‘Hopeful Adaptation’ in Health Geographies: seeking health and wellbeing in times of adversity.

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Abstract

Living with adversity can create wide-ranging challenges for people's health and wellbeing. This adversity may arise through personal embodied difference (e.g. acquiring a brain injury or losing mobility in older age) as well as wider structural relations that shape a person’s capacity to adapt. A number of dichotomies have dominated our understanding of how people engage with health and wellbeing practices in their lives, from classifying behaviours as harmful/health-enabling, to understanding the self as being defined before/after illness. This paper critically interrogates a number of these dichotomies and proposes the concept of ‘hopeful adaptation’ to understand the myriad, often non-linear ways that people seek and find health and wellbeing in spite of adversity. We highlight the transformative potential in these adaptive practices, rather than solely focusing on how people persist and absorb adversity. The paper outlines an agenda for a health geography of hopeful adaptation, introducing a collection of papers that examine varied forms of adaptation in people's everyday struggles to find health and wellbeing whilst living with and challenging adversity.

Key words:

Support; welfare; community; health-enabling; wellbeing; care; hope

Introduction

Adapting to adversity has (re)emerged as a defining theme in the early 21st Century in the Global North. With global politics becoming more hostile and guarded, and a seeming carte blanche acceptance of advanced neoliberalism in Western industrialised nations, there has been a growing sense of precarity and uncertainty in the role of public institutions in people's lives (Hall et al, 2013). Many of the values of solidarity and tolerance that for a time seemed more guaranteed in Anglo-American countries have also been eroded, prompting some to decry the dissolution of liberal governance (Speed and Mannion, 2017). Ideologically-driven decisions to pursue austerity have transformed the landscape of public institutions over the last decade with a ferocious agenda of public sector cuts, particularly across Western Europe, prompting accounts of a post-welfare crisis (DeVerteuil, 2015; Power and Hall, 2018).

While the above political context is neither entirely bleak nor complete in its geographic reach, it has nonetheless prompted much debate over how best society can respond, with equally vocal calls for public protest (Harvey, 2012) and resilience (DeVerteuil, 2015). Many protest movements (e.g. London, Dublin, Athens, Madrid) have articulated the point that austerity is a political choice of government, and one that can be countered (Nolan and Featherstone, 2015). Some academics have sought a middle ground between protest and coping to try and reclaim the terms of debate underpinning these trends in a more progressive fashion (Geddes 2014; Newman, 2014). Featherstone et al. (2012) for example has offered a way to engage with austerity localism by proposing the concept of 'progressive localism' to capture how individuals and communities can establish place-based organising tactics that shape localisms in contested and solidaristic ways around emergent agendas for social justice.

In health geography, there have been efforts to examine more nuanced, personal and experiential accounts of how and where people seek and/or find health and wellbeing within or in spite of austerity. The focus of this paper is to introduce a special issue that brings together a collection of cutting-edge papers from geographers that explore the different avenues by which people seek to sustain a sense of health and wellbeing despite myriad struggles and challenging life journeys. In each case, peoples' diverse adaptive strategies are examined. The contributors to the collection each presented at a Geographies of Health and Wellbeing Research Group sponsored session entitled 'Reconceptualising spaces of health and wellbeing through nexus thinking' at the Royal Geographical Society (with IBG) Annual Conference 2016.

To place the collection in context, this paper seeks to critically interrogate the very idea of adapting to adversity and to outline an agenda for health geographers working in this field. We seek to *adopt* critical perspectives to interrogate the spaces, places and relations that people situate themselves within to 'adapt'. We propose the concept of 'hopeful adaptation' which we outline below. Whilst engaging primarily with people living with ill-health, older age and disability, our arguments speak to the concerns of individuals and groups facing broader forms of adversity, who may experience different types of ruptures in their lives, such as being incarcerated in prison. Understanding the spaces and 'tactics' that are used offers critical health geographers important lessons about how people encounter and weave together different relational, affective and material assemblages to deal with and/or transform adversity.

Much health geography work has examined how people develop what might be considered health-*compromising* behaviours to cope with adversity. Examples include smoking (Pearce, Barnett, and Moon, 2011), excessive alcohol consumption (Shortt et al. 2018), and obesogenic

diets (Thompson et al., 2012). There may also be experiences that curtail people's proclivity to seek and find better health. Adverse moments may arise through living with the individual effects and social barriers associated with physical and mental ill-health and disability, as well as those living in particularly challenging environments, including deprived inner-city neighbourhoods (Davidson, Kitzinger and Hunt, 2006) or institutionalised facilities and spaces of incarceration (Moran, 2015). These myriad situations can present challenging physical, social and relational barriers to people's health and wellbeing, with people's responses offering an important reminder of the tensions within coping strategies that support an immediate sense of wellbeing (or at least release or escapism) whilst compromising one's physical health in the longer-term (Wood et al., 2013).

The spaces through which people seek health has been an on-going theme explored in *Social Science & Medicine,* typically under the rubric of healing, therapeutic and health-enabling places (for example, see Bell et al., 2018 for a recent review). These include spaces of social cohesion occupied, created or even 'self-built' by individuals to cultivate social wellbeing and feelings of inclusion. Examples include so-called 'blue' spaces such as coastal environments (Foley and Kistemann, 2015), 'green' spaces such as parks, woodlands and community gardens (Bell et al. 2015; Plane and Klodawksky, 2013; Laws, 2009), men's sheds (Milligan et al., 2015) and community-based heritage groups (Power and Smyth, 2016).

Yet, while a growing literature examines these health-enabling spaces and adaptive behaviours considered as 'harmful' (as an outcome), less evident has been work that focuses on forms of *hopeful* adaptation (as a process) when living with adversity. By adversity, we refer to particular (often extraordinary) embodied and emplaced circumstances in people's lives that cause pain, disruption, exhaustion, disorientation, loneliness, and grief. People's corporeal being and their states of mind (being content, grateful, hopeful, driven) can be

altered by an illness, accident or stage in the lifecourse. These experiences cross-cut with wider structural challenges that can disrupt people's local adaptive potential, such as austerity-driven cutbacks to a person's support (e.g. benefit reform in the UK forcing disabled people to attend work capability assessments in an effort to reduce welfare expenditure; see Grover 2017). Here, relations of adversity are manifest, 'made', and come into being through the shifting places that people (may be forced to) use, occupy, abandon and shape, for example via social, affective and material relations at home, in the community, and at a cultural/political level. Such emplaced experiences of adversity are encountered through both individual *embodied* changes/difference and through multi-scalar *relations* with others. This understanding of the experience of adversity allows us to better appreciate how we are socio-economically situated or even marginalised through those relations in a way that may overshadow experiences of hope.

Our focus here is on how these relations coalesce as part of an assemblage to shape how individuals develop and negotiate new routines and strategies to reverse or counter adversity, and to (re)discover a sense of wellbeing – or health-in-adversity – in their everyday lives. We would argue that the process of seeking better health *and* performing practices that are deemed health-compromising are not necessary mutually exclusive. Indeed, these lines are often blurred. Recovery and rehabilitation is a complex, non-linear emergent process; health is made in the moment (see for example Duff, 2017). People may aspire towards personal goals, yet 'fall off the wagon' and repeatedly seek to remedy these moments and 'correct' their chosen path. One commonality in this journeying, as Andrews (2018a) suggests, is that hope almost always arises for people more or less and in some form, even in adversity. Understanding where, for health geographers, largely depends on their theoretical orientation. Most scholars see hope as residing in an endpoint; spatial scientists and political

economists, for example, recognise hope as a resource allocation that might mean a service is provided for those in need where once it was not; humanists and social constructionists may recognise hope as residing in a place or personal state reached and experienced. An increasing number of scholars however recognise that hope has a prior quality; an immediacy that envelops the journey itself. Post-humanists and non-representational theorists, for example, see hope emerging in new possibility and potential, and in the affective feeling of bodies acting and moving forwards (Andrews, 2018a, b).

Our coining of the term 'hopeful adaptation' here emphasises the transformative nature of people's efforts to respond to adversity. Understood in this way, hopeful adaptation recognises people's capacity or ability to act, to create something new and forge alternative life trajectories rather than simply withstanding or tolerating change. In using the term adapting, we do not advocate more of the damaging neoliberal agenda that has placed responsibility to absorb structural shocks with the individual. Rather, we highlight in this special issue how the ability to create new routines and forge new 'lines of flight' (a term developed by Deleuze and Guattari, 1987) can be profoundly transformative. With this focus, we are interested in understanding how and why assemblages characterised by adversity become otherwise, how they are reconfigured to generate moments and experiences of hope – again at individual, community, or even larger scales – and how such opportunities for hopeful adaptation can best be nurtured and supported.

We begin with a critical examination of the concept of adaptation to adverse situations and contexts, before proposing a call to action for the future of health and wellbeing research that challenges scholars to move toward a broader engagement with people in unique forms of adversity. To inform the underpinnings of the concept of hopeful adaptation, we urge health geographers to re-think several dichotomies that have diluted understandings of how people

adapt through performing myriad health and wellbeing practices in their lives. We then provide an outline of the papers in this collection, followed by a conclusion.

Outlining an agenda for a health geography of 'hopeful adaptation' to adversity

This section seeks to outline an agenda for conceptual engagement with the practices and spaces of hopeful adaptation and to challenge broader socio-cultural narratives of what it means to be well. By drawing on people's experiences of *adapting* to adversity, we aim to animate alternative narratives of health and illness that might challenge existing norms and practices and open up new nexuses of health and wellbeing to geographic and other enquiry. Such an approach speaks to the transformative capacity inherent in many of the practices that people employ to seek and/or find health and wellbeing, beyond passive persistence and inertia.

Our understanding of hopeful adaptation begins with a link to Klein et al.'s (2003) concept of 'adaptive capacity' which characterises the underlying conditions and processes that enable not just the capacity to cope with change, but also people's ability to learn, experiment, and foster innovative solutions in complex social-ecological circumstances. A person's adaptive capacity, Klein et al. argue, is determined by the range of resources (technical, financial, social, institutional, political) held individually, and collectively by a community. Place actively shapes people's adaptive capacity in terms of the social processes, infrastructure and institutions through which these resources are mediated (i.e. governance). Klein et al. are primarily concerned with how countries may enhance their adaptive capacity. At this scale,

enhancement of adaptive capacity includes, for example, improving education, health care, and income distribution.

To take this idea further and to help understand the spaces of adaptation that individuals occupy when experiencing adversity, Fox (2011) and Duff (2014) propose assemblage theory, which captures the networks of biological, psychological and sociocultural relations that surround bodies during ill-health. Deriving from the work of Deleuze and Guattari (1987), their focus is not upon what a body is but upon its relations and its capacities to affect and be affected. According to Fox (2011: 360), 'this approach decentres the biological aspects of embodiment, while retaining biology and physicality as a (necessary but not privileged) component of the body'. Experiences of health and illness can be understood as arising within assemblages of relationships and connectivities that may incorporate other bodies (caregivers, neighbours, peers), inanimate objects (tablets, ramps), technology (telecare, online support applications) and ideas (care advice, health guidelines) (for a review of these components of assemblages, as articulated by health geography research to date, see Andrews, 2018b). For human beings, our potential relations are more complicated (but the dynamic remains the same) because of the extent and diversity of networks, our self-aware reflexivity, and our capacity for complex social organisation, economics, politics and culture (Fox, 2011). Ultimately Fox's and Duff's point is that humans develop broad (and highly individualised) capacities to affect and be affected by the myriad relations shaping ill-health.

People's 'journeys' into ill-health – which are often compounded by challenging structural relations – can be caused by dynamic, unpredictable changes and encounters/events that compromise the material, affective and social foundations of people's sense of self, identity and wellbeing over time (Duff, 2014; Andrews, 2018b). This has been identified, for example, in the case of chronic illness onset, where Charmaz (1983: 168) talks about how people

'experience a crumbling away of their former self-images without simultaneous development of equally valued new ones.' Similarly, Goffman (1968) describes the 'stripping' of identity, whereby a person's identity becomes redefined by the onset of illness, and their subsequent occupation of new socio-cultural settings linked to that illness (e.g. hospitals, hospices, rehabilitation centres). For many, this is further compounded by a necessary withdrawal from settings that were previously valued (e.g. sites of work, leisure etc.).

Fox (2002) however rejects the idea of a prior, 'interior' self: a self to be 'lost' through such experiences. Rather he contends that a person's embodied self from the outset is always dynamically in flux and is subject to continually being imprinted through its history; as such, he argues that the body-self is 'not the passive outcome of "inscription", but a dynamic, reflexive, "reading" of the social by an active, experimenting, motivated human being' (p. 360). Most people's practices are more akin to 'adapting to health', understood here as a more fluid, on-going process of 'health in the making'. For example, a new environmental risk to health may catalyse a change in the daily practice of an individual living in the affected area. Even if such relative moments are rapid or extreme, they rarely (perhaps never) result in an *absolute* shift in a person's self-hood, instead occurring as part of an on-going process of self-in-the-making over time. With this understanding of self, it is possible to remain open to exploring how and where hopeful adaptation can potentially emerge.

Fox acknowledges that for some people, being a 'patient' or receiving care is an experience that can close possibilities, creating a body-self trammelled by dependency. In some people's journeys, having become unwell, there is no becoming left to do or hope to find, especially if one's material, social and affective resources are highly constrained. In extreme cases, singularity of purpose leads not to the beyond, but to death. Fox's take-home message though is that the locus for understanding the body-self is on the continual confluence of relations, as

these relations together establish what the body can do. To illustrate this latter point, recent scholarship from Duff (2017) turns our attention to the varied places and relational *atmospheres* that support homeless peoples' experiences of health-in-the-making despite their societal exclusion.

Perhaps the converse of health-in-the-making can be found in the literature around social-relational models of disability (Thomas, 2007). Whilst life with impairment may not constitute adversity in itself, the ways in which our societal relations are structured – physically and socially – can act to restrict or disable people who necessarily negotiate through the world in alternative ways because of embodied difference (Thomas, 2007). In this way, new sources of adversity arise, not as a direct result of being impaired, but through the dominance of detrimental socio-cultural attitudes that devalue and fail to recognise the agency of bodies of difference. There is then an intermeshing of the impairment effect with the effects of disablism in the shaping of a person's experience of health and wellness.

More affirmative models are apparent amongst communities that adopt positive identities of, for example, Deafness where Deaf people resist labels of impairment or disability, arguing that the Deaf style of perception and communication is no less skilled or 'able' than those of people who rely on hearing. Recognising this, Hall and Wilton (2017: 729) advocate 'opportunities to think differently about how *all* bodies become dis/abled in and through their everyday geographies and how such becomings might be made otherwise'. We build on this here, calling for more understanding of how all bodies may seek to find moments of *health* in – and in spite of – complex *adverse* everyday relations and how such adverse becomings might be made otherwise. Whilst this requires hopeful adaptation at an individual embodied level, it also requires larger-scale structural transformations; reshaping dominant narratives about

whose bodies matter, what health is, and how it should be enacted in the complex and shifting circumstances of contemporary society.

This is important since people's strategies of 'adapting' are inherently bio-psycho-social; they are *socially contingent* in a materialist sense. That is, in Western societies today, there is a certain socio-cultural 'vocabulary' of strategies that are pre-conceived, promoted and made more readily available, alongside certain technologies and support models that augment people's ability to transform their everyday routines accordingly. At the same time, other behaviours or practices are demonised by state legislation and political institutions as unhealthy or transgressive, implicitly accusing participating bodies of neglecting their moral roles as responsible 'biological citizens' (Little, 2015). Power and Bartlett (2018) have added that these 'vocabularies' are also *spatially contingent*. People's homes, neighbourhoods and local urban or rural settings all shape how people can use different tactics to adapt. We should thus be attuned to the broader roles of space and place in shaping people's adaptive potential, and the degree to which different people are able or inclined to engage reflexively with such widespread social and spatial vocabularies in their everyday lives.

Taken together, this work points to the transformative potential in the process of hopeful adaptation to adversity – albeit being socially and spatially contingent. This potential is a point that DeVerteuil (2015) makes in his critical reclaiming of the term 'resilience'. While we hold a similar level of scepticism with this term, we nonetheless recognise that DeVerteuil's efforts to mobilise and reclaim it are warranted and can be fruitful. DeVerteuil's argument is that resilience is not just about *holding on* to previously hard-won gains, but as the basis for challenging the status quo and *holding out* for incremental change. Here, resilience is potentially more than just 'bouncing back' to a similar or original position as before or as solely 'persisting'. Rather he argues that acts of resilience impart a sense of adaptive capacity,

a pro-activity and potential for learning and finding new trajectories. That said, we remain cautious of the term resilience, as a deeper question emerges of how much adversity we should absorb before we resist and fight for more fundamental transformative changes at a structural level. DeVerteuil's argument that people cannot undertake transformative structural change without a resilient base has merit. We would add hope as another fundamental element that catalyses people towards seeking change and reaching out to broader social and political movements that aim to transform policy frameworks.

We argue that geographic research into people's strategies to adapt to adversity must continue to pursue such theoretical advances, through empirical work that listens to and respects the agency employed in developing such strategies. We are wary about claiming to 'fill voids' in the literature, given the small sub-discipline that exists within health geography. Rather, we seek to encourage health geographers to transcend disciplinary boundaries and reach out to other theoretical perspectives including Non-(or Post-)Representational Theory, new-materialities, post-(or more-than-)humanism, performative and sensory geography, material culture studies, processual thinking, vitalism and so on. The following section, which outlines the papers in the collection, provides some examples of these different theoretical engagements.

Introducing the Special Issue

In this Special Issue, we bring together a collection of eight papers from leading geographic scholars that explore the different avenues by which people negotiate adversity. It brings together papers that explore the improvisation of diverse 'tactics' as people seek out new embodied competences, reflexive self-awareness, supportive social relations (human and

otherwise, on and offline), and emplaced materialities to navigate the myriad challenges they encounter on a day-to-day basis.

Given the focus on personal and relational geographical accounts of people's lives, work in this field has typically drawn on qualitative methods. Such studies have typically involved in-depth (often biographical) interviews and participant observation with participants to understand their experiential personal accounts. Efforts have also been made to conduct *in-situ* and mobile interviews, as people move through and experience particular spaces and relational encounters.

The first paper by Gorman (current volume) critically examines how geographers engage with the very idea of 'health'. By drawing on the insights of a qualitative study of 'care farming' within England and Wales, he takes a more-than-representational approach to consider how health is afforded by human-animal relations. From here, the collection includes a series of papers that look at people's experiences of ill-health and examines how these experiences can close down everyday geographies. Yet, each paper also identifies the strategies used to adapt to such experiences, including challenging dominant narratives that do not recognise the intricacies of life with ill-health.

The second and third paper in the collection (Andrews; Meijering, current volume), both consider how existing engagement by human geographers with the brain can be extended by also considering physical brain abnormalities and Acquired Brain Injuries (ABI), which are amongst the most common causes of disability and death in adults worldwide. Andrews' paper examines how people living with a structural alteration known as Type I Chiari Malformation must (re-)negotiate home space, social space and medical space - emphasizing supportive and challenging aspects of each, as well as meaningful and affective qualities to

encounters. Meijering further expands on the experience of living with an ABI, by examining how ABI survivors and their families renegotiate their engagements with everyday places after rehabilitation. Meanwhile, the fourth paper (Boyle, current volume), investigates how people attempt to adapt to, negotiate and manage everyday life with social anxiety. It introduces a socio-spatial dynamic to otherwise extremely limited accounts of social anxiety found outside of the dominant biomedical framework.

In a similar way, the fifth paper (Ireland et al., current volume) seeks to draw spatial insights into the field of psychosocial-oncology, broadening its scope of enquiry. The paper examines volunteer-led walking groups for women with breast cancer, and explores how adaptation to cancer is mobilised through a therapeutic assemblage of walking, talking and place. It points to the vitality of place in both the process of adaptation to illness through movement and the development of walking group interventions to support recovery and rehabilitation. Whilst recognising the importance and benefits of walking and moving in the context of ill-health and recovery, the sixth paper (Phoenix and Bell, current volume) highlights the risks of increasingly pervasive, yet uncritical, health promotion messages that encourage people to 'Move More', regardless of embodied and relational changes people may be experiencing in mid and later life. They explore the subtle patterns and tempos that frame physical activity in mid and later life and recognise the moments that call for slowness and stillness rather than speed or motion. In line with this focus on how people adapt to unfolding changes with age, the seventh paper (Power and Bartlett, current volume), examines the relationships that middle to older age adults with learning disabilities have with remaining kin, friends, and neighbours within the context of declining formal day services and austerity-derived cutbacks in social care. The findings raise the possibility of a 'care desert' to convey a space of attenuated care that is shaped by increasingly limited fronts from which support can be derived. Nonetheless,

they argue that occupying such a space is not entirely bleak, as the participants still demonstrate some forms of adaptive potential in finding moments of inclusion and social encounter.

The eighth and final contribution to this special issue (Moran and Turner, current volume) moves away from a focus on ageing to consider how incarceration too limits possibilities to health, but like the papers above, it points to the way that people can still find ways to experience health and wellbeing within lives characterised by adversity. The paper examines whether the health-enabling capacities of nature contact can be cultivated in prison. They argue that access to nature can generate the same health-enabling effects in custody as are recognised elsewhere.

Conclusion

During the stages of production for this Special Issue, we were reminded of the extent and depths of adaptive capacity that flow within and between people, and the range of different decisions and practices that people engage with to govern and make sense of their lives when facing adversity. Importantly, people's embodied and emplaced experiences of adversity do not weave a uniform tale of cutbacks and 'getting by'. Rather, it is also a tale of hope; of regaining, repossessing, and reclaiming spaces and meaning that can provide and sustain better health and moments of wellbeing.

Drawing on the papers in this special issue, we suggest that four key elements offer possible resources for challenging the ways in which health geographers engage with adversity. Together, they enable geographers and others to identify and assess the relations through which hopeful adaptation can emerge and reside. *First*, placing our focus on 'health in the

making' as a more fluid, non-pre-emptive process can help us re-think the health-compromising / health-enabling dichotomy that we draw on above and which we challenge. People's everyday assemblages of health include the bodies, minds, relations and places of people affected by adversity but also those affecting adversity and those imbricated in supporting and trying to ameliorate experiences of adversity.

Second, understanding the relational and (socially and spatially) contingent nature of adaptive practices helps situate the entanglement between people's everyday battles and the wider structural constraints in which they reflexively engage. Within this assemblage, we would argue that the apparent dichotomy between individual embodied sources of adversity and the structural dynamics that can aggravate such adversity (discussed above) is less dichotomous in everyday life. Wider constraints manifest themselves in highly tangible ways in people's lives (e.g. benefit cuts reducing a person's weekly spend on groceries). While individual life experiences may have a more temporal quality, and structural changes may be more spatially oriented, setting them apart and focusing on one over the other can hinder enquiry. An assemblage is a helpful way to engage with the intermeshing of the two.

Third, understanding the position of the body-self within such spaces helps to disrupt assumptions of a fixed binary of one's identity before/after health, illness or impairment. In this paper, we argue that a more fluid, reflexive, nomadic self can help to better capture people's journeys through evolving embodied relations throughout life. While we accept that some issues in life can cause more sudden transformations, we would still argue that these are set within longer ever-evolving life paths and situated within a broader assemblage of social relations, place, technology and knowledge.

Fourth, a focus on hope can alert geographers to the moments that catalyse people's everyday strategies to adapt to adversity. The dichotomy that we seek to challenge here is that hope itself is neither solely an endpoint nor a prior quality that envelops the process, but can, in fact be both. If we accept that people's 'vocabulary' of adaptive practices is socially and spatially contingent, so too are the hopeful ambitions that they draw upon and experience.

People's decisions and practices ultimately exist along a spectrum (rather than a binary), from preventative measures that people employ to nullify and deter possible worse health effects, to (often non-linear) recovery journeys that are used to construct health and wellbeing 'in the making'. The range of papers in this collection serve as important exemplars of work that illustrate this range and scope, and point to the differing ways that work by health scholars can be enriched and extended through reaching across disciplinary and conceptual boundaries. We argue that the four elements outlined above offer important guiding principles for scholars, health policy makers and other audiences (e.g. third-sector agencies) seeking a better conceptual understanding of how people cope with and challenge adversity, through hope, in their lives.

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