behaviour relationships (Smith & Louis, 2008) , attributional behaviours (Rotter, 1966) and socially disadvantaged minority groups (Jackson, Tudway, Giles & Smith, 2009). The weakness within these positions is the assumption that behaviours follow a pattern of regularity when combined within certain spaces and social groupings (Brown & Lunt, 2002).

In this vein, Harre & Secord (1992, p. 30) argue that *"(Social) Psychologists are prone to view a human being as a complicated mechanism whose behaviour can be fully explained...by a combination of the effects of external stimuli...People are viewed as objects which are passively affected by events in their environment"*. In addition, Brown & Lunt (Brown & Lunt, 2002) also draw attention to some potentially problematic trajectories within the dominant theoretical perspectives imbued within social identity such as Tajfel's social identity theory. For instance, they discuss the emphasis of social identity theory as being an individualistic phenomenon whilst navigating further away from the social context and importantly, within this particular work, the focus within this theory is on 'rational subjects'. In other words, there can be a tendency within the wider literature to focus on social cognitive processes which in turn, can negate the complexity of social negotiations and circumventions present within daily life.

1.10.1 Assumptions of identity

As an exemplar, I am thinking about the complexity of identity, emotions and the body. I am doing this in the garden bathed in warm sunshine and I close my eyes. Firstly, I can hear a group of children squealing with delight and a male (possibly a father or a close relative) chasing them – there are elements of a common identification here (Brown & Lunt, 2002). This has happened within my own set of memories together with media representations so I have incorporated the codings of familial interactions. I can hear a lawn mower whirring and know that feeling too of the vibrations of the machine running up the arms and trying to capture and cut every single piece of wayward grass. I seem to understand these events clearly. This is largely because I have drawn from a set of appropriate discourses in an attempt to represent the somatic components of feelings (both emotionally and physically) by grounding this account in constituents embracing everyday life (Cromby, 2011; Lefebrve, 1999). In this way, I have focused on presenting a particular repertoire of discourse as a way of describing a largely unproblematic brief moment in time. Consequently, I have framed this series as a linguistic epistemology which is easy to comprehend.

When I listen very carefully however, I can hear birds cheeping and chirping, singing songs but I really don't know what they mean. These noises do not fit within my systematic type of coding. I can make assumptions however, are they calling to obtain a mate, are they protecting a nest or are they just making a noise for the sake of it. This is when situations become uncomfortable for the Westernised mind as one can only assume certain behaviours but never fully understand the nature of the bird's singing. Likewise for me, mental health distress can have the same impacts of assumption, I have never been diagnosed, I have never been caught up in psychiatric services and consequently I do not truly understand the experiences which service users discuss. But this is not to say that I don't, at times, witness and attempt to understand signs of mental health distress such as crying, talking to voices, screaming and unconventional body behaviours. That is to say, I do have access to the medical discourses of pain, aching, trauma (Cromby, 2011) but again this is discursive determinism. I have successfully positioned the worlds of both birds and services users as residing outside of everyday understanding. I have at some level, neatly packaged service users and birds as the discursive 'other', a group of bodies that I attempt to understand but with the underlying knowledge that I can never fully appreciate the nuances of others' daily lives.

1.10.2 Hemming in assumptions of identity

With the above in mind, Western societies have a particular penchant for discursively hemming in all aspects of human life within boxed off categories of human behaviours, or as Deleuze & Guattari (2004) would term 'arboreal[17]' ways of thinking. This way of thinking is too all pervasive and becomes such a part of everyday life it becomes difficult to think outside and subsequently, analyse experience outside of such parameters. To add further elaboration, let us begin at the beginning of human life, namely when one enters the world. No sooner are we born, we are subjected to a series of AGPAR[18] tests to establish normal reactions to certain stimuli. At this point, one becomes coded, either normal response or abnormal response. This kind of testing does not stop here but follows through the developmental experience. Pre-school tests for vision and hearing, the cognitive ability to build blocks in some kind of order all indicate levels of codings. Formal educational examination follows on and with the use of SATS tests, children are either categorised as 'bright', 'average' or having 'special educational needs' and of course, this system carries on and on.

The important feature here is that we become integral (either intentionally or unintentionally) within a system of categorical thinking and the subsequent positioning of people within specific codes spanning intelligence, wealth, ethnicity, gender etc., producing discursive identities such as 'normal' and 'abnormal' or of 'feminine' or 'masculine' for example. This is the traditional way in which contemporary society views people as performed in certain ways and having particular attributes, we have been doing it for years and it is a system which is hard to escape.

1.10.3 Translocational positionalities of identity

Moving away from the traditional psychological representation of social identities as static and stable entities, Anthias (2002) provides an articulate proposition in the ways in which identity within social groupings when combined with cultural determinism can be analysed as unfixed in relation to differing social contexts. Anthias' paper is concerned with the limitations of positioning feminism and multiculturalism as mutual 'bed fellows' when discussing issues such as oppression. She draws our attention to the need to review these somewhat homogenous groupings as more complex and multidimensional than simply 'belonging' to a certain cultural group would imply:-

[17] The concept of arbolic positions within Deleuze & Guattari's work refers to the logical and hierarchal ways in which knowledge/information can be socially constituted
[18] The acronym AGPAR stands for Activity, Pulse, Grimace, Appearance, Respiration

> *"...cultural fundamentalisms often refer to the situated nature of ''knowledge.'' However, such a view may err in the direction of treating subject positions in unitary ways, not recognising the multiple social and cultural contexts and positionalities, and particularly what I refer to as translocational positionalities, raising contradictory issues for individuals."*
>
> (Anthias, 2002, p. 276)

Translocational positionalities incorporate the complex and contradictory ways in which identity, discourses of belonging and shifting locations operate. In this way, Anthias (2002) argues that identification within a group is multi-layered in terms of the diversity of social positions within particular groups operates. This idea of translocational positionalities can be useful, at some level, in conceptualising some service user experiences. For example, there is a plethora of diagnostic labels, which leads to question the assumption of positioning service users as a largely homogeneous group by constituting them as the 'other' within a system of social conflict (e.g. Painter & Philo, 1995) thereby focusing on the individual and negating the social aspects of service user life (Brown & Lunt, 2002). More pragmatically, how is it possible for service users to share and understand the same values, experiences, psychiatric interventions when they reside within such a wide ranging spectrum of psychiatric disorders (see the DSM-IV, 1995, for a full range of current psychiatric diagnoses). Indeed, do the notions of discursive oppressions and discrimination which may be prevalent within the wider society create hierarchies within service user social interactions (this area is discussed in more detail in Chapter Five). More specifically, what is questioned here is the dialogical ways in which service users negotiate their own sense of identity together with the identity of other service users. By dialogical I am referring to the performative ways in which user's *"incorporate the words and voices of others"* (Skinner, Valsiner, & Holland, 2001, p. 5). Focus is therefore placed upon the emergent discourses and discursive practices when service users' discuss their own framing of diagnostic identification compared to others in differing social contexts.

In the following excerpt (this is taken from the corpus of data analysed in this thesis)[19] Jackie discusses her non-participation at her local day centre:

> *…you know I don't want anything to do with (the day centre) (LAS=yeah) that and I absolutely shun it I'm afraid I, I (2[20]) and again it sounds big-headed but*

[19] Participant data extracts are woven throughout this thesis (except Chapter Three) to illustrate the ways in which the wider research literature can map onto daily service user life

I like it with my normal friends (LAS=yeah)…but you know you look at some people here and they've got mental health problems (LAS=yeah) and I don't like to be viewed in that light (2)

Within her narrative, Jackie presents her own sense of identity as not aligned to those service users who frequent her local day centre. Although Jackie is a service user, who has regular meetings with her psychiatrist and spends intermittent periods of time within acute psychiatric wards she does not position herself as having *"mental health problems"*. Jackie prefers to avoid contact with the traditional service user and does not frequent the spatiality of the day centre associated with mental health distress as she would rather spend time with her *"normal friends"*. Consequently, Jackie does not invest her time or identity within this particular grouping and rejects the spatial and social ordering of service users within day centres (Brown & Lunt, 2002). Here we are presented with an account that gives a flavour of the fractured qualities that can exist within the worlds of service users.

Nevertheless, whilst offering a way out of 'hemming in' identity within discrete communities, Anthias does not articulate the ways in which these shifts can operate within particular communities. Lacking is a thoroughgoing analysis of how extant materialistic aspects of life such as poverty, gender and, in this case, mental health distress function within the fragmentation of social identity groupings. The emphasis is on the *"linguistic turn"*, with the focus relying purely on discourse whilst negating the elements of space. At some level, this renders this particular theoretical concept as limiting in exploring the ways in which service users move in and through their everyday spatial lives when the wider ramifications such as the side effects of medication are taken into account.

1.10.4 A material-discursive approach

Yardley (Yardley, 1996, 1997) also takes up some areas within the above theme but proposes that using a linguistic framework alone ignores important elements of materiality. Yardley proposes that drawing from an inter-relationship between discourses and materiality provides a more coherent basis to unpack human interconnectivity and identity. Here she proposes the development of a 'material-discursive' approach as a platform to explore particular areas health and illness, with an acknowledgement that various disciplines have a "distinct knowledge base" of discourses and materiality (Yardley, 1996, p. 486). In respect of mental

[20] Numerical values in brackets denotes the time of a pause

health, Yardley's approach could analyse the interrelations between material elements (or somatic, non-discursive) experience (Csordas, 2008; Tucker, 2010d) (e.g. diagnostic labels, the medicated body, therapies) and the discursive set of relations in which they operate (e.g. the power imbalance of psychiatric practice and service user, the negative discourses of mental health distress, the economic and political power of the pharmaceuticals) (Lynch, 2004; Moncrieff, 2003).

The onset of these interrelations follows a course of similar events for service users. The psychiatrist is presented with the 'patient' showing symptomatic behaviours associated with psychological distress. The psychiatrist draws from a range of classified disorders and provides a diagnosis which best suits the presentation of symptoms. The 'patient' then becomes part of the psychiatric system whether by receiving medication regimens or other therapies. What we are presented with is the procedural ways in which becoming a mental health service user is socially constructed via the means of the discourses of medicalised language (diagnoses) and the resultant material discursive practices (ingestion of medication). What Yardley is interested in however, is the fluctuating relationship between the discursive and the material being. In this way, neither the discursive nor the material operate as different entities but are more so reciprocal bedfellows, thereby avoiding offering a reductionist framework analysis (Tucker, 2010d).

Consider the following extract from Jenny (this is taken from the corpus of data analysed in this thesis) who is discussing the use of *'Advanced Statements'* as a means of psychiatric practices providing service users with a 'voice' within the medical interventions performed under voluntary or compulsory section;

> *Jenny: Do you know what an advanced statement is?*
> *LAS: I'm assuming it's so, if you're going, if you're going to be put into a ward, into a psychiatric unit or something that you have some rights or some say in your treatment*
> *Jenny: What it is, is that while you're well, you have to write it while you're well, (LAS=yeah) right because if you write when you're not well they can say "well you wasn't in the right mind" anyway to write it and you write down what you choose, what your wishes about your treatment about being hospitalised and um (1) everything and um you get it signed by somebody who's willing to say that you're in your right mind I suppose to witness it*

(LAS=yeah) and then it's put in your notes and then if you are needing hospital treatment, they're supposed to take it into consideration (LAS=mmm) or if you're ill and being treated at home, they're still supposed to take it into consideration but what (2) the other psychiatrist said to me was "of course if I section you that will over rule that, that will over rule your wishes and you'll do what I say anyway". So I mean in a way (LAS=mmm) in the, in the um one sense they are helpful but in another sense some psychiatrists would overlook it because you're sectioned anyway so (laughs) (LAS=yeah). Idealistically, it's like a lot of things to do with mental health, idealistically it's a good idea but practicality, practically they could over rule it (2) I never want really again this is ideally, I never want to be sedated either with anti-psychotic drugs or other sedation so that I can't function (3) (LAS=yeah) because that is no good for me…"

Within this account, Jenny presents a hypothetical situation she may or may not be faced with in the future. Jenny offers a taste of how she has been insubordinately inscribed within psychiatric services. On the one hand she is offered a way of destabilising the discursive practices of power imbued within psychiatry by having her own stake in treatment regimens. However, this potentiality of negotiating power is over-ruled by her psychiatrist who advises that Jenny's Advance Statement will be overlooked. Consequently, we have an account of the positive and progressive discourses of contemporary psychiatry (service users have a rhetorical claim in their treatment) but this superseded by the dominant practices of her psychiatrist. Here we have a mesh of psychiatric discourses which seek to categorise service users as both rational; "*you have to write it while you're well*" and irrational; *well you wasn't in the right mind"*. It is within the spaces and objects of psychiatry, the psychiatric clinic and the formalised seating of the powerful (the psychiatrist) and the powerless (the service user) where these elements are played out.

Jenny also elaborates on the materiality of specific medication she does not want to take under section namely, anti-psychotics and sedatives. In this way, she presents a narrative of the material (somatic) impacts of mental health in that anti-psychotics and sedatives do not allow her body to function very well. At these times, she is in a spatial and psychological suspension as such. Overall, we are presented with a mesh of discourses and discursive practices which intertwine with the impacts of materiality/non-discursivity – the body of psychiatrist versus the body of the service user, the quasi discourses (the emergence of

Advance Statements) of handing some agency back to service users, the somatic impacts of side effects due to the unwanted ingestion of specific medication and the spatial domains of psychiatry holding the trump card.

What is of particular interest here is Jenny's use of the words *'idealistically'* and *'ideally'* when discussing 'Advanced Statements' and her own wishes in rejecting certain medications. These kinds of discourses are expressing the virtual or the potentiality Jenny feels there is an idealism here which may or may not happen in accordance with her own wishes. For this potential of *'ideally'* to become reality, the event of being hospitalised under section needs to happen, the event needs to take place (Massumi, 1998). Whilst offering an articulate way of going forward in terms of analysing service user life there are limitations with this approach, especially in terms of the virtual or potential, particularly in the discursive grounding of space, erratic movement and potentiality.

This limitation appears to offer a framework similar to completing a dot-to-dot picture as a young child. The idea here is to join the dots together in a numerical fashion starting from number one and drawing an outline towards the higher number and a predetermined outline of a clown, a dog or house will appear as a visual reward that the puzzle has been completed successfully. In other words, there is a tendency to position materiality and spatial directions as a readily available stable entity simply awaiting a discursive analysis (Brown, 2001; Gillies et al., 2004; Tucker, 2010d). What if one was to complete the dots out of numerical sequence say going from dot numbered 3 directly to dot numbered 8? The predetermined resulting outline image would now be distorted, although one might quite be satisfied with the dog that looks more like a cat for example because one skipped a few of the sequential numbers around the area of the snout. What is trying to be established here is that there can be a myriad of ways that discourses and non-discursivity operate and they do not always provide a coherent discursive entity. As Brown (2001, pp. 188, 180) articulates; "*The non-discursive is often glossed as pure materiality, itself simply given… 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.*"

Drawing from Brown's position, the living of everyday life (both material and discursive) is not generally constituted as a series of discrete unproblematic mechanisms and processes just waiting to be fleetingly lived in and through (it is an active process). But is more so a

hotchpotch of movements such as retracting, advancing, side-stepping and briefly standing still to 'take the air'(Thrift, 2004a).

Consequently, a seemingly parsimonious approach such as that proposed by Yardley cannot offer an analysis that adequately accounts for the embodied potentiality Jenny expresses in her *'ideal'* situation on entry into a psychiatric ward, either via compulsion or as a voluntary patient. Jenny as a psychiatric patient has wishes and emotional intentions that go beyond that by the means of 'offering' a (pseudo) reciprocal framework. In this way, material elements and discursive practices are not static they are in a continual change of flux and always open to new interpretations by Jenny (Brown, 2001; Brown & Tucker, 2010). Additionally, the pivotal interest within this thesis is the performance of mental health distress within and through space which requires a more fluid analytic framework such as Deleuze & Guattari's philosophy of potentiality (e.g. Cromby, 2011). Of course, it is worth noting back to a previous point in this chapter that a diverse array of theoretical concepts such as those offered by Deleuze will not necessarily provide a neat, tight fit when analysing the corpus data (Crang & Thrift, 2000).

1.11 Non-discursivity

Foucault (1965, 1977) elaborates on the relationship between the discursive and non-discursive, the expression and the content. He does this by gathering together the threads of distinct discursive frameworks operating in institutions such as the prison in *'Discipline and Punish'* (1977) and the asylum in *'Madness and Civilization'* (1965) and the non-discursive (e.g. the patient or inmate, the daily institutional regimens).

Institutional structures such as the asylum are not static monolithic structures simply consisting of bricks and mortar, wards and beds to house the bodies of insanity but are built upon a political and cultural discursive framework based on the principals of medical expertise and political power (See Chapter Four for a detailed analysis of psychiatric institutions). As discussed previously, these discourses include classification systems such as the DSM, psychiatry, medication, therapeutic interventions, diagnoses and so on. The language and meaning of these discourses can then be reflected in the ways daily life for patients are structured within the asylum. The non-discursive elements of taking medication, eating meals and bathing are all undertaken at certain times of the day and so on. It is this

conjoining between the discursive and the non-discursive which makes the service user as a psychiatric patient visible within a discursive frame imbued within psychiatry.

At first glance this approach might be seen as using a rigid discursive framework of mental health when exploring the non-discursivity of patient life. In other words, we are in danger of homogenising this particular social context as operating in discrete ways. These forms of representing a stable regimentation are not Foucault's intention as he is primarily concerned with the interdependency of discourses and non-discursivity, in that both the verbal and visible within a psychiatric unit for example, draw from the wider societal frameworks of mental health. Or as Brown notes (2001, p. 185) with particular relevance to the criminal justice system; "*Without criminal bodies, there can be no discourse of delinquency. Without delinquency, there is no formal programme within which the effective division of mass criminality can be effected. But criminal bodies and delinquents are analytically distinct phenomena. It is only in their joint presentation within the whole formed by knowledge – the completed calligram – that they come to appear united.*" There is a series of relational movements here. For the discourses of criminality to be culturally and socially framed there has to be a group of offending bodies from which the non-discursive practices can emerge, both elements feed off each other's continuously changing processes and movements.

For Deleuze & Guattari, these fluctuations of content and expression are central themes within their theoretical concepts. As an exemplar, a bedroom traditionally shared between sexual partners can be positioned as a space of privacy and of intimacy. This space within contemporary cultures attracts the discursive formation of objects and artefacts into a visible and recognisable order. There is a double bed, a wardrobe, a dressing table and so on. These particular items of furniture serve a functional purpose but can also evoke the discourses of emotional content, and more specifically, in terms of the bed.

A bed is more than a piece of static furniture – it can provide the platform for social relationships to unfold. When shared with a partner it can be a space of love, pleasure or conversely, of pain and anguish. The bed can be a particular space where intimate secrets and physical moments are shared but it can also be a space where tensions can emerge especially when culturally defined discursive practices are disrupted. Taking this framework forward, the bedroom is a space culturally allocated for sexual relationships to take place - it is a space of expectation and performance. But this series of events can be interjected with periods of

sexual abstinence and emotional indifference. When these elements are not mutual endeavours between partners, the bed can become a space of friction and emotional anxiety.

In this way, both the discursive (the expression) and the non-discursive (the content) are fluid and interweave in divergent ways. Neither has dominance over the other but more so there is a mutual set of on-going relations between the discursive and the non-discursive which allows for new and alternative ways of movement and performance. There can be elements of shared understandings, discord and confusion here between the discourses of optimal sexual relationships and the non-discursive experiences of those engaged in such events. In essence, space, social performance and identity are not laid out in an indelible series of point-to-points or dot-to-dots but are more so always in a state of a relational transformation of potentiality (Brown & Tucker, 2010).

1.12 Incorporeal transformation

Service users[21] within this research project were not born with a psychiatric diagnosis. They did not come out of the womb hearing voices, with self-harming tendencies or suffering with chronic periods of depression for example. Rather these kinds of psychological and physical (in terms of self-harming) have, over the years, become a crucial part of their persona in that for most service users, there is a sense of envelopment within formalised and less formalised psychiatric institutions. This is how their life is played out with psychiatry playing the leading role.

In this way, identity is not positioned as a stable factor but as a phenomenon that is continually open to new interpretations and expression. The emphasis here is on becoming'; which briefly entails a messy relational concoction of the past, the present and the future (Deleuze & Guattari, 2004). The elements we have purposively embodied, the elements we have rejected and some elements we do not even knowingly hold within our (sub)conscious. On becoming-service user, on becoming-paranoid schizophrenic, on becoming-cured, on becoming-less psychologically disturbed than others (although I share the same diagnosis). The list here could be endless. What is of interest, however, are the ways in which users interpret and reinterpret their accounts of identity drawing from the vast range of codings imbued within psychiatric practice.

[21] The participants within this research all had a diagnosis within the spectrum of 'functional' disorders such as paranoid schizophrenia, borderline personality disorder and bipolar affective disorder

Here, diagnostic identity can be embodied, can become part of the essence of self or, conversely, can be rejected and in turn, alternative identities are sought. Diagnostic classifications can then perform a 'looping effect' whereby identity is inextricably bound up with the prevailing discourses of psychiatric understandings (Hacking, 1995). One becomes psychologically fragile, one might have a psychotic episode, one becomes diagnosed, one enters the system of diagnostic criteria, one enters psychiatric services, one is medicated, one might be lucky enough to have therapeutic intervention, and then one is 'coded' as a mental service user as the outcome of this transformation (Hacking, 1995). Here psychiatric bodies are reduced to a particular type in terms of the commonalities enveloped within psychiatric identity and most obviously, when compared to others who have never been (or yet to be) diagnosed (Hacking, 1995; Massumi, 1992).

This kind of *'looping effect'* suggested by Hacking is reiterated by (Massumi, 1992, p. 40) who discusses the way in which the wedding ceremony and more specifically, the ritual exchanging of marital vows within a particular space (i.e. a church, a registry office). Within this particular event, the utterance of the words 'I do' by both bride and groom, changes the social, relationship and economic status of one without any physical intervention (excepting the exchange of rings). For Massumi; "I do" effects an "incorporeal transformation". Thus, it is the event, the ritual that has effected change. For service users, as alluded to above, it is the event(s) of becoming enveloped within psychiatric services which can perform as the springboard to propel an "incorporeal transformation" in becoming-service user.

1.13 The event is 'key'

The importance of the 'event' or, the prevailing social milieu acting as a springboard when discussing the performances of transformation have become embedded within many post-structuralist texts (Coleman, 2008; Conradson, 2005; Werlen, 1993). In the following research data extract, Tom, a participant, provides a memorial account of when he became a 'schizophrenic'.

> *I wish the schizophrenia wasn't in my system well (2) the way it happened I can tell you now um (sighs) I came down the High Street (1) and there was three people and one came up on a Honda and I said "Oh for God's sake get off, go home and bring it back home" and I sat there and I screamed literally, screamed and screamed instead of it going out (4) (LAS = yeah) (2)*

Here, Tom does not offer a straightforward account of embodying schizophrenia. There are many trajectories here of seemingly disparate elements. Flitting from one interrelation to another, from the High Street, from three people, and another person turning up on a Honda of Tom sitting and screaming seemingly outwardly making an observable noise and internally *(instead of it going out)*. There is no sense of stability here instead what we have here is a layering of multiplicity but what seems central to this is the relational event (Doel, 2000; Massumi, 1992).

This particular social milieu and the constituent performances of others and Tom may appear as a dull backdrop in 'becoming schizophrenic', in that there is no sensationalism within this account, there are no narratives of long-term abuse, violence or sudden loss, but there is a sense of force here, of a spatialised production of anguish via the recollection of screaming (externally and internally) (Wise, 2000: Thrift, 2004a). The emergence of Tom as a schizophrenic is what this memorial event is all about, in the *'there and then'* and the *'here and now'* (Conradson, 2005, p. 107) and also the potential future. This is a heady mixture of the infolding of the *virtual* and *actual*, whereby the 'looping effect' of the diagnosis schizophrenia collides with the performance of encountered bodies, which form new connections (the onset of schizophrenia) (Hacking, 1995; Tucker, 2010d). This transformative 'event' for Tom marks out his first steps on 'becoming-schizophrenic'.

1.13.1 'Anchoring' the event

Taking a diagnosis of paranoid schizophrenia for example, one is not born with this identity but as previously discussed a classification of kind can act as a signifier in the sense 'of becoming' (Butler, 1990: Hacking,1999). In this way recollections of the past, when one did not have a diagnosis for example, can become a messy array of articulations such as 'who I was', 'why I am' and 'what I will be'. This does not mean that memorial accounts such as the one offered by Tom go back and forth in a linear motion to concur with current understandings of self but are more so fragments swirling within a vortex.

Likewise, in the beginning sequences of the film, '*The Wizard of Oz'*, Dorothy is held within the vortex of a tornado with items such as the house she lives in, a chair, a cow from the farm together with significant people, her Auntie Em and the ill-tempered woman on a bike. These are important materialist landscape anchors in Dorothy's life but they are fleeting markers that move in and out of the tornado. It is the ways in which these characters are played out in

her fantastical adventure to meet the Wizard of Oz that are interesting here. The ill-tempered woman is transformed into the Wicked Witch of the East who makes attempts to kill Dorothy. Her companions on her journey are the kind farm workers who are transformed into imaginary entities and take on particular characteristic traits. But above all, Dorothy is in a state 'of becoming' as her journey progresses by drawing from important material sources from the past and then reconfiguring them in different guises to make sense of the present and potential future. It is this variety of discursive ways in which spatialised narratives are articulated in the present which is of interest in this work.

1.14 Discussion

In this chapter I have outlined the main aims and objectives of this thesis. In that older service users are largely neglected within the realms of mental health research and subsequent funding (McCulloch, 2006). An overview of the broader theoretical framework from which this thesis will explore the spatial production of mental health distress has been introduced and this area will be discussed further in Chapter Two.

To add coherence to this work in terms of discussing contemporary psychiatric provisions being conducted within the current 'Care in the Community' programme, a brief history of the emergence of madness has been articulated. This historical and cultural framework of psychiatry is also important from which to frame the multi-layered and fluctuating relational everyday spatial movements of service users. With an emphasis on transformation and potentiality this thesis is interested in exploring the differential ways in which service users negotiate their spatial experiences when combined with the discursive practices of mental health distress. It is these variations of self-identity and psychiatric identity which offer valuable insights into the everyday life of living with a psychiatric diagnosis.

I have briefly discussed some theoretical frameworks which seek to explore heterogeneity, with a focus on the 'linguistic turn' (Anthias' Translocational Positionality approach) and the relational constituents of discourse and material (Yardley's material-discursive approach). These concepts are both welcome and useful and offer ways forward from a more positivist perspective in that groupings such as service users are largely positioned as homogenous. Nonetheless, there are limitations in that experiences and materiality are positioned as unproblematic and almost static 'givens' just awaiting analysis (Brown, 2001).

Hopefully, this chapter has given a sense that through this work I am not seeking to use a rigid theoretical framework which can provide a tight fit for the purposes of data analysis. But, more so, I am more interested in exploring that which is more difficult to pin down namely; spatial performance, emotional expression, transformation and potentiality. In other words, it would be fortuitous now to move towards ‘space’, ‘becoming’ and ‘affect’.

Chapter Two

Affect, Potentiality and Space

"Society is not 'just there'; it is engineered and produced through social practices, through the organization of bodies and materials along with the ordering of categories and identities."

(Brown & Lunt, 2002, p. 19)

2.1 Introduction

In Chapter One I introduced an outline of the theoretical concepts from which research data will be analysed. Now, I would like to provide a more in-depth evaluation of why this intangible (in that there is no concrete stability we can just hang data from) and fluid framework is useful when discussing the spatial performance of mental health distress. In this chapter, I will explore in greater detail the concepts of affect, potentiality and space.

Traditionally, psychology has largely negated the importance of the inter-relations between identity, movement and space when conceptualising daily life (Crang & Thrift, 2000; Tucker, 2010e) but it is noted that a 'spatial turn' is steadily becoming more prevalent in the research literature within the schools of social sciences, i.e. human geographies (Thrift, 2006). In terms of this thesis, it is useful to draw together the strands of the everyday spatial production by older, mental health service users to add another valuable layer to this growing body of literature. However, it is important to initially flag up that there are some divisions when talking about space. For example, what do we mean when we talk about the concepts of space and, indeed place?

Massey (2004) offers the argument that the concept of place is imbued with meaning and intent whereas space is more ephemeral and abstract. Agnew (2005) states that space is a controlled environment associated with objectivity (in terms of quantifying a spatial analysis) wherein place belongs to the lived experiences of subjectivity. Here we have some convergence in that place is contextually positioned as having phenomenological meanings but conceptualising space remains somewhat unresolved (Creswell, 2004).

In terms of seeking to explore movement and performance, Tuan (1997) provides a succinct clarification between space and place. Space is imbued with movement whereas place is a

temporal pause. Or, as Doel (2000, p. 125) suggests, space should be positioned as a *"verb rather than a noun…Spacing is an action, an event, a way of being…"*

This definition of space is in a state of constant motion (whereas place offers a momentary stability) in which the continuous movements or events allows a more dynamic approach towards the spatial analysis of mental health distress. As an example, the participants within this project live, and have lived, within and through a variety of places consisting of boundaries made up of architectural structures of solid walls, doors and windows. Such places include long-term psychiatric institutions, day centres and the home. But these different places are not as static as one might first assume as the divergent use of space can evoke a variety of social performances (Thrift, 2004a). This fluidity is reiterated by Foucault (1986, p. 23) thus:-

> *The space in which we live, which draws us out of ourselves, in which the erosion of our lives our time and our history occurs, the space that claws and gnaws at us, is also, in itself, a heterogeneous space. In other words, we do not live in a kind of void, inside of which we could place individuals and things.*

Consequently, this thesis will use the term 'space' as a means of denoting social performance and movement and 'place' (when used) will be used as a way of discussing a fleeting moment in time of lived experiences within structures infused with a distribution of boundaries (e.g. a psychiatric institution). In this way, I am not attempting to stabilise space or place but more so I am exploring the multifarious ways in which daily life is played out.

In addition, this chapter will also introduce the theoretical concepts of 'affect' and 'becoming'. Affect has become something of a fashionable conception in recent times (Gregg & Seigworth, 2010). This may not be too surprising when one considers the increasing momentum of critical social psychological and geographical research and literature (e.g. Brown & Tucker, 2010; Thrift, 2007). Affect is a valuable analytical tool in terms of this thesis not only because of the focus on emotional expression and somatic behaviours but also the very lack of determinism within this concept offers a fluid framework when discussing spatial production and potentiality. As Gregg & Seigworth (2010, p. 4) note;

> *"Because affect emerges out of muddy, unmediated relatedness not in some dialectical reconciliation of cleanly oppositional elements or primary units, it*

makes easy compartmentalisms give way to thresholds and tensions, blends and blurs."

Fortunately, from this particular perspective, the move towards affect offers a route of trajectories away from the somewhat limiting positions emanating from traditional social psychology theories (as briefly discussed in Chapter One). As indicated in Chapter One, this thesis will not approach the elements of emotion, performance and space as an unproblematic entity from which to analyse research data (Brown, 2001). Rather the emphasis is on the flows and flux of movement, on the actual (the lived) and the virtual (the potential) thereby offering an open network to explore incorporeal and corporeal transformation (Brown, 2001).

2.2 The move to affect

Taking the above positions forward, consider the following piece of poetry written by David K. Fury (this is a pseudonym used by a service user who did not undertake an interview but preferred to write poetry as a way of being involved in this research project).

My Left Sausage

I hate the way you look
Staring at my face
In a certain space
Open the book
Of love
Pages unopened
On the mend
To send
Or on the bend
Of the love train
Crashes into
Something new or old
Bold
Lessons of love
From above
Fold into each other
Sister brother mother

Family trees

Tease me

Farewell my dust

Iron bru and rust

Coach potato

Sausage on my left

Broke tomato

(David K. Fury)

Using notes from my research diary, David has a diagnosis of paranoid schizophrenia, has never worked or been part of a long term, intimate relationship. He hears two voices (one female and one male) which normally do not directly speak to him but instead argue with each other. This can make him angry and resentful as he is not part of the interactions and he feels that the voices are 'parasites' using him as way to play out their own differences. The voices did not mean anything to him in a personal way in that they are not people he has ever known and had contact with. This is unusual with other participants who took part in this research, who share the same experiences of hearing voices but their voices were people who were known to them.

Of equal importance however, is how would one analyse a prose such as this in terms of the discursive and the non-discursive? From a psychiatric perspective, David's work can be seen as that of a cognitively deficient service user with a diagnosis of paranoid schizophrenia. A "mashing" of words with very little meaning. There is an abundance of literature to support this position of people diagnosed with schizophrenia as lacking cognitive skills such as reasoning and memory ((Blairy et al., 2008; Combs & Gouvier, 2004; Kohler, Gur, Swanson, Petty, & Gur, 1998; Kohler, Bilker, Hagendoorn, Gur, & Gur, 2000). Such research draws from experimental methodologies such as using one-off measures to test recall accuracy correlated with time taken when compared to a 'normal' control group (Lyons & Cromby, 2010).

These findings make sense at the level of positioning social representations and relationships as directly connected to cognitive processes by highlighting the ways in which schemas can function as a kind of internalised resource to enable socialisation (or not). However, a weakness of this position is that by placing all the emphasis on cognition in terms of human language and thought processing, we cannot adequately seek to understand the underlying

emotional states at work (Crang & Thrift, 2000; Cromby, 2011; Philo, Parr & Burns, 2005). In other words, we can sometimes make assumptions about the identity and emotional meanings of others based on the array of sociolinguistic positions emanating from the fields of cognitive and traditional social psychology (Thrift, 2004a).

On first glance, there does not appear to be any sense of structured process in David's poem but assuming this kind of position assumes that his work is awaiting analysis in an unproblematic way. But there is a sense of rhythm and movement when we read out the words – this does not appear to be a list of 'random' words David has just scribbled on paper as part of an activity at the day centre for example. Instead, there is an element of wit within this poem together with some darker elements of pathos. David's prose contains a complex mixture of meanings; "*Sister brother mother, Family trees, Tease me… Coach potato, Sausage on my left, Broke tomato"*, which might not immediately make sense in terms of clarity and coherence but maybe intimate writings such as this are not intended to fully reveal the feelings and emotions by the writer. It is this cryptic sensuality of not really understanding (in a cognitive sense of reasoning and logic) of what David is seeking to express which makes such a piece of work full of life and movement, mainly because he may have created this to perform this job. To keep the reader guessing which can then draw the reader in to read and read again but those elements of ambiguity still may remain. It is not only emotion and verbal utterances which need to be included within this framework but also the physical body should be explored as a vehicle for analysing affective meanings.

This thesis takes up Thrift's (2004) translation of affect. Thrift (2004, p. 60) states; "affect as a set of embodied practices that produce visible conduct as an outer lining". Affect, or components such as emotion, can be become tangible via the means of bodily processes, such as crying or blushing for example. Whilst such emotions may not always be straightforward to analyse because they are not located within the more formalised analysis of speech but instead can act as corporeal markers. Here Thrift (2004) argues that social context needs to be considered whereby the body becomes the vessel from which to analysis affect and spatial production in addition to language. As this work is interested in the ways in which service users continuously re(produce) their own spatial production with a focus on language, emotion and embodiment, this approach is best suited to analyse the research data.

2.3 The body and affect

The role of the body when discussing the spatial production of mental health distress and social identity is a useful premise from which to unravel movement and performance. This is a purposeful move away from the dichotomous position of situating the mind and body as autonomous elements. For example, one area within mental health distress that highlights the body as a corporeal marker is that of self-harming. Consider the following research extract from Rose (taken from my body of data) where she is discussing her self-harming behaviours.

> *"…if I get to a phase when (LAS=mmm) I'm in a crisis of self-harm I tend to isolate (LAS=yeah) myself because I can't explain how I feel…you're known to be a self-harmer and you're known and it's in my documents that say it's well documented they say I harm myself but (slight laugh) I'm pretty harmless to other people you know but they make a big thing about this (points to new and old scars on left arm) on my arm".*

In this excerpt, Rose discusses that at certain times of *'crisis'*, she cuts herself normally on her arms but also on her chest and stomach. Here we are presented with an observable marker of the impacts of mental health distress when Rose does not feel in control of her emotions and thoughts *'I can't explain how I feel'*. Rose gives a sense her of own ontological production of self and social identity, as one who regularly cuts herself, *"you're known to be a self-harmer"*.

These acts are spatially organised as well whereby Rose makes efforts to be solitary during these performances, "*I tend to isolate myself*". This indicates that these events take some form of preparation and organisation in that an isolated space has to be found together with the objects she uses to cut herself. By ordering the elements of this performance and possibly sticking to a well-rehearsed pattern of sequences, Rose is able to undertake her self-harming behaviours in secrecy. Nevertheless, whilst this is a private act that Rose performs when by herself, it is the scarred remnants of cutting which remain as a visual reminder that she does have periods of extreme distress. In this way, a person like Rose who self-harms can visually indicate by the means of scars 'critical' times of the past and in the present. Subsequently, the body becomes an affective topographical site through which shifting emotional practices and rituals are inscribed (Crang & Thrift, 2000).

2.4 Translations of affect

Before I move on, it is important to highlight that the term and meanings of affect cut across divergent ontological positions of space, emotions, feelings and identity. The Freudian position of understanding affect is based largely on biologically hard-wired drives and desires, such as the drive for sexual gratification, eating, drinking (Thrift, 2004a). Such desires are only ever known indirectly in that they remain within the realms of the sub-conscious thought although actions can manifest themselves in a myriad of ways, e.g. the Oedipus Complex, motivated forgetting etc. (Cromby, 2011). Thrift (2004a, p. 61) proposes that such a biologically determined approach to affect renders the psychoanalytic position as "too stark" by not offering up a multiple framework from which to explore emotions and feelings. In other words, the quest to understand affect within psychoanalytic terms is founded on primary processes whilst negating the social aspects of emotional content.

Cromby (2011) draws attention to ways in which affect is bound up with the practices of health. Here, he expounds how medical practices and affect can be mutual bedfellows largely because of the emphasis placed upon human activities, behaviours and any subsequent interventions dominant within forms of pathology. Taking psychopathology as an example, this trajectory has some meaning and relevant content for service users. A particularly emotionally painful time within a life can induce extreme feelings of stress and anxiety. Untreated, these feelings may well become part of the psychological and physiological make-up of the person involved, in that chemical imbalances may occur due to the overproduction of certain hormonal or neural substances. Nevertheless, there are limitations here as the discourses and feelings of pain can remain the overriding component when discussing the experiences of health and illness (Cromby, 2011). Consequently, affect can be positioned as pain, relief from pain or the controlling of pain which can again be reductionist when illuminating the spatial production of service user life.

In Deleuze & Guattari's philosophy, affect becomes (quite literally) a different animal. Cromby (2011) highlights the crux of Deleuze & Guattari's perspectives of affect by drawing attention to the intensity of interactional flows (and indeed, blockages) that reside within and between both human and non-humans when combined with space. Affect is not a singular such as a primary drive or an experience of pain but is more so a confectionary consisting of the intersecting of a multiplicity of layers of experience and spatial context (Crang, 2005; Ussher, 2008). These interactions are innumerable and can become infolded into human life but always have the potential to change.

In this vein, Massumi (1987, p. 91) discusses how Deleuze & Guattari point to Pop Art as an example of affect. Take the iconic artistic manifestations produced by Andy Warhol of an equally iconic photograph of the late actress, Marilyn Monroe. These images are repetitive in that the main features of the original photograph of Monroe are static and mimic the original photograph - the eyes, the styling of the hair and the voluptuous lips stare out at one as being instantly recognisably as belonging to Monroe. It is the differential use of vivid colours to the highlight these features such as the hues of the facial blue skin, lurid yellow hair and black lips (there are various coloured mutations within this theme). The point here is that through this process there is no inclination to slavishly mimic the original photograph but more so the multiplex of images produced by Warhol *"take on a life of their own"* (Massumi, 1987, p. 91). Through the intersections of colour, these artistic endeavours individually hold their own spatial position within the series of repetitive prints. In this way, they are not purely mimetic of the original photograph but are the fruitions of an artistic deviation of perpetual potentiality. They are not a copy of a copy, a facsimile of a facsimile.

As I have briefly discussed above, Deleuze & Guattari's turn towards affect allows another way of approaching the main themes of this work, namely, identity, social performance, spatial movement and potentiality (Cromby, 2011; Thrift, 2004a). Rather than falling back on the rigid formulations bound up with categorisation and coding, affect is concerned with understanding the emergence of beings through their multiple interactions with other people and events (Conradson, 2005). As Tucker (2010d, p. 514) suggests;

> *"The concept of affect allows us to talk about experience in a non-representational way, and thus avoid solely re-formulating it through the myriad extant representations already available"*.

2.5 Deleuze & Guattari's translation of affect

What needs to be understood at this point, taking Deleuze & Guattari's perspective of affect into account, is how can we define affect with clarity? Thrift (2004a, p. 60) offers the following summary;

> *"The first translation of affect which I want to address conceives of affect as a set of embodied practices that produce visible conduct as an outer lining…Its chief concern is to develop descriptions of how emotions occur in everyday*

> *life, understood as the richly expressive/aesthetic feeling-cum-behaviour of continual becoming that is provided chiefly by bodily states and process…"*

In this extract Thrift draws attention to affect as being a set of continually changing somatic behaviours in relation to interactions and events encountered in everyday life. Here we are presented with a distinct move from the reliance on the linguistic turn prevalent within the realm of qualitative methodologies (Blackman & Cromby, 2007). There is a shift of focus from the spoken to those which are embodied, of the expression of physical and spatial markers of emotional experience. These kinds of experiences are wrapped up with a set of differing spatial milieus consisting of human and non-human kinds (Conradson, 2005). Consequently, there is a sense of seeking to understand the flux and flow of inter-relational emergence of felt experiences – affect is not a static process, it is always on the move.

A key word here is '*sense'* because affect is sensual as opposed to a rigid set of cognitive processes per se, affect may be ephemeral or in some instances, more tangible (Blackman & Cromby, 2007). Affect and spatial movement do not necessarily proceed in a forward going trajectory of experiences yet to happen but are more so a heady concoction of networks where the realm of potentialised modes of actualisation, from which actualised experience emerges. In this sense, virtuality is never 'felt' as such (Conradson, 2005). Colebrook (2006, p. 198) offers the following explanation; *"space (is the) unfolding of matter with relations being affected by specific expressions which are events or specific powers"*. These are interesting points when considering the spatial events (receiving a diagnosis and treatment) and specific powers (psychiatrist, sectioning) evident within mental health distress provisions as these positions link into Hacking's (1999) conceptual framework of *interactive kinds*.

In brief, Hacking (1999, pp. 104,104) discusses *interactive kinds* as;

> *"a new concept that applies not to people but to classifications...to the kinds that can influence what is classified...the way in which the actors may become self-aware as being of a kind, if only because of being treated...as of that kind, and so experiencing themselves in that way."*

When discussing this concept, Hacking draws from both the historical and contemporary arguments and counter-arguments within psychiatry, especially within the spectrum of schizophrenic disorders. Tucker (2010a) discusses Hacking's concepts and the ways in

which service users following a diagnosis renegotiate their own sense of identity in line with their diagnostic identity, such as schizophrenia. Experiences are then reformulated in line with their new (together with the past and ongoing) sense of self drawing from the wider cultural meanings around psychiatric classifications such as schizophrenia. Transformative experiences can be consequently bound up with and lived through based upon these kinds of psychiatric codings in that service users can embody the social and cultural spatial milieus embedded within psychiatry which did not feature in their lives before experiencing a 'psychiatric episode'(Semetsky, 2003). Much like the concertina effect, *"Experience is then infolded, so that the outside (culturally derived categories) becomes inside (lived experience)"* (Tucker, 2010a, p. 514). It is the event of experiencing psychological distress and receiving a diagnosis which propels the impact of previous codings (pre-service user) and the creation of new connections with other similar bodies (those already in psychiatric services). Affect is pivotal in these transformations by drawing together the sensual strands from the past, present and the future. This does mean however that these processes (whether human or non-human) produce the service user body as a coherent whole but rather affect is concerned with treating the body as an unstable entity, as always open to new spatial and social networks and change, as perpetually in a state of becoming (Deleuze & Guattari, 2004).

2.6 Affect and becoming

"In becoming – wolf the important thing is the position of the mass, and above all the position of the subject itself in relation to the pack or wolf – multiplicity in how the subject joins or does not join the pack, how far away it stays, how it does or, does not hold to the multiplicity"

(Deleuze & Guattari, 2004, p. 32)

In the above extract, Deleuze and Guattari illuminate the concept of becoming, or more specifically of becoming-wolf. Here we are presented with a dilemma of gaining access to group participation based upon the relational position of the lone wolf within the pack. In terms of wolves (and many other pack animals), belonging to a group at any level can increase the survival rates of a wolf. Being part of the pack can be necessary in terms of hunting, the rearing of young and socialisation. What is interesting here is the conceptualisation of the multiplicity of a group in that some aspects of multiplicity may be embodied and conversely, some aspects may be rejected. These kinds of notions are not just confined to the performance of a potential identity but are inextricably linked to a multitude of spatialised experiences (Brown & Tucker, 2010). This conceptual framework needs unpacking further.

Massumi (1992, p. 57) offers the following explanation; *"Even within the limits of its stability, an individual is always changing"*. To support this statement, Massumi presents an analogy of heating water to describe the flux and flow of spatialised movement and the mutable process of identity. Before placing a saucepan of water on a heat source, one is presented with what appears to be a static mass of liquid. But, on first heating, a mass of small bubbles start to form at the bottom of a saucepan, as the heat increases so does the rising movement and increased density of the bubbles – if this process is allowed to pursue to boiling point and further, the liquid loses its stability and erupts over the edge of the saucepan. This concept offers a two-sided prong to explore affect and becoming whereby the material arrangements of the saucepan, the heat and the water allow for the transformation of the stability of liquid to the potential for the liquid to erupt and lose its former tracing of solidity.

It is the impact of the human being providing the power of heat and the containment of liquid within a vessel that is pivotal within the above sequence of events. Consequently, we have an arrangement of designed forms from which an interplay of proliferation can be performed (Massumi, 1998). These kinds of multiple relations can be relevant when discussing the multiplicity of relations afforded to service users in terms of the reworking of identity and space (Semetsky, 2003).

In the following extract (this is taken from the corpus of data analysed in this thesis), Jenny discusses her undertaking a Masters degree in relation to the dominant cultural understandings of mental health distress. Here she draws from the wider discursive ramifications whereby the negative prejudice surrounding intelligence and mental health form the network of relations in her ontological account.

> *…there's still an awful lot of prejudice about mental health (LAS=yeah) that, and even down to um…people assume that you're not intelligent because you have a mental health problem which is just not, well you know and I know it's not the case…well one lecturer, when I was doing my Masters, the lecturers there turned round and said to me, it was a woman and she turned round and said to me "Oh for someone" because obviously you have to declare it (LAS=yeah) (2) but um this lecturer the first time she met she said "Oh for someone with a mental illness you're quite intelligent aren't you?"*

Within Jenny's narrative, she positions her body as one of service user by drawing from some of the negative relations imbued within mental health distress, namely cognitive deficiency. Subsequently, she initially connects herself to a group of psychiatric bodies to maybe provide a firm platform from which to discuss her own transformation from that of 'typical' service user to a more 'socially unusual' position of 'intelligent' service user. There is movement and multiplicity here. Jenny holds onto to some of the strands within her designated membership within the meta-stability of the mass, but chooses not to hold onto to all elements emblematic within the pack (Bonta & Protevi, 2004). Jenny uses her past and present experiences to frame her spatial escape from the socially prescribed discourses of mental health distress to a new future or virtual ontological trajectory, of becoming-formally educated-service user within a new set of spaces which traditionally do not house service users (Coleman, 2008).

2.7 Some limitations of analysing affect

A brief pause is needed now to discuss some of the potential issues which have been muted when analysing affect, becoming and space. It has been noted that to analyse and subsequently represent embodied experiences of emotionality and feeling can lead to a closing off of experience rather than allowing the open-ended and fluid dynamics of potentiality ((Brown & Tucker, 2010; Cromby, in press; Thrift, 2004b). In this way, the relational spatial experiences together with the non-discursive can be positioned as a set of '*a priori'* entities simply waiting for the scribbling of the writer.

As soon as the typed words emerge as a discursive form there is the problem of *'decontextualisation and representation'* (in press). Cromby (in press) also draws attention to how the reliance on discourse is troubling when interpreting experiences and feelings – there may be some elements of sensuality that will get lost along the way. In this way, the elements of sensual feelings and affect can be dissolved and lost in the process and language of analysis. There is a potential problem that analysis simply becomes a reconfigured regurgitation of the spatial experiences of the actual and the virtual. Here *"affect replaces power as a catch-all descriptor…Analysis becomes re-description"* (Brown & Tucker, 2010, p. 10).

Nonetheless, Tucker (2010c) points out that affect is not merely a conceptual receptacle which can be unproblematically operated to produce a coherent body of data analysis. In other words, the selection and use of a particular extract of data for analysis in order to prove

the theoretical rigour of affect. Instead, the analysis of affect is concerned with tracing out an ontological framework from which analysis can be conducted or in this case how experience is spatially produced. This makes sense if we take the premise that analysing affect and the non-discursive can add another layer to the use of language (Brown, 2001).

For example, when I am interviewing service users who hear voices, I am at times aware that the voices are 'active' due to corporeal markers. This can be displayed in a marked hesitance when responding within a conversation, the clutching of hands, some other forms physical agitation such as shuffling in the chair and when participants talk back to their voices in addition to talking to me. What I can't see however, are the actions of misfiring neurotransmitters within the brain – all I can rely on is my own interpretations of what is happening at the time (with some corroboration from service users that indeed the voices are talking). But the analysis of affect is not concerned with containing such experiences by reducing events down to the biological or linguistic phenomena but more so, there is an interest here of how service users can spatially configure and reconfigure their own sense of self within events ((Cromby, in press; Gregg & Seigworth, 2010). This focus on space and mental health distress and difference is an important area to discuss further.

2.8 Exploring space and difference

"Translation is repetition with a difference. If meaning is becoming, it is a becoming-other."

(Massumi, 1992, p. 16)

There is a growing body of post-structuralist human geographers and psychologists who concentrate on the (re)production of spatialised experiences, whereby the interdependent actions of the social being constitute our social worlds (e.g. Thrift, 2004b; Tucker, 2010a). Here the key word is 'action' as space is neither viewed as static nor as an area consisting of fixed boundaries although there may be attempts to stablise the production of space either by structures or time (Thrift, 2006; Werlen 1993).

Crang (2005) takes this position up by discussing how daily life can be set up as a series of regularised cyclical temporalities such as getting up, having lunch, going to work (particularly within Western societies). This kind of cutting up of time and space into defined components has led Crang (2005, p. 208) to criticise such prescriptive notions where; *"…time is deployed as though it were a series of salami slices...a series of 'nows' that follow one after another in a sequence"*. With such critiques, there is a move away from representing movement and

space as both contained and distinct from each other to a focus on the merging of the multiplicity of heterogeneous spatial practices, social identities and senses of belonging (Murdoch, 2006).

Massumi (1992, p. 25) take this thread forward by illustrating the potentiality of space by asking the question of *"What goes into a school?"* Structurally, and in some ways the more stabilising elements are the solid borders within classrooms, the stationary blackboard the aisles leading to rooms and the time-tables when lessons and breaks commence and end. There is a flavour of a geometric solidity at this point. Taking the students as the performing contents within such a space and the school becomes far more complex and fluid. The range of ages and academic and social ability and the potentiality for these students create a series of heterogeneous movements of force based in the actual and the virtual. Consequently, a school cannot be reduced to a tangible entity but is instead a concoction of differentials. This kind of analogy can also apply to long-term psychiatric institutions.

Psychiatric institutions are largely constituted by the construction of wards, the placement of beds, the rooms of therapeutic intervention, the timings of meals etc. But it is the patients who have been admitted that can bring this space into disarray by the distribution of differing identities and potentials, of becoming-less-psychologically-disturbed-than-the-schizophrenics for example.

If we consider the following extract from Jackie (this is taken from the corpus of data analysed in this thesis);

> *"I've never been so terrified in my whole life, never been so terrified in my life and if you ever have a mental illness and you need to go into hospital and you want tender, loving care you do not need to be on a put on a psychiatric ward, excuse me, and it's the most frightening place (LAS=yeah) schizophrenics just suddenly breaking windows and attacking people and this that and the other and it's the most nerve-racking place and frightening place I've ever been in my life (LAS=yeah) (2) you know you want to sit on a nice, comfy sofa and feel safe with a blanket round you, that's what you need".*

In her narrative, Jackie describes how she felt terrified in a way she had not felt terrified before on being admitted to a psychiatric hospital. This space was frightening for Jackie with the risky and violent spatial production of the hospital by schizophrenics. What Jackie

wanted was to feel safe and comfortable and here we are given a strong sense that this space did not offer what she was looking for in terms of security. Although Jackie has been somewhat caught up in the spatial configuration of the ward and of the slicing of time, she has reconfigured this space as one that she does not belong to.

Jackie has translated that whilst she may belong to the same type of bodies in terms of discourse (in that she has been admitted as a diagnosed psychiatric patient) she is not mad enough to feel any sense of fitting into this space. It is the spatially (dis)organised milieu of the institution and the unfolding events where Jackie has transformed her own body as a new one and rejected the body which seeks to mimic or align with some of the other service users. More so she has moved to a different footing within the hierarchal structures of institutional life as somebody who is more able of containing her own behaviours in line with prevailing social norms (Massumi, 1992). This may well be because she feels she has more social and emotional control over her actions, Subsequently her account may be a way of exerting her power of psychiatric and somatic containment, of not being that mad. This is how she has framed her differential ontological realm to those with a diagnostic identity of schizophrenia (Tucker, 2010b; Werlen, 1993).

At this point, I would like to bring together the ideas thus far, not to form a coherent whole as such, but more so to bring together the ideas thus far. Now I want to explore where the action begins – namely in the middle; *"The middle is by no means an average, on the contrary, it is where things pick up speed* (Deleuze & Guattari, 2004, p. 28).

2.9 Deterritorialization and reterritorialization

The concepts of deterritorialization and reterritorialization are key concepts within the 'tool box' of spatial movement offered up by Deleuze and Guattari. The broader framework from which territories or spaces operate is based on stratification, whereby the seeds of codes and categories can produce a group of typified bodies such as service users as discussed in Chapter One (Bonta & Protevi, 2004). This kind of framework is termed a 'machinic assemblage' by Deleuze and Guattari consisting of the dominant discourses and discursive practices which can then envelop and stratify certain people. As noted in Chapter One, psychiatry is not only imbued but financially thrives upon the codes allocated to explain, understand and treat mental health distress ((Bowker & Star, 1999; Kutchins & Kirk, 1997). Such a systematic array of categories constitutes a 'machinic assemblage'. It should be noted however that this system of codings can only operate when there is a connection to a

receptacle (i.e. a formal diagnosis given to a service user), it is nether based on the social collective or the individual per se but requires a connecting flow of materials. The psychiatric episode, the psychiatrist's diagnosis, the administering of treatment, the ingestion of psychoactive chemicals, the excretion of traces of psychoactive chemicals, the monitoring by psychiatric provisions, the day to day living with these elements of mental health distress (Brown & Lunt, 2002). 'Machinic assemblages' operate based upon the elements of materiality and daily life.

Taking the historical perspectives discussed in Chapter One into account, we are presented with a contemporary system of codings and categories, treatments and cultural discourses and practices surrounding mental health. The types of classification systems such as the DSM are what Deleuze and Guattari (2004, p. 5) argue are forms of *'arbolic coding'* – or *'aborescence'*. These kinds of systems are bound up with the formation of the tree – a hierarchal set of codes creating a mass of binary logic, such as '*sane/insane, black/white, rich/poor'* this is "the image of the world-tree". As authors they argue that movement and life is far more multiple, lateral and circular than the dichotomised positions emanating from arbolic systems.

Drawing from this framework is pivotal in gaining an understanding of deterritorialization and reterritorialization. In turn, these concepts form the crux of Deleuze & Guattari's concepts of movement and potentiality. This may well be why Deleuze and Guattari only ask that the reader digests their first and last chapter as these particular chapters both set the scene and illuminate the continual translation of these dual concepts. Although it is worth noting that *"Á Thousand Plateaus' is conceived as an open system"* (Massumi, 2004, p. xiv). Thus this is not a book constituted with a series of chronological chapters with a linear trajectory of the traditional first chapter and concluding with the final chapter. There is no beginning or end, as this kind of bracketed off thinking (arbolic thinking) would go against everything that Deleuze and Guattari's theories are asking their readers to consider, namely that 'of becoming'. This is what the concepts of deterritorialization and reterritorialization are primarily concerned with.

As a concept, deterritorialization is a term used to denote movement, flight and change within a machinic assemblage. Reterritorialization is concerned with how the reconfiguration of movement during deterritorialization is subsequently territorialized in different and alternative ways. Therefore, this is not a top-down (or vice versa) process but instead change can cut

across in all directions through an assemblage to create new codes and territories of thinking and movement.

2.9.1 Territorialization

Discussing some territorializing aspects of service users would be useful before untangling the dual aspects of deterritorialization and reterritorialization. Territorialization with regards to this thesis (whereas Deleuze & Guattari used non-humans such as ticks as exemplars) is concerned with the ways in which certain groups of people can reconfigure and modify their experiences in line with a new set of codes which have been created to reflect the forms of knowledge relating to that particular grouping (Tucker, 2006). There is a link here with Hacking's (1999) *interactive kinds* in that post-diagnosis, service users reformulate their own sense of self and spatial movement in line with the discourses of psychiatry as discussed previously.

In addition, the media can capture and subsequently code elements of psychiatric discourses and feed into both service users and non-service users, with an emphasis on the diagnosis 'paranoid schizophrenia'. For instance, Wilson et al., (2000) studied how mental illness is portrayed within children's television. Their research found instances of linguistic references to mental illness in 46% of the episodes investigated. The discourses used within these programmes included 'nuts', 'wacko' and 'loony' with unusual behaviours displayed by these specific characters. Subsequently the relationship between unconventional bodily movements and mental health distress is subliminally reinforced (Pile, 1993). In a similar vein, Wahl's (2003) research indicated that within children's media, the majority of characters with mental health disorders were depicted as dangerous and aggressive.

The absorption of mental health discourses was investigated with young people from secondary schools in Scotland by Secker et al., (1999). This research found that some of the sample understood depression to be an everyday fact of life. This was a phenomenon they had direct experience of and therefore this diagnosis was not considered to be a mental illness. Conversely, perceptions of psychosis drew heavily on media representations which perpetuate the 'split personality' mythical status of schizophrenia, with some participants expressing fearfulness and the majority stating this diagnosis was a mental illness.

These types of discourses can then be taken up (or not) and consumed by diagnosed paranoid schizophrenics, other service users with a different diagnosis (with particular reference to Jackie's earlier account in the psychiatric institution) together with non-service users. This does not mean however that service users diagnosed with 'paranoid schizophrenia' always embody this diagnosis, but can create their own alternative diagnosis drawing from other 'less risky' accounts within psychiatric discourses.

Nevertheless with regards to the processes of territorializing experiences for service users the modes of classification, diagnosis, treatment, the probability of continuous psychiatric intervention together with the cultural discourses of mental health can become the over-arching set of productive processes from where experiences can emerge. Some service users can then rework and subsequently reframe their experiences in line with these territorializing forces. Here we are presented with some elements of a stable equilibrium in that albeit diagnostic categories and criteria can change over time, once printed and distributed psychiatric manuals such as the DSM can congeal service users as a solid mass (Brown, 2001). This can be the attraction with territorialization – the notions of similarity within a group of similarly positioned bodies.

But as alluded to above, there are differentials in service user's framing and coding of movement and embodied experiences. As Bonta & Protevi (2004, p. 37) note; *"organisms…beside stability display resistance, creative , so there is no servitude but symbiosis, the assemblage of heterogeneity as such."* This is where deterritorialization comes into its own.

2.9.2 The changing rhythms of deterritorialization and reterritorialization

Deterritorialization is concerned with change, with potentiality and becoming-other (Bonta & Protevi, 2004; Jones, Woodward, & Marston, 2007)). Deterritorialization is where bodies may break through the regulatory forces of arbolic codings within a 'machinic assemblage'. This process of moments may be almost imperceptible or with an equal force compared to the overarching domination of the assemblage, such as the conception of revolutionary movements (Brown & Lunt, 2002). As such, deterritorialization does not suggest that people have stable and static social positions prior to this process occurring but it is more so an ongoing sense of the continuity of flows of difference and becoming.

Taking this concept forward, people can follow some of the rules within a machinic assemblage or they can break through some regulations and formulate new arrangements which others can choose to adopt or not (Bonta & Protevi, 2004). Emblematic and physical processes can thus be reformulated by moving from one state to another, in terms of rapid movement, convergence and rest (Lorraine, 2006). In other words, deterritorialization is an on-going series of flux and flows as opposed to a continuum of equal speed. Deterritorialization is concerned with the modelling and re-modelling of interior and exterior milieus of identity and spatial configurations (Tucker, 2010e).

From deterritorialization and the formation of new patterns emerges the concept of reterritorialization (Bonta & Protevi, 2004; Doel, 2000). Reterritorialization is the reconfiguration of new symbolic, political, identity and space. Lorraine (2006, p. 165) points out that these sequences do not necessarily mean that people passively open themselves up to new reconstructions but that creativity is key within evolving contexts. Bodies therefore move and change with other bodies that *"can affect or be affected by them"*.

Consider the following extract (taken from my corpus of research data). Jim has a psychiatric diagnosis of paranoid schizophrenia and has been in formalised services for nineteen years. In the following account Jim discusses an event, an encounter he had prior to our interview. It is worth noting that Jim would usually arrive at the day centre recalling the same sequence of events which led the staff at the day centre to position these instances as forming part of his psychiatric symptoms of experiencing paranoia. The presentation of paranoia as a psychiatric set of symptoms is characterised by Cromby & Harper (2009, p. 335) thus; *"Paranoia can be defined as a way of perceiving and relating to other people and to the world that is characterized by some degree of suspicion, mistrust or hostility…degrees of paranoia inhabit many everyday social relations"*. What I would like to explore in the following account is how Jim's experiences are deterritorialized from the dominant discourses of paranoid schizophrenia as discussed earlier and reterritorialized to align to his own constructions of this diagnosis.

> *Jim - I've settled down a bit now so (LAS=OK then) I'm not so stressy (sic) as I was spat at a little while ago*
> *LAS - So who spat at you?*
> *Jim - This same yobbo who had me like last year (1) up the chemist's up here (points) (LAS=yeah) just round the corner near the traffic lights he spat at me*

and I said and he said to me that nobody would catch him and I said they've got cameras and they're all get you mate
LAS - Is that CCTV?
Jim - Yeah and the police well I haven't seen the police since three weeks now (2)
LAS - Yeah because didn't they threaten you the other day?
Jim - They did um knife with me throat and they wanted two hundred quid and spat at me and I told Penny (member of staff at the day centre) and she said, you know Penny don't you (LAS=yeah) and she said there's no need for it and they shouldn't do that to ya cos' you're kind hearted and I am
(1) (LAS=yeah) and I've never been the same since (starts to cry) me illness (sniffs) I've been suffering thirty years with these voices and it's not nice…

This sequence of events for Jim can appear to be somewhat habitual in that his narrative of these encounters is not based on the singular event but is more so enveloped within a series of similar occurrences. Here we have a system of physical (the spitting, the attack with a knife), symbolic (of the vulnerability of mental health distress) and spatial (the chemist, the CCTV camera) processes. Jim presents a conscious account of these events and anchors these in spatial orientations. In this way, Jim is temporally part of a set of regular patterned forces which have captured and territorialized his experiences within the realms of paranoia, but this is his version of paranoia. These events are distributed and enacted across his spatial and psychological milieus – Jim is a vulnerable, paranoid schizophrenic, he is not dangerous and unpredictable. Jim is the person who is abused and violated. He is part of the formation of *"new socio-political landscapes"* where his interior and exterior milieus seek to establish he is not the atypical paranoid schizophrenic as oft cited in the media (Tucker, 2010e, p. 2).

It is useful to note that these concepts have been positioned in the above writing as demarcated areas of movement and performance. Here we are presented with a neat trajectory of going from a) territorialization to b) deterritorialization and arriving at c) reterritorialization, only to start the process again. As part of the process of potentiality, there is a sequential diagrammatic pattern of events and spatial performance but of course we must also be aware that blockages can occur. Jim for example might not be mindful of the wider cultural discourses surrounding paranoid schizophrenia so there may be no set of psychiatric codings that he seeks to momentarily escape. This kind of position raises questions about Jim's shifting narrative as being positioned as essentially internal but this is not the intention.

More so, what is being explored here are the ways in which a diagrammatic topology of how the discourses and discursive practices of mental health and vulnerability can feed and weave in with the non-discursive (the chemist, the spitting). What we are presented with here is the shifting of spatial and social identity movement per se within a series of fluctuating self-performance when interweaved with other actors.

2.10 Knotting the threads

Bringing the concepts of affect, (emotional and somatic experiences), of the actual (lived experience), the virtual or potential (that which could happen) together with the spatialised production of mental health together, within Jim's extract we are presented with becoming-victim. Jim's journey is discursively rooted within his everyday spatial neighbourhood and movement - this is his route to his day centre. He punctuates and anchors the landscape by pointing out that there is a chemist on a corner near the traffic lights with CCTV nearby. Here the experiences are interactional between human (Jim) and non-human kinds (the corner). They form a crucial part of the pattern of Jim's account by offering a recognisable context from which to unfold this own narratives which may be part of the symptoms of his paranoid schizophrenia, which are not so widely understood.

However, even before he sets out the door, he is captured within the assemblage of psychiatric practices as he is a diagnosed service user who is setting off to a spatiality designated for mental health, the day centre (the day centre is explored further in Chapter Five). Nevertheless, to some extent, he usurps and destabilises the cultural notions of paranoid schizophrenics as being violent bodies by offering a deterritorializing experiential account away from these dominant frameworks.

We are then presented with a plethora of 'actual' human interactional experiences, of being spat on and attacked with a knife, which are subsequently bound up with the virtual non-human elements of the criminal justice system (the lack of contact by the police and surveillance). Here Jim is constructing a narrative of vulnerability, he wants the help of other bodies, Penny and the police as he is kind hearted and cannot enact reterritorialization alone. At this particular milieu, Jim is in the flows of becoming-victim.

But threads can break and fracture and attach to other fibres. I could interview Jim now and his accounts may well be different, he may well have become part (willingly or not), of a

process of the continuous deterriorialized and reterritorialized experiences within other spheres. He may not attend the day centre or even be part of psychiatric services and he may have turned on his attacker and become-perpetrator-of-violence. The thing is, I don't and can never know what becomes of Jim, where is potentialities lay in the future. This is why the middle is where the action begins (Deleuze & Guattari, 2004). I did not know Jim before this project and the probability is I will not meet him again now that the research data collection has finished. This is important to flag up as this work does not seek to tell a coherent and static story – it is not my intention to stratify Jim as a body enmeshed within the constructions of vulnerability and paranoid schizophrenia.

2.11 Discussion

In this chapter I have provided more "meat to the bones" in terms of discussing the theoretical concepts utilised within this work. I have outlined that the term 'space' will be used within this work as a means of conveying movement and dynamics as opposed to positioning space as static and contained. The term place will be used to discuss temporal lived experiences within specific structures i.e. psychiatric institutions, mental health day centres and home.

The concept of 'affect' was introduced and discussed as offering another analytic layer with the dominance of the socio-linguistic turn in qualitative methodologies (Cromby, 2011). For example, discursive constructionist can be limiting in that assumptions of self and group identity can then be stratified and stultified as bracketed off from emotional experience and change (Thrift, 2004a). Subsequently, this work is concerned with the multiplicity of the spatialised productions of mental health distress, of the divergent ways in how service users experience identity and context (Brown & Tucker, 2010). As discussed in Chapter One, this means a move towards utilising discursive and non-discursive concepts of expression and content or more specifically by adopting Deleuze & Guattari's approach to affect.

Deleuze & Guattari's theoretical concepts offer an array of tools from which to analyse movement, change, transformation, performance and potentiality (Cromby, 2011; Thrift, 2004a). Affect is not a static concept. As a theoretical approach affect does not seek to suspend people as being inanimate and contained within certain discursive and spatial frameworks. Instead, a primary concern is on the reconfigurations of experience and in the case of this work, the multifarious ways in which service users make sense of their own everyday experiences of mental health distress. Hacking's (1999) offering of *'interactive kinds'* was introduced as a vehicle to discuss how people, when classified or in this case

diagnosed, can reformulate their experiences in line with the cultural meanings around psychiatric classifications. The limitations and problems of analysing affect and potentiality were also flagged up. In that to capture sensuality and spatialised production assumes that experiences can be positioned as tangible entities simply awaiting analysis (Brown & Tucker, 2010). However, the analysis of affect is interested in teasing out ontological narratives – of how service users discuss their own sense of self (Tucker, 2010c).

Space was important to discuss as there is an abundance of research literature which focus on exclusionary spaces and inequalities of access to community space for minority groups such as service users ((Painter & Philo, 1995; Parr, 1997). It was highlighted at this juncture that post-structuralist positions afford a more fluid and multiplex framework from which to explore spatialised production. Whilst there are attempts to stabilise structural spaces by the use of walls and designated rooms and more particularly within institutional and semi-institutional buildings such as schools and day centres. It was noted that it is the divergence of people who habituate spaces - it is the potentiality of those inhabitants who create the heterogeneous movement of differential potentialities.

These variants of movement were teased out further when Deleuze & Guattari's concepts of deterritorialization and reterritorialization were discussed. By drawing together the cultural discursive frameworks of mental health distress (i.e. the DSM, the media representations) and the material elements of service user life (the ingestion of medication), I discussed the 'machinic assemblage' as a conceptual tool which positions certain groups of bodies as sharing typical traits and experiences (such as a diagnosis) (Bonta & Protevi, 2004) . The correlative concepts of deterritorialization and reterritorialization were introduced. Here we have movements of change whereby the codings within a machinic assemblage can be fractured and splinters of movement and change can be reterritorialized with new meanings and new possibilities of movement and identity. To reiterate, it is the movements of change, transformation and spatialised production together with the potentiality of becoming-other which are pivotal to this work. In Chapter Three I will discuss the methodological approach of this thesis together with the research data collection procedures involved, ethical considerations and reflexivity.

Chapter Three

Methodological and Analytic Considerations

3.1 Introduction

> *"There has been debate about whether or not qualitative and quantitative research methods can complement one another…We believe that the larger issue is the philosophical frame within which one utilizes methods; that is, one's epistemological and ontological frame."*
>
> (Elliott, Fischer, & Rennie, 1999, p. 125)

In the above quotation, Elliott et al., (1999) posit that the choice of research methodology should reflect the aspirations of both the researcher and the intended project focus. These factors are important in order that the project not only maintains a high sense of coherence but that the course of direction from the outset is clearly defined. In this chapter I will discuss the underpinning epistemological objectives of this project together with the resultant choice of methodologies utilised. Consequently, the issues of methodological viability together with the overall philosophical framing of this thesis will be evaluated.

The main thrust of this thesis was to explore the narratives of spatial production from a service users' perspective within everyday spaces (psychiatric institutions, day centres and the home) using one-to-one interviews. To add richness and analytical depth to this method of research collection, visual ethnographies of home spaces were undertaken by two participants (the challenges of this particular method are discussed later in this chapter) together with my ethnographic accounts of performance and movement within day centres. This brief overview will provide a framework from which to unpack the methodological trajectory within this thesis to use qualitative methods.

3.2 A background to dominant mental health research methodologies

There is an abundance of epidemiological research literature which serves to medically classify and subsequently treat mental health distress as a biologically derived illness (Bentall, 2004; Cooper, 1970; Double, 2001). Predominantly focusing on clinical and quantitative methodologies, mental health distress can be reified as a discrete pathology which can be effectively managed primarily by the use of pharmacological intervention. As a result hypotheses including genetic endowment (Gottesman, 2001; Sherrington et al., 1988), neurological disorders and abnormalities of brain structure, (Kohler et al., 1998; Lawrie et al.,

1999), cognitive deficits (Bentall, 2004; Lang & Buss, 1965) and a combination of biological and environmental factors (Sugarman & Craufurd, 1994) dominate the research landscape of mental health. Whilst undoubtedly this research can be beneficial in terms of seeking to potentially treat and cure certain medicalised conditions, the variety of these hypotheses indicates that a divergence of opinion is prevalent when discussing the causality of mental health difficulties. Consequently, there is no one biological paradigm that can explain why some members of the population experience chronic and acute episodes of mental health distress whilst others do not.

Another point worthy of raising is that by solely applying quantitative methods to understand this complex phenomenon, mental health distress can be widely situated as a measurable and objective clinical entity (Lynch, 1992; 2004). Lynch (2004) further argues that mental health is treated much in the same way as biochemical conditions such as diabetes. In other words, mental health distress is widely positioned as a standardised physical, biological 'illness' which is then treated using standardised physical, biological treatments. Placing this premise within common practice, Lynch argues that biochemical illnesses such as diabetes are diagnosed and continually managed by using established laboratorial tests. Conversely, he notes that neither psychiatrists nor general practitioners carry out biochemical tests to assist with the diagnosis or treatment of mental health problems. For Lynch, by purely adopting a medical approach in relation to mental health distress, there is a fundamental failure by psychiatry in negating heterogeneous forms of human expression and experience.

In as much that Lynch's claims are aimed primarily at psychiatric practice, it is feasible to apply the principles of his arguments when discussing research methods. Arguably, the principal criticism aimed at the use of quantitative methodology, especially within the realms of exploring human experience, is that of generalising resultant data as universally applicable (Flick, 1998; Willig, 2001). Subsequently, by placing these tenets of quantitative methodologies within the social context, there is always the danger that service users will be positioned as a largely homogenous group of people (Elliott, et al., 1999).

In direct contrast to the above experimental positions but indeed arguably pertinent to the plethora of the 'scientific' and 'objective' research undertaken are the criticisms put forward regarding the purpose and outcome of such studies. Those critical of contemporary pharmaceutical and psychiatric practices rightly ask questions such as "Who is the main benefactor of biomedical research?" "What about the negative side effects of medication?"

and “Why are complex social and environmental problems ignored in favour of medicalising mental health as an organic disease?”

In this vein, some claim the existence of an imbalance of social, economic and political power which is enjoyed predominantly by the pharmaceutical companies, and psychiatrists who actively set the mental health research agenda (Double, 1992; Moncrieff, 2003). It is argued that this imbalance of power can be at the physical and emotional cost of those people they are trying to help, namely service users (Double, 2001; Moncrieff, 2003). The vast amount of profits to be made by the production and marketing of an ‘effective’ medication neatly ignores other areas of help such as counselling, self- help programmes and forms of therapy (Double, 2001, 2002; Moncrieff, 2003). This negation serves to increase the imbalance of psychiatric power over that of psychology (Smail, 1995).

3.3 Moving towards qualitative service user research

Taking the above positions forward, Foucault (1965, p. xiii) succinctly argues that not only does psychiatry dominate the psychopathological landscape but he also highlights the negation of service user experience within this particular realm;

> *“In the serene world of mental madness, modern man no longer communicates with the madman…The language of psychiatry, which is a monologue of reason about madness, has been established on the basis of such a silence.”*

To further understand the complex and multi-layered aspects of older service user life would be difficult to achieve by the means of quantitative methodology. For example, whilst it could be argued that the one thing common to all service users is enduring mental health distress, this approach remains somewhat reductionist in content as there are numerous forms of mental health distress which may bear no correlation in terms of symptomology and prognosis to each other (DSM-IV, 1995). It cannot also be assumed that all service users have a similar social background and hold comparable cultural values (Bracken & Thomas, 2001; Roberts, 2000). As a key tenet of qualitative research is to explore and represent the individual experiences, motivations and actions when combined with various social contexts (Elliott et al., 1999; Parker, 2005) this choice of methodology is deemed the most appropriate for the valuable dissemination when reporting the findings of this work.

With this in mind, this research drew upon previous studies whereby the daily lives of service users were explored and analysed using qualitative methodology with an emphasis that research should be undertaken from the perspective of those who use mental health services (Canning, 2006; Tucker, 2006). However, it should be noted, this cited research did not primarily focus on old age and mental health distress. Furthermore, it has been claimed that older service users are largely ignored within governmental, practitioner and academic research together with the prevention and treatment of their mental distress (Jolley, Kosky & Holloway, 2002; McCulloch, 2006). In an effort to redress this imbalance whereby the current research literature on older service users is sparsely represented, this thesis aimed to enrich this area further.

3.4 Participants

One of the important aspects for engagement within this work was that that all service users were aged 50 years or above. This age restriction was seen as important and valuable in terms of exploring an under-represented community within the research arena of psychiatric services (McCulloch, 2006). Other factors with regards to researching older service users were also of interest such as generational differences (between current younger service users) whereby service users in the 1970's/1980's did not have nationwide access to specialist services such as Child and Adolescent Mental Health Services (CAMHS) (Black & Gowers, 2005). This lack of resources prevalent at that time, could potentially impact on how service users perceive their past and current engagement and treatment within current psychiatric provisions. As an example, two participants had been resident within a psychiatric institution (Harry's experience is discussed further in Chapter Four) for a long period of time and the intimation was that they would still be resident there if the 'care in the community' programme had not been introduced.

In terms of exploring the everyday spaces of service users, the inclusion and experiences of older service users was seen as integral to further understand the ways in which space is negotiated from a mature perspective. With regards to attending a day centre it was noted that the majority of service users in attendance were aged 50 years and above. This may well be because that many older service users (with enduring mental health distress) have been long-term unemployed and have been in receipt of State benefits for large periods of their adult life (Gould, 2010). This lack of financial means[22] can in turn restrict access to engaging in wider

[22] The negative impacts of financial constraints was a point of discussion with all participants

social networks. This is where the day centre can become the pivotal structure for service users to spend some time out of their residential environments. Of note, however, is that some of the day centres within this research project were not open every day in the week and none of the centres opened during the weekend period. Here, the residual spaces of the 'home' became of interest as this was the space where most time was spent due to lack of funds to enable going out and, in some cases, physical impairments associated with ageing (e.g. arthritis, incontinence) prevented older service users from venturing away from these spaces to more publicly accessible areas.

Together with the above age-related research inclusion criteria, it was also valuable to gain the experiential accounts from service users who had received some form of psychiatric treatment for enduring mental health distress. For all participants these treatments were ongoing. However, it would be pertinent to point out at this juncture, that although any prior clinical knowledge of participants was not important to the outcome of this work it should nevertheless be appreciated that some people who attend mental health day centres are not classified as 'service users' per se. For example, some day centre attendees who suffer solely with long-term learning difficulties and diagnostic specific behavioural problems such as those prevalent within the autistic spectrum of disorders will almost certainly have faced challenges and obstacles during their life experiences but they are not grouped as service users (by other service users, staff and themselves).

To further clarify this distinction, the members of day centres I attended with learning difficulties alone did not come into contact with formalised psychiatric provisions. These particular members did have support from the day centre staff and other governmental services such as social services but their needs are qualitatively different to those within psychiatric care. As it is the self-reflections of long-term, mental health service users which are pivotal to this work those people who had received no treatment whatsoever due to functional, psychiatric ill-health were not included. This exclusion also applied to the degenerative diagnoses of all forms of dementias.

3.4.1 Accessing participants

As the purpose of this study was to unravel some of the challenges facing older service users in the community, participants were all sourced from MIND charitable day centres within the East Midlands area. All day centres were sourced via the official MIND web-site and

Managers were contacted by telephone to request a meeting to discuss the research project and the methodological process. Thus, there was no contact with psychiatric services provided by the National Health Service or private clinical institutions. In total five day centres were visited and overall twenty-one participants, 10 females and 11 males took part within the interview research data collection. 2 male participants undertook the visual methodology whilst 3 male participants did not finish this element of the data collection due to their non-attendance at the day centre (this issue is discussed further in the following section).

3.4.2 Challenges in Accessing Participants

Other observations made during the data collection which precluded the involvement of others should be briefly flagged up. One participant was an alcoholic who spent over ten years living on the streets. Whilst at the time of the research data collection he had been housed he still preferred to live on the street. Four dates were made for an interview to be undertaken and on three occasions he did not show up to the day centre on the agreed days. On the fourth date, he entered the day centre in a drunken state with two cans of 'Special Brew'. He had already been ejected from another day centre due to his inebriety and called me a 'fucking whore' on entering the centre and I did not feel comfortable interviewing him. Consequently, this participant did not take part in the research project.

With regards to the day centres, one centre was burnt down as a result of an arson attack, two day centres closed down due to lack of funding. The main challenge however was the introduction of the 'direct payment' and 'personal budget' schemes to service users. Briefly, at the start of the data collection, day centres were funded by local authorities and raised additional funds via charitable activities and donations. Service users had 'free' access to day centres as a result of this funding. The introduction of the direct payment scheme intended to give service users more choice in accessing community care services by allocating a set amount of annual funds (the personal budget element) directly to service users. These funds were based on assessing the individual needs of those concerned. The impact this had on day centres was that their allocated funding by the local authority was cut by 40% during the summer of 2009. At that time, service users had not been assessed and in order that the day centre could operate, service users were asked to pay £15.00 for each drop-in or activity session they attended. With the vast majority of service users living on state benefits they could not afford to pay this amount. Consequently, the day centres were largely unused during the final stages of data collection. (The implications of the 'direct payment' and

'personal budget' scheme on the spatial production of everyday service user life are discussed further in Chapter Eight).

3.5 Service users as research collaborators

The added value that can be gained from the active involvement of engaging service users in the roles of researchers and/or consultants within empirical research has been the subject of much discussion ((Beresford, 2000; Coleman, 2001; Goodare & Lockward, 1999; Trivedi & Wykes, 2002). Service user research involves the collaboration between a researcher or research team and service users. The over-riding aim when including service users as part of a research team is to allow service users a 'say' and a direct involvement in how research about their particular community is conducted, analysed and written for dissemination purposes. However, this position in itself is not one that can be treated as a discrete pathway as there can be problem areas which need have to be addressed before this route can be taken. For example, parameters need to be established of how much involvement is feasible within time and financial constraints, what formal research training needs to be given and more contentiously perhaps, the level of power devolvement submitted by the researcher to the collaborator(s) concerned. Carr (1999, p. 269) reiterates this important point thus: *"A crucial finding relating to the power dynamics within the process of service user participation then, is that a degree of conflict seems inevitable…"* By conflict, what is meant here are the ways in which research collaboration may result in tensions arising between the primary researcher and the research collaborators when the allocation of specific tasks and necessary timescales can create feelings of potential anxiety and discomfort within the team.

Taking some of the above points forward it was decided that direct user involvement would only encompass the mutual production of an interview schedule together with gathering feedback on the preliminary analysis. This decision was based upon the knowledge and experiential discourses that users could bring to enhance this part of the research process, whilst not impinging upon the time needed to transcribe, analyse and write up.

Goodare & Lockward (1999, p. 724) suggest that; "*We need to recognise that …users…have the experience and skills that complement those of researchers…They will have a good idea of which research questions are worth asking, and when a question should be framed differently*". Whilst it can be appreciated that this fractured approach seems to afford users a limited level of 'lip service' within this project (Trivedi & Wykes, 2002), the pragmatic

limitations (financial and time constraints) within this research project did not easily lend itself to a more comprehensive collaboration .

As the fundamental objective of this research was to explore the spatial production of everyday service user life, it would seem pertinent from the outset that service users were involved in as much of the initial development of the research objectives as possible. This was seen as important because service users could advise on question areas to be included on the interview schedule (Appendix One) that had meaning for them and for other service users they knew.

It is worth noting at this point that some issues pertinent to daily service user life were not explored within this thesis. Service users were only invited to discuss the main spaces in which they spend the majority of their time, i.e. the home, the day care centre. The broader relationships service users had within their community settings was therefore not a focus within this research project. In addition, participants were not directly asked what medication they were taking and their experiences within formalised psychiatric services at the time interviews were undertaken. These factors were not included to allow a more in-depth narrative around the key areas discussed within this thesis such as the experiential spatial and emotional accounts within psychiatric institutions, the day centre and home spaces.

In this way, the draft interview schedule (originally provided by me) was discussed and adapted to include further questions as advised by service users. Four service users were asked to provide advice and suggestions on the questions to be included in the interview schedule. All consultants were provided with a Participant Information Sheet (Appendix Two-a) and asked to sign an Informed Consent (Appendix Two-b).

3.5.1 Interview schedule

The interview schedule (Appendix One) embraced a psychosocial approach whereby issues such as everyday life and routines, living arrangements, employment, medication and benefits were explored together with the self-reflections of how these variables directly affect the self-identity of the service user. Additionally, questions also encompassed areas of physicality in terms of mobility, use and awareness of everyday spaces.

A key area for spatial analysis was the day centre. Therefore, questions surrounding the day centre were initiated by asking practical questions such as "How did you come to be involved in this support group?" Whilst responses within this set of questions may well elicit details relating to other factors of life experiences, their main purpose was to serve as an 'ice breaker' as such questions can lead towards a more emotive and intimate account of the day centre. By following this trajectory the day centre was not positioned as a static place consisting of bricks and mortar but as a valuable area for research purposes. What was trying to be established here was how the day centre made an individual feel both physically and emotionally within varying social contexts. This was a multiplex phenomenon to explore as service users' wants and needs from this space fluctuate in line with expressions of 'feeling unwell', 'feeling social' or 'needing support and friendship'. It was also appreciated that these fluctuations may have been a result of other issues outside of this particular domain which nevertheless directly impacted upon the experiential discourses of this space. These were important factors that needed to be contextualised within an individual's unique social milieu to further understand some of the challenges facing older service users in community care. Consequently, the questions included issues surrounding everyday routines, living arrangements, relationships, employment, practical and emotional support, and medication.

3.6 Interviews

In order to explore the experiences and life stories service users have to tell regarding their everyday lives, in depth, one-to-one semi-structured interviews were undertaken. Previous research has posited this type of interview as the most appropriate for interpreting and representing an individual's experiences and actions (Burman, 1994; Elliott et al., 1999; Flick, 1998). This methodology was undertaken to encourage participants to actively engage in a mutual process to allow a more reflective and in-depth discussion of not only how they see themselves but also how they view their social dimensions as a whole.

All interviewees were given a Participant Information Sheet (Appendix Three-a) outlining the nature of the study. This documentation was discussed in depth to ensure that participants understood what participation would entail and to also assure participants that confidentiality and anonymity would be maintained and that no question needs to be answered. This time was taken to make participants aware that taking part in an interview within the research project was an autonomous decision made by them. When both parties were happy to

proceed further, participants were asked to sign an Informed Consent (Appendix Three-b) to confirm that they both understand and were willing to commence with the interview process.

Eleven participants were interviewed once, seven participants were interviewed twice, one participant was interviewed four times and one other was interviewed five times. This was a valuable way of collecting data as participants who were interviewed more than once, seemed more relaxed to discuss issues at length and showed greater levels of interest in the research project. The use of repeat interviews also offered a better understanding when undertaking the ethnographic element of the research data collection as I had come to know these participants (as they had come to know me as well) at a deeper, more intimate level. This added another layer of observational and analytical interest when narratives were transcribed in conjunction with the research diary notes being written up. One participant withdrew at the time of recording the interview but contributed to the interview schedule content via myself writing down his comments and suggestions. The reasons for conducting more than one interview with participants were due to availability, a willingness to engage in this research and my own desire to explore some areas in more detail with participants that I had spent considerable amounts of time with (over a period of four weeks of informal chatting without a digital recorder).

3.7 Non-discursivity

Discursive and visual methodologies were used to explore the observable spatiality and meanings of content of areas and objects within home spaces. Rather than position such accounts as meaningless within human experience, I will draw on the constituents imbued within non-discursivity. Tucker (2006, p. 77) is useful by succinctly postulating non-discursivity thus: *"…what is taken here as non-discursivity are the objects…that form our everyday environments, and things that make knowledge and experience visible."*

Here Tucker seeks to untangle the complex relations between the content/object and how these spatial experiences can be expressed. Nonetheless, this does not necessarily mean that space remains a static artifact in terms of non-discursivity as changes of configuration, whether relational (in the human sense) or elemental (in the content sense) can produce a different set of non-discursive practices (Brown, 2001). As Deleuze & Guattari 2004, pp. 49,50) suggest; *'Content and expression are two variables of a function of*

stratification…They are only defined by their mutual solidarity". Here stratification or the formation of the layering of experiences, are constituted by these varying configurations.

In this way, non-discursivity offers ways of exploring the myriad ways in which the seemingly fixity of space/objects and the more rhythmic feelings they can evoke proceed through a series of divergent states. They are constantly in a state of flux and flow and for the purposes of this work the layering of space is positioned as continuously on the move. Spatial atmospheres, in terms of gaseous matter and the more ephemeral, differing tensions people can seem to intuitively feel as a psychological and physical phenomenon can never be the same. We can never return to that space and feel exactly as did before. Each time we open our front door the content and expression of our home space is different. However much effort we make to anchor this space as stable, we are always absorbing different practical and emotional elements of daily life, we are always shedding our bodily skin.

Affect, continuous movement and flows within spatial locations as a process of potentiality requires a different form of analysis from relying on the 'linguistic turn' alone. That is not say that language has not importance here but more so a different analytical way of thinking is required to further understand how services users experience their everyday spatial production. Here we have relational elements of the human and the non-human, e.g. the day centre spaces and objects, whereby analysis looks to explore how service users negotiate these various elements. Non-discursivity offers a framework of analysing these areas by placing the focus on how the human and non-human constituents of everyday service user life are never static or stable. They are always on the move and in a flux of change although it is appreciated that the written words within this thesis can only provide a freeze-frame of movement and potentiality. Nevertheless, non-discursivity provides a way of thinking about these particular areas which are largely ignored within the psychological literature.

3.8 Visual methods

Historically, visual methodologies as a means of capturing data within the social sciences has been relatively under used within the realms of qualitative social science research (Bolton, Pole, & Mizen, 2001; Prosser, 1998) and even less so when participants have been given autonomy to record their own imageries (Bohnsack, 2008; Hurdley, 2007a; Knoblauch, Baer, Laurier, Petschke & Schnettler, 2008). However, with the rapid emergence of new

technologies, this method is now gathering momentum as a contextual aid to interpret material culture and social action (Prosser, 1998).

Within the parameters of my research project, the use of visual methodology was advantageous in adding another 'layer' of data on service user life. It was the places outside of day centre that were of interest within this part of the research and more particularly, within the contextualised spatiality of the home. Research has indicated that older people are more inclined to spend time within their household (or places of care) than anywhere else (Tucker, 2010a). Consequently this area was of specific interest to gain a further insight into the strategies employed by older service users in understanding the constituent nature of how a large portion of everyday service user life is produced and continually (re)produced.

Participants had sole access to the camcorder/digital camera for a period of 2 weeks followed by an interview session to discuss which images they have selected to shoot and the reasons why. By using this more interactional methodology, this research aims to illustrate important spaces and objects within a service user's everyday life. Participants were provided with an information sheet which gave an outline of where they could shoot footage and take photographs, i.e. 'places within the home' or 'favourite object(s)' (Appendix Four-a). This sheet was for guidance purposes only and participants were advised within the text that they did not have to include areas that made them feel uncomfortable.

The participants who engaged in the visual methodology aspect of the research were selected by myself based on criteria including being at ease with technology and an indication of being open and conducive to a potentially more intimate and personal method of data collection. All participants were given a Participant Information Sheet (Appendix Four-a) and were asked to sign an Informed Consent (Appendix Four-b).

With regards to the visual data collection, one participant was provided with a handheld camcorder and shot footage around his home. Another participant was provided with a digital camera and took photographs around his home and neighbourhood. Three other participants were provided with disposable cameras to take photographs around the home but did not attend the day centre in order that collection and an interview could take place.

Initially, it was hoped that a video camcorder would be the optimal way to gather visual data but some issues arose with this equipment. Firstly, one other participant found the device

complicated to use and, in addition, could not easily manipulate the buttons due to physical impairment. The use of a digital camera was then seen as a preferred option and this was successful with one participant. Nevertheless, for other potential participants the carrying around of such equipment was seen as making them more vulnerable to mugging and attack within their community (as advised by the day centre staff). The use of a disposable camera appeared to be an option to counteract this. Taking visual images was also problematic for five of the participants who lived in supported accommodation whereby the photographs of others would have impacted upon ethical considerations.

3.9 Ethnography

Ethnography is a useful and informative way of exploring group interactions by the means of immersing oneself within a particular community over a period of time (Hammersley & Atkinson, 1995). Historically, ethnography has its roots in the field of anthropology (see the early works of Margaret Mead for example) which sought to explore cross-cultural ways of living. These kinds of works have caused some criticism in terms of arguing that ethnographic researchers have to some extent presented their findings in an *'ethnocentrist'* way, by presenting a different cultural and socio-political case study as a comparable to their own, resulting in a polarization of *'them and us'* (Krupat, 1992). At some level, these kinds of arguments make sense, as to spend time with communities does not give one unmediated access to their experiential accounts. There is a series of divergent tensions, in terms of cultural and social understandings between the values and norms of the ethnographic researcher and those who are being researched.

Likewise, this argument applies to my own ethnographic research. I am not a service user and can never fully understand the spatial production of living with mental health distress. I can only act as a discursive mediator and an 'outside' observer of service user spatial movements and performance. In addition to the primary focus on ethnographic observation (Taylor, 1994), this particular research method is also involved with collecting many forms of other research medium, i.e. personal documents, poetry and art (Hammersley & Atkinson, 1995; Wolcott, 1999). The use of poetry within this thesis was one way in which a service user could engage with the research project without the necessity for an interview or undertaking the visual method of exploring their personal experiences.

Conducting an ethnographic research of daily living within a group setting and, here I mean within the day centre only, was valuable in adding another layer when exploring the everyday life of service users. A conscious decision was made early on in the research data collection to spend a period of four to six weeks in each day centre before undertaking any one-to-one interviews. This might appear to be a time-consuming choice but this time proved beneficial in terms of trying to 'fit in' and break down some social and power related barriers which may have impeded on the quality and depth of the interviews.

It should be noted, however, that only one extract from my ethnographic research diary has been used in this work. This was largely because the interview and visual data was rich in experiential content but there was one strand of the research focus which was difficult to obtain via these methods. The potential issue of service users' 'othering' within 'otherness', of isolating and excluding some service users in the day setting, was visible to me in some day centres as an observer. Nevertheless, these discriminating behaviours were not discussed during the interviews (except by one participant – see Chapter Five) whereby participants discursively situated their own day centres as consisting of a strong collective of mutually accepting individuals. This reticence to discuss some of the more observable negative behaviours may well be why Parr (2000) undertook a covert ethnography to explore the exclusionary spaces within day centres.

This fracturing of space and social interaction and more especially towards those who displayed unusual and unconventional forms of bodily behaviours (i.e. talking to themselves, shouting, rocking and 'grimacing') was often used as a way to isolate certain individuals. Consequently, the one ethnographic extract used in Chapter Five was seen as an important element to include in further exploring the contradictions and tensions that can be a constituent of the everyday movement and performance within the day centre setting.

3.10 Reflexivity as a methodological tool

The importance of researcher reflexivity is highlighted by Parker (1994) in claiming that our own subjectivity as a production of historically bound practices directly impacts upon the research process. Finlay (2002) reiterates this point by suggesting that most qualitative researchers will acknowledge their own subjective role within the research process by making their own social constructions of phenomena transparent. In this way, the researcher is aware that: *"…research is co-constituted, a joint product of the participants, researcher and their*

relationship. We understand that meanings are negotiated within particular social contexts so that another researcher will unfold a different story" (Finlay, 2002, p. 212).

In terms of mental health this can present a myriad of divergent understandings and (re)constructions. As I have outlined in Chapter One and Two, there are many ways in which madness is positioned within our contemporary society. With this in mind, my own self-references relating to mental health distress were pivotal in the final execution of this thesis. Both in the ways I as a subject engaged with the research matter and the resulting analytic processes I employed. However, caution needs to be exerted at this point to ensure that reflexivity is not purely a narrative about revealing a multitude of my own personal positions but more so that my reflexivity will seek to frame the ways in which I have interpreted the data within this work (Finlay, 2002). Consequently, my own self-reflections were recorded (via a research diary) regularly as emergent challenges and opportunities presented themselves and how these subsequently impacted upon my research journey.

Nonetheless, just as importantly, I would like to discuss my own historical, largely negative values and views of mental health distress before this research was even conceived. It would be supercilious to suggest otherwise. If I take the diagnosis of schizophrenia as an example, I was certainly influenced by the disparaging media representations who sought to portray the schizophrenic as being dangerous and unpredictable due to the populist notion of the 'split personality' being a symptom of this particular classification. For example, prior to undertaking this research I was aware of my sense of potential uncertainty when conducting a one-to-one interview in a separate room and as alluded to above, more specifically with a participant with a diagnosis of schizophrenia. However, there were occasions when I was not even aware that a participant had that particular diagnosis (even though the staff advised me otherwise after the interview). Even when I was aware prior to the interview that a participant had a diagnosis of schizophrenia, I did not find that I felt any heightened levels of anxiety due to the largely negative constructions of this diagnosis. In contrast, these participants seemed to be the most vulnerable, in terms of the malevolent content of what their 'voices' were saying to them.

Taking these thoughts forward, I was encouraged to critique my own understandings of mental health distress during this time. Likewise, with the aging process, in that arguably whilst the social stigma is not so great, the socially constructed definitions of older people can be more negative than other age groups within the population. This was a formative period

both in terms of the definitive change of my own perceptions relating to mental health distress (and more particularly, psychosis) and how I have subsequently positioned older service users in a more positive manner.

It also important to reflect on how the ethnographic methodology used within this thesis played an important part in analysing data but was only used on one occasion as a form of data analysis. Spending time, usually 4- 6 weeks with service users in the day care centre offered an insight into the daily comings and goings within this particular space. As I became more accepted by service users, I noticed that barriers were broken down to a certain extent in that the usual narratives of service users functioning as a collective when compared to the wider community, were more fluid than this. I observed incidences of verbal bullying and the lack of physical access to certain spaces (such as the kitchen or communal room) for some service users who were deemed more deviant in their behavior. Whilst this methodology allowed a valuable insight, I was not entirely comfortable in using notes from my research diary as I felt that the issues of informed consent were not always ethical. This was largely due to the sense that service users did not always appear consciously aware that I was taking notes of their behaviours (notes were never taken with the day centre). Without asking for informed consent immediately after an incident, I felt that this particular methodology was not appropriate in attempting to break down any power relationships between researcher and participants.

3.11 Ethical considerations

In the first instance, an Ethical Considerations application was submitted to the Research Ethics Committee at The University of Northampton, which was subsequently approved. Together with this process, reference also needs to be made to the ways in which the ethical procedures and the role of the researcher are inextricably linked. These statements need to be unpacked further as research into service user life does not operate on an even continuum from both a participant's and researcher's perspective.

Firstly, the researcher has a duty in respecting and maintaining the confidentiality, safety and mental and physical well-being of the participant and the researcher. Measures were taken to alleviate such concerns. Initially, the day centres were contacted and a meeting was arranged with the day centre management and supporting staff. With their agreement and as a way of reducing any potential feelings of continued discomfort service users' may have experienced

when a ‘stranger’ enters the day centre, I spent between four to six weeks attending drop-in sessions and joined in with various activities before participants were approached. All participants were given a Participant Information Letter (Appendix Two-a) and the research project was mutually discussed in detail. If service users agreed to take part in the project, an Informed Consent (Appendix Two-b) was again discussed in detail and signed by both the participant and myself.

As a safeguard against any inducement of anxiety and upset, the questions within the interview schedule (Appendix One) avoided areas of potential emotional negativity. However, this did not mean that participants did not divulge parts of their life that involved sexual, physical or emotional abuse. Such disclosures were duly treated with complete confidentiality and were seen as a means for allowing a participant to talk frankly within a ‘safe’ environment about certain elements within their life. Subsequently, the participant was also shown respect by being given autonomy to talk about what they felt was relevant to them. This process also went some way in offering a diffusion of the imbalance of the researcher/participant power relationship. Nonetheless, I was always aware that such interactions did not suggest some form of counselling, psychiatric or psychological advice being given. Following ethical lines, the ‘researcher’ listens but does not proffer advice or cast judgements on those concerned.

It is also important to discuss the complexity of issues surrounding the psychological and physical well-being of a participant. This section particularly relates to when disclosures should be relayed to staff. If we take the above scenario into account, the lived narratives of participants expressed during an interview, however negative, form part of their self-identity. However, what happens if a participant is talking about actively seeking to commit suicide? In this event, the British Psychological Society (2009, p. 11) state that any decisions of disclosure taken should be exacted in the following situation: *“Restrict breaches of confidentiality to those exceptional circumstances under which there appears sufficient evidence to raise serious concern about: (a) the safety of clients...”*

Whilst on paper this may seem an easy option, of course, yes you disclose but what about all the claims of confidentiality discussed within the informed consent? This is not a hypothetical situation within this particular research experience. One participant did disclose to me that she was feeling suicidal during the interview. Whilst it would seem an easy act to advise the day centre staff of her feelings but her relationship with them was tense and she

often talked to me about her own perceptions that the staff and other service users did not like her. Of course, I did advise a member of staff of her suicidal feelings but this was not a simple, straightforward matter as I did feel uncomfortable in divulging this information due to her awkward relationship with the staff. This instance has been used to illustrate that ethical considerations can conflict with issues of relationship trust and confidentiality. Therefore, within the role of being a researcher, I was required to make rational decisions that may well have competed with a participant's supposition that they are entitled to complete privacy.

3.12 Analytical concerns – the process

Once I had transcribed the interviews, the data was read and re-read over a period of one month. During this process, a rough set of notes were made of interesting narratives that emerged from the interviews to produce an initial set of diverse codes. These initial codes were then cross-referenced across all the interview transcriptions to form a set of main themes for further analysis i.e. diagnostic identity, emotional content and social relationships. The emergent narratives from participants were largely contextualized within day to day spaces (as might be expected when one thinks of discussing everyday experiential accounts). These codes were then noted and subsequently condensed into subject areas (themes) encompassing daily spaces such as 'day centre spaces' and sub-themes emerged whereby different experiential accounts around the set of themes were selected for inclusion (or exclusion) in the final written up thesis (i.e. comfort, anxiety and movement). Through this process, the emergent participant narratives talking about life for a service user focused upon the four spatial areas of psychiatric institutions, day centres and home spaces. The relevant themed extracts relating to the differing areas of spatial contexts discussed by participants were then filed on my laptop.

This process meant that some data extracts were not included in the data chapters even though the participant's narratives were discussing the same area. This selection from the using the above steps was based on the richness and depth of the data extracts with an emphasis on exploring 'different' experiential accounts by participants as opposed to grouping similar narratives together. This approach of exploring divergence and heterogeneity as opposed to analysing and presenting similar accounts (such as used in thematic analysis for example) was better suited in terms of the theoretical framework used within this thesis.

All extracts were subsequently analysed using a mixture of discourse analysis (Parker, 1994), Foucauldian discourse analysis (e.g. Hook, 2001), discursive psychology (e.g. Potter & Wetherell, 1987) and non-discursivity (e.g. Brown, 2001). The reason for using a variety of analytic approaches, although they are all situated within the genre of discourse analysis, was due to the different aspects of research interest within this thesis. In terms of participants discussing experiences of mental health distress, the analysis of language is a powerful tool to understand the ways in which service users for example, make meanings of their inter-relations within the psychiatric system. At times, the language of mental health distress (and all the authoritative systems that these discourses can (re)produce) used can invoke elements of how the discursive practices of psychiatric power can compare to a participant's feelings of social and political powerlessness. The analysis within this thesis will draw from elements of different forms of discourse analysis.

3.13 Drawing the discursive threads together

Arguably, the choice of analytic methodology plays the most crucial role in how the data is both interpreted and finally presented. To consider these points, it is worth revisiting both the opening paragraph of this section and the variety of theoretical concepts which will form the framework to explore the resultant data. Taking these facts forward, it would seem prudent to draw from the corpus of literature which I will loosely term, discourse analysis. Potter et al., (1990, p. 129) advocate this synthesis of approaches, *"…DA/DP is neither a self-contained paradigm nor a stand-alone method"* (abbreviation author's own). This direction makes sense as service users do not live in a social vacuum therefore the analytic strategies undertaken within this thesis should also reflect the complexities of everyday life. It is anticipated that this will provide as great an understanding of the experiences of older service users that can be realistically expected as it is fully recognised that I can only gain a partial understanding of service user life.

3.14 A discursive analysis of the body

> *"Speaking is a kind of sonorous touching; language is tissue in the flesh of the world. Or, to be more graphic, think of language as a bodily secretion."*
>
> (Csordas, 2008, p. 118)

The literature around embodied accounts of spatial production can be positioned as providing somewhat of an intangible account in terms of pinning down experiences through language (Tucker, 2010e). Here, the use of language to explore bodily experiences can be seen as lacking a sufficient repertoire of linguistic terms to offer an articulate account of experience (Csordas, 2008). What we are left with here is a primary focus on the use of language whilst neatly ignoring the more elusive and fluid lived elements of experience (Brown & Tucker, 2010).

Rather than analysing discourses alone, the concept of embodiment allow ways of exploring psychological and emotional change and movement as opposed to an analysis situated in a state of fixity (Tucker, 2001). As Massumi (1992, p. 57) argues; *"Even within the limits of its stability, an individual is always changing."* Here one is offered a fluid framework of concepts which link to affect and non-discursivity, thus providing a diverse set of theories from which analysis can begin to unravel the mediated experiences of everyday service user life. For example, in terms of embodiment and mental health distress in conjunction with movement within the spaces of day centres and the immediate community Parr et al., (2005, p. 96) suggest; *"Not 'showing', 'saying' or obviously 'embodying' strongly negative emotions results in highly competent emotional management strategies through different spaces"*.

These kinds of positions can tie in with Hacking's (1999) *'interactive kinds'* whereby experience and performance are entwined within the classifications and a set of codings from which we are social identified. For service users, this can involve the change from a former identity of non-service user to that of a diagnosed 'paranoid schizophrenic' for example. Receiving such a diagnosis can then propel individuals to reconfigure their own sense of self identity and their movement within socially lived everyday spaces (Tucker, 2010d). Diagnostic classifications are subsequently embodied (they become part of the internal self) and their cultural and social derivatives (the outer layer of a social and clinical identity) can act as a platform from which future experiences can become embodied as a part of daily life.

In other words, we can act as sponges by absorbing cultural and social codes which in turn can lead us into differing emotional and physical trajectories. For example, when a woman becomes a mother the classifications and behaviours associated with 'good mothering' practices may become an important of daily life. The absorption of such cultural categories can then precede the previous embodied identity of 'non-mother' as these codings take

precedence within the psychological and physical layering of everyday life. A woman has become a mother and has a dependent infant; our society has social and cultural rules for how this undertaking should be performed.

Of course, not everybody willingly embodies these changing complexities of self. Returning back to mental health distress, within my research experience, some service users with a culturally and potentially socially isolating 'risky' diagnosis of 'paranoid schizophrenia' rejected this particular clinical entity[23]. Here one can observe a kind of 'smoke and mirrors' series of discursive and non-discursive processes whereby clinical diagnoses and bodily behaviours may change on a regular basis but these fluctuations are not related to psychosis.

Discursively, these service users draw from other 'less risky' diagnoses such as 'Post-traumatic Stress Disorder (all participants spoke of sexual, emotional and physically abusive childhoods) when discussing their psychiatric identity. This particular diagnosis can offer service users a diagnostic 'life-line' in terms of gaining more positive social and cultural interactions. They have experienced extreme levels of trauma within their lives, this they can embody as part of their sense of self. Nevertheless, most still heard voices and had periods of perceived persecution but these were never discussed further within an interview situation or with other service users. Rather these kinds of diagnostic 'admissions' were discussed informally with me and there was a decline to elaborate further when being interviewed. There was an acknowledgement mainly that these kinds of phenomena formed a central part of their life but there was a reluctance to discuss this further.

In terms of the observable body and space, some service users would noticeably sit on their hands or clasp them tightly in front of them for lengthy periods of time, perhaps using my own subjective interpretations these behaviours were undertaken to stop any erratic bodily movements normally associated with schizophrenia. Subsequently, there is a myriad of complex and layered clinical identities, behaviours and emotions within which service users can either (dis)embody or, indeed embody as forming part of their daily life.

3.15 Analysing deterritorialization/reterritorialization and the spatial body

For clarification, what is meant by territories here are the ways of unfolding the multiple relations between meaning and social space. To explore the creation of constant and regular

[23] It should be noted that the service users I am referring to here were all on 'high' dosages of (a)typical anti-psychotics with staff often advising their 'real' diagnosis at the time of the research process

features within space, which in turn have been built through a system of both *"coded connections and distinctions"* (Brown & Lunt, 2002, p. 17). As an exemplar, within the territories of the psychiatric hospital we can have the emergent use of prescriptive medicalised codings to both connect and bind service users (Deleuze & Guattari, 2004; Massumi, 1992). On the flip side, we also have those codings which seek to define and demarcate particular identities. These discourses are producing topologically, i.e. the mental health institution as a means of housing and supporting mental health service users to the differentiating discursive practices of providing solitary space as a means of housing and supporting those too deviant to be part of the wider collective (Sibley, 1995).

In this way, territories are not just marked out by monolithic structures creating permanent borders or forces for example, but territories are more so continuous and fluid, always in a state of morphing. This concept of fluctuating territories forms the crux of Deleuze and Guattari's philosophical approach to the constancy of change; as such we are always in a state *"of continual becoming"* (Tucker, 2006, p. 30). In this way, we spatially shift through and within milieus, we emerge and retreat, we protract and contract. As Deleuze & Guattari (2004, p. 60) posit; *"Nomadic waves or flows of deterritorialization go from the central layer or the periphery then from the new centre to the new periphery, falling back to the centre and launching forth to the new"*. This is not to suggest, however, that movement is formed from a dichotomised sequence of performance but more so spatial movement can be jagged and haphazard.

As alluded to above, bodies and spaces are not static but are always in the process of reinvention. Deterritorialization considers the ways in which this reinvention takes place together with the social impacts of deterritorializing space (Kaplan, 1987). Reterritorialization is concerned with the ways in which alternative territories are formed. These processes are entwined; a territory which is changed becomes deterritorialized which then sparks off the process of reterritorialization i.e. a new territory is formed (e.g. Bonta & Protevi, 2004; Roberts, 2007; Tucker 2006).

However, Buchanan (2006) points out that these processes do not necessarily share an unproblematic mutuality, as the process of deterritorialization is absolute, one cannot change a territory back to pre-territorialization via reterritorialization. There is no restorative process. For example, if a thatched cottage was damaged by fire and parts of the structure are subsequently rebuilt to match the original period specification, it can never be the same

building again. The windows will not have been fashioned by the original maker, the thatch in the roof will never contain the same straw in terms of density and colour and so on. In this way, whilst there is an attempt to stabilize space, to restore the features of space back to its original components, it can never be the same again.

To summarise this chapter, I would like to introduce the following thought from Gilles Deleuze;

> "*I think the narrator has a method, he does not know it at the beginning, he learns it by following different rhythms, on very different occasions, and this method, literally is the spider strategy."*

(Deleuze, 2006, p. 45)

In the above extract, Deleuze discusses the narrator in Proust rather than the position of the analyst but there are some connections here with research data analysis. Deleuze offers a different way of thinking about research methods to the traditional position of the research process as being enveloped within a rigid set of doctrinal practices. Here we have are presented with a more fluid and divergent set of methodological strands than say the more usual trajectory of having a precursory specific method which in turn informs the ways in which the research data is consequently analysed. Deleuze suggests that method and the ways in which verbatim and visual data should be analysed is always within that moment in time, it can never be regained or regurgitated as it was – the spider's web is made in the moment, it is not built with a nearby fly in mind. The spider secretes the web but a passing fly may never land on the web, the vibrations felt by the spider maybe of other things, a dropping leaf for example. Here there is an object of intervention, or an *'emitter of signals'* but there is no solidity, there is no sense of positioning the spider's web as un-problematically capturing prey (Deleuze, 2006, p. 47). Rather the web was made in the moment to catch prey but it was not made because there was a fly nearby (this would take too long). In other words, what happens in the starting moment of undertaking research cannot predict a stable outcome when analysing data. This type of thinking really underpins the ways in which this thesis has been undertaken whereby as opposed to reifying service user experiences as essentially stable more emphasis is placed on the mutability of everyday life.

Chapter Four

Institutional Spatialities

"The cure scene is complex."

(Foucault, 2008, p. 10)

4.1 Introduction[24]

Using one-to-one semi-structured interviews, this chapter will illuminate the experiences of service users who have resided on a long-term basis within formalised psychiatric institutions[25]. All participants who engaged within this research project had memorial accounts whereby their residency within psychiatric institutions formed a significant part of their spatial experiences. These narratives were based in the distant and the more recent past, but there was a sense that re-admission remained an important element of their daily lives. Thus, this potentiality of returning back into hospital was an important area of service user life to explore further.

It is also worth noting that in the geographical area in which participants lived there were two large psychiatric hospitals. One of these spaces was governed by the National Health Service (NHS) whilst the other space was a private, charitable institution[26]. Whilst the NHS institution was in the process of being demolished and rebuilt at the time of data collection, some wards remained open. This particular hospital space was where most participants had spent periods of their lives and subsequently appeared to be where most experiential narratives were based. On a personal note, as a child living fairly close to this area, the name of this institution was often used when teasing and taunting other children, i.e. "you will end up in (name of hospital) in a padded cell". Locally, even though there is now a remodelling process of rebuilding a new structure along with giving the building a different name, there is a generational narrative of negativity around this particular institution.

As discussed in Chapter One, the emergence of psychiatric spaces were abundant between the 1850's through to the 1970's as structures built to accommodate those beings who were

[24] It should be noted that there will be certain sections within the analysis chapters which are not supported by research data. This unconventional route has been taken to add more context (whether theoretical or practical) to the overall framing of the data analysis

[25] As well as the term institution and asylum, this chapter will also use the word hospital to designate these spatialities, in line with participant's own narratives

[26] The private, charitable hospital mainly admitted National Health Service patients deemed too dangerous to be on unsecured NHS psychiatric wards

largely characterised by the cultural discourses of 'defect', 'deviance' and 'threat' (Carter Park & Radford, 1999). These discourses are still prevalent in today's society and can be illustrated by the political and legal pathways from which service users enter into contemporary hospital regimens (Rogers & Pilgrim, 2005).

In modern day society, hospital spaces are still prevalent for the therapeutic treatment of 'extreme' forms of mental health distress, such as schizophrenia whereby the diagnoses of mild to moderate depression are largely contained within General Practitioner surgeries (Sugarman & Craufurd, 1994). The majority of acute, in-patient care is governed by the legislation encompassed with Section 3 of the Mental Health Act (1983) which has now been superseded by the Mental Health Act (2007)[27] (Sugarman & Collins, 1992). The Mental Health Act is primarily concerned with the detention of people with psychiatric disorders through the means of compulsion (Department of Health, 2007).

In terms of behaviours, Parr (1997) draws attention to the ways in which this Act is primarily concerned with the social and bodily behaviours and physical appearance whereby those who do not conform to culturally 'appropriate' forms of behaviour are not largely tolerated within the wider society. Thus, reinforcing the historical discourses imbued within the realms of 'unpredictability' and 'deviance'. Thereby via the Mental Health Act, those who are deemed (usually as a result of unconventional behaviours or suicide attempts) to require intensive psychiatric treatments enter into hospital, either under 'compulsory' or 'voluntary' admission as outlined in Section 3. This sequence of events is more commonly known as being 'sectioned'. Entryways into psychiatric institutions via 'compulsory' or 'voluntary' section are generally administered via the intervention of authorities, such as the police or consultant psychiatrists. Compulsion is generally used when a service user is not deemed to be in a correct state of mind to have the capacity to make rational decisions or, indeed if a service user resists detainment. Conversely, voluntary sections have been and still are decisions made by the service user (or family members) concerned.

At some level this makes sense, when we consider the following extract from Bill when he discusses an event whereby his unconventional behaviours were noticed by the police, which resulted in him being detained under 'compulsory' section. Bill has spent long periods of time within psychiatric institutions but has primarily lived within the community setting. Bill

[27] The Mental Health Act (2007) in terms of entering into psychiatric provisions by detention have remained the same as for The Mental Health Act (1983)

often experiences periods of 'disassociation' where he has no sense of what has happened during these times;

> *"…and I have to have somebody watching over me because I'm dangerous to other people and myself. I mean I can just wander off and I have been stopped by the police down (names town) High Street just with my underpants on. Do all sorts of absurd stuff when I'm in that state…I do absurd things like carry carrier bags full of water around the place and stuff weird stuff like that sometimes I can be dangerous to some sections of the society but (LAS=Yeah) but there you go and to myself of course because I don't know what I'm doing…and back in I go"*

As we can deem from his narratives above, Bill's behaviours at these times are somewhat 'bizarre'. It is highly unusual to walk down a main shopping thoroughfare in underpants as it is to carry bags of water around. Where he is less discursively explicit in this extract is when he describes himself as 'dangerous' to some sections of the society and himself at his times of disassociation. However, I was aware through numerous one-to-one conversations that Bill served a sentence in prison for ten years on a charge of 'attempted murder'. Contextually, Bill told me that he was anally raped as a seven year old boy and he was subsequently raped on a regular basis by a group of males who lived in the same village (this village is two miles from where Bill lives now). Some of Bill's abusers are still alive and live in the same village. On one occasion, he found one of them and nearly beat him to death. Hence the prison sentence and hence why Bill thinks he can be a danger to some sections of society. Here we have an account of being detained under 'compulsory' section as Bill at these particular times, can be deemed as having the incapacity to make rational decisions and perhaps the police are aware of his previous conviction and he has now been positioned as a 'potentially dangerous' member of the community. This sense of Bill's unpredictability which can emerge as a possible violent attack is also embodied by Bill. At some level, he can seem to suggest that when he has his periods of disassociation that he accepts that he should be detained and admitted to a psychiatric hospital as a 'compulsory' patient under section.

It has also been argued that being detained under 'voluntary' section can be a paradoxical set of discursive events (Sugarman & Collins, 1992). The cultural notions of 'informally' entering into psychiatric hospitals as a willing potential patient are still bound up with the threat of detainment under 'compulsory' section (Sugarman & Collins, 1992). In other words,

if service users do not use the pathway of volunteering to be admitted, the chances are high that they will enter hospital under compulsion. Consider Caroline's excerpt below where she describes this paradox:

> *"LAS: So were you ever sectioned or did you go in*
> *Caroline = No nearly, nearly (LAS=yeah) and they said (the police) if I didn't go in voluntarily I would have been sectioned and so I went in voluntarily"*

Caroline has spent some time within psychiatric hospitals but for the majority of her life she has lived within the community. Here Caroline presents the landscape of how forms and behaviours associated with mental health distress are operated under the umbrella of legislation. If she didn't enter into the psychiatric institution as a 'voluntary' patient, she would have been admitted anyway. This appears to be a 'no win' situation but it does highlight how the discursive practices of how lawful jurisdictions such as the Mental Health Act always have the overriding power to force events forward, even if they go against a person's wishes. In this way, Sugarman & Collins (1992) argue that the assumptions of 'voluntary' section do not exist, they just form part of a set of pseudo-discourses insinuating that service user's desires and rights are observed. Consequently, service users can be positioned as having little political will, agency or agenda for their own lives when they become enveloped within the legal realms conjoined with psychiatric practices (Parr, 1997).

The focus on exploring long-term residential psychiatric care within this body of work is of particular interest because the research participant sample consists of service users aged 50 years and above (the choice of this age range was discussed in more detail in Chapter Three). Subsequently, some participants are representative of the portion of service users who were initially admitted as long-term patients but then became part of the current move to 'care in the community' programmes. In addition, some of the narratives are of periods of hospitalisation within more recent times, in that service users resident within the community enter into formalised care for periods of time and are then discharged back into the community. This is the ways in which service provisions within psychiatry tend to operate whereby service users tend to move from the acute ward within a hospital, then maybe to a ward with less restrictions (such as one-to-one observations) and finally back out to the community setting. Or as often cited, service users can become wrapped up within 'the revolving door syndrome', the continuous cycle of becoming hospitalised at one time, only to be released back into the community at a later time and so on (Rogers & Pilgrim, 2009).

Consequently, this chapter will explore the embodied experiential accounts of service users who have lived within purpose built psychiatric hospitals for various amounts of time. Unpacking this further, what is trying to be sought within these accounts are the ways in which bodies negotiate (both linguistically and sensually) their affective feelings of 'self' within the complexity of the discursive practices of these shared, therapeutic social spaces. This does not mean, however, that the individual body is bound as a coherent whole but more so, the discourses of the affective 'self' will be analysed as "*emerging within and through its relations to other people and events*" and space (Conradson, 2005, p. 105). In this way, the focus will be to analyse the data corpus of experiential accounts relating to these psychiatric spaces. Thus, providing a broader platform from which to explore the differential ways in which the psychiatric hospital can serve as a mediator from which social performances can be both executed and framed within these particular milieus (Gillies et al., 2004; Radley, 1997).

4.2 Institutional space as production of clinical order

> *"It was not the notion that madness was curable that changed at the end of the eighteenth century...Rather, it was the notion that institutions themselves could be made curative, that confinement in them...could make the patient better."*
>
> (Shorter, 1997, p. 8)

As alluded to within the above extract, structures built for housing those with mental health difficulties were positioned as being legitimated through the discursive practices of psychiatry and medicine as providing a space imbued with physical and psychological healing qualities (Foucault, 1965, 2008; Porter, 1987). Here we are provided with the notion that institutions are more substantive than a monolithic building comprised of shared wards containing rows of beds, the collection of rooms allocated for periodic patient solitary occupation, a central nurse station with a series of side rooms housing the hierarchal echelons of psychological experts, nurses and auxiliary staff (e.g. Scull, 1979). Moreover, the psychiatric institution is situated within a complex space encompassing the visible and non-visible aspects of therapeutic intervention, a place which emanates a series of curative properties through the means of spatial confinement and arrangement.

Culturally stereotypical imaginings of the psychiatric institution may comprise a stark neatness of an order space from which therapeutic interventions can emerge. Straight

rows of beds, headboards planted firmly against a wall with moments of fleeting privacy offered via the use of a curtain to conceal the visibility of the patient's only assigned territory from the gaze of others. Such brief periods of semi-private space are nevertheless controlled by the staff and only provide a respite from the observable comings and goings of shared, institutional life.

In the following extract, Clara discusses one of the periods she spent with a psychiatric ward. Clara has lived primarily within the community.

> *"Clara: Yeah that's right but they changed it to (names hospital ward) um I was in ICU for most um three years and then a year in (names hospital ward) and in (names hospital ward)*
> *LAS: Yeah and how did you find it?*
> *Clara: Yeah um I found it good um um not at first cos' I was um for the first twelve months I was on suicide watch on me own and (LAS=mmm) um I used to try and take me own life (LAS=yeah). I felt worthless and wanted to end me life I wasn't (1) didn't want to live"*

Here we are presented with Clara's accounts for her relatively long-term residency within hospital. Spatially and temporally, Clara maps out her psychiatric progression starting from being a patient on an intensive care unit to being resident within two other wards. The notions of confinement and more specifically the measures of psychiatric intervention and surveillance are manifested when she discusses some of elements relating to the first year she spent on the intensive care unit; *"for the first twelve months I was on suicide watch"*. 'Suicide watch', or to use the more formalised psychiatric discourses; 'one-to-one observations' are when patients are kept in spatial isolation and can then more readily be monitored on a continuous basis by a nominated member of staff. This surveillance is usually a result of self-harming behaviours, suicide attempts and causing harm to others. Of interest here is the potential force of temporal invasions of privacy Clara faces on a daily basis. She does not elaborate upon the impact of these further. Maybe, because of the length of time she was under constant observation, Clara had both accepted and consequently embedded her body within this space of solitude and surveillance (she was under continuous observation), as one of a service user who did not warrant private moments as she was always in the continuous flows of wanting to and failing to end her life.

4.3 Institutional space as production of depersonalisation

Again, from a cultural perspective, scenes of institutional life are not seen to be peppered with personal objects and memories but are more so spatially ordered to accommodate and highlight the importance of the apparatus relating to the medical and psychiatric domain (Porter, 1987; Rogers & Pilgrim, 2005). In this way, the psychiatric ward is stripped of human remnants of the past and focuses on the medicalised processes of cure and recovery utilising the sterility of linear parameters associated with clinical efficiency (Goffman, 1961). Shared and personal space together with the objects of therapy are therefore segmented and organised in order that the establishment of social and professional boundaries can endure. This kind of hierarchal structuring goes some way to ensure, *"[e]ach individual is fixed in his place"* (Foucault, 1977, p. 195). At this point, this thesis will draw from a Goffman approach to social performance.

For example, the nurse's station within therapeutic structures can be a highly visible central location from which staff can observe patients. This panoptical structure may perform an important role on the ward in terms of patient surveillance, namely the potential enforcement of regulatory practices which in turn, can produce self-regulating behaviours (Foucault, 1977). These kinds of regulatory positions and practices can maybe mediate a framework of social ordering whereby patients either choose to avoid the gaze and attention of staff by blending into the background or, conversely, opt to disrupt this ordering by disturbing the spatial and social uniformity of the psychiatric ward (Sibley, 1995). It is worth noting at this juncture that these types of descriptions may not be a wholly representative set of structures and directives relating to all psychiatric institutions and wards at any given period of time.

Nevertheless, when considering the destabilising of space and regulatory practices, Mary offers an account when other service users temporarily interrupt the 'comings and goings' on within the psychiatric ward.

> *"When I was in there one, one day this young girl came in and she had drugs and whatever related things and in the middle of the night she smashed the door, a window to get out and…she, she was um she was on drugs but*

somebody kept bringing them in for her so they followed her around, literally step by step (LAS=mmm) all the time"

Here we have an account wrapped up in the consumption of presumably un-prescribed drugs. There is a jarring of the rhythms and regulatory order of this space at these points within Mary's account; "*in the middle of the night she smashed the door, a window"*. A door and a window are smashed in the middle of the night – a time of supposed peace and quiet when patients should be fast asleep. Night time is usually associated with sleep, sleep is normally associated with a reduction in patterns of behaviour; it can be a time of solitude wrapped up in personal dreams or nightmares and contemplative thinking. It may also be a time when staff can begin to relax more as the ward becomes more stable in terms of bodily movements and performance.

Not so, on this ward, the space loses its smooth flow and instead becomes the backdrop to a series of events instilled with violent outbreaks. This interruption may be even more powerful because of the common assumptions around the slowing down of bodily behaviours imbued within periods of times allocated to sleep. Here we are presented with a series of events which serve to 'unfix' the patient, the staff and other service users; "*she smashed the door, a window to get out… so they followed her around, literally step by step"*. A feeling of chaos as opposed to order and containment emanates from Mary's narratives. There is very little sense for Mary of an anchoring of space by the means of the arrangement of the ward space at this particular moment in time.

4.4 Institutional space as production of daily regimes

It is not only the place and the patients' occupation of space which may be ordered. Medication and therapies can be administered according to time schedules. In this way, it could be necessary to ensure a strictness and regularity of time, to ensure that clinical order and efficiency is both physically and psychologically maintained (Scull, 2005). The slicing up of time can also be a crucial factor in the ordering of daily life, there could of been specified times to wake up, to have breakfast, lunch and dinner, to bathe, to go to bed and so on. In this way, the institution can continuously evolve as a coherent and tangible social establishment governed by the clinical ordering of space, social behaviour and time (Porter, 1987; Rogers & Pilgrim, 2009).

Of course, the above positions have largely emerged from reading the wider literature and the memorising popular cultural pictures of a stark existence emanating from the realms of critical psychiatry, film and art (Foucault, 1965; Goffman, 1961; Porter, 1987). For instance, Porter (1987) draws attention to the ways in which mental health distress was (and perhaps still is) both enveloped and operated from and within a complex network of biological, sociolinguistic symbols and meanings dominant within the discursive practices of psychiatry. Such discursive practices could, at times, bestow service users as having limited agency which can then eradicate any notions of service users needing to have some say and responsibility within their own treatments (Scull, 2005). These largely negative discourses could then result in psychiatric institutions representing a space where the forging of social relationships and senses of agency are relegated underneath the hierarchal ordering of psychiatric interventions. Ben Silcock[28] (1994) elaborates on these positions of ordering thus;

"I want to try to shed a little light on the experience of madness from the point of view of the afflicted. So often we get descriptions of madness from psychiatrists which can only express their observation in a clinical way, with little consideration for the patient's soul, maybe we should take a breakdown as a sign that our ways of living need to change"

What I am attempting to draw attention to at this moment are the ways in which this institutional space can function from the premises based on daily order, patient depersonalisation and established boundaries of space. From this framework, the performance of cure and recovery can emerge. The cast of actors in this drama may now have their identities confirmed and, just as importantly, be made aware of which sections of the stage they should perform from, which stage props apply to each hierarchal role. It is important however, that these performances should be well-rehearsed and memorised, that day after day the play maybe has the same influence on the observer and the observed. In this way, the social role of the actor(s) and the expectations of the audience can become entwined and made manifest by the visible performance of psychiatric cure (Goffman, 1959). Here, the structures of the psychiatric institution might serve as a stage, resplendent with apparatus, a cast of actors with defined characters and scripts – the performance of cure may now begin.

[28] Ben Silcock became the focus of media attention when Ben entered the lion enclosure in London Zoo in early 1993. Consequently, his father campaigned that Ben's actions may have been as a result of the lack of care in the community and the inconsistent treatment Ben received for this diagnosis of schizophrenia.

4.5 The performance of cure

Foucault (2008, p. 8) frames therapeutic processes within a circularity of influence operating from the *"basis of ...moral orthopaedics, if you like, that cure is possible"*. For Foucault (2008) these possibilities of cure are borne as a result of the actions and scenes of battle and confrontation between patient and certain members of psychiatric staff. Foucault discusses the duality of ways in which such confrontations are acted out. Firstly, he draws attention to the process of "wearing down" or the potential eradication of undesirable behaviours. In this way, lower levels of staff use (for Foucault; the Doctor does not become involved in these conflicts due to his/her either knowledge expertise and subsequent sovereignty) psychological stealth or in some cases the addition of instruments to initially deceive and finally deactivate the offending body of performing further erratic, unpredictable behaviours.

By using a demeanour of visible and psychological authority mediated via verbalising warning threats of recrimination together with a smattering of language rooted in obedience and surrender, the main focus of observation and forces of psychiatric action can then be aimed at the singular patient. At this point, the patient may be unaware of the signals relayed to a team of assistants who ultimately surround and physically overpower the patient. When restraining apparatus are brought to bear, the sequence of events is similar with the exception that the behaviour is broken and subdued by the use of an instrument rather than human force alone.

These set of events do not however form the main crux of psychiatric functions relating to scenes of power, confrontation and patient surrender. The second, and more vital elements in terms of exercising psychiatric power to overcome resistance, resides within a *"...confrontation of two wills, that of the Doctor and those who represent him on the one hand, and then that of the patient. What is established, therefore, is a battle, a relationship of force"* (Foucault, 2008, p. 10) between the patient and the institution (Laing, 1965; Scull, 1989). This complex web of relational spatially produced discursive practices will be unpacked further.

In the following data extract, Rose discusses her experiences spent within various psychiatric institutions. Rose has spent many years of her earlier life in hospital and since she has been discharged has lived within the community setting as an independent resident.

> *"I've had contact with services for as long as I can remember (LAS=yeah) since my teens and…I've always been sort of searching for some sort of help you know (LAS=mmm). Initially I did have more practical problems but, but then you know one thing, lots of things happened and I got misunderstood and not (2) well I was going to say ill-treated, yes I think I was ill-treated initially in hospital you know I went in hospital in the seventies and, and (LAS=mmm) at that point they just locked you up, drugged you up and that was it and that, and that really had a bad effect on me (LAS=yeah) but… I've seen you know there has been so much things ranging from direct physical abuse, mental abuse to just poor treatment you know (LAS=mmm) due to misunderstanding I've seen it all (sighs)…and that has a lasting effect on you, you know"*

Here Rose draws attention to some of the negative elements she experienced as a patient within older types of institutionalised care, prior to the introduction of the 'care in the community programme'. She reinforces the negative cultural assumptions of daily life within institutional life during the period of the 1970's; *"at that point they just locked you up, drugged you up and that was it and that, and that really had a bad effect on me"*. One is given some sense here that patients were completely at the mercy of their more powerful counterparts within the performance of cure. At this time, patients were simply locked and drugged up (there is no mention of the more contemporary widely used interventions such as Occupational Health).

There is a sensual representation here of patient surrender as resulting from the poor levels of treatment at that time. Rose punctuates her position further by discussing some of her observations at that time: *"I've seen you know there has been so much things ranging from direct physical abuse, mental abuse to just poor treatment you know"*. The emergence of the force of social and political powers held by those involved within psychiatric interventions is articulated by Rose's stories of observing instances of abusive actions undertaken by staff. Rose witnessed psychological and physical forms of abuse and elements of poor treatment.

For Rose, her experiences of the psychopathological landscape within the psychiatric institution are subsequently anchored by these series of experiential events. This appears to be a very negative period of time for Rose and she seems to be very aware of the imbalance of power residing within those institutional spaces. Rather than this space as mediating a positive performance of cure, Rose highlights the negative elements of abuse which has been the focus of concern for many scholarly works (e.g. Porter, 1987; Rogers & Pilgrim, 2005; Scull, 1989).

4.6 Institution as space of the production of psychological control

Foucault's notion of the battles between the two wills, the perpetuating psychological conflict between staff and patient is also noted in Goffman's (1961) influential text *'Asylums: Essays on the Social Situation of Mental Patients and Other Inmates'*. Goffman offers an account of how the asylum operates forms of social control via physical and psychological sets of structures; the arrangement of physical structures, the slicing up of time and the staff, to maintain continuous patient conformity, thus creating institutionalisation. Institutionalisation is a progression of becoming formally embodied within a structural set of processes, located away from the wider community. Institutionalisation or indeed, total absorption within these processes is the end result of a series of mediating practices which constitute the life-blood of socially insulated psychiatric hospitals (Cooper, 1970; Goffman, 1961).

Initially, a person is given a diagnostic label usually resulting from the presentation of socially deviant behaviours within the wider community. In turn, this diagnostic label becomes enveloped within the broader labelling of mental health and psychiatric institutions and patients take on the expected behaviours of their particular label (Scheff, 1999). As Cooper (1970, p. 41) notes: *"The mental patient, once he has been so labelled, is obliged to take a sick role. Essential to this role is a certain passivity"*. This is not to suggest that passivity is prevalent on initial admission but moreover it is the series of confrontations between patient and staff as discussed by Foucault, this 'wearing down' and the initiation and continuation of social controls which can enable compliance.

4.6.1 Electroconvulsive therapy as mediator of social control

Electroconvulsive (ECT) or 'shock therapy' therapy is arguably still one of the most contentious forms of therapeutic treatment within the psychiatric community (e.g. Smail,

2007). As such, this treatment has and still remains one of the most 'feared' processes which service users can be involved with. Even from a practitioner perspective, this kind of therapeutic operation is widely positioned as a *"cruel"* form of treatment (Bentall, 2004, p. 497).

Goffman (1961) provides an exemplar of social control via means of such seemingly coercive therapeutic interventions by discussing his own ethnographic study conducted within psychiatric institutions in the late 1950's. Goffman notes how patients who were to be administered 'Electroconvulsive Therapy[29]' by staff were often assisted by other patients. This assistance consisted of the holding down and the strapping of a patient to the designated bed where the intervention was to take place. As the name of the treatment suggests, the requirement to subdue and stabilise the patient within these situations is to minimise the physical damage such as broken vertebrae caused by the convulsing body of the patient. Nevertheless, the need for physical restraint is possibly more involved with the imagined and experiential horrors that patients have embodied regarding ECT. In terms of social control within the psychiatric institution, this is where the power of such a treatment lies – not as an effective form of treatment but as a visible presentation of the stuff human nightmares are made of.

Of interest here, is that within such scenes other patients become an integral part of the unfolding drama as they become immersed in a duality of roles, one of the enforcer and also one of the condoner of such actions. In this way the social division of staff and patient is temporally blurred as the patient crosses the tangible boundaries of their former role and now takes on a fleeting position imbued with power and control over other patients. It is this brief crossing over which goes on to strengthen this form of social control. For this period of time, the patient undergoing this treatment has no allies, there is no sense of solidarity in the face of the aggressor – there is no mutual uprising to defend this course of action. The offending patient is now, for this period of time at least, isolated from the collective – this newly acquired role is one that is deliberately rooted in social, physical and psychological vulnerability.

Goffman (1961, p. 33) goes on to describe the physical and observable ramifications of such a treatment, the *"choking gasps"* and *"foaming overflow of saliva"*. Such scenes were openly visible to other patients as Goffman observed. It is this palpable visibility, again

[29] Electroconvlusive Therapy is also known as ECT

referring to the nightmarish qualities and effect that such observations can have on the human psyche, which in turn may serve as a timely reminder to those onlookers that deviant behaviour within the institution might incur the most frightening of punishments[30]. This sequence of events can work as a warning to patients, it is after all positioned as a well-rehearsed, premeditated exercise in group social control – this is what will happen to you should you step out of line. It is not only the dread of receiving 'shock therapy' but perhaps more potently, on the one hand being part of such a highly visible spectacle but also the feeling of being alone, as situated on a side consisting of only 'one'.

In the following extract, Jane, a 52 year old service user discusses her own feelings of receiving ECT as a form of therapeutic intervention. It is worth noting at this point that ECT is still used today with some research suggesting that older service users benefit from this intervention (Benbow, 1989; Frazer, Christensen, & Griffiths, 2005; Mulsant, Rosen, & Thornton, 1991). Benbow (1989) points to the ways in which clinical studies indicate that ECT helps to alleviate the re-emergence of depression in the older population with only temporary side effects of anterograde amnesia and only a limited loss of retrograde amnesia of about one or two weeks memory loss prior to this treatment[31]. Key proponents endorsing the use of ECT as an effective treatment often draw attention to the wider cultural assumptions that this particular method of intervention suffers from an exaggeration of side-effects and negative portrayals particularly within the media ((Benbow, 1989; Mulsant, et al., 1991). Perhaps for many service users these pervasive and largely negative influences which can be depicted within varying forms of medium act as a platform to instil a feeling of potential fear before treatment is even undertaken.

Jane has spent periods of time within psychiatric institutions but was discharged into the community to live independently. Although Jane discusses the threat of compulsory detainment via 'sectioning', she was resident within the hospital at the time. This is an interesting point nonetheless as she relates the threat of being detained, perhaps for a longer period, as a means of getting her to have this particular treatment. It is also worth noting that Jane had twenty four courses of ECT during her stay in this particular institution.

> *Jane: Yes yeah and then I fell ill and um and (1) I had electric treatment going back about (2) thirty years um and I was forced into it (I=mmm) um (2) they*

[30] It is appreciated however that not all cultures may share the same concerns regarding the use of ECT
[31] Memory loss is often reported as a side-effect of receiving ECT as a therapeutic intervention

said if I didn't have they'd section me so they kept pushing and pushing and in the end I just give in (LAS =yeah) and then I tried to run away cos' I was frightened… I was frightened of it (LAS = mmm I can understand that)… and I had twenty four…um I know you need a lot around you but the fear before it was terrible because when you wake up you don't know who you are you don't know where you are (1) and I was so confused I was then than before (LAS=yeah)

In this extract, Jane initially punctuates her illness as a mediator of receiving treatment *"I fell ill"*. She then goes on to situate her account of this coercive experience in time *"back about thirty years and I was forced into it"*. In this way, Jane plants the stakes of time as a mediating factor, as a means of circumscribing this particular memorial event (Reavey & Brown, 2007). A particular period in time when service users did not have a voice or say (e.g. Cooper, 1970) in their treatment but she also indicates her youth which may serve as a way of negating any form of deviance to resist such an intervention due to her immaturity and vulnerability. To summarise, for Jane, at this period in time she was too ill to resist, service users were largely positioned as compliant to psychiatric intervention at this time and, finally she was too young to fight the system with any kind of confidence in her convictions.

Notwithstanding these mitigating factors, Jane talks about she tried to run away. An assumption can be made that this attempt to flee these circumstances was unsuccessful as she does not elaborate on this point further. What is interesting here is the fear factor, *"I was frightened…I was frightened of it…you know the fear before it was terrible"*. This particular narrative illustrates quite clearly the real fear and dread that ECT holds within the human psyche, that complex mixture of stuff that nightmares are made of. Perhaps, these kinds of anticipated feelings of terror may be exacerbated by the monstrous associations with electric shock therapy, by this I mean the ways as children we associate electric shocks when placed near the brain as having links with fantastical creatures such as the creation of Mary Shelley's fictional character of *'Frankenstein'*. These kinds of images can resonate within our conscious minds as we picture the man-made object which is shocked to life, via electricity, this monster which ultimately becomes a destructive force.

Perhaps for Jane as with many Westernised communities, this imagery is one that pushes the boundaries of what it is to be essentially human and what it is to be a manufactured creature. This may be represented as a step too far in changing one's sense of self identity and changing one's biological structure in that neurological structures are altered. Thus, equating not only to a neurological invasion but also an invasion of the soul, the essence of what makes us human but above all, a sequence of unwanted, personally invasive events.

These types of changing representations of self are reinforced when Jane states *"when you wake up you don't know who you are you don't know where you are"*. Here she emphasises a great loss, the loss of self-identity and the loss of location. Not only had this treatment distorted her sense of who she had been and who she now was but her spatial footings had been uprooted too. Subsequently, this therapeutic intervention had essentially displaced her in all ways possible. Jane then wraps the entirety of this period of her life as one of confusion, both psychologically, physically and space – she has no fight left in her and temporally, no stake in a place to mark her own territory. Perhaps she felt left in a kind of spatial limbo.

These are important elements to bear in mind when discussing ECT as a therapeutic intervention which go some way to explain the contentious arguments that still ensue around giving this particular form of treatment. It is a narrative of an epiphany, an irrevocable moment of change of Jane (Denzin, 2001), as her body was now violated by human touch and moreover, by the force fields of electricity. Or as Denzin (2001) would suggest; it is a narrative testimonial relating to the intersection between the personal and the wider, historical institutional and cultural aspects of her own life story.

Using clinical interventions such as ECT, the notions of the institution mobilsing itself as a spatial entity primarily concerned with producing compliance and conformity have become acknowledged as a well-rehearsed argument. Drawing from the discourses and visual imageries borne out of the uprising of critical psychiatry during the 1960's and 1970's, such debates have created a mixture of political, cultural and social strands seeking to explore the conception, function, method and outcomes relating to the mechanisms of the asylum.

For example, the release of the film, *'One Flew Over the Cuckoo's Nest'* in 1975 was and still is a highly influential and critical portrayal of institutional life (e.g. Anderson, 2003; De Carlo, 2007; Hyler, Gabbard, & Schneider, 1991). In essence, this particular film plays out the scenes of power, confrontation and patient surrender, the Foucauldian concept of psychologically 'wearing down' the patient. In addition, as the drama unfolds one is aware that punctuated throughout the film the use of certain therapeutic apparatus plays an essential part as a means to exert social control as per Goffman's writings.

4.7 Institutional space as production of perpetuating boredom

> *"Of all the afflictions to which human nature is subject, the loss of reason is at one the most calamitous…Deprived of this faculty, by which man is principally distinguished from the beasts that perish…The figure of the human species is now all that remains to him, and like the ruins of a once magnificent edifice, it only serves to remind us of its former dignity and grandeur, and to awaken our gloomiest reflections – our tenderest regret for the departure of the real and respectable man"*
>
> Philippe Pinel (1806, in Porter, pp 12-13)

This quotation by Pinel who some christen the 'father of modern psychiatry' (Gilman, 1985; Szasz, 1971) taken from *The Treatise on Insanity* would seem to suggest that to lose the very essence of all that resembles humankind, that which separates the human from the beast (namely, intellectual reasoning), is to make the irreversible transformation into all that is 'madness'. Subsequently, mental health distress is seen as a fundamentally sub-human experience whereby the superiority of the higher forms of reason, which Pinel aligns exclusively to humanity, are lost and those afflicted exist as an empty shell. Now void of any form of integrity, the beast and the 'madman' merge into one, both unable to rationalise, unable to have any real purpose in life with the end result that the uniquely human psyche is irrevocably lost (Foucault, 1965). All that is left is a psychological abyss; the physicality of the human form is the only remnant that reminds us of the person that once was.

Interestingly from an analogical perspective, in the case of the animal world, any forms of seemingly 'illogical' and 'deviant' behaviours may indeed be instigated and perpetuated by the actions of human beings. For example, one can observe the repetitive bodily actions of

the captive polar bear where there can be the repetitive pacing up and down, with head swaying all operating within the confines of its enforced imprisonment. As a result of these visible negative behaviours, socially organized campaigns have claimed that the isolation and encasement of the bear can be instrumental in mediating excruciating boredom which manifest in a series of bodily movements not seen when bears are living in their natural environments.

Nevertheless, this particular trajectory does not seek to argue the evolutional and social complexities of any pragmatic correlations that may exist between the animal world and that of mental health service users. It is however interesting to note, as an exemplary indicator, of how contemporary Westernised societies have condemned the adverse treatment of such creatures. Arguably, this may be a result of the positive transmission of how the optimal welfare relating to the confined polar bear has been successfully conveyed to the general public via zoologists together with supportive media representations. Nevertheless, have we afforded the same level of concordance to those with mental health distress? Or, has the psychiatric patient been "expected to live in an unlivable situation?" (Laing, 1965, p. 95) Whereby, not unlike the captive polar bear people with mental health distress were and still are contained within exclusive territories away from mainstream society.

Taking the above position forward, I would like to discuss the following excerpt. Harry, a 76 year old user, discusses his long stay within a psychiatric institution. Harry was detained within a psychiatric unit for most of his adult life and was subsequently discharged to live in the community within a supported setting. Harry's details of his personal history of how he came to reside in a psychiatric institution were not discussed. This was due in main because the day centre staff only allowed us to have a short interview (15 minutes) due to his physical and psychological fragility. Harry did not seem to want to discuss his diagnosis during the interview, and I therefore did not explore this area further.

> *LAS: Where were you before you went into supported accommodation?*
> *Harry: I was in hospital as well (object drops off the table) I was in hospital for quite a long while I was quite bad and um (coughs) very bad at one time and um at different times but when I was a bit better I just used to live there instead of going home like you know or anywhere else...and it weren't too bad it was alright um...some people you see they can't understand why I'm fairly*

well now I mean not perfect, fairly well (LAS = mmm) for so long but you see I weren't bad all the time..."

LAS: So did you get any help before you left the hospital um you know cooking lessons for example?

Harry: Um mainly making baskets and trays and um no didn't enjoy that um there were workshops you see and I had to work in one of them.....

What is of interest within Harry's narrative is the feeling he imparts of psychological and physical resignation – a path of least resistance to his residency within the institution. I was there (the psychiatric institution) and there I stayed; "*until I was discharged*" – Harry does not draw from the language of emotions to punctuate his experiential account of this particular time, a factor which was also present during the interview process. This is an important point to note because, unusually within this research project, Harry was the only participant, who did not display outward signs of emotional response such as crying, laughing, shuddering etc., when discussing his memories.

This is a complex pattern of discourses as on one hand, contrary to the prevailing negative discourses of psychiatric institutions as spatialities of oppression, marginalization and imprisonment (Foucault 1965; Goffman, 1961), Harry's narratives suggests this residential arrangement was both inevitable and at some level, acceptable. Harry's notion of his sense of self during that period are expressed thus; '*I was in hospital for quite a long while I was quite bad and um (coughs) very bad at one time'*. Here, he frames his time within that particular space as a reflection of the position of 'illness' he held within the social order at that time, a social position of legitimately belonging within a territory allocated for the 'mad and the bad' (e.g. Foucault, 1965; Scull, 1979). Within this, there is also an implicit acknowledgement here that the psychiatric *'hospital'* constitutes an ordered system of medicalised rules and practices and structurally (in terms of physicality and the discourses of power). The *'hospital'* subsequently can mediate as a disciplinary terrain from which the relations of power between the sane and the insane may take place (Foucault, 2006).

This is not so much the case when his accounts illustrate a change in his mental wellbeing '*but when I was a bit better I just used to live there instead of going home like you know or anywhere else...and it weren't too bad it was alright um...'*. At this point, Harry's narratives illustrate some (albeit) muted positive aspects of being embedded within institutional care. However, exploring these narratives of home and residence, we are presented with a sense of

just 'living' in terms of physically existing as one 'recovering' body residing amongst the madness of others. Elements of the mundane are also illuminated here, the *'not too good and the not too bad', 'it was alright'* present a flavour of living in a sensual void by punctuating his experience with discourses imbued within the ordinary and the everyday. Perhaps, for Harry, during this period of his life the hospital performs as a spatial non-place as he ***'just** used to live there instead of going home like'* suggesting an only, a singular plateau of stable tedium (Tucker, 2010a).

In terms of space as non-place, Augé (1995, p. 86) proffers "…we should still remember that there are spaces in which the individual feels himself to be a spectator without paying much attention to the spectacle". In this way, although it is not made obvious within the above extract as to the circumstances which kept Harry within the institutional surrounding – although this lack of disclosure is emphasized more phenomenologically through his discourses of affective disengagement (Cromby, 2011). Subsequently, Harry discursively locates himself on the edge of this collective terrain; he has dipped his proverbial 'toe in the water but does not immerse himself fully – 'one foot in and one foot out' (Deleuze & Guattari, 2004).

This sense of self ambivalence of only *'just'* may well be bound up with Harry's shift from being a psychiatric patient in need of medical attention and surveillance to that of being a surplus body within the confines of the institution, a body which no longer receives the previous levels of consideration from others. To some extent Harry is now psychologically and physically invisible. In this way, Harry's sense of eroding self-identity as being 'mad' is linked to his own constructions of institutionalised space mapped out within the discursive practices of the medical 'gaze' (Foucault, 1965). This sense of once belonging to the landscaped territory of the asylum shifts and Harry is subsequently spatially deterritorialized. *"Deterritorialization names the process whereby the basis of one's identity, the proverbial ground beneath our feet, is eroded, washed away...(it can produce a sense) of loss, or, becoming-imperceptible"* Buchanan (2006, p. 23) (The concepts are territorialization and deterritorialization are discussed in more detail in Chapter Two). These memorial accounts are therefore located across a range of periods of time which are linked and made concrete from his time spent within a spatiality designated for 'abnormality' (Conradson, 2005).

By weaving these discourses together, Harry's embodied experiences suggest a period of indeterminacy, shifting from a sense of 'belonging', a sense of feeling *'bad'* and thus,

confined within the spaces of psychiatric practices to that of improved feelings of psychological wellbeing, but still remaining confined within a space under the psychiatric 'gaze'. This shifting of experiential accounts intimates a period where Harry may be stuck in limbo, somewhere in the middle or between points, between the hospital as a psychiatric patient, between the hospital as a 'recovering' psychiatric patient and the outside world, between periods of insanity, sanity and the mundane. As Massumi (1991, p. 19) notes; *"No sooner do we have a unity than it becomes a duality. No sooner do we have a duality than it becomes a multiplicity. No sooner do we have a multiplicity than it becomes a proliferation of fissures converging in a void"*. Harry's discourses within his narrative serve to illustrate this sense of continuous reproducibility of living in an emotional vortex, of living in a multiplicity which culminates in an empty space devoid of sensual experiences.

Harry's juxtaposition of narratives may not be entirely surprising as we are provided with an essence of the culturally defined mundane activities such as *(...mainly making baskets and trays)* an undertaking associated with the forced laborious life (*I had to work in one of them...and um no didn't enjoy that)* within institutions such as prisons and asylums, an institutionalised activity assigned for those who do not fit into the grander scheme of life in general. For Harry this was a task he saw as both meaningless but as an activity he thought worthy of mentioning when asked about his transitional preparation from institutional life to that of life in the community. Here we have competing discourses with me as the interviewer asking (*So did you get any help before you left the hospital um you know cooking lessons for example?)* in line with the dominant discourses of normative social functioning and Harry's response bound up within the duality of both meaningless and meaningful practices of institutionalisation. These reciprocal narratives illustrate the division between the affective practicalities of living as an institutionalised body and those of culturally normalised bodies living within the wider community.

4.8 Institutional space as production of habitual practices

Up to this point, I have discussed the ways in which institutionalised structures house varying modes and complexities in terms of place and space. As a reflection of this viewpoint, focus will now be on the repetitive and habitual practices of constituting personalised spaces within psychiatric institutions. Tucker (2010a) provides a starting point from which to discuss the relationship between space and psychological activities by drawing attention to the ways in which psychiatry seeks to stabilise service users by means of medication and psychological

therapies. In this way, any concerns of how service users' create place and space are neatly put on the 'back burner' as the dominance of biocognition still permeates the realms of mainstream psychological literature. Criticisms surrounding the negation of the *'spatial turn'*, or seeking to position space as static, meaningless and impenetrable in terms of adding more layers in understanding social life are further supported by others, particular within the realms of human geography (e.g. Buchanan, 2006; Thrift, 2006, p. 139).

The importance of considering the body within space is articulated by Thrift (2006, p. 141) who suggests that people do not merely move in and through space but are *"constantly sloughing off pieces of themselves, constantly leaving traces – effluent, memories, messages"*. In this way, bodies create a space through the means of movement, temporal habituation and then leave a succession of personal markers to denote a presence of kind (Hodges, 2008, p. 400). For example, we do not just physically move within the spaces of work and home but leave a collection of dead skin cells, hair and other components which make us uniquely us. Even in shared space we leave these corporeal indicators to mark that we fleetingly lived in that place. Hodges (2008, p. 406) offers the following to present a cogent argument of the importance of *"Human temporality, or temporalities if one considers its multiple dimensions, a symbolic process, is thus grounded in everyday social practices, and is the product of these practices..."*.

Perhaps, from a spatially and socially grounded perspective, the following extract from Tom provides the most complex account of how institutional space is at one both extant but also temporally ephemeral. The space of clinical functioning can be broken and thereby destabilised with the body taking centre stage within this particular performance. Tom is a 50 year old service user who has spent many periods of his life residing within formalized psychiatric institutions. Some periods have been relatively short-term, i.e. 3 to 6 months and some periods of residency have extended to five years. These differences of time spent within the confines of hospital also indicate the temporality of Tom's periods of psychological well-being. They fluctuate as opposed to operating on a level continuum.

In the following excerpt, Tom discusses his accounts of residing in long-term psychiatric provisions:-

> *"You know there was one corridor (LAS = Yeah) like the kitchen was right at the bottom end, you start at the other end sort of going up and down (simulates*

moving up and down in chair), drinking tea, coffee, tea, coffee, fag, fag, fag, fag and you're going 'addaddaddaddadda' (waves arms above head) (both laugh) it's like um Prisoner Cell Block H (laughs)"

Firstly, Tom provides a cartography punctuated by stable landmarks; *"You know there was one corridor (LAS = Yeah) like the kitchen was right at the bottom end, you start at the other end"*. We are given a sense of the linear symmetry of a singular corridor with no bends or curves, just a straight line between the kitchen and the other end of this passageway. This regularity of a limited landscape can perform as a mediator to illustrate Tom's feelings of confinement "*it's like um Prisoner Cell Block H"*. Tom could be constrained within a confined linear space with no remarkable features within his landscape and this extract may go some way to illuminate his feelings of intense boredom, and of feeling incarcerated.

Interestingly, here, are the spatio-temporal ways in which Tom momentarily territorialises this space by the means of reiteration or performavity; *"sort of going up and down (simulates moving up and down in chair) drinking tea, coffee, tea, coffee, fag, fag, fag, fag and you're going 'addaddaddaddadda' (waves arms above head)"*. We are now presented with a feeling of the succession of his repetitive behaviours. Tom gives a sensual account of how his everyday life is topologically produced in terms of spatial habituation – his own mapping of events and space. This does not mean that reiteration stabilises or anchors space as a static dimension but moreover as Deleuze & Guattari (2004) proffer the motions of *habit*, is the repetition of performances to enable a production of space as anchored in the present. In other words, each performance is always qualitatively unique and although there is a level of human anticipation and the seeking of assurance that all performances perfectly mirror each other, times of the past can never be recaptured again (Mahler, 2008; Tucker, 2010e). We may never repeat the seemingly repetitive act; we may never recapture the previous memory of performing the same set of sequences today as we did yesterday. *Habit* is fleeting; it is formed through the relations of the indivisibility of unity in terms of time and space (Wise, 2000; Thrift, 2006). *Habit* is never tangible; as soon as it happens it disperses and ultimately dissolves into the ethereal, never again to be felt or lived in precisely the same way again. It is just our expectation that the same movement, the same motions, the same person, the same shedding of dead skin cells fuel our hopes that repetition will anchor and stabilise our sense of space (Deleuze & Guattri, 2004).

Taking Tom's account forward, his discourses of repetition of *"drinking tea, coffee, tea, coffee, fag, fag, fag, fag and you're going 'addaddaddaddadda (waves arms above head)"*, of repeatedly drinking tea, coffee and having a fag after fag are all discursively contained within a kind of circular motion, one event follows the other which serves to fill out his sense of space within the corridor, an act of deterritorialization. The ennui of the spatial symmetry is briefly interrupted and, subsequently destabilised when Tom briefly breaks through the barriers of the linear constraints. This is his own creative circularity, his own version of iteration that seeks to stabilise his space as having jagged edges, of waving arms, of talking in a nonsensical language – all presenting a moral antithesis to the confines of his current situation. Momentarily, the space belongs to Tom; it is his own traces (the smell of coffee, the cigarette ash on the floor) he leaves behind that mediate the relations of usurping the psychiatric space and his own sense of self, of a person resisting the shackles of mental health distress and the institutional constraints contained within such a space.

Within this spatial performance, Tom ricochets back and forth within the boundaries of institutional life. He gives a flavour of his own way of territorializing the space, making it his own against this backdrop of psychiatric regulation. Interestingly, this territorialisation is fundamentally limited by these regulatory practices. He can only walk up and down the corridor and his efforts to territorialise space fit neatly within the perceptions of distressed behaviours. Tom is giving the performance of a veritable 'mad' man. It is almost as if the limitations of the space drive him to these acts of madness which only reaffirms his own status as having a need to be located within this space.

4.9 Institutional space as production of indulgence and retreat

As alluded to previously, the ways in which institutional spatialities are individually embodied are both complex and heterogeneous. Rather than the psychiatric hospital mediating a sense of the mundane and of psychiatric oppression, this space can also exude narratives of desire, comfort and security. Thereby the monolithic structure, the rows of beds within the blocks of wards, the mediocrity (in terms of daily life) and sterile functioning of the psychiatric hospital has yet another layer. We are now presented with a plateau of self-indulgence and psychological safety – a space to retreat and be comforted in times of crisis. The spatial production of the psychiatric hospital as offering feelings of security and emotional well-being is discussed in Karen's story below.

In terms of analyzing Karen's narratives, it is necessary to contextualise her own social status within the realms of the constructed identities of mental health distress (see Chapter One for further discussion). Karen, aged 53 years (at the time of the interview) was middle-class and within a long-term, stable heterosexual, married relationship which was unique within the participant sample as she was the only home-owner. She was an ex-professional Manager within a large, British banking organisation and, as such, had access to limited private healthcare provisions[32] as part of her remuneration package. Subsequently, within her extract, Karen discussed her time spent within a privately managed, mental health psychiatric hospital.

This disparity between Karen and other service users indicates that an imbalance of financial and social status exists between service users. Carter Park & Radford (1994) draw attention to the divergent ways in which the modes of operation within psychiatry function based on a circularity of influence between geo-demographic variables, social constructs of the psychiatric body, officialdom and related institutions of care. In this way, the demographics of being financially secure and professionally accomplished impact on the way a service user is socially positioned, i.e. as not economically dependent on the State. In turn, this social positioning can provide access to other forms of psychiatric care, which are not bureaucratically processed via charities and social workers for example. Karen's identity within the discursive practices of psychiatry and her immersion within therapeutic care are subsequently forged by the salient derivatives of social class and socio-economic status (Rattansi & Phoenix, 2005). As Massey (2004, p. 5) notes "Identities are constituted through practices of interaction. Identities are forged in and through relations..." This is an important factor to bear in mind in terms of Karen's narratives in relation to both Harry's and Tom's narratives when analysing experiences of residing within spaces of state funded hospitals and those that are financed through the private sector.

At that moment in time, where Karen stayed was not unlike the spaces of living within the parameters of being 'financially successful' or 'being part of the celebrity bandwagon of psychological misfits'. Here, hospitals afford a space for retreat from psychological distress. For example, 'The Priory', is such a space of psychiatric therapy and 'rehab' entwined within the lives of the rich and famous e.g. Robbie Williams as openly discussed within popular cultural media (such as Heat, Hello magazines) whereby we are presented with the hospital performing as a buffer to combat the stresses of fame and financial accomplishment.

[32] Karen no longer receives this financial health benefit as there was a financial limitation on her claiming expenses relating to health care

In other words, we are presented with an antithesis here. On the one hand we have the negative 'grubby' constructions of the mass of financially dependent bodies within state care, wherein the balance of power is firmly located within the discursive practices of psychiatry (e.g. Foucault, 1965; Goffman, 1961; Scull, 1979), and the discourses of economic resources procuring higher levels of individualised care, wherein the hegemonic relations shift as the paying 'patient' becomes the key stakeholder within these discursive exchanges (Carter Park & Radford, 1999). As Thrift (2010, p. 2) notes; *"...through the articulation of an ontology of achievement, different associations are able to be made...and different landscapes of possibility are subsequently able to be uncovered."* In this way, there can be a production of variable social cartographies in terms of mapping bodies (service users and psychiatric staff) within the differing political and economic spaces of state and private institutions.

Within the following extract, Karen discusses her residency within private, psychiatric care:

> *Karen: '...but there again you can get um dependent on the (2) the um (3) the fact that you're being cosseted all the while (LAS=yeah) and it's um (6) oh (sighs) um I wanted to stay there (LAS=yeah) you know I would* ***love to be able to go there now***[33] *and just, just shut meself away for a month or so (2) you're, you're just dependent on um I can't, I can't think of the word"*
> *LAS = Did you feel safe there?*
> *Karen = Oh* ***yeah, big time*** *(LAS=yeah)*

Initially, Karen discusses the more dominant discursive constructions of institutionalised care in terms of reliance, of not being able to cope within the wider society without the structural support afforded by psychiatric interventions *"but there again you can get um dependent"*. Karen discursively negotiates her own ontological position as one of a service user located on the periphery of the more dominant constructions of long-term psychiatric care by counteracting the acknowledgement of 'others' becoming dependent 'institutionalised' bodies by offering a perspective wrapped up in the discourses of pampering *"the fact that you're being cosseted all the while"*. This maybe offsets Karen's position against one of being embedded within the medicalised regimes of institutional care to that of being in retreat and being indulged. This sets the scene of a potentially different landscape from which Karen can present her embodied experiences as being located outside of the juridical systems of

[33] Text highlighted in bold indicates louder volume when speaking

coercion, surveillance and control by offering a narrative one could possibly associate with paying to spend time within a health spa for example (Thrift, 2010).

Karen articulates her position further by drawing attention to two areas of interest. Firstly, she alludes to the higher level of personal control she had when in hospital; *"um I wanted to stay there... you know I would* ***love to be able to go there now*** *and just, just shut meself away for a month or so"*. Perhaps for Karen because she was a private patient she has set herself apart from the cultural frameworks of detainment under Section 3 of the Mental Health Act (unlike Harry who remains in the psychiatric unit even during his periods of feeling better).. It could be that these accounts of her past experience illuminate her own sense of retaining autonomy by expressing her desire to remain within this space *"um I wanted to stay there"*. Karen can therefore reiterate her social and economic power which in turn allows her the capacity to move in and out of psychiatric interventions; *"just shut meself away for a month or so"*. This could be a direct contrast to her compatriots who, under compulsion, can remain resident within state funded hospitals. Of course, this does not mean that Karen entered this hospital as a service user who was not wrapped up within the legislation of enforced hospitalisation. But more so, her narratives suggest some levels of social mobility.

Secondly, Karen expresses the relational discourses of desiring to be located within this space which she considers as performing a place of sanctum *"(LAS) Did you feel safe there? Oh* ***yeah, big time****"*. Subsequently, her narratives within are bound up with the sensualities of security, of feeling protected without the impingements of the outside world. Overall, we are presented with an extract where, for Karen, her time spent within the psychiatric unit was one which can absolve her from taking the responsibilities and burdens associated with everyday living. In this way, she uses discursive strategies to make clear distinctions from other long-term psychiatric patients as she is only seeking a temporary retreat from the everyday. Karen is a service user but this does not mean she had any connective sense of belonging to those psychiatric communities that are deemed incapable of 'normative' social functioning.

4.10 Discussion

In this chapter, we are presented with a divergence of experiential accounts and discursive practices relating to the spaces of institutionalised settings. This emergence of variance does not stabilise the institution as either a space of clinical order, a space of oppression or as a space of 'care'. Rather, we have a curious collection of embodied experiences and social

performances, with some relating to the fantastical (Jane's story of ECT – Tom's disruption of space), the mundane (Harry's story) and the discourses of indulgence and escape (Karen's story).

Foucault's concepts of the 'performance of cure' were drawn from to explore how service users negotiated their own sense of self and space in conjunction with the institutional staff and the regulatory practices of psychiatry. Referring to some domination notions encompassing the ordering and arrangement of space, time and performance, a framework of the perceived assumptions of clinical interventions emerged. This platform offered a multitude of the ways in which service users 'felt' their ways around this space. Here accounts appeared to be grounded in the abusive ways of subordinating patients, the perpetual mundaneness of institutional life, of emotional insulation and of disruption.

I also discussed the ways in the production of space is always in a state of flux, even though attempts may be made to anchor space by the use of certain markers (Thrift, 2006). Looking at Mary's account where another service user destabilised the night time space on the ward, a time of peace and quiet was interrupted by the breaking of a window and a door. Tom's accounts of breaking up the linearity of his institutional space were also discussed. These were interesting experiences to explore as a set of meanings elaborating on the mutability of the production of space.

Drawing together all these threads to produce a coherent body of work is a multifarious task to undertake. There is a multiplex of perspectives relating to psychiatric institutions. Social performance(s) and issues concerned with embodied memories of psychiatric space are inter-dependent, they are bound up with the Doctor/patient power relations of psychiatric discourse and practices. What has been explored here is the different ways that these power relations are played out in institutional space. Here there is a diffusion concerned with the various acting roles (and use of props) the performers have embodied together with the different ways in which their personal scripts and actions seek to portray their own experience of institutional life. For sure; *"The cure scene is complex"* (Foucault, 2008, p. 10).

Consequently, the spaces and discursive practices of psychiatric care may mediate a series of social performances. This is not to suggest that such performances are stable, or will indeed be remembered by those concerned in the same way again. Rather these performances whilst neatly frozen on the pages of this chapter are not static, they are subject to movement, change

and more importantly, vulnerable to another version of a different performance. In other words, these narratives are not set in stone and neither should they be. Rather, they can form part of the memorial testimonies within the weaving of a biographical tapestry. Here, the thread can be broken, snapped in pieces or can become entangled within the weft holding other threads or indeed, fade due to the overexposure of sunlight.

Chapter Five

The pervasive socio-medical and spatial codings of day centre spaces

> *"A map has multiple entryways, as opposed to the tracing, which always come "back to the same". The map has to do with performance, whereas the tracing always involves an alleged "competence"...The tracing has organized, stabilized, neutralized the multiplicities according to the axes of significance and subjectification belonging to it...it thinks it is reproducing something else it is in fact only reproducing itself. That is why the tracing is so dangerous. It injects redundancies and propagates them".*
>
> (Deleuze & Guattari, 2004, pp. 14, 15)

5.1 Introduction

In this chapter, I will set out to explore the multiple ways in which the diagnostic identity of service users and the spatial structures pertaining to mental health day centres[34] are embodied and mapped out in everyday service user life. As in the case of institutional spaces discussed in Chapter Four, there are a divergent set of narratives and social practices which can be inextricably bound up with the medicalised and cultural codings of mental health. It can be a heteregenous landscape, with imagined and real boundaries; it can be a space of performance and negotiation based on the consensual psychological and behavioural norms associated with the wider society. However, these positions of multiplicity can create tensions whereby the mental health day centre, and in the case of this research, MIND which is a national organisation of charitable day centres (at both a macro and micro level), may seek to position itself as a stable set of operations. At this level, this stabilisation can be spatially anchored within the identical use of rules and regulations, the specificity of functions of certain rooms and how access to the day centre is granted.

This brings me back to the opening quotation as Deleuze and Guattari note above, a map is a multiplex, there are numerous entryways (as there are exits) but above all a map embraces the temporality of the variable terrains, for example, the water blockages of the dam, the swelling and rapid forces of the tsunami and the continuous erosion of the earth's defining features due to changes in the climate. In this way, the mapping of space is a performance bound up with ebbs and flows, blockages and leaks – these can be fleeting, enduring, ephemeral, and

[34] Mental health day centres will also be referred to as day centres

imagined (Deleuze & Guattari, 2004; Massumi, 1992). Unlike the tracing which only goes back on itself; a repetition of the same. The tracing for Deleuze and Guattari is a manifestation of organisational and social hierarchies, a space of sterilization. There is no chance of individual creativity in a tracing.

By transposing these concepts, we can glean a series of topological theoretical threads relating to space and performance within the day centre. Or as Deleuze and Guattari (2004, p. 51) term an "*isomorphism"*, a conceptual idiom applied when the complexity of dual structures map onto each other. For example, a mountain range and a singular rock have similar constitutive layers such as granite, limestone and both structures have developed their sedimentary elements over long periods of time. The only difference here is that the mountain range is a larger structure than a rock but they both share corresponding features. This concept of *"isomorphism"*, of dual structures being formed from the same components indicates a level of mutuality in that both a rock and a mountain, although different in stature and perhaps geological and geographical importance, share similar characteristics. This particular concept can be useful when analysing mental health geographies, such as the day centre when compared to the wider society.

At the macro level we have a cultural cartography allocated for the *'the other'*, a space particularly allocated for the 'insane' (Parr, 1999; Sibley, 1995). This kind of homogenising mental health distress whereby service users with diverging diagnoses share the same space (the day centre) makes sense when one considers elements such as political, social and economic pressures. It would not be feasible to initially fund and maintain a space solely allocated for Borderline Personality Disorder for example. Instead, what we have here is a space consisting of a 'melting pot' of various psychiatric codings where categories are somewhat positioned as melding in largely unproblematic ways. All service users have a diagnosis emanating from the categories of mental health distress, many are aware of the wider negative connotations that such a diagnosis can bring in terms of social identity. Consequently, this space can provide a platform from which a micro collective of 'us' (service users) versus 'them' (the wider society) can emerge (Conradson, 2003b). Here, the day centre can be situated as a designated place for mental health within the community, a place which can be somewhat romanticised by grounding this space within the discourses of mutual support and socialisation (Hall & Cheston, 2002).

Nevertheless, together with the multiplex of diagnostic categories, the day centre can also perform as a psychiatric and social hierarchal organisation whereby some service users are coded as being 'more ill' than others (Parr et al., 2005). This heterogeneity can be produced by the selective ordering of diagnoses and behaviours where the 'riskier' diagnoses within the psychosis spectrum can be pitted against the more normative diagnoses of depressive classifications. At some level, we have an indication of the mimicry, or a tracing, of the wider social and cultural structures and relations of power emanating from both the psychiatric institution and society as a whole. Certain psychiatric classifications, such as 'paranoid schizophrenia' may therefore be positioned as more extreme (Canning, 2006) than other diagnoses which can then create nuanced and more tangible contradictory behaviours of intolerance amongst this micro collective (Parr, 2000).

From this we are presented with a 'middle ground' spatiality whereby the day centre can reflect a place imbued with the notions and actions of *"alleged competence"*, a space which can be boxed off and compartmentalised when divergent diagnoses are taken into account. The day centre can then become a map of multiplicities when we consider the ways in which some service users are actively isolated from the spaces of the social group (in terms of this research, more specifically when a diagnostic identity and unconventional behaviours are taken into account) by other groups of service users. It is the spatial tensions and the potentiality of social conflicts which are of interest in this chapter.

Drawing from one-to-one, semi-structured interviews together with ethnographic observations and research diary notes (taken over a period of three years), this chapter seeks to draw these strands together to provide a picture of the ways in which space and a sense of place are played out within these (semi)institutionalised therapeutic spaces of care and recovery. These are pertinent themes to explore further as a set of divergent structures incorporating expressions of a sense of displacement or non(place) (Parr, 2000), comfort and safety, engagement and control (Fogel, 1992) when discussing the territorialisation of shared spaces located within mental health care provisions (Buchanan, 2006; Tucker, 2010a).

To provide some empirical context all the day centres visited in my research were run by the charitable organisation Mind and were located in the East Midlands. Initially, I will draw from research data collected around the various participating day centres but towards the end of this chapter, I will focus on one day centre (this centre will be called Walton). The rationale for this analytic trajectory is because this particular day centre was very structured in

terms of allocating space (and the slicing up of time) when providing a series of regulatory daily activities. Largely, on the face of it, this particular day centre space was neatly ordered and arranged whereby the service users and staff engaged in assigned activities. When this spatial ordering was disrupted by some service users it was more perceptible than in other day centres due to the stratified and somewhat, static backdrop. Conversely, in other day centres, where movement and performance were more fluid, unconventional bodily behaviours were less visually pronounced or indeed, frowned upon by other service users and staff alike.

Utilising some of Deleuze & Guattari's concepts encompassing hierarchal identity and the shifting cartographies of space, performance and movement, this chapter will seek to unravel the multiplex ways in which some service users (re)negotiate their way within the day centre. To add further clarification in terms of notions of allocating hierarchal identities, this chapter will focus on the impact of two diagnoses namely, depression and paranoid schizophrenia[35]. These two medicalised and social constructs can have ramifications for how space is allocated based on diagnostic identity, with the wider cultural and service users' positioning of depression as being relatively *'normative'*, whereas schizophrenia can be viewed as the *'maddest of the mad, the baddest of the bad'* (e.g. Bentall, 1990; Burton, 2009; Cannon, 2001).

5.2 Who wields the axe?

Taking this dichotomous position relating to the diagnoses of depression and schizophrenia forward, Bill proffers his own cultural perceptions of these 'dualised' identities;

> *Bill – "A label yeah um and then you mentioned the word depression and* ***outside of here*** *um as opposed to words* ***paranoid schizophrenic*** *well boof you know you're a mad axe man etcetera and you're going to kill me (LAS=yeah) you know"*
> *LAS = So do you think that schizophrenia is seen as something very unpredictable and dangerous?*
> *Bill = Yeah, yeah...Although you're um in a way it's a bit of the extremes between depression and paranoid schizophrenia um (3),(sighs) yeah...Yeah I don't think they (the general public) see depression as being at all serious or*

[35] Depression and Paranoid Schizophrenia were prominent diagnoses within the day centre as far as I could infer.

being um because depression can get worse and it can deteriorate very, very (LAS=mmm) to the point of nervous breakdowns etcetera

In this extract Bill (a diagnosed paranoid schizophrenic) illuminates his own perceptions of the ways in the diagnoses 'paranoid schizophrenia' and 'depression' are culturally positioned within the wider society. Here Bill draws from an oft used analogy when discussing the unpredictability and potentiality for premeditated spontaneous outbursts of extreme forms of violence; *"you know you're a mad axe man etcetera and you're going to kill me"*. As a common thread throughout this thesis, the diagnosis of 'schizophrenia' is positioned as an extreme form of mental health distress. It is this diagnosis when combined with the classified behaviours of schizophrenia which constitute the majority of service users who are detained within psychiatric institutions (Sugarman & Craufurd, 1994).

On the other hand, Bill reflects on the cultural assumptions of depression; *"Yeah I don't think they (the general public) see depression as being at all serious"*. At some level, Bill's perceptions may make sense. Depression is often positioned as a common-day form of mental health distress which requires the ingestion of anti-depressant medication and therapeutic interventions such as Cognitive Behavioural Therapy. For Bill, depression is not taken seriously as a progressively deteriorating form of mental health distress; *"depression can get worse and it can deteriorate"*.

Again one is drawn to the wider cultural discourses and discursive practices of psychiatry and the media which may dichotomise these two diagnoses, with one being extreme (schizophrenia) whilst the other (depression) is more normative within societal populations. Styron (1990, p. 37) elaborates on the language of depression thus; *"depression is a word that has slithered innocuously through the language like a slug, leaving little trace of its intrinsic malevolence and preventing, by its very insipidity, a general awareness of the horrible intensity of the disease when out of control"*. In this way, rather than a social awareness that depression can at times have huge impacts on daily functioning, the populist position, for Styron and for Bill, is that depression is seen as trite and banal. Whereas schizophrenia resides on the other end of the scale in terms of normalcy (Canning, 2006; Laing, 1965).

To explore the ways in which diagnoses can act as cartographical markers within the day centre, a broad mapping out of the 'structured' day centre space and social (service users and staff) interaction would be useful to explore further at this point. Thus, providing a

framework from which to explore the differential ways in which day centres can operate in alternative ways.

5.3 The day centre as producing cultural differences

The 'Mental Health and Social Exclusion, Social Exclusion Report' (MHSESER) commissioned by the Office of the Deputy Prime Minister (2004, p. 47) notes that; *"Traditionally, day services have often focused on specialist support services that are solely for people with mental health problems. They often provide a 'one-stop-shop', providing a practical place of support during the day, as well as access to other services and advice"*.

Nevertheless, the MHSESER report claims that the downside in providing specialised services for those with mental health distress is that these spatialities perpetuate social exclusion as users are only provided limited access to mainstream provisions through day centre activities (Care Services Improvement Partnership, September 2005). This is a valid argument at some level by suggesting that the notions of wider social exclusion are further etched by demarcating places for service users to access support.

Consider the following data extract from Frank who discusses his own perceptions of how his day centre is positioned within the local community;

> *"I don't think if you bring them in here (the day centre) a normal day-to-day person, bring them in for about half an hour to an hour and see how long they last…they would be like "what the hell's all this about oh my", no they wouldn't understand…"*

Here Frank imparts a discursive essence of the cultural dichotomy in terms of hierarchal social positions *'them/us'* and *'sane/mad'* and the subsequent production of space; *"a normal day-to-day person, bring them in for about half an hour to an hour and see how long they last…they would be like "what the hell's all this about oh my"*. This discursive polarization is at some level spatially crystallised by Frank as he grounds his perceptions within the confines of his day centre. Maybe for Frank, the day centre is the space where the performances and movement of 'abnormality' and 'unconventionality' can manifest away from the prying eyes of the wider community. He highlights this by claiming that the wider community lacks an awareness of mental health distress; "*no they wouldn't understand…"*.

In this way, for Frank and maybe for many other service users, the day centre can operate as an exclusive space imbued with the flows and changes pertaining to mental health distress.

In essence, day centres can then mediate the functions of spatially removing service users away from other members of the community as a space of difference (Parr, 2000; Sibley, 1995). It is a smaller mirror image, or indeed, tracing of the psychiatric hospital. Thus, what we are presented with here is an 'exclusive' territory which is bound up with the discursive practices of mental health distress (Smythm 2005).

The traditional route for successful admission to day centres is bound up within the bureaucracy of mental health services. Initially, service users are formally referred via practitioners including psychiatrists, community psychiatric nurses and in some case, general practitioners. This referral largely stems from an assessment indicating a service user needs additional social and psychological support in conjunction with their medication regimens. In this way, people cannot usually access a day centre without a referral from professionals working within community mental health teams Catty & Burns, 2001).

Subsequently, the process of accessing services is enveloped within the political and medicalised structures of mental health as only those people deemed to require additional support are referred to these centres. These kinds of hierarchal codings have been established and are duly administered through the construction of relational discursive practices imbued within psychiatry. In this way, a service user needs to be fairly mad (a mixture of good and bad days) but not too mad (too many bad days would require acute psychiatric attention) though and ideally not too sane (don't need extra help if diagnosed with low level depression). At work here is a neutralizing patterning of behaviours formed through the stratified process of medicalised coding. This can be a process which blots out individual creativity and instead prefers to focus on homogeneity by positioning all service users as a tangible entity.

5.4 The day centre as producing social inclusion and 'recovery'

In an effort to avoid the delineating outcomes of providing dedicated spatialities for service users , there is much focus on providing 'social inclusion and recovery' programmes within day centres (Care Services Partnership, September 2005, p. 6). Such models aim to offer service users support in accessing other services and to "better their lives using education,

training and employment opportunities" (Department of Health, 1999, p. 21). In addition to offering practical sessions, day centres also provide counselling services, cookery classes, money management, creative activities (e.g. art, book clubs) and the more psychologically based sessions such as 'anger management' and 'coping with stress and anxiety'.

Some larger day centres also accessed wider local municipal services such as swimming and other recreational activities. In this way the ideologies of recovery programmes within day centres do not mean that people's problems are necessarily eradicated but moreover there is a move to support and guide service users in realising their own ambitions and to cultivate wider social relationships (Care Services Partnership, September 2005).

5.5 The day centre as producing service user identity

Up to this point, the preceding discourses have effectively created the cultural identity of the service user as a unified and static group of bodies. More saliently perhaps, these social constructions imply that not only are users a largely homogenous group but serves to reinforce their lack of creative ontology. For example, all service users who attend a day centre have one thing in common, namely mental health distress. As a result alongside illnesses such as cancer or coronary heart disease, the symptomologies and prognosis of mental health distress are viewed as a shared continuum,[36] a level playing field whereby those with a diagnosis can empathise and support each other.

This notion of mutuality can be taken one step further and even romanticised by suggesting that service users engage in consensual and non-judgemental social norms in terms of appropriating the social inclusion of those who experience mental health illnesses (Hall & Cheston, 2002). Subsequently, using *a priori* notions of mental health, the wider negative social constructions of abnormality and madness do not appear to permeate this particular geography.

In the following account, Karen draws attention to the emotional and social benefits she gains from attending her day centre;

> *"Um it's certainly been very beneficial when I've really poorly (LAS=mmm) and um I've felt like self-harming (shuffles in chair) um and whatever else um*

[36] This refers to the biomedical position

and just to be um here and sit is, is good enough (2) and just talking about anything can help you when you feel down."

Karen discusses the positive aspects of social support she receives from other service users, especially when she feels like –self-harming. Here we have a mixture of the ways in which the space; "*just to be um here and sit"* together with the interactional exchanges between Karen and others; "*just talking about anything can help you when you feel down"* can provide her with ways of coping with elements of her mental health distress. Perhaps for Karen, the day centre is primarily a spatialised production instilled within the realms of mental health – it is not so much a space of meeting others but can offer her ways of coping with negative periods of her life. Within her account, at some level, we are provided with the day centre as instilled with the aforementioned elements of service users as residing on a level playing field. There is no suggestion of intolerance or misunderstanding within her narrative but rather Karen seems to suggest a fairly stabilised self-identity of a service user who can gain support when she is feeling unwell. In this way, the day centre can be positioned as a secure 'bolt-hole' for mental health distress.

However, conversely, in the following excerpt, Jackie describes her own social identity within her local day centre.

"I've got a saying and it sounds a bit horrible but I don't make a career out of it in being mentally ill if you see what I mean and I won't attend MIND and I won't go to these groups where people are (2) are (3) just um happy to be slotted in (1) but you know you look at some people here and they've got mental health problems (LAS=yeah) and I don't like to be viewed in that light (2)"

Here Jackie presents an antithesis to Karen's accounts (and all other interviewees). Jackie only came to the day centre for the interview because she had seen a poster outlining my research when she had attended an *'Alcoholics Anonymous'* meeting. In this extract, Jackie seems keen to separate her own identity as a non-service user; "*I don't make a career out of it in being mentally ill"*. For Jackie, the day centre can provide a space packed out with the stereotypical positions of mental health distress – these could relate to dependency and reliance. Rather than seeing herself and other service users as sharing common characteristics, Jackie takes care to avoid boxing herself within the parameters of 'illness'.

Here, for Jackie, the day centre can mediate a space of conforming whereby service users are merely "*slotted in"* within the structured boundaries of space. Nevertheless, she has chosen to disengage herself both corporeally and psychologically by identifying herself as residing on the perimeters of mental health distress. She is a diagnosed service user but she does not embody the 'trappings' imbued within the daily lives of other service users.

These two accounts go some way to destabilizing the notions of day centres as producing spaces of shared understandings and mutuality. Day centres are seemingly more complex than such positions seek to suggest, they are more fractured in their ways of production when discussing service users as an homogenous community (Crang & Thrift, 2000; Parr, 2000).

5.6 The day centre as producing visible spatial and temporal boundaries

From a structural aspect, it has previously been noted that day centres and more particularly within the voluntary sector are varied in terms of available space, resources and ease of access (Pilling, 1991). Larger day centres will have one communal room where refreshments are available and users can either chat or engage in formalised activities such as chess and bingo. Generally, this area is quite noisy as service users either sit in small groups or undertake some activity as a collective. At times this group spacing can be humorous and relaxed whilst at other times, arguments can break out between members (and in some cases, with staff) during these occasions the atmosphere can feel very tense and there normally follows a period of hushed talking or silence.

In the following data extract, Daisy discusses the potential impacts of the hustle and bustle at her day centre during drop in times (unstructured sessions for chatting and drinking coffee) .

> *"I think your nerves and nerves play a big part I mean if, if you're constantly sort of tired you um (2) there's a lot um how should I say um (4) and there's quite a lot of ill people down here you know and there's quite a lot of characters and they can be quite loud and the drop in gets very loud at times and people get very stressed…but if you're feeling fragile (2) you know I can understand why some people wouldn't come in."*

Here Daisy goes some way to offer her own interpretations of why some service users do not necessarily engage with the informal drop-ins. These particular times which are less structurally and temporally spatialised do not always appear to offer psychological and emotional support. For Daisy, the more haphazard behaviours of drinking refreshments and chatting as perhaps opposed to the more structured use of space where more formal activities are undertaken (e.g. benefits advice sessions) does not suit service users at particular times of distress; "*they can be quite loud and the drop in gets very loud at times and people get very stressed…but if you're feeling fragile (2) you know I can understand why some people wouldn't come in.*" In this way, Daisy highlights on why some service users do not always feel comfortable and relaxed when informality enters the spatial mix.

Within this extract we are presented with an array of spatial rhythms describing illness, excessive noise and heightened levels of stress. This narrative of course only applies to Daisy's day centre and these kinds of behaviours therefore do not apply to all drop-in sessions at various day centres. Nevertheless, there is some intimation here that the boundaried spaces of the day centre are destabilised by the inhabitants during these specific times. The space and performance of service users can subsequently become more fluid and perhaps, more socially unconventional when the temporal and spatial boundaries of the day centre develop into a milieu of less self-regulated performances of expression and corporeality.

Nevertheless, in contrast, most day centres have other rooms allocated for specific functions such as delivering information sessions and art. For confidentiality reasons, there are usually a couple of smaller rooms allocated for counselling or for 'crisis' periods which are set away from these main areas and consist of two or three chairs, a coffee table and a box of tissues. Of importance to note however, the only area with 'open' access is the communal area as all other rooms are designated for purpose and are only used by those attending specific group activities. It is also usual practice to see members of staff present in all the areas used by service users.

In terms of temporality, not unlike psychiatric institutions (as discussed in Chapter Four) where the issues of how time is managed by hospital staff within these space, the day centre also has similar allocations of time management. For example, art groups will commence at 10.00 hours and finish at 12.00 hrs, lunch will be served from 13.00 hours and finish at 13.30 hours. In this way, time becomes an important element of how day to day life is spent at the day centre. This way of chopping up and boxing off of time into discrete patterns may go

some way in stabilising the structural use of a shared space. Whereby, service users who do not attend the art group during the specified time period are not allowed access within that particular territory. This regimen grounded in the allotment of time and place effectively cordons off and restricts the movement of service users. Therefore this particular landscape can operate as a structural tracing (in terms of space and time) by closing off portals and restricting spatial movement.

5.7 The day centre as producing a 'culture of silence'

However, the body's interaction within the physicality of the day centre is just one area of focus when discussing the embodied experience of service users. The reproduction of the 'unspoken word', although somewhat contradictory in terms, can be evident within this micro-geography. Parr & Philo's (2003) research within the Highlands of Scotland indicates that factors such as social gossip and potential stigmatisation prevent service users from openly discussing their 'problems'. Possibly, the socially embedded values of diagnostic variants discussed later within this chapter are at play resulting in a *'culture of silence'* (Philo, 2004, p. 1) as service users display levels of resistance to engage in conversations surrounding mental health.

> *LAS = Do you ever find that when you're here, do you ever talk about any of your sort of mental health distress here to any of the members or*
>
> *Bill = I personally don't, some people do but I don't (LAS=yeah) because I see it from the point of view is that there are professionals here that sort of (2) trained to deal with that and (LAS=yeah) so I talk to them (LAS=yeah) so...no I don't talk to members, if members ask me why I come here I'll give them the diagnosis routine of post-traumatic stress disorder and if they ask me what does that mean I say "well what happened" and I'll say something along the lines, not precise words but I prefer not to talk about that*

This type of social etiquette whereby mental health is rarely mentioned within communal areas of the day centre was noticeable to me as service users did not seem to openly discuss their mental health distress when in communal areas. The reasons for this varied from *"not being allowed to by staff to avoid bullying", "not wanting other service users to know one's diagnosis"* to *"lack of trust with others"*. However, one common strand within this creation

of silencing was the underlying notions of stigmatization between groups of service users (Parr et al., 2005). This suggests that the conceptual tracings of isomorphism, whereby the wider societal perceptions of stigma and mental health distress and more especially, perhaps, within the spectrum of psychosis can be perpetuated in the day centre. This thread is discussed in more depth later in this chapter.

5.8 The Day Centre as Constraining/Encouraging Particular Bodily Behaviours

Although all day centres are run autonomously from the central administration office of Mind, there are generic rules and regulations which have to be adhered to in order that service users can maintain their admission to the day centre. Subsequently, the day centre is a semi-institutional place where explicitly laid down directives are conveyed to all those attend both verbally and visually (by means of a poster). These rules encompass restrictions on certain behaviours such as no consumption of alcohol, no racial or sexual harassment, no swearing, no shouting, no discrimination and no upsetting of the *'peaceful enjoyment of others'* (Jenkinson, 2008, p. 233). Listing prescriptive behaviours in this way sets out a framework of appropriate behaviours to enable the successful cohesion of the members who share this space. Nevertheless, as Massumi (1992, p. 1) claims *"its twoness is a relay to multiplicity"* suggesting that the day centre as a space encompassing shared understandings of mutual social practices are far more complex than the aforementioned discrete postulations would intimate. The multifarious constituents of creating day centre spaces will now be explored further.

Below we have an extract from Tom, who offers an account as to why at that particular moment in time, he is on his last *'life line'*. In other words, he has once chance left to behave in the desired manner to maintain his attendance at the day centre.

> *Tom= Respect the staff, respect the um don't go off the wire which I, I do a lot of and Tina (day centre manager) I mean Tina's given me one life line left (laughs) in here and um I don't want to lose that life line…I mean I can really rattle my cage and that means getting my temper going…I was losing my temper and mood swings and temper, these things on people to get it off my chest (laughs)*
> *LAS = Do you think you were frightening people?*

Tom = I can, I can, I can (2) and um Tina and I daren't cross her at times. She's the manageress as she has the last say that I can't (laughs)

Within this extract Tom discusses how, at times his behaviours are seen by others as deviating from the norms of the group. Tom appears to be aware of the rules of his day centre; "*respect the staff, respect the um don't go off the wire"*. What is interesting here is the ways in which Tom describes his behaviour and the impact this has on his relationship with Tina, the day centre manager. Whilst he does draw attention to other people who may or may not be directly affected by his behaviour; "*mood swings and temper, these things on people"*, he doesn't explicitly refer to other service users within this space. Perhaps, for Tom, he acknowledges the written, formalised rules of the day centre but does not seem to readily 'buy' into the consensual norms adopted by other service users. In this way, for Tom, it may be that he places more attention on his behaviours around the known authoritative figures within the day centre (Tina) whilst paying less consideration to his interactions with other service users.

Tom appears to be aware that his behaviour can be intimidating to others; "*LAS = Do you think you were frightening people? Tom = I can, I can, I can"*. In this particular narrative, there is not so much a continuous rhythm of perpetually alarming other people but more so his accounts are located within the realms of potentiality. He can frighten other people at times but may not always be the case. Perhaps he scares some service users whilst others are more accepting of his behaviours at these times. Tom's narratives of his sense of belonging and movement within the day centre are explored later in this chapter.

5.9 The day centre as producing mutuality

Apart from offering practical support it is argued that above all, day centres offer a place to enable mutual social support and understanding away from the wider societal stigmatisation that service users' can experience (Hall & Cheston, 2002). In this way, the physical and therapeutic landscapes of mental health facilitate a feeling of mutual camaraderie and act as a buffer from the negative connotations associated with mental health distress (Hall & Cheston, 2002). As Parr (1999a) notes, those people with mental health distress, and more particularly during visible periods of 'crisis' who occupy public spatialities can be faced with a host of potential dangers compared to occupying those places inextricably bound up with therapy and

support. It is important to note for the majority of service users' involved in this research, the day centre was positioned as the primary crux in terms of providing support and maintaining positive social networks (Catty & Burns, 2001; Hall & Cheston, 2002).

In the following data excerpt, Nancy discusses the positive elements of her relationship with other people who attend her day centre.

> *"…but everybody's um all the people that are here down from the volunteers and the students that come (LAS=yeah) and the workers have all been really good, really helpful (LAS=yeah) really nice people and (1) you get the opportunity to say what you think and um (2) um (2) and you can put, put your ideas forward um"*

Within Nancy's account she also imparts a sense of personal empowerment within the group setting; "*you get the opportunity to say what you think*". Perhaps for Nancy her engagement within this centre goes some way to alleviating her own feelings of having minimal agency and 'voice' outside of this particular space. It could be that alongside the help and friendship she obtains from other people, the day centre offers her a space where she can feel she has some social worth and value.

Conversely, Mary's extract does not articulate such positive narratives of attending her day centre.

> *"I don't feel like I want to stay here for very long because I feel (2) I don't know I feel awkward sometimes here and it's just how I feel…I feel like well do they (other service users and staff) really want me to go down there, should I go you know"*

In her narrative, Mary offers her feelings of relative discomfort; "*I feel awkward sometimes*". This sense of disengagement, of not 'fitting in' with ease is articulated both temporally and spatially; "*I don't feel like I want to stay here for very long*". The rhythms and flow of the day centre in Mary's case are not located within the discourses of support and mutuality but are more so bound up with potential isolation and of not feeling a valuable member of the group. Mary's spatialised production in her day centre appears more jagged and ruptured than Nancy's largely unproblematic navigation around this particular space. These two data

extracts go some way in articulating the multiplicity of service user interaction and relationships. Differentials in access and of 'unconditional' mutuality and acceptance are also noted within Parr's (2000) empirical research.

Parr's (2000) research into the '*hidden social geographies'* of day centres provides some insight in this area. Using covert, ethnographic methods, Parr found that contrary to the dominant ideologies endorsing the unproblematic nature of service user's engagement within this place, that socio-medical codings were enforced by the dominant group. Parr (2000) suggests that such codings are consensually agreed by members and staff especially with regard to the use of the body in the day centre setting, which can result in a complex (self)policing of bodily behaviours. Those who overstep the defined boundaries are subsequently isolated by their difference and are in effect excluded, 'the other' within 'otherness'. Interestingly, Parr concludes that the negative mainstream concepts of mental health distress, especially those associated with psychosis, have not only infiltrated this environment but can be perpetuated by the collective. Philo et al., (2005, p. 779) also found that despite repeated narratives of unconditional inclusiveness, service users within their study discussed the group avoidance of those who were deemed *"too unwell or too problematic in their behaviour"*. These positions go some way to suggesting that day centres do not operate as unproblematic and stable entities but are more so bound up with the cultural positions and interpretations of mental health distress.

5.10 'Othering' within otherness

"I know that the periphery is the only place I can be, that I would die if I let myself be drawn into the center of the fray, but just as certainly if I let go of the crowd. This is not an easy position to stay in, it is even very difficult to hold, for these beings are in constant motion and their movements are unpredictable and follow no rhythm"

(Deleuze & Guattari, 1988, p. 29)

The above quotation has been taken from 'A Thousand Plateaus', Chapter Two, *1914: One or Several Wolves?* Here Deleuze & Guattari illuminate the ways in which the survival instincts of the wolf[37] are inextricably bound up with group solidarity in order to hunt successfully as a pack, with each member holding a mutually recognised status within the hierarchical stratum of the group. For example, the ranking of more dominant wolves is obvious as they have

[37] This also applies to other animals and in this case service users

first access to the kill whilst the others wait their turn. Moreover the insubordinate members of the pack indulge in such performances as rolling on their back to indicate complete submission acknowledging the power of the others.

However, what is discussed here is the dilemma faced by the solitary creature who resides at the very boundary of the pack, a member socially isolated from the internal governance of group control but one with an instinctive need to be a part of the pack to ensure a continued existence. It is very much a predicament of 'one foot in and one foot out' or as Deleuze & Guattari coin; *"the schizo position"*. This type of social positioning is not a highly contestable one within the larger domain in that the vast majority of the population do not hold any direct power to the internal functions and ambitions of the controlling sovereignty. It does become of interest however when social acceptance or conversely, avoidance are discussed within a seemingly homogeneous micro-spatiality such as the mental health day centre. Or, more precisely, the ways in which day centre spaces can be multi-layered in terms of acceptance and rejection based on diagnostic identities and corporeality.

Taking the elements already discussed forward, one is presented with an 'arborescent' model of thinking and practice. Based on the production of knowledge operating much like a tree formation e.g. the vertical hierarchy of root, trunk, branch, twig, leaf (caterpillars or other parasites don't come into the equation here), Deleuze and Guattari draw attention to the ways in which this school of thought is rooted in the systematic of coding and categorising, which in turn produces objectification and subjectification of phenomena. Within this extract, Foucault extrapolates the calculative and fractal nature of identity and difference:

> *"…comparison by means of order is a simple act which enables…order to establish relations of equality and inequality…every resemblance must be subjected to proof by comparison, that is, it will not be accepted until its identity and the series of its differences have been discovered by means of measurement with a common unit, or more radically, by its position in an order."*
>
> (Foucault, 1989, pp. 59, 61)

Resulting in such a style of thinking presents a dialectical model of ideology, producing neatly categorised segments of dichotomy; the sane/insane, black/white etc. *"Binary logic is the spiritual reality of the root-tree"* (Deleuze & Guattari, 2004, p. 5). Using this vertical, hierarchal structure of coding, arboreal thinking is the driving epistemological force of

Westernised thinking for example, in terms of the fields of theology and psychology (e.g. Best & Kellner, 1991).

This theoretical concept can provide a framework from which to analyse data relating to the day centre as a space harnessing a layering of performances concerned with difference, change and fluctuation. Rather than the structuralised positions discussed previously; *"Fixity gives way to fluidity... flow upon flow: variation upon variation: differential upon differential...an effect of origami"* (Doel, 2000, pp. 124,125).

Consider the following extract by Ted, a 56 year old service user (who attended Walton day centre) when he discussed his own perceptions of day centre life. In this narrative, Ted alludes to attending the day centre for a *"bit of depression"* or perhaps to use a more clinical term, a diagnosis of mild to moderate depression. Interestingly, during another interview and informal conversations with Ted, we discussed his connection with mental health provisions resulting from a *'bodged'* hernia operation which left him with erectile dysfunction. Ted discussed how he was often in his local Accident and Emergency Department, due to self-harming behaviours and over-dosing on medication and at times, has spent periods in acute psychiatric wards. These kinds of accounts do not largely correspond with the experiences of having a *"bit of depression mainly and that's it"*. These are important points to note as Ted describes his own and the ways in which he positions others' spatial identities.

> *"Alright it's a nice enough place (the day centre) but you know I sit out there sometimes and think to myself "phew what the hell am I doing here?" You know what I mean you know you've got people out there talking to themselves, rocking and Christ knows what else and I'm here for a bit of depression mainly and that's it"*

In this excerpt, Ted clearly draws from the demarcation of depression and the physical attributes pertaining to psychosis; "*I'm here for a bit of depression… you know you've got people out there talking to themselves, rocking and Christ knows what else*". Perhaps, for Ted, psychosis is the main object of psychiatric stigma (e,g, Cannon, 2001). Psychosis is an area of mental health distress that he does not align with his own sense of self identity with and one that he treats with an air of derision based on his own discourses of psychiatric superiority. Ted does not use this spatiality to display unconventional bodily behaviours such as talking to his self nor does he engage in any stereotypical movements such as rocking.

He plays a strategic game here to create a sense of his own agentic power over those 'others' by drawing from the discourses of stigmatising psychosis. Interestingly, though Ted does draw attention to his depression as being the main contributory factor for his attendance but he does at some level make this an ambiguous statement. His account claiming he is a service user with *"a bit of depression mainly and that's it"* does leave open a suggestion that there are other factors in terms of mental health distress at play here as well. These undisclosed issues that may form part of his psychiatric diagnosis and referral to the day centre remain unspoken at this moment as any admission to other symptomologies or behaviours might destabilise his stake of maintaining a 'normative' identity compared to the 'others'.

Parr (1999b) further argues that the unacceptable and unconventional use of bodily space can be a potent indicator of mental health states, including excitatory catatonic movements and holding the body at unusual angles. These actions all reinforce the negatively constructed notions of psychosis which prevail in mental health. Such usage of the body can also instigate close monitoring by staff and other members, resulting in strategies of bodily self-regulation (Parrm 2000). As Boyne's (1990, p. 28) interpretation of a Foucauldian perspective suggests there remains; *"a practical consciousness of madness" , whereby the social group with the powers of exclusion based on the canons of normative obedience deal with the menace of madness through the rites of exclusion legitimised within the homogeneity of the rules of reason and the norms of the social group"*.

Therefore the motions and movements of these geographies can be mimetic in their content and meaning, microcosms of space which emulate their macro counterparts but within different contexts. Much like the archer's target, whereby the larger circles become smaller and more condensed but the content and meaning of the shape remains symmetrical in content. The day centre can be likened to such a cyclical territory, on the one hand located on the periphery in relation to the global and on the other hand, actively creating its own method of expression and signification to maintain the cohesion of the selected group based on the dominant discourses of mental health (Buchanan, 2006). Or as (Deleuze & Guattari, 2004, p. 9) articulate; *"[U]nity always operates in an empty dimension supplementary to that of the system considered (overcoding)"*. In this way, day centres are able to replicate and maintain the dominant discourses and social constructions of the more negative diagnostic identities such as schizophrenia.

At this point one is given a flavour of a landscape with real and imaginary boundaries which neatly create territorial areas as serving distinct functions for various psychosocial needs. Indeed what has been termed a *'semi-institutionalised'* geographical location for psychiatric and ex-psychiatric patients to inhabit and a landscape submerged in the historical, socio-medical discourses of psychiatry (Parr, 2000; Parr et al., 2005). This area of service user life remains largely unexplored especially when discussing the consented narratives from service users.

5.11 Mapping the complexity of mental health geographies

"There are only multiplicities of multiplicities framing a single assemblage, operating in the same assemblage: packs in masses and masses in packs."

(Deleuze & Guattari, 2004, p. 34)

Focussing on a notion of multiplicity and the potentiality of erasing the process of reproducible tracing, of destabilising this sense of unity, I will focus now on the middle ground. In other words, I will discuss some of the areas where the outline of the tracing opens up to new possibilities. Drawing from my own ethnographic observations together with interview extracts, I will now turn to the paradoxical ways in which the embodied aspects of mental health are both relational but also mutable to the wider discursive practices of normality. In addition, I will provide a brief, contextual background drawing from my own observations and un-taped conversations with the participant's whose stories will now be discussed.

5.11.1 Middle ground – corporeality

"The middle is by no means an average, on the contrary, it is where things pick up speed."

(Deleuze & Guattari, 2004, p. 28)

In everyday encounters, it is impossible to observe mental states as a neurological process in that we cannot see chemical imbalances or neurons misfiring within a person's brain. Subsequently, in terms of mental health distress the body can perform a mediating process acting as an observable apparatus from which psychiatric deductions can be reached. For example, the annals of the DSM make reference to physical behaviours as an aid to diagnostic criteria. These issues make sense at this kind of visual level, thereby: *"Bodies are prime*

sites of communication through practical action…making the body a corporeal marker…" (Crang & Thrift, 2000, p. 8) In addition, Sibley (1995) discusses the body as a prime site on which social norms and the discourses of visibility can be engraved to effect potential exclusion as a result of unconventional behaviours.

Schizophrenia is one such diagnosis which includes disturbances in bodily movements acting as a signifier to indicate a greater degree of 'illness' severity within this particular condition (Tandon, Nasrallah, & Keshavan, 2009). Briefly, there are two main areas of diagnostic criteria relating to the movement of the 'schizophrenic's' psychomotor activity, catatonic stupor which is a slowing down or even a complete rigidity of the body and excitatory catatonia whereby the body moves excessively, often displaying complex motions (DSM-IV, 1995). These variations of bodily states are both medically positioned as motor abnormalities (Tandon et al., 2009). As Parr (1999b) notes it is important to recognise that different emotional states, whether positive or problematic are intertwined between the mind and the body, with the body acting as the receptacle to provide a visible indicator for those with mental health distress.

Another area within mental health distress that highlights the body as corporeal marker is that of self-harming. In this way, a person who self-harms can readily indicate an emotional state of stability indicated by old scars which are visibly silver/white in colour from a 'critical time before'. Subsequently, the body becomes a topographical site through which practices and rituals are inscribed (Crang & Thrift, 2000). As discussed in the previous chapters, service user identity and, more importantly, the ways in which a diagnostic identity can create tensions not only within the wider social domain but also for individuals' day to day lives (Tucker, 2009).

These kinds of shuffling of identities can impact both socially and in terms of the management of a psychiatric illness. Likewise, it would be useful to focus on exploring the multiple and contextual positions of how service user identity can both permeate and mutate within the physical boundaries of day centres (Rattansi & Phoenix, 2005). Murdoch (2006) claims that such post-structuralist positions emphasise the qualities of the multiplex meanings and modalities of understanding human relations, These positions are particularly useful when analysing the psychopathological landscape as a multiply layered phenomenon. A landscape which is continuously shifting from passive to reactive from the physical to the emotional from the ephemeral to the more enduring (Thrift, 2006) but with an emphasis on

the socially constituted production of space (Tucker, 2006). In this way, there is no specific beginning or finale of space and performance but moreover it is the in-between, the connecting social milieus which are of interest at this point.

To explore these movements and tensions further I want to explore the narratives of Bill and Tom who both attend the Walton day centre. As previously discussed, Walton is a particularly structured and ordered space in terms of spatial access and the cutting up of time. Activities allocated for service users are run on time and within specified rooms. From my perceptions, the destabilising of these arrangements was not widely tolerated by service users or staff (as in Tom's account earlier in this chapter). Everything seemed to be in order and that was the way that the majority of service users liked it.

5.11.2 On middle ground – Bill's narratives of Walton day centre

To add clarity to this particular section of empirical data, it would be useful to provide some context of how Bill fits into the grander scheme of things, e.g. his activities and status within Walton day centre. As briefly discussed earlier, Walton was, on the face of it, a very structured space in terms of movement and temporal regulation. The drop-in sessions were generally quiet and consisted of small groups of service users chatting or playing games such as chess. During some drop-in sessions videos or CD's might be played where service users would watch and listen in silence excepting the odd remark. Even elements such as the preparation and the eating of lunch were contained within a formalised arrangement by positioning these activities as the 'lunch club'. In this way, the 'lunch club' was bracketed off from other areas of mutual engagement because service users were required to 'join' this club before they were able to have a midday meal. To summarise, within my own experience, this day centre was the quietest and appeared to be the most spatially and temporally organised of all the day centres I visited.

Bill is a diagnosed paranoid schizophrenic, although he has only told me that once. As discussed in a previous data extract, Bill intimated that he uses the diagnosis of Post-Traumatic Stress Disorder when discussing his own mental health distress with other service users. Bill never displayed (in my presence) some of the erratic bodily movements usually associated with schizophrenia such as talking to himself, the repetitive and stereotypical movements of rocking for example or the fairly randomised jerky movements. This is not to suggest however that Bill negotiated this space on a level continuum of positivity as he was

inclined to lose his temper very quickly (towards other service users) and shout and leave the day centre abruptly. Nevertheless, Bill did not generally display behaviours usually associated with a diagnosis of schizophrenia – the day centre did not offer him a milieu for a spatialised production of this particular diagnosis (Thrift, 2004b).

Bill informally organises the art club and other activities such as the lunch club and holds a tangible amount of social power over other service users. For example, if Bill didn't particularly want somebody in a room then this was stated and the 'offending' person would exit and perhaps enter another room or leave the day centre. If somebody encroached into the kitchen when Bill was making lunch (with a member of staff) he would often become cross and verbally rebuke the 'intruder'.

In the following interview extract Bill discusses the egalitarian coding of unconditional acceptance within his day centre *"everybody that comes here as a service user is accepted and treated as an equal"*. In this way, we are presented with a flavour of mutual respect regardless of diagnosis (possibly) and more importantly, potentially incompatible bodily behaviours.

> *Bill – "I think that everybody that comes here as a service user is accepted and treated as an equal and (LAS=yeah) no one person's worse off or better off than the other (LAS=yeah) but outside of here it's a completely different case of course"*
> *LAS – "If you had somebody coming in here say who was fairly catatonic you know sort of moving around and quite unconventional body behaviours (Bill=yes) would you think that would be socially acceptable here? You don't think that people would be discriminated against um"*
> *Bill – "No (LAS=no) because we um we've still got a member although I, I think he's moved (2) um we did have a member here who was very much like that (LAS=mmm) and no because (long pause) no everybody treated him the same and everybody treated him as an equal..."*

In the above account, Bill offers his own ontological identity of one wrapped up in offering 'unconditional acceptance' for all service users attending day centres, regardless of their psychiatric diagnosis; "*I think that everybody that comes here as a service user is accepted and treated as an equal"*. Bodily behaviours, which may be linked to psychiatric diagnoses,

whether socially acceptable or not, did not seem to impact upon the spatial access and movement within Bill's day centre at this particular time.

Bill goes further to crystallise his account by drawing attention to a service user who has displayed unconventional bodily behaviours at the day centre; *"we've still got a member although I, I think he's moved (2) um we did have a member here who was very much like that (LAS=mmm) and no because (long pause) no everybody treated him the same and everybody treated him as an equal"*. Interestingly, Bill seems unsure as to whether this particular service user still attends the day centre or has indeed moved elsewhere. There may be an element of identity movement here as Bill seems unsure as to whether a service user displaying catatonic movements still inhabits the day centre space. When one considers the spatialised backdrop of Walton day centre as an organised and regulated unit, it could be suggested that such behaviours might be more observable in this kind of space.

Taking this thread of unproblematic mutual acceptance forward, immediately after the interview we went outside to the smoking area where Bill verbally reprimanded another service user for his unconventional use of the day centre space. These observations were noted in my research diary, dated April 18th, 2009.

> *We went outside and Dave was rocking back and forth on the wicker seating in the smoking area. (Notes: These rocking motions were not subtle, in that Dave's body went back and forth with his head nearly touching his knees when proceeding in the forward movement and Dave was rarely seen within the interior building – this could be because he was a heavy smoker or maybe he didn't feel so comfortable indoors.) Dave was talking loudly to himself in-between drawing heavily on his cigarette (these actions were usually how Dave behaved every time I had seen him). Bill lit his cigarette and shouted at Dave; "For fuck's sake shut the fuck up you fruit loop you are getting on my nerves with your noise". Dave looked across and shrugged his shoulders. Bill turned round to me as if he had realised what he just said to Dave went against his previous interview comments. Bill said to me; "Sorry about that but I am feeling very intolerant today". Dave heard this and started his repetitive movements and talking (not quite so loudly) again. Bill smoked his cigarette and went inside to organise the lunch club.*

This change of Bill's social position of encompassing all service users no matter what kind of psychological and bodily performances were happening are fairly evident here. What is interesting is how Bill switches his identity in an interview situation of non-discriminator to other service users to that of a being who is somewhat belligerent to other's movements. These kinds of paradoxical behaviours are almost impossible to gain from interviews alone which may be why Hester Parr (2000) found that service users actively 'other' service users by using covert ethnographic methods. In support of these underlying social tensions between service users in day centres, empirical data collected by Philo (2004) and Parr et al., (2005) found that participants do not formally divulge narratives within interview situations of differentiating others based on psychiatric diagnosis and bodily behaviours. More so, these kinds of 'othering' practices can be played out within the relatively informal boundaries of the day centre such as the garden but largely remain unspoken by the perpetrators or, indeed, those who feel isolated by others.

Returning back to Bill's excerpt, here we have complex layering of social and spatial production. On the one hand, Bill discusses his own non-judgemental acceptance of others but on the other, he rebukes a service user who displays behaviours associated with psychosis; *"We went outside and Dave was rocking back and forth on the wicker seating in the smoking area… Dave was talking loudly to himself in-between drawing heavily on his cigarette… (Bill said) For fuck's sake shut the fuck up you fruit loop you are getting on my nerves with your noise"*. In essence, what Bill is doing during this sequence of events is reprimanding another service user for performing in a way which is not normally accepted within mainstream society. He reiterates this difference by calling Dave a *'fruit loop'*, a colloquial term used to indicate both mental health difficulties and unusual behaviour. Here at some level, Bill is drawing from the arbolic codings or, machinic assemblage of mental health to distinguish himself as a service user who does not reside within the classifications relating to schizophrenia.

Although Bill has received this particular diagnosis he does not perform any associated behaviours wrapped up with psychosis – he is in essence providing a topographical site of how the hierarchal elements of psychiatric practices can be spatially produced by rejecting his assigned diagnostic identity as a schizophrenic. He does this by bringing attention to Dave's performance which has links with this diagnosis, thereby both socially and spatially positioning Dave as an 'abnormal' body. Within this extract, one is given a sense that rather than day centres as spaces emanating feelings of largely unproblematic acceptance and mutual

support, these spaces can also potentially (socially and spatially) isolate the 'other'. What is meant here there are those service users (such as Dave) who go some way in destabilising the structured and contained production of maintaining a 'sane' and 'controlled' space such as the day centre.

Spatially, Bill is also verbalising his discontent on the perimeters of the day centre. In this way, he is using a more 'private' space as such, or a space that is not so inhabited on a continuous basis by other service users and perhaps more importantly, members of staff, to administer his dissatisfaction with Dave's behaviours. These 'othering' actions by Bill, who within the formal interview situation (where narratives are recorded and transcribed) intimates that service users within the day centre operate as an egalitarian group become at odds with his interactions with Dave. Bill does become aware of his paradoxical accounts when he says; *"Sorry about that but I am feeling very intolerant today"*. In order to alleviate his actions as forming part of an everyday occurrence, Bill informs me that his outburst is due to him feeling *'intolerant'* on that day. It is almost as though Bill does not have complete control over his emotional and psychological states at that moment in time and this may be a contributing factor as to why he gets angry with Dave. Overall, he is going some way to produce an alternative identity as a service user who both acknowledges the social ramifications of being a schizophrenic whilst explicitly rejecting his own diagnosis of schizophrenia but he can also verbally protest at others who display the stereotypical behaviours of schizophrenia.

From my research diary notes and interviews, Bill seemed to be a key figure in the 'pack'. His higher standing hierarchal position was often based on the assemblages imbued within mental health distress and more specifically, his own rejection of his formalised diagnosis of paranoid schizophrenia. Bill was in the centre of the mass and used the wider cultural determinants which position some corporeal elements of paranoid schizophrenia as socially undesirable. In this way, Bill seemed to assert his psychiatric authority by drawing from the categorical markers whereby schizophrenia is positioned on the outer boundaries of mental health distress. At some level, he was using the wider cultural notions surrounding this particular diagnosis to spatially and socially intimidate and potentially isolate those who readily displayed such unconventional behaviours.

5.11.3 On middle ground – Tom's narratives of Walton day centre

"I know that the periphery is the only place I can be, that I would die if I let myself be drawn into the center of the fray, but just as certainly if I let go of the crowd."

(Gilles Deleuze & Guattari, 2004, p. 32)

By taking these concepts forward; the inter-relationships between the observable (unconventional) individual, the consensual power of the pack and the ways in which these elements are played in the micro-spatiality of the day centre, the precarious *"schizo position"* (the person living at the perimeter of the pack) will be explored further.

In the following extract I asked Tom (who has a diagnosis of paranoid schizophrenia) if he felt that he and others with this diagnosis were treated differently within the day centre. This was a purposeful question asked to Tom as he was a service user who did not appear to have access to some parts of the day centre. He was visibly excluded from the communal area and did not attend many of the more formalised activities within the day centre and at this point of time, he was on his last warning to maintain his attendance.

> *LAS = So do you think, do you think there's a difference between having depression and I'm talking about people who have mental health distress, than having schizophrenia? Do you think that people here (the day centre) see them quite differently?*
> *Tom = "There's a lot of difference with paranoid schizophrenia and all sorts of differences like you can see (waves arms in air)**…**you can go out there (smoking area) with a fag in your mouth and you sit and I mean you know the expression about those faces"*

Within the above narrative Tom discusses his own experiences of having a diagnosis of paranoid schizophrenia. Firstly, he acknowledges a breadth of difference between depression and psychosis and accentuates this difference by waving his arms in air. At this point Tom highlights the visibility of paranoid schizophrenia, the erratic movements that do not comply with the standard norms of bodily behaviour. He talks about going outside to the smoking area (where he was allowed access albeit away from the other users) and his accounts become static at this point. For Tom *"you sit and I mean you know the expression about those faces"*.

This move away from the excitatory catatonic movements illuminates the pathos and the sadness of the faces of paranoid schizophrenics. Rather than paranoid schizophrenia being embodied as a visible catatonic mesh of random movements, Tom draws our attention to the visibility of tragedy and of times that have gone before. At this level, Tom has not rejected his diagnosis as being one that is too risky to discuss but moreover he has positioned paranoid schizophrenia as being at times unconventional but he punctuates this with visual elements of underlying sadness.

Within the same interview, Tom elaborates his own behaviours within the day centre and how these have impacted upon his social relationships with other service users.

> *"I mean I can be nice one minute, I can be a baa lamb…a nasty piece of work or whatever you want to call it. Because of these medications I mean I can be quiet, noisy, quiet, noisy …and they (other service users at the day centre) um say "WHAT'S THIS EH?" (laughs) you know everybody thinks like avoid him (laughs)…Well I put a barrier against them and myself…"*

Here one is drawn to the polarisation of Tom's emotional behaviours, *nice one minute* which is interplayed with being *a nasty piece of work* at times. Discursively he is positioning his own identity of being one as operating within a discrete schism. Subsequently, Tom punctuates the unpredictably of his behaviour by drawing from the discourses encompassing the popular assumptions of 'schizophrenia' equating to having a split-personality syndrome (Hacking, 1995).

In the first instance he uses the term *I can be a baa lamb* to indicate periods when he is nice which demonstrates at some level he is helpless like a young infant and this fragility makes him safe to be around. Here Tom is using language wrapped up in traditional infantile practices in that lambs can evoke feelings wrapped up with the discourses of purity and innocence within young children's books and nursery rhymes. Conversely, his narratives of being *a nasty piece of work* suggest that there is a part of him which can be malevolent. By using these idioms, Tom draws attention to the fractured position of his diagnosis in that he is albeit fleetingly a naive body juxtaposed with an embodied identity wrapped up in the discourses of malice.

These narratives are meshed with other aspects largely associated with a diagnosis of paranoid schizophrenia such as the temporality of outwardly behaviourisms. Here medication becomes the vehicle for his polarised performances of being "*noisy, quiet, noisy, quiet"*. More pertinently perhaps, Tom moves away from the changeable elements of his own (dys)functional social interactions and focuses on the biological ramifications of taking antipsychotic medication. At this point, Tom alludes to a possibility that before he became enveloped within the discursive practices of medication and biological assumptions underlying mental health distress, his behaviour was more stable than it is now. The medications have not only arbitrated this change with the differing ways in which he talks but have also encroached on his current sense of self. Overall, here he sets the scene in terms of presenting his own embodied interpretations of the ways in which stigmatised elements of mental health distress are spatially (re)produced in the day centre (Hacking, 1999).

Acknowledging that these erratic behaviours cause some consternation with other service users, Tom is made fully aware that he is located on the periphery when discussing the cohesion of the pack. There are elements indicating a lack of understanding which presents Tom as a body of confusion and furthermore a body where evasion is consensually sought by the collective. Here, Tom performs an act of psychological retaliation by placing an imaginary barrier between him and the group (Thrift, 2004a). This obstruction is then transformed into a set of concrete physical boundaries within the day centre. By performing this sequence of events, Tom not only reaffirms his own sense of self as being on the outside looking in but indicates that he has manipulated the '*schizo position'* he now occupies (Deleuze & Guattari, 2004).

5.12 Discussion

In this chapter I have discussed how day centres seek to operate as a coherent body of spaces; specifically allocated for those suffering with mental health distress. There are definitive rules which service users are expected to abide by to maintain this sense of stability. This ordering of behaviour within day centre spaces is further punctuated by the demarcation of rooms designated for various activities which can be further regulated by endorsing set times for activities to take place. Overall, one gains a sense that mental health day centres may perform as a set of 'safe', structured spaces as an alternative to the 'confusion' and lower levels of 'social functioning' often associated with forms of mental health distress (Conradson, 2003a). Narratives emerged whereby some participants found the day centre a

space of support and socialisation whereas another participant (Jackie) did not engage in this space as she didn't want to 'make a career' out of having mental health distress.

Alternatively, narratives and observations surrounding the fracturing of the day centre space largely based around diagnostic criteria were also explored. Here we were presented with differing and contradictory accounts of mutual inclusion. Ted gave an active narrative of 'othering' as he did not position himself as belonging to the more unconventional behaviours observed in the day centre. Fred separated his own discursive and spatial service user identity as being fairly normative as opposed to others who displayed elements of distress through their bodily movements. This kind of potentially spatially isolating and discursively positioning some service users as being more 'ill' than others was reiterated by Bill who presented a formal voice within an interview of a consensual collective but then gave a contradictory set of behaviours when outside of the interior of the day centre. Perhaps the exterior or the outer boundaries of the day centre may afford some service users to 'voice' their intolerance of others who do not appear to self-regulate their behaviours to comply with the group norms based on societal conventions (Carter Park & Radford, 1999; Parr, 2000; Parr, et al., 2005).

To summarise, this chapter has explored the ways in which day centres (with a particular focus on Walton day centre) are spatially produced. They can be a space of relative stability but they can also fragment into 'real' and 'imagined' territories when certain psychiatric diagnoses come into play. In essence, these spaces are bound up with the wider social and cultural practices of everyday life which may be why the participant research data highlights the importance of social interaction and space. Or, as Tucker (2006, p. 439) points out; *"Embodied experience is always socially bound, and, as such, emphasis needs to be placed on the ways that it operates relationally with the other occupants of…everyday environments"* (e.g. the day centre).

Chapter Six

Narratives of Home Spaces

6.1 Introduction

In this chapter I will explore the complex area of the spatialities of 'home'[38]. Research has indicated that older service users are more inclined to spend time within their household (or places of care) than anywhere else due to physiological deterioration, financial constraints and, more specifically, for this work, as a result of psychological barriers (Hockey, Penhale & Sibley, 2005; Williams, 2002).

In terms of the lessening of physical mobility and financial issues, it can be difficult for many older service users to access the local community. Most of the participants within this project were in receipt of the governmental benefit, Disability Living Allowance (DLA - this is discussed in more detail in Chapter Eight) and could therefore afford to pay for transport to enable them to get out of the home a couple of days within a week. For other participants, their physical impairments had not been assessed by their General Practitioners as being serious enough to warrant being granted DLA. For these participants the continual stiffening of joints meant that walking to a day centre for example, took a long time and included many stops to ease the feelings of pain.

Psychological barriers can include the emotional feelings of potential stigmatisation, vulnerability and the potential side effects of certain medications. For example, the ingestion of anti-psychotics can have negative social consequences for some service users. Largely in terms of inducing extrapyramidal symptomology consisting of erratic bodily movements such as spasms and twitching ((National Institute for the Clinical Excellence, 2002) and neurological sedation which can result in slower responses and slurred speech (Miller, 2004). Within these terms, the body takes on the semiotic *"role as a medium of communication"* (Radley, 1997, p. 50) when socially interacting with others by displaying periods of wellbeing or, conversely, periods of illness. For example, in terms of service user's social practices, it could be seen as unconventional within the local neighbourhood to display catatonic behaviours, such as the waving of arms in a haphazard manner (Parr, 1999). Such unconventional behaviours can have socially problematic impacts by further isolating people who *"are trying to become reintegrated into society"* (Miller, 2004, p. 3). Here we are

[38] By using the term 'home' I am referring to the place of residence but this does not denote discourses of 'belonging'

provided with some ways in which the occupation of community space can be constituted by the status, identity and the social role of ex-psychiatric patients (Parr, 1997). These kinds of issues need to be taken into consideration when discussing 'home' spaces and mental health distress in that the home may offer the opportunity to be 'insane' away from the politically and socially regulated orders of psychiatric practices (Parr, 1997).

In practical terms, all participants within this research were in receipt of various State benefits and subsequently did not have access to funds to pay for their own car to enable wider socialisation outside of the immediate neighbourhood. Consequently, many narratives emerged within the research data collection when discussing daily life of time spent at home or in a space of residential care. In light of the importance of home spaces when exploring the spatial production of every day service user life, there are two chapters (Chapter Six and Seven) dedicated to the area of home spaces within this thesis.

Taking this position forward, this chapter will explore how embodied experience, which means the ways in which the emotional and social performance of behaviours are spatially produced within the home. This is a distinct move away from defining home spaces as merely consisting of an array of geometric rooms through which people simply physically move within, whereby psychological phenomena is analysed as a separate entity (Tucker, 2010c; Urry, 2005). Moreover this work is interested in the non-discursive elements of the spatial production within these spaces. Here the relational forms of content and expression, of interactive movements within differing home spaces together with the cartographical markers such as ornaments or photographs will be explored in an attempt to gain a sense of how this space is both temporally embodied and produced for service users (Brown & Tucker, 2010). It is an exploration of how participants make sense of their everyday home life (Tucker, 2006).

Consequently, it is this area that is of specific interest to gain a further insight into the strategies employed by service users in actualizing their individual micro milieu and understanding the constituent nature of how a large portion of everyday service user life is produced and continually (re)produced. This focus on the (re)production of space will be informed by the heterogeneous and multi-layered experiential narratives of daily life within these particular territories (Low & Lawrence-Zuniga, 2003; Rubinstein, 1989).

6.3 Different types of home spaces

Taking a somewhat ethereal position, the idealised cultural notions of home can endorse a spatiality of safety and sanctuary, a place where we can 'breathe a sigh of relief' as negotiated social identities are replaced by the need to focus on personal needs and wants and more widely as the place enveloping family life (Somerville, 1997). In contrast, Miller (2001, p. 15) notes *"If home is where the heart is, then it is also where it is broken, torn and made whole in the flux of relationships, social and material."* Subsequently, the aim of this chapter is to explore how realistic these ideologies within service user home environments are. Although these discourses assume the cultural functions of home as providing a private space distinctly removed from the bureaucratic functionality of working subjects, these presumptions remain pervasive within our society and are perpetuated by the plethora of media reinforcing these ideologies (this will be discussed further within this chapter).

In terms of contextualising service user home spaces, I will explore the fluid shaping of this material and affective space by incorporating narratives of identity (Anthias, 2002; Blunt, 2005; Tucker, 2009), security and privacy (Conradson, 2003a; Williams, 2002) and the territorialization of home space (Buchanan, 2006; Massumi, 1992; Tucker, 2010b, 2010e). Subsequently, I will explore the multiplex nature of spatiality in terms of the relational nature between meanings (human expression) and materiality (space/objects) (Brown, 2001; Tucker, 2006).

It is worth noting at this juncture that the home spaces analysed in respect of this research project comprise of supported accommodation, semi-supported accommodation and independent residency. All these forms of residency are provided via the local authority. These are interesting positions from which to analyse the productive nature of mental health and space. On the face of it, all three residential frameworks can offer a divergence of ways in which movement and emotional contexts may be played out.

6.3.1 Supported accommodation

Supported accommodation, by the very circumstantial aspects of shared living with resident 'care staff' may preclude personalising home space. In addition, this type of residency can also be organised within a system of daily routines, i.e. meal times, bathing etc. It is interesting to note here that all participants resident within supported accommodation used the

term ‘unit’ to describe this space as opposed to home or house. This may well be as a result of sharing accommodation within designated rows of houses which were demarcated from other residential homes as purely serving the purpose to provide service users somewhere to live. In addition, maybe the staff, who were responsible for the upkeep of residents and the buildings called these houses ‘units’ as a way of separating them from the immediate, more traditional forms of independent housing.

6.3.2 Semi-supported accommodation

Alternatively, semi-supported accommodation can allow more elements of freedom of expression in that the occupation of home can be spatially configured and continuously adapted to meet a service user’s needs and expressions of self through the spatial ordering of objects and furniture. This kind of quasi independence may offer some sense of ownership but still functions within the parameters of psychiatric understandings.

6.3.3 Independent living

Independent living via housing provided by the local authority may appear to offer autonomy in that space can be personalised and residents are removed away from the immediate ‘gaze’ of mediating bodies (warden and care staff). Nevertheless, behaviour may still need to be regulated whereby unconventional social performances can alert the unwanted attention of immediate neighbours and local authorities. Service users living alone may also be more vulnerable to verbal and physical harassment within their neighbourhood.

Consider the following extract from Caroline a 50 year old service user, who has a diagnosis of Borderline Personality Disorder and has spent some periods of time within psychiatric institutions, due to behaviours linked with drug and alcohol consumption coupled with self-harming practices and suicide attempts. Caroline lives alone in a council-owned, one-bedroomed flat with a small garden. Here she is discussing events when she went into hospital under voluntary section as a consequence of her long-term disagreements with her immediate neighbours. These disagreements stemmed from Caroline’s regular excessive drinking and smoking of cannabis (and in the following event her overt self-harming behaviours by cutting herself and taking a medicinal overdose) in the view of her immediate neighbours;

"Caroline: I did go into town in (names town) bought a load of tablets and a bottle of wine and I went in the garden took the tablets and drank (sighs) and yeah, some cutting, self-harming and um you know

LAS: So it was actually somebody else phoning up (Caroline=yeah) for you?

Caroline: Yeah it was people and yeah the ambulance people and the police came as I did threaten somebody with a knife but she give me all that (imitates talking with hands) so I threatened her with a knife (LAS=yeah) yeah you know so (3)

LAS = So, when the police came, they took you to (names local psychiatric institution) did they?

Caroline = No they got an ambulance as well (LAS=right) ***because the ambulance were called*** *and because of the situation I was in and doing they have to have police escorts*

LAS = ***Oh right****…was that because they considered you dangerous at that time?*

Caroline = Yes, yeah, yeah (sighs)…

LAS = And did you consider yourself dangerous at the time?

Caroline = ***I didn't give a shit at the time****, I didn't give a shit (LAS=mmm) anyone got in my way then they would have got it (LAS=yeah) (clenches one fist) you know anyone but you know*"

In this excerpt, Caroline frames her performance of drinking alcohol, taking an overdose of tablets and self-harming as manifesting in a confrontation within an annex of her home spatiality, the garden. Here she has taken some of the criterion of behaviours imbued within her diagnosis of 'emotional instability' and 'difficulty in controlling anger' (DSM-IV, 1995). Rather than playing out her sequence of actions within her home 'behind closed doors', in a space away from prying eyes, Caroline opted to perform this elaboration of behaviours with an audience comprising of her immediate neighbours. At one level, the intervention of Caroline's neighbours in contacting the Police and the Ambulance Service is understandable. It would be difficult to perceive that people would idly stand by and watch somebody openly cutting themselves in some kind of inebriated psychological and physical state. What is interesting here is the spatial use of the garden (arguably an extension of Caroline's home) where the visibility of her behaviours is made more probable. In terms of cultural performances within garden spaces, Lefebvre (1999, p. 157) notes thus;

> *"This remarkable institution of the garden is always a microcosm, a symbolic work of art, an object as well as a place, and it has 'diverse' functions which are never merely functions. It effectively eliminates from your space that antagonism between 'nature' and 'culture'...the garden exemplifies the appropriation of nature, for it is at once entirely natural – and thus a symbol of the macrocosm – and entirely cultural – and thus the projection of a way of life."*

What Lefebrve is referring to in the above extract is the ways in which people do, or conversely, do not, manufacture and control that which is culturally positioned as a natural production of space. From a macro perspective, to a larger extent, gardens have thereby been produced as a haven of relaxation within natural surroundings. There is a plethora of media advertising families enjoying the availability of this 'open' space peppered with selected shrubs, flowers, borders, rockeries and other adornments such as statues, swings and slides. Subsequently, on the face of it, this space is one enveloped within the use of cultural artefacts associated with easy living.

Undoubtedly to get it culturally correct gardens should be preened, pruned, weeded and adorned with selected garden ornaments or, conversely, they can be left to the forces of nature, whereby the grass is kept long and all manner of plant life is able to exist. In this way garden spaces can be more observably open to interpretation by others which may or may not adhere to social expectations of normative living. This in turn, can lead to assumptions being made about the occupant(s) linked to this particular space. In other words, those that display elements of undesirable behaviours such as allowing a garden to overgrow with all manner of vegetation can be socially positioned as deviant in that their gardens are not 'produced' in line with the more dominant cultural perspectives of this manufactured space. As Lefebrve notes "*the garden exemplifies the appropriation of nature, for it is at once entirely natural – and thus a symbol of the macrocosm – and entirely cultural – and thus the projection of a way of life"* – the architectural landscaping, maintenance and cultural artefacts of a garden can be a window into the day to day lives of occupants (Cwerner & Metcalfe, 2003).

Above all, the garden is a space of cultural performance. Caroline is using the garden to play out her heightened levels of mental health distress. She has been drinking, has taken a lot of tablets and is cutting herself. Not the normal behaviour within a space imbued with natural tranquillity, but then Caroline is not a 'normal' person, she has a psychiatric diagnosis – at

this moment in time she has 'become-psychiatric-patient' – she has deterritorialized the spatial production of her garden as an antithesis of the dominant arbolic codings of garden living. She reiterates this by drawing on her accounts of the intervention by one person and her subsequent response of potential violence; "*I did threaten somebody with a knife but she give me all that (imitates talking with hands) so I threatened her with a knife"* and the ambivalence she felt at the time; "*I didn't give a shit at the time, I didn't give a shit (I=mmm) anyone got in my way then they would have got it"*. In this account, we have a mix of the immediate neighbours, the garden and Caroline all playing a part within an actualized performance of a psychiatric episode.

The outcome was perhaps always going to result in one of Caroline entering into a psychiatric institution and maybe, just maybe, she engineered it to be this way as independent living might have proved too much for her to cope with at that time. This could be Caroline's way of reterritorializing space in an overt and bold manner (there is no suggestion of nuance here within her account) by incorporating other actors to intervene and play a crucial part in this transformation of her garden space. Here the garden has become as much a focal point as the structural elements of a home space (garden spaces are explored further in Chapter Seven). In this way the two spaces are spatially entwined within a set of relations, the interior of the home and the exterior outside space whereby access and exits are allocated for particular individuals. There is a sense of both privacy but also of surveillance in both areas as other people can become involved in the spatial productions of home and garden spaces. It is the ways in which the private and visible spaces of home are culturally constituted which will be explored at this point.

6.4 The social constructions of home

> *"One's sense of home is bound up in a sequence of relationships usually termed 'familial'...but also includes a penumbra of significant others: friends, neighbours and associates. The home thus organizes not only relations of family, gender, and generation, but also relations of class; it is a principal product of human endeavour".*
>
> (Puttnam, 1999, p. 144)

Within the above extract, Putnam proffers a macro perspective of the ways in which home spatialities are socially constructed. Arguably, these notions are further fuelled by the media

in the forms of advertising and the current plethora of television programmes whereby focus rests on the home as a place of privacy and refuge and home as a primary status symbol of wealth and achievement. For example, television programmes such as *'Location, Location, Location', 'Homes under the Hammer'* and *'Escape to the Country'* idealise the home as a space of sanctuary, a space to enable familial and wider social interactions and home as a visible financial asset. Thus, this spatiality is not only a place to support the crux of family life and retreat but is also bound up in the cultural meanings of social class and status (Cwerner & Metcalfe, 2003; Somerville, 1997).

These are important considerations in terms of the *ideal* home portrayed within the media, as it would be reasonable to suggest that participants within the aforementioned programmes are all owner-occupiers with reasonable amounts of disposable income. Cultural positions such as this further reinforce the home as a space of social aspiration and financial power which some would argue was promoted by the ideologies of home ownership (as opposed to council tenancy agreements) proposed by the Conservative government during the 1980s (Clarke, 2001). In addition, such programmes are bound up within the discursive practices promoting the stability of the heterosexual, financially, cognitively and emotionally successful *'nuclear'* middle-class family (Graves-Brown, 2000; Rubinstein,1989; Somerville, 1997).

Nevertheless, by positioning the home as a place to research the meanings of social status and fluctuating trends, renders this particular spatiality as an economical one, merely consisting of square footage and design, Thus, there can be a tendency to negate exploring the ways in which this space is embodied on a daily basis (Dovey, 1985; Doyle, 1992; Williams, 2002).

The cultural creation of social norms within this spatiality has created much interest and comment. For example, Gregson & Lowe (1994) draw attention to the dominant ideologies attached to middle-class and working class homes during Victorian times and more especially the gendered definitions of functioning within this space. Notably, women from middle-class homes were seen as passive creators of home as a form of sanctuary for the man of the household. At this time, home spaces were positioned as a space of emotional serenity which was the prime responsibility of the hierarchal female within the household (Putnam, 1992).

This is not to suggest, however, that signifiers of higher levels of social stratification based on acquired goods to indicate wealth was not important during the Victorian period (and indeed,

in contemporary home spaces) (Morley, 2000). In this way, decor and furnishings served to create a spatiality away from the outside world and moreover, the world of the working-class domain of factories (Abrams, 2001). As a consequence, the ideologies and constructions of home within different historical periods in time can serve enduring functions in terms of reinforcing the cultural norms of home embedded as a matriarchal domain of emotional harmony and materialistic functional order (Altman, Werner, & Oxley, 1985; Gregson & Lowe, 1994; Morley, 2000). It is worth noting here that the gendered relations within home spaces was not an issue which emerged from the research data as none of the participants lived as part of a heterosexual or same-sex couple.

These kinds of ordering and containment of materiality and the stratification of people's roles (the female as *'domestic goddess'* for example) can emanate a sense of morality and stability within home spaces. However, there is a flip side here, namely home spaces linked with immorality – those homes which do not conform to a structured organisation of content and expression (Clarke, 2001). Culturally, there are television programmes which largely focus on the home spaces of social deprivation and low functioning, such as *'A Life of Grime'* and *'How Clean is your House?'* present an array of negative social practices.

Within the set-up of *How Clean is your House?*' we have two middle-class presenters who perform as discursive life-style experts and offer advice to facilitate the (re)production of unkempt and culturally distasteful home spaces into a space of socially acceptable normality and morality. In other words, homes should be kept neat, ordered and clean. Here, home spaces are not part of a process of leaving visibly undetectable traces of bodily performance and movement (such as the shedding of dead skin and hair) (Thrift, 2004b) but are more so bound up with the visual evidence of human mess and murk. Imageries proliferate of dirty washing strewn across spaces, kitchen sinks full of dirty cutlery and decomposing food and toilets embellished with the stains of old faeces and urine. It would also be reasonable to suggest that the well-structured order and daily routine cleaning practices of moral home spaces can also act as an indicator of positive mental health whereby dirt and mess suggest low levels of social functioning (Bijl & Ravelli, 2000; Cwerner & Metcalfe, 2003; World Health Organisation, 2001). In this way, cleanliness and order can present the ideals of a distinctive virtuous qualities of 'righteousness' when compared to the disordered and dirty elements associated with 'deviance' (Cieraad, 1999). Here we have a dichotomy of social positioning linked to behaviours imbued within the regulation of home spaces which can in turn produces adages such as; *"a clean home is a happy home."* These kinds of constructions

are reinforced by commercial advertisements linked with home spaces as well as the television programmes mentioned previously. In contrast, those homes where space is littered with dirt, grime and waste are linked to dysfunctional ways of living.

This can, at some level, support the constructed positions of service users as necessarily having poor levels of day to day functioning (Reynolds, et al., 2000; Slade, Phelan, Thornicroft, & Parkman, 1996). Research has indicated that service users are largely unable to engage in *'normal'* behaviours associated with cleaning and the ordering of space and objects within home spaces (Slade et al., 1996). In other words, mental health distress and home spaces may not be socially constituted within the same prevailing codings and parameters whereby the home is positioned as a cultural space flowing with integrity and organisation. To some extent, service users may reside on the boundaries of these particular constructions. This line of thought is explored further in Jackie's account where such notions of a normative moral order of spatialising her home spaces in line with the social ideals are not particularly evident.

Jackie is a 52 year old service user who has a diagnosis of bi-polar affective disorder. She describes herself as a 'recovering' alcoholic and drug addict. Her addiction to substances began when she was a teenager where she was able to gain access by stealing prescribed medication such as Mandrax and amphetamines from her father who was a General Practitioner. After finishing school, Jackie was employed as a catering assistant for a variety of touring rock musicians (e.g. Whitesnake, David Bowie[39]). This employment gave her the opportunity to indulge her alcohol and drug addiction further without any cost to herself as she readily admits that 'lines of cocaine' for instance, were freely available at any time of the day. She subsequently gave birth to a daughter who was granted full custody with her father due to Jackie's addictions and periods spent within psychiatric institutions. This maternal severing seemed to have the greatest impact on Jackie's psychological and physical well-being as she now is a regular attendee at Alcoholics Anonymous and attends a Christian church (although she is an atheist) to go some way to prove to her daughter that she is now a reformed and respectable person.

In the following excerpt, Jackie describes the ways in which her home space reflected her emotional and physical experiences at the time;

[39] These were some of the names of musicians Jackie discussed in her interview

"I've got this picture of where I come from and I ended up hiding away for three years after I was sectioned, three years I lived on my settee just in darkness drinking and drinking and drinking and I'd go out to the shop at 5.30 in the morning, get my drink, come back and lie on the sofa all day and I would detach myself from reality (LAS=mmm) and my flat just became (5) (sighs) I can't tell you how degrading the state I got into...I had two sack full's, bin bags black sack full's of unopened post (LAS=mmm) (2) can you imagine the state I got into um (LAS=mmm) I hadn't been in the bedroom cos' that was the last room my daughter went into and I just used to live in the lounge and I don't think I even washed my hair and I lost all my teeth (1) so I've got dentures now (3)...Sometimes I had the telly on um (2) I didn't really watch television though (4) I'd um run out of electric because I drank the money (LAS=yeah)...I smoked as well and my money went on cheap cider and um (4) fags and that was it and a can of cold baked beans now and again. Oh I didn't even go in the kitchen um (1) I didn't wash up for three years and I didn't have any knives left cos' they were all in the sink (LAS=yeah) (2) the state I got in you would even believe (2) (LAS=mmm) I should have taken some photos you know (LAS=yeah) but I did get that low and I'd, I'd have sworn it was impossible for anybody to get that low to pull themselves back to the quality of life that I've got now"

In this extract, Jackie sets a psychopathological landscape when describing her home space. Here we are presented with an account that draws together the social, material and the spatialised body; "*three years I lived on my settee just in darkness drinking and drinking and drinking... I hadn't been in the bedroom cos' that was the last room my daughter went into and I just used to live in the lounge... I didn't even go in the kitchen um (1) I didn't wash up for three years and I didn't have any knives left cos' they were all in the sink*". Spatially, the lounge is represented as the space where her experiences manifested which is punctuated by the descriptor *'darkness'* to possibly illustrate the emotional and physical desolation she feels. These narratives of living in a world devoid of the cultural assumptions attached to normative constructions of home life is reinforced by the focus on the limited movement in this account as she describes her daily routine to "*lie on the sofa all day*". Here, the settee provides an

anchor in that this particular piece of furniture is where her life at the time was played out as she avoids facing elements of day to day reality.

This antithesis of optimal home life is reiterated by drawing attention to the ways in which she has spatially concealed the world outside; *"I had two sack full's, bin bags black sack full's of unopened post"*. This concealment involves a conscious decision to purposively leave the settee, find a black, bin bag, open it and place the unopened post inside. There is some structure within Jackie's daily performance within her home space. This spatial and temporal structure is reiterated as she describes an important part of her daily routine; *"I'd go out to the shop at 5.30 in the morning, get my drink…"* This is when Jackie leaves the confines of her flat on a daily basis to purchase alcohol. What is interesting to note is how she frames this event by drawing attention to the time she emerges from her home at *"5.30 in the morning"*. It would be reasonable to suggest that shopping at this time in morning does not fit in with 'normal' day to day life. Here Jackie may be highlighting that at this period of time in her life, her own social performances and identity resided at the boundaries of the collective. As a result, Jackie accounts for a production of space wrapped up in alcoholism together with personal and physical neglect - these narratives constitute a bleak time in Jackie's life. They also represent the embodied degradation of Jackie as a feeling and physical body. She doesn't care about herself – she doesn't eat properly, wash her hair, she loses all her teeth because alcohol and cigarettes are the main focus of her desires and subsequent performances.

Here, Jackie discursively maps out and territorializes her home space as one imbued with mental health distress and affective negativity. Nonetheless, Jackie does not simply bracket off these experiences but instead she illuminates on the actualized events and draws the reader in to the potentiality of Jackie, 'Becoming-other-a-respectable-person'. She does this by contrasting her feelings of climbing out of the depths of depravation to the virtual quality of life she has now. *"I'd have sworn it was impossible for anybody to get that low to pull themselves back to the quality of life that I've got now"*. This is not simply a forward going linear trajectory – it is constituted by a series of contractions and expansions – of back and forth. Jackie is always in the process of deterritorializing and reterritorializing her home space from immoral deprivation to a potential life of positive and moral quality (Massumi, 1987; Tucker, 2010d).

At this point, I would like to return to one of the three divergent elements of the production of service user home life and space, namely, that of supported accommodation. Whilst this

trajectory will proceed from supported to semi-supported and independent living, this does not mean that I am trying to position service users as having different levels of mental health distress but more so I am interested in the layering of experiences which shared and solitary home space are temporally actualized.

6.5 Living in supported accommodation

"Housing is a form of shelter, a refuge, a welfare service ...and a gateway to...services and social support"

(Johnston, Gregory & Smith, 1996, p. 253)

Within the above extract we are presented with elements relating to housing and home. Johnston et al., (1996) proffer a brief synopsis of the practical elements of housing in relation to service users[40]. Here one is presented with the structural support that bricks and mortar provides in terms of practical support. For service users who have spent large swathes of time within psychiatric institutions, this premise gives emphasis to the functional constituents of housing rather than the emotional content(s) or lived experiences therein. This position on housing as colloquially *'providing a roof over one's head'* is one whereby focus is placed only upon the components of providing shelter from the outside elements whether they be social or practical whilst negating the complexity that this space for service users' presents (Fogel, 1992; Gullestad, 2001; Williams, 2002).

In addition, Tucker (2010e) points out that when service users enter into psychiatric services the main focus of achieving psychopathological stability for living within the community, is via the means medication or cognitive therapies. Areas of everyday life such as housing and location can then become ancillary elements of living. This does not mean however that service users do not go through a process from which 'suitable' housing is provided in line with their diagnostic identities and behaviours. Again, here, we have the cultural codings of what constitutes extreme mental health distress, or those who are deemed to 'unwell' to live alone in the community, become enveloped within semi-institutionalised, supported home spaces. The locating of service users into appropriate forms of housing does not necessarily consider the desires and needs of those concerned as within this research project service users did not have any agency when decisions were made about their living arrangements. (Please

[40] Service users within this text means those with physical and mental impairments

note that the political and social implications of service users living within supported accommodation are discussed further in Chapter Eight).

The following extract by Jim, who is describing the structural and practical (in terms of social functioning) components of the supported accommodation he currently resides in;

> *"...um three bedrooms in each little um made in a line all in a line and there was an office and respite room and um you got three bedrooms in each (LAS=mmm) one and that's about twelve, fifteen accommodation for fifteen people suffering with mental illness…(LAS=oh right)...and I don't understand (why he lives in supported accommodation) probably because I need a bit more caring (2) I pay for me bath and I pay for me food, me rent and I pay for me milk all me meals and what else do I pay for? (2) Water when I have a bath what else and um I think they pay for me clothes and I get it and this is what they gave me ages ago (shows jumper) (3) it's alright ain't it?... Um see my bedroom's small (LAS=yeah) and I couldn't get a telly or a record player or a disco in there or a big table as it's too small and I trip up all the time and my bedroom's like a cell the smallest room in (names location)*
> *LAS = Does it feel like a cell to you?*
> *Jim = It does … and lived in a cell all me life mmm"*

Jim provides details of the geometric framework of his accommodation by discussing the linear way in which these units are situated and for what purpose they serve; "*um three bedrooms in each little um made in a line all in a line and there was an office and respite room"* (not unlike Tom's narratives illuminating the linear qualities of institutionalised space discussed in Chapter Four). Drawing from the discourses meshed within mental health distress (the respite room, an office), serves to anchor his narrative of the production of his spatialised surroundings as emanating from his mental health distress (Tucker, 2010e). This crystallisation can go some way to counter his sense of uncertainty as to why he is living there by elaborating the material and practical services this space provides; *"I don't understand (why he lives in supported accommodation) probably because I need a bit more caring (2) I pay for me bath and I pay for me food, me rent and I pay for me milk all me meals and what else do I pay for? (2) Water when I have a bath what else and um I think they pay for me clothes"*. Here he is making the abstract characteristics of supported accommodation more concrete by providing a series of different territorialities and including the goods and services that are *'actively entwined'*, and therefore embodied within his own ordering of living

arrangements (Rubinstein, 1989; Urry, 2005). His way of organising services and goods as pertinent characteristics from the broader (paying for the rent) to the more minutiae (paying for milk) are important elements encompassed within his sense of place. Jim's narratives here focus on the functional needs of this day to day life in line with Local Authority directives, but omitted here is any sense of this spatiality providing him with a place of sanctuary or indeed, he does not discuss any psychological attachment; *"and my bedroom's like a cell*. Fogel (1992) argues that this position is due in some part to practitioners underestimating the emotional needs of those within supported care by placing more emphasis on the bureaucratic components of providing definitive elements of practical care.

What we are presented with here is a catalogue of transactions which take place within the confined space of this accommodation. These are fairly significant as they are linked to his own embodied assumptions of what is appropriate for service users in supported housing require; "*and I get it and this is what they gave me ages ago (shows jumper) (3) it's alright ain't it"*. For Jim, the acquisition of a piece of clothing, the jumper which he did not choose and did not pay for (directly) relates to his own sense that he is dependent on others – it is these others which implement the constituents of every day to day life for Jim. For him, this is what being bound within psychiatric services entails – no choice and no responsibility. Jim does not have the social functioning skills to even buy a pint of milk or an item of clothing.

Jim then goes on to discuss his only private space, namely, his bedroom. Here he describes the limiting elements of his bedroom due to the smallness of space he can both personalise and perform within ; "*see my bedroom's small (I=yeah) and I couldn't get a telly or a record player or a disco in there or a big table as it's too small and I trip up all the time*." For Jim, he is unable to stake out his space using objects as cartographical markers to create a space which has content and meanings for him. He does not have a television, a record player, a disco or a big table because he does not have the room. By listing these objects, Jim is highlighting his desires – what he would like to have in his room or perhaps, what performances he could play out in the bedroom. Jim may be able to dance, to sing or watch the television but this space does not afford him these pleasures as trips up all the time without such appendages. More space and Jim might have the potential to feel a different person, he might become-other as one who can break free from the constraints (both physical and psychological) of his private space.

Therefore, Jim's bedroom appears to be a void of any sensuality and self-expression. He punctuates this feeling of emptiness and elements of incarceration (there is possibly nothing he can do to change his situation – he is a service user who has been designated to live in this particular space) by drawing attention to the discursive framework of life within a prison setting "*my bedroom's like a cell… and lived in a cell all me life mmm*". Jim's narratives can impart feelings of being inextricably and irrevocably entwined within psychiatric confinement as he has become an indelible part of the affective, discursive assumptions of extreme mental health distress. For Jim, he is largely unable in terms of access to materiality and emotionally to deterritorialize and reterritorialize his bedroom space – his narratives evoke a sense of a service user who is spatially stratified and at some levels fixed within the geometric parameters of mental health distress.

Moving forward, in relation to this project, supported accommodation is an interesting and important area to research. As Hockey, Penhale & Sibley (2005, p. 137) note, such forms of housing can be positioned "*as lacking scope for re-arranging living areas to reflect changed personal circumstances…*" This inability to allow the creative and personalisation of home space can be seen as the home space of supported accommodation as simply providing a structure to protect against exterior elements.

6.6 Objects in shared home spaces as social artefacts of performance and identity

> "*There is a certain chronotope to the long commute...After a while the trip falls into routine, into habit (always stopping at that gas station for a drink and chips) or the conscious struggle against it (trying different waffle restaurants). The space outside recedes into a blur... and the world shrinks to the bubble of the car (littered with Pringles cans, McDonalds wrappers and old cassettes).*"
>
> (Wise, 2000, pp. 295,296)

In the above extract Wise draws attention to the ways in which habitual practices such as the routine travel to the workplace or, in this case, the ways in which home spaces are spatialised through the means of objects. Whilst some have argued that there is negligible attention given over to the socio-cultural meanings of objects (e.g. Rubinstein, 1989; Urry, 2005; Woodward, 2001, 2007) research is now emerging with a focus on objects as a means of conveying identity and expression are important elements to consider when discussing home spaces (e.g. Douglas, 2000; Hurdley, 2006, 2007b; Smith, 2004). Here objects are not seen as

inert artefacts collected during the life course but moreover objects can be imbued with meaning and expression. With this in mind, some objects can take precedence within the home over others and can also change their hierarchal position as life progresses. For example, a wedding photograph may be replaced within a focal point by the pictures of new-born infants - in this way, objects can form part of our meanings of identity and social performance, they can tell visitors who we are (Hurdley, 2006; Putnam, 1992). Other, perhaps more mundane objects and performance can elaborate other socio-cultural meanings.

It is fairly straightforward to relate to coming home after a day's work or other mundane excursions such as shopping at the supermarket. On entering the home, the exterior world can be blurred by spatially littering the space of home by staking one's territory in the form of semiotic markers. For example, I might casually throw my coat on the bannister, on the back of a chair or on the floor as opposed to hanging on the utilitarian coat rack purchased for the purpose. These actions are not likely to happen in the workplace or the supermarket because there is an array of acceptable social codes and practices within these particular milieus (Werlen, 1993). Subsequently, at this particular moment in time, the home is spatialised as subordinate to the outside world. I have made my mark on my (albeit shared) home territory. The events of the work place and the supermarket have become an anti-genealogy, a short-term memory (Massumi, 1992; Thrift, 2004a). As the events of going to work and to the supermarket, in my experience anyway, are part of the repetition of daily life this kind of spatialising my home territory involves a change in identity, in this process there is a visual and psychological nuance of difference, I have become-other (Massumi, 1992). I am away from the social and cultural constraints of work and the supermarket. If I want to throw my coat on the floor I can do, temporally I am no longer part of a bureaucratic workforce or another consuming body within the supermarket. Although the next day may be different whereby I may conform to the cultural norms of behaviour within 'institutionalised' spaces resplendent with social rules of behaviour.

In this way, movement within and through space together with the placing of objects can become topographical sites and territories, it is how we can make claims and some kind of sense to our changing of identity and emotional and somatic sensuality (Cwerner & Metcalfe, 2003; Gregson, 2005; Jonathan Murdoch, 2006; Urry, 2005). What is of interest at this particular time, in terms of shared accommodation is how service users' stake out their own personal, temporal markers of space. And more particularly, in terms of external and internal identity and performance when discussing shared, communal space and private space (the

bedroom) Shared living spaces can entail expressions whereby the autonomous body becomes enmeshed within the other bodies who are either resident or control property (Somerville, 1997).

In the following excerpt, Daisy discusses her home space which she shares with another service user within a supported accommodation setting. In this research quotation, Daisy describes the spatial production of her shared home space. Daisy is a 50 year old service user with a diagnosis of Bi-Polar Affective Disorder. She used to live in an annex with Jim who was discussed earlier but has since moved to another section within the same collection of units.

> *LAS: So what is your favourite bit of the house where you live, your sort of favourite room?*
> *Daisy = Um (1) I would say the living room (2)… um I've got pictures of Manchester United up and uh em I've got like my little pot dog on top of the telly (2) you know sort of homely things (LAS=yeah)*
> *LAS: And do they mean something to you?*
> *Daisy: Yes because I love dogs um and I've got a pot dog and I love Manchester United so I've got things I love around me*
> *LAS: Do you have any photographs of family or friends?*
> *Daisy: I don't cos' it'd probably upset me too much so I don't um (LAS=yeah) (3)*

In this extract, Daisy sketches out some objects which she has acquired and has placed around the shared living room. Within this particular space she has a vested interest and staked certain pockets within this space displaying her own desires. What is interesting is the way in which she talks about an emotional attachment she feels to objects not usually associated with home-making and strong expressions of love. *" I've got pictures of Manchester United up and uh em I've got like my little pot dog on top of the telly (2) you know sort of homely things (LAS=yeah)…I love dogs um and I've got a pot dog and I love Manchester United so I've got things I love around me"*. Within the dominant cultural assumptions of adorning home spaces and indeed, in much research, objects such as pictures of a football team and a singular dog made of pottery, perched on top of the television are not generally equated with meaningful emotional and economical investments within home spaces. For example, focal

points such as the top of a television are normally reserved for personal memorabilia such as photographs or family objects (Hurdley, 2007b).

This is not the case for Daisy who does not place any photographs of family or friends in the space at all; *"LAS: Do you have any photographs of family or friends? Daisy: I don't cos' it'd probably upset me too much so I don't um"*. Daisy's explains her disengagement with placing photographic artefacts of family and friends as too upsetting to have around this particular room. Here we have some kind of trade off in creating Daisy's landscape, the items she loves which cannot possibly love her back, the football team who are most probably unaware of her existence and the pot dog she possibly purchased from the local discount shop[41]. It is the negation of displaying cultural objects such as photographs which can create a topographical site from which the outside and interior world can map different times within one's life course which is interesting. Photographs can tell a story, and Daisy does not want to tell hers in this space.

In this way, her human and non-human (objects) relationships within the living room, can be seen as a creative arena to display the transactions of consumption and exchange. Such processes can both form personal connections and conversely, blur other areas of experience (Smith, 2004). Daisy's sense of disenfranchisement, whether economical (Daisy is on benefit so would be unable to afford to purchase an abundance of objects) and more pertinently, the emotional (the hurt she expresses when discussing her family and friends) are creatively masked and visually eradicated, albeit temporarily, by drawing on objects she has access to which do not require such intense levels of engagement (Parkin, 1999). Although this is a shared space, Daisy has to some extent created compartments of personalised space but, as alluded to above, her creations do not fall within the cultural and social assumptions of cultivating a space imbued with self-identity and past experience (Dovey, 1985).

6.6.1 Living in supported accommodation – 'private space' – the bedroom

I would like to continue with Daisy's narratives of living within shared accommodation because she has interesting ways of creating and producing space. In the following excerpt, Daisy discusses her bedroom, her private space within the supported accommodation she lives in.

[41] Daisy often spoke to me about shopping at 'Pound Land' and other discount shops

I'm quite an eclectic (sic) collect things you know that are mine and posters of dogs and um I've got an awful lot of um (2) um a lot of sort of personal things all in bags which are full of stuff and it needs clearing out to be honest but the more the better to more because they're all memories and I feel like (1) I've got you know more well too many things it's strange you know possessional (sic) things... Well (names member of staff) came in once and um she said Good God (laughs) you know and she complained about it and I said I'd actually tidied it up but I hadn't done and I only got rid of one bag or something but luckily she's um eh she's not said since you know which is a miracle (3)

Here Daisy talks about the ways in which she collects objects which belong to her *that are mine… a lot of sort of personal things"*. These items which she highlights belong to her and are personal (there is a social interaction here) may be a way of Daisy creating meaningful ownership within a shared space. These are her things, they only belong to her and by the very way she conceals these objects in bags; "*all in bags which are full of stuff*" there is a suggestion here that this is how Daisy intends her relationship with these objects to remain. She does not want her possessions open to the 'gaze' of others - they are not artefacts for general display to provide a visual mapping of her memorial experiences. These objects are important to her "*because they're all memories"* but only to Daisy. In this way, by concealing her collection of objects in bags, Daisy is both bulking out and controlling her 'private' bedroom space. Daisy may be packing out her space to make her feel safer and more secure - the more bags the better, this is how she may have created her own 'haven of private' space. By doing this, she has deterritorialized her 'private' space by inverting the cultural norms of displaying objects as a means of cultivating her social and self-identity to the interior and exterior world. However, the relational concept of Daisy effecting reterritorialization is continuously precarious as there are limits to her control over this production of space.

By continuously filling her space with her own desires there is an acknowledgement that her packing out of space needs some rectification; "*it needs clearing out to be honest but the more the better"*. Here reterritorialization hangs in the balance, Daisy is aware that she has too many things, her production of space may be visually messy and untidy and may alert the 'gaze' of unwanted eyes. She punctuates this point by drawing attention to her socially unusual behaviour by reverting back to the dominant codings when spatialising objects in

home spaces; *"I've got you know more well too many things it's strange you know possessional (sic) things"*. Daisy acknowledges here that how she hoards and packs many objects in one space is *"strange"*. Her creativity here does not conform to the wider notions of mapping out home space whereby her practices and arrangements of decorations do align to the aspirational endeavours within television programmes such as *"Escape to the Country"* (Clarke, 2001) .

This unconventional behaviour does not go unnoticed; "*Well, (names member of staff) came in once and um she said good God (laughs) you know and she complained about it"*. This is where Daisy struggles to anchor and reterritorialize her bedroom space. For Daisy, this 'private' space is not so private after all. Her interactions (both human and non-human) are continuously under potential scrutiny by more dominant others in her day to day life. Nevertheless, Daisy goes some way in temporally stabilising her sense of reterritorialization by pretending to tidy her space; *"I said I'd actually tidied it up but I hadn't done and I only got rid of one bag or something but luckily she's um eh she's not said since you know which is a miracle"*. There is no suggestion of stability here though – Daisy's 'private', reterritorialized space is always fleeting, it is always awaiting a deterritorializing act as dictated by others to curb her own creative use of producing space. Her spatialised production is based on historical events (being asked to clear her mess), the near past (tidying up one bag only) and the future (the potentiality that she will be asked to clear out again). In this way, Daisy's bedroom is bound up within a mesh of *"temporal qualities…which involve change and stability, recurrence and rhythm"* (Altman, et al., 1985, p. 6).

6.7 The refrain

Deleuze & Guattari (2004) offer the concept of 'the refrain' as part of a framework concerned with repetition and habituation. Or, the ways we can mark both mark identity and territory by the repeated performances of action (Wise, 2000). To provide an analogical anchor, Deleuze & Guattari use the story of a young child who by the very fact he is alone in the dark, feels very afraid. To provide some form of comfort to himself, he hums a familiar song. Here, the child is drawing from experience, maybe from nursery rhymes or a lullaby sung to him when he was an infant, the sound of security as such. He is creating a new milieu for himself away from the sensualities of fear and dread. Using the rhythms of the song, he is deterritorializing and reterritorializing his space by the repetition of his humming, to another milieu of comfort. Using the cultural references he has experienced and embodied of the soothing nature of

certain melodies, he is able to anchor his space through his iterative performances. It is how he has moulded his space to become one of comfort by humming as opposed to his space as simply offering a structural territory of comfort. With regards to home spaces, it is our movements and performances which matter and cause effect and not the house as a residential domain alone (Wise, 2000; Tucker, 2010e).

At some level, we can see some kinds of parallels with behaviourism here. Of Skinner's theoretical positions of classical and operant conditioning imbued within 'Behaviourism'. We learn, through a process of repetition, combined with rewards or punishment, to adopt certain behaviours whilst rejecting others. Wise (2000) draws attention to Skinner's use of 'training' rats contained with a box, to glean food by repeating certain actions such as pressing a particular lever for example, has its core argument in repetition. In other words, we learn certain behaviours by repeating our performances. However, performances are more than an act of neurological processes and are more so bound up with the processes of embodied cultivation.

In Clara's account below, she discusses the ritualised processes of creating space she has adopted to afford her times of relaxation as a way of possibly countering the chaos of the outside world or indeed, ways of coping with mental health distress. To provide some context, Clara lives alone in a warden-controlled, one-bedroom, council flat which offers a higher level of autonomy in personalising space than supported accommodation[42]. Clara was moved to this flat as the end result of a process she went through, progressing from a 'halfway house', following a number of years spent within a psychiatric institution. She has a diagnosis of Borderline Personality Disorder (which was recently revised from Bipolar Affective Disorder) and has been within mental services for over twenty years. Clara has no physical impairments and lives in semi-supported accommodation wholly as a result of her mental health distress.

> *"...well most of me ornaments are all of the Zen. Do you know Zen? It's a Buddha (LAS=yeah) and I've got Buddhas all round my flat um Buddhas (LAS=oh right)...and I'm got scented candles which I um I light them up every night and I sit on um at home for half an hour from um six thirty until seven thirty with me legs crossed and me candles alight and sit there like that mmm, mmm (closes eyes and extends arms) and meditate for half an hour with the*

[42] It is worth noting that no narratives emerged from participants living in supported accommodation where objects became part of a set of ritualised practices

candles on and I um have half an hour's quiet every night (LAS=yeah) half an hour's peace and quiet and I have to turn the buzzer off on me, me flat so that no-one bothers me and I have to turn me phone off for half an hour, that's how it is...they've relaxed me (LAS=yeah) and that's the only way I can get relaxed if I've got a scented candle what I've lit and me sitting there quietly... and I been doing that for ten years um meditate and I got Buddhas all on the wall Buddhas mmm..."

In essence, her course of actions is mediated via her engagement with non-human objects with her identity of home underpinned by the repetitive ritual she carries out on a nightly basis. Firstly, she advises that most of her ornaments *are all of the Zen*, which marks her territory as one that emanates from the practices and beliefs of Zen Buddhism. This may be an important point for her to make as she marks her identification, within this spatiality, at certain times; "*from um six thirty until seven thirty*" and for specified periods of time; "*and meditate for half an hour*". Here, Clara presents an identity of the cultural references imbued within Zen Buddhism, namely, of spiritual and psychological 'self-enlightenment' and of having 'self-control' over her mental and physical activities. Interestingly, this in stark contrast to the discourses imbued within the diagnosis of Borderline Personality Disorder. Although this particular diagnosis is a complex one with many differing features, in essence it is a category bound up with 'emotional instability' and 'impulsive behaviour' (DSM-IV, 1995).

Furthermore, Kriesman & Strauss (1991, in Family Practice Press 2008, p. 1) summarise this diagnosis as follows: *"...as emotional haemophilia; (a borderline) lacks the clotting mechanism needed to moderate his spurts of feelings. Stimulate a passion, and the borderline emotionally bleeds to death"*. Taking these factors into account what Clara is presenting within her account is a flip side to the medicalised discourses of her diagnostic label. Thus, for Clara, her identity within her home is temporally spatialised on a nightly basis as an antithesis with the diagnostic symptomologies contained with the classification of borderline personality disorder.

What is interesting here is the manner in which Clara's nightly performances appear to be mediated by the physical proximity of her Buddha statues. Clara's acts of meditation are constituted by blocking off uncontrollable outside interruptions to enable mental concentration and via sonorous tranquillity; "*half an hour's peace and quiet and I have to*

turn the buzzer off on me, me flat so that no-one bothers me and I have to turn me phone off for half an hour", together with the culturally defined physical positions of Zen Buddhism acts of meditation (the legs crossed and arms extended the low guttural noises). In this way, she has anchored her own sense of intimate space and place by restricting access to others but also displays social interactions with strategically placed inanimate objects (the Buddha's). This is a timed ritual which she undertakes with precision by reconstructing and controlling her home space as one of mental spirituality during these half hour acts. These iterative performances can thus provide Clara with another form of self-identity from that which she embodies on a daily basis, namely, an identity wrapped up within the discursive practices of psychiatry and vulnerability (Butler, 1990). Through this formation of space and spatial objects, Clara has moved from one milieu (psychiatry) and subsequently created and moved to another milieu (spiritual enlightenment) via her personal expression and connections to the Buddha as opposed to the statues of the Buddha's radiating notions of deterritorialization and reterritorialization (Wise, 2000; Tucker, 2010a). For instance, on a personal basis, the positioning of Buddha's around my home space would not induce feelings and actions to enable relaxation. But this is how these objects connect to Clara's identity during these temporal periods of time.

This move away from her self-identity of service user infused with vulnerability and needing additional day-to-day support is reiterated by Clara by turning the buzzer off in her flat. In essence, she actively (re)produces her spatiality from one of being controlled and of being in need to that of independence by using available tools to assert her own control of these situations. As per the opening extract, she attempts to ensure her space is *fixed* by a process of selection (the Buddhas, the candles), the elimination (stopping outside communication) to prevent the chaos of her social diagnostic identity from invading her sensuality of space at these times (Deleuze & Guattari, 2004). Subsequently, the (re)production of her spatiality is that *'of becoming'*, the actual lived experience of meditation and mental control and the potentiality of the virtual, the temporal 'road to recovery' from her mental health diagnosis during her nightly rituals. As Massumi (2002, p. 151) notes; *"Habit is reality. It is really productive"*.

6.8 Home as space of potential cultural identity

The framing of potentiality can offer a myriad of opportunities and ways for people to create and conceive new spaces – and indeed *"to escape the social, to enter a space that is new, a*

place where invention can exist" (Tucker, 2010d, p. 154). Such forms of escape from the wider social world whereby space can be produced and formulated by the organisation of objects offers divergent milieus from which expressions and identities can emerge (Wise, 2000). If we consider the ways in which young children can adapt their immediate surroundings to engage in socio-dramatic play, a settee can become a ship, the floor underneath can resemble the sea, scattered objects can become sharks and other fish or other bodies on the sea. Here children, by using potentiality and imagination, and the breaking away from the reality and functionality of the surrounding objects and space, can become sailors or pirates (Corsaro, 1993; Singer, 1973). In this way, objects can mediate an array of taking on other temporal identities.

Taking these concepts forward, let us consider Clara's narratives of how the organisation of her home space has been physically constructed to provide a series of linking mechanisms to discuss her 'friendship' with Stefanie Powers. For information, Stefanie Powers, an American actress is most widely known for her appearance in the late 1970's/1980's American television series *'Hart to Hart'*. This particular series was based on the glamorous lifestyle of a married couple of millionaires who spent their spare time solving crimes as amateur detectives. Powers lives in the United States of America, has her own website selling merchandise, such as signed photographs and is also well known for participating in polo matches at Ascot (these details are all available at Powers' own internet website located at www.stefaniepowersonline.com). It is worth noting here that the staff and other members did not particularly believe Clara's accounts but rather 'played along' with her discussions.

> *Clara: I've got um photos all round my house of me and Stefanie Powers dating back from 1984...She signs them, she signed one of my photos "To Clara my dear friend" she signs all my photos and I'm quite excited cos' it's something to look forward to you know it's nice to have something to look forward to (I=yeah)*
> *LAS = So have you got pictures of her all round your house then?*
> *Clara = Yeah and framed you know (LAS=yeah) and everyone is signed um everyone is signed and I'm um I'm seeing her again in August now August the 2nd when she's going to do the Ascot Park Polo Club in Surrey (LAS=Oh right)...actually Stefanie Powers taught me how to ride a horse um and I, I sometimes um when she's got a spare time well sometimes she lets me borrow one of her horses and lets me ride round the track but I'm not a genius, not a*

genius and it took me near enough 3 months to learn um it takes a while to learn…and I was invited to her wedding this was back in 93 so I turned that down cos' I said, I said to Stefanie and I spoke to her on the phone and I said "me daughter's gonna have to come first" and I turned the wedding down (LAS=yeah) but she, she did send me a few photos um wedding photos, wedding photos…"

Perhaps, on first reading this extract regarding Clara's friendship with Stefanie Powers, her narratives of a close relationship would appear somewhat doubtful. Firstly, Stefanie Powers lives in America and Clara is in receipt of benefits and lives in the East Midlands. This might make it financially difficult for Clara to maintain physical contact on a regular basis. Nevertheless, by treating Clara's accounts as either true or false there is a failure to actually consider the ways in which Clara is discursively positioning her own self-identity in terms of her positioning and interactions with the photographs of Powers. What is interesting here is how these objects have become 'socially alive' and furthermore, the ways in which Clara discusses her sense of potential self-identity in relation to these photographs

Initially, Clara discusses the correspondence she has with Stefanie Powers the signed photographs and in particular the signed photograph addressed *"To Clara my dear friend.* She discursively anchors these accounts by offering a date when this relationship began.
In this way, she is able to provide a more concrete version of this sequence of events. This stability then paves the way for Clara to discuss more intimate events within their relationship. Clara elaborates on her friendship; "*Stefanie Powers taught me how to ride a horse um and I, I sometimes um when she's got a spare time well sometimes she lets me borrow one of her horses and lets me ride round the track… and I was invited to her wedding this was back in 93 so I turned that down"*. These narratives intimate a close social bond between the two actors involved, Clara was taught to ride (possibly at Ascot and was invited to Powers' wedding and she has Powers' telephone number). Perhaps the organisation of the photographs of Stefanie Powers within Clara's home enables her to feel some sense of stability and comfort from which, in turn can create a revised social identity by connecting her territory to the outside world of celebrity (Massumi, 1998). In other words, the visual elements of the photographs may provide a series of territorializing connections which bind the social interactions between Clara and her potential escape from the immediate outside world. Here, Clara is more able to deterritorialize and reterritorialize her spatial production of daily living with mental health distress by her engagement with these particular objects.

This is a continuous process, it is at one actualized (she has previous photographs) but is also in the virtual; *"I'm quite excited cos' it's something to look forward to you know"*; the future feelings of anticipation she feels can offer a continuous and varied set of potentialities for Clara to continuously create new social worlds for herself. Here Clara is not merely a female, service user living in semi-supported accommodation, who attends a mental health day centre – Clara is always in a flux of becoming-other (Tucker, 2010e). She has created new avenues of social and psychological escape by the visibility of these photographs within her home space. Maybe, for Clara, these photographs offer a variety of differential cultural milieus in which her everyday life is temporally forgotten, her identity as a service user is temporally unimportant – she is temporally transformed into a close friend of an International celebrity. Clara has become a creative cultural performer within her own home space – she briefly rejects her everyday cultural identity imbued within mental health distress and proceeds to invent an alterior identity. This kind of social and spatial transformation may only be experienced in her home because the outside world (the day centre) does not engage and interact (not without question) within the landscapes where Clara emerges with her new cultural identity. Clara is a service user, and not only that, she is a service user who lives in social deprivation – maybe for others that is the only identity Clara can ever have.

6.9 Discussion

In this chapter I sought to explore the divergent ways in which mental health users produce the spaces of home away from the more, formalised orders of psychiatric practices. Focusing attention on three divergent ways of home living; supported accommodation, semi-supported accommodation and independent home spaces, this chapter discussed a variety of elements which emerged from the research data.

What was of particular interest to explore further was the ways in which the social performance of behaviours was discursively illuminated upon with the home. Rather than positioning home as a series of spaces merely consisting of square footage and the structural separation of rooms, attention was given to how psychological phenomena and the organisation of space can become socially visible as joint and interactional entities (Tucker, 2010e). In this way, space can be shaped by a series of markers or objects, which in turn may create a series of expressions of territory and potential identity (Wise, 2000).

The above concepts of shaping space were explored where service users reside in supported accommodation (a home space under continuous scrutiny), semi-supported accommodation and independent living. Drawing from the data analysis, we were presented with a myriad of ways in which service users can produce space or can be impeded by their own sense of lacking a spatial identity (Jim's narratives are relevant here). There were elements of deviant behaviour (Caroline's self-harming and potentiality to commit an act of violence to another in her garden) and Jackie's accounts of how her space was formulated around her alcoholism. I then moved on to explore the discursive elements of residing within supported accommodation, which can impose a level of depersonalising space. Cultural performance as relational to the organisation of objects and markers was also discussed.

What emerged from this chapter was that the dual concepts of deterritorialization and reterritorialization were key elements in the reproduction of space and mental health. These accounts were discussed using the dominant framework of the territorial, arbolic codings imbued within mental health distress (there were no accounts of gender related issues and home spaces for example). In addition, the territorializing features of creating the moral home of decorative order and cleanliness, based on the notions of positive mental health, were not seen as forming part of the connective links between social interactions with space and objects. Rather the milieus from which expression and identity emerged were largely enveloped (although not always contained) within psychiatry.

However, the production of home spaces were mutable and bound up within a process of flows and blockages (the disposal and the pretence of disposal of Daisy's bags, the inertia of Jim's bedroom) (Thrift, 2006). In this way, some service users (apart from Jim) were able to create and invent new spaces (and identities) which afforded a sense of potentiality and of becoming-other. Whether that was becoming-psychiatric-patient-yet-again (Caroline's account) or becoming-friend-to-an-international-celebrity (Clara's account), where the continuous movement and changes of spatial production offered new opportunities of transformation (Tucker, 2010e).

I have explored the ways in which objects and home spaces are more than inanimate entities. For instance, we had Clara's narratives of her ritualised social performances with the fixed statues of Buddhas around her home. For Clara, these particular objects were enveloped within her own production of space within those periods of time. The Buddhas were neither static or sterile but rather they played a key role within her temporal periods of self-regulation

and psychological control (Gregson, 2005; Knappett, 2002; Woodward, 2007). These were regulated times of maybe escaping from the chaotic life of a service user with a diagnosis of borderline personality disorder, these objects may offer a feeling of stability and solidity to counter the uncontrollable forces of the outside world (Deleuze & Guattari, 2004). This could be Clara's consolidation of temporal spatiality, the brief moments when she feels in control of her own patterns of daily living, in terms of her body and her mind. Her habituated rhythms of spatialised production, are much like a repetitive chorus within a song, she repeats the same sequence of events on a nightly basis. As Massumi (1992) notes however habit is the formation of repetition but with different outcomes. Clara does not discuss these other outcomes but instead draws from her experiences imbued within the cultural notions of the positive outcome within meditative performances. She was always situated in the potentality of becoming, of becoming non-service user.

These were not linear trajectories of potentiality but were more so wrapped up in the continuous negotiation of shifting a visible spatial identity within the home space. Here elements of surveillance, mental health distress and lack of access to privacy could create obstacles in the processes of transformation. However, most participants were able to circumvent these kinds of clogging up of spatial creativity by reinventing new spatial identities within their home spaces.

Chapter Seven

A Visual Ethnography of Home Spaces

"The home space is not codified; there is no rule book governing the production of the event of domestic violence (or, on the other hand, caring). Domesticity is coded. Coding is also modelling, but not through formal regulation. The modelling occurs through the accumulation of already-constituted relations, contracted into bodies as habit (which includes belief: habituated meaning)."

(Massumi, 2002, p. 82)

7.1 Introduction

This chapter will draw from visual images of home spaces which were taken and discussed by two participants, Bill and Tom. These two participants were included in part of the data analysis on 'othering' in the day centre as discussed in Chapter Five. It is worth reiterating that whilst both Bill and Tom had a diagnosis of paranoid schizophrenia Bill had rejected this particular diagnostic identity and replaced it with post-traumatic stress disorder whilst Tom appeared to embody this diagnosis on an on-going basis. Bill did not display (at the day centre anyway) any observable, stereotypical movements of paranoid schizophrenia such as rocking, talking to himself or catatonic movements whereas Tom would often move through the day centre in a more unconventional manner, which at times could produce feelings of 'otherness' for him.

I will continue to discuss the cultural significance of objects and the ways in which service users navigate performance within their home spaces in relational encounters with seemingly 'inanimate' items. As Woodward (2001) notes, even mundane objects such as knives, a kettle and a tea towel can be enveloped within the routine of everyday life. These items might seem trivial but they can form part of the mapping and movement of everyday spatial production within home spaces. In this way, engagement with various utilitarian objects can create the perception and feeling that everyday life within homes space can be grounded in repetition and routine (Hodges, 2008; Tucker, 2010e). Referring back to the opening quotation, Massumi highlights that there are no formal jurisdictions surrounding the performance of home spaces – there is no manual here, well apart from the cultural and political interventions

of the media which dominantly propagate cleanliness and order. We can therefore embody or indeed, reject the cultural habitual practices of the home.

For example, if we consider the plights of the homeless person – politically and culturally there is no sense of a system of repetitive movement here – homeless people are perceived to be always on the move. Those people living on the streets are seen to move around in almost aimless and haphazard ways largely because they are usually moved on by authorities. But, however, there can be a prevalent coding of habituation here. Anecdotally, when I travel from Central Milton Keynes to London Euston, each time the same homeless people, sit in the same place (near the entry door) on the same rugs, with the same dogs and with the same hats awaiting money from passers-by, both performances await my departure and my return. The only differential here is that the actors may be more drunk on my return, the dogs may have moved and the hat may have more (or not) coins, but there is a repetition, but *"repetition with a difference"* (Massumi, 1992, p. 16). In other words, what we see as repeat performance or a set of daily rituals for example, are more so produced within a variety of continuous differentials. Things are never the same although perceptually they may seem to be as some events become so ingratiated within our daily lives we fail to take notice of the contradictory and changing nuances around us.

Nevertheless, there is a sense of the ordering of a wider, more precarious temporal space here, but then all space is temporal, what we have just lived can never be the same again although the motions seem mimetic. In essence, we are all performers who can only attempt to conduct repetitive acts which we perceive to be the same. Every time we vacuum the floor, the movements of the hands, head and feet when negotiating areas to be cleaned may feel part of the drudgery or mundaneness of life, psychologically this may be part of our everyday routine. However, there may be slight bodily pains we can experience, psychologically we may feel different to the time before and almost certainly the debris sucked up by the mechanic cleaner will contain a different concoction of skin, hair and dirt. In other words, we can never repeat as a pure tracing what has happened before but this continuous return to the same task can be perceived as anchoring identity and space. This is the very quintessential essence (if there can be a stability of meaning) of Massumi's quotation.

Consequently, this chapter will focus on the ways in which space is reterritorialised based on Deleuze & Guattari's concept of 'the refrain', which has links with repetition and habit (as discussed in Chapter Six). In addition, using visual methodologies whereby two participants

took pictures of their homes, the ordering and arrangement of home and garden spaces is also explored. These are important areas to discuss further as Tucker (2010e, p. 1839) notes with particular reference to the spatial production of mental health distress; *"… routinisation is seen as an accomplishment, as a means to create a perceived stability within an ongoing continuity."* Rather than positioning and analysing the items as purely existing in home spaces, or as stand-alone objects, this chapter will again unite the social performance of human and non-human kinds as one (although not necessarily coherent) entity to explore further (Brown, 2001).

7.2 The anchoring of space

> *"Now we are at home...The forces of chaos are kept outside as much as possible, and the interior space protects the germinal forces of a task to fulfil or a deed to do. This involves an activity of selection, elimination and extraction, in order to prevent the interior forces of the earth from being submerged...A housewife sings to herself, or listens to the radio, as she marshals the antichaos forces of her work... Sometimes chaos is an immense black hole in which one endeavours to fix a fragile point as a center."*
>
> (Deleuze & Guattari, 2004, pp. 342, 344)

Within the above extract, Deleuze and Guattari focus on the emotional content of home spaces and the myriads of ways in which objects can be used to mediate a sense of stability, albeit in a precarious way. Here, one is drawn more to the dynamic and repetitive arrangement of home spatiality as a way of providing sanctuary from uncontrollable exterior forces. By using this position, home is not merely conceptualised as a one dimensional space from which to carry out day to day activities but moreover is a series of spatialities consisting of ebbs and flows, of torrents and blockages (Cwerner & Metcalfe, 2003). Wise (2000, p. 295) elaborates further on Deleuze & Guattari's position by drawing attention to the ways in which repetition (such as housework) and the stabilising of space by the use of physical markers (e.g. walls, furniture), personal territories are mapped out to create "a space of comfort amidst fear, in other words, home". Nevertheless, this does not mean that the spatialities, or indeed, practices of home endure as static entities of establishing one's personal sense of place, rather these elements are both transitional and wrapped up with strands of connectivity to the outside world (Knappett, 2002; Wise, 2000). In other words, the structural elements of home spaces are bound up with the processes of wider cultural and social norms and self-identity. It is these notions of how these spaces are (re)formed and

(re)constructed as a result of interactions with inanimate objects that serve to create home as an affective territory.

This move towards the non-discursive at this point places the focus of interest on the various forms of *content* (objects and space) together with the linguistic discourses of *expression* (emotional content) as a vehicle from which to untangle individual accounts of spatialised experiences. Positions of affective territories are subsequently rooted in untangling the discursive accounts of embodied experience(s) with human or non-human kinds (Brown, 2001; Conradsonn, 2005; Tucker, 2006). To contextualise such interactions, and more especially with non-human kinds, denotes a reciprocal understanding of the cultural and social possibilities that space and objects may offer. This cultural matrix offers the potentiality of exploring the multiplex of intersubjective relations instilled within qualitative research to create a mutual recognition of another person's experiential accounts (Finlay, 2010).

7.3 Storage and clutter

> *"Ongoing lives are present in the oddments, between the gaps of the permanent or ideal display: the wedding invitation, the confiscated toy, or the film awaiting development"*
>
> (Hurdley, 2007b, p. 368)

Home spaces as sites of social aspiration via the arrangement of furniture and objects has gained increasing importance from the mid-1990's onwards, largely due to the impact of media (television programmes and magazines). (Miller, 2001). The shifting and strategic placing of furniture and decorations can even be positioned as facilitating elements such as increasing wealth, happiness, good luck and bad luck, when concepts such as Feng Shui are considered. In addition, the increased consumption within current times of items designed specifically for neat storage, such as the abundance of shelving and bookcases one can purchase relatively cheaply from large furniture stores such as 'Ikea' (Urry, 2005). Consequently, such glossy images of ordered spaces within the paraphernalia available in contemporary magazines and television programmes such as 'Life Laundry', place a premium on reducing clutter and mess to that of containment. Subsequently, the accumulation of too many objects which are not visually arranged with care and thought, can suggest that the flows of everyday life are impeded, whilst storage can facilitate higher levels of social functioning (Cwerner & Metcalfe, 2003; Morley, 2000).

These assumptions of home decoration as a social and cultural set of practices, tidy is positive, messy is negative, can conceptualize these spaces as not just constituting a set of rooms to simply live in. Here, home spaces are more so created to provide a set of channels and movements into, within and through and also out of the home (Cwerner & Metcalfe, 2003). We may then take our identities connected to home spaces outside of this particular domain and into other, less intimate territories – our social and cultural aesthetic tastes and values can be transposed into the wider community (Gullestad, 2001). This production of identity can be manifested in our choices of consumption (i.e. to purchase items from John Lewis or Ikea, for example), which in turn can provide a cultural identity indicating wealth, class and social power (Clarke, 2001; Woodward, 2001). These positions can also apply to ritualised events undertaken on a daily basis, for instance, the eating of a meal. Although this is a common activity in many home spaces, the very ways in which meals are eaten can have sociocultural implications based on spatial and temporal expressions (Dovey, 1985). Eating an evening meal at the dining room table and preferably eating during the times of early evening may be seen as having higher levels of social functioning than eating dinner from a tray, whilst watching the television nearer the time of midnight. Home spaces can therefore be ordered and contained within temporal settings as well.

Here we have a distinct set of discourse which constructs the disorder of artefacts as indicative of social and personal problems whilst the undergoing of storage is constructed as key to overcoming these dilemmas (Cwerner & Metcalfe, 2003). Whilst home spaces are mainly personal and involve the inclusion of intimate objects, there is always a wider cultural network from which the moral and social aspirations of home spaces are played out (Knappett, 2002; Putnam, 1992). Consequently, the material ordering of objects can function as a nexus from which social and power relations can operate (Graves-Brown, 2000; Sixsmith, 1986). With such an emphasis placed on the neat containment of domestic space imbued within cultural frameworks, the arrangement of home spaces can also create a territory of social anxiety whereby visitors can act as a source of potential surveillance where judgements regarding the inhabitants can be made (Hurdley, 2006; Putnam, 1999; Williams, 2002).

7.4 The filtering of objects

With regard to the visibility of decorations to both inhabitants and visitors, Hurdley (2006) draws attention to ways in which focal points, such as a mantelpiece, do not remain static platforms from which to display artefacts. Instead, objects are moved around to indicate their importance at particular periods of time with more potent markers being given more visual prominence than others. Here, objects like inhabitants are always in a process of change and movement as a result of their hierarchal position as an expression of identity at given moments in time (Baudrillard, 2005; Edwards, 2002; Urry, 2005).

Within this network of flux and flow, expressions of identity and the manifestation of these by the visual display and use of objects, even if these objects are utilitarian (such as an egg whisk) are part of the formation of experience, they enable shape and a force of order within home spaces (Csikszentmihalyi & Rochberg-Halton, 1981). Domestic goods are subsequently appropriated according to the social event, be it an intimate or more public affair. For example, the use of inexpensive mugs assigned for the family to drink tea and coffee whereas the lest utilised china cups and saucers when entertaining visitors (Douglas, 2000). This is why the filtering of objects is key to gain a further understanding of how decorations and objects are constituted in everyday life.

7.5 Visual ethnography - audiencing

Gillian Rose (2007) has undertaken a number of empirical works around photography together with interviewing participants. As an exemplar of her qualitative research, Rose (2010) has explored the ways in which family photographs become part of an intricate network of private, cultural and social practices. More generally, she argues that many research projects around the taking of photographs and the display of photographs (as displayed in the home) neglect the social significance that imageries can impart. Rose's concern here is to explore the ways in which images are instilled with their own power relations which are then negotiated between the visual image and the viewer. In this way, photographs are taken and displayed as a means of indicating certain social experiences and relationships (Kolb, 2008; Pink, 2003, 2006). This concept Rose calls 'audiencing', highlights that attention should thus be given to what somebody is trying to impart via the means of imageries which are subsequently interpreted by the viewer.

Hurdley (2007b) supports the above position by drawing attention to the processes that photographs emerge through. Here, she argues that visual data, as a form of materiality, has been through a series of framing, developing, editing and selection. Photographs are not merely snapshots taken without thought and planning, but more so are bound up with cultural norms, hierarchy (in terms of selection) and social identity (Edwards, 2002). In this way, selected photographs for display and analytic interpretation can become part of the production of symbolic spaces; they are presented to the viewer with the intention to communicate a visual record of the cultural self at that moment in time (Heath, Hindmarsh & Luff, 2010; Ruby, 2005).

Banks (2005) suggests that three questions should be asked prior to researching using visual methodologies. Firstly, what is the image, what are the constituents of the photograph? Secondly, who took the photography, when and why? Thirdly, how does one read the visual communications as a viewer? By asking these questions, interpreting photographs becomes a medium from which to explore the productions of spatial human action and human social relations (Banks, 2005). The social context in which the image was produced together with the inclusion of material formations and identity become important elements to consider when discussing visual methods (Pink, 2006). This system of processes involves an on-going series of negotiations between both parties and there is always a distinct possibility that differential interpretations may emerge (Rose, 2007).

Taking these positions forward, photography offers a myriad of ways in which the spatial production of everyday service user life within home spaces can be explored further. From an analytic perspective, visual images form part of an intricate network of ordering and filtering to display a spatial representation of self-identity. It is these elements which can offer a further insight into the differential trajectories service users undertake when presenting visible markers of how they desire to be seen by the 'gaze' of others.

7.6 Social and cultural displays

Consider the following extracts of visual ethnographies taken via video footage of home spaces undertaken by Bill and of digital photographic images taken by Tom (both attend the same day centre). Both participants were asked to take photographs within their home spaces, with Bill providing a narrative whilst he was shooting his footage whereas Tom was

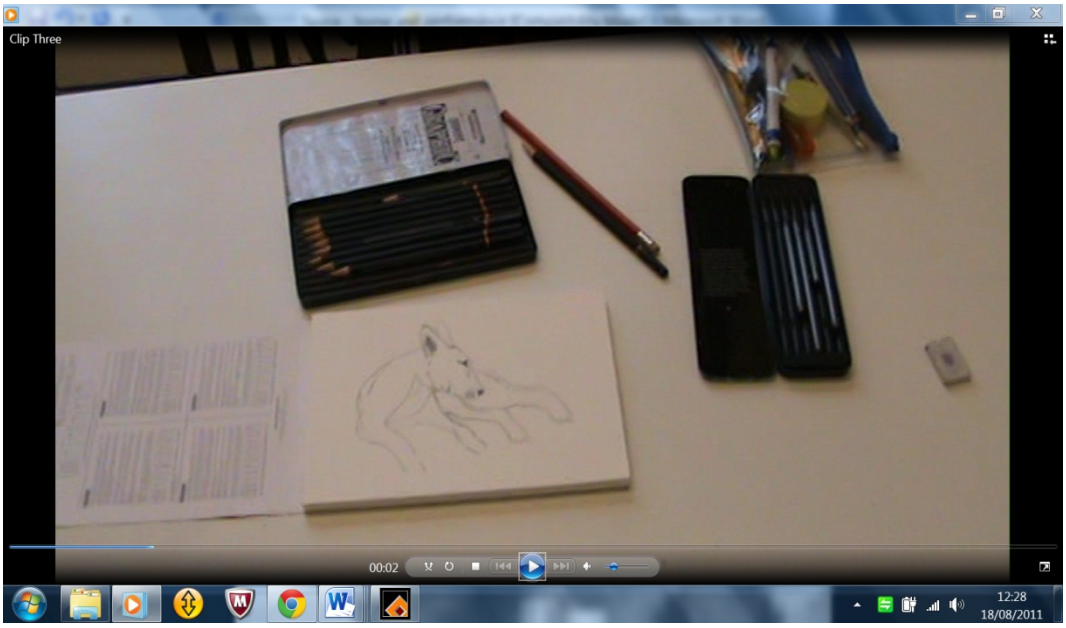
interviewed with a digital tape recorder to discuss his images. There were no other instructions than this so as not to make this a prescriptive exercise.

As discussed in Chapter Five (the day centre chapter), Bill has a formal diagnosis of 'paranoid schizophrenia' although he does not advise this to any other service users and he is reticent to discuss this aspect of his life with me. Rather, Bill tells people he has a diagnosis of 'post-traumatic stress disorder' which may go some way in maintaining the relatively high level of social power he has within the day centre. Bill runs the art group and is active in implementing activities to gain more income for the day centre. Conversely, Tom has largely embodied his diagnosis of 'paranoid schizophrenia' and, at times, he has been isolated by other members and more particularly by Bill at the day centre. Tom does not get involved in group activities and his contribution to the running of the day centre (from my experience of being present at the day centre) is picking up the numerous cigarette butts strewn around the outdoor smoking area. Briefly, it is worth reiterating again that Bill and Tom were the only two participants to undertake this element of the research project (the reasons for this are discussed in more detail in Chapter Three).

7.7 The order of things – Bill's story

Bill lives with another older, male service user called Dan in a two-bedroomed, council-owned bungalow. As discussed he has a diagnosis of paranoid schizophrenia but rarely talks about this although he did disclose during an interview that he hears voices and has periods of disassociation (it is during these periods that Bill is normally picked up by the Police and detained under Section). Bill has lived in this property for a number of years now and shares the property with Dan. Bill describes himself as the 'carer' within their relationship and has often discussed how he undertakes the majority of the domestic chores because Dan is generally too psychologically unwell to share these tasks.

If we look at the following image Bill has presented where he is discussing one of his main hobbies, which is drawing.



> *"I prefer to sketch more than paint but um I do, do some watercolours and it's usually of animals or wildlife or people's pets or whatever you know what I mean so I'm usually using pencils and just sketching really (3) but it's good, it helps me to chill out (1) a bit anyway"*

Within this image, on first glance it looks like Bill was currently drawing at the time this was shot. We have a drawing, a selection of pencils in two boxes, a pencil case, an eraser and two pencils indicating the production of art. Bill may be presenting here a kind of 'snapshot in time', of just having stopped drawing an image but there is a sense of ordering and anchoring of space here (Thrift, 2004b). Certain items are presented at certain angles, the box of pencils on the left, the two pencils on the table and the eraser, are all tilted towards the left hand side of the photograph. These positions jostle with the more vertical positioning of the other box of pencils and the slight slanting of his drawing.

The two pencils, for example, are adjacent to each other, pointing in the same way these two items are spatially ordered. This is an artistic visual production of the undertaking of artistic endeavours. Culturally, the landscapes of creating art can be bound up with assumptions of a lack of containment, so as not to impede upon the flows of creativity. The artist can be continuously in the process of throwing off the constraints of everyday life by blocking out the forces of the exterior world. In this picture, Bill gives the impression of momentarily breaking away from his creative pursuits to take this photograph. There is a sense of rhythm here created by the arrangement of objects but there is also a sense of a purposeful framing and ordering of materiality. From my own interpretation, this visual image has been through

the processes of; *"developing, editing and selection"* (Hurdley, 2007b, p. 354). This suggests not so much a break in his drawing but more so of a cultural display of appropriate materials, arranged and composed to suggest that this photograph seeks to suggest elements of continuous production (Knoblauch, 2008). In this way, Bill has drawn from his own experiences (both somatic and those psychologically embedded) of practices habituated within the creation and production of art (Wise, 2000; Tucker, 2010a). He is performing this process of habit here by replicating a scene of performance and movement connected within this particular set of processes.

Perhaps the ordering and arrangement within this photograph may be visual evidence of his spatial production of self-identity here. Bill is not an idle service user who is solely reliant upon psychiatric medication and therapies alone he is somebody who utilises his engagement with art to help to relax him. Bill's filtering and placement of objects here can relate to the wider cultural images of the production art as he displays all the tools necessary to enable him to sketch (Cwerner & Metcalfe, 2003; Thrift, 2004a). He doesn't just show the finished or partly finished drawing but draws attention to the process as well. Maybe Bill is visually presenting himself as somebody who resides outside of the cultural assumptions of mental health distress, he has some order in his life and this is punctuated by the neatly arranged composition of his photograph. In this way, there are no visual signs of poor social functioning within this particular snapshot (Bijl & Ravelli, 2000; Cwerner & Metcalfe, 2003).

In the following image, Bill draws attention to part of his collection of books.

> *"It's Sunday today and um I thought I'd show you part of my book collection…I collect H.E. Bates' First Editions and um today I've been down to the car boot sale and I've been well enough now, I've got a bus pass I'm much more able to get about and um if I hadn't got that bus pass I'd be more or less getting on towards housebound and it's been very difficult to do these things"*

Again, we have an image of order and system where the books are both displayed and contained within a receptacle specifically designed to house books. This is an image which conforms to the wider cultural assumptions of ordering items and is therefore a symbolic use of space where Bill can reinforce his own sense of social order and moral performance within the home (Csikszentmihalyi & Rochberg-Halton, 1981; Ruby, 2005). The books are neatly arranged and they are all perfectly upright which is largely due to Bill having enough books to ensure that they all stand and display in the same vertical trajectory (as opposed to a half full bookshelf, where some books may lean one way or another). Here Bill has packed out and closed this space as a way of executing his own performance, of an avid reader, with the hierarchal display of his books (Baudrillard, 2005).

What is interesting here is Bill's presentation of differentiation from the psychiatric discourses of mental health, namely, those of reduced cognitive capacities when linked to a

diagnosis of schizophrenia (Barch, 2003; Bentall & Fernyhough, 2008). This difference is illustrated by drawing attention to his hobby of collecting books authored by '*H.E.Bates'* which is punctuated further when he advises he collects *'First Editions'*. Not only does Bill read and engage with a notable literary writer but he also collects the much prized first editions, there is a series of differentiations here with a focus on conspicuous consumption (Woodward, 2001, 2007). Bill's performance here is not one imbued within the dominant psychiatric assumptions of paranoid schizophrenia because he has higher levels of cognitive dexterity than those others who share the same group behavioural characteristics of this particular diagnosis (Werlen, 1993).

Bill's move away from psychological forms of distress is reiterated further when he discusses how he obtains his books by attending car boot sales which is now easier for him to undertake as he has a bus pass. Here, Bill is placing the focus on his physical impairments as opposed to his psychiatric diagnosis. It is the physical aspects of his life which impact upon his movements and performance when acquiring books. Consequently, this is an area of his life which has little association with his self-identity of service user, other than Bill is an aspirational service user which he visually and verbally displays by the use of his version of status symbols to reinforce these points further. As with Bill's photograph of his artwork we are again with a visual a sense of ordering and compartmentalisation to inform the viewer that his home space is instilled within the discursive practices of storage (Cwerner & Metcalfe, 2003).

In the following shot, Bill has displayed some items which mean something to him on a table.

> *"I collect old Northamptonshire postcards and old tins (not shown in entirety within the footage) and as I said books and um (2) I'm a bit mad on books and things but um well it helps me to chill out…and I read a lot as well and um eh I go to the local flea markets and um jumble sales if I can get there and if I'm able to do it physically"*

In this particular shot, Bill frames his possessions in an artistic way in terms of interior design. These particular objects have been placed very specifically for viewing using different angles and hierarchal positioning on the table. Particularly, in this shot we have a sense of Rose's (2007) concept of 'audiencing'. Bill is conveying a social message here by demonstrating an artistic ability in producing a manicured picture which can then articulate his own production of social meanings of order and containment (Pink, 2003). Here, Bill has taken time to arrange a series of objects this has required an amount of conscious thought and physical effort.

Centrally, a page of the book lays open displaying a coloured picture of a woman with two children. The image here is one imbued within antiquity as this does not seem to be a contemporary piece of work. This preference for aged items is reinforced when Bill discusses how he collects old postcards of Northamptonshire scenes. What is interesting is how Bill both displays and keeps these postcards. Contained within the appropriate apparatus of a photograph album Bill has opened the album to provide a brief glimpse of his collection.

This is a tidy and ordered collection rather than having postcards being kept in boxes or strewn around the house for example. Here he has become part of the consumerist society who purchase items for holding and display purposes only to possibly illustrate identities of 'normative' social functioning (Gullestad, 2001; Miller, 2001).

Finally, we are presented with an image of another book titled; 'Book Collecting'. The use of this particular object may be Bill's way of kind of anchoring his social identity of avid book reader. He not only reads lots of books but he also has a book on collecting books. Again there is a series of differentiations here (much like the purchasing of H.E. Bates First Editions) as Bill goes further than many by taking his pleasurable time of reading to another level. He also discusses how reading; "*helps me to chill out*". In this way, these objects perform a psychological function as they are not there purely for the sake of reading or flicking through postcards. What they do is become part of his process of seeking respite perhaps from the chaos of the outside world, they provide an anchor to stabilise his interior space (Wise, 2000).

The arrangement within this photograph can be seen as somewhat staged and sterile but it can also be viewed as having the rhythm of movement, flow and change. As discussed, before Bill does not embody his diagnosis of 'paranoid schizophrenia' , it may be a part of his own introspective psyche but outwardly Bill is a service user with Post-traumatic Stress Disorder who has some difficulties in physically getting out and about. The spatialised production of his home is not seemingly clogged up with blockages as everything seems to have a place – there is a pattern of coherence here. However, it would be interesting to see if the rest of the house was kept in the same manner, or if Bill has home spaces where items are left to gather dust (Cwerner & Metcalfe, 2003). This kind of ordering and containment might well go some way to destabilise and dissipate the wider psychiatric and cultural assumptions surrounding schizophrenia as a diagnosis of 'unpredictability', 'delusion' and 'irrationality'. In this way, the social visibility of Bill's objects are not merely static artefacts for decorative purposes only but are inter-relational within his own production of home space. They form an integral component within his process of 'becoming-other', of 'becoming-rational-moral-service user'.

Bill's visual images of tidiness and arrangement do not stop within the interior of his home space but are also evident in his garden space too. Consider the following photographs and narratives, where Bill displays the fruits of his labours in his garden;

> *"I enjoy my gardening um but um I've not been so physically able as I usually am and these are the last of the tomatoes which in fact have been grown in the greenhouse and we've had pounds and pounds of them and not to mention the runner beans um and eh the French beans and the spuds and everything else from the garden and it's been a really good year for us that way"*

In this photograph, Bill displays his crop of unripe tomatoes, again these items are arranged in an appropriate manner. They are either boxed in containers or perched upon plastic cups but they are not arranged in a haphazard way. These tomatoes are unripe which can visibly indicate that Bill is an active part of the production process of growing vegetables. His input into the process here is vital to ensure that he can display a visible reminder that Bill is a productive service user. Bill also reinforces his engagement with conspicous consumerism and functionality by drawing attention to the fact that he grew his tomatoes in a greenhouse, a building specifically designed to procure all types of vegetation – his garden is one conforming to a positive projection of life (Lefebvre, 1999).

Apart from the arrangement of this shot, we also have strong elements of production here, of being self-sufficient at some level, as not being too dependent on the state or psychiatric services for example. Bill elaborates on his expertise within the garden by discussing the other vegetables he has grown during the season, the beans, the French beans and the potatoes. Essentially, this is a particular shot of self-production, of not being idle or reliant on others for providing food – Bill is more than capable of growing some of his own food. This

sense of productivity is set against a backdrop of physical impairment; *"I've not been so physically able as I usually am"*. Even though Bill feels less able to tend and care for his garden, he still carries on and manages to overcome the physical difficulties he faces. There is no mention of the psychological here as maybe for Bill, it is the visibility and labour of yielding crops within his garden which may provide an element of stability rather than the relaxing cultural assumptions imbued within such spaces.

Overall, Bill's set of visual images are bound up with the dominant cultural assumptions of the positive elements of storage and the negative componentns of clutter. Within his footage together with his narratives, Bill refers to habituation, of reading, collecting postcards, drawing and growing vegetables to illustrate the constitutent processes which form his transformation. Namely, that of 'becoming-less-psychologically-disturbed-than-most-paranoid-schizophrenics'. Thus, his spatialised production is anchored and circumscribed around the acts of creation and manufacture, which he elaborates by focusing on certain objects within his home space. Bill is not your average paranoid schizophrenic, Bill is a service user who has the necessary cognitive capacities and self-regulatory behaviours to conform to the cultural notions of aspiration within home spaces. Consequently, through his spatialised production, Bill is always 'becoming-other'.

7.8 The (dis) order of things – Tom's story

Tom lives alone in a one-bedroomed, council-owned masionette. Tom has a diagnosis of paranoid schizophrenia and his psychological distress can often manifest in bouts of screaming, crying or rapid and repetitive bodily movements. During interviews, Tom would often slump on the table, jump up and down and on occasions, skip around the room. Tom hears voices and often talks back to them when in conversation with others – in other words, his visible behaviours can conform to his diagnosis. When I first interviewed Tom, his mother has just passed away, which was a bleak time for Tom as he had told me that he not seen his father since for over thirty years (he had a problematic relationship with his father due to his father having many sexual affairs). The death of his mother had happened two years before he took the following photographs but as the following research data will demonstrate this event has had a devastating impact on his life . It is also worth noting that across Tom's interviews with me, his day to day life was largely imbued with negative interactions (such as being the target for verbal and physical harrassment within his local community and of being at times isolated within the day centre (see Chapter Five for an

account of Tom's experiences within his day centre). This is not meant to suggest that elements of positivity within Tom's home space are not present but it is worth noting that drawing from my informal conversations and one-to-one interviews with Tom, his daily life was discussed in largely negative ways.

"That's my kitchen right and there's two sides to it and that's what mum gave me um a cooker and that's an old dishwasher which was me mum's which she left me when she died and I miss her and doing errands for her...and that's the other side and it's well you can see it's not a big kitchen and um messy (laughs) so I thought I'll show you my kitchen (laughs and that's a drainer (laughs) and as you can see I can be very lazy when I'm on me own and I've got this stuff here cos' I'd have to pay to have it taken away and they um the Council they charge five quid to do that um looks and that's why my house looks like it does um looks like a scrapyard don't it? (laughs)"

When Tom discussed his kitchen, he referred to both photographs – he had taken two to show both sides of the kitchen. In the first image, one is presented with a landscape of dysfunction with elements of disorder. For instance, although his cutlery is contained within a holder, this particular apparatus is taken from a dishwasher. There is a washing-up bowl in the corner whereas in the sink there is a smaller bowl or small bucket with an empty milk carton and a carton containing milk. Some items of crockery are placed on top of the kitchen units, maybe they are to be washed up or perhaps Tom doesn't put these items in his kitchen cupboards.

We are also presented with an open rubbish bin situated in the middle of the kitchen but more strikingly, perhaps, an unplumbed dishwasher appears to be also 'randomly' situated in the middle of the kitchen. Tom does not appear to have engaged with the conspicuous consumerism of storage apparatus as this space is littered with objects which have not been stored within the appropriate purposeful units (Woodward, 2007). In contrast to Bill's neat and formalised arrangement of objects, there appears to be a limited sense of ordering in Tom's photographs.

Perhaps to keep as many artefacts as he can which belonged to his mother Tom has no choice but to locate items such as the dishwasher in the only available space available to him although he does discuss that; "*I've got this stuff here cos' I'd have to pay to have it taken away and they um the Council they charge five quid to do that*". Here we have two sets of positions on the one hand there may be an emotional attachment to holding onto an unused dishwasher (in conventional terms) and the more materially practical elements of not being able to afford to dispose of the objects he inherited on his mother's death. Tom discusses a kind of hierarchal shuffling here in terms of the importance of this spatial object – there is no specific place to locate this item so it is positioned in the middle of the kitchen, but to dispose of it could result in a loss of a sentimental object and would cost him money that he cannot afford.

Whilst Tom's kitchen is on the face of it a cultural production of this particular home space, in that he has a contemporary built kitchen complete with units which have specific functions, such as for storing cutlery and crockery. As with many modern kitchens, units are located around the perimeters of the available walls thus creating a linear and ordered place in which to carry out domestic chores such as cooking and washing-up. Nevertheless, Tom has created a new production of space by ignoring the cartographical features of the functional layout which promotes orderly containment. For example, although the rubbish bin is positioned next to the sink, the empty carton of milk has remained in the sink. He punctuates these kinds of disordered productions by drawing attention to his own relational engagement within this space; "*and as you can see I can be very lazy when I'm on me own"*. In the second photograph, for instance, the dishwasher placed has become a central feature within the kitchen and maybe due to this prominence, this object has become a space for 'dumping' items during every day living (Edwards, 2002; Hurdley, 2006).

Tom's kitchen does not present the viewer with the production of domesticity. The frying pain in the second image does not sit correctly on the top of his cooker. The microwave is unplugged, there are empty plastic containers on top of the microwave there is a cleaning cloth which appears to have been thrown over another set of cutlery. One item that does seem to be in use is the ashtray positioned next to the cooker with visible cigarette butts. This limited sense of formalised arrangement is something that Tom is aware of; "*looks like a scrapyard don't it?"* Tom is mindful that his kitchen is an antithesis of the culturally bound aspirational images of the functioning kitchen encasing the functioning inhabitant(s) (Altman, et al., 1985; Miller, 2008).

His movements within this space are not those imbued within the flows of such cultural performances. The visibility of tea/coffee stains on surfaces and other debris, such as a bar of soap located in the middle of the draining board become focal points to illustrate this further. Tom's blocking off of 'free' space by the placement of large objects and although they can hinder his performance and movement, maybe they provide Tom with a sense of security and safety (Tucker, 2006). The dishwasher belonged to his deceased mother; "*and that's an old dishwasher which was me mum's"*. His kitchen isn't large enough to accommodate a dishwasher but this is not so important for Tom. What is important to him is that this item belonged to his mother, rather than being functional the dishwasher has become a memorial artefact (Hockey et al., 2005). Perhaps for Tom, he needs to pack out his space in this way, so as to produce a space more emotionally concrete (in terms of structural elements belonging to his mother) as opposed to living within empty, free spaces of containment and social functioning. Overall, Tom's spatialised production within his kitchen is not one imbued with the concepts of domestic habit when attempting to stabilise space and perhaps this spatial configuration is one that suits him whereby he can pack out available space to promote a sense of security.

"and this is me hallway and that's my front door, my living door, bathroom door and that's a radiator (LAS: is that a mattress?) there is me mum's mattress against the wall (on the far right hand side of the picture)and me mum's bed is way up the side and I don't use her bed, use her mattress and um wires everywhere (LAS: do you ever trip over them?) um no well yeah…I don't use the front door much as I like to come in the back way to see the cats so I wanted you to see this because people don't see this as um really I don't use it just to get to bed and stuff."

Within this photograph, Tom is paving the cartographical layout of his home. He does this by drawing attention to the structural features of his hallway; *and that's my front door, my living door, bathroom door and that's a radiator*". Here, Tom is providing the viewer with a visual mapping of an area of home space, which has other avenues for accessing additional rooms. He anchors his narratives by the use of markers (the doors, the radiator) and by doing so produces his hallway as offering a myriad of ways in which movement and performance can be executed within other rooms. Tom can leave the house via the front door, he can go to the toilet or bathe through the bathroom door and perhaps watch television through the living (room) door. There is a listing here by Tom of other options for potential spatialised production (Crang & Thrift, 2000; Tucker, 2010e).

As with Tom's spatialised production of his kitchen, his visual image of his hallway does not conform to cultural aspirations of home spaces. There is no feeling or sense of structure and ordering here. There are no coats hanging up, there are no social decorations but more so we are presented with a series of boundaries which need decorative renovation. The walls show signs of being knocked with patches of missing paint and the markers of evidence where human traces are left behind (Doel, 2000; Thrift, 2004b). Rather than performing a social production of a private/public space his hallway serves only as a functional space for him to gain access from one room to another. It is a means to an end. Tom illuminates this by expressing; "*I don't use the front door much as I like to come in the back way to see the cats so I wanted you to see this because people don't see this as um really I don't use it just to get to bed and stuff.*" This particular area is not usually available for others to physically access or view.

Tom's lack of personalising his hallway in the traditional ways of having coat hooks or some decorative elements on the wall may be a means of providing a visual clue of how he has rejected the more traditional relationship between material culture and societal norms. He illustrates this point further; *"there is me mum's mattress against the wall… and um wires everywhere (LAS: do you ever trip over them?) um no well yeah"*. His hallway is littered with wires which can impede access and movement. The opposite of the functional elements hallways socially produce. There is his mother's mattress against the wall. Again we have a blocking off and packing out of space by the positioning of material objects which have no cultural association with these spaces. At some level, Tom is presenting a picture of some elements lower levels of social functioning here. His ordering of space could be associated by some as a service user who is living in the ways dominant within the psychiatric discourses of paranoid schizophrenia ((Reynolds, et al., 2000; Slade, et al., 1996).

In the following photograph, Tom discusses his garden and living room space. Although the quality of the photograph is somewhat unclear in areas due to the darkness, we are able to glimpse into these two spaces.

Tom – That's me garden there (points to garden space)
LAS – is there any reason you don't grow anything there?
Tom – Well it's myself mmm (1) and the main reason that it's not attractive (LAS=mmm) and the main sort of um eh and I just took it there just to show that I live on my own and eh mmm (2) I mmm just lost me mum which is hard to get over
LAS – what I have noticed is that you haven't got any ornaments. Is there a reason for that?
Tom – (sighs) the reason why is because um I just smashed them up about little time go (LAS = mmm) and I'm clumsy sometimes

Initially, Tom draws attention to his garden space. On viewing Tom's garden appears to be bare of functional and ornamental objects and vegetation. This garden space is constituted by paving blocks, gravel, fencing and an empty washing line. Here, Tom is using the concept of 'audiencing' as he elaborates; "*and the main reason that it's not attractive (LAS=mmm) and the main sort of um eh and I just took it there just to show that I live on my own and eh mmm (2) I mmm just lost me mum which is hard to get over"*. He is using his photograph as a visual form of materiality to lay out his social context of living alone and maybe of still living in a period of grief (Rose, 2007). In this way, his space has been shaped to reflect his feelings of loneliness and loss (Hockey, et al., 2005). It is an empty garden space because there is

nobody else there and consequently there is no reason to make this a space of emotional and physical production.

Again, this is in contrast to Bill's image and narratives of how his garden is pivotal to the ways in which he is able to support himself by growing vegetables. Tom is less independent especially in terms of emotionality and his lack of filling this space (perhaps because his mother did not leave any garden ornaments behind when she died)) may be in an indicator that he is living in a space devoid of positivity (Hockey et al., 2005). There is no sense of production in Tom's garden, there are weeds growing through the gravel and paving slabs – even the washing line is empty. At some level, his garden space omits a sense of (non)place, it holds little social value for him (Tucker, 2010a).

Within the living area we are presented with an image of the packing out of space again. Tom has two small tables located in the access route which can limit easy access and movement out into the garden. There are also what appear to be two speakers blocking part of the borderline area whereby the French doors offer the route directly leading to the garden. His spatialised production here seems to reflect his own feelings of dis-engagement with his garden. There is no reason to clear the routes because Tom doesn't appear to have any connective forms of production within his garden space.

In contrast to cultural assumptions of the moral home and assumptions whereby the neat storage of items can indicate positive levels of psychological wellbeing, Tom's living room space is peppered with out of place objects (Cwerner & Metcalfe, 2003; Morley, 2000). His sofa (much like the dishwasher) is used as a 'dumping' ground to discard items of clothing and other items. Although there is enough space for him to use his sofa for its functional purpose in that he can sit on this item of furniture, it is still an item which he shares with his shedding of garments. Once again, Tom is demonstrating that he has not brought into the consumerist aspirations of home living (Graves-Brown, 2000; Woodward, 2001).

One element which struck me when looking and discussing this image with Tom was the lack of personalised decoration through the display of photographs and ornaments. I asked Tom why this was; *"LAS – what I have noticed is that you haven't got any ornaments. Is there a reason for that? Tom – (sighs) the reason why is because um I just smashed them up about little time go (LA = mmm) and I'm clumsy sometimes"*. Tom did have ornaments but he smashed them up and he can be clumsy. Here we have somewhat of a paradoxical explanation. On the one hand, Tom purposively broke these decorations and at other times,

objects may have been broken due to his clumsiness. The former set of events and actions can be located within the dominant psychiatric discourses of mental health distress encompassing the inability to control emotional pressures with a measure of self-discipline and rationality, whereas clumsiness can happen to everybody. In this way, Tom is discursively circumventing his own actions from that of psychological distress and the incapacity of self-regulation to those which happen by 'accident'.

Neverthess, Tom does have ornaments they are just not located for surveillance by most visitors as they are located in his bedroom (Sixsmith, 1986).

"Um this is the one picture I wanted to show you um that's my mum's cabinet and do you know what that is? (LAS= mmm, mmm eh no) that is silver and (oh right) and you flip it over (right) and that was for a 25th anniversary present that was 1977 and it cost £10.00 (LAS= cost you £10 yeah?) and I worked then...and that;s my mum's radio and em um and that is a sort of elephant I won at Christmas time in a raffle or something...and they are from Holland and they're real clogs...my mum bought them and not me and me mum buys

things she wants and she gets them right....and that is um eh um what do you call it um a bookcase right (yeah) ...and it's me mum's things and it don't get touched"

In this photograph, Tom draws attention to a functional piece of furniture which holds a variety of memorabilia. In this photograph he is displaying objects which hold both social and emotional meanings for him within an encasement to both protect and offer visibility (Parkin, 1999). What is interesting is that he is not entirely sure what this piece of furniture is called; "*and that is um eh um what do you call it um a bookcase right (yeah)"* whereby Tom initially calls it; *my mum's cabinet* "but then Tom switches its functionality as an item to hold books. Whilst Tom has utilised this piece to contain a collection of artefacts, he still seems unsure as to what the correct terminology is. Nevertheless, compared to some other elements within his home space, here he has created an alternative milieu, a milieu which conforms to the cultural consumptions of the moral home (Wise, 2000). Both temporally and spatially, Tom is visibly demonstrating that is home space can be a production of consumerism when objects hold a special meaning to him (Cwerner & Metcalfe, 2003).

Tom's engagement with this photograph was verbally reinforced when he advised; *"Um this is the one picture I wanted to show you"*. This particular image was one that held a lot of meaning for Tom. There is no sense of disorder and discarding within this framing, objects are laid and arranged for visual impact. This ordering and arrangement is punctuated whereby Tom narrates a descriptive catalogue of most of the items; "*that is silver and (oh right) and you flip it over (right) and that was for a 25th anniversary present that was 1977 and it cost £10.00...and that;s my mum's radio and em um and that is a sort of elephant I won at Christmas time in a raffle or something...and they are from Holland and they're real clogs..."*. This is not merely a verbatim reproduction of the physical objects contained within the cabinet but moreover these are milestones within Tom's life. They all represent forms of memorial artefacts which have emotional relevance to Tom's own sense of identity and importantly, because of the relationship he had with his mother.

This spatialised production of social objects act as a shrine from which Tom can remember and recount previous times (Hurdley, 2007b). This is a special focal point for him which is maybe why this item of furniture and its contents are located in the private and intimate area of his bedroom. This sense of isolating this particular item from the wider 'gaze' and scrutiny of others is reinforced when Tom states; "*and it's me mum's things and it don't get touched"*.

Here we have a way of spatialising a space of sanctuary, a space where Tom can reflect alone of what has passed much like a memorial headstone above a grave. A slab of stone engraved with a fitting epitaph elaborating on characteristics of people who have passed away which may, or may not, be adorned with flora and fauna is the memorial spatialising of loss and grief (Hockey et al., 2005). At some level, this display cabinet is Tom's own personal and very private gravestone. It houses the visual and verbal memories of his mother.

In Tom's visual images and narratives we are provided with a sense of packing out and the blocking off of space. This may well be a spatialised production creating the illusion of emotional insulation. The bulking out of space provides a comfort blanket by blocking the flows of everyday life and movement (Thrift, 2006). If space is blocked and more pertinently, the spaces within homes which can be strewn with memorial objects are filled, this may go some way to help with Tom's feelings of loneliness and loss. Why have freedom to move from flow to flow when the intricate navigation within home spaces can partially erase the affective components of negative emotional feelings? Perhaps for Tom, his cluttering of objects which can impact upon his movement and performance within his home space are his way of coping with grief and mental health distress, he has to think in concrete terms about his circumvention around this space. In addition, Tom does not appear to have largely engaged with the cultural aspirations of storage and containment, his home space is cluttered with some sites used as dumping grounds (Hurdley, 2006). He has limited objects on display. In this way, Tom seems to provide an antithesis of cultural and moral home spaces (in terms of functional order), his production and movement through his home space is not one imbued within the plethora of glossy magazines depicting images of functioning and positive family life. Tom is a paranoid schizophrenic and his everyday social performances within his home space perhaps go some way to reflect his psychological distress at that time (Slade et al., 1996).

7.9 Discussion

Within this chapter, in terms of the visual methodology, we were presented with two contrasting accounts of spatial production. On the one hand, Bill illuminated his affective home territory as one involving a series of positive production. Bill had embodied the wider cultural assumptions of displaying objects within neatly arranged compositions whilst negating revealing the larger, more open home spaces (Cwerner & Metcalfe, 2003; Hurdley, 2007b). He particularly focussed on certain aspects of his day to day life which gave visual

evidence of his own sense of psychological well-being. As alluded to previously, Bill does not live the everyday life and movements of the medicalised discourses of a paranoid schizophrenic. Instead, Bill has the cognitive capacity to both understand and embed the somewhat prescriptive features of a 'normal', desirable home. Here he paid particular emphasis to the active and productive mind whilst discussing any shortcomings as a result of his physical impairments. Bill is always in a process of an habituated 'becoming-other'. Of a person who resides on the boundaries of severe mental health distress. He is not a paranoid schizophrenic because he does not (in terms of research data) conform to the lower levels of social functioning associated with this particular diagnosis (Bentall, 1990; DSM-IV, 1995; Slade, et al., 1996).

Conversley, Tom gave a myriad of visual imageries and narratives grounded within mental health distress. Here Tom gave an essence of confusion and chaos, he is a paranoid schizophrenic and has to some extent, embodied this diagnosis. He lives his everyday life within his home space as a paranoid schizophrenic. There was a limited account of the processing of ordering and containment but rather a series of objects blocking spatial access. In this way, Tom had to physically and psychologically maneouvre around these impediments, it may have been his way of dealing with his loneliness and grief. Tom's spatialised home production did not fit with social norms, these may have been rejected due to economical (Tom is in receipt of benefits) and identity issues. He is a non-conformist member of society, he does not fit in with aspirational ideals and neither does he make any attempt to do so.

In summary, as Miller (2008, p. 2) asks; *"Objects surely don't talk. Or do they?"***.** Within this chapter I have attempted to illuminate the ways in which objects and space are more than static, pre-given entities. Rather, these particular sites of homes spaces and artefacts are wrapped up within the accounts of these spaces as producing particular temporal identities. In this way, objects form part of the constituent social elements of daily life within home spatialities. They are more than just static items which may or not be moved for cleaning but instead they hold an array of social and personal meaning.

Chapter Eight

Drawing together the strands of the shifting landscapes of service user spaces

8.1 Key Findings

This thesis has explored how mental health service users make sense of their spatial production within psychiatric institutions, the day care centre and home spaces. The research data threw up a variety of discourses around psychiatric institutions, the day centre and home spaces whereby 'difference' became the key focus. For example, within the day centre service users discussed the ways in a psychiatric diagnosis (such as schizophrenia) could impact upon the destabilisation of this space. For some service users, the more visible, unconventional bodily behaviours displayed within a day centre could allow them to demarcate themselves from the 'extremes' of mental health distress by drawing from medical model of diagnostic behaviours associated with some forms of psychosis. For those who engaged in diagnostic behaviours, a sense of 'othering' within 'otherness' was also elaborated on. The analysis of home spaces also threw up a mixture of differentials of how this particular space was shaped, both discursively and visually. For service users living in supported accommodation, a lack of autonomy and personalisation of space was a prevalent finding within interviews. Using visual methodology, two service users took photographs of their home spaces which offered a divergence of how they both produced and made meaning of their home space.

From a methodological stance, this thesis has drawn from post-structuralism, human geographies and critical psychology/psychiatry perspectives to offer a more fluid account of daily service user life than those proposed by the more dominant medical model located within psychiatry for example. Therefore, space, mental health distress and identity were not positioned as being independent and relatively stable factors but instead, the focus was on how these elements are mutable and in a continuous movement of change. In this way, there was a layering process entwining these inter-relational components. Subsequently, these elements were woven together to present a body of research exploring the diversity of what it is to be a mental health service user living within the community care programme together with periods of time spent within formal, psychiatric institutions.

This thesis has also explored narratives and visual images of the 'middle'; the intersection between the past and the potential future (Deleuze & Guattari, 2004) and at this point, this thesis is still in the middle – there is no beginning or end. The middle is a pertinent place to begin this final chapter as the changing wider landscapes of mental health distress are still in the process of shifting largely due to the changing political and economic climate of this country at the current time. These are not nuanced and imperceptible changes but moreover they are a mesh of interconnecting governmental policies which can have a tangible impact upon the spatial movement of everyday service user life.

These movements initially operate from the structures of governmental policy but their forces are ultimately felt within the more intimate spatial worlds of individuals (Deleuze & Guattari, 2004; Smail, 2007; Thrift, 2004a) . Consideration is also given to living within the 'community care' programme with narratives discussing the relational encounters within the immediate neighbourhood. The impacts these elements have had in the past (i.e. when the research was undertaken) will be unravelled at a micro level using interview extracts and my own ethnographic notes together with a discussion to highlight potential new directions in service user research. This has been the main trajectory of this thesis, to gain experiential accounts of the past, the temporal present and also looking to the future, to the potentially changing shape of mental health distress and service user life. These areas are important to include and discuss further as the spaces of service users are always on the move, they are not the same as they were when the research data collection was undertaken. Service users are always in the process of 'becoming-other' (Massumi, 2002).

Consequently, this thesis has contributed to the body of existing service user research by exploring the continuously changing micro-spaces and micro-politics of daily service user life using the experiential narratives of those concerned, namely, mental health service users. This type of approach adds another layer to the wider literature, which some argue is still largely framed by using evidence-based methods as opposed to drawing from the testimonials of service users (Canning, 2006). As Kalitzkus & Matthieseen (2009) note, research around mental health distress has tended to focus on the emergence and efficacy of modern psychoactive medicines wrapped up within the discourses of science and objectivity. Consequently, the narratives of mental health service users, whilst gaining some ground within the realms of this area of research, remains the 'poor relation' when compared to the dominant medicalised positions (Greenhalgh & Hurwitz, 1999).

Theoretically, this thesis offers a dynamic and fluid framework from which to explore and further understand the changing landscapes of daily service user life. Here, space was not positioned as either static or indeed as relatively stable but more so the emphasis was surrounding the mutability of everyday mental health spaces and the myriad ways in which space can invoke a variety of movements and performance. Indeed the primary analytic focus within this thesis was exploring 'difference'.

Using the concepts of 'arborescence' or a 'machinic assemblage' as offered by Deleuze & Guattari (2004), the historical and the more contemporary cultural assumptions of mental health distress were explored. These were important elements to include as a backdrop when discussing everyday service user life as the spatial movements and performances of participants did not (and will not in the future) emerge from a social vacuum. They were very aware of how their various diagnoses and subsequent psychiatrically diagnosed labels are positioned within the wider society and also within their own immediate neighbourhoods (Scheff, 1999). This awareness had a direct impact on how participants both accessed and moved within their own social settings.

Within psychological research drawing from a multi-disciplinary armoury of spatial and social performance conceptual tools as offered by theorists such as Gilles Deleuze, Felix Guattari, Brian Massumi, Nigel Thrift and Michel Foucault remains scant. Psychology is still mainly rooted within researching the areas of fixed identity, intention, perception, cognition and psychophysiological factors whilst ignoring the social contexts in which we live (Smail, 2007). However, to undertake an exploration of daily service user life with all the extant potentialities and movements of change needs to be based in the political and the social – this is where service user daily life unfolds and infolds (a service user is given a psychiatric diagnosis, ingests medication and has exclusive access to particular spaces such as the day centre or the psychiatrist's office). Daily life and mental health distress are entwined within the wider political and scientific bodies of medical knowledge and expertise; they are in a simultaneous cycle of feeding in and feeding off each other.

In addition to pulling together the threads within this thesis, this final chapter will also discuss issues surrounding state benefits such as Disability Living Allowance (DLA), the 'direct payment' scheme and the potential impact upon the on-going financial viability of day centres. In addition, narratives of living in community care will be explored further. These specific areas are the primary focus within this chapter as they weave together the main thrust

of this thesis which is to explore content and expression in the everyday spatial production of mental health service users' lives. In other words, the following issues have very important future implications for service users in social, emotional, performance and spatial terms[43]. Here service users who are deemed capable to return to work will leave the spaces of the day centre and when benefits are stopped or cut, access to socialisation may be subsequently restricted. This may mean more time spent in home spaces or perhaps more time spent out in the immediate neighbourhood.

8.2 Bringing the strands together

In Chapter One, I laid out why this body of work was important in terms of further illuminating the potentiality of the everyday spatial production of service user life and the ways in which service users make sense of their experiences. To add context to this primary aim, I explored the shifting historical and contemporary discursive and spatial landscapes of mental health distress. Here I discussed the movement of service users as residing in an asylum to the current 'care in the community' programme. In addition, consideration was also given to the heterogeneous ways in which emerging and temporal self-identities can be related to receiving a psychiatric diagnosis, or as living within a 'classification of kinds' (Hacking, 1999). I discussed some theoretical perspectives of exploring 'difference' and the material-discursive elements of service user life (Anthias, 2002; Yardley, 1997) and illuminated why a more fluid, non-discursive approach was more appropriate to analysing the more ethereal concepts of spatial movement and potentiality (Brown, 2001). Here I provided an argument to introduce some of Deleuze & Guattari's theoretical concepts which can offer a fluctuating analytical narrative of spatial movement and transformation (Massumi, 1992).
In Chapter Two I provided more of an in-depth argument as to why this work has drawn from post-structuralist schools of thought in terms of analysing the research data. The focus here was on non-discursivity as a preferred analytical tool together with and the socio-linguistic concepts of 'affect' (Cromby, 2011). Rather than space being positioned as stable and structured, I discussed the multiplex ways in which spaces can mutate and transform. Here I drew from the dual Deleuze & Guattari concepts of 'deterritorialization' and 'reterritorialization' as a means of offering a way forward in analysing the fractured and temporal constituents of spatial production (Tucker, 2006). At this point the multiplex of

[43] It should be noted that psychiatric institutional spaces were not talked about when discussing the future and the on-going government economic directives but this is not to suggest that these functional structures will not be directly affected by cuts in funding allocations.

service user movement and performance was articulated as perhaps having links with the dominant socially and medically constructed codings of psychiatric diagnoses, or to use a Deleuze & Guattari's term, a 'machinic assemblage' (Deleuze & Guattari, 2004). In this way, rather than positioning service users as an homogenous group, an argument was put forward to explore the new meanings of identity, for example, and the changing spatial productions which service users can continuously create on a daily basis.

These two introductory chapters paved the way to present the multifarious cartographies of mental health distress and space which were subsequently teased out further in the data chapters. Here three key spatial areas namely, psychiatric institutions, mental health day centres and home spaces were explored further using participant data (consisting of narratives and visual imageries). The choice of utilising these qualitative methodologies and analytical tools (discourse analysis and non-discursivity) were considered further in Chapter Three. Nevertheless, it was the four data chapters which brought the thesis 'to life' as such.

Chapter Four considered the variety of ways in which service users made meaning of their time spent within psychiatric institutions. Drawing from Foucault's (2008) position encompassing the 'performance of cure' and the ways in which institutional life attempts to stabilise its psychiatric functions by the compartmentalising of space, order and time, participants discussed their own experiences. Here we were presented with divergent accounts of the fear of being administered ECT, of feeling abused and witnessing abuse to other service users, of the mundane and routine structures of daily institutional life, to feelings of safety and comfort and the disruption and fracturing of space by other service users. In addition, Tom illuminated the ways in which his spatial performance splintered the linear order of the institutional corridor he was resident in.

In Chapter Five, day centre spaces became the focus of everyday spatial production. Attention was given here to disrupt and destabilise the notions whereby day centres are seen to offer unconditional support and social networks for all service users regardless of a psychiatric diagnosis (Hall & Cheston, 2002). Previous research into the heterogeneous ways in which day centre spaces can be both accessible for some and closed off to other service users who display unconventional behaviours has been explored previously (Parr, 2000; Parr et al., 2005) using ethnographic methods. However, this thesis was able to offer some participant narratives which articulated on some of the more divisive social and psychiatric positions within day centre spaces. As an example, Ted a participant with a diagnosis of

'depression' discussed how he did not 'belong' in the shared day centre space with another service user who was displaying behaviours largely associated with schizophrenia. Tom, a diagnosed paranoid schizophrenic articulated on his experiences within the day centre which shed some light on how we was at times isolated by the others but in turn, he sought to isolate himself as well. To summarise, rather than positioning the day centre as operating as a stable monolithic structure, this chapter illuminated the ways in which this space was imbued with 'real' and 'imaginary' territories and boundaries. This bracketing off of space and social inclusion was largely based upon the somewhat socially and psychologically constructed polarised diagnostic codings of 'depression' and 'schizophrenia.'

Home spaces were the focus of spatial production and performance in Chapters Five and Six. In Chapter Five the variants of residential space are discussed drawing from narratives of living in supported accommodation, semi-supported accommodation and independent home spaces. The shaping of home spaces was explored by considering the ways in which some participants created and arranged this space by the use of objects and markers to articulate sensualities of territory and of potentiality (Wise, 2000; Tucker, 2010a). In this way, participants (except for Jim) were at some level able to anchor their home spaces by using materiality and creativity as a connective means of forging alternative and new potential identities. Nevertheless, the narratives of home spaces in this chapter were still bound up within the discursive and non-discursive elements of psychiatric codings. These psychiatric constructions were considered further whereby Clara discussed her ritualised social performances with Buddha statues. This interaction appeared to give Clara a sense of her trying to gain some kind of psychological and physical control within her daily life as compared to the 'haphazard' discourses associated with her diagnosis of Borderline Personality Disorder.

In addition in Chapter Seven, visual images were presented and discussed by Bill and Tom (both diagnosed paranoid schizophrenics). These visual images were very interesting to analyse and interpret as another means of exploring the spatial production of everyday service user life as they added a rich and observable layer of research data. Interestingly, both participants displayed very different landscapes of their home spaces. Bill's images were formalised and evoked a sense of production, of a service user who is not the 'typical' dysfunctional, paranoid schizophrenic, service user (Slade et al., 1996). Bill reiterated this kind of identity by presenting an organised set of photographs of his books, his artwork and his gardening endeavours. Conversely, Tom's home space was cluttered, grimy and in some

respects bleak and presented a manifestation bound up with bereavement. Tom packed out his space largely drawing upon his dead mother's belongings such as the dishwasher which blocked off the functional access within his kitchen. Overall, we were presented with two divergent ways of producing home spaces which may have been bound up with both rejecting and, on the other hand, embodying a psychiatric diagnosis of paranoid schizophrenia.

8.3 A social materialist approach to the spaces of mental health distress

> *"The societal operation of power and interest is immeasurably more important in understanding human conduct than are the components of personal 'psychology'.*
>
> (Smail, 2007, p. 21)

In the above quotation David Smail draws attention to the ways in which power and interest (these could entail political, economic and cultural factors) function as an over-riding framework from which to understand human behaviours. In terms of mental health distress, the wider societal policies and cultural assumptions can have varying levels of impact on daily service user life (Williams, 2008). They can have major ramifications upon the ways in which space is either opened or indeed, closed off for service users. Deleuze & Guattari (2004) also reiterate the ways in which life is inextricably bound within a mesh of political factors, whereby macro-politics feed simultaneously into micro-politics. Our intimate spatial worlds our governed and are subject to change as a result of political directives. There is a circularity of influence here which could have many ramifications for the future experiences of everyday service user life. It these potential changes of the micro-political and the changing landscape of service user daily life which will be discussed further in this chapter.

8.4 The potentiality of macro-politics for older, mental health service users

From a macro perspective, politically and economically, the ageing population within the United Kingdom is a topical area of discussion for past and present Governments. With older people forming a larger demographic within society, the pension age for retirement has been raised to 65 years for men and women (an increase of five years for women) with a projected increase to 66 years in 2020 (Directgov, 2010). These factors have had impacts on some older service users as the arena of claiming and maintaining the receipt of government benefits has changed markedly over the years.

8.4.1 The return to work

Whilst many older service users have been registered as long-term unemployed (Carter, 2010), the changes in the benefit system has led governmental moves to medically reassess those who were (and currently are) in receipt of state benefits to establish their suitability to return to work (Kilapsy, 2006; Perkins, 2002). Consider the following extract from Karen who had a successful career as a Senior Manager within a Corporate Bank before her admission into a psychiatric institution and the ensuing difficulties she has experienced with mental health distress which is when she stopped working:-

> *LAS: Do you ever sort of miss that going to work*
> *Karen: No, no not at all*
> *LAS: Because there's this government thing now*
> *Karen: I know it petrifies me (LAS=yeah) absolutely petrifies me (1)there are some people who shirk (LAS=yeah) you know you see in the paper people who are claiming for bad backs and um you know playing golf and all that stuff but I think with mental problems it's, it's hard to prove that you've got a mental problem (LAS=mmm) I think and it's going to be, the onus is on the person to prove that they can't work rather than (LAS=Yeah) to, for them to prove you can work so yeah it petrifies me (3)*

In the above extract, Karen evokes a sense of fear; *"it…absolutely petrifies me"* regarding the governmental initiative to promote a programme of service users (in terms of physical and psychological distress) returning back to the work place. Perhaps because Karen previously held a senior post within a well-known banking organisation her feelings of dread are intensified as she has a wealth of commercial experience. Karen prior to having an identity of mental health service user was a well-paid and successful businesswoman. This is contrary to all other participants' accounts of work experience where the manufacture of shoes and other unskilled and semi-skilled jobs were discussed. In addition, all other participants had been in receipt of state benefits for the majority of their adult life; Karen did not share these experiences.

In addition, within Karen's narrative (and this applied to all participants when discussing areas such as this) there is a focus on the potential problems for mental health service users being correctly assessed; *"it's hard to prove that you've got a mental problem"*. Initial

statistics dated the 26th October 2011, indicated that 38% of claimants who went through the process of the 'Work Capability Assessment' were deemed 'fit for work' (Grayling, 2011). Nonetheless, Babalola (2011) draws attention to the considerations that should be given within assessments to ensure that the equal weighting of mental health and physical health impairments are conducted by qualified doctors and staff . This is a set of concerns which have also been voiced outside of personal narratives and remain prevalent within the wider media (Lawton-Smith, 2011). An independent report (commissioned by the Department of Work and Pensions) was undertaken by Harrington (2011) who reiterates these positions that there largely is a lack of empathy and understanding displayed by assessors when dealing with claimants with mental health distress. As Paul Farmer, the Chief Executive of the charity Mind notes;

> "*Thousands of people with mental health problems are being wrongly assessed as 'fit for work' under the new sickness benefits regime. On top of this some parts of the media are giving the impression that everyone on a benefit is a workshy scrounger."*
>
> (Farmer, 2011)

In this way, political directives can impact upon the divergent ways in which space will have to be constituted and reconstituted (Thrift, 2006) and also a potential shifting of identity (Brown & Lunt, 2002). Here identity could transform from 'workshy scrounger' to that of being a 'productive' member of society. In terms of embodying a return to work, these kinds of changes could also have major ramifications for how daily space and routine will have to be reconfigured for those service users who are assessed as 'capable' to return to work. Routines will have to be established in terms of getting ready to go to work, of getting to work and being enveloped within a set of processes bound up with time and production. Emotionally, service users may have to adapt to perhaps concealing periods of psychological distress to avoid any potential stigma and discrimination from work colleagues (Lawton-Smith, 2011; Rogers & Pilgrim, 2009). In this way, there is a possibility of a major reconfiguring of service user identity and performance within these previously coded 'exterior' spaces of 'normality' which have been played out by other actors (Brown & Tucker, 2010). However, this was not the only financial, physical and psychological mandate to affect service users, the changing directives of obtaining and securing Disability Living Allowance (DLA) was also a prevalent topic when discussing change.

8.4.2 Disability Living Allowance

DLA is a benefit consisting of two components namely, 'care' and 'mobility'. DLA is not means-tested and is allocated to people who have been medically assessed to have sufficient physical and psychological impairments to impact upon daily living in terms of mobility and care, compared to the lives of non-disabled bodies (Hirst, 2002; Kasparova, Marsh, & Wilkinson, 2007) . As can be seen below in Table 1 (sourced from Directgov, 2011), there are different financial levels of DLA allocated which are based upon an assessment of the severity of an individual's physical and psychological impairments. In terms of participants, the majority received the mobility component only (at both financial levels) which was provided to pay for transport to the day centre or for a psychiatric consultation for example. Due to the improved levels of access to enable socialisation at the day centre, DLA was seen by participants as an important element within their daily living.

Table 1

Care component	**Weekly rate**
Highest rate	£73.60
Middle rate	£49.30
Lowest rate	£19.55
Mobility component	**Weekly rate**
Higher rate	£51.40
Lower rate	£19.55

Consider the following extracts by Bill and Jenny on the practical issues of obtaining DLA;

> *"…the DLA is very tough to get on (LAS=mmm) and it seems to me that there are a lot of double standards applied by the people who have the* ***power*** *to apply those double standards and those people who are really need it and* ***I do really need it*** *because getting out and about is my life, without that I would go completely bonkers I would be institutionalised very quickly."*
>
> (Bill)

> *"I suppose I am lucky because of the amount of (physical) disabilities and medical problems I've got, I do get…quite an adequate amount whereas I know some people, and again this is where it is wrong, some people who have only got mental health problems are on a very limited budget (LAS=mmm) and yet they're still as debilitated by their mental health problems as, as I am by my mental health problems and my physical problems."*
>
> (Jenny)

Within these two excerpts from Bill and Jenny both draw attention to the difficulty in obtaining DLA when mental health distress forms part of the initial assessment. In Bill's narratives he discusses the power relationships between those who make the final decisions as to who is eligible for additional financial support; *"a lot of double standards applied by the people who have the **power** to apply those double standards"*. Here we have the unfolding relationships between the assessor (be that a psychiatrist or General Practitioner) and the assessed (the service user), with the balance of power residing with the former. It would appear from these accounts that rather than giving service users 'a voice' in contemporary society that emotional feelings of powerlessness still ensue. These perceptions of benefit allocation as being bound up with 'double standards'; the physical versus the psychological, the balance of the visible to the less visible were points made by the majority of service users when discussing the current benefits system. These notions of how some participants positioned the 'invisibility' of mental health distress; *"and yet they're still as debilitated by their mental health problems as, as I am by my mental health problems and my physical problems"*when discussing the successful allocation of benefits are interesting to briefly unpack further.

In Chapter Five I discussed the ways in which service users who displayed unconventional bodily behaviours can be isolated in the day centre by other service users. These kinds of exclusionary activities appeared to be based upon socially extreme levels of mental 'illness' and subsequent behaviours has also been noted elsewhere (Parr, 2000; Philo, et al., 2005). Here we have a paradox of that which is visible (physical impairment) to that which is seemingly invisible (mental health distress). These kinds of socially and medically constructed discursive juxtapositions appear to indicate that psychological experiences remain unobservable and reside within the confines of the mind whereby the body is positioned as disconnected to the functioning of neural activities – or the Descartian mind/body dualistic

concept (Gillies et al., 2004). This sense of 'invisibility' of mental health distress can have future ramifications for service users when being assessed for DLA or other benefits.

Nevertheless, the data extracts intimate that these kinds of 'double standards' whereby physical impairments may be more prevalent within the assessment regime are punctuated by Jenny who says; *"I suppose I am lucky because of the amount of (physical) disabilities and medical problems I've got, I do get (2) quite an adequate amount"*. Here Jenny considers herself 'lucky' because she has many physical ailments and she cannot walk so she uses a motorised wheelchair. Due to the visibility of Jenny's physical impairments she is more able to obtain DLA than if she was seeking support for mental health distress. Issues such as having to prove a disability can also elevate levels of psychological distress largely because this benefit goes some way to enabling mobility. Spatially, service users could become housebound and perhaps would not only be access their immediate neighbourhood. Bill highlights this further by stating that; *"because getting out and about is my life, without that I would go completely bonkers I would be institutionalised very quickly"*.

These issues of obtaining DLA in the future could mean a shifting of Bill's (and maybe for Jenny) socio-psychopathological landscape. He may well be more spatially confined within his home space in the future. This is an area which would be ripe for future research to explore how the implementation of macro-politics ultimately implode within the micro-politics of service user life (Deleuze &Guattari, 2004). Theirs are narratives of the connections between governmental directives and the ways in they can affect their daily lives. However, these are not the only issues when considering the receipt of state benefits.

8.4.3 Who can gain from DLA?

Both Bill and Jenny live independently as opposed to Jim who resides in supported accommodation (see Chapter Five for an overview of this area). In the following data excerpt, Jim elaborates on how he has been awarded DLA but he doesn't actually seem to receive it in hard monetary terms.

> *"I get DLA but that don't go to me it goes to Frank (Landlord) and it's in my name which is wrong really because he pays all my bills see (LAS=mmm) you see and I can't argue with him cos he's a millionaire but there's a lot of tenants there who don't get it and some of them do but I don't (2) I get me*

spending money and that's all I get, £10 day and by the time I get me cigarettes it's nearly all gone (3) um, um so I don't know why I don't get DLA but um you see (names Landlord) the boss and he goes to Spain seven times a year and he can afford it and he's got three different cars...

(Jim)

Whilst I would not seek to suggest that all service users living in supported accommodation share the same experience of Jim, there is some intimation here that whilst Jim is aware that this benefit should be received by him. Jim goes some way to try to understand why his landlord receives his DLA payments; *'because he pays all my bills see'*, however the reality is more likely to be that Jim's living bills are paid via his housing and incapacity benefits. The reason why I have included Jim's narrative here is to sketch out that for some, perhaps more vulnerable service users, there can be feelings of powerlessness both in terms of having the social power for standing up for one's rights; "*I can't argue with him cos he's a millionaire*", but also because of ways in which some service users may live within a paternalist regime; *"I get me spending money and that's all I get, £10 day and by the time I get me cigarettes it's nearly all gone"*. Here Jim discusses how he is both aware that he should directly receive his benefit; *"I get DLA but that don't go to me it goes to Frank (Landlord) and it's in my name which is wrong really"* with his narratives of observing that his landlord appears to have a wealthy lifestyle; "*and he goes to Spain seven times a year and he can afford it and he's got three different cars"*.

Just as future research could be useful to explore the contemporary changes of those service users who will or will not receive DLA in the future; it would also be fortuitous to explore the experiences of service users who are enveloped within dependent living arrangements to explore their accounts of receiving benefits. Is Jim's account a one-off where he happens to live or do his narratives reflect events that are happening for similarly positioned service users living in supported accommodation?

8.4.4 The 'Direct Payment' scheme

An in-depth analysis around the spaces of charitable, mental health day centres is discussed in Chapter Five. One issue which was prevalent within these spaces when undertaking the research was that of the recent introduction of the Department of Health initiative to offer 'personalised' programmes of care (Department of Health, 2008). This programme aims to

provide service users with an individual choice to access a variety of services via the means of a 'direct payment' plan (Dunning, 2011). In this way some organisations such as charitable day centres like Mind, have had their allocated operational funding cut by the local authorities and service users now receive payment directly to afford them personal choice in accessing a wider range of services.

Research undertaken in June 2011 suggested that early results appeared to indicate that for most service users this is a positive programme and has the impacts on service user life was largely favourable (Hatton & Waters, 2011). Nevertheless, concerns have also been muted that for those service users with mental health distress are not benefiting from this new directive (Dunning, 2011).

Academically, this is a difficult area to discuss in terms of reviewing any research literature regarding this implementation although I am aware that the Mental Health Foundation are currently (at the time of writing in October 2011) researching the impacts of the 'direct payment scheme' with people diagnosed with dementia. Whilst this is a move in the right area if early indications suggest that mental health service users do not appear to be feeling the positive impacts of managing their own budgets and choices, arguably, the participants within my research project have a very different set of social and financial problems.

Drawing from my own conversations with staff employed by Mind day centres, there were concerns regarding the changes that would need to be made both in terms of which services could be offered and that many service users would stop attending the day centre in favour of paying to access other activities such as a local gym for example. Recommendations from the local authority appeared to suggest that activities within day centres should be more formalised and structured by offering specific programmes imbued within the concepts of 'recovery'. Such programmes would include courses on eating well, anger management and information technology training with a view to service users returning to work. Activities such as the more informal and perhaps socially important interactions of drop-in times were widely discussed as ceasing in the future.

In relation to space these political changes may create a different set of experiential meanings when everyday spaces of mental health distress are discussed. The day centre may no longer offer a space for the creation and maintenance of social relationships. Service users will not be able to access their day centre at times of seeking social interactions or 'popping' in for a

quick chat. Instead, the proposals of offering a more structured programme of events may position this particular space with a similar set of sensualities and at times, authoritative restrictions, associated within the realms of formal psychiatric provision.

Certainly, from my own observations towards the end of the research data collection, there were very few and in some cases, no service users attending the day centre at those times. This lack of attendance caused concerns for staff that in the future, their day centres would have to close due to a lack of financial income as service users might choose to spend their money on other activities and material items.

Other issues were raised when I attended the Mind Annual General Meeting in 2009 where a representative from the local authority gave a presentation regarding the, then proposed 'direct payment' scheme. Staff from day centres were concerned that some service users had on-going problems with alcohol and substance abuse and that the money allocated would be spent on obtaining these. Other potential problems were highlighted in that all service users in receipt of 'direct payments' would need to keep a personal account of expenditure together with receipts proving purchase of activities and access. These issues raised by staff were noteworthy as many service users I came into contact with, whether they took part in the research or not, had a complex set of daily problems surrounding substance abuse and also many, and mainly due to the period in which some older service users were educated[44], ranged from those who professed to being wholly illiterate to those only having a partial understanding of the written word. Here we are presented with a potential, complex set of problems which may face service users in the future as this programme is rolled out within communities.

In terms of service users with enduring, mental health distress this could be an area which would benefit from further research. How will mental health service users feel if their day centre is closed down? Where will service users go and where will they socially engage? On the face of it, giving service users more autonomy can be positioned as a positive engagement but on the other hand, this can potentially cause huge daily obstacles for service users to navigate successfully.

Overall, it would be beneficial for future research to explore the outcomes, in terms of social and self-identities together with the embodied expressions of emotional, physical and spatial

[44] What is meant here is that learning assessment needs for those experiencing difficulties were not prevalent at this time

impacts the aforementioned directives may have. Such research would go some way in providing a set of experiential accounts when understanding the affective components involved when service user daily life may move largely away from the day centre and spatial production may involve movements and performance within the immediate neighbourhood or even the work place.

These are important elements to consider as this chapter has discussed the political changes of 'real' events which are happening to 'real' people – in other words, there will be some kind of impact whether that is felt materially, emotionally or spatially. All participants were very much aware of the on-going political movements around assessment and potentially capping benefit claimants such as mental health service users for example, and from my observations and discussions, these areas produced heightened levels of anxiety and distress. Of course, these shifts may never be actualised for some participants but the perpetual potentiality of continuous change (this is how participants perceived these particular social policies) when combined with living with mental health distress present a set of important considerations which should be researched further.

Undoubtedly, to reiterate with the new political directives, the landscapes of mental health distress are going through some fairly rapid changes. As a consequence, the spatial productions of everyday service user life look set to change in many ways, some which may be beneficial to certain service users and others which may hold negative connotations in respect of maintaining elements of social interactions, if local day centres close for example. These potential spatial changes of moving from the more structured daily spaces of the day centre to the more informal encounters within the neighbourhood will conclude this chapter.

8.5 Some final thoughts…

By summarising this thesis, I would like to in some way hand this part of work over to service users who were asked how they felt about themselves and their spatial interactions within their local communities.

In the following extract, Ray illuminates his feelings about how his local neighbourhood can view both him and other service users;

"I still feel strongly about this but normal minded people should be made more aware of our problems (LAS=mmm) and why we've got problems and we have to cope against how they have to cope (2) (LAS = mmm) and it should be made more (2) they should be made more aware of our problems and we can get on with our lives instead of them getting on with theirs…"

In this excerpt, Ray articulates the discursive practices which seem to engage the social positioning of 'the other'; *"normal minded people should be made more aware of our problems (LAS=mmm) and why we've got problems"*. Again, we have a sensuality of difference not in the discursive terms of his neighbourhood being made aware of mental health distress but also spatially; *"and we can get on with our lives instead of them getting on with theirs"*. Here Ray is drawing together the strands of his own experiences of suffering with enduring psychological distress, the apparent ignorance of his local community (and the wider public perhaps) and the ways in which these interweave to block and clog up his spatial movements. He wants to get on with his life but there is a seeming real or imaginary set of boundaries here as *"them"* appear to proceed within and through their daily life with little impediment.

Although Ray does not discuss being harassed within his community, he does articulate the affective components of living with mental health distress; *"we've got problems and we have to cope against how they have to cope"*. In this way, Ray draws from the arbolic codings of psychiatry and the cultural discursive practices by reiterating the oft cited dichotomy of 'mad/sane'. His spatial production and senses of identity appear to be always in a state of comparison, of Ray compared to the *"normal minded people"*. That is not to suggest that his narratives stratify him, whereby Ray is the static 'other' but more so he seems to be looking for ways in which his identity as a service user can change. There are sensualities of movement and change but maybe he feels too powerless to change the over-riding cultural assumptions of living with mental health distress.

In the following extract Tom articulates how he would desire mental health service users to be understood at the present and in the future, in terms of his local neighbourhood;

Tom = I'd like to be ordinary, like everybody else is these days, not diagnosed cos' that labels you, it labels you from everybody…Yeah a lot more understanding in (sic) the world of people…and a lot of car drivers' gang

round me and once upon a time they used to go "Schizo" you know "mental man" and that really um jeering and everything

LAS = Do you think people should be more accepting as well

Tom = More acceptable for us people like you know who are diagnosed and they ought to thank their stars that they're not diagnosed…Their not understanding they're always taking the Michael I mean there's a lot of people being diagnosed with different things and you're one as yourself you've got to realise you can't say this, you can't say that or the other..."

In Tom's extract we are presented with a very real and affective polarisation, of them and us. Those who understand and do not stigmatise compared to those who do not and subsequently verbally harass people who do not fit neatly within the social norm; "*Their not understanding they're always taking the Michael"*. Here Tom discusses how he sensually feels of having a diagnosis of paranoid schizophrenia. Within this thesis, Tom has never completely fitted in with other service users, especially in terms of social and psychiatric conformity. Tom is in the middle, he wants to fit in; *"I'd like to be ordinary, like everybody else is these days, not diagnosed cos' that labels you, it labels you from everybody"* but his behaviours and maybe his version of a 'classified kind' of having this particular diagnosis impedes him from undertaking this potential transformation to that of being the 'other' normative person. Tom also imparts a sense that he experiences a lack of acceptance by others; "*More acceptable for us people like you know who are diagnosed"*. These are interesting concerns as bodies such as The Royal College of Psychiatrists, Mind and the Mental Health Foundation run anti-stigma campaigns together with the governmental rhetoric advocating social inclusion for those diagnosed with mental health distress. Perhaps for Tom, these are merely words on paper which do not appear to have impacted upon his everday life in a positive way. Tom is a body imbued with difference; he both acknowledges and embodies this difference. The fact that he has a label of paranoid schizophrenia discursively demarcates this difference. The very spaces (such as the day centre) he moved within and through on a daily basis reverberated with this difference, the normal and the abnormal.

Tom has elements of difference in terms of mental health distress and other service users. He doesn't display conventional bodily behaviours (see Chapter Five for more discussion), he is at times catatonic and often talks to his voices, and this is maybe why he appears to stand out in his local neighbourhood and at times has been subjected to harassment; "*and a lot of car*

drivers' gang round me and once upon a time they used to go "Schizo" you know "mental man" and that really um jeering and everything". Taking this extract forward, perhaps for Tom the shifting of his daily spatial production from the confines of the day centre to the more 'haphazard' spaces of his neighbourhood could indeed have implications in the ways in which his potentiality or of becoming-other are played out. Tom may fluctuate and flit between becoming-schizo-mental-man to that of becoming-ordinary, his spatial domains may be wrapped up within the everyday 'ordinary' regimes of the workplace, his day centre may remain open or he might spend more time in his local community. Whatever the ramifications of his shifting cartographies, Tom will continue to become-other.

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APPENDIX ONE

WHAT ARE THE CHALLENGES FACING OLDER MENTAL HEALTH SERVICE USERS IN COMMUNITY CARE?

INTERVIEW SCHEDULE

Interviews will be semi-structured and based upon daily activities, social relationships, living arrangements, experiences with mental health professionals, levels of practical, familial and social support together with employment (paid or voluntary). These areas will be investigated by asking varying exploratory questions in the hopes that different levels of responses are proffered. The different topics under the broad frameworks of 'pragmatic', 'evaluative' and 'phenomenological' will be investigated as follows:-

1. The Day Centre:-

How long have you been coming along to this day centre (mention name) then?
How did you come to be involved in this support group?
(If unsure of question) - Were you referred e.g. psychiatrist, social worker? Was it a self-referral?
How often do you attend this day centre on a weekly/monthly basis?

Can you remember your first few visits here?
How did that feel?
Do you feel different now?

Do you have lots of friends here?
Is that important to you attending this day centre?
Are you able to discuss your mental health distress with other members?

What sort of activities are you involved in here?
Do you enjoy your time here?
Which is your favourite activity?
Since your time here, have you discovered new activities that you have never done or thought of doing before?

How do you get here?
Are there times when you can't get here?
Are there times when you don't want to come here?

Do you feel that there is enough social, emotional and practical support here?
Does this day centre provide a means of support if you need it in an emergency?
Can you get counselling here?
Do you discuss your mental health distress with day centre staff?
How does this place make you feel?
Would you like more day centres to go to?

2. Routine/Everyday Life:-

Do you have a daily routine?

For example, if you are coming to the day centre, do you get up at a certain time?
Do you have certain chores/activities that you do at a certain time or day?

Is your day different if you don't have anything planned?

What do you do if you have an appointment with your psychiatrist/GP/CPN/social worker – is your routine different?
If different – why does your routine change?
Do you feel different when your routine changes, such as to come to meetings?

Do you like to take holidays?
When was your last one?

3. Living arrangements:-

Do you live on your own?
YES - If so, has that always been the case?
Do you do your own domestic chores e.g. shopping, cleaning and cooking?
Do you like it this way?
Are there times when you don't want to do any housework?
Why is that?
Do you feel that you would like more practical support with household jobs?

IF NOT –
Do you do the domestic chores, e.g. shopping, cleaning and cooking?
Does your spouse/partner/other household member help?
Does your spouse/partner/household member offer you practical support?
Does your spouse/partner understand why sometimes you do not feel like do the domestic chores?

What sort of things do you do at home?
Do you enjoy this time?
Do you like it where you live?

4. Employment:-

Do you work now?
Have you ever worked?

If not worked for a while – why did you stop work? (This may be due to mental health distress or economic policies prevalent at the time of cessation of work)
Would you like to have carried on working?

What benefits did you feel you got from working? – (financial, social support, purpose in life etc.,)
How did going to work make you feel?
Would you like to work now?

5. Practical support:-

Do you receive any benefits?
How did you find out about what benefits you were entitled to?
Do you feel that these benefits are sufficient for your daily living requirements?

Would you like more financial support?

Do you have a psychiatrist/CPN/Social Worker/Support Worker/Care Worker?
If not, would you like to have additional support - Why?
If has, do you find this level of support enough - Why?

Are you on medication?
If yes, do you think your medication has helped?
Do you remember to take your medication?
Do you have strategies to make sure you take your medication?
Have you ever forgotten to take or stopped your medication?
If yes, did you notice any changes?
What kind of things make you think your medication is working?

Has your medication changed over a period of time?
Does your psychiatrist/GP explain why you are having this treatment (diagnosis)?
Do you feel that you are able to be involved in your treatment? Do you have a say in what is prescribed?
In your experience, do you think medication has become better?
Were you told about any side effects when your medication was first prescribed?

Have you ever been offered any other treatments such as counselling, psychotherapy, CBT etc.,?
If yes, did you find this helped?
If not, would you like to be offered this additional support?

6. Relationships/Emotional Support:-

Do you see much of your family and friends?
Who else do you see?

Would you like more friends?
Would you like to see more of your family?
Do you find that family and friends offer enough support?

If not, are there people that you can contact in an emergency?
Would you like more support?

Are you in a relationship?
Would you like to be in a relationship?

Do you like spending time on your own?
Do you prefer being with a group of people?

7. Phenomenological:-

Is there anything that you can think of that could improve your quality of life?

What kind of things have you found to be important in regards to your ‘road to recovery’?

Is there anything else you would like to say?

APPENDIX TWO (a)

PARTICIPANT INFORMATION SHEET
CONSULTANCY FOR INTERVIEW SCHEDULE

NATURE OF THIS STUDY

I am a Higher Research Student at the University of Northampton and I am carrying out a study on the impact of life transitions on older mental health service users. In essence, this means that the project seeks to explore the everyday life of older service users within the wider community and the home setting. This study is also based on the belief that service users' own experiences should be placed at the forefront of research in the area of mental health. This project is funded by the University of Northampton.

WHAT WILL THIS CONSULTANCY INVOLVE?

Participation in this study would involve your advice and recommendations on how the interview schedule should be presented and structured. It is a key aim of this research to obtain the experiences and views of those who use mental health services and it is therefore your input that will prove to be invaluable in this process.

WILL OTHER PEOPLE KNOW ABOUT WHAT I SAY IN THE INTERVIEW SCHEDULE?

The only people who will look at your suggestions will be my Research Supervisor and me. Nobody within the University or others will have access to your comments. Additionally, everything you tell me will remain completely confidential and anonymity is guaranteed throughout.

WHAT IF I DON'T WANT TO ANSWER A QUESTION OR TAKE PART IN THE STUDY ANYMORE?

You have the right to stop your participation in the formation of the interview schedule at any time and you do not have to provide any reason for this withdrawal. Furthermore, I will not ask a reason why you do not want to participate in this.

WHAT WILL HAPPEN TO THIS RESEARCH?

This research will remain the property of the University of Northampton but it is hoped that the findings will be submitted for publication to bodies such as the Mental Health Foundation, academic, clinical journals and conferences. These submissions will add to the body of research which seeks to inform future research directions, as well as the advice and guidance it provides regarding the relevant issues of older service users and mental health.

Thank you for your help, it is much appreciated.

APPENDIX TWO (b)

WHAT ARE THE CHALLENGES FACING OLDER MENTAL HEALTH SERVICE USERS IN COMMUNITY CARE?

INFORMED CONSENT FORM
INTERVIEW SCHEDULE CONSULTANT
(to be completed after Participation Information Letter as been read and discussed)

The purpose and details of this study have been fully explained to me. I understand that all procedures have been approved by the University of Northampton Ethical Advisory Committee.

	Please tick to confirm
I have read and understood the information letter and this consent form.	□
I have had an opportunity to ask questions about my participation and areas surrounding this research.	□
I understand that I am under no obligation to take part in this study and I do not have to answer any questions that I do not want to.	□
I understand that I have the right to withdraw from this study for any reason and that I will not be required to explain my reason for withdrawing.	□
I understand that all the information I provide will be treated in strict confidence and my real name and location will not be mentioned in the final report.	□
I agree to participate in this study and I would confirm that I am over 50 years of age.	□

Your name _____

Your signature _____

Signature of Investigator _____

Date signed ____

APPENDIX THREE (a)

PARTICIPANT INFORMATION SHEET
ONE-TO-ONE INTERVIEW

NATURE OF THIS STUDY

I am a Higher Research Student at the University of Northampton and I am carrying out a study on the impact of everyday life for older mental health service users. In essence, this means that the project seeks to explore the daily activities of approximately forty service users within the wider community and the home setting. This study is also based on the belief that service users' own experiences should be placed at the forefront of research in the area of mental health. This project is funded by the University of Northampton.

WHAT WILL THE RESEARCH INVOLVE?

Participation in this study would involve partaking in a one-to-one interview which would last approximately 30 minutes to 1 hour. If you feel that this time is too long, we will be able to make another date and time to finish the interview – just let me know so that I am able to stop when you have had enough. The interview will be tape-recorded and aims to gather information about how you spend your time and the social groups you spend your time with. The interview does not involve any tests and there can be no right or wrong answers. I'm only interested in your opinions and you will be encouraged to talk about what you feel is important to you. Your interview will be transcribed (typed up) by me and will be analysed in terms of key themes which emerge across all interviews.

WILL OTHER PEOPLE KNOW ABOUT WHAT I SAY IN THE INTERVIEW?

The interview will be tape-recorded but all the information that you provide will only be available to both my Research Supervisor and me. All audio recordings will be stored under lock and key. When the interview is typed up, your real name and location will not be used in the final written copy of the study although some of the things you tell me may be used and appear in the final report. In place of your own name, I will make up another name to ensure that your personal details are not available to anybody else. Additionally, everything you tell me will remain completely confidential and anonymity is guaranteed throughout.

WHAT IF I DON'T WANT TO ANSWER A QUESTION OR TAKE PART IN THE STUDY ANYMORE?

You have the right to stop the interview at any time and you do not have to answer any questions that you don't want to. Furthermore, I will not ask a reason why you do not want to answer any question. This interview 'belongs to you' and is your chance to say what you want or do not want to say – I am only here to ask questions. Also, you can ask for your taped interview not to be included in the final writing up if you so wish but you will need to let me or a member of your day centre staff know after the interview has taken place so that I can delete your recording.

WHAT WILL HAPPEN TO THIS RESEARCH?

This research will remain the property of the University of Northampton but it is hoped that the findings will be submitted for publication to bodies such as the Mental Health Foundation, academic, clinical journals and conferences. These submissions will add to the body of research which seeks to inform future research directions, as well as the advice and guidance it provides regarding the relevant issues of older service users and mental health.

Thank you for your help, it is much appreciated.

APPENDIX THREE (b)

WHAT ARE THE CHALLENGES FACING OLDER MENTAL HEALTH SERVICE USERS IN COMMUNITY CARE?

INFORMED CONSENT FORM – INTERVIEW PARTICIPANT
(to be completed after Participation Information Letter as been read and discussed)

The purpose and details of this study have been fully explained to me. I understand that all procedures have been approved by the University of Northampton Ethical Advisory Committee.

	Please tick to confirm
I have read and understood the information letter and this consent form.	□
I have had an opportunity to ask questions about my participation and areas surrounding this research.	□
I understand that I am under no obligation to take part in this study and I do not have to answer any questions that I do not want to.	□
I understand that I have the right to withdraw from this study for any reason and that I will not be required to explain my reason for withdrawing.	□
I understand that all the information I provide will be treated in strict confidence and my real name and location will not be mentioned in the final report.	□
I understand and agree that only the Research Supervisor based at The University of Northampton will also have access to my data.	□
I agree to participate in this study and I would confirm that I am over 50 years of age.	□

Your name _____

Your signature _____

Signature of Investigator _____

Date of Interview ______________________________

APPENDIX FOUR (a)

PARTICIPANT INFORMATION SHEET
PHOTOGRAPHIC DATA AND INTERVIEW

NATURE OF THIS STUDY

I am a Higher Research Student at the University of Northampton and I am carrying out a study on the impact of life transitions on older mental health service users. In essence, this means that the project seeks to explore the everyday life of older service users within the wider community and the home setting. This study is also based on the belief that service users' own experiences should be placed at the forefront of research in the area of mental health. This project is funded by the University of Northampton.

WHAT WILL THE PHOTOGRAPHY AND INTERVIEW INVOLVE?

Participation in this study would involve partaking in taking photographs with a camera (supplied by the University of Northampton) over a period of one to two weeks. It is up to you what you photograph – this could be in your own home or in other places, the choice is completely yours. We will then meet at on an agreed date and time and discuss your photographs. This conversation will be tape-recorded and typed up myself. The interview does not involve any tests and there can be no right or wrong answers. I'm only interested in your opinions and you will be encouraged to talk about what you feel is important to you. Your interview will be transcribed (typed up) by me and will be analysed in terms of key themes which emerge across all interviews.

WILL OTHER PEOPLE SEE MY PHOTOGRAPHS?

The photographs you have taken will be kept on my own laptop. Photographs may be used within this research project, academic journals and conference presentations. Photographs will not be used for commercial purposes. If you do not want to have your photographs published, then please let me know at the time of the interview and I will destroy all footage. Any photographs taken of yourself and others will not be used.

WILL OTHER PEOPLE KNOW ABOUT WHAT I SAY IN THE INTERVIEW?

The interview will be tape-recorded but all the information that you provide will only be available to both my Research Supervisor and me. All audio recordings will be stored under lock and key. When the interview is typed up, your real name and location will not be used in the final written copy of the study although some of the things you tell me may be used and appear in the final report. In place of your own name, I will make up another name to ensure that your personal details are not available to anybody else. Additionally, everything you tell me will remain completely confidential and anonymity is guaranteed throughout.

WHAT IF I DON'T WANT TAKE PART IN THE STUDY ANYMORE?

You have the right to stop at any time and you do not have to provide any reason for this withdrawal. Furthermore, I will not ask a reason why you do not want to participate in this. These photographs and the interview 'belong to you' and is your chance to say what you want or do not want to say. Also, you can ask for your interview not to be included in the final writing up if you so wish but you will need to let me or a member of your day centre staff know after the interview has taken place so that I can delete your recording.

WHAT WILL HAPPEN TO THIS RESEARCH?

This research will remain the property of the University of Northampton but it is hoped that the findings will be submitted for publication to bodies such as the Mental Health Foundation,

academic, clinical journals and conferences. These submissions will add to the body of research which seeks to inform future research directions, as well as the advice and guidance it provides regarding the relevant issues of older service users and mental health.

Thank you for your help, it is much appreciated.

APPENDIX FOUR (b)

WHAT ARE THE CHALLENGES FACING OLDER MENTAL HEALTH SERVICE USERS IN COMMUNITY CARE?

INFORMED CONSENT FORM – PHOTOGRAPHIC DATA
(to be completed after Participation Information Letter has been read and discussed)

The purpose and details of this study have been fully explained to me. I understand that all procedures have been approved by the University of Northampton Ethical Advisory Committee.

	Please tick to confirm
I have read and understood the information letter and this consent form.	□
I have had an opportunity to ask questions about my participation and areas surrounding this research.	□
I understand that I am under no obligation to take part in this study and I do not have to answer any questions that I do not want to.	□
I understand that I have the right to withdraw from this study for any reason and that I will not be required to explain my reason for withdrawing.	□
I understand that all the information I provide will be treated in strict confidence and my real name and location will not be mentioned in the final report.	□
I understand that my photographs may be used within this research project, academic journals and conference presentations.	□
I understand that I can request that my photographs are not used within this research project, academic journals and conference presentations.	□
I agree to participate in this study and I would confirm that I am over 50 years of age.	□

Your name _____

Your signature _____

Signature of Investigator _____

Date signed