Open Research Online

The Open University's repository of research publications and other research outputs

Vital spaces and mental health.

Journal Item

oro.open.ac.uk

Vital Spaces and Mental Health

Abstract

The impact of social and material conditions on mental health is well established but lacking in a coherent approach. We offer the concept of 'vitality' as means of describing how environments facilitate 'feelings of being alive' that cut across existing diagnostic categories. Drawing on the work of Daniel Stern, Thomas Fuchs, Frederic Worms and Cameron Duff we argue that vitality is not solely a quality of an individual body, but rather emerges from attunements and resonances between bodies and materials. We use vitality as a lens to explore how movements within and between assembled sets of relations can facilitate or disable feelings and expressions of being alive. Building upon extended discussions of both inpatient and community based mental health care, we sketch out a research agenda for analysing 'vital spaces'.

Keywords: vitalism; forms of vitality; assemblages; therapeutic landscapes; secure psychiatric care; community mental health; recovery

> I would say this place has amputated my sexuality. Definitely, it's – it's not my home, it's not – it's not a free environment and ... it's a – it's so anti-life. I just don't even think about sexuality in here and I grieve over that quite a lot. And ... I try and cope with this place on its own terms, you know and whatever it has to offer me I will engage with. So I try to make it a reality, its own reality but I still can't feel human enough to be a sexual being in this environment. (Anne)

Introduction

Anne is a patient in a medium-secure forensic psychiatric unit. This is a hospital environment where patients are detained under a section of the UK Mental Health Act (i.e. 'sectioned') for an indefinite period of time. Patients like Anne are cared for within a 'forensic' pathway, meaning that they have been convicted of a criminal offence (referred to as an 'index offence'). However their mental health issues are considered sufficiently severe to warrant treatment in a hospital rather than a prison setting. Medium-secure units have locked wards and other security measures. Patients here are under no illusion that they are formally considered to be a risk to themselves, to others, and to the environment itself.

We talked to Anne (the name is a pseudonym) as part of a study on sexuality and intimate relationships in secure settings[1]. Her way of describing how the environment shaped her experiences was a revelation to us. We had expected that patients might be unhappy or feeling that their needs were not being met. We were aware that many patients experience unpleasant side-effects from the medication they are obliged to take, which can result in weight gain, restlessness and sexual dysfunction. This all contributes to significant issues with body image and self-esteem. But we did not anticipate hearing this framed in terms of *vitality* – of the tension between what Anne calls 'life' and 'anti-life'. Anne's comments have led us towards an exploration of the potential of vitality to serve as an alternative conceptual basis for understanding the relationship between mental health and the environment.

Our aim in the paper can be simply stated: we want to do justice to Anne's experiences by elaborating her distinction further. In doing so, we are not suggesting that her words need to be 'theorised' or translated into a

philosophical language. Anne is, in effect, an 'expert by experience', and we do not regard what she says as in any way lacking or as standing in need of qualification in an academic discourse. What we are proposing instead is to see her lived experience as a point of departure into a series of conceptual experiments that have the overall ambition of providing an enriched vocabulary for describing how environments are 'anti-life', and conversely how to think about those that support vitality. We will refer to both aspects of environments using the term 'vital spaces'.

What motivates these experiments is the desire to address the lack of systematic attention to the impact of social and material environments on mental health. It is well established that poverty, poor living conditions and social inequalities are key factors in increased levels of mental health issues[2]. But the dominant approaches to mental health in most Western nations remains wedded to an individualized and often biological model of causation and treatment[3]. Where environmental factors are considered, it is often as broader moderating variables, rather than as central issues. What is lacking is a holistic approach where the relationship between person and environment is not treated as dualism where the 'outside' enters into the 'inside' of the individual[4]. The promise of vitality as a concept is that it draws upon a rich tradition of thought that destabilizes dualisms of this kind. Life cannot be contained within any stable distinction between persons and the worlds they inhabit. It is inherently excessive as a term, provoking reflection on what we mean when we speak of bodies and health.

In what follows, we first offer a range of contemporary approaches to vitality in order to demonstrate the need to move beyond limiting person-environment distinctions. We then turn to the 'critical vitalism' of Frederic Worms to argue that 'life' and 'anti-life' are in a necessary tension with one another, and demonstrate how recognition of this tension reframes how we understand mental health. We then proceed to describe how person-environment relations can be grasped as 'assemblages', following the work of Cameron Duff. This is then contextualized in the case of both inpatient and community based mental health care. Finally, we offer the concept of 'vital spaces' as the basis for an agenda for studying mental health through a vitalist lens. As the paper develops, we shift from a conceptual language to an empirical focus on the specific material contexts in which vitality is experiences. This mirrors the tensions with vitality itself that Henri Bergson[5] described – from thought to action, from experience to space. Any reflection upon vitality is, we argue, inevitably caught within these tensions.

Conceptualising Vitality

In *Forms of Vitality*, the clinician Daniel N. Stern offers a bold account of what he terms 'the manifestation of life, of being alive' (p.3)[6]. Vitality is, for Stern, effectively hidden in plain sight. In common sense terms, it is easy to recognise the experience of 'feeling alive', of feeling connected to the world around us and sensations of efficacy and the possessing capacities to act. But the precise status of vitality is more difficult to identify. Stern begins with the mundane observation that to feel alive is to feel that one is either in movement or poised to engage in some movement, that one's body and mind are capable of action.

Movement then implies both a spatial and a temporal trajectory. Actions have a directionality, a patten that unfolds in its own space and time, and which has some implied object or objective, even if that is merely the expression of the body's capacities themselves (e.g. as in dancing or running). The moving body also has its own force of expression, a distinct pattern to the way movement is enacted.

Stern goes on to characterise the innumerable 'dynamic forms' through which vitality is expressed. For example, the feeling of 'surging' is distinct from that of 'floating', which is different again from that of 'halting'. As forms of experience, these terms mark very different ways in which the force of the body 'goes somewhere', lasting sometimes a few brief seconds, sometimes considerable longer. What Stern attempts to describe are the 'felt experiences of force' (p.8) that are involved in sensations of 'being alive'. These cannot be partitioned into the existing psychological grammar of experience since vitality is 'separate and distinct from the domains of emotion, sensation and cognition' (p.149). For example, the experience of feeling a welling in the chest and throat that gives rise to an uncontrollable sobbing has its own very specific dynamic form that involves, at once, a range of sensations in the upper viscera, a rising and swelling emotion, and a rush of difficult-to-manage thoughts. But vitality itself - what it feels like to be alive, to be in the world at that moment - is irreducible to any of these psychological dimensions. It is what underpins them all and animates them in a dynamic orientation to the here and now - 'vitality dynamics are thus crucial for fitting a living organism into the world that it encounters' (p.15).

Drawing on clinical practice, Stern goes on to demonstrate the place of 'dynamic forms of vitality' in social relations. He argues for a phenomenon of 'affect attunement' where persons match the same dynamic form across different modalities, as in the following:

> A ten-month old girl is seated on the floor facing her mother. She is trying to get a piece of puzzle into its right place. After many failure she finally gets it. She then looks up into her mother's face with delight and an explosion of enthusiasm. She 'opens up her face' [her mouth opens, her eyes widen, her eyebrows raise] and then closes back down. The time contour of these changes can be described as a smooth arch [a crescendo, high point, decrescendo]. At the same time her arms rise and fall at her sides. Mother responds by intoning, "Yeah" with a pitch line that rises and falls as the volume crescendos and decrescendos: "yeeAAAaahh". The mother's prosodic contour matches the child's facial-kinetic contour. They also have the exact same duration.[7]

The key to this example is that it is a kind of mirroring, but of the form of the other's behaviour rather than its exact expression. More precisely, for Stern, it is a mirror of the dynamic pattern of expression - the same movement of crescendo and decrescendo with the same temporal unfolding - but crucially with a switch in modality (voice rather than facial expression). Stern argues that switching modality demonstrates an involvement and taking seriously of the other that avoids the appearance of simple repetition. Life responds to life by taking up its energy and transforming it into a new medium. Vitality is then not merely the expression of one individual body, but a co-ordination or 'attuning' of forces

(which can involve potential issues of 'under' or 'over' attuning when the co-ordination misfires - e.g. the dynamic form is repeated in a way that is either underwhelming or completely excessive).

Stern's work identifies vitality as a distinct concept and suggests ways in which its expression might be described. But, in line with the clinical context in which the concept has been developed, much of Stern's focus is on dyadic contexts rather than the broader social environment, coupled with an emphasis on the biological factors that are involved in 'dynamic forms'. By contrast, Thomas Fuchs' work points to the inherent relationality involved in vitality. Fuchs begins with a definition close to that of Stern of vitality as 'the feeling of being alive: a pre-reflective, undirected bodily self-awareness that constitutes the unnoticed background of all intentional feeling, perceiving or acting'[8]. This definition is couched in phenomenological terms and draws attention to the centrality of body as the fundamental medium through which the world is experienced. Drawing on Heidegger, Fuchs posits that there are a number of 'existential feelings'[9] that constitute the background to any kind of elaborated experience. These correspond to what Heidegger called 'stimmung' or 'mood'[10]. A mood is a form of background affect through which particular relations to the world are established. Fuchs describes these as including 'elementary existential feelings' such as 'the feeling of being alive, of feeling oneself, at home in one's body'[11], 'general existential feelings' such as 'states of feeling healthy, fresh, strong, or, on the other hand, tired, weak ill' (p. 615), and 'social existential feelings' such as 'feeling at home in the world with others, feeling welcome, familiar, connected' (p. 616).

What all of these 'existential feelings' have in common is that they create an affective tone that sets out a relational map of the person's felt place in the world. To feel 'at home in one's body', for example, is primary to any particular sense of pleasure or health. It is, we might say, a direct experience of vitality that sets a kind of corporeal agenda for sensation. The person who finds themselves in such a mood is unlikely to be troubled by nagging feelings of incipient illness or of alien and threatening sensations within their body. But for Heidgger 'stimmung' or 'mood' is not reducible to a personal orientation. Mood is as much 'in' the environment as it is 'in' the person (hence the term *dasein* or being-in-the-world that Heidegger uses in place of a person-environment distinction). As Gumbrecht describes, the term stimmung draws in part on the idea of an instrument being 'tuned' to a particular melodic scale[12]. The person may then be said to be similarly 'attuned' to the atmosphere of the world around them. This operates at both the level of the fundamental 'existential feelings', such as the fundamental orientations in which persons find themselves, and in the more moment-to-moment affective relations that we experience, such as feelings that the mood in an audience has soured, or that the neighbourhood into which we have just arrived feels threatening.

For Fuchs, the idea of affectivity as located within our attunement to the atmospheres in which we dwell relocates vitality outside of the narrow confines of the person as places it within the relationships we have to others and the broader world. But this relationship is dynamic - it is not a simple matter of 'picking up' on feeling that come from elsewhere. Fuchs speaks of a 'bodily resonance' involved in attunement which 'includes all kinds of local or general

bodily sensations: feelings of warmth or coldness, tickling or shivering, pain, tension or relaxation, constriction or expansion, sinking tumbling or lifting etc'[13]. Resonance acts as the 'sounding board' through which affectivity is felt. We do not feel sad, happy or indifferent, but rather crushed in the stomach by feelings of despair, giddy in our heads with elation, or cold and unfeeling across our skin with an unfathomable world. Resonance is both a medium for experiencing the world and at the same time a medium through which our feelings are expressed. Others then 'act back' on the resonances we express, a feedback cycle that Fuchs and Froese term 'inter-bodily resonance'[14]. Whilst this term bears some resemblance to Stern's notion of 'affect attunement', Fuchs and Froese go further in arguing that such resonances effectively create a higher-order unit of experience that they term an 'extended body'. When we resonate with another, we form together a relational nexus that has, to some extent, its own distinct forms of vitality and existential feelings.

Following Fuchs, we can now relocate vitality away from the confines of an individual body and place it into a broader relational context. We can also see how vitality underpins much of the existing psychological vocabulary. This has important implications of how we approach mental health. As Fuchs makes clear, 'embodied affectivity' is a primary form of experience that underpins the kinds of phenomenon that fall under traditional diagnostic criterion[15]. If these are seen as fundamentally 'shared states' then the way in which mental health is approached must, as a consequence, be shifted towards a relational understanding of distress, rather than an individualistic model of personal pathology.

Both Stern and Fuchs provide a very rich means of describing vitality. But what of the 'anti-life' that was so important to Anne? Should this be seen as a 'lack' or vitality, or a form of 'under-attunement' to the world? This is not really satisfactory, since as Anne makes clear, what she is referring to is a force that degrades her own sense of vitality. Yet in trying to orient to this force, we are led towards a new version of the person-environment problem, where vitality comes from within, and that which opposes it comes from without. Is this the best way to conceptualise 'life' and 'anti-life', or is there perhaps a way of rendering that relationship in ways that undercut such a dualism?

Critical Vitalism

Frederic Worms is at the forefront of French philosophers working in what is commonly termed the 'continental tradition' (i.e. the body of thought that develops post-Kantian philosophy, where phenomenology and post-structuralism are key moments). Worms is best known for his extended exegesis of the work of Henri Bergson[16], which he has recently come to characterise as 'critical vitalism'[17]. Critical vitalism is a neologism that combines two distinct philosophical movements. Vitalism is a 'philosophy of the organism', which typically asserts the primacy of the category of 'life itself' as the central object of philosophical enquiry and the means through which a direct experience of the world may be enacted[18]. By contrast, 'critical philosophy' is the name given to Kantian and post-Kantian philosophy which seeks to found knowledge through a critique of the inadequacies in existing thought and establishing the proper limits in which reason may be applied to an always partial account of the world. These are clearly opposed traditions – life versus reason, experience unbounded

in organic movement versus experience tightly bounded to empirical self-consciousness. The idea that they might be brought together in a single term is provocative, to say the least.

The key to this apparent paradox is, Worms claims, to be found in Bergson's work[19]. In *Creative Evolution*, Bergson developed a view of evolution as a process of life searching for 'solutions' that would allow the organism to overcome the difficulties in their environment[20]. For example, the eye is a solution to the problem of spatial relations in that it allows the organism to enter into relations that go beyond the immediate environment, thus extending the range of the organism's 'attention'. For Bergson, it becomes necessary to posit that organisms participate in a single category of being called 'life' in order to argue that evolution is not piecemeal process of gradual adaptation but rather a series of partial solutions to problems that are solved without any sense of a 'final cause' towards which evolution is proceeding. Life is the continuous, endless searching to overcome existing forms, a perpetual reaching for new solutions to changing problematics posed at the organic level. Bergson termed this vital force 'élan vital', which he placed at the very centre of his philosophical project (despite some 25 years elapsing before Bergson felt able to demonstrate how élan vital could ground an ethical system)[21]. Although *Creative Evolution* offers a highly speculative metaphysics, its influence on later figures such as George Canguilhem, Michel Foucault and Gilles Deleuze is clear. All these thinkers take 'life' to be a fundamental category of social and political thought, and to be central to any philosophical project that seeks to understand what constitutes

liberty when the very conditions of life and death are objects of governmental concern.

Most scholars would see *Creative Evolution* as representing the apex of Bergson's concerns with life, but Worms argues that in the earlier text *Matter and Memory*, a more nuanced account of vitalism is contained[22]. In this work, Bergson sets out an account of life as that which continually distorts contact with 'reality'. In an inversion of the usual way in which psychological processes are described, Bergson reasons that perception is a means by which aspects of the world and 'cut out' or reduced in order to provide the organism with a manageable foothold in the environment. Perception is a subtractive rather than additive process. What we perceive is a structured by our particular needs, which operate like a kind of searchlight shone into the environment, such that we only pick out that which is most immediately useful to us. Bergson places perception within a process he calls 'attention to life' - an expanded attention that extends our potential reach into the world, but at the risk of neglecting our needs, whereas a limited attention contains the opposite risk of ignoring relevant features of the environment (i.e. threats to our actions).

The description of life in *Matter and Memory* seems, paradoxically, closer the limited and partial view of knowledge found in the Kantian tradition, such that it may appear that here Bergson is concerned with critique, whilst *Creative Evolution* takes forward vitalism. But Worms argues that this would be to neglect the ways in which the two texts in fact deal with the same paradox:

> We should, however, stress first, and very forcefully, what seems to us to be one of the major lessons of Matter and Memory ... We cannot obtain

pure life, but we have to criticise the knowledge and power on or over life. But at the same time, we cannot forget that we are living and creating our lives through individual time and history. That we are leading a temporal, and durational life that builds ... an individual body and brain, an individual memory and history, an individual (and one should add relational) past, present and future. Yes, even the present is not only the constraint of the action, but the peak of our creation, when it is pushed by our time and into our future[23]

Worms here argues that life must inevitably confront the particular forms of power and knowledge in and through which it is manifest. To return to Stern and Fuchs, we have to consider how 'life responds to life', the ways in which it is relationally embedded in tensions between different and limiting expressions of forms of life. Thus the critical project of Kant, an evaluation of the modes of judgment and discernment through which life finds a foothold in the world is relevant here. But life only appears to be purely critical when we consider it in terms of present needs, with regard to the immediate 'attention to life' that the organism expresses, which is inevitably limited. The central lesson of *Matter and Memory* is to think in terms of duration - that is, to see our lives as unfolding in an indivisible temporal structure where the 'present moment' is an artificial construct. We are as much in the past as we are pointing towards the future that is in the process of coming to be. From this perspective, where we are right now is at the limit of a creative force that is surging to express itself as fully as is possible. Life is both the ultimate reality of vital force, and the critical and limited foothold in the world. There are two faces through which our experience is

necessarily structured. The tension between the critical and the vital is found within life itself. The question, for Worms and for Bergson, is then the extent to which this pluralist expression of life allows the organism to move forward, to find new and novel ways of relating to the world, or locks the organism into a more rigid and inflexible set of relationships.

On this basis we can claim that the dualism of 'life' and 'anti-life' can be recast as a pluralism within life itself. We are at once beings who are necessarily restricted by the limited foothold in reality that comes from attention to the immediate conditions of existence, and beings who express broader dynamic forms of vitality that have a temporal structure linking our pasts and futures. Living is both dealing with the here and now that shows up in the affective relations in which we are currently entwined, and the broader sweep of our lives as efforts at expressing our capacities as embodied beings. It is the relation between these 'two faces' of life - the 'attention to life' afforded by the immediate setting and the broader 'rhythms of living' that define our trajectories through these settings - that ought to concern us.

Life and Space

We now begin to turn from a broadly conceptual discussion towards the material contexts in which vitality is expressed. In doing so we are following the tension that Bergson identifies between life and its foothold in the world, and that Worms sees as at the heart of 'critical vitalism'. If we have been concerned up to this point in describing how the dynamic forms that vitality takes, we now shift towards describing the spaces in which those forms relationally unfold and confront one another.

Gesler's formulation of the concept of a 'therapeutic landscape' remains the dominant approach for understanding the relationship between vitality and space[24]. Gesler argues that certain kinds of places acquire a longstanding reputation as possessing the power to 'heal' or to positively impact on wellbeing (e.g. spas, forests, mountains). This effect may be either direct - such as through the supposed benefits of water, air or light - or indirect - such as via the sense of community and history which the place affords. A therapeutic landscape may then be considered in terms of its material, symbolic and social dimensions. In material terms, there is a rich body of literature that describes how 'green' and 'blue' spaces support wellbeing by providing spaces for relaxation and stress reduction. For example, studies of the Japanese practice of *Shinrin-yoku* ('forest walking') have demonstrated a range of positive health benefits[25]. Similarly, positive effects have been demonstrated of 'taking the water'[26] and spending time near large bodies of water[27]. The principal benefit here seems to be the sense of tranquility that is afforded by viewing or contact with 'blue space'.

The symbolic dimensions of a therapeutic landscape arise from the enculturation of space within human activity. For example, the therapeutic benefits of visiting Lourdes in France come not just from the mineral water for which the site was originally known, but also from the symbolic association with miraculous appearances of the Virgin Mary, which have arisen over time[28]. In this way the symbolic may 'laminate' the material, serving as a framework of meaning that is overlaid on the physical properties of place. Meaning may also emerge through an individual relationship to space. As Jack describes, it is common for persons to have specific places that are experienced as symbolically rich (e.g. places visited

as a child, places where a particular event occurred)[29]. These 'place attachments' can facilitate wellbeing in the absence of any clear material effects through associations with past feelings and felt qualities (e.g. a place where one has previously felt 'joyful', 'safe' or 'able to be oneself'). Places can also afford particular kinds of social activity - such as collective physical or recreational activity - that in turn promote association and a sense of belonging. In their different ways, forests, mountains and beaches can facilitate these kinds of socialised wellbeing effects.

The concept of a therapeutic landscape disposes us to think of particular kinds of spaces as enhancing vitality. But as Moon et al argue, the converse also holds[30]. There are spaces, such as urban landscapes, impoverished housing developments or desolate rural environments that may undermine wellbeing, or even, in the case 'spectral' or 'dark' places, landscapes that are corrosive of wellbeing because of their material or symbolic properties (e.g. former asylum sites, places associated with catastrophe or specific tragedy). These tend to be under-researched in the therapeutic landscape tradition. Moreover, the very idea that a space necessarily gives rise to wellbeing for all visitors is problematic. It would be more apposite to observe that place often gives rise to a mixture of affects, both enabling and potentially disabling, in an unstable and changeable mixture. Former county asylum sites in the UK, for example, are often situated in pleasing 'green spaces' which can be associated with 'retreat' and 'protection' (i.e. one of the meanings of asylum). But they are also marked with a history of seclusion, a lack of liberty, and potential violence that can be experienced as a complex affective milieu with competing 'tones'. Life responds to different forms

of life, to different affective tones of experience. Much also depends on how the engagement with place fits into a broader temporal and biographical trajectory. Rural places may serve as spaces of retreat and pleasure for those who pass through them 'unmarked', but as Agyeman shows, persons of colour can find that they are highly visible and potentially subjected to prejudice in ways that undermine any therapeutic sense of belonging or escape[31].

Vitality then needs to be relationally defined with respect to the properties of space and aspects of temporality. We should be concerned with specific forms of embodiment-in-place that become entwined within particular rhythms of living, as a person's temporal trajectory is folded into that of the place. For example, a repeated trope in the writing of the novelist WG Sebald is the return of a character who is currently undergoing an episode of crisis to a place they knew earlier in life, only to discover that the space has changed almost beyond recognition, and the impossibility of recovering a felt sense of that past life[32]. Describing these complex sets of affectively charged relations requires a very different language, such as that provided by Cameron Duff[33]. In *Assemblages of Health*, Duff develops the concept of an 'assemblage', taken from Deleuze & Guattari[34], as an analytic tool to study situated experiences of health within particular settings[35]. An 'assemblage' is a relational nexus of bodies, materials, affects and signs which are gathered into an ongoing process of 'arranging'[36]. A key aspect of the term is that no prior distinction is made between either subjects or objects, or material or symbolic aspects. 'Subjects' and 'qualities' emerge from within the relational gathering rather than underpin its processual development (or 'becoming'). For example, from an assemblage perspective, a

hospital ward is not a space where care is delivered to patients by staff, but instead an ongoing mixture of actions, feelings and utterances emerging between bodies and materials through which 'subjectivities' emerge. What constitutes 'care' and 'health' are properties that are entirely relative to the assemblage itself. Brown & Reavey demonstrate the difference in perspective here by re-describing life on a psychiatric unit in assemblage terms:

> The secure unit is complex and changeable arrangement of medical, legal and governmental practices, mixing together nurses, former prisoners, airlock doors, depot injections, charts, televisions, plastic cutlery, cigarettes, staff rotas, sunlight, and bedrooms littered with belongings. The unit can be a lively place, especially during times when patients arrive on transfer from prison, where the contradictory demands of care and containment can rub up against one another uneasily, notably around issues like personal relationships. The space of the unit is difficult to properly gauge, since patients may be allowed off the ward into the general hospital grounds and to make community visits; there is a distinctly different 'feel' to the common areas and the individual bedrooms, reflecting the various kinds of activities that are possible in each. Whilst there is a clear management structure, it is difficult to know where exactly the unit sits – are we in the prison system, the medical system or somewhere else entirely? This partial ambiguity allows for the emergence of practices and relationships that are particular to the unit, some of which would be difficult to understand if one approached the unit as either purely a space of containment or purely a space of

treatment. Everyone and everything that enters the unit lends something specific, from East African nurses to long-term service users to middle-class psychiatrists mixed together in this space; this unique confluence of identities and experiences seems integral to how the place seems to 'work' as whole. Yet precisely because it is such a mixture, the unit seems to be rather porous – people, practices and objects seem to be displaced, to move through and across the extended space of the unit in unpredictable ways. The place has its own history, one that seems to be written and rewritten on an almost daily basis.[37]

This description emphasises the variety of elements that are in the process of being arranged, and the kinds of relationships and affects that emerge between them. Whilst the concept of assemblage is meant refer to a process of spatio-temporal arranging, rather than a distinct space, a key aspect of this process is 'territorialisation'[38]. Territorialisation refers to an exchange of properties between what we might crudely call the discursive and non-discursive aspects of an assemblage[39]. For example, the act of diagnosing a person with a mental health disorder, such a 'Personality Disorder', does not just simply label that person or make them subject to a particular kind of service. It acts to 'reorganise' their embodied relations. The person is now recruited into a discourse where the expression of their feelings may be considered by others as 'manipulation', and where their efforts to describe their needs is seen to flow from a lack of concern for others. This inevitably transforms the person's relation to their own embodied moods and sensations and, moreover, brings them into different sets of relations with other embodied practices. Guattari spoke of this as the creation

of a new 'existential territory' or a reshaping of the actual conditions of life[40]. For Duff, this means that we should 'treat the lived experience of health and illness as a complex of affective and relational transitions within the various assemblages which express human life[41]. Or put different, vitality can be seen as what emerges from an assemblage, rather than as the underlying properties that are affected by an assemblage.

Duff offers the concept of 'enabling space' [42]as a corrective to the idea that health and place can be defined separately from one another[43]. Whilst this term captures the relational dimension of an assemblage perspective on space, we prefer the term 'vital spaces'. We use this to refer to both the relational nexus of bodies, affects and materials that are assembled together in a specific setting (e.g. a hospital ward, a public space, a forest), and to the potential range of trajectories that may be recruited into these settings. Any space can be analysed with respect to how it shapes vitality, not simply those kinds of spaces typically studied as therapeutic landscapes. In this sense, vital space is a lens for addressing vitality 'in the world'. It provides a focus on the tensions as 'life confronts life' within a specific material and discursive context. In the following two sections we will illustrate how the concept of vital space may be developed by considering the cases of inpatient and community based care for mental health. Our concern here will be the ground the issues raised in the conceptual discussions around vitality in the work Stern, Fuchs and Worms, and the trace our way back to Anne's experience which served as the point of departure.

Inpatient Mental Health Care as Vital Space

Our discussion here is predominately informed by work we have carried out in medium-secure forensic psychiatric settings[44][45][46][47], but serves to illustrate similar issues found in other kinds of inpatient care. Being admitted to inpatient care can be an overwhelming experience for many patients, who are typically enduring an episode of mental health 'crisis'. As described earlier, being admitted to such care involves being formally detained under a section of the UK Mental Health Act. There are a number of different kinds of 'sections', which specify the general length of inpatient care and the process for returning to the community. The most stringent are sections 37/41, otherwise known as 'forensic sections', which mandate care in a secure hospital setting rather than prison, and that the patient is deemed to be a risk to self, others or the environment. These sections make it explicit that the patient is a threat to their own vitality - the 'anti-life' dimension comes from the person themselves rather than their environment. It is then the purpose of secure care to facilitate the person's journey back to taking control of their own life and health, or 'recovery'. For some patients this is greatly desired. It is now extremely difficult for persons struggling with mental health issues in the UK to access inpatient care, even during periods of crisis. But for others, especially those on forensic pathways, the loss of liberty following 'being sectioned', can be experienced as either a punishment or as inexplicable. Not all patients see the hospital environment as a 'vital space' on admission.

Most inpatient wards in the UK are single-sex with individual bedrooms for use by around 15-20 patients. The decade long 'austerity' programme enacted by the Cameron and May Conservative governments has led to an overall reduction in

the number of beds available, meaning that every ward is normally operating at full capacity. Patients often view one another with a degree of suspicion, particularly on forensic pathways. Whilst the levels of violence between patients in inpatient mental health care does not differ significantly from that within the overall healthcare system, adjusting to the particular needs and forms of expression of other patients is an ongoing process. Patients are also not encouraged to develop friendships with one another since this is seen as involving risks, particular where there is a concern of a potential intimate relationship. In this latter case, explicit sanctions will occur and patients may be moved around the hospital to prevent further contact. If we consider vitality to be inherently relational, such that 'feelings of being alive' depend in part on how we interact with others, then this aspect of inpatient care is inherently 'anti-life'.

Having a private space is usually associated with being able to exert some control over personal activities. Bedrooms can act as a spaces of retreat from the ward. Patients often go to their bedrooms as kind of 'time out' from the noise and activity of the ward space when they feel it is becoming overwhelming. Much here turns on how the physical environment of the ward is defined. The older county asylums followed the Victorian principle of having large open spaces which allowed plenty of light and the circulation of air. By the mid-twentieth century, pressure on hospital space, particularly on urban sites, created more cramped ward space. Contemporary designs have turned back to the older model, where possible, and tend to utilise open spaces along with spaces dedicated to specific activities (e.g. outdoor spaces; recreational spaces; spaces for prayer/spirituality). But the limited footprint of the hospital means that

when patients are in their bedrooms, they are still exposed to the often cacophonous 'soundscape' of the ward, which can including shouting, loud televisions or music, the sound of keys jangling and heavy locked doors slamming. The extent to which bedroom space supports 'forms of vitality' is often determined by the acoustic atmosphere of the ward. Moreover, all patients are subject to regular monitoring, which in many cases can mean that staff physically enter their bedroom on an hourly basis during both night and day. Feelings of safety are then continuously undermined by the practice of surveillance.

Outdoor spaces have become particularly important in modern psychiatric hospitals (again, this can be seen as a return back to older practices). There are a number of drivers for this, but within forensic pathways this is in part because legal restrictions on detention can mean that patients are not allowed outside the building. Constructing outdoor spaces within the unit is a way of ensuring that patients can access natural light and fresh air without violating the terms of their detention. The outdoor spaces usually feature plants and other 'greenery', and can sometime have gardens where patients are encouraged to become involved in growing flowers or vegetables. Fostering organic life through gardening or merely appreciating the natural world (i.e. 'biophilia') is normally thought to enhance individual vitality[48]. However, in our work we have found that many patients do not necessarily enjoy spending time in these 'green spaces'. In some units, there is actually very little activity formally planned, with the result that patients become restless and prefer to go to their bedrooms. Some patients can feel that the green space symbolises their current lack of liberty and

is therefore a limit to their vitality, rather than an enhancement. Access to outdoor space is often limited to particular times during the day. A patients own 'rhythms' of activity can be determined by how they respond to medication, with the consequence that their sleep/wakefulness does not map onto the structure of the day on the ward. The times when they would most benefit from being outside are sometimes not when access is available.

Food is for many people a major source of vitality. Aside from the immediate pleasures of taste and satiation, eating provides an opportunity for sociality, for coming together around a pleasurable activity. We have found that when patients are asked to describe what they most desire for their life outside of hospital, along with having a 'place of their own', the ability to cook for themselves is without fail what is stated[49]. It is then unfortunate that the quality and provision of food in many inpatient units is greatly lacking. The pressures on funding in the National Health Service have led to a reduction in the amount spent per meal, per patient, and in the use of outsourcing, such that the majority of food is prepared outside the ward itself. Whilst individual dietary and calorific needs are met, food rarely inspires much by way of pleasure. Mealtimes are also a problematic time for staff. Disputes between patients about the food they have been served are common. There is also the risk that cutlery and plates can be 'weaponised'. The tendency is to have patients eat either alone or in small groups, and to curtail mealtimes as quickly as possible. Thus the social benefits and affective attunements of eating together are negated. On some units, there are small kitchens where patients can engage in supervised cooking. But the need to manage risk means that these activities are often not regular, and

require substantial planning and management by staff. The potentially life-affirming aspect of feeding oneself (and others) becomes highly limited.

In the discussion of intimate relationships and of food, we have begun to address the more sensuous aspects of vitality, the potential embodied pleasures of engaging with others and the world around us. This leads us towards an aesthetic dimension of life, or the 'form-giving' modes of vitality. We feel alive through the capacity to create forms through which vitality can be expressed. Within inpatient mental health care, there is a rich tradition of using art, drama and music as a means for patients to explore their feelings. Undoubtedly for some patients, there is a therapeutic gain from participation in these kinds of activities. However, Reavey et al found in a study with young people detained in a locked inpatient setting, that the programming of art based activities could have unanticipated consequences[50]. The participants described how they experienced art activities as a particular moment where they could 'pour out' their feelings. However, the structure of ward life meant that these activities were confined to a limited time. Afterwards, they returned back to the ward with the feelings that they had surfaced during the activity still 'on their mind', without any means of being able to address of manage them. As a result, some young people reported self-harming in their bedrooms following these art sessions. From the perspective of vitality, we can say that facilitating self-expression without providing a framework for dealing with what emerges is, ultimately, corrosive of vitality.

The examples we have given above have deliberately focused on some of the more problematic aspects of inpatient care. Nevertheless what they begin to

articulate is that vitality is not a unidimensional construct. It is rarely the case that some activity or aspect of the setting unilaterally supports or represses vitality, rather that there is a mixture of competing forces out of which vitality emerges. Analysing this tension between different relational aspects of the setting is crucial. We have also shown that much depends on the ways that persons pass through the setting. It really matters how someone comes to be sectioned, and where that trajectory is leading them when they are discharged from inpatient care. The rhythms of daily life, which can be highly individual, also matter greatly. The space itself is neither intrinsically 'good' or 'bad' in vital terms - everything depends on the capacity of the space to facilitate what may be required, when it is required.

Community Mental Health Care as Vital Space

The vast majority of mental health care occurs within community settings. This is a consequence of unusual convergence of social and economic drivers which have sought to reduce the stigma and loss of liberty associated with inpatient care whilst simultaneously driving down the costs associated with high intensity interventions. Persons who access mental health services in the community do so via local teams of nurses and clinicians, alongside other social welfare professionals. Many mental health service users continue to be in either full time or part time employment, or are engaged in voluntary work or study. This provides access to communities and settings that may be supportive of vitality, not least by providing purpose and social support. Service users who are not engaged in these activities may be in receipt of disability benefits, although there has been a progressive drive under the 'austerity' programme to assess

increasing numbers of persons with mental and physical health issues as 'fit to work', especially under the new 'Universal Credit' system.

Ian Tucker's work, dating from before the implementation of current austerity measures, describes the situation of service users who are not considered as 'fit to work'[51]. One of the major issues is that of 'filling the time' in the absence of a work or study regime. Inevitably this means spending prolonged periods of time at home, either living independently or in supported housing. Tucker notes the tendency to 'bulk out' domestic space by filling it with goods and objects (e.g. food, bottles of drink, clothes, DVDs). The purpose of this 'bulking' appears to be to territorialise the space, that is to create a zone of meaning and purpose within the domestic environment. In particular, arranging objects for their symbolic rather than practical value (e.g. a chess set positioned in a central location) accomplishes a sense of materialising the process of recovery by expressing the person's capacities (i.e. as someone who could engage in the skill of chess playing should they choose to do so). Territorialisation is both an expression of vitality, and a marking out of the spatial boundaries that can facilitate vital forms.

The alternative to spending time at home is to visit a local day care or drop-in centre. These are spaces that provide care and support, through counselling and practical sessions aimed at developing skills for independent living, alongside art or music classes and 'lunch clubs'. As Conradson describes, there can be a plurality of experiences as service users engage with the space in different ways[52]. From a vitality perspective, one common feature is that of promoting social interaction and 'being listened to'. In this sense these centres may serve as short-term refuges from managing mental health issues in public. However, as

Smith & Tucker describe, inclusivity may be performed in variable ways, such that persons who visibly express distress (e.g. loud vocalisations, agitation, rocking movements), may be subject to stigmatisation or exclusion[53]. Not all forms of vitality are supported or encouraged. Increasingly centres of this kind are disappearing from the social landscape, under the twin pressures of reducing 'semi-institutionalised' settings and the economic drive to 'do more with less'. In their absence, some service-user led organisations have begun to emerge (e.g. The Dragon Cafe in central London), which provide spaces for mutual support focused around a social 'third space'. The very fact that the parameters of the space have been defined by service users rather than as institutional mechanisms for care delivery render these existential territories as more apt to enhance vitality.

McGrath & Reavey refer to the kind of care delivery that has increasing replaced day centres as 'helicopter services'[54]. Here healthcare professionals, such a Community Psychiatric Nurses (CPN) or clinicians, appear briefly in the lives of service users - perhaps a five minute consultation with a psychiatrist once a month, or a half-hour conversation with a CPN in a pub - to perform a monitoring activity, before disappearing. For service users, this brief interaction can be problematic because they are encouraged to gather up their feelings and experiences consequent to the previous interaction and rapidly report them. This requires performing a very particular vitality form - a kind of rapid emotional outpouring followed by 'zipping up' feelings such that the service user can now return back into public space. As, Julie, one of McGrath and Reavey's participants put it - 'The other problem with sitting in a pub … is that if you get

upset about anything … you can't really be in tears in a pub without everybody going (whispers) what's going on there so you tend to kind of put on your social face' (p. 65-66). The problem here is that whilst helicopter services may provide a 'bridging function', they encourage the expression of vitality forms that they are not then able to manage. There is a similar issue of managing vitality amongst Duff's participants[55]. One of the solutions they adopt is to keep moving through the urban environment. Rather than focus their efforts at sociality in one place, the participants describe a process of 'learning to be social' through practices such as taking long train journeys where they can observe other people's behaviour or using hair salons or supermarkets as sites to experiment with interactions with others. It is the movement through these spaces, they ways they connect up with the broader activities of the day that appear critical here.

The vitality perspective draws attention to the ways in which spaces connect with one another through the activity of service users passing through the spaces. The sense of 'feeling alive' is not associated directly with just one space, but rather in the patterns of movement involved in making transitions between space. Home, for example, can be a place of refuge, on the condition that there is a separate space where socialising can occur (e.g. day centre)[56]. Conversely spaces that might thought of as facilitating vitality, such as cafes or pubs, can become problematic when forms of vitality are elicited there that become difficult to subsequently contain. An exploration of how public and private spaces can be joined together into patterns of activity becomes important. For example, Duff describes how his participant Matt would take walks around the

city at 3AM[57]. For Matt, the streets felt safe at this time, with the manic energy of the daytime city now absent. His ability to move through the streets unimpeded in the early hours created a novel form of vitality.

Vital Space: A Research Agenda

In this paper we have explored the promise of vitality as an alternative framework for engaging with lived experiences of mental health. This has taken us on a journey through contemporary work in the vitalist tradition, which provides a rich vocabulary for describing the tensions at the heart of forms of vitality, the conflicts that emerge as 'life confronts life'. In doing so, we have passed from the conceptual to the empirical, from life itself to the footholds in time and space wherein the vital is expressed. In particular, we have focused on inpatient and community care as the two overarching contexts in which lived experiences of mental health are enacted. In this concluding section we return our point of departure by offering some brief reflections on vitality can be operationalized as a research agenda in which to understand and articulate lived experiences of mental health, such as those described by Anne.

We began with Anne's description of her time on a secure unit as being in an 'anti-life' environment. In this sense, we may be tempted to distinguish between those spaces that support vitality and those that are corrosive of it. However, as the argument has developed it has become clear that space is rarely experienced in a unitary way - there are a plurality of potential experiences for any given space, which, moreover may change as a function of the activities that unfold within the space. Already in Anne's description, there was the sense that how one engages with the space is crucial to experiences of 'feeling alive'. In her case,

Anne had chosen to 'cope' with the environment by drawing out those aspects that could make 'living' into a specific kind of manageable 'reality'.

Viewing Anne's experiences through the lens of vitality rather than that of mental health offers a very specific gain. We share the unease expressed within much of the service-user movement and by Critical Psychology in the rigid application of diagnostic psychiatric categories[58]. It feels to us that these categories often overlook fundamental questions about the kinds of life that persons who use mental health services are living and on the broader trajectory of their lived experience. As Dillon states, rather than ask people what is what is wrong with them, we should ask instead what has happened to them (and also what they want to happen in their future)[59]. Because vitality cuts across distinctions between cognition, emotion and sensation, it draws attention to the actual embodied conditions of living. However, as Fuchs demonstrates, bodies should not be considered in isolation from one another, but rather with respect to their relations and the kinds of attunements and resonances that occur between bodies. As Stern argues, movement is the principal property of 'being alive'. Vitality is felt and expressed through the ways that we move in relation to one another and in the ways that we move through space. Rather than ask of a given space 'what are its properties?', we should instead ask 'how does it feel to move within and through this space?'.

There is a now a rich body of work that describes space in relational terms[60]. To do so is to think of the space of human activity not as a particular measurable area in which something occurs and is contained, but rather to think of relations between bodies and materials as creating their own specific spatiotemporal

forms[61]. As we showed in the example of the hospital ward, what counts as a particular space is constituted through ongoing interplay between forces and relations. The notion of assemblage is fruitful here because it refuses to reify distinctions between the different kinds of relations that are in play in advance. It focuses attention instead on the interactional processes between bodies and materials. A space is not then vital or anti-life in advance, but can rather shift between these poles according to how relations unfold within the assemblage.

As Worms shows, there is also a fundamental tension within the concept of vitality. We must engage in specific kinds of activities to be able to live at all. This is what Bergson terms 'attention to life'. These would include routine maintenance activities (e.g. sustenance, sleep, exercise, shelter) and efforts at marking out and establishing our place in the world (i.e. 'territorialisation'). One face of life is then concerned with making distinctions and demarcations, separating ourselves to some degree from the broader world. The other is constituted by the 'rhythms of living', the temporal trajectory of our experience as it expressed in 'forms of vitality'. Here it is openness, change and the modulation of our embodied experience that is key. For Worms, vitality is what emerges from the tension between these two faces. Hence, not only are our experiences of space likely to be plural, but the very sense of what it means to be alive is also pluralised as our lives unfold.

We then propose four elements to the analytic framework of viewing any space in terms of vitality:

-The *first* is the study of the relations within an assemblage (e.g. a hospital ward, a public park, an individual home). Here we are concerned with identifying the

various bodies and materials within a setting and the ways in which they are
'attuned' with one another, the kinds of activities that are involved, the patterns
of movement with the loose boundaries of the space and so on.

-*Second*, analysis of the ways that the assembled relations that make up a given
space can be folded into another space as persons move between settings (e.g.
admission or discharge from a ward, the times of day when persons walk the
streets or a park, the ongoing process of making a space 'homely') and the ways
these movements fit within their broader temporal trajectory. The same space
may give rise to very different emergent 'forms of vitality' depending on the
place it has in a person's life and their 'rhythms of living'.

-*Third*, a concern with the practices of 'territorialisation' where persons mark
out the boundaries of their 'existential territories', whether that be a home, a
bedroom in a hospital, or the provisional space they temporarily occupy in a
street or a park. This takes material along with symbolic form, involving the
arranging of materials along with discourses.

And *fourth*, the ways in which space is transformed and opened up through
activity or 'deterritorialised'. This is akin to inventing a new kind of space or
expressing novel 'forms of vitality' through finding different resonances between
bodies. For instance, the discovery that it is possible to briefly retreat from the
ward through listening to music, or of turning the city into a new landscape by
experiencing it at night, or creating a new community through service user led
initiatives.

The agenda that we call for is one where mental health is no longer seen through the narrow perspective of diagnosis, or with respect to the specific spaces where services are provided. Through the lens of vitality, we want to explore how the most varied of public and private spaces can support feelings of being alive. In so doing we hope to go beyond the restricted sense of 'care in the community' to think instead about what spaces and communities of vitality might offer to mental health.

Patient and Public Involvement

This paper does not report new data. Please refer to original works cited for further details on PPI.

Bibliography

Agyeman, Julian. "Black people in a white landscape: Social and environmental justice." *Built Environment* 16, no.3 (1990): 232-236.

Andrews, Gavin J. "Health geographies II: The posthuman turn." *Progress in Human Geography*, online first.

Bergson, Henri. *The Two Sources of Morality and Religion*. Notre Dame: University of Notre Dame Press, 1980.

Bergson, Henri. *Matter and Memory*. New York: Zone, 1991

Bergson, Henri. *Creative Evolution*. Mineola, NY: Dover, 1998

Brown, Steven D. "Psychology and the art of living." *Theory & Psychology* 11, no.2 (2001): 171-192.

Brown, Steven D. and Paula Reavey, "Institutional Forgetting/Forgetting Institutions: Space and memory in secure forensic psychiatric care." In *Institutions INC*, edited by Elke Weik and Peter Walgenbach, 7-29. Basingstoke: Palgrave, 2015.

Brown, Steven D. and Paula Reavey, *Vital Memory and Affect: Living with a difficult past*. London: Routledge, 2015.

Brown, Steven D., Paula Reavey, Ava Kanyeredzi and Richard Batty, R. "Transformations of self and sexuality: psychiatric inpatients accounts of sexuality and relationships." *Health* 18, (2014): 240-260.

Conradson, David "Spaces of care in the city: the place of a community drop-in centre." *Social & Cultural Geography* 4, no.4 (2003): 507-525.

Conradson, David "Landscape, care and the relational self: Therapeutic encounters in rural England." *Health & Place* 11, no.4 (2005): 337-348.

Cromby, John, David Harper and Paula Reavey *Psychology, Mental Health and Distress.* Basingstoke: Palgrave Macmillan, 2013.

Curtis, Sarah *Space, Place and Mental Health*. Farnham: Ashgate, 2010

Deleuze, Gilles and Felix Guattari *A Thousand Plateaus: Capitalism and Schizophrenia*. London: Athlone, 1988

Dillon, Jacqui "Just saying it as it is: Names matter, Language matters, truth matters." *Journal of Critical Psychology, Counselling and Psychotherapy*. (2013)

Duff, Cameron "Exploring the role of enabling places in promoting recovery from mental illness: A qualitative test of a relational model." *Health & Place* 18, no.6 (2012): 1388-1395.

Duff, Cameron *Assemblages of Health: Deleuze's Empiricism and the Ethology of Life*. Dordrecht: Springer, 2014

Froese, Tom and Thomas Fuchs "The extended body: A case study in the neurophenomenology of social interaction." *Phenomenology and the Cognitive Sciences* 11 (2012): 205–36.

Fuchs, Thomas "The Phenomenology of Affectivity." In *Oxford Handbook of Philosophy and Psychiatry*, edited by K.W.M. Fulford, Martin Davies, Richard G.T. Gipps, George Graham, John Z. Sadler, Giovanni Stanghellini and Tim Thornton, 612-631. Oxford: Oxford University Press, 2013.

Gesler, Wilbert M. "Therapeutic Landscapes: Medical Issues in Light of the New Cultural Geography." *Social Science and Medicine* 34, no.7 (1992): 735–746.

Gesler, Wilbert M. "Lourdes: Healing in a place of pilgrimage." *Health and Place* 2 no.2 (1996): 95-105

Gesler, Wilbert M. "Bath's reputation as a healing place." In *Putting Health into Place: Landscape, Identity and Wellbeing*, edited by Robin Kearns and Wilbert M. Gesler. New York: Syracuse University Press, 2012.

Greco, Monica "On the Vitality of Vitalism." *Theory, Culture & Society* 22, no.1 (2005): 15-27.

Guattari, Felix *The Three Ecologies*. London: Athlone, 2000.

Gumbrecht, Hans Ulrich *Atmosphere, Mood, Stimmung: On the Hidden Potential of Literature*. Stanford: Stanford University Press, 2012.

Heidegger, Martin *Being and Time*. Oxford: Blackwell, 1962.

Herzog, Thomas and Patrick Bosley "Tranquility and preference as affective qualities of natural environments." *Journal of Environmental Psychology* 12 (1992): 111-117.

Jack, Gordon "The role of place attachments in wellbeing." In *Wellbeing and Place*, edited by Sarah Atkinson, Sara Fuller and Joe Painter, 89-104. London: Routledge, 2012.

Kanyeredzi, Ava, Steven D. Brown, Laura McGrath, Paula Reavey and Ian Tucker "The atmosphere of the ward: Attunements and attachments of everyday life for patients on a medium-secure forensic psychiatric unit." *The Sociological Review* 67, no.2 (2019): 444-446.

Massey, Doreen *For Space*. London: Sage, 2010

McGrath, Laura and Paula Reavey ""Zip me up, and cool me down": Molar narratives and molecular intensities in 'helicopter' mental health services." *Health & Place* 38, (2012): 61-69.

McGrath, Laura and Paula Reavey "Introduction." In *The Handbook of Mental Health and Space*, edited by Laura McGrath and Paula Reavey, 1-36. London: Routledge, 2018.

Moon, Graham, Robin Kearns and Alan Joseph *The Afterlives of the Psychiatric Asylum: Recycling concepts, sites and memories*. Farnham: Ashgate, 2015.

Morita, E., S. Fukuda, J. Nagano, N. Hamajima,H. Yamamoto, Y. Iwai, T. Nakashima, H. Ohira and T. Shirakawa, T. "Psychological effects of forest environments on healthy adults: Shinrin-yoku (forest-air bathing, walking) as a possible method of stress reduction." *Public Health* 121, no.1 (2007): 54-63.

Reavey, Paula, Steven D. Brown, Ava Kanyeredzi, Laura McGrath and Ian Tucker "Agents and spectres: Life space on a medium secure forensic psychiatric unit." *Social Science and Medicine* 220 (2019): 273-282.

Reavey, Paula, Jason Poole, Richard Corrigall, Toby Zundel, Sarah Byford, Mandy Sarhane, Eric Taylor, John Ivens and Dennis Ougrin "The Ward as Emotional Ecology: Adolescent experiences of managing emotional distress in inpatient settings." *Health & Place 46*, (2017): 210-218.

Ratcliffe, Matthew "Existential feeling and psychopathology." *Philosophy, Psychiatry, & Psychology* 16, (2009): 179–94.

Sebald, W.G. *Austerlitz*. London: Penguin, 2011.

Smith, Leslie-Ann and Ian Tucker ""Mad, Bad and Dangerous to Know": The pervasive socio-medical and spatial coding of mental health day centres." *Emotion, Space & Society* 14, (2015): 3-9.

Stern Daniel N. *The Interpersonal World of the Infant: A View from Psychoanalysis and Developmental Psychology: A View from Psychoanalysis and Development Psycholog*y. London: Routledge, 1985.

Stern, Daniel N. *Forms of Vitality: Exploring Dynamic Experience in Psychology, the Arts, Psychotherapy and Development*. Oxford: Oxford University Press, 2010.

Tucker, Ian "Mental health service user territories: Enacting 'safe spaces' in the community." *Health* 14, no.4 (2010): 434–448.

Tucker, Ian, Steven D. Brown, Ava Kanyeredzi, Laura McGrath, and Paula Reavey "Living 'in between' outside and inside: The forensic psychiatric unit as an impermanent assemblage." *Health and Place* 55, (2019): 29-36

Wise, J. McGregor "Home: Territory and Identity." *Cultural Studies* 14, no.2 (2010): 295–310.

World Health Organization *Mental health action plan 2013-2020*. Geneva: WHO, 2013.

Worms, Frederic *Bergson ou les deux sens de la vie*. Paris: PUF Press, 2013

Worms, Frederic "A critical vitalism." *Espirit* 1 (2015): 15-29

Worms, F. "The life in matter and memory." Presentation to Rebooting Matter and Memory, 9th International Colloquium of Project Bergson in Japan, Toyko, 2017.

Notes

[1] Brown et al "Transformations"

[2] WHO *Action Plan*

[3] Cromby et al *Mental health*

[4] McGrath and Reavey "Introduction"

[5] Bergson *Matter and Memory*; *Creative Evolution*

[6] Stern *Vitality*, 3

[7] Stern *Interpersonal World*, 140

[8] Fuchs "Affectivity", 613

[9] see Ratcliffe "Existential feeling"

[10] Heidegger *Being and Time*

[11] Fuchs "Affectivity", 615

[12] Gumbrecht *Atmosphere*

[13] Fuchs "Affectivity", 621

[14] Fuchs and Froese "Extended body"

[15] Fuchs "Affectivity"

[16] Worms *Bergson*

[17] Worms "Critical vitalism"

[18] Greco "Vitality"

[19] Worms "Life in matter and memory"

[20] Bergson *Creative Evolution*

[21] Bergson *Two Sources*

[22] Worms "Life in matter and memory"

[23] Worms "Life in matter and memory", 4

[24] Gesler "Therapeutic landscapes"

[25] Morita et al "Forest environments"

[26] Gesler "Lourdes"

[27] Herzog and Bosley "Tranquility and preference"

[28] Gesler, "Bath's reputation"

[29] Jack "Place attachments"

[30] Moon et al *Afterlives*

[31] Agyeman "Black people in a white landscape"

[32] Sebald *Austerlitz*

[33] Duff *Assemblages of Health*

[34] Deleuze and Guattari *A Thousand Plateaus*

[35] see also Andrews "Health geographies II"

[36] Wise 2000 "Home"

[37] Brown and Reavey "Institutional forgetting"

[38] Duff *Assemblages of Health*

[39] Brown "Art of living"

[40] Guattari *Three Ecologies*

[41] Duff *Assemblages of Health*, 52

[42] Duff "Enabling places"

[43] see also Conradson "landscape" on 'relational selves')

[44] Brown et al "Transformations"

[45] Reavey et al "Agents and spectres"

[46] Tucker et al "Living in between"

[47] Kanyeredzi et al "Atmosphere of the ward"

[48] see Curtis *Space*

[49] see Reavey et al "Agents and spectres"

[50] Reavey et al "Emotional ecology"

[51] Tucker "Territories"

[52] Conradson "Spaces of care"

[53] Smith and Tucker "Mad, bad"

[54] McGrath and Reavey "Zip me up"

[55] Duff *Assemblages of Health*

56 see Tucker "Territories"

57 Duff *Assemblages of Health*

58 see Cromby et al *Mental Health*

59 Dillon "Just saying"

60 see Massey *For Space*

61 see Brown & Reavey, *Vital Memory* and Reavey et al "Agents and spectres" on

'life space')