



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



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ABSTRACT

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, the focus is directed towards two key patterns of movement, 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 are explored, with agency being established through seeking, and utilising, greater possibilities for action and engaging others. In addition, the opposite pattern of movement is also explored, using incidents where participants described moving indoors, using 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.

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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

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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.

Within the the huge spectrum of experiences which can be encompassed by the term 'mental health problem', only a very few will 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 et al., 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, not located in environments specifically designed to accommodate or treat them. Instead, they are located in the same places as other people who are not having these experiences, which are also places they themselves occupy, when in less extreme states of distress. 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 et al., 2013).

Despite these benefits, the move to community has also brought about new problems for service users. (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 et al., 2011; Wallcraft, 2001). This issue has been captured in a large body of literature looking at service users' everyday experiences of stigma (Newnes et al., 1999, 2001). Corker et al. (2013), for instance, report that in 2011, 88% of surveyed service users reported experiencing direct discrimination. Phelan et al. (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.

1.1. *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 location of experiences of inclusion and exclusion, 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 et al., 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, 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 et al. (2007) similarly argue that homeless people are seen to "infect, spoil or taint" (p. 722) the purity of public spaces, while Dixon et al. (2006) argue that dislocating behaviour which is seen as properly 'private' into public space can be viewed as "transgressing the moral geography of everyday behaviour" (pg. 197). The use of purity metaphors recalls Mary Douglas' (1966) 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 et al., 1989; Scheff, 1974, 1999), are placed in this role, of symbolic 'dirt', in the sense of "matter out of place" (James, 1902, p. 107; 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 the ideal, spatial order of society (see also Curtis, 2010).

1.2. *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, and a consideration of the material grounding of the self (e.g., Brown, 2012; Brown and Stenner, 2009; Burkitt, 1999; Cromby and 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

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