Part V

Loss<>Recollecting

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Travelling Memories: Repairing the past and imagining the future in medium-secure forensic psychiatric care

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Chapter abstract

Remembering can act as a work of connecting past and present, providing a connective tissue for making lives meaningful. In cases where the remembered past is traumatic or 'difficult' in some way, remembering constitutes an act of repair that is grounded in the very specific ecological settings and practices in which the person is located. In this piece, we discuss the case of mental health service users detained within a secure forensic inpatient mental health facility where remembering intersects with a broader notion of mental health 'recovery'. We describe the ways in which memory comes to matter for patients and the dilemmas this creates. We focus in particular on the informal practices adopted by ward staff as they support patient's memory work. We argue that a 'process-ecological' approach to remembering can inform practical decisions are around care planning and the ward design of the setting.

Chapter keywords

lived experience; forensic mental health; social remembering; process-ecological psychology; vital memory

Introduction

Memory is the connective tissue that makes lives meaningful. A connection to the past enables sense making in the present and renders possible futures as thinkable. In the case of traumatic or difficult pasts, this connection becomes intensely important. At personal, collective and national levels, past harms and injustices need to be made visible and subject to commemorative exploration in order for victims to 'go on' in the present. In this context, repair is usually considered to be a memorial work of putting the past in order to meet ongoing moral and epistemic demands (Margalit, 2002; Blustein, 2008, Campbell, 2014). Through this work it becomes possible to envisage a reconstruction or 'healing' of personal and social ecologies of thought and feeling.

This understanding of memorial work as repair is complicated by issues around mental health. For example, whilst some approaches to trauma (e.g. Johnstone & Boyle, 2018) emphasise the need to understand personal histories – 'what happened to you' – as a way of addressing current feelings and experiences – 'what's wrong with you' – there is also a counter-discourse around the inherently unrepresentable nature of traumatic pasts (Caruth, 1996). Pain and suffering incurred through extraordinary and horrific violations of social and personal relations may be simply incomprehensible and hence difficult to both recollect and to narrate. Mental health issues may also call into question the reliability of memory. Victims – and in some

cases perpetrators – may have their recollected experiences problematised or discounted (see Haaken & Reavey, 2010). They may also be accused of focusing unduly and unhelpfully upon the past rather than facing up to problems in the present. Here, repair can take the form of an injunction to disconnect from a difficult past in order to 'move on' with living.

In this paper, we want to explore the tensions in memorial repair work around mental health. We will be concerned with the question of when and how the past comes to matter for persons managing severe and enduring mental health issues. Crucially, we look at the practices which are enacted to manage these tensions, and how they are collectively performed within an institutional setting. Our argument is informed by work we have conducted in a medium-secure forensic pathway in a large inpatient psychiatric unit. The mental health service users who participated in this study arrived at the unit in question through the criminal justice system, and some had been convicted of serious offences[1]. However, all of the participants had challenging life experiences, and many had also been victims of offences. As we will go on to discuss, memorial repair work is a complex matter for both service users and for the institution in which they are currently detained.

In conceptualising how remembering is at stake within secure psychiatric care, we draw upon Astrid Erll's notion of 'travelling memory'. Erll uses the term to emphasise the fluid and mobile nature of memory as 'the incessant wandering of carriers, media, contents, forms and practices of memory, their continual 'travels' and

ongoing transformations through time and space, across social, linguistic and political borders' (2011: 11). The contrast here is with an approach that treats memory as stable units of meaning that are 'contained' within an individual, group or place (see Middleton & Brown, 2005). The relevance for us is that the service users in our study were typically detained for significant periods of time at a considerable distance from their usual place of residence in a specialist mental health care service. Memories of these geographically and temporally remote places and persons had 'travelled' with each service user. But at the same time, these travelling memories remained connected to these other spaces and times. As service users pass through the criminal justice and mental health care systems, these connections experienced through remembering became transformed.

We define our approach to memory as 'ecological' in the sense that we treat remembering as a practice that is shaped and enacted within the settings in which it takes place. There is, in fact, a long tradition of ecological thinking within Psychology, which dates from William James, but includes E.B. Holt, J.J. Gibson and Ulrich Neisser (see Heft, 2001). The potential of this work has often gone unrecognised when it has been read through the lens of the dominant Cartesian ontology of much twentieth century Psychology. The re-emergence of distributed cognitive, open systems and process thinking provides an opportunity to re-author psychological approaches to remembering, and much else besides in the discipline (see Brown & Reavey, 2015; 2020a). Remembering and imagining are central to how

we engage with organized settings in which we dwell, because they involve the mobilisation of versions of the past in order to realise the potential futures that inhere in our fleeting and ongoing relationships. In this sense, the past is not an inert record of 'what happened' but is a living, active, dynamic presence at every moment, which is never settled or entirely put in its place.

We begin our argument by describing an approach to difficult pasts we have referred to elsewhere as 'vital memory' (Brown & Reavey 2015). This approach seeks to expand the usual remit of memory beyond the individual, and indeed beyond the usual boundaries of what we take to constitute the person, whilst at the same time recognising the unique trajectory that makes for personal remembering. We then offer some contextual details around forensic psychiatric care and discuss some of the clinical and social care practices which complicate memorial work in settings where this care is provided. On this basis, we then go on to describe some of the informal memorial repair work techniques that service users and staff have developed and the ways in which they impact upon capacities to imagine potential futures beyond present detention. We conclude by situating this very particular set of practices within the broader 'experience ecologies' of the contemporary mental healthcare system in the UK.

An expanded view of memory

Memory is often considered to be a personal property, something that is primarily 'held' by the person and which is organized subjectively as a function of their own thoughts and feelings. One of the principal concerns within the emerging interdisciplinary area of Memory Studies has been to counterbalance this with a notion of 'collective memory', originally derived from the work of Maurice Halbwachs. This is usually understood to refer to social and cultural processes occurring at group or community levels wherein versions of the past are commemorated and contested. From this perspective, whilst our own memories feel as though they belong uniquely to us, they emerge from the ecology of thought and feeling constituted by the memorial communities to which we belong. The 'collective frameworks' which Halbwachs (1980; 1992) theorised as at work here were posited as complex processes of translation and distribution of perspectives on the past – or 'vibration' between actors and the spaces they inhabit – which enabled memorial communities to make sense of their shared history. The term 'collective memory' is simply shorthand for this ongoing cognitive, social and material work.

Whilst this approach arguably affords more elaborate and nuanced understanding of the work of memorial repair, it raises some difficult questions around personal participation. Does subjective repair involve a subsumption of personal memories to a collective framework? What is the nature of the agency that now intuits and 'holds' the tensions around trauma and reparation? We can begin to address this by working through two initial propositions. First, remembering depends

upon others. The ways in which we speak of the past are shaped by the interlocutors with whom we tell our stories or provide accounts. Not only are there common frameworks and norms which structure how and when we are able to recount past events, but we rely upon other to assist in elaborating, completing and revising our accounts. Remembering personal experience is a thoroughly collaborative process (see Mead et al. 2018 for varied approaches to this). The interactional dynamics around *who* we address our recollections to, *what* is said and *how* it is received all shape the process of remembering. Moreover, even when those recollections occur privately, others are present both as actors within what is remembered and as anticipated interlocutors to whom we either desire or fear to share our accounts with. In this sense, whilst past experiences are 'ours', in that we are uniquely positioned with respect to them (i.e. these are events *I witnessed*, these things happened *to me*), they are not our property in any clear sense, in that others are integral to how recollections are shaped and expressed.

Second, remembering is a situated, contextual activity. It occurs somewhere, in a definite time and place – *where* and *when* remembering happens shapes what can be told of the past. For example, recalling a past traumatic experience is very different in the context of therapy than it is in a court of law or a social-welfare interview. This does not solely concern the words that can be used, but rather more substantively the ways in which it is possible to make sense of what is being remembered and the meanings which will be accorded to it within the setting where recollection occurs.

Settings – such as therapy rooms, legal chambers, administrative offices – provide normative constraints which serve to 'frame' how remembering can proceed within them. What counts as a 'good' or 'reliable' or 'acceptable' memory is thereby locally determined by the practices and properties of the setting. If we take it as a given that the fidelity or the truth of our recollections are always important to us, then the importance of these framings in shaping memory within the setting suggest that, in a strict sense, it is the setting-level interactional processes rather than the person who 'does' the remembering. Elsewhere we have referred to this as the 'setting-specificity' of memory (Brown & Reavey, 2020a).

The approach to remembering that begins to emerge from these considerations can be called an 'expanded view of memory'. In this view, memory is not strictly located within whatever is taken to be the boundaries of the person (e.g. the mind, the brain, the body), but rather extends out or 'travels' into the world in a diffuse way that moves across interactions and settings. Rather than treat memory as a property that is held by a given person or collective, we must look instead at the multitude of potential functions that remembering enacts in specific times and places, and how these are subsequently involved in reorganising the ways each of us turns around on our past experiences, including the work of reparation. These functions cannot necessarily be established in advance. Whilst some may reflect the action programmes of the settings in which they occur (e.g. the purpose of a trial is encode accounts of the past within legal claims), other emerge within interactions (e.g. managing one's status as a victim

of a past offence). This can produce tensions within accounts, or enact contradictory effects simultaneously (e.g. an apparent disparity between the details and meaning of testimony given across different contexts). If memorial reparation is an activity that is distributed across multiple settings, then on this account it is unlikely to be enacted without conflicts, dilemmas and lacunas that arise from the incommensurability of setting-specificities.

We have previously drawn upon the work of Kurt Lewin (1936; 1997) to conceptualise this expanded approach to memory (Brown & Reavey, 2015). Lewin describes ongoing life experience as 'the totality of facts which determine the behaviour of the individual at a certain moment' (1936: 12). A 'fact' is to be understood here as an affective-behavioural potential that emerges in relation to others and the world. These relationships are structured topologically, rather than being clearly positioned in a Euclidean mapping of space or a strictly chronological ordering of time. Persons or places that are geographically remote from us can become relationally close at a particular moment, in the same way that the past can return to the present. Lewin defined psychological reality in terms of 'what has effects' (1936: 19), or that which provides the possibility of affording action in the present moment. Our psychological 'life space', as Lewin termed it, is a topologically organized field of relations that is continuously expanding and contracting as our actions realise possibilities for acting. Life space extends our experience beyond the confines of our immediate setting or the present moment. For instance, whilst service

users may be detained within the relatively confined space of a locked ward for a prolonged period of time, their life space may expand beyond the boundaries of the ward through material practices of communication, imagination and remembering.

Lewin's notion of life space draws analytic attention to the relational structuring of experience. Our lives flow and travel through an ongoing weaving of relationships. For example, I hear a piece of music and the sounds open a point of contact to the places where I previously listened to it, the events which it has soundtracked, the people with whom I am emotionally connected through the music. My life expands beyond the here and now, this place where I am sat. I pick up a photograph of my mother and my father. I cannot bear, right now, to think of his voice and his behaviour in those last few months of his life. I put the photograph away. My life contracts and withdraws itself into the rhythm of my fingers as I type, the screen and the desk in front of me. Life space has a diastolic and systolic character. It pulses with the expansion and contraction of experience as relationships become affectively intimate and distant. Henri Bergson's (1991) notion of 'attention to life' as the mobile horizon of our ongoing concerns and experience describes this well. The boundaries of our experience, at any given moment, are not defined by the spatial limits on our movement, or the formal organization of the setting we are presently engaged, by rather by the shifting topological foldings of life space.

There is a risk here that life space might be conceptualised as sufficient unto itself rather than being culturally and historically grounded. Lewin (1997) introduced

the somewhat confusing term 'psychological ecology' to refer to the 'boundary conditions' of life space. We prefer the term 'experience ecology' as shorthand for the distribution of ways of thinking and feeling which become available within a given setting and which are undergoing a constant process of transformation (Brown & Reavey, 2020a; 2020b). This is derived in part from previous work where we explored the ways in which secure psychiatric care promotes particular ways of understanding sexuality and sexual conduct (Brown et al., 2014). Service users are typically inculcated in a discourse that sexuality is a risk and a threat to their current well-being. This leaves service users feeling that sexuality is something that must be 'left behind' or 'amputated' until they are well enough to engage with it again. We argued that this experience of sexuality that had been 'learned' within the ecology of secure care travelled with service users as they transitioned back to the community, where it had demonstrably negative effects on their ability to engage in the kinds of relationships and forms of intimacy which many craved (and which would aid their mental health recovery). Our approach to memorial reparation then necessarily involves an understanding of what is afforded by differing experience ecologies and what happens to the ways persons relate to themselves as they move between them.

Forensic Psychiatric Care

The mental health care system in the UK has been progressively 'de-institutionalised' over the past century. Up until the 1950s, the system had been dominated by the

network of large hospital institutions known as 'county asylums' where persons diagnosed with severe mental health conditions might be forcibly detained under the terms of a section of the Mental Health Act (i.e. 'sectioned') for either a determinate or indeterminate amount of time (see Parr & Philo, 1996 for one local history). In the post-war era, social reform was coupled with economic reform to reduce the numbers and size of county asylums, with care being provided in community settings by teams of clinical and welfare professionals. However, unlike other European countries such as Italy which attempted to permanently move away from secure hospital care for mental health entirely, the UK retained a significant number of inpatient bed services (roughly 8 beds per each 100,000 of population).

This is particularly noteworthy for forensic pathways through inpatient care. Persons detained within a forensic pathway are typically transferred from the prison estate to secure care (i.e. they are detained on a locked hospital ward under sections 37 or 41 of the Mental Health Act). Forensic psychiatric care is provided with three large 'high secure' units, around 80 'medium secure' units, and through an extensive network of mostly community based 'low secure' housing facilities. Section 37/41 detention does not have a specified time limit but is subject to review by clinical staff and yearly tribunals. The process of ultimately being discharged from inpatient care typically involves a gradual 'stepping down' through levels of secure care which can take several years and may involve the use of a 'Community Treatment Order' specifying provisions for living within the community, with involuntary return to

secure care mandated if they are breached. A primary concern within psychiatric care is managing the risks which a patient poses to 'themselves', 'others' and the 'environment' (Drennan & Alred, 2012). The dominant language currently used in this context is 'recovery', which is conceptualised as the process whereby a person gains awareness of their mental health conditions, establishes some form of control over their own thoughts and behaviour, and demonstrates adherence with their treatment regimen (usually taking psychiatric medication on a regular and permanent basis).

The site where our study was conducted was a large specialist provider of inpatient psychiatric services in England. This charity provider supplies mental health services on referral across the UK, meaning that a great many patients at the time the study was conducted (2018/19) had been referred at some distance from the hospital site. When we began collaborating with the institution, clinical staff there identified facilitating contact of patients with relatives and prior communities as a significant issue. They were aware that a noticeable number of patients were electing to remain in the local area following their discharge from the service and had hypothesised that this might be related to problems of maintaining contact with 'home' during their time in detention. Our study was designed to explore how practices of remembering might maintain attachment to 'home' for patients on the forensic pathway in the main hospital site.

The hospital site itself is a large green site with multiple units and wards offering a wide range of inpatient mental health services. Service users admitted to the forensic pathways are placed on gender and age specific wards, mostly within new-build specialist facilities. As with all secure psychiatric care in the UK, wards on these units have limited space, with patients having small single-occupancy bedrooms, along with communal areas and some enclosed outdoor space. Some service users may have other conditions attached to the detention, which mean that they are effectively confined to the unit and may not be able to access the wider hospital grounds. Visits from relatives and friends are permitted, depending on current capacity of the patient, and are sometimes conducted through telephone and video calls. All visits are heavily supervised and physical contact is typically not permitted. Patients have limited access to other means of maintaining contact (e.g. internet, social media etc) outside of these times.

The number of possessions which service users bring with them on admission is highly limited and may constitute only a small number of clothes and personal possessions such as books or photographs. Sections are often initiated following police arrest or intervention by a local mental health crisis team. On these occasions there is limited scope for gathering the service user's possessions. Depending upon the nature of the offence (referred to as 'index offence'), it may not be possible for service users to acquire some of their possessions once they are detained, for instance, in cases where the index offence involves family members who may subsequently

break contact. Detention may not only fracture the service user's relationship with 'home', it can also make it difficult to retain possession of the items which might make it possible to preserve a memorial link.

From previous work, we were aware that service users in medium-secure forensic care have often moved multiple times through different institutions, and in some cases have a long history of being placed in institutional care prior to incurring their index offence. Their memories have travelled some considerable distance with them throughout their journey, although service users themselves leave very little by way of traces of themselves and their time spent in the institution when they leave. In general, service users do not tend to build longstanding friendships during their time in detention. In part, this is because there is a reticence to discuss index offences with other service users, or to disclose personal information which might come to be used by others as a kind of social currency on the ward. Friendships are also typically not encouraged by ward staff, out of concerns that either controlling or intimate relationships might subsequently develop. It is not uncommon that patients to be moved in order to break up such developing relationships.

The most common non-pharmacological therapeutic intervention in forensic care is the use of variants of Cognitive-Behavioural Therapy (CBT), in particular Dialectical Behaviour Therapy (DBT). This latter was developed for working with patients who are given the controversial and contested diagnosis of Borderline Personality Disorder (BPD), and its use is widespread within UK inpatient psychiatric

care (Ivanoff & Marotta, 2018). Like all forms of CBT, DBT focuses on supporting the patient to manage their own current thoughts and emotions and to break free of existing behavioural patterns and the past environments which are supposed to have reinforced them. Dwelling on past events is antithetical to the approach. Moreover, DBT has a strong element of mindfulness, encouraging a focus on current experiences. The net effect of this is continuously shift focus away from the past towards the here and now or 'present-ism'. As we have described elsewhere, this reinforces a concern with 'being well' in the present that can make forensic psychiatric care operate as a 'system of forgetting' (Brown & Reavey, 2016). In summary, whilst it might be assumed that sustaining a relationship to the past (i.e. 'what happened to you') might be a highly valued aspect of in-patient psychiatric care, structurally and practically service users are strongly directed towards the present moment.

Memorial Practices

There is not an abundance of activities to keep patients occupied during their time on a locked ward. Whilst there may be some group sessions for service users to attend, aimed at either managing behaviour or dealing with strategies for improving recovery, hours are usually marked by mealtimes or by watching television. Detention under section 37/41 is indeterminate. Discharge dates are not fixed but are decided by clinicians with reference to indicators that gauge whether the service user is able to

take charge of their own recovery in a community setting. The lack of fixed markers can mean that service users focus on what are actually arbitrary signs without any real clinical meaning – such as feeling that they are being treated as an object of reduced concern by ward staff. As is common in most secure psychiatric settings, patients are left for the most part to occupy themselves, with comparatively little intervention by staff, who tend to be engaged in either collecting routine wellbeing information about service users, or alternatively managing crisis events. Having long stretches of time to fill can leave patients with plentiful opportunities for chance distractions. Patients can find themselves 'triggered' to think about past events or persons through chance associations arising from music they hear or television programmes that have been selected by others on a communal screen. This gives rise to pleasant and threatening and/or disturbing memories in apparently equal measures.

A key issue here is that patients lack the ability to control or programme the sonic environment of the ward. Whilst many are able to play their own music in their own bedrooms, patients are encouraged to spend time in communal areas (since this enables both better monitoring by staff and is driven by the belief that is patients spend time on their own, they will ruminate on their own mental health issues). But since the 'soundtrack' to the ward is a matter of, at best, collective negotiation, or, at worst, the wishes of the most persuasive patient, communal areas become filled with a wide range of unpredictable sonic cues for memory. Elsewhere, we have argued the relative lack of sonic agency has effects on recovery and undermines efforts to create

therapeutic atmospheres on closed wards (Brown et al., 2020). But it also serves to mediate memorial agency. Sonic cues can expand life space, making otherwise distal relationship suddenly proximal, but do so in ways that do not allow patients the opportunity to engage in their own 'memory management'. For example, a music video that appears unexpectedly on the television can transport a patient back to the times when they first listened to it and make the people they were then close to suddenly reappear in their thoughts and feelings.

Modern mental health institutions have their roots in the former 'county asylum' system, where institutionalization took the form of a 'retreat' from the timings of everyday life in which daily markers of work or domestic labour were removed. Time can be experienced differently on a locked ward, particularly when embodied rhythms of sleep and wakefulness are further disturbed through psychiatric medication. The division of the day into meaningful units can be difficult to sustain. However, this does not mean that life is lived entirely without reference to calendrical and other temporal markers. Holidays and other seasonal events, such as Christmas and Easter are celebrated on the ward. Other events may permeate the boundaries of the unit. For instance, the sounds of fireworks set off in celebration of 'Bonfire Night' on Nov 5th can act as memorial cues. The recurrence of specific dates and the memorial associations they hold, creates a punctuated backdrop for everyday remembering, irrespective of whether or not the dates are specifically recognised by ward staff and the patient community.

Each patient has their own series of specific dates each year that represent challenges for memory management. These can include birthdays of family members, dates marking transition in and through the healthcare and prison system, and dates which are associated with an index offence. Staff are typically aware of these personal memorial cues and arrive at informally negotiated arrangements to help patients manage their remembering around these dates. These include practices such as temporarily taking custody of photographs, letters or cards such that patients will not feel drawn to ruminate on these objects at this time. Through providing managed access to tools through which remembering is accomplished, staff become custodians of memory. But the work they do here is informal – the institution does not see it as their role to share ethical responsibility over patient's memorial work. There is to some extent a tension here with the project of supporting recovery, which by definition includes repairing relations with the past in order to establish hope for a future life. Whilst the institution promotes itself as 'recovery led' (in common with the dominant ethos in UK mental health care), the crucial temporal dimension of recovery as a form of repair between past, present and future is absent from formal care planning.

The design of the built environment in secure mental health units is often meticulous. A dominant concern is with managing patient safety through embedding technical security measures into the physical structure of the unit. For example, the furniture and fitting of patient bedrooms are designed primarily to remove ligature

points from which patients might potentially self-harm. The hinges and mechanisms of doors function to prevent deliberate trapping of fingers in the closing mechanism or barricading of rooms. Every inch of ward space embeds a programme of risk management. As a consequence, it can be difficult for patients to personalise the space they occupy during their time in detention. It is as though the unit were designed to remove all traces of their presence as soon as they have departed (by contrast, it is not uncommon in much older units to see names and messages etched into external walls and other features of the environment – see Reavey et al., 2021). Patients do, nevertheless, find ways of marking out the space. One common practice is to fix photographs or cards to bedroom walls. This can be something of an achievement on some wards, where common fixing agents such as reusable adhesive putty ('blu-tack') are proscribed. Decorating walls in this way creates something of a 'world within a world'; it folds relations together to expand life space beyond the immediate boundaries of the unit. But it also makes these relations into live matters of concern for the patient, who may be continuously reminded of matters that need to be settled, issues that need to be addressed. Making the past both visible and intimately present – for instance, literally the first thing that is seen when waking – has its own particular risks for patients.

An alternative strategy is to have the means to access the past accessible but not necessarily available at any given moment. For example, some patients have a set of photographs or letters stored within a drawer in their bedroom or elsewhere on the

ward. They may view these at particular moments when they 'need' or 'feel able' to do so. This is a strategy that arises in part through the experience of travelling through the mental health and criminal justice system. A service user must be able to pack and take with them all the personal possessions they need at relatively short notice. The practice may then be retained as a way of being able to unpack and repack a 'world within a world' depending on whether one seeks to expand or contract life space. In other studies, we have observed that female patients, for example, may show the contents of their handbags as a way of offering a narrative of their recent history. Memories travel not only in the sense of moving with persons as they engage in remembering across different times and places, but also literally in these material practices of temporarily unpacking the past for oneself and for others.

The 'unpacking' practice has its own particular risks. When the past is accessed through a specific set of images or artefacts (e.g. a letter, a signed card, a piece of clothing) it can become 'frozen in time' and unable to take on other forms. Some service users, for instance, have been distant from family and friends for some considerable period of time. During the course of this, they rehearse an account of 'home' that reflects a very specific moment, which is now long passed. Children, for example, may be remembered not as they are now, but as they were during the times when the service user was most involved in their lives. This can lead to an account of the past that appears to be idealised, along with the expression of a desire to return to a place that no longer really exists in the ways in which it has been remembered. We

have termed this relationship to memory one of 'spectral agency', where a highly crystallized, frozen image of the past is invoked as a central facet of what one is seeking in the future (Reavey et al., 2019). This leads to what can appear to be highly unrealistic imaginings of life outside of secure care, since they involve an impossible return to a no longer existing state of affairs. By contrast, in other work, we have pointed to the importance for those who are living with a 'difficult past', to develop a view of their personal history and critical events as 'unfinished' or 'unsettled', and thus available for re-narration, and more important to be 'felt differently' at subsequent points in the future (Brown & Reavey, 2015).

Part of the difficulty here is the dominance of the idea around both personal and cultural memory that a coherent, well-structured narrative is necessary to come to terms with the past. On this basis, things such as gaps in memory, contradictory versions of events and ambiguity are seen as problematic and as obstacles to wellbeing. But in work we have done on memories of child sexual abuse and with adoptive parents, we have come to see what the value can be of maintaining a certain degree of ambivalence as a critical resource. The capacity to willingly hold onto differing potential readings of the same event can be a means to engage with tensions and contradictions that might otherwise be overwhelming. Coherency is not and should not be the absolute goal of remembering on all occasions (see Brown & Reavey, 2020b). As we see it, the problem on the unit is that the unpacking practice is not a focus for care planning. It could very well be taken as a starting point for a

shared process of narrating and engaging with the past collectively (along the lines of the forms of reminiscence therapy common in dementia care). Or alternatively, it might be seen as a way into a collective 'memory work' practice, where persons might be encouraged to re-work and re-author their relationship to the past. Again, the broader issue here is that memorial work is not seen as integral to the way the institution supports recovery.

One outcome of the lack of attention to remembering is in the expressed future plans of patients around where they will live following discharge from secure care. Very few patients we spoke with had plans to return 'home'. Some patients imagined that the best option would be a 'fresh start' somewhere else, where they could seek new friendships and employment where they would be free of the past and those influences that had shaped their behaviours prior to secure care. This would both allow them to 'stay out of trouble' and not render them as a burden to their family. This imagined future seems to be of a piece with the personal change that is promoted by DBT, where it is necessary to break with past patterns of thinking, feeling and acting in order to be mindfully aware of one's present circumstances. But an equal number of patients imagined a future where they might be living independently close to 'home', but at a sufficient distance. This is a more demanding version of the future, which requires the person to maintain potentially contradictory versions of themselves as 'they were then', 'they are now' and 'they might become'. Such a version of self might potentially be challenged or rejected by others. In this instance, repair would

involve a great deal of living with ambivalence and being able to interactionally manage the ambivalence of others, rather than closing down and moving on from the past.

What these memorial practices demonstrate is the difficulty service users face in mobilising their travelling memories within the complex ecology of secure psychiatric care. We might say that the programme around which care is organised in this setting is 'recovery without reparation'. In other words, stabilising the mental health of service users without opening up the question of how they are able to put the past in order and address the complex web of injustices in which they may be both victims and perpetrators. But for service users, it appears to be almost universally impossible to focus on their recovery without addressing these past relationships. The informal practices which have arisen within secure care then represent a delicate negotiation between staff and service users that goes on in the interstices of the setting. They keep memory and the possibility of reparation in play, but in ways which may ultimately not be sustainable as patients move towards discharge.

Memorial Work as Ecological Repair

Memory is the connective tissue that makes lives meaningful. This truism is easily stated, but horrendously difficult to operationalise adequately. Our lives are not really 'ours', in the sense that the borderlines between the person and the collective, the past and the future, living and the ecologies that sustain it, are perpetually shifting and

blurring. For each of us, our lived experience is most certainly a unique trajectory, but one that consists, that is constituted out of relations that are both distal and proximal. A '100% relational' view of the psychological, to borrow a phrase from Eduardo Viveiros de Castro (2016) requires the invention of an array of concepts that do not really fit together well in analytic terms, and that perhaps expresses something of the ambivalence that is found in the object of enquiry. In our work, this is further complicated by the desire to have this make sense in very specific empirical settings, such as secure psychiatric units. We want a 'process-ecological' approach to remembering and personhood to be able to inform the practical care and design decisions made in these institutions (see Reavey & Harding, 2017). This would blend an understanding of the psychological as distributed and organized across ecological settings with a treatment of questions such as agency, subjectivity, health and relationships informed by process philosophy (see Brown & Reavey, 2021).

For example, secure psychiatric care environments place considerable emphasis on boundaries, including: physical boundaries between the hospital and the community; symbolic boundaries between staff and patient and within patient groups; affective boundaries between mental health and other aspects of personhood; temporal boundaries between a difficult past and present thoughts and behaviours. From a process-ecological perspective, we can observe that experience cannot be contained within these boundaries – it expands and contracts through memorial work of engaging with photographs, listening to music, handling objects. Agency and

recovery are not 'things' located within the person, but are, at any moment, the undulation of this movement between and across boundaries. It is possible to conceive of care practices and designs of the built environment that act to support rather than restrict this movement (see Reavey et al., 2021 for practical examples). In ecological terms, we can make judgments about the practices that enable reparative forms of living both within secure care and subsequently within the community.

Such ecologically grounded forms of repair may take many forms. In some instances, it may refer to the capacity to contract or narrow life space, such that the relationships which are in play become concentrated and focused on the present. When the past is literally unbearable, secure care can revert back to its roots in the notion of asylum, a refuge from everyday life. But repair must also involve the centrifugal movement of expanding life space, of going beyond the boundaries of the here and now. Memorial work can play a central role here in terms of mobilising the past in order to invoke potential futures. But much turns on whether the past is treated as a living, dynamic presence rather than a frozen moment in time. As Michel Serres (2018) observes, the past is most valuable to us when its contingency can be reorganized in multiple different series – 'you will only discover it in its truth at the moment it will no longer do you any good'. Again, this is more easily stated than lived. Reparation, ultimately, is a not a putting of the past in order, but rather the capacity to 'bear' the past, to live and work with ambivalence. The memorial practices that 'work' in the ecology of secure care may not do so in the wider

ecologies through which service users move. We all need multiple versions of ourselves and our pasts to get by. The experience ecology of secure care tends to encourage a thinning out of persons such that they can reduced to their bare capacity to function – no longer a risk to self, others, environment. It could instead become a site for supporting the multiplying and expanding of personhood and, as a consequence, of the imagined futures that lie therein.

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[1] We use the term 'mental health service user' because it is the preferred non-medicalised descriptions of persons receiving mental health care. At points we use the term 'patient' when drawing attention to an aspect of inpatient or

ward-based practice. Whilst we are referring to same persons throughout, the distinction remains important.