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## Seeking fluid possibility and solid ground: Space and movement in mental health service users' experiences of 'crisis'

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Since the closure of the UK asylums, ‘the community’ has become short hand for describing a variety of disparate, and complex spaces, in which service users manage their experiences of distress. An examination of such spaces here forms the basis of an analysis of the way in which service users move through and within space, to establish agency and dis/order while distressed. Seventeen participants, with various experiences of mental distress took part in a qualitative study, and a further textual analysis was conducted on eight published autobiographies. In the context of the interviews, participants presented drawings of the spaces they occupy during times of crisis, wellbeing and recovery. All texts were analysed using a thematic approach, informed by theories of embodiment and relational space. In this paper, two key patterns of movement have been focused on, in order to explore ways in which participants experiencing various forms of mental health crisis used space in order to maintain and manage feelings of agency. Firstly, incidents where participants described moving towards fluid, outside spaces have been explored, with agency being established through seeking, and utilising, greater possibilities for action and engaging others. In addition, the opposite pattern of movement has also been explored, using incidents where participants described moving indoors, in these cases tending to use the private space of the home to establish order and restore feelings of agency and strength, in contrast to overwhelming experiences in public space. Connections between these patterns of movement and particular forms of distress are discussed. It is argued that community and private spaces are integral to the ways in which selfhood, agency and action is experienced in mental distress, which in turn has implications for policy, treatment and community action.

## **1. Spaces of mental health crisis and care.**

One of the flurry of new policies produced by the UK Coalition Government in the wake of their election in 2010, was a new strategy for mental health services, armed with the strident title: “No Health Without Mental Health’ (D.H., 2011). Three ‘guiding principles’ are outlined in this document, consisting of: “Freedom”, discussed mainly in terms of greater service user choice; “Fairness”, under which the well-documented (e.g., Fernando, 2010) inequalities in mental health services are acknowledged; and “Responsibility”, which emphasises the importance of ‘social connections’, valued social roles and ‘cohesive communities’ in promoting good mental health (p. 2-3). The rights and wrongs of these principles for mental health services are not what we wish to discuss here. Instead, we want to draw attention to the sheer number of people, organisations, and places which are included in a strategy for a single area of policy and service provision, mental health services. Included here in the treatment of mental health problems are, essentially, everyone, located, more-or-less, everywhere. This is stated explicitly at the beginning of the policy: “Mental health is everyone’s business - individuals, families, employers, educators, and communities all need to play their part” (p 5).

Compare this all-encompassing vision to the shape of the UK mental health system of thirty or more years ago, which primarily consisted of large, out of town institutions built to house and treat those diagnosed with mental health problems (e.g., Goffman, 1961). The scope of mental health services was, for the most part, limited to these concrete, easily defined places, with little professional support offered outside of the asylum. Here, the institution embodied the mental system. The nearest contemporary incarnation of these institutions, the acute psychiatric ward, by contrast, is barely mentioned in ‘No Health Without Mental Health’ (D.H., 2011). Where it is mentioned, one of the main aims put forward for the ward is in: “avoiding hospital admissions through effective ... community care and ensuring that hospital inpatient care itself is effective and that unnecessarily long stays are avoided” (p. 65). From being the embodiment of the system, it seems that the hospital is now reduced to a slightly embarrassing after thought; necessary, but to be avoided if at all possible.

Of the huge spectrum of experiences which can be encompassed by the term ‘mental health problem’, therefore, only a very few will therefore now lead to, or be managed in the context of, institutional admission. Indeed, while inpatient admissions for people with ‘psychotic’ diagnoses have remained stable, the fall in admissions of people with other diagnoses, such as depression and dementia, accounted for a 29% overall reduction in available beds between 1996 and 2006 (Keown, Mercer & Scott, 2008). Much of the time, when people experience their most extreme, overwhelming states of distress or madness (often referred to as ‘crisis’, see below), they are, therefore, not located in environments specifically designed to accommodate or treat them. Instead, they are located in the same places as other people not having these experiences, which are also places which they themselves occupy, when in less extreme states. No wonder mental health is now ‘everyone’s business’.

This paper will hence examine how service users experience and use these expanded spaces of mental health care, when experiencing their most extreme states of distress and madness, drawing on empirical accounts of UK service users' experiences. The many consequences of this seismic shift in the lives of service users, their families, employers, and their wider communities, have indeed been widely discussed by both academics and activists. The greater freedom of service users to live lives not wholly defined by their experiences of distress and status as a ‘patient’ has been rightly celebrated (Beresford, 2000; 2012; Campbell, 1996a; S.C.M.H., 2001), especially alongside the extraordinary achievements of service user activists in gaining visibility, power and influence within and beyond the mental health system (Campbell, 1996a, Cromby, Harper & Reavey, 2013).

Along with these benefits, have come, however, new problems (Curtis, 2010; Estroff, 1981; Knowles, 2000a). As one of the participants in our study commented: “they forgot to tell the community [who] weren’t expecting people to suddenly turn up with really complex problems and behaviour that’s sometimes bizarre” (Julie, l. 721-723). While service users may have been moved from ‘stigmatised’ institutions to ‘normalised’ community spaces, the experiences and behaviours which lead to a mental health diagnosis, as well as the label itself, are still far from being normalised and accepted (Rapley, Moncrieff & Dillon, 2011; Wallcraft, 2001). This issue has been captured in a large body of literature looking at service users’ everyday experiences of stigma (Newnes, Holmes & Dunn, 1999; 2001). Corker et al (2013), for instance, report that in 2011, 88% of surveyed service users reported

experiencing direct discrimination. Phelan, Steuve, & Pescosolido (2000) found that people in 1996 were twice as likely to describe a service user as violent and dangerous than in 1955, despite no rise in violent offences. One aspect of living, and experiencing distress, in distributed community spaces, therefore, could be increased exposure to everyday stigma.

## **1.2 Placing distress in the community: public, private, and pure spaces.**

A further set of researchers, particularly those influenced by human geography, have also examined the detail of the location of these experiences of being included and excluded, across the multitude of spaces which service users now occupy (Knowles, 2000a; 2000b; Parr, 1997; 2008; Davidson, 2000a; 2000b; 2001; 2003; Pinfold, 2000). A key theme we wish to highlight here is that public space is often cited as particularly problematic for service users. Parr (1997), for instance, noted that behaviour indicating distress (such as shouting; crying) invited more notice and censure in the street, than in a mental health drop in service. Pinfold (2000) also found that the service users she interviewed tended to have a few 'safe havens', such as their homes and friend's houses, in which they spent the majority of their time, avoiding more difficult public spaces. Similar arguments have been made by research with people diagnosed with agoraphobia (Davidson, 2000a; 2000b; 2001; 2003) and our own research with people diagnosed with anxiety disorders (McGrath, Reavey & Brown, 2008). In both studies, participants described retreating to the home: in an attempt to stabilise experiences of insecure bodily boundaries (Davidson, 2000b; 2001; 2003); and as a reaction to feeling that public spaces were hostile (McGrath et al, 2008). Knowles (2000a), furthermore, looked at homeless people experiencing distress, arguing that they were not welcome in the public spaces they had to occupy during the day, having to forge out 'nooks and crannies' (Estroff, 1981) where they could remain relatively invisible. One example of this practice was the habit of sitting in convenience food outlets, for several hours; in these places they were still insecure occupants, however, and were ejected if they made themselves visible, for instance through talking to other customers, or shouting (Knowles, 2000a; 2001).

A number of researchers have drawn on purity metaphors to explain the makeup of public space in ways which help to inform these findings. David Sibley (1995) argued that public spaces are

'purified' of people who display or signify difference; Hodgetts, Radley, Chamberlain & Hodgetts (2007) similarly argue that homeless people are seen to "infect, spoil or taint" (p. 722) the purity of public spaces, while Dixon, Levine & McAuley (2006) argue that dislocating behaviour which is seen as properly 'private' into public space can be seen as "transgressing the moral geography of everyday behaviour" (pg. 197). The use of purity metaphors recalls Mary Douglas' (1961) classic text 'Purity and Danger', in which she argues, looking across multiple societies, that those objects, people or behaviours which are conceptualised as 'dirty', 'dangerous' or 'impure' are generally those which disrupt or trouble whichever order has been constructed by that society; she argues that order is constructed to create purity, and purity to maintain order. These authors seem to be arguing that stigmatised groups in society, including mental health service users (Link, Cullen, Struening, Shrout & Dohrenwend, 1989; Scheff, 1974, 1999), are placed in this role, of symbolic 'dirt', in the sense of "matter out of place" (James, 1901, p. 129; cited in Douglas, 1961) when in public spaces; key here is the idea that people who display difference, such as the distress observed by Parr (1997), can disrupt the usual, or more precisely ideal, spatial order of society (see also Curtis, 2010).

### **1.3 Social psychology and the material: Space and subjectivity**

These studies exploring the spatial location of distress, can be seen as allied to a resurgence of interest, in social psychology, to a consideration of the material grounding of the self (e.g., Brown, 2012, Brown & Stenner, 2009; Burkitt, 1999; Cromby & Nightingale, 1999; Cromby, 2004; McGrath, 2012; Reavey, 2010; Tucker, 2010). Drawing on these approaches, we here take the view that psychological experience is spatially distributed, in the sense that different self-identifications can emerge in and across settings, rather than understanding the self as being composed of its own fixed, determinate properties, which then move, relatively untouched, through different spaces. One key assumption underlying this approach is that 'the self' must be seen as a matter of process, rather than substance; of becoming rather than being. As Foucault (2000) wrote:

*It [the self] is not a substance. It is a form, and this form is not primarily or always identical to itself. You do not have the same sort of relationship to yourself when you constitute yourself as a political subject who goes to vote or speaks at a meeting and when you are seeking to*

*fulfil your desires in a sexual relationship. Undoubtedly there are relationships and interferences between these different forms of subject; but we are not dealing with the same type of subject (p. 290-1).*

It is here argued that the participation of the material environment (space; objects) is part of this process, whereby a person multiply constitutes themselves across and within different settings. The self is hence understood as multiply realised across a variety of spatial locations (e.g., at home, at work, in the pub) and that the spaces we occupy and the objects that surround us participate in the constitution of self at any given time (Latour, 2005; Reavey & Brown, 2009; Brown & Reavey, 2014). It is important to emphasise that space here is also not conceptualised as static (Massey, 1994), or determinate (Reavey, 2010); spaces in themselves are not fixed, but also shift over time, due to changes in human relations. The breakup of a family can also lead to the dispersal of a family home; socio-economic shifts have led to the re-appropriation of industrial buildings as homes and leisure spaces in the centres of post-industrial cities like Manchester. It is therefore crucial to maintain a relational model of space, human activity and experience, each seen as mutually constituting the other.

It is this relational aspect of space and experience that we wish to flesh out in the analysis of the data presented here, considering the context of service users' experiences of managing crises in the community. In the context of the continued retraction of residential facilities in contemporary mental health services (Pilgrim & Ramon, 2009), this paper will in particular consider the experience of being in states of intense distress, or 'crisis', when these are not experienced in institutional spaces. 'Crisis' is a widely used term, which has been variously defined (James & Gilliland, 2013). In this context, it is used to describe the most intense and overwhelming phase of experiences of mental distress and/or madness; often where someone's usual problem solving and coping strategies break down (Brammer, 1985; Caplan, 1961; 1964; Poland & McCormick, 1999), involving acute emotional distress, severe disruptions to usual behaviour patterns and experiences, and often including a feeling of loss of control (Belkin, 1984; Hoff, Hallisey & Hoff, 2009). This translates as times when experiences of distress or madness become un-manageable or overwhelming, to the extent that these experiences seriously disrupt everyday living, working and relationships, or crucially for contemporary services,

pose a risk of harm to self or others. In the UK, this kind of experience is formally separated out from ongoing mental health problems, as can be seen in the institution of separate crisis teams in community mental health care, who respond specifically to these kinds of situations. As discussed above, psychiatric wards are also now mainly reserved for this kind of acute, intense, 'mental health emergency' (Mind, 2011; DH, 2014), rather than ongoing rehabilitation. Crisis care has been raised as a key area for improvement in the NHS by both service users and policy makers (Mind, 2011; DH, 2014). This paper will therefore examine the detail of where service users go when they are in these kinds of states, and why they choose these places, when given, if not unlimited, at least more numerous, options.

## **2. The study**

The material analysed below was collected for a broader project looking at the role of space in service users' experiences (McGrath, 2012; McGrath & Reavey, 2013). Two sets of data were collected. Firstly, 17 current UK service users were interviewed using visual methods: participants were asked to draw one map of the places they went to as part of service use, and another of non-service use places. Participants were asked to explain their drawings, as well as to rank in each place in terms of how much they liked being there, and explain their reasons. This was the bulk of the interview, and was then followed up with more general questions such as 'where do you go when you are most distressed?' (a question which prompted much of the material for this particular paper).

This approach drew on the tradition of 'participatory mapping', widely used in geographical and development research, which is interested in exploring subjective experiences of places (e.g., Chambers, 1994; Herlihy & Knapp, 2003; Herlihy, 2003; Lynch, 1960; White & Pettit, 2008). In using visual material, we also drew on a growing interest over the past fifteen years, across the social sciences, on analysing and using images in research (Knowles & Sweetman, 2004; Prosser, 1998; Reavey, 2011; Rose, 2001). Two main claims were of interest here. Firstly, that using visual material is better at prompting participants to discuss the settings and context of their experiences, as visual materials are organised spatially, rather than temporally (see, Bolton, Pole & Mizen, 2001; Gabb, 2009; Knowles, 2000a; 2000b; Knowles & Sweetman, 2004; Radley & Taylor, 2003; Reavey, 2011).



Secondly, that ‘multi-modal’ methods can help participants to articulate aspects of experience which are hard to put into words, as has been established by work investigating embodied experiences (e.g. Bowes-Catton, Barker & Richards, 2011; Brown, Reavey, Cromby, Harper & Johnson, 2008; 2011; Del Busso, 2009; Gillies, Harden, Johnson, Reavey, Strange & Willig, 2004; 2005). Both of these claims held; the interview discussions included many detailed descriptions of places and specific details of how the participants felt there, which were not as apparent in the two interviews where the participants declined to draw.

The research was approved by the ethics committee at London South Bank University. Participants were recruited through service user networks, UK voluntary sector organisations (online and posters in centres), and snowballing and so they were from differing parts of England. Most participants lived in London, but also some lived the North West, as well as around the South Coast. Participants were not recruited on the basis of any particular diagnostic category. Instead, participants were sought who had the shared spatial experience of currently accessing community mental health services. One reason for this choice was that we are persuaded by the arguments against the capacity of diagnostic categories to meaningfully describe and distinguish between forms of distress and madness (Campbell, 2007a; Bentall, 2003; 2006, 2007; Boyle 1990; 2007; May, 2007), and so were aiming to take specific, located and embodied experiences as our focus instead (see, Cromby, Harper & Reavey, 2013; Johnstone & Dallos, 2006). Most participants did however volunteer diagnostic information as part of the interview. Eight were currently diagnosed with Bi-polar Disorder and six with Clinical Depression. Of the three participants who did not reveal their diagnosis two described psychosis-like experiences. This strategy of course had some downsides. The participants were a self-selecting group, and so by virtue of being actively interested in taking part in research potentially separate themselves from other groups of service users, as has been noted before (Cannon, Higginbotham & Leung, 1991). The participants were all white, for instance. Five participants were employed full time, one part time and two on a regular freelance basis. Of the remaining participants who were not in paid employment, one was a full time student, another a full time mother with a child under one, five engaged in at least part time voluntary work, and one was retired. Fourteen participants lived in their own home (either owned or rented), two in mental health supported housing and

one in supported housing for physically disabled people. The participants were evenly balanced in gender, and ranged in age from 25-67. Nine participants lived alone, seven with family and one in a shared house with friends. This recruitment strategy also meant that there was variety in the participants' experiences of mental health and the mental health system. About half (9 out of 17) of the participants had experiences of acute psychiatric wards, and the rest only of community services. The length of time participants had been accessing services also ranged widely, from one year, to over 40 years, meaning some participants had experiences of asylums, while others only of community care.

The second kind of empirical material analysed was a set of eight published autobiographical accounts by service users, accessed from a specialist mental health publisher: Chipmunka Publishing. Chipmunka is a highly prolific publishing house, so the search was narrowed by selecting narratives which were from the UK, and had been published within a similar time period as the interviews were conducted (2007-9), and were descriptions of experience, rather than political or reflective works. The autobiographies collected were all published as e-books, and were not professionally edited. All of the chosen autobiographies included descriptions of inpatient admissions, as well as detailed descriptions of experiences of distress and madness in the community. Diagnoses described by the authors included: bipolar disorder (Gilmour, 2007); schizophrenia (McIntyre, 2007; Scally, 2007; Allen, 2005; Sutton, 2007; Black, 2008); and schizo-affective disorder (Black, 2008; Sutton, 2007; Knight, 2007). Most of the authors did, to some extent, agree with their diagnosis, although Allen (2005) completely rejected this understanding of her experiences. The autobiographies all covered multiple years of the author's lives, some from childhood to the present day, while others focused on the years they had experienced mental health problems. Nearly all were broadly structured as a 'healing narrative' (Adame & Hornstein, 2006), presenting their distress/madness as a thing of the past from which they were now recovered. This structure may have been encouraged by the campaigning focus of Chipmunka, which explicitly aims to combat stigma. More pertinently, however, this mean that these accounts were not, in contrast to the interviews, mainly produced by current mental health service users.

### **2.3 Analytical approach**

The interviews were transcribed and collated in Nvivo, along with scanned copies of participants' drawings, and electronic copies of the autobiographies. The three types of data were analysed together, as a 'multimodal' analysis (Boden & Eatough, 2014; Reavey, 2012). The drawings were primarily understood as prompts which helped to elicit accounts focused on space, and hence given meaning by the participant in the context of the interview, rather than treated as data to be analysed independently (Prosser, 1998; Rose, 2001; Reavey, 2012). Hence there are no drawings in the data presented below although they were central to the research design. The two datasets (interviews and autobiographies) were analysed together as a form of 'methodological triangulation' (Denzin, 1978). These data sets were collected to complement each other, and to help compensate for the limitations of the other. The interviews had the advantage of being specifically focused on experiences of space, rather than other aspects of experience. Often noted limitations of interviews, however, is that they tend to be a 'snapshot' encounter (Knowles & Sweetman, 2004; Rose, 2001), and are defined by the interaction between researcher and participant (Kvale, 2006). The autobiographies, in contrast, were far more long term in focus, covering many years of experiences, and were produced outside the research process (although, of course, still within their own specific context, here an explicitly political mental health publisher). The most pertinent example of these differences for this paper, was that more prominent in the autobiographies, and almost absent from the interviews, were detailed, rich descriptions of the content of experiences of madness and distress, and, particularly strikingly, the content of 'psychotic' experiences: voices, visions, and unusual beliefs. In the interviews, the content of distress and/or madness were rarely described; participants tended instead to use generalised phrases, such as "crisis" (Bryan, l. 78), "if I'm distressed" (Julie, l. 438), or "when very I'm low" (Janet, l. 316). The language of 'crisis' or 'distress' seemed to act as an easily shared shorthand between the participants and myself, whilst, on reflection, actually sidestepping in-depth descriptions of these experiences. It was in part this discrepancy between the accounts which led to focusing on experiences of crisis for this paper.

Initially, the material (interviews, drawings and autobiographies) was organised into spatial categories, separating those experiences described as located in the psychiatric ward, community services, and community living, in line with the structure of the interviews. As a second stage, we created four ‘analytical directives’, which guided further reading of the material, all of which were designed to explore the overall research question of the role of space in service users’ experiences. These were: a) what kind of space is being conjured?; b) what are the objects within these spaces contributing to the action, interaction and emotions described?; (c) what else is interacting with space in driving the action described?; and (d) how are the experiences described interdependent with space? After notating and coding the material with these questions in mind, the data was re-organised into themes, as well as considered in the light of literature which could help to contextualise the analysis. This process bears most resemblance to a thematic analysis (Braun & Clarke, 2006), in particular one of a more ‘theoretical’ and ‘latent’ persuasion (rather than ‘inductive’ and ‘semantic’).

To guide the analysis theoretically, we identified key theoretical assumptions which underlay the ways the data was approached in this project. These were: a) spaces are understood as dynamic and productive, rather than being merely a static backdrop for people’s interactions and experiences (influenced by human geography theory, particularly Doreen Massey, 1994); b) objects are understood as potentially meaningful ‘participants’ (Latour, 2005) in experiences, both in terms of having been made meaningful by people and within culture, and also being actively used by people when constructing the meaning of their ongoing experiences in the world (Latour, 2005; Serres, 2000; Brown, 2001; 2010; Reavey, 2010; Cromby, 2004; Burkitt, 1999). These theoretical interests meant that we were focussed, when reading the data, on the material aspects of the accounts provided by participants, as well being convinced that these material aspects were psychologically important.

### **3. Analysis**

Of the multitude of experiences which could be covered by the term ‘crisis’ which were referred to in the accounts gathered for this research, we have here focused on two key uses of space recounted by participants. We have defined as ‘crisis’ either those experiences explicitly described in this way

by participants, or looked at episodes which describe acute experiences where usual functioning was disrupted, in line with the definition of crisis given above. In the autobiographies, these tended to be episodes which precipitated contact with mental health services. It is important to note that the incidents focused on here are not definitive descriptions of the full range of experiences of crisis, or indeed even of the entirety of the experiences described by each participant. They are instead taken as potentially illuminating cases which highlight the complex and manifold relationships between space, distress and movement. The first set of accounts here focus on instances where participants described going out of the house when experiencing crisis. These tended to also be participants and authors who described experiences such as hearing voices, visions, intensely elevated mood, and/or unusual belief systems, which would often lead to a psychotic diagnosis. It is not, however, the case that all participants with these experiences described this pattern of movement, but this analysis will focus on the incidents when psychotic experiences *was* paired with a movement outdoors, and examine the reasons why this kind of experience and pattern of movement might go together. The second set of accounts are those where participants describe instead moving inside, to the home. These tended to be participants who described experiences of intense worry or prolonged low mood, which tend to lead to diagnoses of depression and/or anxiety disorders. These categories are not intended to be prescriptive, but instead are ways to explore how particular experiences of distress and madness might intersect with particular patterns of movement and uses of space. There were participants and authors who described differing practices than those outlined below, so this analysis is also not intended to be exhaustive, but illustrative. These experiences have been considered together to also illustrate how these seemingly opposing sets of behaviour (out or in) can be seen as being driven by similar concerns: of finding space to breathe, stretch out, in relation to overwhelming and oppressive experiences, and to seek feelings of improved agency and safety.

### **3.1 Seeking fluid possibility: Agency and movement in outside space.**

One striking aspect of the many of the descriptions of psychotic ‘crisis’, in both sets of data, was how active these experiences often were. Madness is often described as a metaphorical or emotional ‘journey’ (e.g., Laing, 1960), but multiple participants here described physical, literal journeys, describing

their periods of 'crisis' or 'high' as often being ones where they were out of the house, actively engaging others, travelling across towns, cities and countryside. While we do not wish to make the claim that movement outside is a necessary outcome of psychotic experiences, which are of course hugely heterogenous in nature (Bentall, 2003; Romme, Escher, Dillon, Corstens & Morris, 2009) this was still behaviour which was described with striking regularity. Jimmy, author of 'I Thought I Was the King of Scotland' (2008), for instance, described one such period of 'high'. This episode was described as being prompted by discovering that someone he had considered a friend ('he' in the first sentence) had, in the past, spiked Jimmy's drink, precipitating his second stay on a psychiatric ward:

*I got on my bike with my baseball bat down my coat I had no intention of using it but I knew he was my enemy and I just wanted to scare him so he would leave me alone [...] I got off my bike and made my way through the shop floor with the baseball bat still in my coat. I thought I was Grant Mitchell he was in the canteen I shouted him and let him see the baseball bat [...] He didn't say a word he looked scared and I felt that I had scared him off for good [...] I went and had my haircut (sic) really short then went into a shop and brought a suit and an orange tie [...] tried my suit on I thought I was Grant Mitchell. I went out that night to The Boot for a drink I had my new suit, shoes and sunglasses on. I sat on the stool at the bar drinking my pint and my best friend came in [...] he didn't recognise me. I said you have known me for eight years and I kicked his stool and it scared him. I went into the toilets where I saw another one of my close friends and I asked him if he had slept with my key worker [...] I said that I would forgive him and walked out. I felt so good about myself as the highs had started to kick in (p. 30).*

Jimmy's 'high' here seems characterised by restless energy, movement and action. Far from only an internal 'journey', he recruits multiple sets of people, objects and spaces into his 'high', as he takes on the persona of a symbol of aggressive masculinity, Grant Mitchell, from the British soap opera, EastEnders. Fuelling his adoption of the Grant Mitchell persona can be seen to be the need Jimmy feels to intimidate his former friend, arguably a move which helps Jimmy to regain feelings of agency, strength and masculinity, in the face of his friend's betrayal of trust, as well as Jimmy's loss of status amongst their mutual friends due to his admission to hospital. Central to his experiences here is active

movement through space, as he engages others, and seems to feel a sense of mastering the various environments he enters. The everyday spaces of his community here seem to be transformed into a game-like, ludic space, where Jimmy is able to play with, embody and perform a strengthened and empowered version of his masculinity. It is crucial to note here that Jimmy's experience of this 'ludic' relational space is layered on top of the everyday geography of the canteen, the pub and the street. Jimmy still knows exactly where he is, he has not completely 'lost contact with reality', as psychotic experiences are often characterised. Instead perhaps it is more accurate to say that his 'inner' symbolic, relational world has spilt out, augmenting his experience of external 'reality', and driving his multiple, fluid encounters with people and spaces.

Bryan, an interview participant, also commented that an urge to be outside, and be active, was a common part of his experience:

*looking back over over a period of years my tendency is to go out to be walking to be quite to be quite feeling I've I've got to be moving and not being in one place as a sort of anxiety maybe and a sort of claustrophobia type thing I mean I know I know a few years ago I was when I was having crises I I would have this very strong feeling that I that it it say late in the evening that I've got to go out and at the same time I would kind of know that its not a good cos I'd but this kind of claustrophobic feeling is kind of I've got to I've gotta get out of my flat I've got to go somewhere I've got to do something um and usually that wins out (l. 446 - 454).*

Bryan's description of wanting to be 'moving ... not in one place' can be seen as reflected in the multiple encounters described by Jimmy, above, where he is never present in one space for long, but instead constantly moving onto the next place and set of people. Bryan here also describes this movement outside as being prompted, in part, by a feeling of enclosure at home ('claustrophobia'). His home here it seems to take on an oppressive, containing, quality, which he describes needing to break out from. Julie also commented that she tended to go out into the 'open air' (l. 449), as:

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

Julie's home here seems to take on a similar enclosing quality that Bryan describes. Julie describes her home as leading to 'going into yourself', describing a static, claustrophobic experience of self which can exacerbate rather than relieve her distress ('that's when I'll overdose'). Rather than the range of possibilities Bryan hints at as being available in other spaces ('go somewhere, do something'), Julie's description of her home seems to offer only one possibility: collapse. Compare this to Jimmy's experiences above, where his experience of self is far more dynamic, active and agentic. Part of this feeling of agency did seem to be located in Jimmy's ability to playfully master the different environments he can access and encounter out of the house; once at home, after the same incident, he describes a very different experience of the same 'high':

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

Rather than filled with aggressive, dynamic agency, Jimmy instead here describes being over-powered, crouching under his window. The window here concretises the relationship between outside and inside, between his self and the world (Reavey & Brown, 2009). Bound up in the experiences which Jimmy and Julie here describe seems to be a complex net of shifting power dynamics, which are difficult to locate in any one particular space, or set of relations. Power relations have been argued to be central to structuring experiences of both voice hearing (Romme & Escher, 1993; Haywood, 2003; Jackson, Haywood & Cooke, 2011) and unusual beliefs (Bullimore, 2012; Cromby & Harper, 2005; Harper, 2011), to the extent that therapeutic approaches have been developed to encourage voice hearers to develop more equitable, mutual dialogues with their voices (Romme & Escher, 2000; Romme et al, 2009; Vaughan & Fowler, 2004). Here, a more static, enclosed experience of self is promoted by being in the private, hidden space of the home, as opposed to the more fluid, dynamic, active nature of being out in the world, doing things, seems to promote, for these participants, a more



powerless position in relation to their distress. Michael, the author of 'Angels, Cleopatra and Psychosis' (2009), gave a particularly evocative description of this phenomenon. He described a particular night, when he started at home, describing terrifying experiences in his house:

*The next few hours were terrifying and are hard to describe. Darkness somehow fell almost immediately that day or seemed to, and by the evening I knew I was effectively living in Hell. It was still June in 1994, and the lights in the house still worked of course, but didn't seem to make any difference to how dark it was. [...] The invisible Cardinal's [a malignant spirit] presence was everywhere. I could move around the house, but the spirits of Leonardo da Vinci and Michelangelo [good spirits] were still stuck in my office-bedroom, so I was on my own (p. 27).*

Michael describes his home here as being transformed into a battleground between good and evil, personified by the good spirits of Michelangelo and Leonardo da Vinci, and the malignant spirit of the Cardinal. Michael also described extended encounters with the devil, God, and the four horsemen of the apocalypse, all located in his flat. In his home, he is barricaded in, attacked from all sides, and trapped. He then decides to leave:

*Henry [his dog] was right. I got the feeling he was telling me that going out into York on such a night was at least as safe as staying in the house, and after the experiences I'd been through, I entirely agreed. So that's what I did. I took Henry for a walk round York at 3am (p. 32). I also decided not to look backwards as Henry and I walked along a row of terraced houses opposite the railway line because I very quickly realised that I had the Devil on my tail. I could hear his breathing, I could almost hear his footprints. I half wanted to know if he really was red, or whether he glowed in the dark, but there was no way I was going to be so stupid as to look backwards and find out. Henry and I would stay on our walk until the morning came, because I simply assumed that come sunlight my nightmare would be over, at least for one day at least, and then I could talk to Leonardo and Michelangelo again (p. 33).*

Michael, in a similar way to Julie, above, seems to describe here a changed relationship with the spirits which plague him. Once outside, able to move agentically, to stride forwards through space, rather than being trapped in his home, he describes being able to outrun the Devil, to both literally

and metaphorically keep at bay the worst of his experiences. His decision to walk his dog at 3am, which could easily be characterised as a symptom of his 'illness', is a self-protective move, helping to disperse the intensity of his experiences, by giving himself a larger playing field, of all of York, over which his ongoing battle between good and evil can stretch out.

The experiences described here have several implications. First is perhaps the relations drawn between self, world and distress; here, experiences of the self, 'crisis' and 'distress' are thoroughly embodied and situated, with divergent experiences of self, distress and madness emerging as these service users describe moving through a variety of spaces and engaging in multiple actions. Understandings of the self as a process of becoming, rather than a static, unified entity (Foucault, 2000; Reavey, 2010; Brown & Reavey, 2014) are therefore crucial to understanding the experiences of 'crisis' here being described. The path 'crisis' takes is far from inevitable (Johnson & Fincham, 2008), or determined purely by individualised, static 'symptoms' (see Cromby et al, 2013); instead crises unfold as part of a complex interplay between personal experience, space, embodied movement, as well as relations with others and the material world. For this reason, we also need to make clear that we are not arguing here for a schematic that, in psychosis, inside is always bad and outside is always good. Instead, we wish to highlight that movement into outside space appears to open up new zones of fluid possibility, which can be seen often to have benefits, potentially of de-centring, stretching out, and dispersing some of the burgeoning intensity of experience and expansive symbolic relationality which can characterise a 'psychotic crisis'.

If movement outside is hence seen a relatively positive move for many in this state, then it is worth noting that outside, public space is also precisely where people in states of visible distress are often least welcome (Parr, 1997; Philo, 1997; Knowles, 2001; McGrath, Reavey & Brown, 2008; Moon, 2000; Foucault, 1965; Wolch & Philo, 2000). As Bryan commented: "and so that part of the reason why I quite often have been picked up by the police in public places because basically that kind of drive to to be out" (l. 456). Julie described her solution to this dilemma:

*if I'm distressed sometimes I will actually surface in the grounds of the psychiatric hospital because it's safe [...] the ward wouldn't feel safe to me [...] but actually being in the grounds*

*in sense has a sense of safety in that I know there are people sort of around that understand me which I don't feel like if I went into town I wouldn't feel anything like that [...] the other thing I do is I just go out into the countryside yeah cos from here I can kind of wander out over the fields and stuff we're right on the edge so I can just be straight out into the countryside [...] so open air (l. 438 – 451).*

Julie here outlines a dilemma between different forms of 'safety'; her static, enclosed home is unsafe for the reasons outlined above, but the different kinds of outside space are not equal either. In the grounds of the psychiatric hospital, she is within a space officially allocated for the expression of distress, rendering her experiences less likely to be noticed or censured (Parr, 1997), but still not enclosed in the oppressive space of the ward (Bowers et al, 2009; McGrath & Reavey, 2013). The countryside, on the other hand, is relatively devoid of people, and so again, less likely to lead to problematic encounters, but still give a sense of fluid possibility and expansion. Julie describes a complex landscape which she has to negotiate, to find a balance between the open fluidity of outside space, and protection from the harm that the greater exposure to the world can potentially attract.

### **3.2 Seeking solid ground: Order and safety in the home.**

Instead of seeking fluidity and possibility outside, there were also many accounts where participants described the opposite movement when intensely distressed, of retreating indoors, particularly to the home. These tended to be participants who described 'depressed' and/or 'anxious' experiences (which are of course, not mutually exclusive from the psychotic experiences described above, see: Bentall, 2003; Cromby, Harper & Reavey, 2013). When describing these particular experiences of intense worry or sadness, in line with the research described above (Parr, 1997; Davidson, 2000a; 2000b; 2001; 2003; McGrath et al, 2008; Pinfold 2000) participants also often described public spaces as being particularly uncomfortable places to be when they were distressed; as being a place they wanted to escape from, rather than to:

*I don't like shops when I'm very low because I get quite agitated [...] I start to panic and not be able to breathe I have to get out there doesn't even need to be that many people just a*

*normal amount of people and I can't bear it I feel stifled and panicked you know. (Janet, l. 345 - 349).*

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

Here Janet and Lou discuss feeling that the experience of being in a state of “anxiety” or “feeling low” can be exacerbated by being in these particular, ‘populated spaces’ (Davidson, 2003). Both talk about a feeling of “panic” or being “stifled” as being prompted through their presence in these “exposed” public spaces. Note these experiences are described by Janet as occurring over and above an underlying experience of “feeling low”; these are heightened experiences emergent in these particular places. Janet, indeed elsewhere commented that “I’ll go pretty much anywhere when I’m feeling ok” (l. 373). It appears that location in populated, public spaces, argued to be ‘purified’ of difference and distress (Dixon et al, 2006; Hodgetts et al, 2007; Sibley, 1995; Parr, 1997), here augment ongoing experiences of distress, experiences which seem to render the participants to feel ‘out of place’, or discordant, to the expected ‘rational’, non-distressed norms of the space. This can be seen in Lou’s description of where she is most likely to feel distressed:

*it matters sort of where you are as well like if you're in an environment [...] where you just feel like you know I feel like it wouldn't matter if I had a moment um I generally am more relaxed so I tend to not get distressed so I sort of gravitate towards those places (l. 678 - 683).*

As well as Zoe’s comment encapsulating her experience of the “moral geography” (Dixon et al, 2006) of distress being a private, hidden experience, and discomfort caused when potentially flaunting that norm:

*I always feel a lot more safe it it feels like its safer to be anxious and depressed in a room where other people can't really look at. (l. 137- 138).*

Perhaps unsurprisingly, those participants who talked about populated spaces as problematic, in this way, seemed to also often describe their homes as places of safety and sanctuary:

*[It's] my space [...] you come home to your own space and to your safe place (Zoe, l. 258-60)*

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

'Safety' and 'sanctuary' re-occurred when participants described their homes in particular, and private spaces more generally. These words imply positive aspects of the home space, as contained and comforting, of course, but also that these spaces offer an escape from something explicitly hostile (Harding, 2014); sanctuary is, after all, only necessary when fleeing from external dangers. Part of this 'sanctuary' seemed to be that home space offered an escape from potential social censure and surveillance (Saunders & Williams, 1988); as Lou put it: 'I think part of it is not being judged [...] I don't wanna have to explain why I'm crying non-stop. (l. 702 - 709). Compared to the pressure to conform in public space (Goffman, 1963), described above, an association of home as a private space for self expression and hidden emotion (Elias, 1978; Curtis, 2010; Mallet, 2004; Morley, 2000) can be seen to render the experience of being a person experiencing extreme distress less problematic and uncomfortable for these participants, in these particular spaces. The idea that populated or open spaces can offer a zone of possibility, where distress can be dispersed or stretched beyond the self, here is not experienced (or anticipated) positively. Being opened up to outside forces, here is described as being felt as less, rather than more stable. Instead being 'inside' 'the home' creates a more stable and concordant experience of both their distress, and their wider sense of self (see, Davidson, 2003).

That distress can be seen as more concordant, or fitting, with home space, can be seen in this comment by Zoe:

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

The 'freedom' described here by Zoe can be seen to be freedom from social surveillance, and the restrictions of public space (Saunders & Williams, 1988). Her home space is described as facilitating the expression of the "extremes of the low", or crisis. Experiences of distress can be seen therefore, to be more allowable, and therefore more comfortable for these participants to experience, in home space, than in more populated, public spaces.

The other aspect of home space which seemed to facilitate it being a 'sanctuary' for certain participants, was described as participants' ability to materially order the spaces and objects of their homes (see Belk, 1988), as well as to actively manage and limit their interactions with others (Harding, 2014). As Rachel said:

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

Rachel here describes herself in a position of agency in the home, from where she can 'choose who to seek out', rather than having to more passively react to the fluid unpredictability of potential social encounters in public space. Zoe also commented that:

*at my house if someone came round and I was really down I probably would have a cry that's because it's my house and I can and it's not putting anybody out so if they've come round to see me and I happen to burst into tears well that's tough cos you've come to my house (l. 429-431).*

Again here, the status of the home as a place for unfolding the private self (Mallet, 2004), seems to place Zoe in an agentic position. Rather than having to suppress, hide or monitor her behaviour, the source of the augmented distress described above, at home she instead feels able to express her distress ('have a cry') in front of others.

In addition to these aspects of the home, enabling some participants to actively direct, rather than passively react to, their social interactions, participants also described the ability to order the objects and spaces of their homes as central to the creation of a feeling of home as a safe place of 'sanctuary'. As Rachel commented:

*[it] does make quite a difference to your sense of wellbeing and how you're able to relax at home and things and also just remove yourself from like we've now got a room like a spare room where we can just dump everything that we don't want to see (laughs) like like household bills and all of that rather than rather than living with it (l. 389-394)*

*the problem [with our old bedroom] was all of our stuff was in there all of our bills and everything [...] [in the new bedroom] I've completely forbidden John my husband from putting any of his work related stuff in there and it's just a real and again we've wallpapered the back the back wall ourselves and painted it and it just feels it feels [...] clear. (l. 365-380).*

Julia Twigg (2000) argues the privacy of the home: “rests on a material affordance... the ability to shut the door on the outside world” (p. 384). For, Rachel, here, this observation seems to extend to within the home as well, as the ‘material affordance’ of a second bedroom is described as enabling her to ‘shut the door’ on external responsibility, here ‘contained’ (Reavey & Brown, 2009) by the material objects of the bills and ‘work stuff’. This action of placing a physical barrier between one’s self and the world, in the context of feeling swamped by the judgement of the world in populated spaces, can also be seen to allow enough room for Rachel to expand in relation to the world, to breathe and stretch out. The described actions of tending to the bedroom, wallpapering and painting it, actively excluding any external influences, have created a ‘clear’, calm, still space, ready for sleep. The importance of ordering material objects in creating a space as ‘home’, can also be seen strongly in Lou’s description, below, of her approach to living in her supported housing accommodation:

*my kitchen stuff [...] I've got quite a lot of really good stuff it's all in boxes and it sits in this corner of my room just in a stack of boxes and [...] I just I don't want that part of me to settle in this house [...] I don't want to be in the kitchen I don't want to make it my space [...] I need to keep it a temporary thing like I don't want to still be there in two years time I want to keep it really temporary and therefore I'm not willing to settle in and [...] I'm not going to unpack my kitchen stuff and use it [...] I don't wanna invest any emotion in it because it's it's it's only temporary and it's because it's an institution because somebody has to look after me (l. 190-230).*

Lou here describes resisting the implication that her supported housing accommodation is a 'home', and its related implication that she will be a long-term service user. She does this by resisting materially investing in the space, firstly through not engaging in everyday domestic practices as well as through the ordering of objects in her room, leaving her kitchen utensils firmly packed away, waiting for a permanent home. By implication, therefore, the everyday routines and practices of domestic life can be seen as part of what helps produce 'home' as a permanent, stable space, echoing Serres' (1995) claim that objects 'stabilise' our social relationships (Brown & Stenner, 2009; Reavey & Brown, 2009). Bryan also commented on this aspect of home:

*I think having my flat right is important I mean I really like coming in here and I've got all my books set out exactly how I want them [...] I try and keep to routines and that it's when I start losing my routine that I start getting stressed and having things just right (laughs) and keeping them just right in the flat is important (l. 477 – 496).*

Bryan here comments on the relationship between routine and order in his flat, within the enclosed, controllable space of home, and a wider sense of routine, in life; maintaining order in his flat is here linked to maintaining equilibrium in his mental health as well. Bryan, of course, was a participant who described having to 'get out' of his flat when in crisis, and so this particular example again underlines the importance of considering the experiences described here as specific interactions between space and experience, rather than seeing, for instance, calmness, sanctuary or restlessness as being inherent properties of either the space, or the person. When not 'in crisis' therefore, Bryan describes his home as comforting, rather than constraining; routine is here calming, rather than oppressive.

Stability, routine and order, therefore, can be seen to be key features of home space which contributed to feelings of 'sanctuary' in the home, as well as having the agency to "shut the door" (Twigg, 2000, p. 384) on external surveillance. Whereas those in the midst of a burgeoning, expansive experience of psychotic 'crisis' seemed to often find the enclosure and stasis of their home stifling and oppressive, the participants discussed in this section mainly described the same places as offering relief. Both sets of participants can be seen to be actively seeking the same thing, however: an oppor-



tunity to stretch out, breathe and feel a sense of relief from their experiences of distress and/or madness. Part of these anxious or depressed experiences seemed to be a sense of also being particularly porous to the demands, and the exclusionary norms, of public and populated spaces (Davidson, 2003; Goffman, 1963; Sibley, 1995; McGrath et al, 2008; Parr, 1997). The fluidity and unpredictability of public space, far from providing the escape of 'open air' as with participants in the first section, was hence rendered overwhelming, stifling, and de-stabilising, requiring a retreat to the solid ground of the home.

#### **4. Space, mental health crises and community care.**

For both of these, loosely assembled, patterns of movement and experience, it is clear from the analysis presented above that material setting was a central part of the unfolding and ongoing management of their experiences of crisis. Threaded through the accounts presented here was concern with agency. Whether the accounts described seeking action and adventure in the fluid possibility of outside space, or safety and security in the static, enclosed space of the home, we have here argued that they were often seeking a position of greater agency, and equanimity, in relation to their experiences. Several examples of behaviour emerged here which could be interpreted as a further 'symptom' of an 'illness', such as retreating to the home, or walking a dog at 3am, but which when seen in the context of the specific, located experiences of distress can be re-formulated here as moves to modulate intense experiences of distress and madness.

Whilst both sets of participants examined here can be understood as having equally valid, and strikingly similar, reasons for their use of space when experiencing 'crisis', the responses described to these uses of space were notably less equal. Those who described heading out into the world, as mentioned above, were also far more likely to describe being detained and sectioned via encounters with the police. Indeed, police powers to detain people under the Mental Health Act (Section 136) are most commonly on people with diagnoses of schizophrenia, mania and personality disorders (Borschmann, Gillard, Turner, Chambers & O'Brian, 2010); the first two categories in particular can be seen to encompass the kinds of experiences which might involve movement outside, as explored above.

Arguably, those people most in need of the capacity to engage in the fluid possibilities offered by outside space, therefore, are also those most likely to end up, by consequence, in the most static and oppressive spaces of them all: a police cell and/or a psychiatric ward. Contemporary psychiatric wards have been argued to be characterized by surveillance, increasingly likely to be locked, and often chaotic (Bowers et al, 2005; 2006; 2009; Quirk & Lelliot, 2001; Quirk, 2002; Quirk, Lelliot & Seale, 2006; McGrath & Reavey, 2013). In addition, service user activists have long highlighted the problems of using of police cells to detain people under the Mental Health Act (e.g., Campbell, 1996b), and the experiences recounted above can add further weight to this argument. Beyond any humanitarian concerns, participants here described explicit dangers of being in enclosed, static spaces when experiencing particular forms of distress and/or madness. These points bear similarity to those who have pointed out the intensifying effects of sensory deprivation on psychotic experiences (e.g., Grassian & Friedman, 1986), certainly a danger in a stark police cell, or secluded in a psychiatric ward. We similarly here argue that static and enclosed spaces, offering little capacity for movement, action or engagement with others can be particularly, and potentially dangerously, oppressive and destructive for those in the midst of certain forms of psychotic experiences. With this in mind, the definition of a 'place of safety' suitable for detention under the Mental Health Act (usually a cell or a ward) needs to be thoroughly re-thought; for people having the kinds of experiences described above, contained and bare spaces are amongst the least 'safe' places possible (see also Campbell, 1996a; 1996b). Of course, containment is driven by other concerns, namely perceived potential risks to either the detainee or others (R.C.H, 2008), but these could perhaps be better balanced with the provision of spaces which provide the capacity for action, interaction and movement; which enable experiences of fluid agency rather than static passivity. Existing international and UK based alternatives to hospital care, such as Soteria (Mosher, Menn & Matthew, 1975; Mosher, 1999), and crisis houses, which are rated more highly by service users (Mind, 2014) offer a potential model here.

Contained and secure spaces, could potentially offer a more appropriate space for those participants who described seeking sanctuary, seclusion and order when experiencing crisis. This might be especially true of those service users who do not have homes which provide sanctuary, or in which they do not have the agency to create and order the space as they wish; many people, of course,

experience oppression, abuse and exclusion in their homes (Wardaugh, 1998; Sibley, 1995). Yet institutional space provided for those with diagnoses of anxiety and/or depression has fallen, both in terms of inpatient beds (Keown, Mercer & Scott, 2008) and in the reduction of day centre facilities (Pilgrim & Ramon, 2009). In addition, those service use spaces which remain often place service users in positions of passivity (McGrath & Reavey, 2013), rather than providing the potential for a renewal of feelings of agency central to the experiences discussed by our participants. It can be seen from these examples that discussing uses of space can be a useful part of crisis care planning, including discussions of different kinds of 'safe space' which can be sought during crisis.

This paper has examined the role of space in service users' experiences of 'crisis' in the community, finding a complex interplay between space and experience lead participants to seek out those spaces which most helpfully mediated their experiences of distress and madness. Demonstrating the importance of attending to the spatial, temporal and personal specificity of experience, action and movement in the community, these findings also point out limitations in current provision of spaces for mental health crises. The major kinds of institutional space provided can be seen as directly opposed to the way in which service users themselves modulate and moderate their experiences of distress and madness.

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