# QUALITATIVE RESEARCHER VULNERABILITY

## Negotiating, Experiencing and Embracing

*Edited by Bryan C. Clift, Ioannis Costas Batlle, Sheree Bekker and Katharina Chudzikowski*

First published 2023

ISBN: 978-1-032-39329-2 (hbk)
ISBN: 978-1-032-39333-9 (pbk)
ISBN: 978-1-003-34926-6 (ebk)

# Chapter 11

## FRAMING TRANSDISCIPLINARY RESEARCH AS AN ASSEMBLAGE

### A case study from a mental health setting

*Mark Batterham and Aled Singleton*



DOI: 10.4324/9781003349266-15

The funder for this chapter is Swansea University

Routledge
Taylor & Francis Group
LONDON AND NEW YORK

# 11

# FRAMING TRANSDISCIPLINARY RESEARCH AS AN ASSEMBLAGE

## A case study from a mental health setting

*Mark Batterham and Aled Singleton*

### Introduction

In this chapter, two authors, Mark, a practising mental health nurse, and Aled, an early career human geography researcher, report and reflect on the issues of vulnerability as they collaborate on bringing the practice of walking therapy to support mental health recovery. Due to factors such as lack of resources and the risk-averse nature of clinical practice, the research journey is often in flux and its boundaries are stretched and squeezed. To reflect how these slippery characteristics were encountered, we have framed this account as what we call a *transdisciplinary assemblage*. This conceptual model, which we define in the first section of this chapter, allows us to explore four cases of vulnerability at key moments. Point A relates how bringing walking therapy into clinical practice challenges the risk culture of the organisation and reveals the weak position of nurses as leaders in research. Point B shows how the influence of geographical thinkers causes the work to accelerate too quickly and nearly brings the whole process to a premature end. Point C is principally a period of strength as the process of interviewing service users and practitioners is underway. However, this latter moment is also a chance for us as researchers to stop, reflect, and better understand ourselves as subjects in the process. In this stage, Aled appreciates how precarious academic contracts restrict his work and Mark wrestles with the realities of incorporating meaningful service user involvement. Arriving at Point D, there is a particular weakness realising that there may be no resources to take the approach further.

We firstly explain why we have combined the terms *transdisciplinary* and *assemblage* and outline why it is useful.

DOI: 10.4324/9781003349266-15

## How we understand and define the transdisciplinary assemblage

The background of this writing is the research experience of developing, documenting, analysing, and making the case to further embed walking therapy within clinical practice. The walking therapy in this case was formalised and expanded by mental health practitioners with the aim of taking practice outside the physical confines of the institution and to help service users (re)gain confidence in public space. As the practice developed it became attracted to – and to some degree enveloped within – forces beyond the day-to-day relationships between service users and practitioners. For example, nurse Mark was apprehended by an abortive attempt to gain research funding in Stage B. In Stage C, there was a need to bring in the expertise of social researcher Aled to lead the interviews for a formal service evaluation. His precarious employment in academia made this task harder. The burden that this put upon the individual is not uncommon. We argue that our case of pursuing walking therapy, and therapy whilst walking, in a mental health setting became a subject in its own right. Trying to advance the practice means that it is now an entity which exists beyond the people or the institutions concerned.

We reason that the research process starts to have some of the characters of an *assemblage*, as originally developed by Gilles Delueuze and Félix Guattari in *Capitalism and Schizophrenia* (1977). Writers such as Bruno Latour (2007) have developed assemblage thinking into further theories, but it is human geographers who seem particularly interested in the latter concept. For example, Woodward, Dixon, and Jones (2009, p. 401) explain how:

> Deleuze presents a world encountered from the perspectives of movement and force relations: rather than structured, whole objects (the human, the subject, what have you), there are continuously interconnecting multitudes of partial objects affecting and being affected by other partial objects, constituting – if only for a moment –assemblages that appear to cohere by working together or initiating processes that are specific to that relation.

The attention to movement and forces is important to the case presented in this writing. For example, institutional processes both threaten and give opportunities to develop the practice of walking therapy. Outside the institution, the unexpected COVID-19 pandemic opens up new possibilities at Point C. Therefore, the aim of using Deleuze and Guattari's assemblage theory in our work is to reflect on the vulnerabilities we have faced and perhaps relax a little. By accepting that entities are never fixed, pre-determined, or that they have a completely stable ontological form, we can see our research journey perhaps as an adventure movie. The protagonist has a chance meeting, they squeeze through a door as it is about to close, they are chased down a street, and eventually they emerge into sunlight at the conclusion.

The term *transdisciplinary* is important to our study of researcher vulnerability because it goes beyond the mixing together of disciplines that is generally

considered to be *interdisciplinary*. Lawrence (2004, p. 489) puts transdisciplinary practice into terms that researchers studying vulnerability will understand: 'This implies the giving up of sovereignty over knowledge, the generation of new insight and knowledge by collaboration, and the capacity to consider the know-how of professionals and lay-people.' We will start with Point A, which reveals the potential for a mental health service to encourage and accommodate walking therapies. In this case, we specifically focus on how the mental health nurse becomes vulnerable when they move closer to the discipline of human geography. Stylistically this is written in the present tense and the third person to show how the events unfold. As such this approach is designed to invite the reader to imagine how they would act in such a situation.

## Point A: The opportunity to develop new practices in mental health

There is potential to innovate in the mental health system in England as it has undergone fundamental and far-reaching changes over recent decades, for example, the significant shift to community care in the early 1990s and 'National Service Frameworks' introduced by the New Labour government (Department of Health, 1999). These policy drives established new specialist community services, as well as directing clinical provision. Not all of these services have survived, but the modern landscape of mental health care is barely recognisable from those not-so-distant days when service users were housed and treated together in large asylums. Indeed, McGrath and Reavey (2015) note that few individuals with severe mental health difficulties are now cared for within specialist institutions; the majority occupy geographical spaces alongside persons who do not share similar experiences. Although specialist services may *reach in* to mental health wards and other institutional environments, the community is their main operational territory. This spatial level, namely around the city and nearby areas, is the focus of our research. This general shift towards community care has obvious benefits, but concerns have been raised regarding the isolating reality of service users' day-to-day existence (Sayce, 1999; Parr, 2011). The walls of the 19th- and early 20th-century asylum have been replaced by the spatial consequences of the enduring image of the psychiatric patient and the indifferent politics of neoliberalism. Many mental health service users continue to experience discrimination and alienation and the patchwork of community services and resources developed over many years to support recovery has been unpicked, and in places completely dismantled. Under austerity and its contemporary manifestation, adequate provision for one of society's most vulnerable groups is, like many other social matters, deemed a luxury we can no longer afford. This hollowing out of state and voluntary sector support has been re-packaged as an emancipatory opportunity for service user self-management (Deering, 2016).

The new spatial arrangements of mental health care throw up new problems for research. Through exercises such as audits and service evaluations, organisations acknowledge their own vulnerability and are open to changes in the

conceptualisation and planning of interventions. Although convincing arguments to look beyond conventional knowledge limits exist – for example, see Abrahamyan Empson et al. (2020) – three related factors operate to slow or thwart innovative practice within contemporary mental health care in England. First, much of the mental health system retains a focus on the monitoring and management of risk, shaping relationships and day-to-day service delivery in a way that reflects this priority (Deering et al., 2019). The routine use, and design of the psychiatric clinic itself, embodies this preoccupation with risk (McGrath & Reavey, 2013) and undermines efforts to forge a therapeutic alliance. Second, mental health services are chronically under-staffed. As of writing this, the current (Q3, 2021/22) registered nurse vacancy rates in mental health services are 21.7% in the South East of England and 16% in the South West (NHS Digital, 2022). Third, as innovators in this case study, mental health nurses are criticised from within their own ranks for lacking a clear purpose and sense of identity, instead acting as mere handmaidens to a more powerful medical establishment (Barker & Buchanan-Barker, 2011). Even where nurses have involved themselves in radical movements challenging oppressive practice, such as the closure of the Italian asylums in the 1960s and 1970s (see Foot, 2014), they have tended to follow the lead of their superiors. This vocational self-doubt combines with a defensive risk culture, and what are at times overwhelming job demands, to create a climate where nurses feel vulnerable and consequently hesitant to innovate through practice development or research. Indeed, even where nurses are enthusiastic to involve themselves in research, the pivotal nature of their clinical roles can mean that opportunities are withheld or even withdrawn. This long-standing problem is critical to this discussion of the authors' vulnerability as researchers as it is a nurse (co-author Mark Batterham) who has collaborated with other frontline staff to initiate the changes discussed below.

Notwithstanding the operational pressures and constraints, there is scope and motivation amongst mental health workers operating in community services to develop and broaden the interventions offered. Clinical guidelines promote a more holistic approach to care that opens the way for treatments that extend beyond medical orthodoxy. Within and beyond the case study area, 'wellbeing groups' have been set up to reduce social isolation and improve physical health. In our locality, long-standing social activities include a weekly badminton group and a Saturday morning coffee group. There is an occasional bouldering group and an annual bodyboarding trip. These groups represent a progressive shift from conventional practice and prioritise the relational dimension of recovery, yet they are spatially bounded.

Mark and his colleagues spotted an opportunity to meet the presenting clinical needs of mental health service users in the early stages of recovery by expanding on the activities already offered to include a walking group. Their reasons were threefold. First, understanding that walking with others provides individuals who may be experiencing difficulties with social contact with a choice to opt in or out of conversation. Second, the organisers hypothesised that the shared and companionable experience of walking together would allow for different and perhaps

deeper conversations to take place. As Rebecca Solnit (2001) notes, walking is as much a social and conversational activity as it is a means of individual fulfilment. Finally, they felt that group walks may help defuse the threat of the city. Urban living is a known risk factor for the development of particular mental health problems, for example see Vassos et al. (2012), and there is growing evidence that it may also impact recovery. By way of illustration, busy city streets have been found to increase negative beliefs about the self and others for service users struggling with persecutory delusions (Freeman et al., 2015) and highly stimulating urban spaces can leave individuals feeling overwhelmed (Söderström et al., 2016).

The first outing took place in the spring of 2019 and the group has continued to operate, with breaks over the colder winter months and briefly during the first national lockdown in 2020 to halt the spread of coronavirus. The initial walks were not explicitly staged as opportunities for gathering data; nobody takes field notes, makes surveys or conducts interviews, and brief records are only made after the event. Whether explicitly done for research or not, walking practices change the power dynamics and thus relative vulnerability of both the service user and staff member. This is explained in the Evans and Jones (2011, p. 850) participatory scale of walking interventions, with the practitioner-led 'guided walks' at the bottom and interviewee-led 'natural go-along' walks at the top. As a result, there is a tension between a walk that can help one service user gain confidence through leading, but which may make it harder for the member of staff to manage timings or step in if things go wrong. On the other hand, the practitioner being overly concerned with practicalities and managing risk means that they are less able to spend time focused on service users. In this case, most group walks are planned and led by mental health staff, with a handful of routes organised by service users. In Point D, we reflect on the benefits derived from embracing these potential pitfalls and furthering our approach, with a former service user who previously led a walk becoming part of the team selected to present a conference paper. First, we will explain how the practice is developed through Point B. In this phase, Mark is inspired by the work of Aled, a social researcher promoting walking techniques outside of clinical practice. By trying to encourage democratic involvement in the research process, but eventually failing, Mark's efforts are put in jeopardy.

## Point B: Weakness revealed by accelerating too early

In September 2019, Mark takes a day of study leave from his job in the health service and meets Aled, who is slightly out of his comfort zone, presenting to a group mostly researching the psychological aspects of climate change initiatives. Having met over a hot drink, the two sit next to each other. Aled presents initial findings from his research into place attachment and the lifecourse, where he encourages participation through walking interviews and walking tours (Evans & Jones, 2011). The two stop for a deeper chat over lunch, and swap email addresses. Aled writes later that day and attaches a paper by Tina Richardson (2017) which presents 'schizocartography' as an urban walking technique, and which relies heavily on assemblage

theory. Important terminology is introduced, and efforts seem underway to find a space between disciplines. Mark's immediate response is to recognise the therapeutic potential of Aled's walking method, noting that he will talk to his colleagues. Aled invites Mark to a public event using participatory walking that he has organised for the Economic and Social Research Council Festival of Science in November 2019.

Early in 2020, Mark approaches Aled asking to meet, explaining that he is applying for some funding and needs some guidance on participatory methods. He writes: 'I need to propose ways in which I will address the gaps in my knowledge and skillset… I think the methods you have been using in your study are very relevant to my proposal.' The assemblage starts to resemble how Richardson (2017, p. 6) describes the practitioner-analyst(s) being '…not distanced from the space under examination: they choose the tools and at the same time recognize their own subjectivity in the moment that becomes the assemblage.' This assemblage pursuing walking interventions now includes Mark, the service users he works with, his colleagues, the location in southern England and is bridging into concepts from human geography and a potential new working relationship with Aled. The meeting does not happen due to the start of the pandemic. The lines of communication between the two run cold, until Aled emails Mark at the end of August 2020.

Mark writes back to Aled on 3 September 2020 to say that:

> Unfortunately my [funding] application was rejected: mainly, it seems, because it was too sociological and not clinical enough. So I am in the process of speaking to various contacts to see if I can re-orientate my proposal in a way that will be more fundable yet remain innovative, relevant & interesting.

It transpires that Mark had applied for a research fellowship which would have paid for half of his time, over two years, to lay the ground for a geographical research project alongside his clinical practice. Had it been successful Mark would have been given the time, space, and training to develop a study proposal focussing on the everyday practices of young people living in neighbourhoods that hold a greater risk to the development of serious mental health problems. Not getting the funding meant that the walking groups would continue as before, supported by the goodwill of staff members with busy schedules, and with little scope to design a research approach or gather data.

The assemblage has been thwarted in its moves to interrogate what Mark calls 'sociological' and therefore the doors to the social sciences, including human geography, are impeded. However, Mark shows a degree of resilience and explains that he wants to get some further understanding of human geography and relationships between stress and urban life and asks Aled for some guidance. Aled writes back:

> My work is towards the experimental end of things and – given my supervisors and funders [Economic and Social Research Council] – more about understanding sociological factors rather than the individual. That said, I would be very interested to know more about the clinical.

In the subsequent emails, Mark and Aled agree to meet. The pandemic rules out a face-to-face meeting, and so they connect online. Mark shares some work on restorative environments, citing the work of Weber and Trojan (2018), and explains that he is embarking on an internal service evaluation to evaluate the group and one-to-one walks between service users and mental health staff. As indicated in Point A, such service reviews are the gateway to practice being accepted. Completing such an exercise would enable the nurse to strengthen their position as a producer of knowledge. Moreover, Mark acknowledges that he cannot lead this project on his own. For example, he cannot simultaneously play the role of the champion for walking therapy, the researcher and also the person providing a degree of quality assurance.

A meeting in January 2021 starts to form a service evaluation working group, which includes a junior psychiatrist working with Mark and a clinical academic psychologist. The latter two professionals extend the range of disciplines within the research assemblage. In many ways there would be a trade-off: the service evaluation would have greater credibility, but the social science component risked being compromised. Nevertheless, Aled would bring a geographical approach to potentially interview staff and service users. Beyond the members of the working group, there is an internal approval procedure to follow before the service evaluation can work. Fortunately, there is scope for the service evaluation to focus more on the experience of collaboration and co-production, rather than systematically reviewing impact. Two recent articles published by *Advances in Mental Health* provide useful precedents for service evaluations completed with the limited time and resources available to Mark and team, namely focused on one-to-one semi-structured interviews with a small number of staff and service users. Specifically, Kearney et al. (2021) report on an arts-based family initiative and Patel et al. (2021) focus on cognitive behavioural therapy groups for postnatal women.

Framing the evaluation more around service user involvement and innovation, and less as an account of clinical outcomes, would play to the strengths of the research team. As a human geographer, Aled would consider the spatial qualities of where the walking therapy had taken place. The *public realm* is important to American sociologist Richard Sennett, who states that: 'in public, people can access unfamiliar knowledge, expanding the horizons of their information' (2010, p. 261). The opportunity to use public space was taken up more widely as the coronavirus pandemic washed in from spring 2020. For example, some clinical appointments that would ordinarily be held in an institutional setting moved outside. Individuals diagnosed with severe mental health problems are not always comfortable with telephone or video conferencing interactions, for example because of the nature of their ongoing symptoms. Consequently, many medical reviews, less formal contacts, and even structured therapeutic sessions started to take place on the streets and in the parks. By necessity, walking became a method for delivering broader mental health care. This scenario created an excellent opportunity for our walking therapy research project to gather evidence.

In Point C, we will find out how the research team responds to this opening. There is a chance for Mark to step back and Aled to arrive to conduct in-depth

conversations for the service evaluation. In the following writing, there is an analysis of the interviews themselves and a chance for Mark and Aled to speak in the first person and give their own more personal reflections. Though this moment is largely positive, inherent fragilities are revealed due to the nature of Aled's employment and the limited time available. From this position we approach Point D, where the future of this ongoing work is open to a new set of possibilities.

## Point C: An illusion of strength

Across three visits in the spring of 2021 Aled interviews a psychiatrist, two mental health workers, an employment support worker and two service users. Two of the staff interviews are conducted outside, as the weather is good and also because mask-wearing is still enforced within the building but not outside. Service user participants are required to be interviewed within the walls of the institution and a mental health worker sits in as Aled conducts the discussions. This arrangement is at odds with the matters being discussed, namely the repositioning of social relations. When viewed through the lens of power, we are left wondering whether institutional research processes unintentionally return service users to a position of passivity and vulnerability. Psychiatric environments have been found to stigmatise and devalue service users, as well as reinforcing safety and risk management rather than therapeutic interaction as the primary service concern (McGrath & Reavey, 2013). In this case, service user autonomy is traded in to appease the institution's own sense of vulnerability.

Early analysis from the data gathered during these interviews reveals a conscious rescripting of the therapeutic relationship through co-operation and a creative shift towards the spatial in the delivery of mental health care. For example, the walking group passes through busy urban neighbourhoods, historic centres, and quiet woodlands. Gentle conversations take place and new associations are formed as the small group makes its way over peripheral hills and along repurposed former industrial routes. Seeds of hope are sown as service users in the early stages of their recovery walk alongside their peers approaching discharge.

An interview with a psychiatrist reveals that individual appointments and medical reviews, for so long routinely conducted within institutional settings or private homes, are increasingly taking place outside. Staff speak about abandoning the familiarity, security, and authority of the clinic for the more textured and less formal spaces of the urban street or park.

> I just think [walking] really helps with engagement for us. Instead of coming into my clinic and 'come and have a seat'. It just feels so sterile.
>
> *Psychiatrist*

The psychiatric environment of control signalled by locked doors, alarms, and strengthened glass is exchanged for a stroll together down a rural lane or a cup of coffee on a bench overlooking a canal. This unorthodox practice, already existent by

the onset of the coronavirus pandemic in March 2020, is propelled and legitimised by its restrictions. It stands in quiet determined defiance of the conventional norms and inglorious history of the mental health system. At points, the dominant culture sought to reassert its traditional ways of doing through peer pressure thinly disguised as banter.

> They laugh at me and say, you know, 'Off for another walk? Off for a game of badminton?' Yeah, I want [service users] to see me make a fool of myself and teach me how to play.
>
> *Psychiatrist*

The psychiatrist has an important role to play in advancing walking therapy being adopted within the service. As such, latter comments give an idea of how such innovative practice could be apprehended because practitioners lose confidence to try new approaches.

The group activities and individual practices can both be understood as a conscious embrace of vulnerability on the part of frontline mental health staff. Indeed, taking the research out of the institution is a deliberate move away from environments of monitoring and control. Grbin (2015) acknowledges the influence of architectural arrangements on social relations. For example, it allows mental health workers to pursue a more humanistic approach to care that offers hope, promotes dignity, and foregrounds relationality (Kogstad et al., 2011). The following quote gives an introduction to taking practice outside:

> It was kind of a nice opportunity for them to feel some autonomy because they chose the route because they know the area.
>
> *Employment support worker*

This latter practice is consistent with the participatory typology described by Evans and Jones (2011). For many individuals working in mental health, it accords with their personal values and allows them to reconnect with their original vocational motivations. A change in practice can however have a personal cost in terms of time and the demands of work. Staff appear to consider this a price they must pay if they are to deliver care in the manner they consider best. It enables the relationship between the service user and the mental health system to be redrawn in a more democratic and less imposing direction.

> Being side by side and going in a direction when the surroundings are changing, I think there's something a little bit less kind of putting someone on the spot or under pressure than a sit-down face to face meeting.
>
> *Employment support worker*

Indeed, an example of service user resistance to clinical settings is provided by the psychiatrist interviewed. They describe a young woman who would often shut

down in a clinic room, clearly troubled by her exacerbated symptoms. Walking together in the service user's local park, the conversation was easier, broader, and crucially more productive.

In contrast to scrutinising the presenting mental state of the individual service user within a sterile clinical setting, a focus on the activity of walking is identified as helping to foster a welcoming and safe therapeutic space. As well as being a shared experience, both of the service users interviewed describe attending group walks as a personal achievement, literally *stepping out* towards recovery. On the practitioner side, the psychiatrist and other frontline workers are much less able to shape the outdoor session than when an appointment is held in their own clinic. Perhaps they will remain vulnerable until new procedures are developed in due course.

Thus far we have explained how this research project has developed and changed over time. Framing this journey as a transdisciplinary assemblage has allowed us to engage with the complexity of the relations between the different actors and the constraints put upon the individuals. Sometimes it felt like the goal of developing walking therapy had become engulfed in something else completely. Having completed the individual interview stage for the service evaluation, there are some positive developments in terms of Mark gaining support to promote involvement from service users. The assemblage takes a different form as there is another discipline which demands attention.

## *Emerging from the assemblage allows a chance to reflect*

As Aled conducts these interviews in the spring of 2021, the assemblage is boosted and reformed as Mark gains an internal grant to develop a research proposal. The focus is the spatial dimension of recovery described in Point A, and whose wings were clipped in Point B. Moreover, the health service specifically encourages service user and carer involvement, a sharply progressive aspiration. A recently discharged service user who had led walks for their peers becomes an 'involvee' researcher and helps facilitate group discussions with those still in treatment. Mark finds himself working alongside someone he used to care for, and with whom he walked alongside during the course of treatment. This demands a degree of magnanimity from Mark and may make it more difficult for him to appear as the producer of knowledge for some service users. Resources and power shift towards the service user dimension of the assemblage, impacting on both subjectivities and processes. Most significantly, a former recipient of care is recast as a specialist research assistant, presenting their newly acquired knowledge to the very same clinical staff who used to treat them. The assemblage seems to have achieved the main characteristics which Polk (2015, p. 111) demands of the transdisciplinary approach: 'the inclusion of both multiple disciplines and practice-based knowledge and expertise in the knowledge production process.' As this moment arrives, we step forward and reflect on our positions.

## *Mark's reflection*

Reflecting on our transdisciplinary assemblage, our experience has at times felt like turning up to a fashionable dinner party in the wrong clothes and with an imposter (Aled) as my plus one. The hosts seem well-disposed to our demeanour, yet eye us cautiously as we enthuse excitedly about unfamiliar and seemingly alien writers and concepts. As we offer our coats in the entrance lobby, we try to catch the eye of some of the regular guests gathered inside. They themselves debate the past, discuss the matters of the day, and dispute the way ahead. The third figurative member of our group (the service user) paces nervously outside, hoping to be admitted at an opportune moment through the rear door. It is this opportunity, this space, this potential to connect that defines our assemblage.

My role as a practitioner-researcher has simultaneously been one of *education* (disseminating information relating to the spatial dimension of mental health), *persuasion* (stating and modelling the case for new, more lateral forms of clinical and research practice), and *organisation* (mobilising resources within and beyond the health service). Granted, it is a position of individual vulnerability but through the development of collaborations and networks, it has forged collective strength. A direction made now to terminate walking practices or exclude service users from the research process would appear reactionary.

*Within* our assemblage, Aled's position as an outsider seems to impact on the research process in a number of ways. As a human geographer independent of the health service, he is untainted by the omnipresent undercurrent of monitoring. This enables his interviews with service users to be more curious and less complicated. Indeed, Aled's comparative ignorance of matters pertaining to psychiatric illnesses places service user participants in a position of relative power. Although Aled drafted the interview schedule with me, the service users hold superior knowledge about the clinical context and chose what and how much to reveal. This relational dimension was magnified in the interviews with clinicians and support workers. Health staff can appear defensive when quizzed on their practice by their peers (Råheim et al., 2016), and so Aled's neutrality may allow for more open, reflective discussions. In both sets of interviews, Aled places himself in a position of vulnerability as he sets about 'studying up' (Nader, 1972; Rose, 1997). He risks being dismissed as a green and ignorant outsider, yet utilises this vulnerability to establish rapport in discussing topics of potential sensitivity.

## *Aled's reflection*

As planning for Stage C started, I was in possession of a doctorate, but my monthly PhD stipend had ended and I was holding an honorary (unpaid) position at my own institution. I was now part of the significant academic workforce chasing precarious employment through short-term funding (Morgan & Wood, 2017). To undertake the interviews with Mark, I would effectively be on loan to the health service. Being in a situation which is familiar to many recently qualified doctors

of philosophy (Herschberg et al., 2018) meant that I was in the habit of keeping positive by projecting my forward programme of work. For example, I wrote about these yet-to-commence interviews in an abstract to a significant geographical conference. A quick acceptance for the latter paper gave our little team confidence, but there is an irony that we could have had nothing of substance to present. In this sense, I was bringing a degree of susceptibility to the work, and to my own reputation, before research had even begun.

The interviews were carried out over three separate sessions. Some of the health service staff meetings were staged in the playing grounds attached to the institution, where a voice recorder was placed on the bench between us. This setting both helped to comply with COVID-19 restrictions at the time and furthered the theme of being outside the clinic. Before launching into the prescribed questions on the topic guide, I wanted to come across as somebody who had been through the process of walking therapy myself. I followed what feminist geographer Kim England wrote in her much-cited paper on reflexivity and positionality: 'We need to locate ourselves in our work and to reflect on how our location influences the questions we ask, how we conduct our research, and how we write our research' (1994, p. 87). I shared how walking with friends and counsellors had helped me during a period when my father had terminal cancer, and subsequently through a period of grief after his death. Although I risked not coming across as an expert, appropriate self-disclosure can help move the relationship between researcher and researched to a more equal footing. Moreover, the discussion of sensitive topics in particular appears to provide space for sharing personal accounts (Dickson-Swift et al., 2007). The transcripts show that this approach helped both service users and mental health practitioners to open up. As I listened through the interviews again, I gained knowledge about the specialist community mental health service, its terminology, and the staff perspective.

The final stage of the interviews was with service users. For procedural reasons, these were staged inside a 1920s building accessed through stone steps. I was shown through various doors and taken down a corridor to a little room with windows that barely opened. As standard health service practice, I was advised that I could activate a mobile alarm if the situation became dangerous. Having a support worker to accompany me meant that there was not an obvious physical threat, such as described by Liamputtong (2007). However, the atmosphere was initially unsteadying and affected my ability to do the interview. I had certainly felt more confident and potentially more able to quickly develop a rapport with the other person when the interviews had been delivered outside. The experience helped to sense that such austere and bounded spaces impact on the research dynamic. Indeed, McGrath and Reavey (2015, p. 213) argue that confined spaces offer 'little capacity for movement, action or engagement with others.' Moreover, I fear what may have happened if the recollection of a walk could have triggered the memory of an episode of acute distress.

The practice of delivering mental health care in the public realm has opened all parties – Aled, Mark, service users, and colleagues – to uncertainties and unknown opportunities. Stage D of the assemblage is the period when our research project

renders in plain view what is often invisible, namely conference presentations, preparing papers for academic journals, and applying for research funding. We now theorise what it means to plan this next stage.

## Point D: Does this use of assemblage theory allow us to draw conclusions?

So far, our research journey has shadowed Anderson and McFarlane's (2011) three main characteristics of assemblages: the transdisciplinary nature of our collaboration relates to the *heterogeneous elements*; the opportunities that have arisen through points A, B, and C resemble *processes of emergence*; and our current position is *open to transformation*. At the time of writing, we find ourselves at a point of being exposed. We have been through a process where we have responded to challenges and have gathered first-hand experiences. There is a growing momentum for service users to shape the next stage of the work. The assemblage resembles more of an 'actant-rhizomatic' entity which geographer Nigel Thrift (2000, p. 1) describes as being valued, if it is ever accepted, within structures and institutions only after a series of performative actions. The performative notion seems apt as we expose ourselves to the judgement of our peers and crucially those who can propel or condemn the research assemblage that we have created. Readily available resources to take the work forward are scarce. Mark awaits the outcome of his study proposal whilst the recently mobilised service users watch on. Aled's attention may be taken up by something else. The clock ticks steadily louder with each passing day. Will it end with a chime or an explosion, and would the latter spell the end?

We have cleared a path to a more democratic and inclusive research space by embracing what being vulnerable means for our practice (Lambert & Carr, 2018). The service users that are now joining us in deliberative discussions for further research (including presenting to a conference in the summer of 2022) are generally those we have accompanied on group walks. This exemplifies the shifting positions and *lines of flight* of our assemblage as we move from conventional practice, through innovation, to transdisciplinary research (Lawrence, 2004; Polk, 2015). Our final thought is to underline the conceptual value of this assemblage approach. By tracing the four points of a transformative process, namely: entry (A); accelerating too early (B); an illusion of strength (C); and now realising that the practice has reached a point of danger (D), we can write in the first person (plural and individual) and see our research journey. We can either push harder or accept that the assemblage may have run its course for reasons of not being able to resolve our own disciplinary constraints, resource shortage, or an unsupportive policy environment.

Ours is not a tale of yearning, nor one of resentment. However, we should pay heed to what queer and feminist human geographer Eden Kinkaid (2020, p. 469) warns us about the assemblage: 'The danger is that, in disavowing social categories, assemblage thinking may further obscure the operations of power and inequality.' We have presented a celebration of the possible, the messy, the uncertain, the disruptive, the mobile and the unpredictable. As a case study it offers other

researchers a different framework to conceptualise how to respond to vulnerabilities. Ultimately some actors are more powerful than us and many constraints are beyond ourselves and our own efforts.

## Disclaimer

The views expressed in this chapter are those of the individual authors and do not necessarily represent those of the organisations by whom they are employed.

## Acknowledgements

Mark thanks colleagues and service users who have joined us at various points in this journey. Aled is grateful for financial support from Swansea University and the Economic and Social Research Council Fellowship Grant ES/W007568/1.

## References

Abrahamyan Empson, L., Baumann, P. S., Söderström, O., Codeluppi, Z., Söderström, D., & Conus, P. (2020). Urbanicity: The need for new avenues to explore the link between urban living and psychosis. *Early Intervention in Psychiatry*, *14*(4), 398–409. https://doi.org/10.1111/eip.12861

Anderson, B., & McFarlane, C. (2011). Assemblage and geography. *Area*, *43*(2): 124–127. https://doi.org/10.1111/j.1475-4762.2011.01004.x

Barker, P., & Buchanan-Barker, P. (2011). Myth of mental health nursing and the challenge of recovery. *International Journal of Mental Health Nursing*, *20*(5), 337–344. https://doi.org/10.1111/j.1447-0349.2010.00734.x

Deering, K. (2016). Neoliberalism and self-management: The case for social justice. *Mental Health Nursing Journal*, *36*(4), 10–12.

Deering, K., Pawson, C., Summers, N., & Williams, J. (2019). Patient perspectives of helpful risk management practices within mental health services. A mixed studies systematic review of primary research. *Journal of Psychiatric and Mental Health Nursing*, *26*(5–6), 185–197. https://doi.org/10.1111/jpm.12521

Deleuze, G., & Guattari, F.(1977). *Capitalism and schizophrenia* (Vol. 1). New York: Viking Press.

Department of Health (1999). *National service framework: Mental health*. https://www.gov.uk/government/publications/quality-standards-for-mental-health-services [Accessed 16 March 2022]

Dickson-Swift, V., James, E. L., Kippen, S., & Liamputtong, P. (2007). Doing sensitive research: What challenges do qualitative researchers face? *Qualitative Research*, 7(3), 327–353. https://doi.org/10.1177/1468794107078515

England, K. V. L. (1994). Getting personal: Reflexivity, positionality, and feminist research. *The Professional Geographer*, *46*(1), 80–89. https://doi.org/10.1111/j.0033-0124.1994.00080.x

Evans, J., & Jones, P. (2011). The walking interview: Methodology, mobility and place. *Applied Geography*, *31*(2), 849–858. https://doi.org/10.1016/j.apgeog.2010.09.005

Foot, J. (2014). Franco Basaglia and the radical psychiatry movement in Italy, 1961–78. *Critical and Radical Social Work*, *2*(2), 235. https://doi.org/10.1332/204986014X14002292074708

Freeman, D., Emsley, R., Dunn, G., Fowler, D., Bebbington, P., Kuipers, E., … Garety, P. (2015). The stress of the street for patients with persecutory delusions: a test of the symptomatic and psychological effects of going outside into a busy urban area. *Schizophrenia Bulletin*, *41*(4), 971–979. https://doi.org/10.1093/schbul/sbu173

Grbin, M. (2015). Foucault and space. *Sociološki pregled*, *49*(3), 305–312. https://doi.org/10.5937/socpreg1503305G

Herschberg, C., Benschop, Y., & van den Brink, M. (2018). Precarious postdocs: A comparative study on recruitment and selection of early-career researchers. *Scandinavian Journal of Management*, *34*(4), 303–310. https://doi.org/10.1016/j.scaman.2018.10.001

Kearney, L., McCree, C., & Brazener, L. (2021). Making it together: A service evaluation of creative families: An arts and mental health partnership, *Advances in Mental Health*, *19*(2), 139–151. https://doi.org/10.1080/18387357.2019.1684828

Kinkaid, E. (2020). Can assemblage think difference? A feminist critique of assemblage geographies. *Progress in Human Geography*, *44*(3), 457–472. https://doi.org/10.1177/0309132519836162

Kogstad, R. E., Ekeland, T. J., & Hummelvoll, J. K. (2011). In defence of a humanistic approach to mental health care: Recovery processes investigated with the help of clients' narratives on turning points and processes of gradual change. *Journal of Psychiatric and Mental Health Nursing*, *18*(6), 479–486. https://doi.org/10.1111/j.1365-2850.2011.01695.x

Lambert, N., & Carr, S. (2018). 'Outside the original remit': Co-production in UK mental health research, lessons from the field. *International Journal of Mental Health Nursing*, *27*(4), 1273–1281. https://doi.org/10.1111/inm.12499

Latour, B. (2007). *Reassembling the social: An introduction to actor-network-theory*. Oxford: Oxford University Press.

Lawrence, R. J. (2004). Housing and health: From interdisciplinary principles to transdisciplinary research and practice. *Futures*, *36*(4), 487–502. https://doi.org/10.1016/j.futures.2003.10.001

Liamputtong, P. (2007). *Researching the vulnerable*. London: SAGE Publications, Ltd. https://doi.org/10.4135/9781849209861

McGrath, L., & Reavey, P. (2013). Heterotopias of control: Placing the material in experiences of mental health service use and community living. *Health & Place*, *22*, 123–131. https://doi.org/10.1016/j.healthplace.2013.03.010

McGrath, L., & Reavey, P. (2015). Seeking fluid possibility and solid ground: Space and movement in mental health service users' experiences of 'crisis'. *Social Science & Medicine*, *128*, 115–125. https://doi.org/10.1016/j.healthplace.2013.03.010

Morgan, G., & Wood, J. (2017). The 'academic career' in the era of flexploitation. In E. Armano, A. Bove, & A. Murgia (Eds.), *Mapping precariousness, labour insecurity and uncertain livelihoods: Subjectivities and resistance* (pp. 82–97). Abingdon: Routledge.

Nader, L. (1972). Up the anthropologist: Perspectives gained from studying up. In D. Hymes (Ed.), *Reinventing anthropology* (pp. 284–311). New York: Pantheon Books.

NHS Digital (2022). NHS vacancy statistics England April 2015 – December 2021 experimental statistics. *NHS*. https://digital.nhs.uk/data-and-information/publications/statistical/nhs-vacancies-survey/ [Accessed 16 March 2022]

Parr, H. (2011). *Mental health and social space: Towards inclusionary geographies?*. Hoboken, NJ: John Wiley & Sons.

Patel, R., Ezzamel, S., & Horley, N. (2021). Improving access to cognitive behavioural therapy groups for postnatal women following partnership work: A service evaluation. *Advances in Mental Health*, *19*(2), 127–138. https://doi.org/10.1080/18387357.2020.1761263

Polk, M. (2015). Transdisciplinary co-production: Designing and testing a transdisciplinary research framework for societal problem solving. *Futures*, *65*, 110–122. https://doi.org/10.1016/j.futures.2014.11.001

Råheim, M., Magnussen, L. H., Sekse, R. J. T., Lunde, Å., Jacobsen, T., & Blystad, A. (2016). Researcher–researched relationship in qualitative research: Shifts in positions and researcher vulnerability. *International Journal of Qualitative Studies on Health and Well-Being*, *11*(1), 30996. https://doi.org/10.3402/qhw.v11.30996

Richardson, T. (2017). Assembling the assemblage: Developing schizocartography in support of an urban semiology. *Humanities*, *6*, 47. https://doi.org/10.3390/h6030047

Rose, G. (1997). Situating knowledges: Positionality, reflexivities and other tactics. *Progress in Human Geography*, *21*(3), 305–320. https://doi.org/10.1191/030913297673302122

Sayce, L. (1999). *From psychiatric patient to citizen: Overcoming discrimination and social exclusion*. New York: Macmillan International Higher Education. https://psycnet.apa.org/doi/10.1007/978-1-349-27833-6

Sennett, R. (2010). The public realm. In Bridge, G., & Watson, S. (Eds.), *The Blackwell city reader* (pp. 261–271). Hoboken, NJ: Wiley.

Söderström, O., Empson, L. A., Codeluppi, Z., Söderström, D., Baumann, P. S., & Conus, P. (2016). Unpacking 'the City': An experience-based approach to the role of urban living in psychosis. *Health & Place*, *42*, 104–110. https://doi.org/10.1016/j.healthplace.2016.09.002

Solnit, R. (2001). *Wanderlust: A history of walking*. London: Penguin.

Thrift, N. (2000). Afterwords. *Environment and Planning D: Society and Space*, *18*(2), 213–255. https://doi.org/10.1068/d214t

Vassos, E., Pedersen, C. B., Murray, R. M., Collier, D. A., & Lewis, C. M. (2012). Meta-analysis of the association of urbanicity with schizophrenia. *Schizophrenia Bulletin*, *38*(6), 1118–1123. https://doi.org/10.1093/schbul/sbs096

Weber, A. M., & Trojan, J. (2018). The restorative value of the urban environment: A systematic review of the existing literature. *Environmental Health Insights*, *12*. https://doi.org/10.1177%2F1178630218812805

Woodward, K., Dixon, D. P., & Jones III, J. P. (2009). Poststructuralism/poststructuralist geographies. In Kitchin, R. & Thrift, N. (Eds.), *International encyclopedia of human geography* (Vol. 8, pp. 396–407). Amsterdam: Elsevier.