

Fractal Heterotopia and the Affective Space of Psychosis

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The Modern Asylum

Foucault regarded the asylum as a quintessential *heterotopia of deviation*, a counter-space with the distinctive spatial logic to house the socially deviant.¹ The project of the early asylum to morally eliminate and quarantine madness² is resonant with the medical objectives of modern psychiatric hospitals seeking to contain the risk of mental illness and eradicate the symptoms most destructive to social functioning. With its discourse of acuity and emergency, the modern inpatient psychiatric hospital may be more appropriately classified as a *crisis heterotopia* – namely an inaccessible space reserved for those undergoing transitional crises. In facilitating the rite of recovery, the acute psychiatric inpatient hospital orientates upon the rehabilitation of individuals into wider society. However, tracing the historical arc of the asylum’s death in the mid-twentieth century to the radical reforms of the 1990s,³ the UK’s geography of psychiatric care is no longer

¹ Michel Foucault, “Des Espaces Autres”, *Architecture, Mouvement Continuité* 5 (1984), 46– 49, trans. Jay Miskowiec “Of Other Spaces” in *Diacritics* 16(1) (1986).

Available at <http://web.mit.edu/allanmc/www/foucault1.pdf> [accessed June 19 2017].

² Michel Foucault, *Madness and Civilisation: A History of Insanity in the Age of Reason* (New York: Pantheon Books, 1965).

³ Gerald. N. Grob, *From Asylum to Community: Mental Health Policy in Modern America* (Princeton: Princeton University Press, 1991).

Service failures which led to the death of Jonathan Zito, murdered by Christopher Clunis, a schizophrenic patient, catalysed a series of reforms to the risk–assessment practices and dialogue between hospital and community care. For further information about the development of community care, see Helen Gilbert, Edward Peck, Becky Ashton, Nigel Edwards and Chris Naylor, *Service transformation – Lessons from mental health* (London: The King’s Fund, 2014).

bound to the bricks and mortar of the central asylum.⁴ Rather, the locus of psychiatry has been dispersed across a network of professionals, legal frameworks, policies and service providers⁵ and diversified into a range of specialised National Health Service and independent residential provisions.⁶ More ambiguities arise when recognising the bidirectional permeability of the modern hospital, where the hosting of both inpatient and outpatient services and voluntary admissions further perforate the bounded asylum's partitions.⁷ Neoliberal terms like the *service user*, gradually replacing the traditional *patient*, also insinuate this migration from the paternalistic methodologies previously characterising psychiatric care.⁸

The modern psychiatric situation is not, however, entirely fluid. In accordance with Foucault's fifth heterotopic principle, heterotopias are penetrable yet their opening and closing is regulated by specific 'disciplinary technologies'.⁹ In this regard, increases in the number of involuntary detentions under the Mental Health Act (MHA) 1983¹⁰, the continuing use of physical restraint¹¹ and seclusion render secure

⁴ Erving Goffman, *Asylums: Essays on the Social Situation of Mental Patients and Other Inmates* (New York: Doubleday Anchor, 1961).

⁵ Winnie S. Chow and Stefan Priebe, "Understanding psychiatric institutionalisation: a conceptual review", *BioMed Central Psychiatry* 13(169) (2013): 169–182.

⁶ Graham Thornicroft and Michele Tansella "Balancing community-based and hospital-based mental health care", *World Psychiatry* 1(2) (2002): 84–90.

⁷ Alan Quirk, Paul Lelliott and Clive Seale, "The permeable institution: an ethnographic study of three acute psychiatric wards in London", *Social Science and Medicine* 63(8) (2006): 2105–17.

⁸ See Rebecca McGuire–Snieckys, Rosemarie McCabe and Stefan Priebe, "Patient, client or service user? A survey of patient preferences of dress and address of six mental health professions", *Psychiatric Bulletin* 27 (2003): 305–308. This study cited that 98% of an East London mental health sample reported preference for the term 'patient' over 'client' or 'service user'.

⁹ Edward Soja, *Third Space: Journeys to Los Angeles and other Real and Imagined Places* (Oxford: Blackwell, 1996), 2.

¹⁰ Health and Social Care Information Centre, *Inpatients Formally Detained in Hospitals Under the Mental Health Act 1983 and Patients Subject to Supervised Community Treatment, England – 2014-2015, Annual figures* (Leeds: HSICS, 2015).

¹¹ Revisions to the Code of Practice (2015) for the Mental Health Act, 1983 (MHA) elaborated upon stipulations of the 2008 Code of Practice's instruction that the use of restraint must be proportionate to risk. The document states that

units (at least) as eligible zones of closure and this is particularly accurate of the long-stay unit. Length of Stay (LoS) has most commonly been studied in acute settings to unravel the problem of prolonged admissions and delayed discharge within emergency mental health services.¹² Conventionally separate from acute services, long-stay (or complex care) units support a minority of inpatients with severe mental health needs, including neurodegenerative diseases, brain injuries or ‘treatment-resistant’ psychiatric disorders¹³ which, due to patients’ enduring risk or vulnerability¹⁴, cannot be managed appropriately in the community.¹⁵ Information about the duration of long-term admissions for this group is notably absent from the literature, particularly within the UK. With the possibility of Section 3 of the Mental Health Act being reinstated every six months to a year, patients within this category can be hospitalised for years, or even decades.

Drawing upon an understanding of space, not as a ‘void... inside of which we could place individuals and things’, but as ‘a set of

restraint is to be used only when it is the least restrictive option. Restraint should avoid any techniques restricting breathing or circulation and seclusion can only be used for those detained under the MHA.

¹² Rosa E. Jiménez, Rosa M. Lam, Milagros Marot & Ariel Delgado, “Observed-predicted length of stay for an acute psychiatric department, as an indicator of inpatient care inefficiencies. Retrospective case-series study”, *BMC Health Service Research* 4 (2004): 4.

¹³ Treatment-resistant schizophrenia (TRS) is sometimes less fatalistically referred to as ‘incomplete recovery’. A proportion of long-stay inpatients, suffering from ‘treatment-resistant’ psychiatric disorders conditions have lived on wards for decades under renewing Section 3’s of the Mental Health Act 1983. See Department of Health, *Mental Health Act* (London: HMSO, 2007 [orig. 1983]). For further information about treatment resistant conditions, see Charles Nemeroff, ed. *Management of Treatment-Resistant Major Psychiatric Disorders* (Oxford: Oxford University Press, 2012).

¹⁴ For further information about the characteristics of long-stay inpatients, see Marc Afilalo, “Characteristics and Needs of Psychiatric Patients with Prolonged Hospital Stay”, *Canadian Journal of Psychiatry* 60(4) (2015): 181-188.

¹⁵ The Care Quality Commission, *Monitoring the Mental Health Act in 2014-15* (London: Williams Lea Group, 2015). Available at: https://www.cqc.org.uk/sites/default/files/20151207_mhareport2014-15_full.pdf [assessed June 19 2017].

relations that delineates sites',¹⁶ this article reflects upon an abstraction of the long-stay psychiatric unit to explore the quality of space emerging from the long-term hospitalisation of chronic schizophrenia. Using Bachelard's evocative topoanalysis of the home as a starting point, I propose that the daydream of the institutional home creates a *fractal heterotopia*. Following a brief exploration of the phenomenology of psychosis, I suggest that the unit's independent inclination toward the uncanny elicits, or intensifies, the fractal's dystopian elements. A final thread engages with Deleuzian-Spinozan concepts of affect to explore the interaction between the institutional praxis of the hospital and its psychotic fractal. Here, focus is placed upon its most intimate encounter - that between the body and the antipsychotic injection. This analysis uses the modern heterotopia of the long-stay unit, and its affective condition of stasis and destabilisation, to highlight the propensity for therapeutic spaces to become *other* and opens a conversation about how space, materially and relationally, may better integrate the individual during the ruptures of psychosis.

The Fractal Heterotopia

Bachelard's *The Poetics of Space*¹⁷ was seminal in its presentation of the life-worlds of our homes and the human persistence to carve out intimate space. In this, Bachelard posited that all inhabited space is imbued with memory and imagination, meaning the individual 'experiences the house in its reality and its virtuality'.¹⁸ If, however, 'the house shelters day-dreaming, the house protects the dreamer, the house allows one to dream in peace',¹⁹ what then when the house is a psychiatric hospital and the day-dream is psychotic?

At its most basic level, the home belonging to the imagination could qualify as a heterotopic counter-space unto itself. Indeed, the psychic projection of the home onto our dwellings connects with Foucault's third heterotopic principle of spaces, otherwise unrelated,

¹⁶ Foucault, "Of Other Spaces", 3.

¹⁷ Gaston Bachelard, *The Poetics of Space*, trans. Maria Jolas (Massachusetts: Beacon Press, 1994 [orig. 1958]).

¹⁸ *Ibid.*, 5.

¹⁹ Bachelard, *The Poetics of Space*, 6.

juxtaposing, or layering upon, each another. But, more pertinently, when the long-stay unit is lived in, the heterotopia of the psychiatric hospital becomes a new interpretive site for the unfolding of the imagined home. It is from here that, I propose, the *fractal heterotopia* emerges. Fractals are, by definition, geometrically self-similar; therefore, in a literal sense, the heterotopia's fractal would be an exact cognitive replica of the space encountered. The fractal's self-similarity, or symmetry, is not however in its character, but is realised through the notion that the hospital and its imagined form inhabit the same physical dimensions and coordinates. In accordance with the third principle, the hospital and its fractal are tessellated upon a *place* which is one and the same. As Bachelard conveyed, the imagined home can be a radical permutation from the shelter it is based on. This challenge to self-symmetry is arguably no more pronounced than when the fractal heterotopia is refracted through the lens of psychosis.

Clinically, psychosis is a prevalent symptom of schizophrenic disorders and is defined by an impaired relationship with external reality, manifesting in disorganised thought, delusions and hallucination.²⁰ On a phenomenological level, psychosis is underpinned by anomalous self-experiences and disturbances of subjectivity which destabilise the integrity of the minimal self - the pre-reflective core of selfhood.²¹ These distortions can be *hyperreflexive*, referring to an objectification or alienation of the processes normally experienced as part of the self, or *diminished*, where one does not perceive oneself as a separate agent or 'an experiencing entity'.²² Delusional assessments of the outer world often accompany these

²⁰ For more information about the diagnosis of schizophrenia and the removal of paranoid schizophrenia as a distinct clinical subtype of the disorder, see Rajuv Tandon, Wolfgang Gaebel, Deanna M. Barch, Juan Bustillo, Raquel E. Gur, Stephan Heckers, Dolores Malaspina, Michael J. Owen, Susan Schultz, Ming Tsuang, Jim Van Os and William Carpenter, "Definition and description of schizophrenia in the DSM-5", *Schizophrenia Research* 150(1) (2013).

²¹ Barnaby Nelson, Josef Parnas and Louis A. Sass, "Disturbance of Minimal Self (Ipseity) in Schizophrenia: Clarification and Current Status", *Schizophrenia Bulletin* 40(3) (2014): 479-482.

²² Louis Sass, Elizabeth Pienkos, Barnaby Nelson and Nick Medford, "Anomalous self-experience in depersonalisation and schizophrenia: A comparative investigation", *Consciousness and Cognition* 22(203), 431.

self-disturbances and are commonly expressed through themes of paranoia, persecution and imminent threat.²³ In light of these disturbances, what kinds of psychic projections are placed upon the institutional home? Funnelled through *delusions of reference* (the tendency to attribute significant meaning upon relatively neutral stimuli) and the schema of paranoia, it is conceivable that the fractal heterotopia produced by the psychotic mind veers toward the dystopian. Here, benign hospital design intending to create humane spaces and ameliorate the anxiety of being detained²⁴ is interpreted by the patient as a clandestine attempt to conceal the true nature of the hospital. By aping ideals of domesticity, as will be explored further, the hospital may be interpreted as a ‘wolf in sheep’s clothing’ and, as a result, imaginatively reconstituted into a terrain of spiritual war, a derivative of the Soviet Union, an alien experiment, a virtual reality show, an extermination camp, or a conspiracy of the like.

Under the warped spatial logic of the fractal heterotopia, food and medication are transformed into poison. Amiable nurses and care assistants are attributed with ulterior, often malevolent, intentions. Misplaced objects are stolen, confiscated or destroyed. The fuzz of staff walkie-talkies are proof that nurses are robots. The laughter of friendship becomes evidence of patient collusion and the alarms of panic buttons confirm this as a place of danger. The mechanisms of opening and closing are governed by the holding power of the psychiatrist, an agent of spiritual warfare or a leader of the KGB. Even the intangible spacetime between the psychiatrist’s weekly visits to the unit is susceptible with their absence corroborating their status

²³ Ion Papava, M. Lazarescu, C. Bredicean, M. Ienciu, L. Dehelean, V. R. Enatescu and R. Romosan “Delusional themes in paranoid schizophrenia and persistent delusional disorder”, *European Psychiatry* 28, no. 1 (2013), S1. See also Shitij Kapur, “Psychosis as a State of Aberrant Salience: A Framework Linking Biology, Phenomenology, and Pharmacology in Schizophrenia”, *The American Journal of Psychiatry* 160(1) (2003): 13-23.

²⁴ For best-practice guidelines for the construction of new psychiatric healthcare buildings, see Department of Health, *Health Building Note 03– 01: Adult acute mental health units 2013* (London: The Stationery Office, 2013).

Available at
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/147864/HBN_03– 01_Final.pdf [accessed June 19 2017].

as a behind-the-scenes puppeteer of the system and a dehumanised emblem of power.

The Uncanny

The dystopian quality of the unit can be unpacked further through Freud's characterisation of the uncanny.²⁵ Freud referred to the *unheimlich* (directly translated as the unhomely) as that which is familiar and at once estranged. The dissonance between the shelter and its daydream already works upon the vectors of being the same but disconcertingly different, yet I argue this is sharpened by the *unheimlich* potential of the long-stay unit in its own right.

Extracted from the broader structure of the house, the inpatient's room can be viewed as the home in miniature. The hyperpersonal assembly of the individual's possessions – their books, toys, ornaments and photographs of loved ones – is challenged by its immediate annexation to institutional corridors threading together the rooms of strangers. Punctured by the surveillance of staff performing clinical observations, this home is prone to slippage between the private and institutional, thus lacking the impervious and intimate shelter Bachelard described. Reminiscent composites of the domestic – the unit's TV room, kitchen worktops and bounded garden patios – are familiar but also alienating as family characters are substituted with strangers, rooms are tellingly devoid of opportunistically risky implements and the patient is unable to leave on their own accord. This disorientation may be compounded by the proliferation of unknown and unseen spaces within the hospital. Jentsch simply defined the uncanny as 'something one does not know one's way about in',²⁶ therefore the unchartered architecture of neighbouring wards and prohibited, locked spaces, from the nurses' station to medication stores, may unexpectedly emulate the surreptitious and

²⁵ Freud, *The Uncanny*, 240.

²⁶ Ernst Jentsch's comment in "On the Psychology of the Uncanny" is cited in Sigmund Freud, "The Uncanny", *The Standard Edition of the Complete Psychological Works of Sigmund Freud, Volume XVII (1917– 1919): An Infantile Neurosis and Other Works*, 217–256 (1919), 220. Available at http://layoftheland.net/archive/ART6933-2012/weeks6-12/Freud_TheUncanny.pdf [accessed June 19 2017].

foreboding entity of Bachelard's cellar and further animate the patient's belief in the subterfuge of the hospital.²⁷

Time, in the long-stay unit, can undergo a similar distortion. By operating outside the traditional regimes of time, Foucault proposed that heterotopias host their own heterochrony. As with the museum or library, the slow acquisition of artefacts in the patient's room comes to resemble a 'heterotopia of indefinitely accumulating time'.²⁸ This archival quality, where 'time never stops building up and topping its own summit',²⁹ combined with the monotony of life on the ward, can produce a sense of stasis, invariably at odds with the wider cross-rhythm of the institutional routine. Here, the unit's time-reckoning practices are repetitive and cyclical, tied to the socio-ecological activities of eating, washing, medicating, sleeping, and the cycles of bi-annual/annual meetings to review detentions under the MHA.³⁰ Another layer of disorientation is introduced when considering the unknown duration of the patient's hospitalisation which fluctuates with their psychiatric progress and the funding of their placement. At once fixed and circular, it seems the heterochrony of the unit lends itself to an institutional inertia which, when arbitrated by the characteristic disruptions of schizophrenic memory, may only intensify the temporal discontinuity at the centre of psychosis.³¹

The Encounter of the Two Heterotopias

²⁷ Bachelard, *The Poetics of Space*, 18.

²⁸ Foucault, "Of Other Spaces", 7.

²⁹ Ibid.

³⁰ For more on the construction of time through ecological activities (albeit a different cultural context), see Edward E. Evans-Pritchard, "Nuer Time-reckoning", *Africa: Journal of the International African Institute* 12(2) (1939): 189-216.

³¹ Disturbances in time-perception and detachment from the self in schizophrenia are excellently explored in Brice Martin, Marc Wittmann, Nicolas Franck, Michel Cermolace, Fabrice Berna and Anne Giersch "Temporal Structure of consciousness and minimal self in schizophrenia", *Frontiers in Psychology* 5(1175) (2014): 1-12.

Deleuzian-Spinozan concepts of affect³² are particularly helpful for a study about psychotic elision, where the self/world boundary is fragile, where one's contents are not necessarily experienced as separate from others and where psychosis reaches to reterritorialise its environment. Affect theory thus refers to the 'composition of harmonious or disharmonious relations amongst diverse collectivities of humans and nonhumans',³³ the intensities and passages which are 'never self-contained, or fully self-present in an individual body existing "in" space or "in" time'.³⁴ Neither pivoting upon a subject or object-centred framework, affects are trans-subjective; 'they are becomings that go beyond those who live through them (they become other)'.³⁵ Remarkable parallels can be drawn between the trans-subjective parameters of affect and the subject/object disruptions central to schizophrenia. Equally, while affect theory makes it possible to speak about the minute exchanges of all matter, the schizophrenic appraisal similarly latches onto all things and empowers the seemingly negligible. The fragility of the internal/external binary in both affect theory and schizophrenia contests the exclusively interior and 'fantasmatic'³⁶ character of the fractal heterotopia. In this regard, the hospital heterotopia and its dystopian fractal interact via the patient's retaliation. This response can result in the patient boycotting medication, refusing to eat, neglecting self-care, becoming agitated towards staff and aggressive towards other patients. These presentations often lead to the clinical decisions to increase the dosage of antipsychotic medication, apply physical restraint and/or remove privileges. In an ironic misfortune, the firmness of the institutional response can be consistent with the patient's reading of adversarial care, seemingly confirming the credibility of the fractal heterotopia.

³² Gilles Deleuze, "Spinoza and the three ethics", in *Essays Critical and Clinical*, trans. Daniel W. Smith and Michael A. Greco (London and New York, Verso, 1997).

³³ *Ibid.*, 139.

³⁴ Ben Anderson "Becoming and being hopeful: towards a theory of affect" *Environment and Planning D: Society and Space* 24(5) (2006), 737.

³⁵ Deleuze cited in Daniel Smith *Essays on Deleuze* (Edinburgh: Edinburgh University Press, 2012), 204.

³⁶ Foucault, "Of Other Spaces", 2.

Perhaps there is no more intimate encounter between the hospital and the patient than the chemical ‘depot’ injection meeting the body. These injections contain prescribed antipsychotic medication targeting delusional and hallucinatory symptoms and are administered on a weekly/monthly basis. While psychotic, the patient may view their medication as a potion of black magic, as an implant to control them from within or a deadly poison. However, when administered, a new schedule is at work. A biochemical clock, initiated by the chemical intervention, subjects the body to a new rhythm dictated by the medication’s decay and subsequent renewal. Like Deleuze’s analogy of arsenic, the ingested antipsychotic not only enters new relations with the body, but its entry marks a radical re-composition of the body’s relations to itself.³⁷ This is especially pertinent when recognising the well-documented side effects of both typical and atypical antipsychotic medications, which extensively affect the body’s motor, gastrointestinal, metabolic, cardiac and autonomic systems.³⁸ In the vein of affect theory, which recognises the affects discharged by objects, an intriguing situation arises when the object’s *raison d’être* is to discharge and induce new energies. Modulations in neurochemistry inevitably re-orientate the sensory processing of sights and sounds on the unit and may contribute to an entirely new reading of space. The fractal heterotopia is then profoundly altered by the drug’s application: dissolving altogether, persisting faintly or sporadically in shards, only to become more persistent when the medication wanes. This new source of destabilisation means the integrity of the fractal heterotopia now hinges upon an interplay between fluctuating psychosis and a timed chemical intervention.

Reflecting upon these multiple disturbances – the dystopian daydreams of psychosis, the unit’s propensity toward uncanny, the

³⁷ Gilles Deleuze, “Spinoza: Cours Vincennes” (1978). Available at <http://www.webdeleuze.com/php/texte.php?cle=14&groupe=Spinoza&langue=2> [accessed June 19 2017].

³⁸ Anne– Marie Bagnall Lisa Jones, L. Ginelly, R. Lewis, Julie Glanville, S. Gilbody, Linda Davies, David Torgerson and J. Kleinen, “A systematic review of atypical antipsychotic drugs in schizophrenia”, *Health Technology Assessment* 7(13) (2003): 1–502. Available at https://www.ncbi.nlm.nih.gov/pubmedhealth/PMH0015112/pdf/PubMedHealth_PMH0015112.pdf [accessed June 19 2017].

fragility of the private/institutional, time distortions, objectifications of the body and the chemical fluctuations of the antipsychotic – this analysis indicates that the long-term hospitalisation of schizophrenia may be susceptible to recreating ‘the dominance of multi-layered disconnectedness’³⁹ at the core of psychotic experience. What emerges is an affective zone of both stasis and destabilisation, inadvertently stalling the individual’s reconnection with external reality and, most importantly, their minimal self. Using an abstraction of the long-stay unit, I argue that an affective reading of modern psychiatric heterotopias is crucial for understanding how dystopian spaces might proliferate in therapeutic institutions and thus impede patient recovery.

Concluding Thoughts

In *Of Other Spaces*, Foucault distinguished between the ‘external space... in which we live’ and the ‘internal space’⁴⁰ of the daydream. Drawing upon the trans-subjective properties of both affect theory and schizophrenia itself, this article proposes that psychosis does not exist in one universe and the institution in another. Rather, this analysis critically engages with the vital exchange between the heterotopia and its fractal to explore the spaces emerging from the context of long-term hospitalisation.

This is not a renouncement of the psychiatric hospital; to borrow Guattari and Rolnik’s caveat, ‘there is not the slightest doubt that it is absolutely necessary that asylums and refuges should exist’.⁴¹ In praxis, the spatial relations of a psychiatric unit and the individuals inhabiting them will undoubtedly be diverse. Moreover, many have survived serious psychiatric crises and succeeded in independent living after life on the secure unit. Rather, my proposals agree with Jentsch that ‘the better orientated in his environment a person is, the less readily will he get the impression of something uncanny in regard to

³⁹ Brice Martin, “Temporal Structure of consciousness and minimal self in schizophrenia”, 2.

⁴⁰ Foucault, “Of Other Spaces”, 3.

⁴¹ Felix Guattari and Suely Rolnik, *Molecular Revolution in Brazil*, trans. Karel Clapshaw and Brain Holmes (New York: Semiotext(e), 2008), 376.

the objects and events in it'.⁴² One might presuppose that the derived fractal heterotopias of schizophrenic patients will be equally dystopian in any setting. This analysis puts forward the possibility that spaces exist, materially and relationally, that are simply *better* at re-orientating people during their experiences of fundamental alienation.

Accordingly, by acknowledging the phenomenology of the porous self/world boundary of schizophrenic experience⁴³ and using affective analysis to highlight the granularity of the *in-between* and the 'passage between contexts',⁴⁴ critical conversations can be had about how psychiatric protocols responding to psychosis inhibit the integration of the person. Can the mistrust emanating from professional risk-managing practices be internalised as an essential mistrust of the self? Does the objectification of the body via the unit's constraints recreate the hyperreflexive objectifications of the subjective elements? Do the priorities of eliminating psychotic symptoms only reify basic rejections of parts of the self? Alternative therapeutic designs, such as La Borde, Kingsley Hall and the Soteria paradigm,⁴⁵ have had variable success in remodelling the treatment of mental illness. Their common approach, however, was to rearrange the hierarchical anatomy of psychiatric care and, adopting the parlance of Soteria, re-characterise treatment as a process of *being with*, rather than *doing to*. The collaborative core⁴⁶ of *being with*, in the case of psychosis, may model, initiate and sustain a more harmonious way of

⁴² Freud, *The Uncanny*, 220.

⁴³ Josef Parnas and Peter Handest, "Phenomenology of anomalous self experience in early schizophrenia", *Comprehensive Psychiatry* 44(2) (2003): 121-134.

⁴⁴ Anderson, "Becoming and being hopeful: towards a theory of affect", 736.

⁴⁵ Mosher was an associate of R.D. Laing and was exposed to Laing's work at the radical Kingsley Hall. For further information on the Soteria model, see Loren R Mosher, Voyce Hendrix and Deborah C. Fort, *Soteria: Through madness to deliverance* (Indiana: Xlibris, 2004). To see results about the effectiveness of the Soteria paradigm, see Tim Calton, Michael Ferriter, Nick Huband and Helen Spandler, "A Systematic Review of the Soteria Paradigm for the Treatment of People Diagnosed With Schizophrenia", *Schizophrenia Bulletin* 34 (2008): 181-192. The results suggest equal, or better, outcomes in people with first or second episode schizophrenia spectrum disorders when compared to medication-led approaches.

⁴⁶ Larry Davidson and John S. Strauss, "Sense of self in recovery from severe mental illness", *British Journal of Medical Psychology* 65(2) (1992): 131-45.

being. Consequently, I suggest that by diverging from the *doing* strategies of elimination and objectification, the individual can be more productively re-orientated and re-territorialised back into the body and back into human connection.