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Emplacing recovery: How persons diagnosed with psychosis handle stress in cities

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Abstract

The background of this study is recent work on the correlation between urban living and psychosis. It is part of a larger interdisciplinary research project using an experience-based approach to the city-psychosis nexus. The aim of this paper is to investigate how, soon after a first episode of psychosis, patients manage urban factors of stress. Methodologically, it is based on video-elicitation interviews of urban walks and ethnographic observations in a community care centre in the city of Lausanne, Switzerland. It shows that patients use three tactics: creating sensory bubbles; programming mobility; and creating places of comfort. On the basis of these findings, the paper discusses how the approach and results of our study can inform strategies of recovery that are both user-driven and take into consideration the importance of places and situations in the city in the phase following a first episode.

Introduction

Various recent studies in different national contexts have shown that there is a correlation between urban living and the development of psychosis (Allardyce et al., 2001; Kelly et al., 2010; Kirkbride et al., 2007; Lewis, David, Andréasson, & Allebeck, 1992; Marcelis, Navarro-Mateu, Murray, Selten, & Van Os, 1998; Mortensen & Pedersen, 2001; Sundquist, Frank, & Sundquist, 2004; van Os, 2004; Vassos, Pedersen, Murray, Collier, & Lewis, 2012; Zammit et al., 2010). The link between urban living and increased risk of developing a psychiatric disorder is specific to psychoses and not to other diagnoses, except perhaps for severe depression, but in this case, with a much lower incidence (van Os, 2004). Various factors on an individual or neighbourhood scale, such as the experience of social defeat (Freeman et al., 2015), density (Vassos et al., 2012), social adversity (Heinz, Deserno, & Reininghaus, 2013) or social deprivation (Kirkbride, Jones, Ullrich, & Coid, 2014) have been investigated to explain why the prevalence of psychosis is, on average, two times higher in urban than in rural areas. However, for the time being there is no clear model of how different factors

combine to make urban living as a whole a trigger in the onset of this illness (Söderström et al., 2016).

In contrast to an exploration of the urban dimensions of the aetiology of psychosis, the aim of this paper is to investigate how, soon after a first episode of psychosis, patients manage the difficulties that urban milieus represent for them. This research strand relates to recent work in human geography and social anthropology on how persons living with a diagnosis strive to create the social, affective and environmental conditions of recovery in urban environments (Bister, Klausner, & Niewöhner, 2016; Duff, 2016; Klaas et al., 2016; McGrath & Reavey, 2015; Parr, 2008). These dimensions are generally absent from recovery models in psychiatry which rightly concentrate on individual efforts and the help of peers, but rarely consider the socio-economic and material conditions in which recovery is experienced. Our paper focuses on concrete material situations encountered by first episode patients. We analyse more specifically the tactics of patients in cities, how they deal with a milieu that is often stressful, especially soon after a first episode.

'Tactics' is a term often used in urban studies in the wake of the influential work of the French philosopher and sociologist Michel de Certeau (1984). It refers to the ordinary and often tacit ways of doing things, in contrast with the more intentional strategies of different types of institutions such as state urban planning agencies. These 'tactics' are usually described as creative and resisting norms and rules imposed by the State or private economy; they are distinct from 'coping strategies' which refer more specifically to psychological and cognitive dimensions of stress management (Bister et al., 2016). While we are sceptical about this frequent romanticisation of users' tactics, we still think the term aptly captures important (and often unconscious) ways through which we go about our everyday lives, notably in the city. Drawing on video-elicitation interviews with ten patients, semi-structured interviews with ten further patients and ethnographic observations in a specialized early psychosis programme in the city of Lausanne, Switzerland recruiting 50 new patients each year since 2004, 'tactics' are what this paper studies, in an attempt to explore a set of recurring ways of

handling the city developed by these patients. In our concluding discussion, we argue that knowledge of these tactics provides orientations for service users, care professionals and urban planners.

Method

Design

The methodological design of the study is based on an interdisciplinary dialogue between members of the team. It includes video-recorded go-alongs as well as video-recorded film-elicitation sessions with ten patients of an early intervention programme for psychotic disorders called TIPP (for *Traitement et intervention précoce dans les troubles psychotiques*), semi-structured interviews with 10 other patients based on non-recorded go-alongs and participant observation over a three month period in a community care service in the city of Lausanne, Switzerland. The go-alongs took place in Lausanne and the itineraries were chosen by the patients who were accompanied by a friend, a member of the family or, if nobody else was available, by a member of the research team. The ten video-recorded go-alongs lasted between 40 and 120 minutes each.

For the video-elicitation sessions, patients were shown the videos of their walks and asked to freely comment on them. A semi-structured interview followed immediately in order to discuss aspects that had not been spontaneously addressed during the video elicitation. It involved questions regarding routine urban practices, stress, comfort, and social interaction in urban milieus as experienced during the go-along; while more general questions concerning patients' successive places of residence were asked in the concluding part of the interviews. Questions were open and related to ordinary urban situations (for instance: "What are you doing when you encounter a crowded place?"), avoiding technical terms present in academic studies, such as 'stress' or 'social interaction'.

These video-elicitation sessions took place at the outpatient clinic, one to four weeks after the walks and involved a psychiatrist and a geographer who led the interviews with the patients. These video-elicitation sessions were themselves video-recorded and analysed within an interdisciplinary workshop that included the psychiatrists and geographers on the team.

The video-elicitation interviews were transcribed and thematically coded. Thematic coding was done on the basis of three elements: a. themes that resulted from a previous preparatory interview-based study with a group of patients involved in the same program (Söderström, 2016), b. themes that emerged from the analysis of the interview transcripts and c. themes that emerged from the previously mentioned interdisciplinary workshop where interpretations of recorded interviews were shared between geographers and psychiatrists. Psychiatrists on the team brought their clinic- and research-based knowledge, while geographers brought their expertise on place-related social practices to the workshop. Following procedures of thematic interview analysis in human geography (e.g.: Dunn, 2005), coded interview transcripts were then extracted and grouped by a geographer on the team in thematic documents in order to successively analyse convergences and divergences between interviewers' statements. The recording of the go-alongs is a time-consuming and labour-intensive procedure. This is why it was limited to ten patients. However, ten further interviews during and after non-video-recorded go-alongs were conducted to increase the sample of participants. They were transcribed, coded and analysed following the same procedure. Finally, following ethnographic data collection procedures in human geography (Crang & Cook, 2000), participant observation by one of the authors of this article (a geographer) used regular note-taking and photography to record information for the research. Thematically coded notes from participant observation were used to enrich and contrast the results of the interviews. The aim of the participation was declared to the service users and the researcher was involved in taking part in and organising activities in the community care centre. Thus, the following results are based on interviews and ethnographic work with a total of 36 participants.

Recruitment

The research focuses on young patients with recent first experiences of psychotic disorders. The patients are all involved in the Treatment and Early Intervention in Psychosis Programme (TIPP) launched in 2004 by the Department of Psychiatry at the University Hospital in Lausanne, which provides specialized integrated care for a period of 3 years, based on current international guidelines (Baumann et al., 2013). The urban region of Lausanne, where the study took place, is Switzerland's fifth largest, with a population of 335,000 inhabitants in 2014. Patients aged between 18 and 35 were included in the Programme following their first psychotic outbreak (but excluding those for whom psychosis was induced by illicit substances, those with an IQ below 70 and those suffering from severe neurological problems): the majority of participants had never been exposed to antipsychotic medication before entering the Programme. These patients are routinely assessed every six months over a treatment period of 36 months. Only those patients with diagnoses of schizophrenia or non-affective psychoses participated in the present study after providing written consent to a research protocol that was approved by the local Ethics Committee.

Results

All participants, except one, expressed a preference for the countryside rather than urban areas, based on the fact that the latter are associated with factors of stress. Another publication drawing on the same study, shows that the factors of stress identified by the participants were: density (of people and buildings); levels of sensory stimulations; obstacles

to mobility; and questions of role management in public situations (Söderström et al., 2016). Participants' urban tactics are, of course, connected to these factors: their ways of dealing with the city are in part determined by attempts to avoid or regulate these sources of stress. These tactics are varied because they are related to participants' specific health problems and the urban situations encountered in their daily lives. However, systematic analysis of our interviews and observations shows that tactics fall into three groups: programming and regulating mobility; creating 'bubbles' of isolation; and creating atmospheres of comfort. These tactics are described before we discuss them in a larger theoretical and empirical context.

Programming and regulating trajectories of mobility

Patients' experiences of the city are rarely analysed as a mobile phenomenon (but see: Ellett, Freeman, & Garety, 2008). The walks undertaken during the study allowed us to understand how participants organise their mobility. Although the walks had no specific predetermined goal and participants were invited to spontaneously go wherever they wanted, a majority of walks had been carefully planned beforehand by participants. For instance, Laure wanted to avoid the city centre and possible encounters with people she knows. She therefore made an appointment with us for a walk in the suburbs.

The video-elicitation sessions showed – either by explaining the videos or by commenting more generally on their urban habits – how all participants strive to produce a predictable environment. They do so, they told us, by the careful *planning of pathways in the city*: “I optimise my journeys down to the smallest detail” explains William. Before going out “I already know everything” says Rachel. Trajectories in the city are well-prepared in advance, but also carefully controlled during a walk in the city. Alex puts it this way: “I hear

everything. In the city you need to be vigilant about everything: it's tiring. I have very clear perceptions of my environment. I am a super-analyst. I analyse whatever small thing close to me is not in its place."

This constant monitoring of the urban milieu is a means of avoiding sources of stress - density (problematic for 80% of participants), noise and the proximity/gaze of other urban dwellers. Pointing at the screen when he is shown in the video taking a little side-street, Benoît explains how he "cuts the city": "On purpose, I cut the density of the city. I choose small isolated streets where there is less noise."

Another way of organising mobility is the rhythm of walking. Six participants said they accelerate their rhythm when they encounter sources of stress and slow down when the milieu is more favourable. Finally, urban practices are also programmed according to moments during the day or intensity of symptoms. Some places considered by participants as highly demanding in terms of sensory solicitation or social contacts may, however, be appreciated early in the morning (when they are less busy) even when symptoms are present; and they can also be considered unproblematic when symptoms are absent. In sum, these different ways of planning and regulating mobility are used to produce predictable experiences in a milieu characterized by the frequent irruption of the unexpected.

Creating bubbles of isolation

Participants mentioned different ways of being, and at the same time, not being in the city. In other words, they described how they go about their activities while protecting themselves from factors of stress. These are at first sight differing individual tactics within a small group of participants, but if we consider them together as 'bubble-making' tactics, they correspond to a consistent element in our findings. We use the term 'bubble' because it

was used by different participants when mentioning how they protect themselves from factors of stress in the city, such as the gaze of others often perceived as judgemental. For two participants, it is primarily a technological bubble. They use portable IT devices – headphones, smartphones, laptops.

Other participants (n=9) use *peers* in their ‘bubble-making’. While it is not the case for all patients – some see peers rather as intruders into their bubble –, for these participants, friends or members of their family are filters that mitigate sensory stimulations. Therefore, they immerse themselves in conversations they’re having with them and entrust them with the task of organising the trajectory in the city. William thus says: “I follow others and completely let myself go”. Participants also describe how *thought bubbles* work as protections. They look at the pavement and engage in an interior dialogue, they think about fond memories or about people they like in order to be there while being also partly absent. Finally, three participants explained how they actively disconnect socially and sensorially. Matteo says: “I stay indifferent. I pretend nothing happens”; while Rachel explains that she does not respond when people ask her something. She pretends she has neither seen nor heard the person addressing her.

Using social interaction, technology, thoughts and disconnection to this end is not specific to persons with psychotic disorder. However, if we follow the aberrant salience thesis (Kapur, 2003; van Os, 2009) the use of such tactics by patients becomes understandable.

Creating atmospheres of comfort

The term ‘atmosphere’, rather than place, zone or situation, aptly summarizes our findings concerning how participants try to create comfort in the city. Rarely did participants point to specific places or situations as providing comfort: they rather described how they *relate* to a

series of elements present or absent in a place. Atmospheres are made of these relations. As Duff (2016, p. 63) puts it: “atmospheres belong neither to an environment nor a subject”. It sits between those two poles and captures how we experience and are affected by the conjunction of different aspects of what surrounds us: the presence of others, physical space, light, heat, color or other elements perceived by our senses.

Not surprisingly, considering how psychosis is related to isolation and often domestic retreat, for many of our participants (n=15), home in its different forms (their own apartment, a temporary therapeutic housing, their parents’ apartment) is the primary place associated with an atmosphere of comfort. It works as a safe haven, especially in periods of anxiety. In those moments, says Rachel, “even if I have someone to meet or something to do, I immediately head home”.

This role of home is well known, as is the fact that it can be both a place of comfort and of discomfort (Bonsack & Garcia, 2015). However, to understand patients’ urban tactics in their recovery trajectory after a first episode, it is crucial to move beyond the home and examine the process through which a broader perimeter of urban space is progressively conquered (see also Bister et al., 2016). In this process, *interactional* comfort plays a central role: the perception of other people’s mood is carefully monitored by the participants. They explain how the speed of gestures, for instance, is an indicator of people’s mood, revealing whether or not they are calm and relaxed. Thus, other peoples’ positive moods - ‘good vibes’ - are a crucial aspect of a comfortable urban atmosphere in our participants’ experience.

Comfort is also linked to open spaces, possibilities of escape (n=8) and unobstructed views. Four participants mentioned large public squares, and eight described places where the way out - a possibility of escape - is clearly perceptible. Others mentioned places where they can look at an open landscape: for instance, the lakeshore or parks from which the mountains

can be seen. Participants associate these open spaces with a sense of freedom, calmness and the capacity to control their environment. This contrasts with the sense of discomfort expressed when facing visually-charged urban contexts (tags, adverts, etc.) which tend to produce psychotic interpretations of sensory perceptions.

Finally, comfort is also actively created by using what the psychologist James Gibson (1979) called *affordances*. Affordances in his theory describe the latent possibilities of action offered by objects or spatial settings. Guy, for instance, has been sleeping and working for months in a student bar in a university building. Other persons running the bar as well as people responsible for security and maintenance all know and accept this situation. Guy has created a niche where he both belongs to a group and “can easily stay on [his] own”. In sum, comfort in cities is not simply provided by patients’ homes or features of the built environment, but produced by patients’ active engagement with the social, physical and sensorial dimensions of places’ atmospheres.

Limitations

There are three limitations to our research. The first is the rather small sample due to the time-consuming methodology we used. A survey with a larger group of patients building on these findings would allow us to see if the tactics we identified are congruent with the experience of a larger group of participants. The second limitation relates to the characteristics of the study site. Urban areas have variable characteristics which lead to differing ways of dealing with the city for patients after a first episode. A better comprehension both of ‘urban stress’ and of recovery tactics requires comparative work across a range of cities differing in their size, socio-economic structure and geographical

location (Global North versus Global South in particular). However, as we discuss below, our fieldwork-based results with first episode patients provide new insights into how they deal with urban stress and new elements for user-driven and context-sensitive recovery strategies. Finally, in this paper we focused specifically on the tactics used by patients in order to handle stressful urban situations during periods of recovery following a first episode of psychosis. Our study design did not allow us to extend the analysis neither to the possible impact of exposure to urban milieu prior the emergence of psychosis, nor to the role played by urban milieu in the recovery process.

Discussion

Our analysis shows that three tactics (creating sensory bubbles, programming mobility, creating places of comfort) are used by first episode psychosis patients. The common denominator of these tactics lies in how they contribute to handling the relations between persons and their milieu (both physical and social) in order to avoid factors of stress during a phase of recovery. They show how persons living with a diagnosis of psychosis try to avoid density, noise and unpredictable events and how they search for calm 'niches', such as parks. The tactics we identified are important resources used by first episode patients in their efforts to re-establish what, for them, would be a sustainable form of urban living: they are part of their struggle for recovery. Therefore, in this discussion section we focus on what the approach and results of our study brings to the literature on recovery in the field of mental health.

In their systematic review of personal recovery in mental health, Leamy et al. (2011, 450) observe that the "philosophy of recovery gives primacy to individual experience and meaning". This, they add, "may underemphasize the importance of the wider socio-

environmental context, including important aspects such as stigma and discrimination". Our study responds to this limitation in two ways: first, by looking at practices of everyday life rather than using standardised evaluation scales and interviews; and second, by showing that recovery is an emplaced process rather than an abstract model made of a series of successive phases.

The CHIME model for instance, based on a systematic review of the literature, identifies five processes: Connectedness, Hope and optimism, Meaning and purpose, and Empowerment (Leamy, Bird, Le Boutillier, Williams, & Slade, 2011). However, as Duff argues (2016, p. 62), if CHIME is a rich and rigorous model, "it remains unclear how the five recovery stages posited in the CHIME model actually engender an experience of 'becoming well', and how these stages are enabled or inhibited within a broader web of social, political and economic contexts". The risk with such a model is "that recovery is treated as a function of a given individual's effort or will to recover" (ibid.). It might thus mean, as a carer quoted by Roberts and Boardman (2013, p. 405) puts it, that "people will be denied supports and services to promote 'independence'". In other words, introducing context in approaches and analyses of recovery is a means to bring social, material and political dimensions back in. Responding to these risks and limitations and drawing on a qualitative study, Topor et al. (2011) argue that recovery is also a social process involving the contribution of others (family, friends, carers, colleagues), good material conditions (proper housing, decent revenue) as well as access to knowledge about the recovery process and a positive reciprocal relation with care professionals. They thus conclude that "it is not only the individual who needs to develop in a recovery process but also the social network" (Topor et al., 2011, p. 96).

These recent developments in research on recovery point towards the importance of user-focused recovery research and user-oriented guidelines in the promotion of recovery in

mental health policies. The TREE programme (Toward Recovery, Empowerment and Experiential Expertise) developed in the Netherlands promotes such an approach. A recent study of the results of this program as implemented in four mental health care organizations in the country shows that TREE is “associated with increased mental health confidence, less self-reported symptoms, lower level of need for care and reduced risk of institutional residence” (Boevink, Kroon, van Vugt, Delespaul, & van Os, 2016, p. 295). Our study shares this user-oriented perspective. However, it is not an evaluation of a recovery program. It looks at recovery practices *in situ* and, compared to factors of recovery usually identified in psychiatry which insist on personal identity and social integration (Leamy et al., 2011; Roberts & Boardman, 2013; Topor et al., 2011), it shows the importance of places and situations in the city in periods of recovery following a first episode of psychosis.

Duff (2012, 2014, 2016) has also studied recovery in this way. In his studies of recovery in mental health, he looks at enabling resources in cities to allow service users “to examine the social, material and affective conditions of recovery” (Duff, 2016, p. 65). He finds that affective atmospheres in terms of opportunities for social interaction, safety, belonging and hope are important factors when recovery is approached ‘in the wild’ (Callon & Rabeharisoa, 2003) rather than in a laboratory or clinical setting. Our findings about the role of active bodily and affective engagement with ordinary everyday milieus converge with Duff’s studies. However, our study is part of a larger research project on the relation between urban living and psychosis. Therefore, it focuses more specifically on the tactics developed by young patients in order to manage aspects of the urban milieu that had been identified as stressful in previous studies (Söderström et al., 2016). As a consequence, the three tactics we identified – mobility planning, fabricating protective ‘bubbles’ and creating atmospheres of comfort – can provide helpful orientation for care professionals and service users, and

provide some response to Topor et al's (2011) call for better provision of knowledge in order to empower members of recovery networks.

Beyond knowledge for carers and service users, these findings also provide indications for urban planning. They show how noise limitation, free access to calm public spaces, and clear means of orientation matter for mental health. The importance of home for the participants in our study highlights once more how important affordable and autonomous housing, such as advocated by 'housing first' programs, is for the process of recovery. In other words, taking context seriously in recovery approaches shows the importance of better connecting mental health and urban development policies.

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