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Coping with COVID-19: The sociomaterial dimensions of living with pre-existing mental illness during the early stages of the coronavirus crisis

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ABSTRACT

In this article, we use the case study method to detail the experiences of five participants who reported living with pre-existing mental illness during COVID-19. We adopted a sociomaterial analytical approach, seeking to identify how human and nonhuman agents came together to generate states of wellbeing or distress during this challenging period. As the case studies show, feelings of anxiety, fear and risk were generated from the following sociomaterial conditions: loss of face-to-face contact with friends and family members; concerns about hygiene and infecting others; financial stress; loss of regular paid employment or volunteering work; public spaces; and the behaviour of unknown others in public spaces. The agents and practices that emerged as most important for opening capacities for coping and maintaining wellness during lockdown included: the space of the home; contact with a small number of intimate others; online therapeutic care; practising self-care skills learnt from previous difficult times; helping and supporting others; engaging in leisure activities; and the companionship of pets. Contributing to an affirmative approach to more-than-human assemblages of health, distress and recovery, these findings demonstrate what bodies can do in times of crisis and the agents and practices that can generate capacities for coping.

1. Introduction

Since its emergence on the final day of 2019, COVID-19 has spread rapidly across the globe. More than a health crisis, restrictions on movements, orders to stay home and lockdowns implemented to control the novel coronavirus have severely affected social life and the economies of most countries. Several countries, including China, Brazil, Spain, Italy, Germany, India, Iran, Israel, South Korea, Singapore and New Zealand, instituted regional or national lockdowns during the early months of the crisis in the attempt to slow the spread. In Australia, international borders were closed, and a national lockdown was implemented by the Australian national and state governments, beginning from mid-March 2020 and gradually easing from mid-May 2020. This lockdown involved restricting people’s movements outside their homes, closing businesses and schools and thereby isolating them from many of their friends and family members outside their households. At the time that most of these initial lockdown restrictions were removed or eased in Australia, it was clear that they had been successful in eliminating the novel coronavirus across the country and had significantly reduced COVID case numbers and deaths. Most Australians were able to return to a relatively normal life by early June 2020. However, further outbreaks emerged later that year, requiring the implementation of new restrictions in some regions, including the state of Victoria from late June to October 2020 (Lupton, 2021).

The effects on people’s mental health and wellbeing from the social and economic stresses of the COVID-19 pandemic have received considerable attention from health authorities and mental healthcare professionals worldwide (Robinson et al., 2021). Particular concern has been expressed about the welfare and wellbeing of people who were already living with a major mental health difficulty prior to the pandemic, assuming a greater vulnerability to exacerbation of mental distress or relapse from recovery. However, findings from a systematic review and meta-analysis of longitudinal cohort studies on mental health prior to and following the COVID outbreak showed that in contravention to these expectations and assumptions, in some cases people with pre-existing mental illnesses did not report significant worsening of symptoms during the first six months of the pandemic: some even experienced an improvement in their wellbeing (Robinson et al., 2021).

Quantitative surveys are important in identifying broad trends in...
mental health status across populations. However, a qualitative approach allows for a richer, more contextual analysis that can identify the manifold dimensions of mental health and distress states. In this article, we present findings from a qualitative study employing semi-structured telephone interviews that investigated what life was like in the early months of the COVID pandemic for Australian adults from a range of backgrounds and geographical locations. We use the case study method to detail the experiences of five participants who reported living with pre-existing mental illnesses. Our study was not specifically directed at mental health. It had a much broader aim: to investigate Australians’ everyday experiences of the first six months of the COVID crisis, including eliciting what it was like for them to experience lockdown conditions and what helped them cope. We purposively recruited our participants to take part in in-depth interviews to be as heterogeneous as possible, with a wide spread of ages, health status and geographical locations across the Australian continent. As it turned out, even though we had not specifically recruited for this sociodemographic characteristic, a total of 14 people out of the 40 study participants reported a pre-existing mental illness. We selected our case studies from this group of participants for further analysis, seeking to provide some further insights into the research outlined above concerning how people with such conditions experienced the COVID crisis.

In what follows, we offer an overview of relevant sociomaterialism perspectives, outline the details of our study and methods, present the five case studies we selected for analysis and discuss what they can contribute to an affirmative approach to assemblages of health, illness and recovery that acknowledges the contributions that nonhuman creatures and things can make to human flourishing.

1.1. Sociomaterialism perspectives on health, illness and recovery

When analysing our research materials, we noticed some interesting and important aspects in the accounts of the experiences provided by some of these people with pre-existing mental health conditions. We identified a range of experiences, including relapse or exacerbation of mental illness or distress but also resilience and even a degree of wellbeing during lockdown conditions. We adopted a sociomaterial analytic approach, seeking to identify how human and nonhuman agents came together to generate affective states of wellbeing, coping or distress during the initial phase of the COVID crisis in Australia. By agents, we mean not only other living creatures and things but also material objects, places and space.

Sociomaterialism perspectives are diverse, drawing on Spinoza’s philosophy, Deleuze and Guattari’s writings and actor-network theory (Fox and Aldred, 2017) as well as feminist new materialism (Bennett, 2020; Barad, 2003; Braudotti, 2019) and Indigenous and non-western cosmologies (Hernández et al., 2020; Rots, 2017). Across these perspectives, sociomaterialism inquiry shares an emphasis on challenging the notion of human exceptionalism: replacing it with the idea that people are always already part of more-than-human assemblages. These perspectives also view agencies as emergent, shared and distributed between humans and nonhumans when they come together in assemblages. This is a relational view rather than the orthodox assumption that sovereign, autonomous human subjects possess agency. People are defined and agential in relation not only to other people but also with and through other living things, non-living objects, place and space. Capacities (including affective forces and intensities) can be opened or closed off by people’s encounters with other people and with things (Bennett, 2020; Barad, 2003; Hernández et al., 2020; Braudotti, 2019; Fox and Aldred, 2017; Rots, 2017).

Braudotti (2019) argues for the importance of adopting an affirmative approach to sociomaterialist analyses. Part of this affirmative approach is working towards understanding how much bodies are capable of (Braudotti, 2008: 32), acknowledging the temporal, spatial, affective and biographical coordinates of people’s lives. From the sociomaterialist perspective, states of health, illness and wellbeing are constantly changing as humans enter and leave assemblages of other agents (Duff, 2016; McDougall et al., 2018). Concepts such as ‘therapeutic spaces’ or ‘landscapes’ have received attention, highlighting the role of place and the objects in these locations as contributing to or detracting from states and feelings of health (Brittain et al., 2010). Previous scholarship on therapeutic spaces has demonstrated that places that are infused with affective atmospheres of safety, including engagement with things such as plants or bodies of water, generate very different intensities from places that are experienced as frightening and alienating (Bell et al., 2017; Foley, 2017). Empphasis in research on the sociomaterial dimensions of mental health and wellbeing has also thus far largely focused on place and space: for example, identifying how spaces of the home (Tucker, 2010a), the community (Fletcher and Barroso, 2020) and public places such as parks, cafes and child-care centres (Duff, 2012) can contribute to opening capacities for recovery. Other researchers have identified digital services and platforms as spaces for support and recovery from mental distress (Ellis and Tucker, 2020).

As this work demonstrates, spatial dimensions can be integral in the generation of the intensities and capacities that lead to feelings of mental wellbeing, distress and recovery. There are people, other living things and manifold other objects that contribute to wellbeing assemblages, however; and these objects are located within place and space. For example, Duff (2016) has sought to identify the enabling resources that can lead to assemblages of recovery from mental illness. These enabling resources include pharmaceuticals and psychological or psychiatric care but also a range of non-medical practices and objects: making and drinking cups of tea or coffee, cooking, playing musical instruments, meditation practice, exercise, creative arts engagements and so on. Further, cultural geographies research (Pazhoohandtahali and Bailey, 2020; Holmberg, 2019) and psychological literature (Brooks et al., 2018) has begun to identify the importance of pets for mental health and wellbeing, including for people in aged care homes or those confined to home with chronic and severe mental health conditions.

Building on this previous scholarship, in this article we have sought to identify how much bodies are capable of in the context of living both with a pre-existing mental illness condition and in the unprecedented times of the COVID crisis. We were therefore interested in exploring the sociomaterial conditions of possibility, including the relational connections established and agential capacities generated which helped people with existing mental health conditions cope with the difficult conditions of these months, as well as those agents and practices that may have exacerbated their distress.

1.2. Details of the study

A case study approach is an ideal method to highlight the details of everyday life and encounters with other people and with nonhuman agents that contribute to states of mental health and wellbeing. They provide ‘descriptive narratives’ (McDougall et al., 2018) of people’s experiences and practices that can work to highlight the sociomaterial dimensions.

In the broader study, 40 indepth, semi-structured interviews were conducted with adults living in Australia by the second author between late May and late July 2020. The study was approved by the UNSW human research ethics committee. All participants provided informed consent prior to the interview. We offered a gift card to thank and compensate participants for their time. We chose to use voice calls by telephone to conduct the interviews: both because face-to-face interviews could not take place during this period of physical distancing restrictions and because in using this method we could easily involve people living across Australia and therefore promote diversity in our participant group. While telephone interviews do not allow for observations of interviewees’ bodily demeanours and other visual cues, they can still generate rich and detailed accounts. Indeed, sometimes the more anonymous nature of the interview encounter can encourage
more expansive discussion, particularly of sensitive topics (Trier-Bieniek, 2012).

The study was not designed to be representative but to ensure heterogeneity in our participants we set sub-quotas in our recruitment, resulting in a spread of participants across gender, age group, and place of residence (metropolitan, regional and rural/remote areas). Interested potential participants responded to an advertisement about the study on Facebook. At the time this study was carried out, figures on Australian Facebook use show that 60 percent of all Australians (including those aged under 18) were regular Facebook users, with 50 percent of the Australian population logging on at least once a day (Social Media News, 2020). Using this method of recruitment proved to be fast and effective, and we easily met our sub-quotas. The interviewee group comprised 18 males, 19 females, and 3 transgender or gender non-conforming people, aged between 18 and 75, who were living in a mix of metropolitan (17), regional (13), and rural or remote (10) areas. None of the participants had tested positive to COVID-19 at the time of the interview, but 11 people reported knowing someone personally who had tested positive and we easily met our sub-quotas. The interviewee group comprised 18 males, 19 females, and 3 transgender or gender non-conforming people, aged between 18 and 75, who were living in a mix of metropolitan (17), regional (13), and rural or remote (10) areas. None of the participants had tested positive to COVID-19 at the time of the interview, but 11 people reported knowing someone personally who had tested positive (including friends or family members living overseas).

We used a semi-structured interview schedule which allowed participants to elaborate on their answers. Participants were asked to talk about how they had first heard about COVID-19, what the most helpful or useful source of information for them to learn about the coronavirus, how their everyday lives had changed during lockdown, what have been the most difficult or challenging aspects, how they have coped with these difficulties, what services they had used and their view on how well the Australian federal and state governments have dealt with the crisis. The final questions invited the participants to imagine what life would be like once the crisis had passed. All interviews were audio-recorded and professionally transcribed. To maintain confidentiality, participants were assigned a pseudonym and all contextual identifiers were removed from the transcripts. To further preserve anonymity, the participants’ specific location of residence is not disclosed in the findings.

1.2.1. Analytic approach

Our approach to the interviews positioned them as a way for our participants to engage in a form of storytelling in response to our prompts. This is a mode of social inquiry which recognises that interviewees’ accounts are co-produced with the interviewer: shaped with and through the prompts they are given, the responses of the interviewee to their accounts throughout the interview, their biographical experiences and the broader temporal and sociocultural understandings, discourses and other contexts in which the interview takes place (Denzin, 2019). As such, the interviewees’ accounts offer the opportunity to identify meanings, practices, relationships and sociocultural dimensions in people’s accounts of their experiences (Lupton, 2019). In Denzin’s words, interviews are ‘traces of presence’ (Denzin, 2019). As the questions we asked in the interviews followed a rough timeline, beginning with how the interviewees had first heard about COVID and ending with their thoughts about the future, the interviews were already asking people to outline a sequential narrative of their COVID experiences.

The second author wrote detailed fieldnotes for each participant soon after each interview was conducted. Both authors then used the transcripts to augment these notes, inserting illustrative quotations to configure a detailed narrative case study for each interviewee. In this way, our approach is akin to understanding the in-depth interview as a form of storytelling, in which participants recount narratives in response to our questions and we formulate their accounts into our own narratives (Rodríguez-Dorans and Jacobs, 2020). Writing the case studies was part of our analysis, therefore. We focused on the contextual details in how the interviewees recounted their experiences of the early phase of the COVID crisis. Some of our findings are reported thematically across the case studies, while others use the case studies to provide a detailed biographical narrative. We were interested in identifying the broader social contexts in which people’s experiential narratives were situated and the relationships between personal experience and macro-social dimensions (Rodríguez-Dorans and Jacobs, 2020).

For the present analysis, we selected five case studies from those participants who reported living with a pre-existing mental illness, selecting for diversity of mental condition (including depression, anxiety, obsessive compulsive disorder, agoraphobia and post-traumatic stress disorder), age (ranging from 24 to 56 years of age), gender (two women, two men and one transgender person) and geographical location (both cities and rural regions). In analysing the case studies through a sociomaterialism lens, we focus on how these narratives illuminate the varied experiences of the participants and the role played by other people as well as by nonhuman agents, the affective intensities and relational connections emerging with and through these assemblages, and how agential capacities were opened or closed (Lupton, 2019).

1.3. Michael

Michael is 56 years old, identifies as white Australian and has a Year 10 level education. He shares a rural property with his partner. Michael said that he lives with depression and chronic high blood pressure. His high blood pressure had made him aware that he might be more vulnerable to COVID, and this was partly the reason why he decided to self-isolate once he became aware of the risks. Michael described unsettling feelings of uncertainty. While at first he felt safe because he lived in a rural location away from the big cities where initial COVID cases had been reported, hearing in news reports that there were some cases of COVID in his region had made him wary and afraid, realising that the threat of the pandemic had drawn near.

Some of the local radio stations would indicate how many cases were identified in the towns around where I live, because of the regional aspect. So you would then hear that my town had three cases and you go, ‘Oh!’. Even some of the localities around the town, which I’m a local, I’ve seen two cases in the suburb or the locality next to me, and you go ‘Wow, that’s even closer to home than I thought’.

Michael had a full-time administration job in a nearby town pre-COVID but decided to leave the job because he was concerned that he would be exposed to the risk of infection due to constant face-to-face interactions with the public. He also said that he did not want to bring the coronavirus home to his partner. Michael’s depression had been exacerbated not only by financial troubles due to leaving his job but also the feelings of foreboding and living under a threat that was invisible. Leaving his property, where he rarely saw or engaged with other people beyond his partner, and going into town, made him feel there is no way of knowing where the coronavirus is, and who might be infected.

Well, it sort of created a bit of a Big Brother watching over. Is the virus in my town, should I go into town? If I go there, how many people will I come in contact with? I’d better stay at home … When you have depression, it makes it even harder. It’s like something, a cloud, over the whole area you’re living, because you just don’t know where the virus is or where – whether it’s – yeah, what’s happening.

Michael said that his mental wellbeing had been badly affected by the loss of social contact due to COVID-related restrictions. He had stopped going out to places like the local pub for dinner or engaging in volunteer activities with his local rural fire service. This loss of regular social activities made him feel less socially integrated and engaged with the local community, and more isolated, stressed and anxious. He has tried connecting on social media but said that he found it a very poor substitute for in-person socialising. He also worried about not being able to see his elderly mother because of needing to physically distance from her to protect her from the risk of COVID infection.

It’s hard enough to keep in touch with my family because they’re a little bit far away, but even my mother, she’s 80 … I don’t see her
very often and even when you’re sitting there doing nothing, you still can’t go ‘I’ve got time to go and see her’. You can’t go and see her because it’s not good (for her health).

Michael has tried using distractions such as cooking and gardening to help him deal with his feelings of boredom, anxiety and depression, but these have not been very successful. He noted that he was drinking more alcohol, including during the day, as he had much more time on his hands due to not working. For Michael, it has been his five dogs that shared his property that have offered the most emotional support during the COVID lockdown. He had spent far more time with his dogs now that he is mostly confined to home, including long walks with them around his property: ‘They offer a lot of companionship ... It’s interesting watching having them around and just enjoying their time. They have such a good life’.

Michael’s narrative, therefore, presented a situation in which his depression, anxiety and feelings of isolation from others were exacerbated by stay-at-home orders and the loss of his job and income, together with his feelings of personal vulnerability and concern for his partner’s and mother’s health. His anxiety about whether public spaces were safe hung over him like a dark cloud whenever he left what he felt was the safety of his isolated property, closing down his capacity for connection with others. Nevertheless, his spacious rural setting and the animals with which he shared it also opened capacities to find pleasure in spending time outside. While connection with people for Michael was frightening, the dogs offered ‘safe’ physical contact, generating possibilities for him to share their uncomplicated enjoyment of life.

1.4. Emma

Emma, aged 29, lives with her husband and mother-in-law in a regional town. She described her race/ethnicity as ‘white’. Emma has technical qualifications and is currently unemployed but is restarting (retraining) for a career in digital art. Emma recounted having previously lived with obsessive compulsive disorder (OCD). She said that this condition had been quite well under control prior to the COVID outbreak (she noted that ‘I was largely past it’) but it had worsened during lockdown.

For Emma, some of the most challenging aspects of life during the crisis were related to seeing other people around her in public spaces not adhering to the rules around distancing and hygiene practices. These observations made her feel unsafe and anxious, stirring up elements of her OCD that had previously lain dormant.

I think part of it has been things like going out shopping. It probably sounds silly but seeing other people not obey those sorts of rules – that’s been a source of stress. A woman coughed as she walked past me in Coles [supermarket] and I was like really agitated afterwards. Yeah, it’s just borderline paranoia after a certain point.

Emma also described the guidelines in relation to hand hygiene during COVID as especially triggering her OCD, causing her to become compulsive again about handwashing.

You’re constantly being fed information saying stand this far apart from people and do this and wash your hands and so on and so forth ... it was largely around handwashing – having the government put out messages all the time saying wash your hands.

Emma said that she was using methods that she has learnt in the past from psychological therapy, such as distraction and self-soothing to self-manage her mental distress. These methods include playing video games, watching YouTube videos and making herself a cup of tea. Spending time with her pets had also been a source of consolation and helped her relax: ‘I think that’s a really useful destressing thing all of the time, having animals around’.

Emma had also used online mental health resources such as websites offering information about how to deal with mental health conditions during the COVID crisis. She was still able to see her psychologist throughout the crisis using digital platforms. Emma described how her prior knowledge and practice of the mindfulness approach had meant she has been able to help not only herself but other people (who had not previously needed or received therapy) to manage during the lockdown period.

It’s an interesting sort of thing for me, because I had a lot of stress and issues growing up, so it’s almost like I manage better when things are a bit chaotic, because I feel that’s my element. So, I actually feel like I’ve been managing pretty well. So, it’s kind of strange because, yeah, just seeing people who are normally quite happy and well-adjusted and normal getting very stressed out and upset about what’s happening.

In Emma’s narrative, therefore, similar to Michael, public spaces were sites of distress due to the perceived risk of other people potentially spreading the coronavirus. Her OCD had worsened due to the intensification of public messages about hygiene in the context of the COVID crisis. However, Emma was able to manage this distress successfully. Previous experiences of therapy and the skills she had learned in pre-COVID times opened her capacity for coping. Digital media were also a great help in connecting with other people, including her psychologist, and also enabled her to offer help to others, which contributed to her feelings of wellbeing. Her relationships with her pets were described as generating capacities for ‘destressing’, allowing the sharing of affective forces that she found relaxing and relieving of the intensities of her anxieties concerning other people’s behaviours.

1.5. Joe

Joe is aged 41, with an Anglo/European background. He lives in a share house in a large city, with two other men. He is currently unemployed, though he is studying at university fulltime, seeking to re-train in health science after previously working in customer service. Joe’s unemployment predates the COVID crisis and is related to some serious mental health difficulties. In the recent past, he had experienced social anxiety, major depression and severe agoraphobia to the point that he became house bound. At the time of interview, Joe had moved to a new house and that was the impetus for improvement in his anxiety levels and a desire to ‘restart his life’, including returning to study.

During the COVID restrictions, Joe’s routine changed significantly, due to his university shutting down and going online. The full load of university study kept him busy, which was helpful in managing his mental health, but Joe did not find online study as enjoyable. As a mature age student, he valued (and missed) the face-to-face interaction with other students and the lecturers.

It’s not the same online. You don’t have the conversations that you would have face-to-face, and you just miss out on all the nuances, online. You don’t get the same level of support, as well, I think.

Given his pre-existing mental health difficulties, after the outbreak of COVID, Joe found it hard to feel safe enough to leave his house, go out in the world and mingle with other people. He more frequently engaged in digital media contact with family and friends as a way of keeping in touch with them, including greater use of text messaging services, but he found this a rather ‘superficial’ form of communication. For Joe, this period of crisis was reminiscent of previous times in his life when he had to deal with social isolation because of his social anxiety and agoraphobia. He harkened back to how he felt during previous mental health crises and noted that he had learnt from his experiences of how he managed during those times.

To be honest, because I do – well, I have had that experience of agoraphobia and I do have social anxiety anyway, it’s not been too bad. It’s reminiscent of a bad period that I went through previously, where I just never left the house. So, it feels like I’ve got all of that
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going on, but without the same sort of mental health issue actually persisting, because, surprisingly, I seem to have coped quite well. I've coped a lot better than a lot of the other people that I know. Yeah, I think that, in some ways, I was prepared for it previously by having some really isolating experiences.

Joe had undergone extensive psychological therapy in the past and continues to see a therapist once a month: ‘I think that certainly helps, because I learnt skills to deal with what was going on previously, this didn’t become too much of a shock.’ He has been able to participate in telepsychology sessions over Zoom during the lockdown and appreciates this service, given his difficulties in leaving his house. Joe’s cat has also been important to his feelings of wellbeing: ‘I’ve got a cat, which also helps me as well, maybe it’s something I should think of as a coping mechanism. It’s been great to have him keeping me company all the time. My other housemate has one as well. So, pets, I think have really helped.’

Joe’s state of wellbeing was strongly affected by his encounters with other people in public spaces and his agoraphobia and anxiety intensified when he left his house during the pandemic. However, the familiarity of these affects he experienced during COVID, despite their distressing nature, meant that at least he understood why he was responding in these ways. He was thus able to manage these feelings quite well because he was ‘prepared’. By contrast, Joe found online encounters as less supportive and helpful, except for the access to his therapist that he was still able to find online. Joe characterised his cat as a ‘coping mechanism’, offering him a more profound intimacy than that he found online.

1.6. Georgia

Georgia, aged 24, lives with her grandmother in a large city. She describes herself as a ‘white Australian’ and is a full-time university student with a casual tutoring job. Georgia lives with post-traumatic stress disorder and fibromyalgia.

In her interview, Georgia talked about feeling helpless at the beginning of lockdown when her counselling session for which she had been waiting six months for was cancelled and no replacement session was booked for her. She was forced to take on self-care for her mental health and that observed that in the end, these actions may have been more helpful than counselling: ‘I think it just meant that I had to consciously choose to actively take care of my own brain, which was possibly more useful than the counselling would have been, who knows?’. While she was able to manage her own distress, dealing with the affective intensities expressed by members of her family was challenging for Georgia. She found herself navigating and managing their stress and anxiety as well as worrying about infecting her vulnerable grandmother with the coronavirus. Like Emma, Georgia started obsessively washing her hands in the attempt to avoid spreading or contracting the coronavirus.

The biggest change to Georgia’s everyday life following the implementation of COVID restrictions was that she spent almost all her time at home, whereas before she had gone out on most days for to attend university and for work. She described feeling more stressed when she was in public crowded areas where she was unable to adequately distance herself from other people. Staying at home relieved these feelings. Georgia thought that mostly confinement due to COVID had a positive impact on her mental health and wellbeing, as it allowed her to ‘slow down’ and gave her more time to engage in leisure activities such as daily walks, reading, writing and experimenting with cooking new dishes. Staying home and having more rest periods reduced her pain levels associated with fibromyalgia and allowed her freedom from having to plan and think through the complexities of her day.

For Georgia, the most challenging part of lockdown life was the loss of physical touch from intimate others from her life, including close family members, friends and her boyfriend. I mean, I didn’t see my boyfriend for about a month and that sucked. I’m a very ‘huggy’ person: I need to touch people, and so no hugs from friends, not seeing my sister, not seeing my boyfriend, it was a lot.

However, social media were helpful for Georgia in gaining new forms of connection or building stronger relationships with family members or friends.

Using social media to at least get some sort of social connection was really important. I reached out to family members who I’ve always felt like I should be closer to, so like cousins of mine. I focused really hard on building new relationships with people who are special to me, if that makes sense, so that at least if I couldn’t have the experience of being close to a person and near a person, I could experience the novelty of becoming emotionally close to a person.

Georgia’s narrative outlines a situation in which mental wellbeing had been improved by a greater simplicity in her busy lifestyle and a chance to slow down and spend more time relaxing. In her case, while the loss of direct physical contact with people who were close to her had affected her mental wellbeing, social media were portrayed positively in her account of coping during COVID lockdown by opening a capacity to strengthen relationships with other people. For Georgia, intimacy could be generated to at least some degree online, offering a feeling of closeness.

1.7. Charlie

Charlie is a 45-year-old transgender person who lives alone in a country town. Charlie described themself as having a European Australian background and possessing qualifications from technical college. Charlie is living with chronic pain, mental illness (anxiety disorder), sciatica, scoliosis, asthma and hyperthyroidism and has been supported by a disability pension for some time.

At the time of the interview, Charlie has not left the house since the COVID crisis had started in Australia. After hearing about a woman with COVID who was living in their town, Charlie became fearful about going out of their house and interacting with other people. This decision was also based on the advice of their doctor, who said that because of Charlie’s asthma and other chronic health conditions they should self-isolate. Charlie found the loss of independence and pain they were experiencing due to not receiving physio treatment for a fractured knee difficult. They talked about how not being able to go for walks has also been difficult for them as they haven’t done any exercise since self-isolating began. Charlie recounted how the combination of social isolation, anxiety and fear associated with the crisis has resulted in needing new medication to cope with anxiety and sleep disruptions.

Charlie described themself as ‘a loner’ and already very socially isolated, in part by choice, in part due to illness, and in part from having a gender identity that is misunderstood and stigmatised. They discussed how their sense of social isolation has worsened during the crisis, with implications for their mental health status. While Charlie was not in paid work, before COVID lockdown they had a regular volunteer job at a mental health support group at the local hospital. This work stopped during the crisis and meant that one of Charlie’s few weekly outings and sources of social interaction also ceased. Charlie said that they worried about the clients who attend the group and missed the social engagement they experienced through this volunteer work.

Charlie talked about feeling dependent and anxious due to the food shortages at the local supermarket, and how this increased their anxiety about whether they would have access to the essential items.

Not being able to go out and get my own shopping and when the toilet paper and serviettes, paper towel and even like cat food and things like that, you couldn’t even get, that worried me but that was the biggest worry. I mean the virus worried me, but I think that was
the biggest worry with groceries, not being able to get them and the prices went up.

Another major aspect of daily life that changed for Charlie during the COVID lockdown was that they have had to adapt to not seeing people in person and had to try to get used to talking on the phone, which they had always found difficult. However, Charlie made progress with this, and began phoning and checking in on their neighbours every night. This social activity was a beneficial source of connection and belonging, so that Charlie felt less alone: ‘We all have a bit of a chat. And yeah, makes a bit of a difference, make sure that we’re all okay before bed’. Charlie said that their cat was crucially important to them during this time and provided a key source of comfort and company as well as physical touch.

I’d be lost without my cat. I mean I already would’ve anyway, but yeah, he’s a huge help. He’s putting up with me a lot. Like they feel things too, so when I’m anxious, he feels it and when I’m upset or when something upsets me that I see on the telly, he knows and comes over and wants a pat.

Loss of access to health care as well as strong feelings of physical vulnerability and fear of infection due to a combination of health conditions meant that Charlie’s capacities for mobility, wellbeing and intimacy were severely limited by lockdown restrictions. In the absence of human physical connection, Charlie described their cat not only as tolerant of Charlie’s mental distress but as relieving it through a sensitivity to Charlie’s feelings and demonstrating care. Charlie was able to offer care to others in their location by using a telephone as a mediated mode of connection to check in, which opened capacities for wellbeing and feeling safe.

2. Discussion

The COVID crisis has constituted a series of constantly changing more-than-human assemblages of risks, distress and threats. Our case studies demonstrate the complexity of the agents, practices and affective intensities that have gathered in the initial six months of the crisis and the implications for mental health and wellbeing. Participants recounted embodied sensations and intensities that they experienced as distressing and incapacitating: feeling watched, depressed, vulnerable, at risk, isolated, stressed, anxious, afraid, bored, having difficulty relaxing and sleeping. In pre-COVID research on therapeutic spaces for mental well-being, some public spaces were identified as enabling resources (Tucker, 2010b; Fletcher and Barroso, 2020; Duff, 2012). In contrast, due to public health warnings about the risk of contracting or spreading COVID in spaces outside the home, for our participants, feelings of distress mostly emerged in situations where they were moving around in public spaces populated with others who they viewed as representing some kind of threat of contagion. This was particularly the case if these others were evaluated as not behaving appropriately in protecting themselves and others from possible infection with the coronavirus.

Consequently, whereas in pre-COVID times, places such as workplaces, pub and clubs, clubs and community organisations offered participants the capacity to socialise meaningfully in ways that supported their mental well-being, during the early months of the COVID crisis these spaces became marked as assemblages of risk. Previously familiar and safe spaces become unsafe: generating feelings of discomfort and threat. The coronavirus was experienced as an invisible danger that could not easily be avoided in public places, due to potentially infected others populating those spaces. For example, for Michael, Charlie and Joe, feelings of depression and anxiety were exacerbated by feeling ‘watched’ when out in public and uncertainties about where the COVID risk might be. For Georgia and Emma, compulsions around hygiene were exacerbated by constant public health messages and warnings about washing hands constantly. These public health campaigns, therefore, became agents in assemblages of anxiety. News media coverage (online but also legacy media such as television and radio reporting) also participated in these assemblages of distress by alerting participants (as in Michael’s and Charlie’s cases) to the presence of dangerous others in their locales and exacerbating their feelings of risk in relation to exposure to strangers. These responses were experienced as disorienting, producing a sense of being detached or cut adrift from community and public life. They illustrate the necessity of thinking and acting in more insulated and even individualised ways, but also how the act of spatial distancing was intertwined with feelings of estrangement, mistrust, self-reliance, and emotional distance.

It is notable that while green spaces such as parks or home gardens and blue spaces such as lakes or rivers (Bell et al., 2017; Foley, 2017) have been identified in previous research as therapeutic spaces, these did not feature strongly in the participants’ narratives. Other researchers have identified the home as an ‘everyday’ therapeutic space for people living with mental health challenges (Tucker, 2010a): this space took on a new symbolic significance as a place of safety and protection during COVID lockdowns. People were urged by government authorities and health experts to ‘shelter from home’ or ‘stay home’ to avoid infection. In contrast to the affective atmospheres of distress and risk people recounted when describing moving around in public spaces, feelings of safety and wellbeing were associated with keeping to the home – and for some people, their rural surrounds – where strangers could not enter. The home provided an affective atmosphere where people could feel more relaxed, with less need to watch themselves and others to ensure correct hygienic behaviours were being followed (cf. Fletcher and Barroso, 2020). Participants talked about feeling safe, comforted, protected and connected with other people who were well known to them and shared the same familiar space: partners, family members, housemates, friends and neighbours.

Participants also appreciated and benefited from being able to communicate with other people remotely by using online media or by telephoning. While these technological means of communication were not always viewed as substituting completely for face-to-face social experiences, they at least offered some way to connect with others, support relationships and find relief from feelings of loneliness, boredom and isolation. Georgia is an example of someone who was able to build on and deepen intimacy using social media, while Emma appreciated being able to offer support to others online and Charlie overcame a previous reluctance to use the telephone and found a new way of connecting with and caring for others. Several people described the importance for their mental wellbeing of being able to continue to access therapy using online platforms. Furthermore, digital technologies used for leisure and work (as in Emma’s practices of playing video games and watching YouTube videos and in her tutoring work) or learning (as in Joe’s and Georgia’s university studies) supported continuing income-generation and education and kept people occupied and distracted. These findings echo previous research on the value of digital media and devices as enabling resources for recovery or alleviating mental distress (Ellis and Tucker, 2020) and for opening capacities for intimacy and sociality during periods of stay-at-home orders (Watson et al., 2021).

In COVID conditions, where people’s opportunities to engage in person with intimate others beyond their households, and where they are spending far more time at home, it would seem that pets have taken on even more importance as ‘companion species’ (Haraway, 2003). The beneficial role of participants’ relationships with their companion animals was particularly highlighted in their accounts. According to accounts by Joe, Charlie, Michael and Emma, their pets provided embodied trust, reliable and reassuring physical and social support that was invaluable in supporting their mental health and well-being. Spending time with companion animals opened capacities for multisensory intimacy and physical touch with other warm-blooded creatures that went a long way towards filling the gaps left by the loss of in-person inter-embodied connections.

Learning from their previous experiences of coping with or recovering from mental distress and difficult times was also a valuable therapeutic resource for this group of participants. Several participants (such
as Emma, Georgia and Joe) noted that they had been able to draw on their past experiences of mental distress and the skills they had learnt through therapy to get them through the COVID crisis conditions. They were able successfully to engage in activities that they knew from previous experience opened capacities for coping, distraction or self-soothing, such as walking, cooking and creative pursuits (cf. Duff, 2016) and felt that they were managing quite well with lockdown conditions: even compared with people without pre-existing mental health difficulties. The ‘slowing down’ of everyday life during lockdown was a boon for people like Georgia, helping her mental wellbeing. However, some participants sought relief from boredom, loneliness or stress from increased food and alcohol consumption (Michael and Joe) or needed additional medication (Charlie) as they came under financial stress or confronted feelings of loneliness and isolation. Further, the emphasis in the participants’ narratives on self-care is suggestive of the burden on the individual (and their personal agency) to be more active and deliberate in ameliorating distress or coping with the stress of the COVID crisis.

3. Concluding comments

Across the case studies here presented, we have shown how assemblages of wellbeing, recovery and distress came into being and how capacities for coping at a time of crisis were opened or closed by the confluences of agents that were gathering in these assemblages. This study highlights the importance of understanding the sociomaterial dimensions of living with pre-existing mental health problems during the COVID crisis. Adopting an affirmative approach (Braidotti, 2020), we have attempted to identify not only the conditions for worsening mental health and wellbeing but also which more-than-human agents came together in assemblages of health, wellbeing and recovery in times that were challenging for many people. As the case studies show, feelings of anxiety, fear and risk were generated from the following sociomaterial conditions: loss of face-to-face contact with friends and family members; concerns about hygiene and infecting others; financial stress; loss of regular paid employment or volunteering work; public spaces; and the behaviour of unknown others in public spaces. The agents and practices that emerged as most important for opening capacities for coping and maintaining wellness during lockdown included: the space of the home; contact with a small number of intimate others; online therapeutic care; practising self-care skills learnt from previous difficult times; helping and supporting others; engaging in leisure activities; and the companionship of pets. These findings demonstrate what bodies can do in times of crisis and the agents and practices that can generate capacities for coping.

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References

Barad, K., 2003. Posthumanist performativity: toward an understanding of how matter comes to matter. Signs 28 (3), 801–831.

Bell, S.L., Wheeler, B.W., Phoenix, C., 2017. Using geonarratives to explore the diverse temporalities of therapeutic landscapes: perspectives from ‘green’ and ‘blue’ settings. Ann. Assoc. Am. Geogr. 107 (1), 95–108.

Bennett, J., 2020. Influx and Efflux: Writing up with Walt Whitman. Duke University Press, Durham.

Braidotti, R., 2008. Of poststructuralist ethics and nomadic subjects. In: Düvell, M., Rehmann-Sutter, C., Mith, D. (Eds.), The Contingent Nature of Life: Bioethics and Limits of Human Existence. Springer Netherlands, Dordrecht, pp. 25–36.

Braidotti, R., 2019. Posthuman Knowledge. Polity, Cambridge.

Braidotti, R., 2020. ‘We’ is in this together, but we are not one and the same. J. bioeth. Ing. 17, 465–469.

Brittain, K., Corner, L., Robinson, L., et al., 2010. Ageing in place and technologies of place: the lived experience of people with dementia in changing social, physical and technological environments. Social. Health Illness 32 (2), 272–287.

Brooks, H.L., Rushton, K., Lovell, K., et al., 2018. The power of support from companion animals for people living with mental health problems: a systematic review and narrative synthesis of the evidence. BMC Psychiat. 18 https://doi.org/10.1186/s12888-018-1613-2. Available at:

Denzin, N.K., 2019. The death of data in neoliberal times. Qual. Ing. 25 (8), 721–724.

Duff, C., 2012. Exploring the role of ‘enabling places’ in promoting recovery from mental illness: a qualitative test of a relational model. Health Place 18 (6), 1388–1395.

Duff, C., 2016. Atmospheres of recovery: assemblages of health. Environ. Plann. 48 (1), 58–74.

Ellis, D., Tucker, I., 2020. Emotion in the Digital Age: Technologies, Data and Psychosocial Life. Routledge, London.

Fletcher, E.H., Barroso, A., 2020. ‘It’s a much more relaxed atmosphere’: atmospheres of recovery at a peer respite. Emotion Space Soc. 36, 100705.

Foley, R., 2017. Swimming as an accreditive practice in healthy blue space. Emotion Space Soc. 22, 43–51.

Fox, N.J., Alldred, P., 2017. Sociology and the New Materialism: Theory, Research, Action. Sage, London.

Haraway, D., 2003. The Companion Species Manifesto: Dogs, People, and Significant Others. Prickly Paradigm, Chicago.

Hernández, K., Rubis, J.M., Theriault, N., et al., 2020. The Creatures Collective: Manifestings. Environment and Planning E: Nature and Space Online First.

Holmberg, T., 2019. Walking, eating, sleeping. Rhythm analysis of human/dog intimacy. Emotion Space Soc. 31, 26–31.

Lupton, D., 2019. Toward a more-than-human analysis of digital health: inspirations from feminist new materialism. Qual. Health Res. 29 (14), 1998–2009.

Lupton, D., 2021. Conceptualising and managing COVID-19 risk: the six phases in Australia. Available at: https://deborahalupton.medium.com/conceptualising-and-managing-covid-19-risk-the-six-phases-in-australia-eb3b5a91b5d5.

McDougall, A., Kinsella, E.A., Goldsmith, M., et al., 2018. Beyond the realist turn: a socio-material analysis of heart failure self-care. Sociol. Health Illness 40 (1), 218–233.

Pazhooheshnath, N., Bailey, A., 2020. Cherished Possessions, Home-Making Practices and Community. Health 14 (4), 434–448.

Robinson, E., Sutin, A.R., Daly, M., et al., 2021. A systematic review and meta-analysis of longitudinal cohort studies comparing mental health before versus during the COVID-19 pandemic. medRxiv. Available at: https://www.medrxiv.org/content/10.1101/2021.03.04.21252921v1.

Rodriguez-Dorantes, E., Jacobs, P., 2020. Making narrative portraits: a methodological approach to analysing qualitative data. Int. J. Soc. Res. Methodol. online first.

Rots, A.P., 2017. Shinto, Nature and Ideology in Contemporary Japan: Making Sacred Forests. Bloomsbury Publishing, London.

Social Media News, 2020. Social Media Statistics in Australia. June 2020. Available at: https://www.socialmedianews.com.au/social-media-statistics-australia-january-2020/.

Trier-Bieniek, A., 2012. Framing the telephone interview as a participant-centred tool for qualitative research: a methodological discussion. Qual. Res. 12 (6), 630–644.

Watson, Ash, Lupton, Deborah, Michael, Mike, 2021. Enacting intimacy and sociality at a distance in the COVID-19 crisis: the sociomaterialities of home-based communication technologies. Media Int. Aust. 178 (1), 136–150.