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GENERATING SOCIALITY THROUGH THE SENSES IN MOVEMENT AND MUSIC THERAPY AMONG PEOPLE WITH RECURRENT PSYCHOSIS

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Psychosis analyzed from a phenomenological orientation is a disembodied experience that involves a constant negotiation of self and reality. For people experiencing recurrent psychoses, its medicalisation and stigmatisation further complicate the relationship of self, medication, and society, as shown by the political economy of psychosis. In these cases where full recovery from the illness may not be possible, I reconceptualise psychosis as a *pastime:* a strategy to coexist with rather than be defined by the illness experience. Accordingly, I turn towards non-pharmacological interventions; arts-based therapies, such as dance and music, have been shown to benefit people with psychosis by reestablishing their experience of reality within the body and empowering them to regain control over their lives and interpersonal relationships. In my ethnography of the Psychosis Therapy Project (PTP) based in Islington, London, UK, which serves people with recurrent psychoses, I explore *how* its movement and music therapies work towards re-embodiment using bodily techniques of heat, synchronicity, synesthesia, and the transportive role of music. Thus, I take a sensory anthropological approach to sociality that also decenters vision as the main sense in healing—to be well is to *feel* well rather than just to *look* well. Finally, my fieldwork presents a case where a service user, who regularly participates in the movement group, manages psychosis as a pastime through practical and social enskilment. Ultimately, my work strives to demedicalise and destigmatise the lived experience of psychosis and honour the legacy of the PTP.

Keywords: psychosis, phenomenology, sensory anthropology, movement therapy

The rhythm of house music chugs in the background as we sit on couches facing each other, chatting. People move through this common area, joining and leaving conversations between refilling tea, attending their therapy appointment, and participating in the various sessions

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offered by the Psychosis Therapy Project (PTP). Every Wednesday for eight weeks, I started my fieldwork on these couches, building rapport with service users who were self-referred or referred by a medical practitioner to the PTP for experiencing recurrent psychosis. As service users shared about their day, I learned more about their experiences with psychosis, medication(s), and relationship to broader society, thus contextualising my phenomenological analysis of psychosis and its various therapies which follows.

To begin with theoretical underpinnings, phenomenology posits that human reality exists from within the body and is perceived by the senses including kinesthesia and proprioception (Fridland 2011); for instance, Merleau-Ponty elaborates that 'the lived body is the "thereness of human reality", and the body as it is lived in everyday dealings with the world is the centre of the field of perception and action' (Morris 2012: 49). Thus, the body's direct presence in and engagement with the environment, through posture and movement for example, allows people to constantly create identity, paving the way for embodiment orientations. How the body *feels and lives* becomes a form of knowing.

Accordingly, my research interest lies in cases where people experience *dis*embodiment, such as during psychosis: a condition that medically manifests as delusions, hallucinations, disorganised thoughts and behaviours, catatonia, and reduced facial expressions (Calabrese and Khalili 2019). Phenomenologically, these symptoms can be explained as the loss of intuition over one's body, making their body and environment feel confusing and at times frightening. For example, doubts of what is real may lead to the positive symptoms of delusions and hallucinations, whereas the negative symptoms of withdrawal and reduced facial expressions may stem from an unclarity of how to relate to others. Koch et al. (2017: 864-866) suggest that this disembodiment in psychosis includes 'lost body boundaries, lost agency, and determination by external forces… [People] experience their body or parts of it as alien, their outer world as alien, and themselves as separate from it'. Therefore, these symptoms may be caused by and reinforce a lost connection with the bodily self— 'a stable, continuous sense of the body across time'—which is 'a core component of selfhood' (Benson et al. 2019: 111).

Moreover, in people with more *recurrent* psychoses and thus a prolonged use of medication, their relationship with pharmacotherapy further complicates their bodily function and identity formation. For instance, while anti-psychotics may help manage the symptoms of psychosis, they may also over-suppress one's ability to feel, diminishing their experience. In conversing with Mark, a mid-career artist and service user, I learned that his medication 'messes with his feelings [by making him] feel unmotivated'. Along with the medication's range of side effects, these resulting changes in motivation levels may also result in medical noncompliance, which can be anthropologically explained as existential problems in subjectivity 'within the domains of self, agency, identity, social relations, and cultural and community response' (Jenkins 2010: 38). In a separate essay, Jenkins and Carpenter-Song (2006: 392) provide an ethnography of people with recurrent psychoses, revealing how the sensory experience of self can be characterised as a palpable struggle to situate themselves relative to their illness and medications. For participants, negotiating a sense of self involves teasing out the effects of their medication, symptoms of their illness, and aspects of their personality... Rendering the self entails both explicit and tacit negotiation of a sense of 'me'

versus 'not me.'

Therefore, psychosis is not only a disorienting experience on its own, but also its medicalisation may leave the person particularly vulnerable, prompting them to act in culturally unconventional ways to manage their disorientation. For instance, Akira, an older service user with a strong voice, mentioned, '[some transfer patients to people] want to put you on edge… and the medication does it anyway, you know?'

In the broader healthcare system, the political economy of psychosis suggests that 'antipsychotics have been used not as an *adjunct* to psychosocial treatment… but often an *alternative* to such care… Too often the psychiatrist is called upon to wedge the person [with psychosis] into an ill-fitting slot because an appropriately therapeutic setting is not available, affordable or even considered feasible…' (Warner 2003: 250). This narrative of people experiencing psychosis as a burden and thus rushing 'to the community—to cut institutional costs regardless of social costs' (ibid) is also prevalent within the NHS, according to Walter, a service user with beard stubble and a pensive demeanor. As he fidgeted with his lighter, he mentioned that 'it's all about recovery and rehab and trying to get people back to work, out of the system. This works for some people, but not for most. [The current mental health system tries] to do "quick fixes"'. As such, people with psychosis may experience isolation on the levels of individual experience—from the medication—and collective social identity— due to stigmatisation—as they 'contend daily with embarrassment and discrimination in their struggle to get better in the wake of serious mental illness' (Jenkins 2006: 406). Ultimately, this phenomenological landscape of psychosis reveals the interplay of symptoms, medication usage, and stigmatisation that shape one's 'being-in-the-world'.

As the rates of psychosis continue to increase despite the development of various pharmacological treatments, I endeavoured to investigate cases of recurrent psychosis where recovery does not occur. During my fieldwork, these service users often redefined 'recovery' or 'healing' as the 'management of life' or 'being able to live a normal life… that's bearable and sensible'. Similarly, after conducting anthropologically developed subjective experience of medication interviews (SEMIs) for patients experiencing psychosis, Jenkins and Carpenter-Song revealed that 'while medication is given a primary narrative placement in processes of recovery… [it] could not be expected to do all of the complex and subtle "work" involved in the process of recovery'" (2006: 390). Control of the illness was cited as a strategy, manifesting as 'efforts to "keep busy" to relax, and to distract oneself from otherwise disturbing symptoms' (ibid). Finally, Jenkins and Carpenter-Song demonstrate that humanising social connection is paramount to managing psychosis as they allow 'the individual to be treated as "just another person" rather than being marked as ill and excluded as such' (2006: 394). Thus, to further destigmatise and demedicalise psychosis, I reconceptualise psychosis as a pastime, a way of being that, despite its management evidently containing hardships, can also be filled with "'small" and "everyday pleasures'" of the joie de vivre[2] (Jenkins and Carpenter-Song 2006: 397).

[2] Jenkins and Carpenter-Song (2006: 397) explain that these small pleasures are 'typically thought to be a domain of experience that is largely absent in lives of persons with schizophrenia [or psychosis]'. As I intend to uncover the nuances of psychosis management using a desire-based approach (Tuck 2009), I aim to decentralise the damage-based narrative of mental illness in these peoples' lives. Yet, I do not intend to

While my role as a medical anthropology student familiarised me with the political economy of psychosis and its pharmacological treatments, my background as a dancer prompted me to creatively turn towards non-pharmacological arts-based therapies, shown to help people with psychosis regain balance and trust with their bodies and world. For instance, music and movement therapies are forms of healing based on intuition and non-verbal communication. Movement therapy has been medically shown to improve patients' physical wellbeing at the biochemical, neuronal, and psychological levels (Jola and Calmeiro 2017), while also building on the social connection healing of intersubjectivity as patients move and create meaning with their therapist and/or other patients. Ultimately, it is a '*relational process* in which clients and therapist use body movement and dance as an instrument of communication during the therapy process' (ADMP 2023, my own emphasis). While body techniques vary, a common strategy is mirroring, which develops kinesthetic empathy: 'a re-living or an epistemological placing of ourselves "inside" another's kinesthetic experience' (Parviainen 2003: 152). Current neuroscience research explains mirroring as when we move with others in a shared manner, our mirror neurons fire in

> […] our own sensory and motor brain areas when we observe the actions of others […] in order to build implicit relational skills and predict the actions of others. This skill is what we know as 'intuition'—to be able to predict approximately what is going to happen in the course of an action or interaction. (Koch et al. 2017: 868-869)

This intuition helps to build kinesthetic empathy, which 'fundamentally involves the observance of physical bodily action… [and] actively embodying the experience of the Other' (Douse 2017: 288). Therefore, the active movement between people during mirroring helps to develops kinesthetic empathy, which is therapeutic for those experiencing disembodiment. Finally, what separates movement therapy from therapeutic exercise classes is often the free movement to *music*, which one of my early interlocutors described as 'the *movement of the soul*'. Hinton and Kirmayer (2017) show that music can act as 'flexibilisers' that metaphorically push patients to embody flexibility and change in their own lives. For instance, 'alterations of the musical line both represent and evoke bodily and cognitive impressions of movement, change, and flexibility. Music with these forms encourage the listener to experience their own capacity for shifting, and by analogy, flexibility and change. This effect may be heightened when the *person actively participates in making music or dancing to it*' (Hinton and Kirmayer 2017: 20, my own emphasis). Through these metaphors of movement, both movement and music therapies can be beneficial to people with psychosis where they may feel disoriented and lose intuition towards outward experience. What follows will be an analysis of the PTP's movement and music sessions through participant observation and interviews with service users and therapists.

To begin, I situate myself in my fieldwork by painting a vignette of the PTP's movement and music therapy groups. During my initial meeting with the PTP Director in January 2024, I was introduced as a medical anthropology researcher to the therapists and the service users

invalidate the negative experiences one may have had; rather, I strive to show the fullness of the experience and that these people are more than their illness or than being broken by their illness.

present in the common area that day, many of whom as regulars would remember me on my first day of fieldwork. During my initial attendances of both sessions, I introduced myself as a 'researcher' or 'master's student' and briefly shared about my research question and role. My positionality as an Oxford student garnered interest from most service users, acting as a conversation starter to build rapport with them. For example, I learned that Walter's daughter had also studied at Oxford. To my surprise, that and my status as an international student were not as intimidating as I anticipated, despite hearing the occasional paranoid statement about institutions and foreigners.

After spending the first hour of my time at the PTP mingling with or interviewing the service users and therapists, I climbed the stairs to the second floor of the Islington MIND building for the movement therapy group. During the next hour, I conducted participant observation while also actively partaking in the session. In the movement group, the activities varied per week but, from the third week onwards, it revolved around a theme set by the therapist. With this change, the therapist would also ask for our reflections on the theme using paper and crayons—adding a visual arts element to the session. Examples of themes included: 'relating to others', 'coping with stress' and 'building self-confidence'. During this check-in activity, we sat on chairs formed in a circle, which we would either continue to do during our warm-up or which we would push aside to warm-up standing. Our seated warm-ups occasionally included mindfulness body scans. After the warm-up, the therapist played music from a speaker and we moved freely, mirroring each other, and answering the therapists' questions about how our bodies felt. Then, the therapist would often bring an object prop for us to use: a percussion-based musical instrument, fabrics, beanbags, balls, etc. We would tactilely explore these objects, on some weeks name them, and then we would move with them. Finally, at the top of the hour, we would debrief about the session, revisiting our written or drawn reflections, and provide feedback about our bodily sensations and each other's movements.

By contrast, the music group had a fixed structure and the only variation per week was the time dedicated to each activity based on the number and talkativeness of that week's participants. The session began with an improvisation session where we all played the musical instruments laid on the table—a lamellophone, ukelele, lyre, guitar, bongos, maracas, keyboard, tambourine, etc. Next, each service user requested a song to be played from a speaker for the group to listen together. The service users would often start with why they chose that song for the week, and a discussion would usually follow once the song ended. The therapist facilitated the conversation's flow. Finally, the session would close with another improvisation session—where service users may choose different instruments—and a quick debrief of the session. In the music therapy group, I held more of a passive observation role contrary to my active participation in the movement group; for instance, I partook in the music improvisation but not the song sharing part of the session although I occasionally shared my thoughts on a song that was played. I also did not participate in the debrief but listened carefully to the service users instead.

In narrowing the scope of my article I will focus on *how* these two sessions work rather than *why* they work.[3] Therefore, my aim is to describe the body techniques used in these sessions by applying a sensory medical anthropology approach and specific ethnographic examples from my fieldwork. The following sections are structured as the flow of my fieldwork day, starting with the movement therapy group where I have identified the warm-up, mirroring, and the use of props as consistent components of the session's structure. Then I present the music therapy group, structured into improvisation (first and last 5-10 minutes) and song sharing components (remaining time).

In the final section, I provide a case study of psychosis as a pastime by applying Ingold's concept of 'enskilment' (2000) to demonstrate how a service user, Thor, manages their day-to-day living with recurrent psychosis.

Heat in the movement therapy

Each week, the movement therapist started the session with light stretching. During my first week of fieldwork, she also invited us to warm up our hands by rubbing them together. This motion caused heat through friction which we then touched to different parts of our bodies, warming them up and connecting with them. Taking turns, we each demonstrated touching a body part, such as the head, legs, arms, back, shoulder, belly, and neck. The movement therapist commented that 'we often forget about our back or the backside of the body' during this 'transfer of energy' from the hands to the respective body parts. She checked in with each of us to see if our bodies were feeling warmer.

Potter defines heat as 'a crucial sense of energy that is discussed and experienced informally among dancers' (2008: 454). Drawing on her ethnography of contemporary dancers in London, she reveals that "'warming-up", or increasing the body's internal temperature, is considered a necessity […] for bodily learning during training […] Muscles begin to feel more mobile' (ibid). Although my fieldwork's bodily learning did not pertain to training choreographed routines or styles of dance, the warm-up attuned us to our bodies and facilitated the movements that followed. For instance, it prompted us to locate the areas in our bodies that felt stiff or in pain, such as my neck and lower back, leading to a deeper level of awareness of my body in that present moment. By working through those tensions with gentle movement, warming-up also allowed us to create bigger movements during the subsequent freestyling exercises with less risk of injury; thus, it provided a safe way for us to explore the limits of our bodies with our surrounding environment. Furthermore, in the particular exercise of rubbing our hands together and then touching different parts of body, heat was generated and transferred through touch, a 'boundary sensory mode (in contrast to the trans-boundary modes of heat and smell) […] bringing explicit attention to the body's boundaries' (Potter 2008: 456). As my hands patted my thighs, I became aware of how my

3 Instead of striving to prove why movement and music therapies work for people experiencing psychosis, I assume that these sessions are in fact therapeutic to the service users, given the benefits of kinesthetic empathy and 'flexibiliser' properties to psychosis management.

hands felt on my legs and how my legs felt for my hands, echoing the sensation that 'whatever you touch, touches you too' (Hsu 2008: 440).

Finally, as the 'social shaping [of boundary sensory modes such as touch and taste] defines what external objects may be contacted or consumed by individual bodies within a cultural group' (Potter 2008: 456), I found that the movement therapist's comment about how the backside of the body is often forgotten fascinating. With Western society's emphasis on vision as the main sense for creating our 'reality' (Ingold 2000), and that we mostly only see what is *in front* of us, this socially constructed hierarchy may thus shape how our other senses operate, focusing our tactile experience to what is in front of us including our bodies. This does not imply that we question whether our backsides exist—we know proprioceptively[4] we have heels, calves, buttocks, back, shoulder blades, etc.—but that these float in and out of awareness compared to our hands, bellies, thighs, and knees which we can always visually access. Therefore, vision shapes what we conventionally touch (actively, such as with our hands), such that the group was surprised by this reminder that we could also place our warm hands on our backs.

'During the warm-up, the temperature of the skin increases and sweat begins to coat the body as internal heat is released into the surrounding air… its perception leads to the recognition of other bodies and external heat sources in space' (Potter 2008: 454-456). Prior to starting the session each week, the movement therapist first asked how we felt about the room's temperature. She would often offer to turn a portable radiator on if we found it too cold, and, as the weather transitioned into summer, she would in turn run a fan if it was too hot. One of the service users, a quiet gentleman named Giuseppe, consistently commented that, although he felt cold at the start of the session, he did not need the radiator because he knew the room would feel warmer as we carried on with the session. Indeed, by the end of each session, the room felt warmer as evidenced by some service users removing a jumper or unzipping their jackets.

Yet, what stood out at the end of the session was the liveliness that had been created during the session. We recognised this different type of heat by contrasting it to cooling-down, where we debriefed the session, packed up our bags, exchanged a 'thank you, see you next week' and moved towards the door. Drawing on Chau's explanation of 'red-hot sociality' or social heat (2008: 488), Potter argues that

> perhaps most importantly, heat in the studio [is] a means of sensing the life force of others […] generated by the gathering of living bodies and heightened through an explosion of sensory activity […] A sense of heat thus begins within the individual body but quickly transfers into the social realm. (2008: 455- 456)

Therefore, not only did we physically cool down, by slowing our movements and heartbeats once the session ended, but also the metaphorical cool-down of being dismissed and dispersing back into our own daily routine shows the different types of heat created in the movement group. The act of coming together and *moving in a unified manner and rhythm*

[4] I follow Fridland's definition of proprioception as the 'intracorporal tracking of somatic location and limb position' (2011: 523).

amplified the production of the heats, revealing the importance of synchronicities, which will be explored next.

Mirroring movements and synchronicity in the movement therapy

Once our bodies are warmed up, the movement therapist played music from her tablet and speaker. It was usually slow, instrumental, and contained sounds of nature. We first moved around freely to the music for a few minutes, sometimes making use of the physical space around the room. Then, the movement therapist invited us to go around in a circle and demonstrate a movement on the spot for the others to copy. We would each perform for a short period and the remaining group members would take a few beats to appraise the movement before attempting it in their own bodies. Then we would pass the turn onto the person next to us through pausing our own movement, turning towards them, and either nodding or making eye contact with them. There were shoulder rotations, fingers stretching and closing, swaying, arm waves, popping and locking, knee bends, marching… Some weeks, the movement therapist challenged us to make our upcoming round of movements more complex than the first. This often required more focus from the participants copying the movement; one interviewee mentioned, 'and then it takes so much coordination mentally [to mirror the other participants' movements] doesn't it? Yeah, to be able to consider a group… Yeah, I could manage, but a bigger group like that I would have found very difficult because I wouldn't be able to contain all the information that was coming out…'

In his essay about collective effervescence among Australian Indigenous peoples, Durkheim writes, 'the very act of congregating is an exceptionally powerful stimulant. Once the individuals are gathered *together*, a sort of electricity is generated from their closeness and quickly launches them to an extraordinary height of exaltation […]' (Durkheim 1995: 217, my own emphasis). This electricity, felt by a group focusing in on their shared experience of the present, is an example of synchronicity, 'a situation in which all participants involved are acutely aware of only one single event and turn their full attention to it' (Hsu 2005: 85). In the movement group, as we all intently discovered how each other's movements felt in our own bodies, we moved in a synchronised manner that pushed us to exist as a collective beyond our individual bodies. On such transformation, Hsu writes that 'these intense moments of synchronicity between people […] are important not only because of the sensory experiences, emotions and memories that they create in the individual. More importantly, they make the social group physically real, engendering vitality in the group as whole' (2008: 439). A manifestation of synchronicity was particularly prominent when we were asked at the end of a session what our energy level was; each response revealed that our energy levels coalesced at around 5-6 on a self-reported scale of 10: energised but still calm, with those who initially had higher energy slightly dropping and those who had started the session more tired now feeling more energised. Thus, the collective moving—of the same moves, at the same place and same time—emphasised sensory relatedness and generated synchronicity.

What was unique about this exercise, compared to simply following a choreography or sequence of moves led by the movement therapist, was that we tried *each other's* movements.

Thus, not only were we intentional about the move we wanted to share with group, but we were also intentional with how we received the performer's move in our own bodies, at times modifying it to our own abilities. For instance, Akira mentioned in her interview,

> I quite like the idea of taking a movement, you know, and each expressing a movement. And I think, you know, there's something about expressing each other's which works quite well, as well… Because when I did [a different movement therapy group in London], we copied it exactly. But I think that idea that you have an interpretation yourself is quite nice.

Trying each other's moves in our own bodies prompted us to create intersubjective milieus by enhancing our somatic modes of attention towards bodily reciprocity. To begin, Csordas reveals that 'a somatic mode of attention means not only attention to and with one's own body, but includes attention to the bodies of others' (1993: 4). Therefore, as we mirrored each other's movements, our embodied presence in the exercise created an intersubjective milieu between our body-selves and the performer's body-self, an act of seeing and being seen. Such presence is crucial; in my interview with the movement therapist, she explains,

> when we share movement, it creates a space where people feel like they've been witnessed; even if I'm not talking, my presence, my movement and what I bring is quite important… By witnessing others, we form a connection for them in the context of feeling safe… Mirroring and sharing that movement of witnessing and attuning to that person.

I argue that attuning to a person involves turning our somatic modes of attention towards the relationship between each other's bodies. For Merleau-Ponty,

> the internal relation between my body and that of the other is bodily reciprocity. It is not simply that the infant perceives the other's intentions immediately in perceiving his gestures […] but that it perceives its intentions in its body, and my body with its own, and *thereby my intentions in its own body* […] It is as if the other person's intention inhabited my body and mine his. (Morris 2012: 115)

Therefore, in the mirroring exercise, we heighten our bodily reciprocity by practicing each other's intentions in our own bodies through somatic modes of attention. This created intersubjective milieus that ultimately built kinesthetic empathy as we witnessed and attuned our body-selves to each service user. This social connectedness can be further enhanced by creatively introducing props into the moving group thereby adding multisensory and synesthetic dimensions.

Object use in the movement therapy

In Week 4 of my fieldwork where the session's theme was 'relating to others', the movement therapist handed us a play parachute. We each took a corner and made waves at times so

large that the parachute's centre rose above our heads, and we could see each other from under it. We then took turns creating different wave-like patterns with the parachute, such as by varying the timing of our hands. One by one, we took turns demonstrating the movement which was then mirrored by the rest of the group. We rotated the parachute counterclockwise such that the colours facing us continuously moved to the right. Then, the movement therapist placed a beanbag on the centre of the parachute, and we tossed it around. Cynthia, a petite but energetic service user, mustered a powerful push, propelling the beanbag off the parachute onto the side shared by Giuseppe and the movement therapist. After the session, we drew our present thoughts onto sheets of paper using coloured crayons and shared them with the group (Figure 1).

Figure 1. Left: Our drawings and words using crayons for the debrief of the play parachute activity. Right: my sheet of paper outlining my thoughts and feelings from the session

Although the warm-up and mirroring components of the movement group engage one's senses such as hearing music, touching and feeling heat and proprioception, adding props heightened multisensory engagement through further visual, auditory and textural affordances.[5] For example, the parachute's bright colours, loud flapping, and nylon texture created different sensations than watching each other, listening to calm music, or touching our own skin as was the case in mirroring and warm-up. This incorporation of objects beyond the body was conducive to building social relations. For instance, as I received the parachute handle from the person on my left and passed my own parachute handle to the person on my right, I engaged in an '*exchange* of material objects' which creates and reinforces social relations (Hsu

[5] Gibson (1977) defines affordances as properties of the environment that can be used by an animal (in this case the session's participants) and that are unique to that animal.

2008: 438). These objects also act as a vehicle for intersubjective sociality or what Hsu calls the 'joint experience of real stuff, such as the sweat from dancing or from gardening' (ibid). In the beanbags exercise, as we created waves in the parachute to keep the beanbag afloat, I felt Cynthia's playful and mischievous energy in my own body through each parachute ripple, as she created large waves to jostle the beanbag off the parachute. Thus, we entered a social relation through the parachute, as I tried to counter her waves with similar energy to stabilise the beanbag. In this exercise, we had engaged closely with the parachute, spending the bulk of the session moving it, accomplishing different exercises with it, and to the point where both Giuseppe and I drew its colours on our sheet of reflection paper (Figure 1).

In contrast, the following week's session took a more distant albeit still meaningful approach to incorporating objects. The session, whose theme was about 'stress relief', began with drawing or writing our interpretation of stress. After we shared our work with each other, we placed these sheets around the room to be revisited later. At the end of the session prior to debriefing, the movement therapist laid a set of props around the room and invited us to decorate the space in front of us with our sheets of paper (Figure 2).

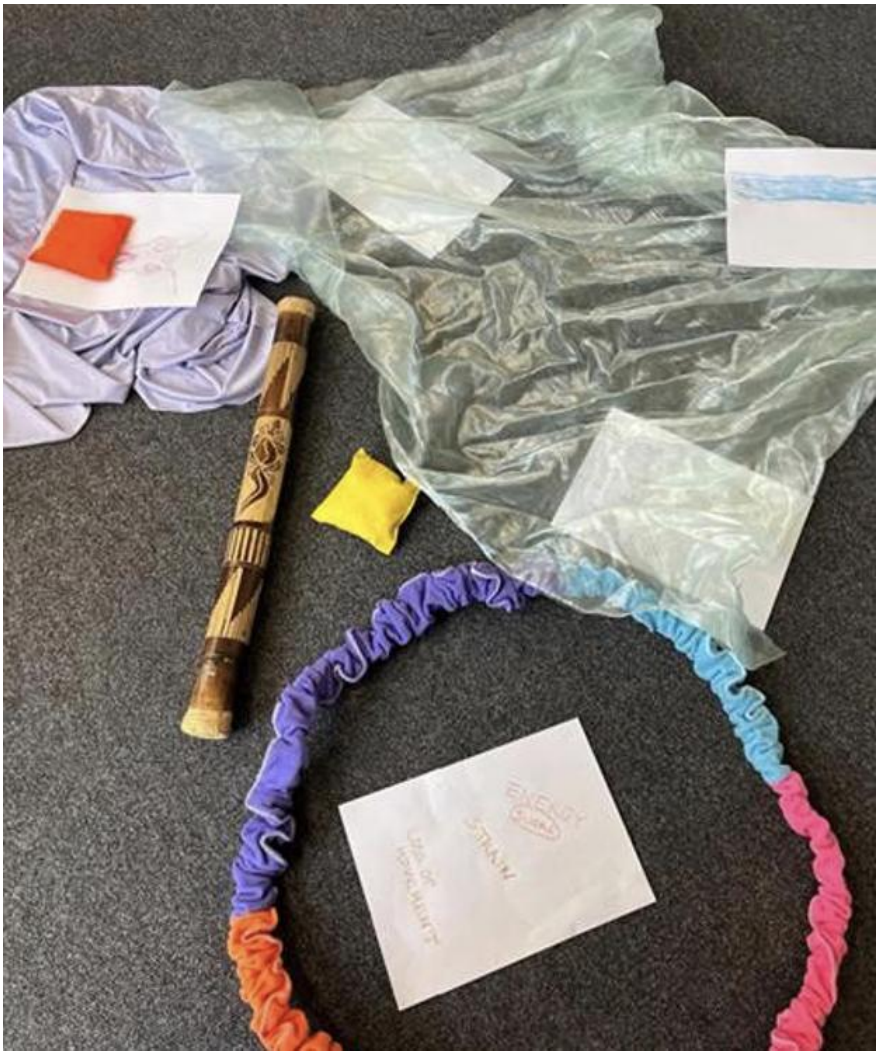

Figure 2. Our debrief included intentionally placing our sheets of paper among the objects in meaningful configurations.

When asked to justify why we put our paper in that particular location, Akira mentioned putting their paper in the circle as if to constrain the topics of stress that have been on her mind; upon closer inspection of the figure, these topics read 'ENERGY' and 'SUGAR' (both in red crayon, the latter word circled), 'STRAIN' and 'LOSS OF MOVEMENT' (in light brown crayon). We reflected on each other's decision and gave each other feedback before closing the session.

In this exercise, we did not interact closely with the objects; at most, we briefly lifted the object to slip our paper underneath before returning to our seats. As such, instead of affording us with multisensory stimulation,[6] the props played more of a metaphorical role. I propose the role of metaphor as, in accordance with Michael Jackson's *Thinking through the body: an essay on understanding metaphor*, '[mediating] a transference from the area of greatest stress to a neutral area which is held to correspond with it' (Jackson 1983b: 138). This occurs when 'a movement is facilitated from the domain where the double-bind[7] is manifest and where, before anxiety is most intense, to another domain which is relatively free from anxiety and accordingly still open to control and manipulation' (ibid). In our movement therapy exercise, Akira had moved with her own body the sheet of paper listing her stressors, placing it inside the closed ring. Accordingly, she desired to contain the stresses of strain and loss of movement, to be relieved from them. Her intentional action was a 'disruption in the habitus […] [which] lays people open to possibilities of behaviour which they embody but ordinarily are not inclined to express […] it is on the strength of these extraordinary possibilities that people *control and recreate* their world, their habitus' (Jackson 1983a: 334-335, my own emphasis). By actively altering the environment of objects laid on the carpet floor—representing the habitus in this case—Akira reoriented herself to the stressors in her life. Therefore, through metaphorising the ring-shaped object, she was able to counter the stressors of strain and loss of movement.

On the other hand, I have yet to address the full contents of Akira's sheet of paper, and I now turn my attention towards the word 'ENERGY' written in red crayon. Along with justifying why that word contributed to her interpretation of stress, she briefly mentioned she had deliberately chosen to write it in red crayon by association—providing an example of synesthesia, 'a correspondence between two or more senses usually considered as separate described in western aesthetic and scientific terms' (Young 2005: 61) However, it would be an oversight to simply assume that Akira is 'innately' or psychologically synesthetic, meaning one perceived input provides two sensory outputs in the brain. Although this may be the case, Young (2005: 64) reveals in her ethnography of the Pitjantjatjara peoples' appraisal of the colour green that 'synesthesia must be socially based or at least socially influenced' as well[8]. In Akira's case it is possible that energy as a release of heat and vitality is culturally associated

[6] As we did not directly touch the object, we did not experience its tactile affordances, nor its sounds, smells, etc., which would often require lifting the object close to the respective sensory organs to be perceived. Thus, we experienced these objects distantly, primarily through vision.

[7] In this case, Akira's real-life experience of stressors.

[8] I lean more towards synesthesia as socially influenced, thus leaving space for the individual differences in senses and perception. Accordingly, I recognise a limitation of my ethnography, which follows a general criticism of phenomenological approaches, is the assumption that our senses, bodies, and perception are universal entities such that I, the ethnographer, am able to follow the service users' experiences of the therapies.

with the colour red as tends to be the case in Western society. She also explained that 'energy' in the context of stress is mostly positive or a productive form of energy, but it could also be negative as is the case with sugar highs and crashes; thus, the association with the colour red may be multifaceted, denoting not only heat, but also a *warning* to maintain proper sugar levels. Nevertheless, using objects in the movement therapy promotes multisensory engagement that may lead to synesthetic experiences among service users. These affordances of metaphor and multisensory engagement were also prominent in the techniques used in the music group, into which I delve in the upcoming section, thereby closing my analysis of the body techniques used in the movement group.

Instrumental improvisation in the music therapy

After moving downstairs to a room next to the common area, I sat with another group of service users around large tables holding musical instruments. Every week, we would start and end the session with improvising on these various instruments of which I most often found myself playing the mbira, ukelele, or maracas (Figure 3).

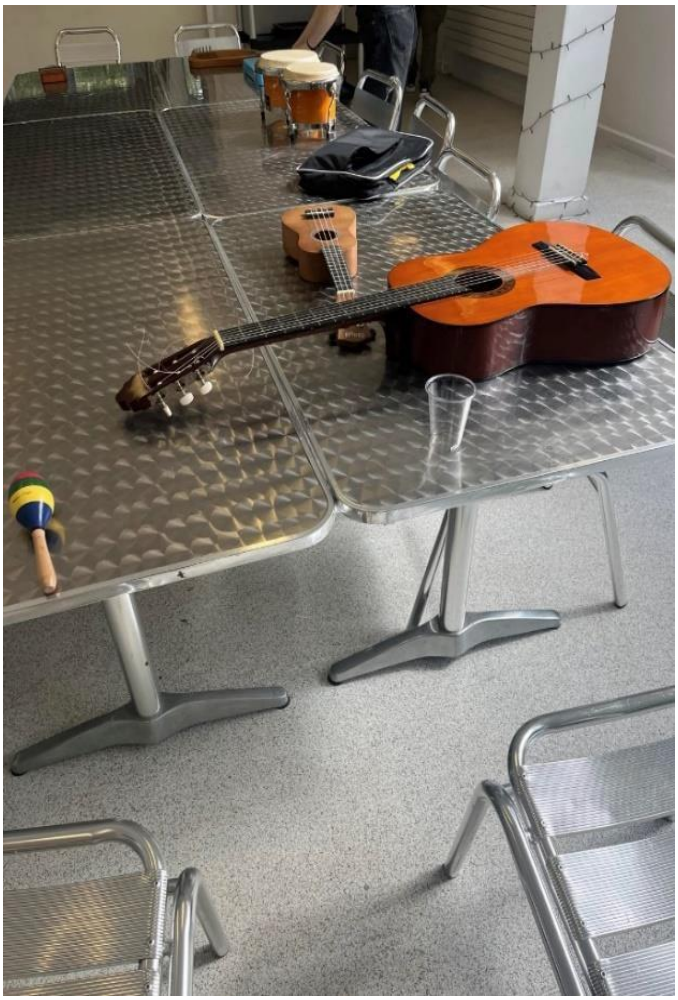

Figure 3. The instruments we played at the beginning and end of each session.

The service users also naturally gravitated towards certain instruments, with Terry, a talkative man with dyed hair and a captivating personality, opting for the acoustic guitar each week and Eric, another service user with a warm smile that reached his eyes, playing various tunes on the electric keyboard. The music therapist also joined, playing the piano, flute, and once even singing. Despite having some knowledge of music and rhythm through childhood piano lessons, I did not know how to play these instruments, but many of them were self-explanatory and percussive in nature. While some of the service users had musical knowledge, many others also fiddled with their instruments—creating an uncoordinated cacophony where somehow a melody and harmony often arose.

Interestingly, these improvisations adopted textures that expressed the intentionalities[9] of the service users through their instruments. For example, in the third week of my fieldwork, the starting improvisation felt more vibrant, whereas the ending one felt more 'delicate' (direct quote from Walter). To describe the sounds as 'vibrant' or 'delicate', adjectives respectively associated with visual or tactile senses, points to Young's argument about synesthesia as 'a different way of thinking' (2005: 73). For example, these two adjectives are related by the different energy levels they convey, meaning their association with the improvised music communicated the resulting intentionalities of the service users. Compared to the 'vibrant' improvisation, the lack of rhythmic cohesion and instead an emphasis on exploratory riffs of the 'delicate' improvisation suggested a more personal touch, as if people were playing the music for themselves rather than as a group. Through synesthetic metaphors, these improvisation sessions provided service users with a means of moving in and out of sociality by their own means.

Accordingly, these sessions, enabled us to enter conversations with each other without relying on speech; for instance, Eric mentioned, 'you use your hands, you know, you use your hands. It's something quite important about using your hands. Like in pottery, that's the real satisfaction. But if you bang on the piano, you know, it's like somehow you communicate with your hands…' This multisensory communication—as in, not only through hearing but hearing-touch—engendered a feeling of presence, a deliberate attentiveness to one's being-in-the-world because it is less cerebral and more bodily. Similar to Desjarlais's fieldwork with the Yolmo peoples and their spirit-calling rituals (1996), these improvisation sessions required less intellectualising and instead more feeling. For instance, Desjarlais wrote about an embodied definition of healing, suggesting that 'healing transformations take place not within some cognitive domain of brain or heartmind, but within the visceral reaches of the eyes, the ears, the skin, and the tongue. Indeed, the *feeling* of rejuvenation (rather than just its ideas or symbolic expression) is essential' (1996: 159, emphasis in the original). This resonated with some of the service users who shared,

> I find healing to me is, feeling and being well. To come together and not just *looking* well. I think looking well is kind of off and putting up a bit of a front when

[9] I distinguish intentionality from intention, defining the former as the intention to act or experience of acting and the latter as a particular plan to be acted upon (Searle 1980). In this case, the service user may not know how or what they will play on their instrument, but only that they have deliberately chosen to play that particular instrument, hence demonstrating intentionality rather than intention.

> people are looking at visual things which are in terms of often superficial things, even if in your face or your eyes, you *look* well. (my own emphasis)

Of note is the importance of stimulating the senses in these healing rituals to *create such feeling*. In the improvisations, actively playing music prompted us to feel our skin on the instrument in producing sound and to feel our bodies resonate, tingle, shiver in receiving such sounds.

Additionally, Desjarlais (1996) suggests that presence in the Yolmo healing ritual was experienced, not only by the person whose spirit was lost, but by everyone, thus generating synchronicity. In other words, the ritual is a communal experience wherein the audience is key to its efficaciousness. In the context of my fieldwork, I noticed a similar phenomenon during the first improvisation of Week 8: Eric, on the piano, and I, on the xylophone, engaged in a call-and-response that organically rose to the melody among the other instruments. As I played a sequence of random notes on the xylophone, I heard a similar melody repeated back on the piano. At first, as I was turned away from the pianist, I did not pay much attention; however, when the piano repeatedly echoed my xylophone notes, I latched on. We continued this call-and-response a few times, reversing the roles such that I copied his sequence of notes. I felt a tingle in my body, perhaps from the heightened anxiety of wanting to correctly mimic his melody in front of the others, but also from anticipating his response on the piano keyboard. After the improvisation ended, leaving us both with broad smiles, we were greeted with buzzing from the rest of the group who exclaimed their excitement of listening to our back-and-forth riffs. Ultimately, even though the rest of the group did not directly participate in it, the redirection of their attention to our call-and-response demonstrated synchronicity. Their senses were stimulated, creating a feeling of 'presence' grounded in their body-selves.

My analysis of the improvisations and Yolmo healing rituals, both of which rely on a collective experience of feeling rather than thinking, prompt me to revisit the Western epistemological prioritisation of vision as a more rational, intellectual, analytical sense compared to hearing. Here, I aim to leverage hearing and touch in that hierarchy by arguing that hearing, especially music, enables *e-motion* and thus reaches a deeper level of understanding into one's social experience through accessing the body.

To begin, 'when it comes to affairs of the soul, of emotion and feelings, or of the "inwardness" of life, hearing passes seeing as understanding goes beyond knowledge, and as faith transcends reason' (Ingold 2000: 246). Music, compared to sounds of speech, adds an additional layer of emotionality; Ingold suggests 'what essentially distinguishes verbal sound is that its significance can be extracted from the sound itself. Musical sound, by contrast, delineates its own meaning: it is meaningful not because of what it represents, but simply because of its *affective presence* in the listener's environment' (2000: 408, my own emphasis). Therefore, hearing music is emotional, 'yielding a kind of knowledge that is intuitive, engaged, synthetic and holistic' (Ingold 2000: 245). For Eric, hearing music even unlocked feelings of which he may not have even been aware, pointing towards its intuition: 'sometimes, I'm surprised how *moving* [the music group is]… you know, you don't think that you're feeling vulnerable or emotional, but then something about music can like, just *touch* that emotional part you know' (my own emphasis). Through his use of synesthetic metaphors associating

music with felt movement[10] and touch, I suggest that emotions or e-*motions* are grounded in bodily experiences, drawing on Fuchs and Koch's concept of embodied affectivity (2014). Particularly, they argue 'bodily feelings should not be conceived as a mere by-product or add-on, distinct from the emotion as such, but as the very medium of affective intentionality […] Emotions can thus be experienced as the directionality of one's potential movement, although this movement need not necessarily be realised in the physical space' (Fuchs and Koch 2014: 3-4). Indeed, music generates a bodily experience, as suggested by an interviewee: '[some sorts of music] … more *metaphorically* sort of go… through my body, maybe my heart also, maybe… my arms? Yes, heart, well heart as well…' (my own emphasis). Hearing and sound thus may better align with embodied definitions of healing than does vision, echoing the criteria for a successful Yolmo spirit-calling and the service users who prioritise feeling well rather than merely *looking* well.

In terms of hearing contributing deeply to one's social experience due to its emotionality, Ingold establishes that 'voice[11] and hearing establish the possibility of genuine intersubjectivity, of a participatory communion of self and other through shared immersion in the stream of sound… hearing defines the self socially *in relation* to others' (2000: 246-247, emphasis in the original). Thus, sounds and music, which we can hear all around us rather than merely *in front of us*, pushes us to regain a more 'harmonious, benevolent, and empathetic awareness of our surroundings. Then, perhaps, we may rediscover what it means to *belong*' (Ingold 2000: 246, emphasis in the original). In the following ethnographic example, I aim to show how hearing promotes sociality, where a moment of synchronicity within the improvisation session fostered the emotional experience of Walter's pain to be collectively felt through music.

During the second improvisation of the same session, we did not try to recreate the call-and-response, instead letting our hands take charge of the instrument. At one point, Walter began banging the bongos with great force, explaining after that it was because of his ingrown toenail. In my interview with Eric, which was scheduled immediately after this music therapy session, he shared, 'yeah, I was kind of a bit anxious in case he was angry, but he seemed alright…' Thus, Eric had turned his attention towards Walter's pain, as a response to the bongo noise. In her essay about inflicting acute pain through acupuncture, Hsu argues that 'the presence caused by acute pain infliction can be understood as an alertness that opens up the patient to a potentially positive input from the social environment, and possibly, it is this directly felt social connectedness that is therapeutic' (2005: 84-85). When a patient is poked with the acupuncture needle, their reaction of shouting and shivering or catching a breath of air is felt through somatic modes of attention by the therapist and anyone else present. Accordingly, 'the acute pain event can be viewed as a trigger for an embodied experience of sociality' as people turn their attention towards the patient (Hsu 2005: 85). In this case,

[10] Hearing inherently includes movement through biophysics (such as air pulses on the ear drum), which is why I use 'felt movement' to suggest *conscious* bodily movement.

[11] I recognise that voice can also be related to words, which I have argued is an intellectual form of communication, suggesting a possible contradiction. In this case, I am interpreting voice as the *sounds created by the vocal cords* which may not necessarily have rational or linguistic meaning. Ingold distinguishes between rationality/speech and emotion/music dualisms in *The perception of the environment: essays on livelihood, dwelling and skill* (2000).

Walter's acute pain was not externally inflicted, instead arising from his ingrown toenail, and his response was to aggressively bang on the bongos instead of shouting. Synchronicity was generated as we collectively noticed the loud sounds he made, and our noticing allowed Walter's pain to be heard literally and metaphorically[12]. This synesthetic metaphor abounds; it is also present in the song discussion component, to be explored next.

The collective listening to and discussion of songs in the music therapy

When the first improvisation organically tapers off—when people feel that they have had enough and someone disengages from their instrument, which is noticed and followed by others—we begin our songs discussion. As an enthusiastic participant to this exercise, Walter shared,

> I find I've got sort of an ingrown toenail, and I've got nerve damage, and I've got sort of problems with my hips with wear and tear, arthritis about, and I find when I get into the conversations [about the song choices], listen to music*, it distracts me from physical pain* that I feel that when I'm sometimes sitting alone. (my own emphasis)

How does hearing music distract one from the physical sensation of pain? In the previous section, while delineating the *affective presence* of music, I shared that music moves one through e-motion, a bodily experience integrating hearing with felt movement. How do these various sensory modalities overlap? In keeping with Young's definition of synesthesia (2005), Ingold shares that

> the senses exist not as distinct registers whose separate impressions are combined only at higher levels of cognitive processing, but as aspects of functioning of the whole body in movement, brought together in the very action of its involvement in an environment. Any one sense, in 'honing in' on a particular topic of attention, brings with it the concordant operations of all the others. (2000: 262)

Thus, if we shift our somatic mode of attention from pain to musical sound that evokes its own feelings, our *whole being* moves rather than senses if they were siloed. As phenomenology posits, there is less of a distinction among the senses than Western pop-psychology perpetuates, and this 'different way of thinking' (Young 2005) is all grounded in bodily motion.

While motion can encompass the heart beating faster, the jaw tightening, the eyes tearing, etc., I will demonstrate that the listener may also experience metaphorical motion of music across time: nostalgia. This may be another mechanism for pain distraction, actually taking a person out of their embodied presence and instead bringing them to their imagined

[12] The phrase 'I hear you' means literally 'I hear the sounds you are making' but may also adopt a deeper meaning of 'I understand where you are coming from'. Thus, similar to the movement therapist's idea of witnessing, I argue that Walter's bongo-banging allowed us to better understand his pain and sympathise with him.

past self. Such techniques of invoking nostalgia were consistently referenced in the music therapy group's choice of songs and subsequent discussion. Over the weeks, service users chose songs from the same genre (20th-century rock, blues, and jazz were quite common), talking about various artists from their youth. One week, Walter continuously mentioned 'how music is a mode of transportation to different eras in one's life' and multiple service users played music they remembered being 'obsessed with' during their childhoods or teen years. As we listened to these songs, I often noticed a pensive expression on the song requester's face, as if they were elsewhere. Could it be that they found themselves back in a bodily experience they once had decades ago?

Finally, as the concept of interaffectivity emphasises, 'emotions are not inner states that we experience only individually or that we have to decode in others, but primarily *shared states* that we experience through interbodily affection' (Fuchs and Koch 2014: 7). Therefore, this technique of sharing music in real time with the group through collective listening distinguishes itself from simply giving each other music recommendations for their own time because it generates synchronicity. During my interview with the music therapist, she shared that

> choice of song is very significant in how someone shares about themselves… I think there is always something interesting and positive about any song choice; there will always be something to say. It helps to validate. And that *vulnerability or 'being quite exposed' is something that people sometimes speak about in group*… (my own emphasis)

Unique to the group is the heightened feeling of being *witnessed* as the group listens to the song choices together. One interviewee explained

> the social connection from being witnessed as fostering friendship and sort of listening to other people's experiences… of music and the ages that they were influenced, 'cause you know the music group has got people of all different ages and all different nationalities and background. And it's really interesting and I think there is a *shared sort of emotion that music can maybe evok*e, and I think in the music therapy that we have here… it seems like a very safe environment to be able to express that.

Finally, in reference to the various ages and nationalities of the music group participants, I argue that this technique of collectively listening to songs promotes sociality regardless of whether the song lyrics are even cognitively understood. To begin, Langer writes 'when words and music come together, music swallows words' (1953:152); Ingold clarifies that 'sounds of speech, to the extent that they are incorporated into a total musical phenomenon, cease to draw the listener's attention to meanings beyond themselves – meanings that, in speech, the sounds had served only to convey or deliver up to the listener *rather than actually to embody*' (2000: 408, my own emphasis). Thus, even when the song choice is unfamiliar and thus does not necessarily evoke nostalgia, it still has the capacity to move the listener.[13] For example,

[13] Here, I suggest that to evoke nostalgia, the song must be familiar; either the song must have been directly heard in one's past or contain references to which one can relate their past experiences. If the person does

Bela, a younger service user whom I met in my second week of fieldwork, chose an Icelandic song, which began with a rumbling noise before transitioning to violin and a choir of layered voices. Although no one in the group could understand the words sung, people felt their own emotions and the *weight* of the song, remembering and alluding to these sensations in that session's debrief and even weeks later. The words no longer carried the same meaning as would have occurred had they been spoken; instead, the service users related this unfamiliar music based on their own backgrounds, sparking conversation to foster social connection. Ultimately, as the music therapist highlights, 'the space is very open and can go many different directions. That's where there is the *aliveness*…'

Halfway through my fieldwork, I learned that after eleven years of servicing the Islington community, the PTP was closing in the upcoming autumn of 2024. In pondering the PTP's legacy such as destigmatising and demedicalising psychosis as a pastime,[14] I present a final case study of how a service user, Thor, becomes more enskilled to manage his psychosis in a manner meaningful to him.

Ingold starts his argument by defining enskilment as "'understanding in practice" […] in which learning is inseparable from doing, and in which both are embedded in the context of a practical engagement in the world' (2000: 386). In delineating its process, he explains that it involves, 'the fine-tuning of perception and action' wherein 'to observe is to actively attend to the movements of others; to imitate is to align that attention to the movement of one's own practical orientation towards the environment' (Ingold 2000: 37). Therefore, we learn by doing; we learn through embodiment. Ingold's examples, however, revolve around hunter-gatherer societies and the use of tools in craftmanship, for instance with the Koyukon having

> perceptual systems [that are] attuned to picking up information, critical to the practical conduct of his hunting, to which the unskilled observer simply fails to attend. *That information is not in the mind but in the world, and its significance lies in the relational context* of the hunter's engagement with the constituents of that world. (2000: 55, my own emphasis)

Thus, we become enskilled not due to a drastic change in ourselves or our environment, but by refining our somatic modes of attention, modulating our relationship to our current environment. In reimagining enskilment for my fieldwork, Thor is a regular member of the movement therapy group who has a strong interest in breakdancing, which he first learned in boarding school. Many of his movements in the sessions are deliberately robotic, hitting the music's occasional sharper beats.[15] For Thor, the PTP is a 'place to come to' on Tuesdays to

not understand the words because the song is in a different language, for example, I argue that it does not feel familiar and thus does not evoke nostalgia (although other feelings may arise).

[14] When speaking with staff about the potential impact of the closure, he mentioned that 'it's easy for us to say is "it will be a loss for [the service users]" but the *experience is different for everyone*. It might just be "finding a different thing to do at that time each week"; sometimes it's more of a practical versus emotional matter…' Thus, for some, the PTP occupies diverse roles in service users' lives, ranging from being psychologically therapeutic, to a quotidian distraction, to an opportunity to learn new skills.

[15] As aforementioned, the movement therapist often opts for slower and flowing music, but at times the playlist included a song with sharper beats. In sessions where he is the only attendee, Thor has also requested his own music choice be played. Similarly, he hopes to have more input on music choices in upcoming sessions so that the service users can get to dance to each other's music choices.

Thursdays and specifically the movement therapy session is 'something to look forward to on Wednesdays'; in elaborating, he mentions that it is a 'good space to explore movement'.

When I meet him in the common area before the movement group, he is usually sitting there among the others silently, wearing headphones. In our interview, he shares that he is 'not super close to the other users' as 'he is just often there for the group'. Nevertheless, he prefers to have larger groups because there is more 'scope for copying other moves'. He shares that he enjoys copying peoples' movements because 'everyone has different ways' of moving; for example, a new person joining the movement group often does 'moves he has never seen before' and that 'it feels good because there are new and extra movements'. Although he mentioned he can feel a bit apprehensive with new participants, the movement group's atmosphere is relaxed compared to other therapy groups where the presence of new participants can feel 'intense' or 'intimidating'.

During these sessions, Thor is not directly taught how to move as there are no instructions on how to move one's limbs. However, he learns new ways to engage his body through 'routinely carrying out specific tasks involving characteristic postures and gestures…' (Ingold 2000: 162). These routine tasks are the loose set of instructions to explore our own and each others' movements provided with the movement group's safety and open-mindedness. As such, when he tries one of my movements or I one of his, the postures we copy allow us to feel the sensations that the other feels but in our own body.

As sessions have progressed, the movement therapist has noticed how Thor engages and what he obtains from the sessions. These potential benefits extend beyond the acquisition of new dance movements; for example, the movement therapist shares that during the drop-in,

> [Thor]'s usually quiet and verbal communication may not be the most comfortable way for him… since coming to the group he's showing himself a bit more and appears to *trust this space a bit more* and has found something new that is quite exciting to him based on his feedback. And he has been taking a *more proactive role to show himself and feeling more accepted,* based off what I seen. *His movements have also become more dynamic*. (my own emphasis)

Therefore, Thor becomes more skilled at the movements themselves and at directing somatic modes of attention towards the intersubjective milieus he shares with others in the session. Moreover, the resulting new-found confidence of relating to others in his desired mode of communication becomes embodied as more dynamic movements rather than the initial rigidity. Thus, by treating psychosis as a pastime, rather than an all-consuming illness at which medication is merely thrown, Thor learns new skills that are meaningful to him and experiences the resulting sociality and *joies de vivre*.

Ultimately, these forms of enskilment become the 'psychocultural strategies for struggle and control not through overcoming the illness or "fixing" the illness but, rather, through accommodating the illness. An accommodation or learning orientation to recovery stands in contrast to a problem-oriented approach that situates the illness as an enemy in relation to the self' (Jenkins and Carpenter-Song 2006: 392, my own emphasis). Therefore, enskilling service users to manage their psychosis as a pastime demedicalises and destigmatises the illness

by enabling them to exist alongside the illness rather than being wholly defined by it. It recenters their personhood in their experience of psychosis by providing new hobbies and creative outlets. In keeping with this desire-based framework, the PTP creates a therapeutic environment that is 'warm, protective and enlivening without being smothering, over-stimulating or intrusive… [its service users are] allowed to maintain a valued social role, together with their status, dignity and a sense of belonging to the community at large' (Warner 2003: 242). It accomplishes this culture of care through the body techniques discussed within the movement and music therapy groups such as heat, synchronicities, synesthesia, and the transportive role of music. Although the PTP may soon no longer exist, its legacy of fostering such a community shall live on, serving as a standard for future psychosis interventions.

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