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Zip me up, and cool me down”: Molar narratives and molecular intensities in ‘helicopter’ mental health services.

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Abstract

Experiences of the space-time dimensions of contemporary mental health services are shaped according to what we describe here as a 'helicopter service', where professionals drop down into service users' lives for short, often pre-determined bursts of time. This can create a system where users' experiences are observed and assessed from a more distanced and circumscribed perspective. This paper considers the implications of these systemic changes, using interviews with current UK service users. To help in the exploration of the complexities faced by service users', we use Deleuze and Guatarri's (1987) distinction between molar and molecular forms of organisation. A process oriented thematic analysis discusses: a) Affording narratives of distress: Molarity, monitoring and space in service interactions and b) Narratives in therapy: Compartmentalising the distressed self. Multiple aspects of the relationship between space and distress are explored. An understanding of experiences of distress beyond the boundaries of the molar, which considers its intensive, molecular and transformative nature, may help to open up engagement with the affective and emotional dimensions of mental health.

1. Space-time in mental health services

In the twenty years since the advent of community care in the UK, mental health services have tended increasingly to be focussed on moving service users away from fixed institutional sites of mental health care, and into community spaces. The successions of policy buzzwords which have characterised mental health policy and practice in the era of community care underline this trend: moving from

59 ‘Mainstreaming’ (D.H., 1999) through ‘Social inclusion’ (O.D.P.M., 2004; D.H., 2006), and

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finally, to 'Freedom' (D.H., 2011). All these terms echo the same idea, that the ultimate aim and purpose of mental health services is to become absent from service users' lives, to 'empower', 'enable' and 'support' service users to be able to carry out their everyday activities without any interference from mental health services. In practice, this trend has often lead to the closure of specific mental health service sites, especially day services (Pilgrim & Ramon, 2009), and a move to using psychiatric wards for short term crisis care only (Keown, Mercer & Scott, 2008). The 2006 Department of Health report, 'From Segregation to Inclusion', stands as a good example of the discourse of such policies, stating in the section of the report entitled 'Beyond Buildings':

> *A day service does not necessarily require a dedicated building or centre. It is the function of day services in maintaining and extending social networks and access to mainstream roles and activities that is critical and there is a need to move from group-based to individualised support (p. 17).*

Implicit in the description here is a kind of service common in the early days of community care, and increasingly rare now: a day centre providing some therapy and group activities, but also acting as more informal space for service users to use as a safe place away from home. Such places were designed to provide both respite from a difficult world, and the opportunity to gain support from others in the same situation (see Taylor, 2014; Chase, 2011). An idea of respite or peer support is, however, completely absent from the above guidance on day services. Instead, the focus is on more individualised 'bridging' than group-based 'bonding' activities (Chase, 2011, Foley, 2013). Implied here is that any long term engagement with services (as opposed to 'mainstream activities'), or association primarily with other service users, constitutes 'dependency', and is *a priori* negative.

The focus on 'social inclusion' at the expense of institutional or ongoing care have been widely discussed. The affinity of these policies with a neo-liberal agenda of the individualisation of responsibility, state shrinkage, and the primacy of economic

productivity has been noted (Rogers & Pilgrim, 1996; Spandler, 2007; Symonds & Kelly, 1998; Taylor, 2014). Spandler (2007), for instance, points out that 'social inclusion' can have the effect of placing blame on individuals for the effects of structural inequalities which are beyond their control, thus playing down the role of structural factors such as poverty, oppression, or racism in their experiences (see also Cromby, Harper & Reavey, 2013; Johnstone, 2000; Rogers & Pilgrim, 2003; Smail, 2001). Additionally, the idea that 'dependency' is always a negative that needs to be escaped has been criticised; in her memoir 'The Last Asylum', Barbara Taylor argues:

> *People need other people. True independence - for everyone, well, or ill - is rooted in social connection; without this, it is mere isolation and loneliness. This deep need for connectedness is insufficiently acknowledged throughout the whole of our society […] But the lack of it hits the mentally ill [sic] particularly hard since it is so often failures of social connection, particularly in early life, that cause such disorders [sic] in the first place. 'Recovery', if it is to happen, must address this (2014, p. 252-3).*

In addition to these concerns, what is also notable in the idea of moving 'beyond buildings' is the assertion that the places where the service use interactions take place are immaterial. Indeed, these shifts of focus in service provision involve a wholesale transformation of the space-time of mental health services. When day services consist of a particular place, then service users and staff inevitably spend extended periods of time together, leading to a variety of interactions, from formal therapy to casual conversation. As mental health services have dissipated into multiple community spaces (Rose, 1998a; McGrath & Reavey, 2013, see also Deleuze, 1992), then the time which service users and professionals spend together has correspondingly become more hard edged and formalised; appointments and meetings have become the norm for a service user/professional interactions (Bloomfield & McLean, 2003; Moriarty et al, 2007). These changes go together; if service users can be anywhere, then professionals

understandably have to create specific times in which to see them. As the spaces in which mental health services operate have become less and less easily defined and boundaried, the time in which service use interactions take place has arguably become more formalised, individualised, and limited (see Pilgrim & Ramon, 2009).

These features of the space-time of contemporary services can be seen as constituting a 'helicopter service', where professionals drop down into service users' lives for short, often pre-determined bursts of time, but spend most of the time circling above their lives, attempting to manage and survey them from afar. We have coined this machinic metaphor to help illuminate the distal, crisis-led strategies currently dominant in UK mental health services. This paper will consider the implications of these changes, using interviews with current UK service users. To help in the exploration of the complexities for service users in negotiating the contemporary space-time of mental health services, we will use Deleuze and Guattari's (1987) distinction between molar and molecular forms of organisation. Our disciplinary roots within psychology often neglect the spatial dimensions of experience, often positioning 'minds' as the prime site for investigating distress. Our aim here is to broaden the field of inquiry to locate lived distress in a wider ecological landscape (see McGrath & Reavey for a more extended discussion, forthcoming).

1.2 Seeing from a distance: Technologies of a helicopter service.

Within this landscape of community care: one of expanded space and limited, boundaried time, different technologies and tools of observation, control and, indeed, caring are needed. In the 'total institution', as Goffman (1961) argued, the institutional gaze was absolute; assessment of how 'well' or 'ill' a person was deemed to be, and also to what extent their freedom was to be constrained, was made from a position of constant surveillance, shared between staff. Goffman pointed out that this meant that 'misdemeanours' in one area (e.g., in occupational therapy) lead to global punishment, such as the retraction of freedom of movement outside the ward. In contemporary

services, this level of surveillance is impossible, as service users no longer operate only within the concrete site of the institution. As Bloomfield & McClean (2003) argue:

> *when patients resided in an asylum they could in effect be observed at will, but in the context of care in the community this is no longer possible. Instead they are rendered visible though information (p. 79).*

The forms of information gathered about service users, through which decisions are made about their care, therefore become crucially important. These might include assessment tools, such as the Beck Depression Inventory, administered at every session in IAPTs services, risk assessment measures, or clinical case notes. A high profile example of the primacy of technologies of information in the new landscape of mental health is the explosion of discourses of risk and risk management practices (Rose, 1996; 1998, R.C.P., 2008). Without literal walls giving limits to the extent of psychiatric observation, the psychiatric gaze has been extended out into the community (Rose, 1996). Risk management can be seen as a technology developed for psychiatrists to manage this new distal form of accountability, in part a response to mental health professionals being held responsible in media reports for high profile, but very rare, occasions when service users have committed violent acts (Moon, 2000; R.C.P., 2008; Harper, 2004).

The information which feeds into these various measures, forms and tools is most often the result of an interaction between staff and service user, and is dependent on the service user formulating and communicating their ongoing level of distress. This central role of service user/staff communication has lead to research which has investigated various interpersonal and contextual factors which might interfere with communication (Hassan, McCabe & Priebe, 2007). These include the gender, age, and education level of the participants (Sleath & Rubin, 2002; Sleath, Svarstad & Roter, 1997; Sleath, Rubin & Huston, 2003), level and form of distress experienced by the service user (e.g, Bouhuys & Albersnagel, 1992), and the agenda of the

professional/institution (McCabe, Heath, Burns & Priebe, 2002; Pinto, Ribiero & Dantas, 2005). It has been pointed out that service users and professionals can have competing agendas when interacting in services. McCabe et al's (2002) conversation analysis of psychiatrist/service user interactions, for instance, found that while service users attempted to use the time of the consultation to discuss the content of their psychotic experiences, psychiatrists tended to deflect or ignore these topics when raised. A large body of research hence exists considering the various factors which might mediate and shape the kinds of interactions which happen in services, much of this work coming under a concern with building successful 'therapeutic alliance' or a strong 'therapeutic relationship' (McCabe & Priebe, 2004).

What has been less considered, arguably, is the relationship between service users' ongoing experience of distress, distant in space and time, and the narratives gathered during interactions with services. Distress is experienced over multiple spaces and time periods and is shifting, manifold and at least partially intangible. For an account to be given in a consultation however, clearly defined sets of feelings are required: "I felt depressed, I was anxious, my symptoms have returned, my medication is making me drowsy", etc. The time of the consultancy thus punctuates complex, moving sets of sensations and feelings, not necessarily easily captured (see Brown & Tucker, 2010). Intense emotional experiences are, in addition, known to disrupt the ability to construct coherent narratives; memories of trauma, for instance, tend to be less detailed and more unstructured than narratives describing other life events (Porter & Birt, 2001). Within contemporary 'helicopter' community services, where professionals and service users spend most of their time separately, this disjunct between experience and the narration of that experience is arguably increasingly crucial.

1.3 Molar and molecular: Affect, affordance and narratives of distress.

One way to consider this tension, between ongoing, multitudinous experience and linear, fixed narratives, assessment outcomes and clinical notes, is through Deleuze and

Guattari's (1987) distinction between molar and molecular modes of existence. In their work, Deleuze & Guattari (1983; 1987) variously describe the individual as a machine or an assemblage – broadly, a functional arrangement operating productively in connection with other materials, and flows. Brown & Lunt (2002) argue that rather than being reductive (in calling humans machines), this framework allows us to connect experience with the world, to consider ourselves in connective synthesis with both the social and the material. In this mode of enquiry, we must then accept that what appears singular (e.g. a narrative describing what happened) is always embedded within the multiple (e.g. multiple sets of spaces, containing multiple sets of affective experiences). Multiplicity is a key characteristic of what Deleuze and Guattari (1987) call the 'molecular', understood as a: "collection of heterogenous elements – bodies, objects, equipment – all of which have their own particular functions, sets of relations and indeed history" (Brown & Lunt, 2002, p. 13). 'Molar' modes of existence or organisation, are contrastingly described as being overly rigid, overarching and having the appearance of simplicity. Using the concepts of molar and molecular can thus help to describe how multiple, fluid, laterally linked moments, events and affects are folded into the singular: an end narrative; a clinical decision; a diagnosis. The forms of assessment detailed above can all be understood as 'molar', requiring that which is multiple (waxing and waning experiences of distress, which occur across different times and spaces) to be expressed as singular ('I am feeling more depressed').

As well as expressing experiences as singular, rather than multiple, molar forms of expression can also be seen as more rigid and prescriptive than the 'molecular', as Deleuze and Guattari (1987) say: "One type is supple, more molecular, and merely ordered; the other is more rigid, molar and organized" (p. 46). They hence argue that codification of experience is an act of transformation rather than only description; capturing an experience, or a multitude of experiences in narrative or otherwise externalised form, those experiences are then transformed. As they state: "Strata [rigid forms of organisation] are acts of capture" (p. 45); by creating a molar, formalised version of the complexity of ongoing, disparate experience, the meaning of those

experience is 'captured' by the person, body or discourse producing that particular version of the meaning of the experience, person or group under question.

Within mental health practice, the classic example of this process is perhaps an experience of being diagnosed. Before meeting with a psychiatrist for the first time, a new service user may have had a number of intersecting experiences, ranging from 'not feeling right', problematic interactions in their personal and professional lives, changes in the way they have used space or experienced time, such as spending more time at home, and shifts in their affective capacity, such as feeling less energised or slowed down (e.g., Fuchs, 2001). These multiple experiences and relations, both social and material, which can be seen as a 'molecular' description of a particular form of distress, are then given form and structure through a diagnosis of depression, a 'molar' description which then potentially transforms the experiences which have lead to seeking help. After the meeting when they experience a slowing of time, dysphoric affect, or a problematic relationship with others, then this can all be understood as being 'because of my depression', which can serve to displace the molecular formation of the problem. Of course some transformation of experience is inevitable following contact with services, but a diagnosis, simplistically applied, could be seen as 'molar', as it offers a rigid prescription of the meaning of behavior and experiences; in contrast, a formulation, could be seen as potentially more 'molecular', as it is based on an open negotiation of making sense of the distress of the service user; organized, but potentially not as rigid or normative (Johnstone & Dallos, 2014). Arguably, as psychiatric services have become more spatially distant from service users' lives, they have become more reliant on such molar forms of measurement and observation through which service users can be 'made visible' (Bloomfield & McClean, 2003) to services.

This distinction between the molar and molecular can also be used to illuminate another potential relationship between the experiences of distress and attempts to codify, measure and describe them, using a metaphor of temperature. As well as being more fluid than rigid, and more multiple than singular, experiences of distress as they happen in the world can also be seen as 'hot' in contrast to the 'cold' representation of

complex emotional experiences in measurements, reports and diagnostic tools. Brown and Reavey (2015) draw on the idea of affect as an 'intensity' (Deleuze & Guattari, 1983; see also, Brown & Stenner, 2001; 2009; Massumi, 1995; 2002; Thrift, 2004), an embodied relationship to the world which can propel or restrict movement, open up or close down possibilities in relationships, actions and activities (see Brown & Tucker, 2010; Davidson & Shahar, 2007; Fox, 2002; 2011; McGrath & Reavey, 2015). In this sense we are using the work of Deleuze & Guattari in order to make visible the ontological interrelationship between spatiality, sociality and distress. Most diagnoses of mental health 'disorders' involve a description of 'excessive' intensities of feeling or emotion, for instance of dysphoric affect in 'depression' and euphoric affect in 'mania' (Brown & Stenner, 2001; 2009). Brown & Reavey (2015) point out crucial differences between 'intensive' properties, such as temperature and pressure, and 'extensive' properties, such as mass, distance, or indeed, scores on a psychological test. Division of an 'extension', such as splitting a mile in two, results in two identical lengths, half a mile each. Dividing an intensity does not have the same effect: divide a room at temperature 20°C in two and you are left with two smaller spaces, still both at 20°C. To change an intensity, an overall transformation is required; the substance must be cooled or heated, pressure increased or released. Intensities, like affect, can hence be understood as behaving more like molecules than rigid or linear structures: molecules expand, move differently depending on the temperature, and resemble quite different substances. When water turns to steam or ice, it is not partitioned; the chemical property remains stable but the substances are different. If affect is a relational intensity (Deleuze & Guattari, 1983; 1987; Brown & Reavey, 2015; Brown & Stenner, 2009), then attempting to evaluate what we are feeling is likely to change the experience. If we examine our self-knowledge at the point when our affective temperature if you will, has cooled, we may be left with an account – the molar- that doesn't attend to, or adequately reflect the intensity of feelings and their inherent messiness (see also, Fox, 2013). The 'substance', or account given in interactions with services will hence be different from the 'substance' of the ongoing experience of distress.

To illustrate these principles more fully, the following analysis of interviews with UK mental health service users will draw on these ideas. Issues of representing and communicating ongoing, molecular experiences of distress within the strictures of the 'helicopter' structure of contemporary mental health services will be explored in more detail.

2. The study

The material analysed here was collected for a broader project looking at the role of space in service users' experiences (first author, 2012; both authors, 2013; 2015). For the part of the project discussed here, 19 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. 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 were a part of 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; Reavey & Prosser, 2012). 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 themselves organised spatially (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 participants find difficult to put into words, as has been established by work investigating embodied experiences (e.g. Bowes-Catton, Brown, Reavey,

Cromby, Harper & Johnson, 2008; 2011; Cromby, 2012; 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, with the majority residing in London. Ethically this meant that individuals were volunteering, without any mediation via services. Participants were sought who had the shared spatial experience of currently accessing community mental health services, rather than on the basis of diagnostic categories. 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 recruitment strategy of course had some disadvantages. 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. 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 there was variety in the participants' experiences of mental health and the mental health system. 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 the asylum system, while others only of community care.

2.3 Analytical approach

The interviews were transcribed and collated in Nvivo, along with scanned copies of participants' drawings. 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 & Prosser, 2012). Initially, the material 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 contexualise 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. Most broadly, 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 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). In particular Latour's argument for the central role of objects in experience was important for our analysis; he claims: "things might authorise, allow, afford, encourage, permit, suggest, influence, block, render possible, forbid, and so on'" (p. 72), which drew our attention to the specific role which objects were playing in the interactions and experiences described.

Most crucially for this paper, in addition to observations made on the application of molar and molecular, we drew on Gibson's (1977) idea of 'affordance' as a way to understand how the environment in a broader sense might play a role in shaping, limiting and enabling different experiences. Gibson draws on an ecological metaphor to consider the relationship between person and environment, arguing that: "the affordances of the environment are what it offers the animal, what it *provides* or *furnishes*" (p. 56). This idea orientates us to consider the capacities which a particular space might give to people or close down, but without essentialising meaning or fixed purpose in the environment itself. A window, for instance, can provide a view onto the outside world, a potential for escape, or an invasion of privacy, depending on the particular position of the person using it. 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. Affective narratives in community mental health services.

Participants' descriptions of their various interactions with mental health services did point to a 'helicopter' relationship with mental health services, where they were

monitored through regular interactions with professionals, but had limited ongoing spatial contact with services. Excluding those participants who were living in supported housing (three of those interviewed), the majority of interactions described by participants were therefore in the form of appointments and meetings, across various community and institutional spaces. Broadly, the purpose of these interactions seemed to fall into two categories, both requiring a particular form of narrative to be produced by the service user. One set of interactions seemed particularly focussed on monitoring, on making visible ongoing experiences of distress and recovery which happened 'out of sight' of mental health service practitioners. These were resolutely present-focussed. The second set of interactions were more traditionally therapeutic, asking service users to invoke and explore past, difficult and distant emotional experiences, "digging into my soul" (**Lou, l. xx**), as one participant put it. The analysis presented here explores each of these in turn, arguing that the spatial, temporal and affective complexity of the production of narratives has been insufficiently considered.

3.1 Affording narratives of distress: Molarity, monitoring and space in service interactions.

Within the context of the un-boundaried spaces of contemporary services, participants described relatively fixed, formalised portions of time in which they were asked to produce narratives of their current state of being. Bryan described his two main forms of interaction with service staff as being primarily concerned with monitoring. First his psychiatrist:

> *the outpatient clinic certainly in the last couple of years has has bin a question of going in talking to the doctor for a maximum of five minutes and then that's it [I:mmm] so very very basic erm just answering simple questions like are you taking your medication what is your medication and taking erm are you taking your medication are you sleeping are you eating or is your appetite alright that*

sort of thing so very very basic and quite often the the doctor looks quite bored and is yawning (Bryan, l. 78 – 85).

And also his Community Psychiatric Nurse (CPN):

[My CPN] comes for some every erm about every two or three weeks and stays for about um up to half an hour […] it depends very much on what sort of shape I'm in […] if things are going ok and there's not much to talk about he may only stay for about ten minutes […] and we have a good conversation [I:mmm] and it's fine erm and it makes a real difference to me that he comes to into my space and talks to me and we kind of have quite an easy conversation and we sometimes talk about books or things that I'm doing and that makes a real difference […] so I kind of feel feel in control of the relationship because it's take because he's coming here er meeting me in meeting me in my own space it makes quite a bit quite a bit of difference (l. 103-118).

The professional agendas of the two staff members can clearly be seen to structure the interactions here (McCabe, Heath, Burns & Priebe, 2002). The first interaction, with his psychiatrist, is limited to biomedical functions: sleep, appetite, and medication. The second, in keeping with the broader remit of a CPN's role is more holistic; located in his own space, Bryan describes becoming more than just a biomedical subject. This second interaction is also described as more fluid, driven in part by 'process time' (Davies, 1994), meaning the time varies depending on his current needs, as well as extending beyond his role as a service user, incorporating 'books and things that I'm doing'. Both, however, also serve the same purpose: during these limited periods of contact with staff, Bryan must produce a coherent and representative narrative of his ongoing experiences of distress, recovery and everyday living; a molar account of his molecular experiences. These are present-focussed narratives; Bryan is not asked here to reflect on past experiences, but instead to account for his state of being only in the period since

his last contact with services. These narratives are hence described here as the key technology through which services monitor service users' state of being (Bloomfield & McClean, 2003) within the un-boundaried, disparate spaces of 'helicopter' community care. This presenteeism is what is called upon to structure the interaction (see also Brown & Reavey, 2015). These accounts are hence described here as the key technology (Bloomfield & McClean, 2003) through which services monitor service users' state of being is read, within the expanded, disparate spaces of 'helicopter' community care. One participant, James, highlighted a key limitation of a reliance on such monitoring strategies:

> *when I go and see the consultant I'm normally quite compos mentos and he says how have you been and I say well a couple of weeks or a couple of months ago I wasn't feeling well th er er then they would ask questions well in what way weren't you feeling I can't I couldn't remember I feel and er I can't really describe it so I go away feeling a bit frustrated not pinning the problem down (James, 237 – 241).*

James here can be seen to capture a disjunct between the 'molecular' intensities of his ongoing distressed experiences, and the compulsion to produce a narrative of those multiple experiences, now distant in both time and experience. To use the temperature metaphor developed above, James here describes the inherent difficulty of translating the 'hot' intensity of distress into the form of a linear narrative ('I couldn't really describe it'), whilst in the 'colder' affective state of being 'compos mentos'. This can be seen as a problem of form: narrative explanations demand linearity and clear lines of explanation, while much of distressed experience is inherently ineffable, characterised by uncertain sensations, intensities of feeling, and ambiguous relationships (see Brown & Tucker, 2010; Fox, 2013). As his experiences are not transformed into coherent narrative form at the time of being experienced, he describes finding it hard to produce them in the limited space-time made available for the communication of his ongoing experiences of distress.

Another issue outlined with the reliance on monitoring narratives in contemporary services was the role of space in affording (**Gibson, 1977**) or inhibiting discussions of distress. One participant, Julie, for instance, described her experience of meeting her CPN in a local pub:

the other problem with sitting in a pub of course is that if you get upset about anything [I: yeah] you know you can't really be in tears in a pub without everybody going (whispers) what's going on there [I:mmm] you know so i it you tend to kind of put on your social face [I:mmm] you know how you would if you were going out or something [I:yeah] but you're not going to talk about stuff that really worries you because you don't want to get upset [I:mmm] you don't wanna feel vulnerable because you're in public you're kind of on show (Julie, l. 112 – 121).

While another participant, Zoe, compared the two rooms she met with mental health professionals in her outpatient clinic:

the consulting room is really really big and there's quite a lot of windows [I:mmm] and its not I mean its not in a public place so the windows nobody goes past them [I:mmm] but I always feel a bit like I really wish there wasn't six windows in here [I:yeah] because I want to sit here and cry [I:mmm] and tell you that I feel really bad but there's six windows and it feels a bit bare [I:mmm] whereas in the CBT room there's one window you sit with your back to it and there's blinds there [I:yeah] so its a lot more private and I think 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 (Zoë, l. 124 - 138).

Both Zoe and Julie here highlight the crucial importance of providing a space which affords a more molecular experiential account of distress, with all its intensity and messiness. Julie was unable to meet her CPN at home, and so following the closure of her community mental health buildings, was forced to meet with her CPN, to provide them with a monitoring narrative, in various community spaces. In the local pub, like James above, she highlights the difficulty in accessing and producing the parts of her emotional and affective experience which are needed here. The affective atmosphere (Anderson, 2009) of the pub, of enjoyment and social display, is described as affording Julie's 'social face', rather than enabling her to discuss her ongoing distress. Distress is still normatively placed as a 'private' experience, one which belongs 'out of sight' (Parr, 1997; 2008; McGrath & Reavey, 2015; McGrath, Reavey & Brown, 2008; Sibley, 1995), and this concern runs through both Julie and Zoe's accounts. In Zoe's case, the 'big windows' 'suggest' (Latour, 2005) public space and exposure to her, and hence 'blocking' the discussion of her distressed experiences.

In contrast to the affordance of rationality and sociability in public space, participants also described private space as affording a greater intensity of feeling. As Zoe put it:

> *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 […] the extremes of the low it's less likely to happen in other places (Zoe, l. 376 – 387).*

Part of the production of different 'intensities' of affect and feeling can thus be seen to be the spaces in which the person is placed. Distress is not only normatively excluded from public space (Sibley, 1995; Dixon, Levine & McAuley, 2006; Parr, 1997; 2008 ; McGrath & Reavey, 2013), but here Zoe outlines that the greater intensities of feeling, the 'heat' of distress is actually 'less likely' to occur in public spaces. Public space is here described as carrying expectations of a 'colder' kind of affective experience, such as

'being rational' (Parr, 2008; Foucault, 1965) or as Julie puts it, the 'social face'. Service users are hence being asked to provide narratives of affective experiences which are expressly excluded from the space within which they are being asked to provide this narrative. This presents a fundamental contradiction: the closer they get to the 'heat' of their distressed experiences, the more danger they are in of violating the norms of the space. In the context of community services, where interactions between service users and staff are increasingly taking place in community spaces, the norms of emotional expression in different spaces need to be taken into account in considering what kind of account of experience is possible or likely to be afforded in that particular space.

A contrast with these experiences can be seen in Rachel's description of a day centre which she had attended in the past:

> *[the lounge] was was really really nice and first thing in the morning when you came in you could just sit in there and I think probably for the first couple of months I went to the day centre that was all that I did I didn't join any of the I didn't like go to any of the groups and I dunno I think I just kind of saw it as a place to get away from pressures of work or […] just to relax I suppose and I saw the day centre just as somewhere to do that and [I:mmm] I didn't see any particular use in going to anything like art therapy or woodwork or relaxation but […] I think the fact that it was a nice place to be anyway meant that I kept going even though I didn't chat with any of the groups and things (Rachel, l. 139 – 151).*

The day centre here is described as a container for Rachel's experiences of distress; with no pressure to join in with the official therapy on offer, she describes the space of the day centre as affording her the ability to 'be', rather than 'be treated'. The walls of the day centre here provide a material boundary, within which Rachel is 'using services' but the less structured nature of time within that boundary enables more variety in the form of that engagement with services. Here, she seems to describe an absence of a

compulsion to produce of the kinds of structured narratives described by the participants above; Rachel seems to have little pressure to molarise her experiences, to produce linearity out of the molecular experience of her distress. Instead, she is able to experience her distress in the space of services, relatively un-transformed. This can be seen as emergent from the space-time of services; when existing in concurrent space with services, the kinds of monitoring narratives described above become less necessary; Rachel can be directly observed, and so, paradoxically, is more able to be left alone. Of course, there are multiple problems with observation as it has been implemented as a tool of control in mental health, particularly inpatient, services (Bowers & Park, 2001; Bowers, Gournay & Duffy, 2000; Manna, 2010), and we do not wish to idealise services from the past. But it does seem here that the provision of some less structured space-time in mental health services has benefits that are perhaps being lost in the drive to 'social inclusion' (Spandler, 2007; Chase, 2011; Taylor, 2014).

2. Narratives in therapy: Compartmentalising the distressed self.

Not all of the interactions described with services took the form of a monitoring, present-focussed encounter. Participants who described regular psychotherapy, described a very different, past focussed and intimate narrative which they had to navigate during therapy. Appointments were described as having very clear temporal edges, characterised by 'clock time', with no contact between carefully kept appointments (Davies, 1994). Lou described her psychotherapy:

> *I just felt like someone was digging into my soul and and pulling up all of this rubbish all this junk that had been festering at the bottom and then just leaving me to deal with it [I:mmm] so bringing it all to the top and sort of this big revelation well I really think you don't like yourself in fact I think you hate yourself well I think that I do 'ok that's the end of the session see you next week' and it was just like what am I supposed to do and and it was two weeks until the next session what*

am I supposed to do with that with those emotions and I go back to this place where I don't like to be and and … e wa and yeah and try and deal with it and it was awful (Lou, l. 260-268).

The process of therapy, of 'digging into my soul', is here described as painful, and even toxic, in involving being overwhelmed by 'rubbish' and 'junk', 'festering' inside Lou. Images of poison are here used to describe the process of excavating backwards and inwards, uncovering what has been hidden, or strategically forgotten (Middleton & Brown, 2005), in Lou's everyday experience of subjectivity. To use our temperature metaphor, in therapy, Lou describes being heated up, through dialogue with the psychotherapist, to a greater level of affective intensity ('all these emotions'). Once the strict time of the psychotherapy session has come to an end, Lou describes being transformed (a different 'substance', to continue the temperature metaphor) to a greater level of embodied intensity, a burgeoning, toxic jumble of emotion and external narrative ('I think you hate yourself'). Lou then has to return to her room in supported housing, where she feels stigmatised and isolated:

it's really it's really kind of sterile the whole house is like a real institution it's it's like the walls are painted this hideous colour blue every wall in the house and um and the um the doors there's like fire doors on everything and there's doors everywhere and they're always closed all the doors are closed so you just walk in and there's just a corridor of closed (l. 321-328).

The isolation evoked by the image here of closed doors along a "sterile" corridor, painted in institutional blue, through which Lou walks to her "room, not home" (l. 319) is starkly cold. Above, Lou describes being transformed in therapy to the point where her emotions are overheated and flowing beyond her control and bodily boundaries ("what am I supposed to do with those emotions?"). Outside the strict temporal limits of the therapy session, there seems little consideration of the ongoing implications of

how her affective embodied state has been transformed, and whether her everyday spaces are places which can afford the containment and processing of this changed state.

Similarly, Karl described therapy as necessitating a shift in his embodied self:

> *in our little counselling room um [therapist] has said to me you know you're too strong you're too guarded you're too this is you know is this how you are in the world [I:mmm] well yes it's how I am in the world because I'm not going to just be a puddle of pudding for [I:mmm] every no-one else needs to see that or wants to see that and it isn't useful or … or you know efficient or effective [I:mmm] how would you live your life if you were just wearing your heart on your sleeve all the time (Karl*, ***l****. 201-206)*

Karl describes therapy as necessitating being emotionally "raw" and open, describing a corresponding embodied experience of being a soft "pile of pudding" with his "heart on my sleeve". In his everyday life, in contrast, Karl describes a contained, armoured self consistent with a normative Western, and particularly white, middle class, and male subjectivity (Brannon, 1976; Kilmartin, 2005). As argued by Ian Burkitt (1999), drawing on Elias (1978; 1982; 1985) armourment can be seen as a key experience of the body which emerged in tandem with the privatisation of emotion and sexuality following the Renaissance period:

> *these are bodily experiences that are private; they pulsate under layers of clothing, behind the barriers of reserve and are expressed only in private chambers of the household. The barriers of reserve and the restraint on feelings become a body armour, frozen into our movements, gestures, posture and musculature (Burkitt, 1999, p. 52).*

Like Lou, Karl here describes that therapy necessitates a ‘heating up’ of affective intensity; his very body seems here to be transformed into a different substance, through the intensity of therapy, becoming soft rather than stiff, as his emotions become open rather than guarded.

He discusses how during everyday life, he therefore acts to compartmentalise this version of himself, the ’pile of pudding’, pouring all of his intensified affect into one part of his week:

> *say on Thursday when something else had come up again related to er all of this um I was I thought ok I’m feeling anxious about that but I have a place for that you know my Tuesday afternoon [I:mmm] at three o’clock I will go in and that is when I will deal with that so you it it helped me to compartmentalise it or it didn’t help and I was avoiding it but instead of falling apart on Thursday evening I was saying ok save that and let’s look at that on Tuesday [I:mmm] well I’m y’know so I was pleased to have not a physical space to go to [I:mmm] but a space in my week or a space in my head (Karl, l. 266-273).*

While Lou describes her heated up, toxic emotions as overflowing, being unable to be contained in the everyday spaces she was left to negotiate between therapeutic encounters, Karl here describes the maintenance of his more ‘armoured’ emotional self in the week as in part dependent on having the space where more intensified, extreme emotions are allowable, visible, and indeed, demanded by the process of therapy. Karl described the transition between these two states as far from easy, describing using the toilet of the outpatient unit as a “decompression zone” **(l. xx)** between the two:

> *in the toilet [...] I say catch my breath I kind of brace myself both before and after um [I:mmm] literally and metaphorically [...] I go in there before hand just to that last moment between outside world […] and so that’s my kind of um er like the decompression zone [I:mmm] on a space ship I go in I go ah ok look in the mirror*

and kind of put myself into that space of being able to let this complete stranger [I:mmm] ask me incredibly private questions [...] and then afterwards you know we do the classic thing of well 'I'd really like us to explore this more next time but we've run out of time' right ok I'll just pack everything back up [I:mmm] put it inside zip up the front of me and go back out into the world [...] so my my kind of ritual is that I go in I feel very raw I have my decompression back into the world so I'm not going to cry in the street on the way out [I:mmm] and then [...] I need to sit somewhere for half an hour […] and just kind of get myself back to going out into the rest of the world (Karl, l. 352 – 393).

Karl describes here the process of de-armouring and re-armouring himself, captured evocatively in the phrase "zip up the front of me", having to quickly re-suppress, cool down and hide, the emotions which have been churned up in the therapeutic encounter. This account highlights the lack of any space made available for this process with the service itself; Karl is here forced into the toilet, the only available private space, to construct his own ritual of transition. In part, what can be seen here is a tension between the linear nature of the time of therapy, and the molecular, voluminous nature of affect and emotion. While therapeutic time has a strict beginning and end, the affective transformations which happen during that time are not 'over'. Both Lou and Karl here describe being transformed by the therapeutic encounter; emotions are intensified and heated up, toxic feelings excavated, body armour dissolved. The very boundaries of the body seem to become more porous, leaving the self more vulnerable to the external world, an embodied experience which has been more widely noted as often occurring in experiences of distress (Parr, 1999; McGrath, Reavey & Brown, 2008). In order to then function, back in the world, Karl describes needing to transform himself again, to cool down, re-armour, 'zip back up'. No space is made available for this crucial process; instead Karl is left, overheated and exposed, to splash water on his face in the toilet.

4. Space-time of helicopter services: Making room for molecular distress.

The accounts examined here speak to inherent tensions within the 'helicopter' space-time of contemporary UK mental health services. In a landscape of expanded spatiality and shrunken temporality, a central function of service user/professional interactions was that of monitoring the service user's present level of distress. Two layers of complexity to service users producing these crucial monitoring narratives have been identified. Firstly, inherent difficulties in translating multiple and intangible experiences of distress into coherent, linear narratives have been explored. Deleuze & Guattari's (1987) distinction between fixed molar and fluid, multiple molecular forms have been used as a way to understand an inherent disjunct between experiences of (molecular) distress and the (molar) narratives through which service users' distress is made visible. Layered on top of these difficulties is a seeming lack of consideration of the affective affordances of the spaces in which staff/service user interactions are taking place. The normative expulsion of distress from public space (Parr, 1997; 2008; McGrath, Reavey & Brown, 2008; Sibley, 1995) played into service users' experiences of attempting to discuss distress in public space. A second form of service user/staff interaction was also explored, of a therapeutic encounter which excavates into the past, described as an experience which heated up intensities of emotion in the present, transforming participants' affective embodiment. This kind of intensified, 'heated up', embodied experience was described as at odds with the everyday spaces into which service users were ejected following therapy.

The types of interactions which have been explored here are, of course, not the only kinds which pepper the multitudes of ways in which staff and service users interact in mental health services. In addition, 'molar' linear narratives are not the only ways in which mental health professionals assess the level of distress of a service user; more holistic considerations, such as visible changes in level of self care, housework, mood or interaction style all play a part (e.g., Barker, 2008). The forms of narrative explored above were, however, chosen in order to highlight particular issues emerging in the expanded space and truncated time of contemporary services. An understanding of

distress as intensive, molecular and transformative, may help to consider ways in which services could better gather information from service users, as well as highlighting the need for spaces which are more sympathetic to the intensive experience of distress. Many of the experiences outlined above seem to call for spaces which are less structured, which afford the expression and experience of distress, in ways which many community spaces do not. For those participants leaving therapy, some form of less structured 'buffer space' could be provided, potentially to perform the same 'decompression' function as Karl describes above.

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