ORIGINAL ARTICLE

Ronaldo on the Clapham Omnibus: Complex Recoveries in Complex Psychosis

Henry J. Whittle[1,2] 🄭

Abstract

Dominant cultural framings of recovery in psychosis describe a process of increasing social connection, community integration, identity reclamation, and hope. Drawing on 6 months of ethnographic fieldwork on a psychiatric rehabilitation ward for 'complex psychosis' in London, I consider what we might learn from recoveries that appear not to follow this trajectory. My primary case study, of a man diagnosed with treatment-resistant schizoaffective disorder who identifies with/as the famous ex-footballer Ronaldo, interrogates the social implications of his attempts to 'mask' his identity while on leave from the hospital to avoid "caus[ing] trouble"—strategically embodying, in effect, the fictitious 'ordinary' person denoted by the English idiom *the man on the Clapham omnibus.* I argue that his complex recovery, built on a trial-and-error process of retreat from social connection and caution towards hope, reflects a degree of clinical complexity seldom acknowledged outside psychiatric rehabilitation. Engaging with more nuanced anthropological theories of recovery in psychosis, my analysis illuminates how the time, space, and relative safety of a lengthy involuntary hospital admission proved necessary for his complex recovery to unfold. This insight contrasts with the dominant operationalisation of recovery in contemporary mental health systems, which seems to be fuelling disinvestment in such rehabilitative admissions.

Keywords Recovery · Psychosis · Schizophrenia · Rehabilitation · Stigma

✉ Henry J. Whittle
   henry.whittle.14@ucl.ac.uk

1 Division of Psychiatry, University College London, Maple House, 149 Tottenham Court Road, London W1T 7NF, UK

2 Department of Anthropology, University College London, London, UK

Introduction

> We walk all the way, along one of the grittier roads in the area—nothing too exceptional, but just that inner city London where you keep your head down. Except not Shepherd. Along the whole way he does his own thing—darts in front of people causing them a fright, mimes taking penalties while pointing at passers-by, lets out sudden cries to strangers of "Hi sir!" and "'Ey, David Beckham!" In the café we stop at, he greets strangers like old friends and doesn't close the toilet door, such that I have to close it then guard it . . . all the while with a radio hung round his neck blurting out static. Nothing seems to phase him. People are celebrities, ancestors, characters in his journey back to the top.

The above fieldnote was taken near the beginning of my time on Apollo Ward, the psychiatric rehabilitation ward in London where I conducted fieldwork from August 2022 to February 2023.[1] Shepherd was one of its inpatients at the time, a man in his forties diagnosed with a particularly severe, complex, and disabling form of schizoaffective disorder, who was admitted to the hospital involuntarily under the Mental Health Act.[2] The extract describes a walk we took together, during his authorised daily leave, to an amateur football complex some 45 min by foot away from the ward.[3] It captures both the carefree *joie de vivre* and scattergun commotion of his character, reflected in the mix of boisterous excitement and acute social anxiety I often felt when out in the local community with him at that time.[4] This was Shepherd *well*, treated with clozapine, lithium, and sodium valproate, plus an arsenal of medications to ameliorate the adverse effects of the psychotropics. Shepherd *unwell*, on the other hand, had been admitted over a year previously to the same hospital, so floridly manic and disinhibited that he had needed stabilising in the psychiatric intensive care unit.[5] Even after he was transferred to Apollo nearly a year

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[1] Apollo Ward is a pseudonym, as are all names of participants mentioned in this article. Potentially identifying details related to individuals have also been changed, without altering the meaning of the relevant data, to protect their confidentiality.

[2] The Mental Health Act 1983/2007 legislates for the involuntary treatment of people with mental disorders in England and Wales. Most patients on Apollo Ward during my fieldwork were involuntarily detained in hospital for 6 months or longer under Section 3 of the Mental Health Act.

[3] 'Football' here and throughout the article refers to the game known as soccer in the United States.

[4] The term 'community' is pervasive in mental health discourse but rarely unpacked. It is mostly used as a binary pairing with the hospital, essentially to mean everything that is not in the hospital. I use it sometimes in that respect, as later in the article, and sometimes in its more everyday meaning, as in 'local community' here. While the hospital/community binary is useful in the UK context insofar as it reflects a legal demarcation about where somebody can be detained (hospital) and where they cannot be detained (community), it is undoubtedly an oversimplification that is worth problematising. However, this is beyond the scope of this article, and for present purposes I am using 'community' as described.

[5] In the UK, a psychiatric intensive care unit is the name for a ward with higher security measures and higher staff-to-patient ratios, which is typically used to treat acutely psychotic patients deemed to be presenting too much of a risk to others for the acute wards.

prior to my fieldwork, he had apparently been sprinting up and down the corridors so thought disordered he could barely sustain a conversation.

Yet, with time, much of that manic energy and formal thought disorder had settled, and by the summer I got there he had returned to his clinical baseline: a place of stable grandiosity in which he identifies with, or indeed as, the Brazilian ex-footballer Ronaldo Nazário (known as Ronaldo, with the nickname 'R9' after his shirt number), inhabiting a world crowded with celebrities from the 1990s and 2000s. While this had been the same for many years and did not change during my fieldwork, Shepherd's functional abilities steadily progressed. He kept to a routine and programme of community activities. He re-learned how to take care of himself and his personal environment. He started cooking and taking responsibility for his medications. Then he was stepped down to one of the community rehabilitation units shortly before I finished. In this regard, as a patient, he was a model of psychiatric rehabilitation.[6]

However, it is another shift, a more *situational and relational* shift, that is the focus of my analysis here. This other shift was exemplified by Shepherd but was present in the experiences, narratives, and behaviour of many of my participants.[7] Consider the following fieldnote, which concerns a similar journey (albeit with a short section taken by bus) but towards the end of my fieldwork, just prior to Shepherd's discharge:

> On the journey Shepherd is almost silent, eyes quietly scanning from inside the hood of his big coat. I think about how different he seems even from our last outing here a month or so back, when he was notably intrusive to passers-by several times. Today, however, he blends in seamlessly to the average London bustle, totally anonymous in the crisp night. All my questions are met with short answers or quiet smiles—relaxed but controlled. Even when we get off the bus and the one time all journey he approaches a stranger—to ask for a cigarette—he gestures to a young woman in silence, quick and opportunistic, making a smoking signal with his fingers. She gives him a cigarette and lights it up for him, and he gives a quick thanks and we walk on.

I recall this latter journey vividly, sat on the double decker bus pulling my coat around me in the cold on the seat behind Shepherd, and thinking how, in contrast to many of our previous forays into the community, no one was looking twice at him.

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[6] I use the word 'patient' here quite deliberately, despite general trends towards alternatives such as 'service user' or 'client' in reporting social research. While the emphasis on these alternatives is driven by a spirit of empowerment and de-medicalisation, which I support, here I am referring primarily to people detained involuntarily in an inpatient setting. In this context, my view is that the use of such alternatives might serve to obscure the material, role, and power relations that exist within the hospital, which are captured better by the term 'patient'. Where I refer to people using community services voluntarily, on the other hand, I have used the term 'service user'.

[7] My use of the term 'participant', as opposed to the term 'interlocutor' used frequently in reporting anthropological research, is similarly deliberate. The people I spoke to were participating in a research study, which inevitably conditioned their social relationships with me. In my view, this is worth making explicit.

He might have been R9, but to everyone else, he was just anyone. I was reminded of the English idiom, *the man on the Clapham omnibus*, which was first used in legal circles in the early twentieth century to denote a hypothetical 'ordinary and reasonable' person, the benchmark of what English institutions should apparently expect from the public.[8] And we might not have been in Clapham then, but here was Ronaldo Nazário, to all appearances the man on the Clapham omnibus—a portrait of this fictitious 'ordinary' condensed from the "extraordinary condition" (Jenkins, 2015) he otherwise lived and breathed. Moreover, once we were alone in the park again, that mundane ordinariness evaporated and the extraordinary footballer I was so fond of re-emerged.

The aim of this article is to analyse this shift in Shepherd's embodied disposition—from Ronaldo *standing out proudly* to Ronaldo *blending in warily*—in critical dialogue with the concept of 'recovery' in psychosis. To do this, I first outline recovery's cultural history and operationalisation within contemporary mental health services, before describing the clinical and historical context of Apollo Ward and its patients. I then detail the study's methodology before returning to the ethnographic findings to consider some key questions. What animates Ronaldo to become, on a temporary and selective basis, the man on the Clapham omnibus? How does his experience align with the more dominant recovery discourse that seems to pervade contemporary clinical services? And if there is *mis*alignment, what can we learn from this? Specifically, who or what might be illuminated or obscured by our current framing of recovery in psychosis?

Recovery

In the social field of mental health, recovery is a culturally significant idea with an intricate history. It was first elaborated as a concept by psychiatric service users in the 1980s in order to move treatment goals away from more medicalised aims of symptom reduction and towards the person's own vision for a meaningful life (Deegan, 1988; Houghton, 1982; Leete, 1989). For these pioneers, a person's recovery from mental illness was a highly individual and almost ineffable subjective experience, a unique journey grounded in their own hopes, strengths, and identity through which they could find meaning in or alongside their illness. However, as Braslow (2013) has described, this concept was then grasped enthusiastically by clinicians and reformist politicians alike, who transformed and operationalised its original meaning. Recovery thus evolved. From its origins as an almost mystical personal journey, recovery first became a clinical approach—a new lens through which

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[8] 'Ordinary and reasonable' is, of course, a socially constructed fiction of normativity, and a harmful one at that. I use it here not to give it any validity, but instead to illustrate the structural pressure on people with severe mental illnesses to conform to this fiction, at the expense of freedom to embody their own identities. This phrase also invokes the legal concept of reasonability, which it is beyond the scope of this article to explore. Nonetheless, I have included the word 'reasonable' to underline the juxtaposition between R9 as the embodiment of Shepherd's so-called 'madness' and his suppression of this identity to try to embody a socially presumed state of 'reason' (the antonym of madness).

clinicians re-thought what to prioritise with their patients and how to go about their work—before it gained enough momentum to envelope entire services and systems as explicit *raison d'être*. Here, recovery symbolised everything that the asylums precluded: independence, responsibility, and a life free from chronic patienthood. Recovery-orientated services would be structured to aim for these goals, and hence recovery emerged as a value system perfusing and animating services (Braslow, 2013).

Importantly, this conceptual shift—from the subject to the institution—motivated a need to *define* recovery more precisely. After all, if investing in recovery-oriented institutions and services was the future, should we not know precisely what we mean by this? Thus, the conceptual evolution of recovery, which Rose (2014) has called its "mainstreaming", has fuelled a wealth of research on personal recovery that has arguably consolidated its transformation (Ellison et al., 2018). The result is a culturally dominant model of recovery streamlined through frameworks that attempt to draw together its putative building blocks. An example from the UK is the CHIME framework, which names social **c**onnectedness, **h**ope and optimism, cultivating a sense of **i**dentity, finding **m**eaning in experiences and goals, and becoming **e**mpowered to exercise agency and control in one's life (Leamy et al., 2011). Elsewhere, the Substance Abuse and Mental Health Services Administration (SAMHSA) of the United States defines recovery as "a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential" (SAMHSA, 2012), spearheading consensus that recovery is an individualised/person-centred experience of empowerment, purpose, and hope (Ellison et al., 2018).

Yet, such attempts to define recovery have been critiqued. Dissenting service users have argued that these efforts defy the inherent messiness, decentralisation, and complexity of the original recovery model (Recovery in the Bin et al., 2019; Rose, 2014). Such universalist frameworks get particularly problematic, these critics assert, when they are operationalised to organise whole mental health service systems—what McWade (2016) has called "recovery-as-policy" in the UK context. Their argument is that contemporary recovery's emphasis on empowerment, independence, and autonomy may sound liberatory, but in reality, it has become little more than a discursive cloak for cost-cutting neoliberal services. In other words, such services seem to employ recovery's discourse to justify time-limiting support, structurally embedding 'flow' and 'stepdown' into systems, and scapegoating more open-ended support as 'dependence'—all while using compulsory acute admissions and other coercive legislative elements to manage populations deemed risky (Braslow, 2013; McWade, 2016; Recovery in the Bin et al., 2019).

Anthropologists have entered this debate. In her ethnography of a recovery-orientated peer-led service in the United States, Myers (2015) found that the recovery model the service operationalised was similarly infused with American cultural values around work ethic and independence. In her analysis, this produced unrealistic aims that set more severely disabled service users up to fail. She has argued instead that the essence of recovery in psychosis, and therefore what services should support, is the cultivation of moral agency—the capacity to be recognised as a "good person in a way that makes possible intimate connections to others". For Myers,

there are three components to moral agency: "autobiographical power", or the capacity to be editor of one's own life story; "social bases of self-respect", where meeting cultural ideas of being respected enables one to respect oneself; and "peopled opportunities" to try (and sometimes fail at) forging the social connections these elements collectively permit (Myers, 2024; Myers & Ziv, 2016).

This article draws on my time on Apollo Ward to complement and develop these critical arguments in the context of severe and longstanding psychiatric disability. Against the backdrop of more streamlined, normative visions of recovery, I am asking what it means if Shepherd and certain other patients I knew did something quite different to what such frameworks capture—if they purposefully pulled away from social connection, elected not to engage with what others think of them, curtailed their own sense of identity, or disavowed hope in favour of realism—and, as a result, felt more confident, calmer, and happier. This is the ethnographic conundrum that confronted me on Apollo Ward, prompting my central research question of what our current recovery discourse illuminates and obscures. This question, in turn, feeds into clinical and anthropological debates around how we should best support people's diverse recoveries. If, for example, Myers' work provides a better conceptual model for recovery—an assertion I would support—then what kinds of clinical implications follow? I shall return to these debates in my concluding remarks.

Complex Psychosis

As a psychiatric rehabilitation ward, Apollo Ward exclusively admits people, like Shepherd, who meet clinical criteria for 'complex psychosis'. Although new terminology, this classification represents the latest clinical intervention into a centuries-old debate: how to treat, support, manage, and/or socially integrate 'madness' that remains resistant to technological intervention.[9] From the early nineteenth century to the mid-twentieth century, most people in Britain who lived with severe and enduring psychosis were housed in asylums, before a raft of socio-political, institutional, and technological changes co-occurring from the mid-1940s onwards triggered deinstitutionalisation (Turner, 2004).[10] Although of contested significance in closing the asylums, among these factors was the invention of the first-generation neuroleptic drugs in the 1950s, which, for the first time, offered a chemical means to dissipate the more acutely disturbing symptoms of psychosis (Turner, 2004). For a proportion of people diagnosed with schizophrenia and other psychotic illnesses, however, these drugs only dampened rather than dissipated their symptoms. Voices became quieter but remained present; idiosyncratic beliefs less salient but still active; and thought processes not so severely derailed but still somewhat disorganised. And these are

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[9] I use the term 'madness' here in its historical context as an archaic label for those deemed to be suffering from what would now be called mental illness, while also acknowledging contemporary contestations of clinical terminology and reclamation of the term 'madness' by people self-identifying as mad today.

[10] Deinstitutionalisation refers to the closure of the asylums and the subsequent transfer of previous residents into the community in the latter half of the twentieth century.

just the so-called positive symptoms. The most disabling aspects of psychotic illness, the negative symptoms (social withdrawal, lack of spontaneous speech, avolition), and cognitive impairments (particularly around planning and goal-based thought processes) rarely responded to psychotropic medications (Fusar-Poli et al., 2015). The development of second-generation antipsychotics shifted this picture somewhat during the 1980s through clozapine, the only antipsychotic ever found to have efficacy over others in 'treatment-resistant schizophrenia' (Kane et al., 1988).[11] Yet, positive symptoms, negative symptoms, and cognitive impairments persist even for many on clozapine (Luykx et al., 2023), sometimes further complicated by other mental and physical illnesses and alcohol and substance use.

The co-occurrence of all these factors is profoundly disabling, eroding the capacity of those affected to live their day-to-day lives, involve themselves in communities, and sustain social connections. The recognition that around 20–25% of people diagnosed with psychotic illnesses will go on to develop this clinical picture has led to increasing use of the descriptor 'complex psychosis', which was endorsed by the UK's National Institute of Health and Care Excellence (NICE) in 2020 (Killaspy et al., 2021). In the NICE guidance, complex psychosis refers to the presence of a primary psychotic diagnosis (schizophrenia, schizoaffective disorder, bipolar affective disorder, delusional disorder, or psychotic depression) with severe and treatment-resistant psychotic symptoms *and* persistent functional impairment, usually in the presence of one or more of the following: cognitive impairments associated with psychosis, co-occurring mental illnesses (including alcohol and substance use), pre-existing neurodevelopmental conditions such as autism or attention deficit hyperactivity disorder, and comorbid chronic physical illness (Killaspy et al., 2021).

Curiously, the severe disability that arises in this clinical context is profoundly under-represented in much academic literature—just as it is in the public imagination, where hallucinations and delusions predominate the perception of psychotic illness rather than the arguably more impairing negative and cognitive symptoms. Even in the long and important history of applied anthropological research on psychosis, explicit ethnographic engagement with these most disabling forms of longer-term psychosis has been limited. Moreover, where chronicity *is* evoked in anthropology, there has been a tendency to attribute these more severe illness courses almost wholly to Western cultural and clinical approaches (Estroff, 1989). For example, Luhrmann's (2007) classic article '*Social defeat and the culture of chronicity: or, why schizophrenia does so well over there and so badly here*' draws its subtitle from the major epidemiological studies comparing schizophrenia recovery rates in the 'developed' and 'developing' worlds.[12] But while these did find that there were

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[11] For most second-generation antipsychotics, aside from clozapine, the effects on psychotic symptoms were equivalent to the neuroleptics, with the primary advantage being the option of a different side-effect profile (swapping extra-pyramidal stiffness and tremors for truncal obesity and the metabolic syndrome). In treatment-resistant schizophrenia—defined as when two other antipsychotics, including at least one second-generation antipsychotic have failed to reduce psychotic symptoms—clozapine improves symptoms, lowers global clinical severity scores, and reduces risk of psychiatric hospitalisation.

[12] The International Pilot Study of Schizophrenia (IPSS) and the subsequent—and more comprehensive—Determinants of Outcomes of Severe Mental Disorder (DOSMD) study.

higher rates of complete clinical remission in developing countries, there were actually no significant differences in the proportion of cases experiencing "continuous unremitting [psychotic] illness" (Jablensky & Sartorius, 2008). This suggests that Luhrmann's cross-cultural research project to address this conundrum (Luhrmann & Marrow, 2016), as uniquely important as it is, builds on a premise that potentially brackets those people suffering from the most disabling forms of psychosis—whose illnesses seem just as complex globally as they are in the West.

My time on Apollo Ward brings these experiences into sharp focus. Among my participants were people who had been admitted after they were found lying in their own body fluids half-starved and dehydrated to the point of medical emergency; or who had let limb injuries fester for so long without seeking care they had only narrowly avoided amputation; or whose thoughts were so disorganised that the act of making a simple sandwich was insurmountable without assistance. Alison, for example, had not washed, changed her clothes, or voluntarily spoken to anyone for several months when she was admitted to Apollo Ward under the Mental Health Act. Among the first priorities identified by staff were to support her to shower of her own volition and to go for a short walk in the neighbouring park. Both these goals took 6 months' intensive work with her to achieve.

Moreover, the desperate circumstances I have described were almost unanimously resolved through care saturated inseparably with coercion, whether enforced through the legal mechanisms of the Mental Health Act or enacted through everyday behavioural reinforcement. This milieu spawned complex, contradictory experiences that crystallised in unpredictable narratives. Shepherd, a working-class man racialised as Black, was detained by police from his home after neighbours called to report behaviour they perceived as erratic and threatening. This premise could easily have set the scene for another tragedy of the lethal structural racism our systems are repeatedly failing to address (Nazroo et al., 2020). And yet, when we spoke about it, Shepherd made his perspective on the police clear: "They *helped* me. I could've died in that flat; I had no food, no money". Of course, these narratives in no way negate the brutal realities of either psychiatric restriction or structural racism in psychosis, however, they do demonstrate the extent to which the messy complexity of psychiatric anthropology "on the ground" destabilises simplistic moral binaries about what constitutes "the good" (Bromley, 2019). As an inpatient psychiatric rehabilitation ward where most patients were involuntarily detained over an average stay of 9–12 months, Apollo Ward proved a useful ethnographic setting for interrogating such complex recoveries.

Psychiatric Rehabilitation

Apollo Ward is one of a few inpatient rehabilitation wards in the National Health Service (NHS) trust where I did my fieldwork.[13] Collectively these wards constitute the first step of a longer rehabilitation clinical pathway extending into the community (Fig. 1). Patients meeting criteria for complex psychosis are mostly transferred in from the trust's acute wards (or occasionally a forensic mental health setting), usually after a pattern of repeated acute admissions in a short space of time. At this point their clinical team might decide that a period of psychiatric rehabilitation is indicated.

Psychiatric rehabilitation is a long-established idea. Its conceptual roots reach back to the pioneering of 'moral treatment' at the close of the eighteenth century (Anthony & Liberman, 1986), which emphasised balance, order, and routine above the era's physical and pharmacological treatments (Charland, 2012; Porter, 2003).[14] Contemporary rehabilitation then developed during deinstitutionalisation in the latter half of the twentieth century. As thousands of asylum residents were released, various legislative and health service innovations were implemented to support community integration. Psychiatric rehabilitation emerged amid this milieu as a subdiscipline concerned with supporting people with severe mental illnesses to live and work in the community. A key part of this was a deliberate shift in the psychiatric gaze away from internal or phenomenological change towards the material and pragmatic realities of day-to-day living—an orientation to "reality factors rather than intrapsychic factors" (Anthony & Liberman, 1986). However, the most severely disabled psychiatric service users were ultimately underserved by twentieth-century rehabilitation, in large part due to gross underinvestment. The political economy of the Reagan–Thatcher consensus (Harvey, 2007) devastated any chance of developing the infrastructure required to implement rehabilitation's ideals (Braslow, 2013)—which, studies showed, was as expensive as housing people in asylums (Leff et al., 2000). This underinvestment in longer-term psychosis has never been reversed; in recent years an orientation towards preventive medicine in psychiatry has prioritised early intervention in psychosis instead (McGorry, 2015).

In this historical context, the recent development of contemporary NHS rehabilitation services specifically for complex psychosis is significant, facilitating a specialised focus on supporting these most disabled psychiatric patients. This has included an appreciation that, for this population specifically, sustained community living may paradoxically require a longer initial *inpatient* rehabilitation phase, to

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[13] The NHS, which is the public health system of the United Kingdom, is subdivided into organisational units known as trusts, which organise the provision and delivery of specialist services within their geographical area.

[14] Moral treatment was pioneered by Pinel at the Parisian Hospice de la Salpêtrière and Tuke at the York Retreat for the Insane during the 1790s, in direct opposition to previous confinement of people deemed 'insane' alongside criminals and vagrants. Key therapeutic principles encompassed general hygiene, physical comfort, good nutrition, regular exercise, meaningful occupation, an appropriately supportive but disciplined interpersonal and social milieu, and time for the natural recovery of 'reason' believed to be possible in many cases.

ensure patients are sufficiently stable at the point of discharge. This was prompted in part by recognition that many people with complex psychosis were being increasingly detained long-term anyway, in private sector beds sometimes hundreds of miles from home with no route out—a phenomenon labelled "re-institutionalisation" (Turner, 2004). This NHS innovation has been buttressed by a clinical evidence base of well-designed observational studies. Their findings suggest that rehabilitation for complex psychosis is associated with sustained discharges from hospital and improved quality of life and autonomy in the community (Killaspy et al., 2016a, 2016b, 2020). Additionally, the more rehabilitation services operate in line with clinical principles derived from the recovery movement—that is, recovery as a clinical approach (Table 1)—the better the outcomes for patients (Killaspy et al., 2016a).

Yet, despite this evidence base, scepticism towards rehabilitative admissions remains, reflected in recent disinvestment in NHS inpatient rehabilitation facilities (Killaspy et al., 2024). Interestingly, this scepticism tacitly unites even stakeholders with otherwise disparate views. For psychiatry's strongest critics, lengthy involuntary admissions evoke the spectre of the asylum or prison, bringing the psychiatric hospital into current debates interrogating all forms of state intervention with a forceful or compulsory component (Ben-Moshe, 2017; Birkeland et al., 2024). The racialised inequalities characterising involuntary psychiatric admissions across Western societies give weight to these perspectives (Halvorsrud et al., 2018). On the other hand, even among the most biomedically oriented clinicians, community-based recovery is now mainstream (Rose, 2014), and the dominant orientation towards inpatient admission is for stabilisation only, for as little time as possible, and only when absolutely necessary (NHS England, 2023).

This is particularly true in public mental health systems, where recovery-orientated motivations to preserve individual liberty and avoid institutionalisation dovetail neatly with persistent reductions in bed numbers and broader fiscal austerity policies (Braslow, 2013; Chow & Priebe, 2013; Gong, 2019). However, the result is often less than ideal for those with the most complex mental illnesses, who are prone to circulation around the "institutional circuit" of hospital, shelter, supported housing, and jail (Hopper et al., 1997); or what Gong (2019) has called "tolerant containment", sometimes verging on clinical abandonment, in *de facto* segregated spaces of the city; or indeed "re-institutionalisation" in the prison wing or private sector long-stay ward, both more definitively dislocated from the person's community (Chow & Priebe, 2013). To help interrogate this convenient marriage of community-based recovery discourse and neoliberal statecraft, the nuanced experiences of those with complex psychosis in inpatient rehabilitation services, which are thus far missing from this debate, need to be brought into the fold. What does it mean—and take—for such people to recover?

Clinical Ethnography In-between

HJW: "You know what I do here, yeah?"
Andrew:"Yeah".
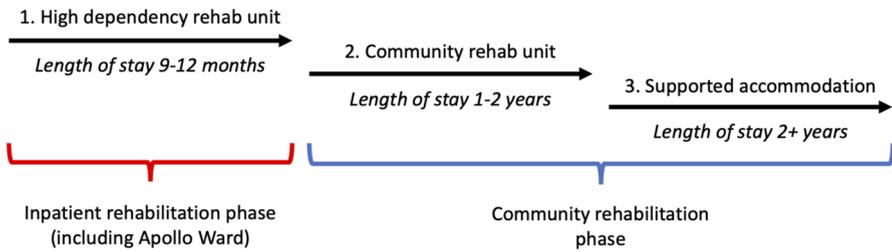HJW: "Yeah, I'm a researcher".

Fig. 1 Average lengths of stay in the local NHS rehabilitation pathway

> Andrew: "You're an in-betweener".
> HJW: "In-betweener?"
> Andrew: "Yeah, in-between the staff and the clients. And they get jealous of you".
> HJW: "Who do?"
> Andrew: "The staff".
> HJW: "Yeah, you reckon?"
> Andrew: "I know it. I can see it".

The summer of 2022 was not the first time I had stepped onto Apollo Ward. I had worked there for three months as a doctor a year previously, which is significant both ethically and methodologically. While this helped to reassure the ethics committee I was competent to navigate the challenging clinical context of the ward, it also opened the possibility for role confusion, which I tried to mitigate by repeatedly reminding people I was now there as a researcher. I was also mindful that my history risked patients feeling coerced into participation. In practice, however, of the few I knew who were still on the ward, more declined to participate than consented. Of those patients I recruited, I knew only two from when I worked there. Methodologically, my previous role meant I already knew the ward environment and logistics. The good relations I had established with many staff there, as well as these two patients, also helped to expedite the trust integral to participant observation.

During the 6 months of participant observation, I spent most of my days (including some weekends, evenings, and nights) in the communal areas of the ward. Apollo Ward is a 16-bed mixed gender ward, arranged like most other NHS psychiatric wards: separate corridors for bedrooms adjoining a central atrium next to the nursing station and office. In the atrium is a lounge area with a table, chairs, sofas, and TV, adjacent to a dining room. These areas are always open to patients. Other rooms, which a staff member must unlock, include a games room, occupational therapy kitchen, activity room, and meeting room. The main doors are locked with swipe card access. There is no ward garden and no outside area; the hospital

Table 1 Features of recovery-orientated clinical treatment (Turton et al., 2010).

Features of recovery-orientated clinical treatment
• Treatment negotiated between patients and clinicians
• Facilitating patients' engagement in meaningful activity
• Empowering patients to promote their autonomy, dignity, and self-management
• Supporting patients to reclaim their identity, overcome stigma, and develop self-acceptance
• Maintaining hope and optimism

courtyard is used for fresh air.[15] When I was not on the ward, I was in the community with patients on leave under Section 17 of the Mental Health Act.[16] Patients often had unescorted Section 17 leave for several hours a day and spent their time in the local neighbourhood, a highly urbanised, ethnically diverse, and relatively deprived part of the city.

Regardless of where I was, I strove for an *embodied* participant observation, attending to a heightened awareness of my own body/mind (Csordas, 2002; Holmes, 2013; Scheper-Hughes & Lock, 1987). On the ward, my head stung from dehydration, sleep took my eyes in the slow afternoons, I strained my shoulders from shooting pool, and I tuned into my own embodied emotion—particularly around the patients, akin to how I would analyse my countertransference. This gave me sensory and affective data I found particularly useful, which I captured in my fieldnotes alongside all the descriptions of events and conversations. Finally, during the 6 months of participant observation, I gave all participants an opportunity to audio-record a semi-structured interview with me, which was taken up by 14 staff and seven patients.

Analytically, the "methods/theory package" employed is situational analysis (Clarke et al., 2017), a recent elaboration on grounded theory. Rooted in the same schools of American pragmatism and symbolic interactionism, situational analysis attempts to "push grounded theory around the interpretive turn" (Clarke et al., 2017), correcting for critiques asserting that grounded theory formulates theories too simplistic, normative, authoritative, and dismissive of prior or contradictory voices. These critiques share a recognition that all knowledges are *situated*—they are constructed, elaborated, and employed by particular people in particular places at particular times.[17] The advantage of bringing such critique into ethnographic

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[15] Smoking, a significant part of life on a psychiatric ward, is technically banned in the hospital courtyard—a rule that was seldom enforced during the initial part of my fieldwork but then cracked down on halfway through. Otherwise, patients went to the hospital gates or a nearby park to smoke.

[16] Section 17 of the Mental Health Act legislates for the provision of leave away from the ward for detained patients. Section 17 leave is given at the discretion of the Responsible Clinician, who also stipulates conditions such as how long the leave should be for and whether the patient must be escorted by a staff member.

[17] That is not to make any value judgement on the utility of such knowledges; when I quote clinical studies on psychiatric rehabilitation, for example, I can stress the importance of such research, while also acknowledging it is a particular form of knowledge shaped by historically and geographically contingent assumptions and institutional structures.

methodology is that it allows us to fracture simplistic analytic narratives and open the possibility for heterogeneity, contradiction, complexity, and partiality.

Reflexively, my professional clinical identity was particularly significant. While my aim was to shake this off, I could only ever reach the "in-between", as Andrew put it—neither patient nor quite staff member. That I possessed a swipe card, could freely enter the nursing office and locked rooms, and went home for the night establishes the vast social distance between me and the patients, even prior to me having never experienced psychosis. But more important analytically are my socialisation into the discourse of clinical psychiatry, my predisposition towards clinical application, and my aspirations to work in psychiatric rehabilitation, all of which structured my practices and perceptions. Even if I tried to work against these, which I frequently did, this is an impossible task and they colour the analysis.

The study received NHS ethics approval in August 2022. As part of this process, I sought to engage with recent concerns about the systemic exclusion of people with complex psychosis from clinical research, which has contributed to their under-representation in the clinical evidence base (Luykx et al., 2023; Taipale et al., 2022). To minimise perpetuating this bias, the ethics approval included provisions to avoid automatically excluding patients where the nature of their illness diminished their capacity to consent to the research (e.g. due to severe negative symptoms or cognitive impairments).[18] This meant that if such patients were freely engaging with the research process without any sign of distress, they could still be included following an established NHS ethics process that involves informed written consultation from a designated consultee. Informed written consent was obtained from all participants with capacity to consent. All patients on Apollo Ward were aware of my status as a researcher and no fieldnotes were written about non-participating patients.

Spaces of Asylum

Life on Apollo Ward is unexciting, which is the aim. Collectively the doctors, nurses, support workers, occupational therapists, psychologists, and managers who worked there attempted to give patients a scaffolding of calm and predictable routine, with a steady programme of activities to occupy the days—breakfast groups, drawing sessions, creative writing hours, park walks, and the occasional trip out to a café, shop, or bowling alley. They generally kept the environment quiet and stable, even as they regularly enforced the ward's rules and boundaries. Monthly care reviews involved pragmatic problem-solving in microscopic detail, including exhaustive discussions of patients' medications, side effects, physical health, behaviour, and social and occupational status on the ward. The plans formulated by the senior psychiatrist attempted to facilitate ever greater levels of engagement in self-care and meaningful occupation, with every action thought out step by step. Occasional psychological formulations were constructed, particularly when the ward psychologist was involved, but these were similarly pragmatic in their application,

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[18] Mental capacity here is operationalised as per the criteria enshrined in the Mental Capacity Act 2005.

mainly used to break through or sidestep barriers to more independent daily functioning rather than unpacking or interpreting the meaning of patients' experiences (the latter of which, when occasionally attempted, were almost unanimously resisted by patients). The nurses and support workers who spent most time on the ward got to know the patients well—although for complex reasons I discuss elsewhere (Whittle et al., 2024), their relational engagement was limited. Nevertheless, in contrast to the often-labile chaos of acute psychiatric wards, Apollo Ward exhibited, for the most part, an atmosphere of calm, familiar, and placid routine, with neither much pressure on patients to divulge their experiences nor much judgement for enacting them. The days passed full of high-dose medication but without much medical tinkering. Instead, the focus was firmly on perpetuating the slow, steady march towards the ward's main treatment priority: more independent daily functioning in preparation for community stepdown.

The culture of the ward, therefore, resonated with an applied clinical register of recovery discourse. Even if some staff occasionally waivered in their sense of therapeutic optimism, expressing doubt as to the "rehab potential" of certain patients at times, the more senior staff reiterated their perspective that everyone belongs to this category—and that maintaining therapeutic hope was essential, no matter the current or historical challenges. Staff prioritised patients' engagement in activity, sometimes assertively so, and tried to empower them to take a more active role in their own treatment plans. Indeed, seeing the patients take some degree of ownership over their trajectory was usually required for stepdown into the community. In this respect, then, at the level of service organisation, Apollo Ward was also a recovery-orientated institution: the first step of a clinical pathway characterised by the principle of stepdown to lower levels of support.

Yet, crucially, in certain other ways, the ward conflicted with what recovery has become, if the latter is understood as a community-orientated cultural value system animating the wider system (Braslow, 2013). The average length of stay on Apollo Ward was 9–12 months, and some patients spent even longer there (very occasionally years) before they were deemed ready to progress. For the NHS trust, therefore, Apollo Ward blocked the 'flow' of the system, with patients on the waitlist for the ward also spending longer than they normally would on acute wards before transfer. This decreased acute bed availability and, for the patients transferred to Apollo, lengthened the total duration of admission at the start of what could become a 10-year pathway. This slower moving current through a faster flowing river of provision therefore created an impression of stasis among Apollo's inpatients, who, to a superficial viewing, seemed trapped in the system relative to their fellow patients on the acute wards.[19] This paradox evokes an inherent tension between Apollo Ward and the dominant driving ethos of contemporary mental health systems, which is to

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[19] To be clear, it was the fundamental purpose of Apollo Ward to *stop* patients getting trapped in the system—that is, the system of revolving door admissions—by curating a slower and more thoughtful admission that nevertheless maintained a clear exit path. What I am highlighting here is the *perception* of admissions to Apollo Ward from the perspective of the wider service, which was created by the stark contrast with high-throughput acute admissions.

get people *out* of hospital *into* the community. In other words, even though this was the explicit (and also evidence-based) aim of Apollo Ward over a longer timeframe, there was a contradiction between the slower clinical recovery culture curated on the ward and the fast-moving recovery-as-policy culture of the wider system. Over the years, this had resulted in multiple threatened closures to Apollo Ward, as the trust hierarchy found different reasons—ideological, financial, etc.—to try to shut down what they perceived as an anachronistic (and expensive) way of doing things.

This spectre evokes previous ethnographic critiques of public mental health systems in the United States, where entrapment in longer-term relationships of clinical patienthood, premised on fundamentally biomedical illness narratives, has appeared *socially defeating* and obstructive of recovery (Carpenter-Song, 2019; Luhrmann, 2007; Luhrmann & Marrow, 2016; Myers, 2019; Myers & Ziv, 2016).[20] During my research, there were undoubtedly many examples that might lend weight to such arguments—patients like Andrew who wanted to be discharged as soon as possible, or Janet's identification of the hospital as "a prison", or Jim's insistence that he had been "punished for a crime [he] didn't commit". Yet, even in these examples, ambivalence abounded. Andrew, in an affecting moment of quiet vulnerability in the lounge, shared with me his deep fear about the possibility of discharge, not least because "in here you get looked after". Jim, in fact, was one of the only voluntary patients on the ward. And Janet, for all her disdain for "the nuthouse", as she called it, admitted it was her only space of friendship and community. To denounce the long admissions of Apollo Ward, therefore, would only amount to an erasure of the frequent ambivalences and periodic positivity I witnessed towards containment. Never mind, I would be implying, that Hamza asked me to take him back to the "fun" hospital when I went to see him in residential care post-discharge; or that Ayla *did* come back one afternoon after discharge, much to the staff's surprise, for some social contact with them and the other patients; or that Fiona insisted to me that during her last admission they had rescinded her status of involuntary detention too early, before she was really ready to become a voluntary inpatient. Shepherd, for his part, had reconfigured his involuntary admission under the Mental Health Act into a memory of voluntarily checking himself into the hospital, a place "for higher up people", to "learn new skills", and jumped at the chance to ask me if he could visit the ward when I bumped into him post-discharge. When we got to Apollo, his face erupted into a jubilant smile at the sight of the staff on duty, and he stayed to have coffee and catch up.

As the patient with whom I spent most time *off* the ward, Shepherd gave me the best insight into why these orientations towards the hospital were more complex than we might otherwise assume. Standing beside Shepherd, that is, I glimpsed what lay in wait outside the hospital gates. The first time we went together to the football

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[20] Anthropologically, social defeat is a concept articulated by Luhrmann (2007) to describe "an actual social encounter in which one person physically or symbolically loses to another one." Luhrmann proposed that social defeat might be a unifying concept that can explain some of the diverse social factors that elevate risk for developing psychosis. She also postulated that it might explain why, across the spectrum of psychotic illnesses, outcomes are generally better in non-Western contexts than in the West, because our entire cultural approach to treating psychosis in the West may be socially defeating.

complex, the shock was painful. Shepherd went there during many afternoons and evenings off the ward, and most Apollo staff seemed to believe he had found a niche in the amateur training sessions and practice games there where he was accepted and integrated into the community. With this portrait in my mind's eye, I was viscerally saddened, when we arrived, to see him more or less ignored by the other attendees, occasionally acknowledged but also shouted at for getting in the way—and, ultimately, I watched him isolated to his own corner to kick a ball around alone.

My ethnographic data reveal many instances like this—the thousands of daily encounters of stigma and social defeat where people turn away, avert their eyes, move on quickly, or end the conversation. Even when people had no idea what Shepherd and the others were diagnosed with, or whether they had any diagnosis at all, they appeared to want to avoid the mere embodiment of complex mental illness—the slightly odd appearance, perhaps, or the unfamiliar turns of phrase, or the dysarthria or incongruous affect or unusual speech patterns, the curious topics of conversation. Much of this, tellingly, I realised through analysing my own socially conditioned affective and embodied responses—my acutely awkward social anxiety when Janet asked out of the blue if someone's dog had a brain tumour, only for them to shut her down abruptly; or my reflex to want to pull out my NHS badge when Shepherd stopped two women in the street to ask them an idiosyncratic question about childbirth, which was met with outraged silence. Yet, the clinician in me, used to such behaviours, often felt profound anger as well. This was embodied, for example, in my glares around the football complex, or my impulsively curt and irritated response of "you can ask *him*, you know?" when a community receptionist directed a simple question for Shepherd towards me, right in front of him, as if I was some kind of interpreter. It is through such experiences I came to understand Apollo as constituting *two spaces of asylum*, enmeshed inseparably: the space of confinement, sometimes oppressively carceral but sometimes reassuringly containing; *and* the space of shelter, of relative safety and calm relief from these everyday encounters of social defeat.

"I keep myself to myself"

In one sense, the vignettes I presented to open this article are unremarkable. After all, who among us is not more reserved, more anonymous, more *ordinary* in public spaces than we are in more private spheres of familiarity and comfort? Certainly, in rehabilitation terms, this was Shepherd re-learning an appropriate integration into community life. Yet, I was struck by the *abruptness* and the *sheerness* of these self-restraints towards the latter part of my fieldwork, as if Ronaldo pulled out a mask of wary anonymity to don as soon as we neared any strangers. 'Mask', of course, reverberates with multiple meanings here. Masking, in the neurodiversity framework—which, in its original conception, includes psychosis as neurodivergence (Chapman, 2019)—refers to the often harmful "conscious or unconscious suppression of natural responses and adoption of alternative [behaviours]" (Pearson & Rose, 2021). 'Mask' also invokes the work of Fanon (1967) and the "phobogenesis" of Blackness in a predominantly White society—pertinent here because of Shepherd's

"double jeopardy" (Hickling, 1991) as a man with severe mental illness racialised as Black, in a British cultural context notorious for its disproportionate rate of psychotic diagnoses, criminalisation, and psychiatric restriction among people of African and African–Caribbean heritage (Eliacin, 2016).[21] Was this Shepherd masking to survive? Hiding away his subjectivity in public when he began to remember how vulnerable he was, just how much of a threat other people were?

> On the way to the football complex, I notice again that almost as soon as we leave the hospital, Shepherd switches from his usual chatty persona to a much more silent, serious one. As we pass people on the street, he is almost completely silent, even when he bends down to pet a dog or stands aside for someone coming the other way. This is a definite shift I have noticed during our time together these past few months. When we're on a side street, notably out of earshot of anyone else, he starts talking again. […]
>
> [I ask him,] "Shepherd, I've noticed that when we're out recently, you tend to keep your head down, not talk to people so much. Is that right?"
>
> "That's right", he says. "It's like [*pause*] it's like cops and robbers. You know? You've got good people and bad people. Me? I just walk straight through the middle of them, keep my head down, keep myself to myself, because you don't know".
>
> "Like, you don't know which is which?"
>
> "That's right. [*pause*] It's like Jim and Andrew said to me, they said, 'Ronaldo, you're doing well'. I said, 'What do you mean?' They said, 'You're out by yourself, you don't cause trouble, keep going'."

Even more than this, what really convinced me, regrettably, was when Shepherd was exploited by a local hustler right in front of me, in an off-licence on the main road, quietly bullied out of £30 before I even realised what was happening.[22] This man, who he was already acquainted with, had sidled up to him playing on some manipulative sense of camaraderie previously curated, slapping him on the back and laughing, "You got some love for me today?" Shepherd, telling me uncertainly that he owed the man £10, then struggled with the dexterity to separate the notes he had pulled out his bag and ended up handing over the whole £30. The man disappeared sharply, and when I tried to ask who he was and what had just happened, Shepherd laboured to provide a coherent account, giving me a scrambled explanation that did not quite hold together—as the man eyed me warily, escaping across the street.

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[21] Phobogenesis is a psychoanalytic term referring to the exaggerated generation of irrational fear and anxiety that a 'phobic object' creates. The higher rates of psychotic diagnoses amongst people of African and African–Caribbean heritage in England have been known for over four decades, and a recent meta-analysis (Halvorsrud et al., 2018) showed that people in both these groups continue to experience disproportionate police and criminal justice contact on entry to mental health services, as well as higher rates of involuntary detention overall.

[22] In the UK, an off-licence is a term for a shop with a licence to sell alcohol for consumption off the premises. The term is usually employed to refer to small, independent shops that commonly sell a range of groceries and other household items alongside alcohol.

Weeks later, after I had needed to break confidentiality about this event to inform the ward staff—which, excruciatingly, I have no doubt further humiliated him—Shepherd brought it up during our interview, reflecting:

> "[He was] looking around, looking around. Stalking me, for money, which I haven't got to lend him. […] So I'd rather be in a hospital, or a hostel, where I'm safe, than be in me own flat where that's a problem. […] When you're under pressure, it's very hard to cope with your mental health, you do a lot of errors. Meaning when you build up the confidence, someone pulls you back down again and you can't [*trails off*] you get scared, you [*pause*] you feel vulnerable [*pause*] you can't talk to no one. It's very hard for you to open up to someone who you can trust".

So, just as Fiona explained she had thousands of pounds in an abusive ex-partner's account she did not know if she could ever get back, just as Tristan told me of being pressured into taking drugs and "feel[ing] unable to say no", just as Janet spoke dismissively of people who "annoy me, demanding huge amounts of money", Shepherd's narrative sheds new light on the refrain I heard from multiple patients as they neared discharge: "I keep myself to myself".

The notable thing about this mantra is that it contradicts sharply with the dominant framings of recovery I referenced above, which unanimously emphasise the centrality of social connection and integration. Yet, on Apollo Ward, I saw patients shifting in the opposite direction, almost pulling away from social ties as they progressed, or at least being far more cautious and selective in which to pursue. "That's why unwell people, they only talk to each other, keep away from the well", Andrew told me. "So our minds don't collide".

I observed similar dynamics with another cornerstone of mainstream recovery: hope (Leamy et al., 2011). Therapeutic hope is indispensable for recovery-orientated treatment (Turton et al., 2010)—and to be clear, my data support that notion thoroughly. But equally, for those living with complex psychosis, I came to understand, unqualified hope can be a dangerous thing:

> "I'd love to do your job", Shepherd says. […] "I'd love it, but they said I can't because of my illness. They said, 'It's your illness, R9'. But I love to get out and about, do things and that".
> "What would be your ideal job, to aim for?"
> He shakes his head, grimacing as if to dismiss my naivety, "Ah, I don't like to wish, 'cause it never comes true".

Fiona put it in the starkest terms, when she was explaining to me, during her interview, why she had "put a stop to" the nursing staff's attempts to organise a voluntary role for her in a local shop, which she dismissed as "a downer, because I [will] just have disappointment, frustration":

> "If you accept that it's a short life, and you've been very mentally ill, and you can't have expectations of yourself, you're a lot happier. You know, you'll be a lot happier if you have lower expectations. I said, 'Look, my life has been shaped up by this illness, I've not led a normal life, there's nothing normal

about me, you've suffered a lot and I've got bad memories, and I'm exhausted from mental illness, so you're a small person'. I say to myself, 'Fiona, you're a small person, in a small world—but aren't you happy?'"

Conclusion

What lessons might we learn then? Ultimately, I find Andrew's imagery of a 'collision' most instructive. For what these data seem to illuminate is the trial-and-error process of working out how best to navigate what Bleuler (1911) called the "double bookkeeping" of living simultaneously in two worlds (Parnas et al., 2021)—the idiosyncratic and the shared, the psychotic and the real; that of R9 the legendary striker and that of Shepherd the 'ordinary' man—in short, figuring out how Ronaldo can ride the Clapham omnibus. In many ways, this is recovery in the sense Myers theorises it: a self-directed editing of Shepherd's life into an identity drawn from a culturally valued figure of respect in R9. Yet, for Shepherd, the third stage in Myers' model, those "peopled opportunities" to forge social connections, actually prompted a strategic withdrawal from social connection rather than enabling it, at least in the time I knew him.

This phenomenon has been described before. In Corin's studies of people living with schizophrenia in Montreal, she found that those community patients who avoided rehospitalisation maintained a stance of what she called "positive withdrawal" in relation to the social world—a kind of half-in-half-out engagement "at a distance" that could simultaneously avoid the disappointment and rejection of stigmatising contact *and* the loneliness and exclusion of total isolation (Corin, 1998; Corin & Lauzon, 1992). To me, Shepherd appeared to be doing something similar. But importantly, the social complexities of this identity and social position meant that figuring it all out was a *fundamentally slow and complex endeavour*, fraught with the dangerous collisions that peopled opportunities in this context bring—as I glimpsed momentarily in the off-licence.

Safe navigation therefore required a few key ingredients—ingredients which Apollo Ward could provide but which are generally in short supply in public mental health services, both in the UK and elsewhere. These were (1) *time, space, and containment in a safe and protected place*, which was (2) staffed by people embodying a *pragmatic neutrality towards his recovery*, neither judging nor indulging its idiosyncrasies (which, far from being experienced as disinterested, seemed to provide him with an ideal test audience in front of whom he could rehearse his recovery); and (3) being *locally situated*, such that he could gradually test out this complex recovery in his own community. So, this is what Apollo Ward could provide, aided by its principles of recovery-orientated treatment and an older logic of rehabilitation that predates the recovery movement. Yet, ironically, the repeated existential threats that Apollo Ward had faced over the years seem wrapped up in another recovery discourse, a normalised and streamlined vision that does not capture these complex recoveries. Yet, this latter vision of recovery has been operationalised into a community-based service ideal apparently blind to Apollo Ward's therapeutic ingredients. To return to my central question, then, I am arguing that our dominant recovery

discourse obscures the complex recoveries experienced by people living with complex psychosis, as well as the power of rehabilitative admissions to nurture such recoveries.

To date, this conclusion has not been shared by the more nuanced analyses of anthropological studies on this topic. In previous ethnographies, public mental health services and institutional psychiatry have appeared to *erode* the capacity for moral agency through their coercive apparatus and biomedical reductionism (Carpenter-Song, 2019; Luhrmann & Marrow, 2016; Myers, 2019; Myers & Ziv, 2016). Their findings concur with McWade's (2016) policy analysis of UK mental health services. Yet, echoing Bromley (2019), I am emphasising here the need to take seriously my participants' ambivalent dispositions towards the matrix of care and coercion that constituted longer-term inpatient treatment on Apollo Ward. The ward might not have been showered with ringing endorsements from its inpatients, but its social environment (including extended detention under the Mental Health Act) was experienced as reassuringly predictable and accepting just as much as it was derided as restrictive and disinterested. This ambivalent relationship resonates with other accounts of the lived experience of hospitalisation in psychosis (Fusar-Poli et al., 2022), and, as I have argued, was key to the complex recoveries of Shepherd and the others.

This may be an uncomfortable conclusion for those working in pursuit of more just and equitable mental health systems, where community-based recovery and the abolition of coercion seem far more intuitive and appealing goals (Birkeland et al., 2024). Yet, it is an insight we must grapple with all the same, because its grounding in ethnography with a profoundly marginalised group of people emphasises that this is not merely theoretical debate. To the contrary, the material consequences of missing this complexity are stark, especially when contemporary preferences for community care dovetail so neatly with neoliberal austerity (Braslow, 2013). In the UK at least, rehabilitation pathways like the one fronted by Apollo Ward are being increasingly scalped by disinvestment in NHS inpatient rehabilitation services, seemingly fuelled by our normalised recovery discourses. But what happens to these complex recoveries then? When the time, space, and relative safety to work out how Ronaldo can ride the Clapham omnibus is gone? Perhaps we can find these scarce ingredients elsewhere, but then again perhaps we cannot. And if we cannot, who will be the ones who pay the price? For this is the clear and present danger of streamlining what it means to recover—and therefore oversimplifying what is required to support complex mental illness—and of missing those who may be kept alive by the complex containment of clinical institutions.

Declarations

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