Improving Transitional Care for Individuals with Severe Mental Illness:

The Role of Narrative Repair

by

Zaharenia Vasiliki Tsikopoulos

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Graduate Supervisory Committee:

Gerri Lamb, Chair
Jennifer Anne Eve Krahe
Sarah Amira de la Garza

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ABSTRACT

Traditional healthcare narratives have set the stage for the care of the population with Severe Mental Illness (P-SMI). Thus far, two prevailing health strategies anchor services for mental illnesses, acute psychiatric care, and mental health, psychosocial rehabilitation. Between these, care transitions mediate PSMI's needs and their movements from the hospital to the community and home. However, as individuals with Severe Mental Illness (i-SMI's) leave the hospital, time is short with little opportunity to make known authentic narratives born out of self-evidence. After transitional care, maintenance treatment re-centers these individuals back into a playbook with operatives of pathology and disability and inconsistencies with the narratives on recovery and rehabilitation.

This project sought to hear i-SMI's stories and propose how their experience can be used to create a new "counter" story of transition that empowers these individuals through a better understanding of their "space": conceptualized here, as all that surrounds them and is dynamic and responsive to their interactions and needs. Underpinning this inquiry is a post-modernist conversation that converges on the critical perspectives in the theory of architecture, philosophy of mind, cognitive science, and the aesthetic practice of psychiatric nursing in the context of transitional care. A qualitative paradigm of narrative repair guides an ethical appraisal, "*deprivation of opportunity*," and "*infiltrated consciousness*," regarding relational power dynamics that are at work in healthcare master narratives.

Narrative findings of this study reveal that identity and agency come together in a personal space of safety born out of a core sense of self, belonging, and control. Space emerges within the self-narrative as physical sensibilities in the constructs of agency and safety, and as with emotional responses, metaphor and meaning can repair personal transitions.

The counterstory derived from the narrative findings reveal: *Equitable relational dynamics attune social space, the physical environment, and meaning*, as a response to the dismissiveness and overcontrolling health professional power. Thus, the journey toward narrative repair from the perspective of i-SMI's uncovers a deeper counternarrative, Ecosystem of Space: the manifestation of a personal architecture for healing, making a systematic organic-space-experience for the core sense of self to transition and flourish.

DEDICATION

This work is dedicated to my family, my friends.

It is for those suffering from severe mental illness.

Σωκράτη

For my Elders’ memory eternal

Πρός τιμή τοῦ μακαριστοῦ Γέροντά μου Ἐφραίμ

Πρώτα με το νους, και τέλος με την πράξη

Πνευματικό έργο

Ευλογίες

Α Ω

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Humility completes this undertaking.
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Chapter 1

CONTEXT

This project seeks to examine the current state of transitional care for those suffering from severe mental illness (SMI), in the hopes that there is a better way. Chapter 1 sets the context for this project, exploring what it means, socially and economically to be an adult living with a severe mental illness and the impact of transitions between acute care and community. The complexities of caring for the severely mentally ill adult population are presented alongside an overview of the research and practice frameworks that exist for doing this. I then detail at length my own experiences, as a healthcare architect, a sibling, and a student of phenomenology, in designing for, living with, and caring for severely mentally ill family members and how my deep involvement in this has informed this work. Following this, I will describe the factors that led me to this study and the way in which I seek to understand the needs of the severely mentally ill adults during transitions of care within this project: a qualitative method using Narrative Repair to uncover the story they wish to tell.

Living with a mental illness: Personal and financial cost

It is estimated that more than 43 million people in the United States will experience mental illness at some point in their lives, and 10 million live day-to-day with debilitating and ongoing impairments (NAMI, 2015; Roehrig, 2016). Those suffering from SMI often have up to ten relapses within less than one year and are admitted and readmitted to acute care settings (Buckman et al., 2018; de Zwart, Jeronimus, & de Jonge, 2018; Fuller, Sinclair, & Snook, 2016; Lyons et al., 1997). These disorders, and the complexities that arise around them, continue to make them the costliest conditions in the United States (Pennington & McCrone, 2017; Roehrig, 2016). It is estimated that the cost of services for individuals with severe mental illness is around $200B and the cost of lost earnings, approximately $193B (Roehrig, 2016).

The cost of living with a chronic mental illness, both personally and economically, adversely affects the quality of life of the SMI population as well as their family members and the larger community (Chang, Chiou, & Chen, 2010; Friedli, 2009; Kennedy, 1963; Pennington & McCrone, 2017). At least 10 million individuals suffering from a severe mental illness have problems with day-to-day functioning and may experience auditory or visual hallucinations, which impact their emotions and behaviors (Substance Abuse and Mental Health Administration, 2014; Federal Register, 2010; Jones et al, 2009). Compounding this reality are trends like the rise in short-term mental health care services (Luhrmann, 2016; D. Mechanic, 2014; Nordstrom et al., 2019) and a lack of long-term support opportunities for these individuals (Coles, 2018; Simona & Marshall, 2017; Vrotsou et al., 2017). In addition, the SMI population encounters various social problems such as loneliness, poverty, unemployment, poor physical health and bad living conditions, all of which contribute to a shorter lifespan (Bazelon, 2014; Colton & Manderscheid, 2006).

Individuals with SMI find themselves isolated, under-employed, and marginalized by stigma and denial of civil rights (Kelly, 2006). The effect of this social stereotyping disparages the SMI individual’s identity and agency, with assumptions made about this population that can result in structural oppression and an imbalance of power dynamics that does not effectively support their needs (Phelan, Link, Stueve, & Pescosolido, 2000; Young, 1990b.).

A lack of agency.

I-SMI are often unable to make decisions about their care. Lacking knowledge about their options and the larger system context (Kelly, 2006), this population has been shown to have a fundamental difficulty understanding themselves and creating and maintaining continuity in their understanding of self while functioning in the world (Slade, 2009; Tew et al., 2011). Compounding the difficulties faced by people with SMI (P-SMI) as they move through the world and seek this continuity is the fact that the care, they receive is often fragmented. Although individuals re-integrating to community socialize peer-to-peer they remain within the Mental Health Services community and have difficulty achieving their goals toward recovery (Pahwa et al., 2014).

Much of the current research and literature related to the needs and treatment individuals with SMI is framed from the standpoint of health professionals (Hinton & Kirmayer, 2013; Luhrmann, 2001). Although grounded in evidence, best practice, and prevailing knowledge about patient-centrism, the lack of attention to the perspectives of the P-SMI and how they might understand their own experience is noteworthy and may contribute to the systematic exclusion and stigmatization. This project seeks to better understand the experience of transitional care of the P-SMI from their own perspective and to use this knowledge to improve their transitions and reintegration into the community.

Lack of continuity: Care fragmentation

Since the early 1960s, the American context in which care operates has been reported in the literature as system-wide fragmentation and gaps in care for adults with severe mental illness (Hogan, 2003; Mechanic, 2012). However, the history of providing care for these populations stretches back even further, with Western scholarship often focusing on the phenomenon beginning in the 1800s with the inception of the asylum and later, at the turn of the century, the deinstitutionalization movement, wherein individuals with SMI were moved from asylums to community-based facilities (Grob, 1983; E. F. Torrey, 2010).

According to the Centers for Medicare and Medicaid Services (2015), delivery of comprehensive health services for individuals with SMI (i-SMI) continues to be problematic. The literature identifies widespread restriction of access to primary care and mental health services for these populations (Grazier, Hegedus, Carli, Neal, & Reynolds, 2003; Mechanic, 1987, 2014). Indeed, access is complex and difficult in psychotherapy and pharmacotherapy (Jindal & Thase, 2003), rehabilitation treatment (Kopelowicz & Liberman, 2003; Lenroot, Bustillo, Lauriello, & Keith, 2003), and primary care (Azrin, 2014; Spatz, Bricker, & Gabbay, 2014). This can result in gaps in service between and across health systems, including behavioral health (pharma/psychopathology), primary care (pathological), and social services (psychosocial).

Transitions between these services, especially as i-SMI move from acute to outpatient care, are often fraught with difficulty (Felds & Dooren, 2014; Mechanic, 2014; Slade, 2009; Tew et al., 2011; Torrey, Fuller, Geller, Jacobs, & Ragosta, 2012; Torrey, Kennard, Eslinger, Lamb, & Pavle, 2010).

I-SMI are prone to frequent triggers, complex interplays between emotions, motivation and subsequent behavior that can derail the recovery journey and result in mental health crises (Luhrmann, 2001). As a result, people with SMI may experience care as multiple short-stays (often referred to as acute care) interrupting recovery-oriented care and delaying movement into long-term management and recovery within community settings (D. B. Herman, 2013; Lysaker, Roe, & Buck, 2010; Stein & Test, 1980a). For example, when patients' psychopathology and/or social problems and/or poverty trigger a mental health crisis, new care coordination services are invited in, which may modify and/or increase possible clinical objectives, thus splintering the patient experience and adversely affecting patient outcomes (Luhrmann, 2016; Myers, 2016).

This project is focused specifically on the i-SMI's experience of transition from acute care to community settings. It is the coordination of these care transitions, foundational to the ways in which this population experiences care, that presents both opportunities and obstacles for an i-SMI. While the body of research on care coordination dates back more than half a century, much of the current theory and research on transitional care may be traced to the early 1990s and the rise of managed care in US health care.

One of the pre-eminent frameworks used to explain care transitions, Meleis' Transition Theory (Meleis, 2010) resulted from an extensive series of studies on transitional care conducted by nurses and interprofessional teams at the University of Pennsylvania (see Brooten & Naylor, 1995; Cipriano et al., 2013; Konick-McMahan, Bixby, & McKenna, 2003; Naylor, 2000; Naylor, 2002; Naylor, Bowles, & Brooten, 2000; M. Naylor et al., 2013; Naylor et al., 2009; Naylor & Keating, 2008; Naylor & Sochalski, 2010).

Initiated with Brooten's research on transitional care for at-risk expectant mothers, the field rapidly shifted focus to assisting individuals with multiple chronic illnesses in moving from hospital to community (Brooten et al., 1988; Brooten et al., 1994; Naylor et al., 1999; Naylor et al., 2004) in an effort to reduce hospital readmissions and the many adverse outcomes associated with them. The well-known Transitional Care (Naylor, 2000; Naylor, 2002) and Care Transitions Models (Coleman, 2003; Coleman & Boult, 2003; Coleman et al., 2004) emerged during this latter stage.

Attributed to these models are two primary insights: the design of the follow-up care service after discharge, typically 2 – 3 months, and the requisite skillset of the health professional involved in treatment and transition. The key feature of the Transitional Care Model (Naylor) is the role of the Advanced Practice Nurse (Transitional Care Nurse) focusing on the patient and caregiver relationship, helping patients manage health issues and prevent decline, medications reconciliation and management. The key feature of the Care Transition Intervention (Coleman) is the role of the Transition Coach focusing on educating patients' own self-management skills regarding medication management, use of personal health records, scheduling primary and specialty care follow-up appointments and self-monitoring of declining health conditions.

While there were a few studies exploring the transitional care needs of individuals with SMI built on Meleis transition framework and Naylor's research (Hanrahan, Solomon, & Hurford, 2014; Solomon, Hanrahan, Hurford, DeCesaris, & Josey, 2014) much of the body of work on transitional care for this population evolved from psychiatric clinical research and align to the Assertive Community Treatment model (Stein & Test, 1980a, 1980b; Test & Stein, 1979).

The Assertive Community Treatment (ACT) model of Stein and Test questioned what was at the time standard practice and prevailing assumptions in psychiatry. Reliance was heavy on hospital training programs that prepared patients for community living; and Test and Stein (1976) found these to be ineffective (Test & Stein, 1976). The ACT model was designed in response as multidisciplinary and direct-service-oriented, relying on clinicians rather than referrals elsewhere. Limitations to the ACT model are most evident in contexts of rural health, where there are sparse populations of providers.

Foundational to the ACT model were an holistic approach to services, *in vivo* assessment, training and support, and assertive outreach to clients. Two aspects of the ACT model are no longer considered best practice: that clients receive services indefinitely (this has been replaced with “graduation”) and that multidisciplinary teams are required. Instead, the importance of existing team members learning new skills is now stressed.

The understanding of transitional care that emerged from ACT and the transitional care models of the 1990s reflected a complex interplay between the patient-provider relationship and system needs, especially those related to reducing costs. Although Stein and Test (1980a) get us partly there, problematic is the fact that transitional care models do not define a transition system related to the *experiences* of the *P-SMI* (Johnson, 1998). While these models attended to the needs and goals of patients, they did not explicitly integrate the experience of patients into the design of the transitional care interventions.

Transitional care for SMI individuals

The experiences of the SMI population unfold against the backdrop of transitional care processes. The literature shows that often, these care transitions fail to effectively integrate this population’s experiences in social and physical environments. A recovery-oriented “protective effect” (Loch, 2014, p.137) is the main concern in mental health, to manage care and transitions beyond the one episode/discharge event. Regardless of length of stay, impairments part and parcel to severe mental illness remain with patients as they transition across care settings. In her memoir, schizophrenic and cancer survivor Dr. Elyn Saks, professor of law, psychology and psychiatry at the University of Southern California wrote: “the question, of course, was not so much *if* I would have a psychotic episode as *when*” (Saks, 2007, p. 246).

A lack of understanding in a transitional care context regarding this population’s experiences (Leamy et al., 2012) presents challenges for combining effective behavioral health and primary care services (Hanrahan et al., 2014; Mechanic, 1994, 2014; Roberts, 2000; Silverman et al., 2014).

Thus, in the United States, the “fragmented” system of care, for these populations is shown in the literature to increase what care coordination research identifies as “high risk” behaviors when the p-SMI transition from short stay to recovery-oriented and into long-term management (Hanrahan et al., 2014; Harris, Beurmann, Fagien, & Shattell, 2016; D. B. Herman, 2013; D. B. Herman et al., 2011; L. E. Rose et al., 2007) with continued possibilities of service gaps and problematic outcomes (F. Chen, 2014; J. Chen, 2017; Croft & Parish, 2013; Luhrmann, 2016; Mechanic, 1987, 1994, 2012, 2014; Mechanic & Rochefort, 1990; Solomon, Hanrahan, Hurford, DeCesaris, & Josey, 2014).

As Saks’ writes of the disconnect in transitions between acute and long-term services: “…how, in [each] new and unknown landscape, does one construct a completely predictable, familiar, manageable life, one in which there are no surprises? And construct it quickly, because your life literally depends on it” (Saks, 2007, p. 246).

This project seeks to better understand the experiences of i-SMI as they transition from acute to long-term services, navigating what the literature shows is a fragmented system. Hopeful that what is uncovered through this work will serve as “self-evidence-based” practice in the context of the i-SMI’s experience, this project seeks to offer these insights in contribution to the extant evidence-based best practice in serving these populations.

Presented below are the research aims and research questions that drive this project. Prior to introducing these, however, in keeping with the qualitative grounding of this study, I believe it is very important to introduce the unique, personal frames that shape my connection to this research. The reader is treated to my sensitizing framework immediately below, beginning with the concept of Space, which informs my work in this area to a great degree, and followed by additional concepts introduced here and explored more deeply in Chapter 2.

Sensitizing frames: Personal experience and insight

My experiences as a healthcare architect, a caregiver of two siblings suffering from severe mental illness, and a student of phenomenology, have convinced me that we cannot rush to conclusions regarding the needs of individuals with severe mental illness. I believe the following three things: P-SMI have the capacity to heal on their own, to participate in their own healing, and to tell us what they need to do this. These beliefs directly inform the sensitizing concepts for this study, described below.

As I have mentioned, my intimate involvement with my siblings' illness-to-wellness journey, the experience of caregiving in a culturally diverse environment, navigating mental health services, and serving as a project architect in 'healing' oriented environments have profoundly influenced my perspective of how people with severe mental illnesses experience care: I believe that foundational to understanding the needs of *i-SMI* is an understanding of how they interact their surroundings, both physically and phenomenologically, what I have come to understand as "Space."

Space

Space, for me, is "architecture from within," and "architecture from without," comprised of the SMI individual's identity, phenomenological experience, and physical places in society. I understand space as both phenomenological and physical, in line with phenomenologist Merleau-Ponty (2014): "*being has sense only through orientation"* (p. 259); architects Holl (1991): *"building transcends physical and functional requirements by fusing with a place, by gathering the meaning of a situation"* (p. 9) and Pallasmaa (2016): *architecture triggers the "sixth sense—the atmospheric"* (p. 133), and transdisciplinary scholar Gallagher (2012): "*integration with the spatial environment…*

‘*body image’ (system of perception) and ‘body schema’ (system of sensory-motor capacities) employ various intentional acts”* (p.24). Space, in sum, is all that surrounds the SMI individual - dynamic and responsive to their interactions while at the same time informing them. “Space,” in the context of this project, is a lens through which I see my work and is closely tied to my sensitizing concepts, described below.

The five sensitizing concepts for this project are derived from my own thinking, my synthesis of selected tenets of architecture and philosophy, and are purposefully transdisciplinary, an important paradigm in social-narrative research such as this project. These five concepts will be introduced briefly here and discussed in greater depth in Chapter 3.

Sensitizing Concepts

Five sensitizing concepts will be used to guide this work. Husserl’s *Homeworld* serves as an umbrella of sorts, enabling us to extract and examine those things that are perhaps taken for granted or go unnoticed in the experience of the i-SMI during transition and in the journey to recovery. Homeworld will be used to collect the i-SMI’s personal narrative through the two fundamental phenomenological couplings of mind-body and person-environment, and of their unfolding within the remaining four concepts: *genius - loci*, *ekistics*, *attunement* and επιμέλεια ευατοΰ (care of oneself).

Understanding the *genius loci*, or “spirit” of a place socially, ecologically and aesthetically is thought to improve the human condition. This belief stretches far back in history to the Roman Empire. The seminal work of Norberg-Schulz (1979) uses *genius loci* in its current application as a deep re-framing of architecture, empowering us to re-engage with our civilization, the poetic meaning of space, and imbue a ‘sense of spirit’ in that space. The science of *Ekistics* (Dioxiades, 1970) is an epistemology aimed at achieving harmony between the inhabitants of a settlement and their physical and socio-cultural environment. *Attunement* as understood for this project, is both a neurological and a phenomenological phenomenon that architecture is able to trigger with empathy for an individual or population regarding *atmosphere* and *mood*. And finally, *επιμέλεια ευατοῧ* [*epimēleia heatou*] – *Care of Oneself* is based on the historic Platonic and Aristotelian assertion that via reflection, we are able to know ourselves and thus take care of the self.

Two of the sensitizing concepts, Επιμέλεια ευατοῧ [epimēleia heatou] – *Care of Oneself* (Aristotle), and *Homeworld* (Husserl) loosely connect what the individual does as personal space becomes apparent. The three remaining sensitizing concepts, *Genius-loci* (Herman 2009; Huhn et al. 2014; Norberg-Schulz, 1979) and *Ekistics* (Doxiadis, 1966) and *Attunement* (Pérez-Gómez, 2016) loosely connect the apparent ways in which the institutionalized 'physical' place can influence the personal experience. Respectively, the Power of place as it is experienced in the description of narratives (Herman 2009; Huhn et al. 2014) and as well as the physical aspects of place can enhance some characteristics of the human condition (Norberg-Schulz, 1979), potentially shaping a system of places that sustain human flourishing (Doxiadis, 1970), and lastly, places that are built to enhance social atmosphere and mood (Pérez-Gómez, 2016).

Thus, for me, the SMI individual's illness-to-wellness journey and the associated care and care teams accompanying the individual on that journey must be mapped to the individual's perception of space as I have defined in the paragraph above, Kogstad, Ekeland, and Hummelvoll (2011, 2014), situated within the discipline of psychiatry, refer to this as taking a "humanistic approach" (2011, p. 1), in which the individual with SMI is able to incorporate meaning along the way. The product of these understandings and framework is a result of my direct experience, which brings focus to my work as I try to understand the different ways in which a SMI individual makes sense of the space around him or herself and lends a prerequisite sensitivity to both observe the i-SMI and to address their difficulties.

Research Aims and Questions

An opportunity exists to address the difficulties that severely mentally ill individuals experience during care transitions. In close collaboration with the care teams supporting these individuals, this project proposes that a convergence of architecture, phenomenology, cognitive science and “being” mentally ill invites the emergence of a ‘complex’ and dynamic systems approach (Fuchs, 2012) towards re-conceptualizing mental health care for the severely mentally ill population (Kendler & Parnas, 2015; Parnas & Gallagher, 2014; Parnas, Sass, & Zahavi, 2013.)

Most important to this work is an inclusion of the experience of the i-SMI as they transition from acute to community settings, and the insights that their experience could provide in healing the fractured transitional care system. The qualitative approach to this work and its use of the methodology of narrative repair are well suited to exploring the stories of the (people with severe mental illnesses) P-SMI and the transition experiences of these individuals. The research aims of this work are to:

1. Understand the transitional care experience from acute care hospitalization to the community for individuals with SMI.
    a. ***Research question 1a.*** What is the experience of the P-SMI?
    b. ***Research question 1b.*** How do we understand the i-SMI within the larger context of transitional care?
2. Propose how this experience may be used to create a new story of transition that empowers individuals with SMI, through a better understanding of their “Space.”
    a. ***Research question 2a.*** How do individuals with SMI perceive the making of their space, related to their experiences of transitional care?
    b. ***Research question 2b***. How do we respond to their needs throughout the transitional care process and journey to recovery?

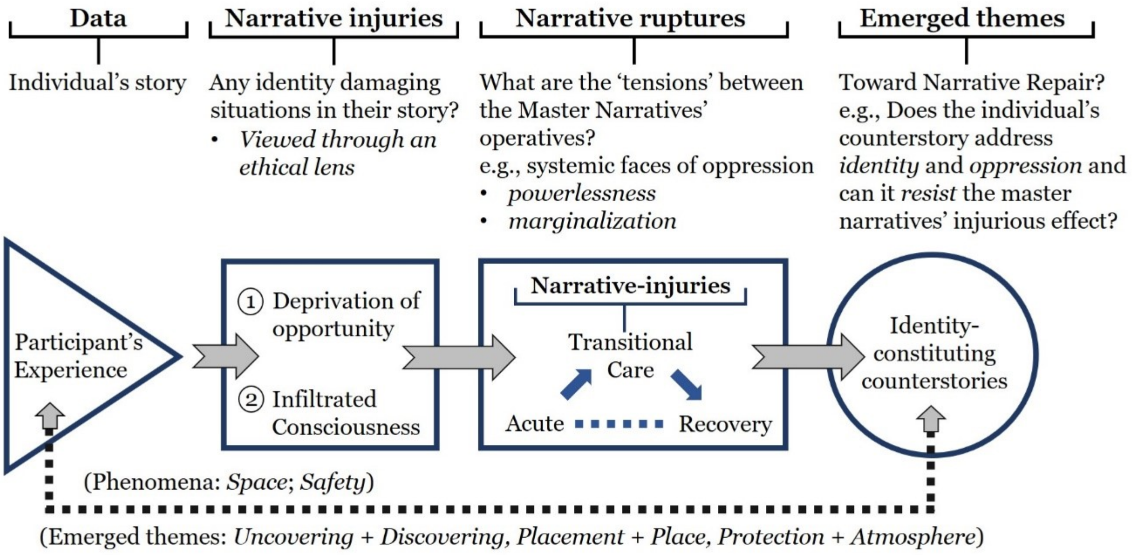
It is this human interplay with the environment, a unifying principle in phenomenology, in experiencing architecture that overlaps with four distinctive disciplinary domains. In this project, the post-modernist conversation converges on the critical perspectives in the theory of architecture, philosophy of mind, cognitive science, and the aesthetic practice of psychiatric nursing in the context of transitional care. Central to this conversation are the SMI's narratives, a "language" of sorts, the main speakers of this story, binding experientially the phenomenon and proposed methodology for this work: a qualitative paradigm using narrative repair to understand the needs of individuals with SMI as regards space. The methodology is introduced below and then presented fully in Chapter 3.

Research Approach: Narrative Repair Theory

Narrative Repair theory employs a process of interpreting data that is situated within Lindemann-Nelson's (2001) theoretical framework of narratology: *Damaged Identities and Narrative Repair*. It is a narrative approach in examining the established traditions of the Master Narratives, the prevailing or common wisdom about a phenomenon that affects engagement with those who may be experiencing or part of that particular phenomenon. The Master Narrative may positively or negatively inform the identities or experiences of a specific group in society, and in this study, the individuals under consideration are those suffering from a severe mental illness. Narrative Repair principles consider an ethical approach in reclaiming these individuals' moral agency with the discovery of what is called the Counterstory, an experience, or story, that perhaps runs "counter" to the Master Narrative, or adds insight that the master narrative does not contain, that can be used to unseat potentially injurious effects that could be caused by the influence of the master narrative and any misrepresentation of those individuals. As Lindemann-Nelson (2004) writes of the power of stories and their ability to strengthen agency: "…[b]ecause stories can represent both the complexity and the subtlety of the moral life, they are an invaluable medium for moral deliberation – a medium whose strengths and weaknesses we are only just beginning to understand" (p.

179). Thus, resulting in the choice of Narrative Repair theory (Lindemann-Nelson, 2001) to code and analyze participant interviews.

The diagram below of Lindemann-Nelson's theoretical framework illustrates the narrative approach to study the relationships of the individual's story and the master narratives. This diagram is my interpretation of her systemic process, for data analysis, introduced here and operationalized in Chapters 3 and 4.



Lindemann-Nelson's theoretical framework: Damaged Identities and Narrative Repair

Figure 1. Lindeman-Nelson's theoretical framework: Damaged Identities and Narrative Repair

First, the individual's story is collected. After that, damaging identity experiences arising from the individual's story are examined through an ethics-oriented lens. *Deprivation of opportunity* assumes that an individual is not a free agent and cannot access social goods and services and *Infiltrated consciousness* describes, in the case of this project, the i-SMI's acceptance of the dominant group's understandings of the i-SMI and a failure to gain their own sense of self-worth. Next, the narrative backdrop of which the individual is subject to oppressive forces, occur in the environment of the master narrative. For the purposes of this work, this includes the three 'care' master narratives;

acute, transitional, and recovery, and all share a transhistorical tradition in medicine. However, together these represent a diverse practice, and systemic narrative tensions arise between disciplinary operatives, psychiatry and primary medicine, and nursing and social work. Finally, after following the narrative ruptures and their iterative tracings of powerlessness and marginalization arises the counterstory. Narrative repair realizes the counterstory as 'resisting' narrative injury, and it seeks to insert new themes based on insights gained that propose a metanarrative more suited to the actual experience of the individual.

Conclusion

Pervasive risk factors such as violence, homelessness, and limited access to care, make the journey to integrating meaningful experiences very difficult, if not impossible for individuals with severe mental illness. There is a wide gap in the research about these lived experiences of individuals with SMI (Jones, 2014; Kirmayer, 2014), this has implications for healthcare costs, lost productivity, and quality of life for these populations.

With Becker's (1997) assertion in mind: "during transition, a person enters as "*one kind of person*" and emerges altered in some essential way" (p. 119), this study seeks to bring to the forefront the SMI individuals' stories about what it is like 'living' with a severe mental illness, the fragmentation of care, and the prevailing notions about severe mental illness that may hide a much different Counterstory about the spaces they seek to create. As Frank (2013) states: "stories are a way of redrawing maps and finding new destinations" (p. 53). Opportunities exist to address these issues with a closer look at transitional care models and integration of care for these individuals around the phenomenon of space.

Chapter 2

MASTER NARRATIVES

As mentioned in Chapter 1, this project looks at the experience of the SMI population within the context of transitional care. Informing this is a long and complex timeline of events in history that have informed the treatment of individuals with SMI and their transitions from acute to community settings.

The review of literature for this project tracks two selected threads of history that have profoundly informed the experiences of the SMI population, returning then to the ways in which transitional care has been informed by these points in history and explores transitional care's strengths and weaknesses. These points, and their relationship to the P-SMI and their care transitions, form a "story." In the terminology of the qualitative methodology for this project and the framework of Narrative Repair, (Lindemann-Nelson, 2001, 2004), this story is understood as the Master Narrative, or prevailing direction, common wisdom, and majority decisions made about, in the context of this study, the treatment of i-SMI over the last several centuries.

Major Beliefs of the Master Narrative

Foundational to the Master Narrative, according to Lindemann-Nelson (2001), is that it is built upon and presupposes power differentials between groups of people. This, Lindemann-Nelson contends, leads to a widely accepted "story," - an understanding of, assumptions about, and reactions to a particular population or phenomenon - the Master Narrative - that reflects the experiences of those with power vis-a-vis those without. Lindemann-Nelson, however, believes that potentially underneath or running contrary to this prevailing story is another set of experiences entirely - those of the individuals *without* power and agency. This counternarrative emerging from this research will be shared in Chapter 4.

Key Elements of the Master Narrative in this Work

In this study, Foucault’s work on a far-reaching power differential between professional groups (in this context, healthcare providers) and nonprofessional groups (p-SMI) is employed to explore the Master Narrative. Foucault’s assertion is that the dominant social group, healthcare providers, control knowledge, and thus have power over the non-dominant social group, SMI populations. To better situate Foucault’s philosophical positioning on relations of power, Shiner (1982) recommends keeping in mind these questions: “(1) who has power? (2) how is it exercised? (3) what are its effects?” (p. 390).

Landmarks of the Master Narrative

The contention of this work is that the healthcare professional/i-SMI power differential is often thrown into starkest relief within the processes of transitional care. Transitional care, by definition, takes place between settings and providers. The shift from one provider to another or one setting to another is fraught with potential for gaps, communication errors, and adverse outcomes (Fisher & Elnitsky, 2012; M. L. Goldman et al., 2020; Goodrich, Kilbourne, Nord, & Bauer, 2013; Hanrahan et al., 2014; Kathol, Butler, McAlpine, & Kane, 2010; Kraus de Camargo, 2011; Manderscheid & Kathol, 2014; Manderson, Mcmurray, Piraino, & Stolee, 2012; Tomita & Herman, 2015; Weerahandi et al., 2015). The insights that transitional care generates for patients and providers open an incredible opportunity space to best understand the experience of individuals with SMI.

Transitional care has been grounded in and shaped by what this project has identified as two important historical threads that braid together power and knowledge as informing where the p-SMI is situated in terms of agency. First are the ways in which the population suffering from severe mental illness has been physically located and second is the way in which populations suffering from severe mental illness have been defined and re-defined many times over by those in power.

The literature review briefly surveys the sweeping movements of institutionalization and deinstitutionalization (multiple physical locations) and how these have informed the experiences of those suffering from severe mental illness. Stemming from the discussion of this movement comes an examination of the birth of transitional care. Second, it examines the history and iterations of clinical nosology (definition) through the lens of the Diagnostic and Statistical Manual (DSM) of Mental Disorders of the American Psychological Association, which has both crystallized historical understandings of the p-SMI and more recently, permitted new iterations of this understanding.

Foucault begins the section through his explanation of power differentials between individuals seen as "professionals" and those who are non-professionals; in the case of this study, this second group is the severely mentally ill population. The contention of this review of the literature is that these power differentials, coupled with perception of severe mental illness as a religious issue, and then a moral failing, followed by a societal willingness to remove the p-SMI from the environments (albeit imperfect) that had, for better or worse, offered them some protection and structure, shaped the experience and even the reality of the severely mentally ill. They were (and, Foucault asserts, continue to be) subject to these assumptions underpinned by power differentials. For this project, this reality is, in Lindemann-Nelson's terms, the Master Narrative.

First Historical Thread: Institutionalization and Deinstitutionalization

In Foucault's monumental work *History of Madness* (1972), the psychiatric hospital, or asylum of Western society in the 1800s, was distinguished by its social placement (away from everyday life and shared perceptions of a proper existence) and imbued with a moral order of practice (mental illness was seen as a religious issue, a moral deficit). It stood apart both physically and metaphorically from the prevailing perception of a "normal" way of life, and housed societies' deviants as confined criminals, the poor and/or the mentally ill.

Foucault (2009) tells us that within this up-and-coming industrial society, the political economy drove changes and social division of labor. The people who specialized in medicine worked on the cause and effect of deviant human behavior and what was perceived at the time as defective reasoning, to develop the science on mental illness. This led to the birth of institutionalized care, the asylum. Asylums served two purposes: they were a way to remove the individual with SMI from the larger community, protecting that community from what was perceived at the time as the p-SMI's deviance and moral failing, and they were a way to sequester the patient in a setting devoted solely to treatment, with no interference.

And as psychiatry was beginning to branch out from medicine and psychology it supplanted ancient metaphysical perspectives about healing techniques, the natural order of human beings, and the connection between mind and body. Mental illnesses became understood as an ailment of the human soul and framed as a moral issue removed from the larger society, and cemented differential power relations between people with authority and the subnormal or, reference Foucault (1973), "nonprofessional populations" (including perceived deviants, criminals, and mentally ill) peoples as identified by those in power, "professional people" as lacking moral agency for themselves.

From the 19th to the 20th Century, Kessler et al. (2005) suggests there were three prevailing beliefs that drove the migration of p-SMI from the asylum to the community: that the asylum was inhumane, that emerging developments in antipsychotic medications for the severely mentally ill population could prove helpful in their treatment (or cure them entirely), and that a new financial model for engaging with this population was needed.

The belief that asylums were inhumane is discussed by H. H. Goldman, Gattozzi, and Taube (1981), who assert that most state mental institutions began as productive communities that included vocational training, workshops, and medical treatment; some facilities even had farms to supply the food. However, this focus, according to Goldman et al. (1981) shifted around the 19th century when enterprising individuals began selling services to these facilities at a lower cost, taking residents' ability to contribute away and filling their time instead with less meaningful and more sedentary tasks that would leave them unoccupied for much of their days.

The belief that anti-psychotic medications could aid in the treatment of severe mental illnesses began in the 1950s. With their discovery, anti-psychotic medications were thought to be the answer to many issues for the p-SMI, and there was a sense that with these medications, recovery was possible (Kessler, 2005). However, non-compliance with these medications was identified as an issue in p-SMI and found to adversely affect recovery, due to patients' frequent relapses (Lindström & Bingefors, 2000). The mechanisms of these mediations were further homed in the 1960s in order to increase medication compliance to prevent relapse (Davis, Matalon, Watanabe, & Blake, 1994). Relapse remains a severe problem (Haddad, Brain, & Scott, 2014). These medications continue to be used widely to treat severe mental illness, with accompanying research and policy focused on the antipsychotic medication and its administration in p-SMI, as well as advocacy for strategies for encouraging adherence while preventing relapse.

The belief that new financial models were needed in treatment of p-SMI arose in response to shifts in the perception of institutionalization as well as the belief that medication could manage and possibly cure severe mental illness. In 1963, President John F. Kennedy passed the Mental Retardation Facilities and Community Mental Health Centers Construction Act (Kennedy, 1963), which brought 'physical presence' in community care settings, stressing that "custodial mental institutions will be replaced by therapeutic centers (p.1)...the mentally ill and the mentally retarded need no longer be alien to our affections or beyond the help of our communities" (p.2). At the same time, he mobilized the country to address the development of community-based clinics, and rehabilitation programs and managed care. The projected goal was widespread deinstitutionalization by the year 1983 - reducing the number of individuals in institutional settings fifty percent by this time.

With the introduction of Medicaid in 1965, financial supports and funding models for healthcare within the United States began to shift, and treatment for severe mental illness was shaped by this as well. For several subsequent decades, what had been historically State-funded facilities for the p-SMI were closed and these individuals were moved into facilities partially paid for by Medicaid and the federal government. With the 1981 Omnibus Budget Reconciliation Act, federal funding ended for community-based nursing homes serving p-SMI, so that States once again had to fund facilities for the p-SMI, which resulted in underfunded state facilities and private facilities seeking to reduce costs at the expense of care.

These initiatives led to many other initiatives, policies, and continued research. For the purposes of this project, however, psychiatric rehabilitation and the corollary trend of a strong orientation toward recovery, as well as the birth of transitional care, will be highlighted.

Psychiatric rehabilitation and recovery orientation.

Part and parcel to deinstitutionalization has been the practice of psychiatric rehabilitation, rooted in several historical events, tracing back from the 1800s moral therapy era to the inclusion of the psychiatrically disabled into community-supported rehabilitation vocational programs in the 1960s. This progressed into advancement in community mental health settings, the psychosocial rehabilitation movement, and then the development of practical skills training intervention (Anthony & Liberman, 1986). Moral treatment rising from asylum care valued the individual's ability comprehensively, at work and recreation, and underpinned social activities with therapeutic goals. It is important to note that early psychiatric rehabilitation aligned its standpoint with a pathological basis of impairment. Foundational to this was an assumption that individuals with SMI was starting from a place of less-than or deviant to conventional society.

Thankfully, as deinstitutionalization, antipsychotic medication options, and new financial models took hold (all imperfect initiatives themselves, but better than no movement at all) widespread acknowledgement that p-SMI face many barriers began to emerge (Anthony & Liberman, 1986; Morris, 2001). (Perhaps a glimmer of hope within this master narrative.) The response to this was a focus on strength-based philosophies working with the limitations of i-SMI's capabilities, including coping skills training and developing these further in vocational community settings.

The notion of changing one's habits by introducing i-SMI to fresh air, a clean environment, and having things to do, are now central in the contemporary context of recovery care, psychosocial mental health and managed health services (Borthwick et al., 2001; Saifnia, 1984). A 20-year longitudinal study showed P-SMI managed to gain employment and social agency (Anthony & Margules, 1974). Unfortunately, a common language and framework for psychiatric rehabilitation does not exist (Bond & Resnick, 2000). This lack of a shared framework is doubly important, when one considers the centrality of transitional care for these populations, discussed below.

The birth of transitional care.

It is at this juncture in history that how to best care for populations suffering from severe mental illness, now deinstitutionalized and moving from acute to community settings and back again, began to be explored corollary to the psychiatric rehabilitation movement and recovery-oriented care. The rise of the coordination of care across healthcare settings occurred soon after state psychiatric hospital closings which began in the mid-1950s and in the early 60s with the rise of Medicare and outpatient community clinics.

In the 1970s, social work, behavioral health, and health services were the first disciplines to usher in frontline care coordination, between the hospitals and community clinics. The channeling national demonstration project for older adults (see Carcagno, Applebaum, Christianson, Thornton, and Will, 1986) was one such initiative. Also identified during this time was the rise of the "institutional circuit" (Luhrmann, 2016), referred to in the literature as "systemic deinstitutionalization," which ushered in diverse forms of psychiatric (Kendler, 2009), behavioral, primary health and social work practice (Clarke, 1979; Grob, 1983; Gronfein, 1985; L. E. Rose, Mallinson, & Gerson, 2006; S. M. Rose, 1979; V. K. Rose & Thompson, 2012).

Lamb (1995) asserts that transitional care practices foundational to current nursing care coordination models did not evolve from these earlier models *per se,* but highlights their importance to nursing practice. In a review of the literature, Lamb notes that coordination of care for patients suffering from chronic mental illness was most often situated within the disciplines of psychiatry and social work, but that nurses served as principle investigators in this research.

Deinstitutionalization and transitional care for i-SMI's.

Looking at the realities of deinstitutionalization, Stein and Test (1976; 1980) (mentioned in Chapter 1) realized, that, without continuity of care and comprehensive programs in place "patients [*are*] on the brink of rehospitalizations" (Stein & Test, 1980a, p. 410), in effect redistributing the social economic burden on families and the need for more community resources (Stein & Test, 1980b).

To address this, psychiatrists Stein and Test (1980) identified six Functional Requirement areas for community settings lacking mental health care service bridging protocols in the care of i-SMI, because "[a]bsences of one or more of these factors leads to a tenuous community adjustment that keeps patients on the brink of rehospitalization" (Stein & Test, 1980, p.393). Stein and Test were most interested in psychosocial rehabilitation, which led them to design the Assertive Community Care (ACT) model. The (ACT) model contains the following functional requirements (FR's): (1) material resources such as food, shelter, clothing, and medical care, (2) coping skills to meet the demands of community life, (3) motivation to preserve and remain involved in life, (4) freedom from pathologically dependent relationships, (5) support and education of community members who are involved with patients, and (6) a supportive system that *assertively* (Stein and Test's emphasis) helps the patient with the previous five requirements.

Critical Time Interventions.

Sein and Test were among the first to argue that Critical Time Interventions (CTI) in the care of i-SMI are foundational. The Critical time frame in (brief) B-CTI model (Dixon et al., 2009) is 6 months and the main concerns are to prevent patient relapse within 30 days post discharge and prevent treatment dropout. In this intervention, a multidisciplinary team incorporates the concept of Assertiveness by combining some of Stein and Test's Functional Requirements as listed above, and tailoring Functional elements as they are listed below according to the teams' collective knowledge base and timeframe of transitional care; (1) medical care, (2) psychoeducation about mental illness symptoms and medication, (3) follow-up appointment scheduling, and (4) support from psychiatric outpatient hospital services and primary care. Dixon et al. argue that by extending the traditional 3-month follow-up to 6 months borrowed the 'bridging-point-of-entry' hospital discharge planning techniques to establish patients' correlation between understanding how to manage their symptoms and to begin making connections with community services.

The Critical time frame in Herman's (2013) (long) L-CTI model is 9 months and the two main concerns are identical to B-CTI (Dixon et al., 2009) except for extending therapeutic dyadic-relational concepts which are grounded in psychoanalytic therapies. In this instance, the L-CTI intervention includes all FR items from Stein and Test (1980) by exploring the patient's real-time experiences in their Assertiveness training development during their transition from hospital to community and home. Although the time frame is longer than B-CTI, it is considered a less intensive application of Stein and Test's (1980) FR's within a 14-month intervention.

The L-LCT intervention manages the work of the 6 FRs of Stein and Test's (1980) model by creating a bridging-point-of-entry strategy in three phases, *transition to community* (1-3 months), *tryout* (4-6 months), and *transfer of care* (7-9 months) in order to develop a relationship between the social case worker (CTI) and their client/outpatient and understandings of the structuring of Transition processes.

In the Transition to Community phase, the CTI begins to form a relationship with the patient prior to discharge in the acute setting. After discharge the CTI worker's activities are; follow-up face-to-face home visits, accompanying patient/client to health appointments, and conflict mediation between clients and caregivers, client and case managers and other service providers. In the Tryout phase, the CTI worker facilitates the client's problem-solving skills. The role of the CTI worker shifts from the hands-on approach to observing the activities of the client and initiates the client's *in-vivo* experiences. Mediation is offered by the CTI worker during the client's confusing experiences only when necessary instilling Assertiveness. During this phase, the client practices life skills in situ at their place of residence. The final phase Transfer of Care, the CTI worker prepares to end the relationship while long-term planning is set up and the supported network is in place. The relationship ends with a symbolic celebration party, reaffirming the Assertiveness training.

Important to note for the specifics of this project, central to service-defined recovery has been the clinical direction, typically defined by hospital discharge and providers' organizational strategies and health professionals' services (Davidson & Roe, 2007). This is seen by some scholars as a deficit-oriented service protocol, focused on stabilizing side effects with medication management, and risk management such as relapse prevention (Le Boutillier et al., 2015; Mechanic & Olfson, 2016).

Perhaps indicative of the power differential that underpins the master narrative traced here in the review of literature for this project, there is an emerging concern regarding the coercion of i-SMI participants in ACT recovery-oriented services, due to relationship-based forms of power over controlling p-SMI consumers (Angell & Bolden, 2016). Contributing factors have been identified that are linked solely to clinical assumptions, such as reducing hospital readmission with medication compliance, which may be in stark contrast to the way p-SMI are trying to adjust in their day-to-day lives, as well as during transitions (Watts & Priebe, 2002). Under these circumstances, without the voice of the i-SMI, assumptions are made, and clinical expectations of this population perpetuate these individuals' marginalization and institutional discrimination (Onken, Craig, Ridgway, Ralph, & Cook, 2007).

Manifestation of the metanarrative in the first historical thread.

The manifestation of the metanarrative in this first thread, the migration of p-SMI from institutionalization in asylums to deinstitutionalized settings within the community more oriented toward "recovery," underpins the i-SMI's experience and reality. As the above discussion demonstrates, decisions have historically been made by Foucault's "professionals" about "non-professionals," the p-SMI. Of course, these decisions have their grounding in more ethical treatment of the p-SMI, but at the same time they seek "recovery" for this population – without these individuals' input – and have been shaped by the healthcare system's responses to financial constraints.

The first thread of the metanarrative described runs corollary to and is informed by a long-standing tool used to define and re-define the i-SMI over the last several decades, the Diagnostic and Statistical Manual of Mental Disorders by the American Psychological Association, or DSM. These definitions have served as a crystallization of the p-SMI and who they are – a one-sided process that some would assert stretches back decades.

Second Historical Thread: The DSM

As mentioned in the sections above, the DSM has served as the tool for defining and identifying severe mental illness in the United States since 1952 and even before (Surís, Holliday, & North, 2016; Wilson, 1993). In a seminal article, Wilson (1993) reminds us, that, the in the 1970s the DSM-III had not clearly distinguished the mentally well from the mentally ill, shifts to a research-based approach and narrow clinical perspectives. Wilson, examining the mainstream view of psychiatry notes the profound changes that accompanied DSM-III:

> There are three interrelated ways in which the psychiatric gaze has been narrowed. First, there has been the loss of the concept of the mind, a loss of the concept of the unconscious. We are now teaching our residents to focus on the superficial and publicly visible. Second, the consideration of time has become sharply limited. The biopsychosocial point of view, within which I include psychoanalysis and Meyerian psychobiology, emphasized the unfolding of a life over time—the development of the person and the place of his or her symptoms within this development. Finally, and most importantly….personality and the ongoing development of character, unconscious conflict, transference, family dynamics, and social factors are aspects of a clinical case that are deemphasized, while the careful description of symptoms is often taken to be adequate or even proper assessment of the patient (Wilson, 1993, p. 408).

As noted at the outset of the literature review, the DSM was highlighted as an historical thread of the metanarrative. It has informed the treatment of the p-SMI because it has put forth a clinical definition of these individuals, re-defining them again and again over time without their input, which Foucault would tell us comes with its own troubling power differentials. This is important to note because these definitions are a fundamental driver of the working understanding of mental illness, part of clinical perception, shapes policy such as insurance reimbursement, and informs transitional care. And, as Wilson asserts in the quote above, the narrowing reflecting in the DSM-III labeling process potentially distorts the story of the person experiencing SMI.

Prior to DSM III, there was a connection acknowledged between the p-SMI's diagnosis and experience. At DSM-III and after, this connection was no longer acknowledged. The most current iteration, DSM-V, has been built upon international collaboration, but troubling aspects remain, explained in more depth below. While progress toward better understanding these populations has been made, there remains a lack of insight into the i-SMI's experience.

Here in the United States, the broad definition of the *severely mentally ill* population used for policy making and operationalizing clinical practice is:

> Adults aged 18 or older who currently or at any time in the past year have had a diagnosable mental, behavioral, or emotional disorder (excluding developmental and substance use disorders) of sufficient duration to meet diagnostic criteria specified within the diagnostic statistical standard manual (DSM-IV) (APA, 1994[1]) that has resulted in severe functional impairment, which substantially interferes with or limits one or more major life activities (Substance Abuse and Mental Health Services Administration, 2014).

The broad working definition above has its roots in DSM-III (Goldman & Grob, 2006; Grob, 1983; Mechanic, 1987). However, early 20th century definitions (see footnote on Dilthey) [2], pre-dating DSM-III, were grounded in the assertion that agency, phenomenology, and experience *must* remain central to how we understand mental illness, in that, agency is central – as life unfolds, the patient's psychological space is validated through self-conscious "reflexive awareness…of reality and time (Dilthey, 2002, p. 214). Integral to this is what Dilthey refers to as the interplay of "agency and suffering, of action and reaction" (p. 219). For Dilthey, "agency" is interwoven with the social world phenomenologically, forming the basis for understanding what an individual internalizes, what Dilthey refers to as "poetic mood" (p. 157) and a connection to one's physical body.

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[1] https://www.psychiatrictimes.com/view/what-you-need-know-about-dsm-5-and-icd-10-cm

[2] Dilthey's 1910 writings, on *The Formation of the Historical World in the Human Sciences* [including William James (1890) *The Principles of Psychology*] pertain to a holistic 'phenomenological' attitude of human experience which provided a framework of understanding during the 1920s and, 1955 DSM-I and, excluded in the 1970s of the DSM-III edition. However, DSM-III made it possible to classify mental disorders (psychiatric nosology), to quickly diagnose/isolate patients' experiences by symptomology by introducing the 5 levels of an Axial taxonomy related to various observed behaviors, e.g. neurological, e.g. biological, to select and evaluate from. See http://www.psyweb.com/DSM_IV/jsp/dsm_iv.jsp for the "Multiaxial System of Diagnosis" in DSM-IV.

The perception of people with SMI post DSM-III externalizes the patients' symptomatic conditions and thus does nothing to ameliorate the individual with SMI "lived" phenomena nor facilitate their agency or awareness (Finlay, 2011; James, 1890).

The current edition, the DSM-V continues to evolve in cooperation with the World Health Organization (Regier, Narrow, Kuhl, & Kupfer, 2009; Reiger, Kuhl, & Kupfer, 2013). Earle (2014) and Raabe (2014) argue that DSM-V nosology used in practice today still varies widely, and as patients are transitioned across settings and providers, this proves problematic. The variation exits because practitioners who assess and evaluate the cause and effect of p-SMI's symptomatic conditions could dismiss or are unaware of their personal experiences. The connection that Dilthey (1910) was so focused on maintaining perhaps remains unclear.

However, while there are alternate definitions emerging, there is no telling whether they will inform the DSM's design in the future. One such area of hopeful new insight is arising from the neurosciences – specifically within research that maps out brain functions (Craffert, 2014; Kandel, 2005; Passingham, 2013). For this insight to be useful, it would need to be carried over into practice, by understanding philosophy of mind (Gallagher & Zahavi, 2008; Varela, Thompson, & Rosch, 1993), restoring phenomenology to psychiatry (J. Parnas & Gallagher, 2015; J. Parnas et al., 2013) and thus welcoming the fact that human experience is shaped by the physical environment (Albright, 2015; Farling, 2015; V. Gallese & Gattara, 2015; Pérez-Gómez, 2015, 2016a)

As mentioned above, a shared definition of the characteristics of the p-SMI and their experiences, needs, and wants does not exist in the DSM yet. Without a formalized, shared sense severe mental illness and those suffering from these chronic conditions, as patients are transitioned across settings and providers, insights and best practices could be lost or remain unknown, hindering the efficacy of transitional care for these populations.

Manifestation of the metanarrative in the second historical thread.

The manifestation of the metanarrative in this second thread is grounded in the way Foucault's "professionals" define and re-define the "non-professionals,' in the case of this project, the p-SMI. Pre-DSM III, Dilthey (1910) supported an assumption foundational to understanding the p-SMI and defining their illness: consider their agency, their phenomenological relationship to the world, and their personal experience. DSM-III, however, removed this assumption replacing it with a reductionistic perspective, focusing on symptoms and lacking a holistic view of the individual, their agency, their relationship to the world, and their experience (Finlay, 2011; James, 1890). DSM-V offers hope, but there remains a lack of formalized terminology that again endangers a definition and re-definition of the p-SMI that is not holistic.

Conclusion

The contention of this literature review is that the metanarrative around transitional care for individuals with SMI has manifested most clearly in two selected historical threads: the choices made about the physical location of the p-SMI and the ways in which these individuals are defined – both the result of a far-reaching power differential between Foucault's "professionals" and "non-professionals," the i-SMI. Within this environment transitional care came into being and was and continues to be iterated by healthcare professionals seeking to most effectively treat the p-SMI.

What the metanarrative does not permit us to see is that locating and defining the individual with a severe mental illness involves a perpetual conversation between provider and individual in addressing the patient's mental problems in various specialty therapeutic settings, which correlate cognitive, social, cultural, biological, neurological, behavioral, mood affect and emotional experiences (Scheid & Brown, 2009).

As a result, there can be various interpretations that dictate where, when, and how a patient is treated and how that individual is diagnosed or defined. These decisions affect health policy terms and definitions and inform the transitions between psychiatric care and community health care services. Such interpretations may not align with an individual's underlying self-defining needs (American Psychological Association, 2009). The National Alliance on Mental Illness (NAMI) takes a grassroots approach and encourages SMI individuals and family members to respond to clinicians, with "what it means to have a mental illness" (McLean, 2017, para 1) based on their own lived experiences,

> No two days are the same, nor is each person's experience. Beyond the clinical classification…there is the personal experience that shapes the life of someone who is affected by these [complicated] conditions (McLean, 2017, para 3).

Chapter 3

METHODOLOGY

Introduction

In order to explore the i-SMI's experience of space, i.e., "architecture from within" and "architecture from without," this project employed a methodology rooted in basic qualitative analysis, largely as framed by Corbin and Strauss (2015a). This approach, informed by the useful aspects of analytic methods used by those developing Grounded Theory, was used to identify the nature of participants' experience, resulting in the choice of Narrative Repair theory (Lindemann-Nelson, 2001) to code and analyze participant interviews. Additional sensitizing concepts were used to guide the inquiry. These sensitizing concepts effectively identify the epistemological assumptions, and were introduced in Chapter 1, and will be fleshed out here, including Husserl's *Homeworld,* as a reminder to maintain an awareness for data that speaks to the tentative interplay between mind-body and person-environment, to help better understand the i-SMI's conception of space. This chapter begins with an in-depth treatment of the sensitizing concepts introduced in Chapter 1 and how they will be used in this work, followed by a discussion of Narrative Repair, situated within the framework of Narratology, that will drive the final analysis of the data. Following these are the specifics of the research design.

Sensitizing Concepts

In keeping with Blumer's *symbolic interactionism,* the use of sensitizing concepts in emergent social research "gives the user a general sense of reference and guidance in approaching empirical instances" (Blumer, 1954, p. 7).

The sensitizing concepts I have chosen below helped to frame a form of thinking iteratively, as I move between philosophical and interdisciplinary perspectives in the context of this work. The sensitizing concepts presented immediately below guided my focus as I worked to understand the care transition experience, the needs, and the interaction with space of the individual with severe mental illness with whom I spoke - they sensitized me to the phenomena they were describing, to the lived experience of their stories. As mentioned in Chapter 1, the five sensitizing concepts for this project are derived from my own thinking, often considered *tacit knowledge* in qualitative research, including my synthesis of aligned architectural and philosophical work, and follow the influence of David Herman (2013) and Arthur Frank (2010) in pursuing a transdisciplinary approach in social-narrative research. Clearly articulating the sensitizing concepts in many ways sensitize the researcher to the data, and work to prevent projection of personal opinions or preferences onto the words of the research participants.

Homeworld. The overarching sensitizing concept used in this project is that of Husserl's *Homeworld*. Husserl saw Homeworld as the coming together of the phenomenological concepts of *lifeworld* and *natural attitude*: *Lifeworld* is understood as an experienced world of meaning, and *natural attitude* is related to our unconscious acceptance of day-to-day experiences. Homeworld combines the *lifeworld* and *natural attitude* on a personal scale (Beyer, 2018; Luft, 2002). As cited in Seamon (2017): "…there is only a people-world entwinement and co-mingling whereby what is conventionally understood as two—person/world, people/environment, subject/object—is existentially realized as one—people-immersed-in-world" (p.2). As a means to specify this lived people-world connectedness, Homeworld is a valuable sensitizing concept to this project because it guided me to remember to seek and spotlight those things that are often taken for granted in the i-SMI's experience, what the literature identifies as those things for a particular population that goes unnoticed and often remain hidden as phenomena (Finlay, 2011; Seamon, 2013; Van Manen, 2007).

As mentioned in Chapter 1, *Homeworld* as a sensitizing concept could be understood as a sort of basket, collecting the i-SMI's narrative through the two fundamental phenomenological couplings of mind-body and person-environment, and of their unfolding within, *genius- loci*, *ekistics*, *attunement,* and *επιμέλεια ευατοΰ*.

Genius loci. According to D. Herman (2009), in literary theory, *genius loci* is about the individual's experiences in space and time. The narrative serves as a container of sorts, filled with rich descriptions created in myth and legend and oral tradition that preserve "spirit" of place, what Romans called *genius loci* (Huhn et al. 2014, p. 934). The central idea [in genius loci]— "an emergent property that in some way is related to how 'places' function socially, ecologically and aesthetically" (Thompson 2003, p.69) enhances some characteristic of the human condition.

The seminal work by Norberg-Schulz (1979), introduces a theory of *genius loci* which understands architecture in concrete, experientially based, phenomenological terms. According to Otero-Pailos (2007)*,* Norberg-Schulz's re-framing of architecture allows us to re-engage with our civilization, the poetic meaning of space, and imbue a 'sense of spirit' in that space. Hence, architects can "build" phenomenologically - identifying inherent patterns of inhabitants and others engaging with the space, while acknowledging the characteristics of the spirit of place, bridging design principles in the making of a space. This would come to be important in listening to the stories of participants describing their transition of care experiences.

Ekistics. The work by anthropologist, architect, urban planner, and engineer, Doxiadis takes an ecological approach in designing an optimal physical environment improving the quality of human settlements (C. A. Doxiadis, 1970b). The science of

Ekistics is an epistemology aimed at achieving harmony between the inhabitants of a settlement and their physical and socio-cultural environments (Bromley, 2003). Doxiades' five principles: Nature, Anthropos [Greek term for a human being, for our purposes individuals with SMI], Society, Shells [typology of building structures] and Networks [ranging from roads to telecommunications] create a conceptual framework for *oikizio* [οἰκοζω], the Greek term for creating a settlement via transdisciplinary work to arrive at "a proper conception and implementation of the facts, concepts, and ideas related to human settlement" (Theodosis, 2016, p. 251). In this respect, Theodosis (2016) summarizes that "*ekistics* was conceived as a holistic science (both descriptive and prescriptive) system that would manage and eventually synthesize other systems" (p. 253). Ekistics as a sensitizing concept helped me to remember to inquire and listen for evidence of the way participants discussed elements of their physical and socio-cultural environments, as indicators of how they were expressing the nature of their experience.

Loukaki (2014) traces the Hellenistic attitude towards "urban sensuousness and the city as an organic and participatory possibility of wholeness" (p. 196) back to Aristotle's teleological notion of *evdiamonia* [ευδαιμονία], the Greek term for human flourishing, which underpins both the cultural disposition of a population and the concept of optimizing human flourishing in Doxiadis' Ekistics framework. Beginning with the base unit to the scalable, (i.e., from individual to the needs of a population) and understanding the potentiality of human flourishing, Doxiadis (1970, 1972) produces four guiding principles for addressing the optimizing of space for a population, what he calls "the potentiality of space" (Doxiades, 1972, p. 4). These define an individual's orientation, contact with wildlife and features of nature and developing the senses, the efficacy of time and economic effort, in terms of resources that are required to achieve the individual's potentiality, the protective space in which the proximal social and physical dimensions are realized without causing any kind of sensory or psychological discomfort and the quality of the individual's relationships in contact with the proximal environmental dimensions (both physical and social).

Doxiadis (1966, 1970, 1972) claims that the fourth principle leads to an optimal synthesis (political which informs art and architecture - the individual's aesthetic experience, responses, attitudes, and emotions). However, because of population growth, the combination of the depletion of natural resources, and the increase in technological achievements, a high-level complexity has resulted. Doxiades embraces urban evolution, envisioning that each major city could grow into an immense network of world-wide-urban sprawl, what he referred to as *ecumenopolis*. He calls out for transdisciplinary intervention to address this sprawl, to evaluate the components that impact systems in keeping with the individual's scalable needs optimization (Bromley, 2003; C. Doxiadis, 1966; C. A. Doxiadis, Papaioannou, & Oikistikes, 1974; Loukaki, 2014; Theodosis, 2016). Doxiades' assertions align with my own, in calling for a transdisciplinary conversation in the care for the i-SMI, and addressing the requirements of physical space, as well.

Attunement. Pérez-Gómez' (2016a) groundbreaking work in attunement brings to light that historically, "architecture was responsible for circumscribing social life and establishing limits within which one could place oneself" (p. 5). He focuses on the contemporary problems facing the practice of architecture, the drive to enhance human values and capacities, including expression of spirituality. However, he acknowledges that these are complicated because technologies alter the way we communicate with each other and experience spaces. These problems that Pérez-Gómez highlights, coupled with Dioxiadis' assertions about technology and complexity, have helped me to unpack the elimination of spaces [also eliminate aspects of social opportunity] for the i-SMI, who are often in a state of transition. This, to me, is also the phenomenon of the absence of place, reminiscent of Foucault's (1963, 1972) discussion of deinstitutionalization found in Chapter Two's literature review.

Returning to Pérez-Gómez and attunement, meaning is central to our psychosomatic health (Kirmayer, 1992) and in relationship with our environment from which we derive our sensibilities (Hinton, Howes, & Kirmayer, 2008; Robinson, 2015). Both are vital to human existence and irreducible. Attunement then, as understood for this project, is both a neurological and a phenomenological phenomenon (Fuchs, 2012b; V. Gallese, 2015; V. Gallese & Gattara, 2015; Heidegger, 1971, 1977; Merleau-Ponty, 2014b), that architecture is able to trigger with empathy for an individual or population — in this case individuals with SMI, regarding atmosphere and mood (Bille, Bjerregaard, & Sørensen, 2015; Havik & Van Haeren, 2017; Pallasmaa, 2007, 2016; Pérez-Gómez, 2011; Stewart, 2011).

Επιμέλεια εvατοΰ [***epimēleia heatou***]. Translated from the Greek as care of oneself, this concept is a famous Platonic and Aristotelian assertion that via reflection, we can know ourselves and thus take care of the self. Foucault (2005) traces its spectrum of meaning grounded in Hellenistic philosophy. Meaning — is a way of cultivating an individual's agency arising from a systematic way of behaving in the world, a form of paying attention (*επι* [epi], in terms of knowing and taking action) to one's interactions with the world and informed by a personal internal system (*μελετέ* [melete], in terms of exercising and meditating), which leads to morality and spirituality unique to each individual, which then leads to the agency of that individual. From a phenomenological hermeneutic perspective, Foucault's analysis of Plato's work focuses on the importance of developing personal 'techniques' that lead to agency, which for the purposes of this project, inform the construction of space with and for the i-SMI.

Summary

The sensitizing concepts for this study come from architecture and Western and Greek philosophy, spanning centuries of thinking about the relationship between people, their environments, their well-being, and healing. Husserl's *Homeworld* helps us to uncover that which may remain hidden in the day-to-day lives of individuals, which may be taken for granted, or missed. The ancient concept *Genius loci*, along with Dioxiades' *Ekistics* and Pérez-Gómez' *Attunement* highlight the importance of surroundings, not just physical but also spiritual, emotional, and aesthetic. The above three sensitizing concepts triangulate the possibility that healing happens both through external environments and in our relationship to them as well as through internal, personal processes. Foundational to these concepts is an assumption that agency is important to the healing process, as are the unique needs of the individual, which, when prompted, they can identify. For the purposes of this work, this reflected most directly in the assertion of the final sensitizing concept *Επιμέλεια ευατοῧ* [*epimēleia heatou*]*,* the development of personal strategies that lead us toward healing, unique to each person. These were chosen to ground my approach to transitional care for individuals with SMI because they permit a triangulation of that which surrounds and is internal to the i-SMI and primes me to look at them as individuals in contexts of agency and strategies for healing.

Methodology

As mentioned above, I chose to apply Narrative Repair theory as conceptualized by Hilde Lindemann-Nelson (2001). This theory was selected as a way to examine the stories of individuals with severe mental illness, juxtaposing them against the Master Narrative and seeking to uncover what Lindemann Nelson calls the Counterstory (p. 6) if one exists. This narratological approach to the analysis of the data will be described first, followed by discussion of several of the key decisions influencing its application in this research, as well as possible challenges of the methodology.

What is Narratology?

Narrative Repair is situated within Narratology. The science of narratology is a systematic study of the narrative, which is constituted by actions and discourse that organizes these actions linguistically (Todorov & Weinstein, 1969). In practice, the critical position in studying the structure of narrative moves back and forth between theoretical and descriptive attitudes. As Todorov and Weinstein (1969) assert, this is not accomplished by pure description nor by its interpretation but to, establish "a hierarchy of order" that coincides with the tenets of literary theory (see Kindt & Müller, 2003; Todorov, Moss, & Braunrot, 1973; Todorov & Weinstein, 1969). For example, Propp's (1928) systematic study of Russian folktales found that clusters of actions defined the character's identity or the stereotyped social role (e.g., the hero) and Genette's (1988) narrative structure reveals the multiple ways in which a character theoretically choose to tell a story (Barry, 2009).

What are the goals of narratology?

Narratology as methodology seeks to understand individuals' stories – not simply how they are written or spoken, but what they actually contain, and how these constitutive parts of the story work together to frame experience. The objective of this dissertation was to analyze the stories of the participants in order to identify the possibility of dominant or master narratives. A Master narrative provides the framing of storied experience to guide people to the consideration of what is often considered to be the "real story."

Lindemann Nelson (2001) is concerned with the way that the existence of master narratives can cause what she calls "narrative injury," whereby the quality of one's subjective and lived experience is harmed by the limiting framing power of the master narrative. The value of her theoretical methodology is that it asks that the researcher listen to the story in its complete form, analyzed in all its perceived imperfections or possible incoherencies – acknowledging that there are often underlying "counterstories" (Lindemann-Nelson, 2001), provided by subjects, buried beneath, around, and perhaps within the Master Story itself. Once these counterstories are uncovered, it is the job of the researcher, working with the storyteller, to unseat the master story, and to uncover the counterstory, unique to that individual, through what Lindemann-Nelson (2001) refers to as "narrative repair." It was the objective of this dissertation to determine if there exists potential for such narrative repair within the stories of individuals with SMI.

By identifying the narrative structure, this project seeks to identify a counter story, should one exist, that could function to unseat this population's marginalized social position through analysis using narrative repair theory (Lindemann-Nelson, 2001). Hence, individuals with SMI as speakers themselves have a unique position, full of potential, both as storytellers and the main character in the story. By identifying the counterstories implied in the existing stories of SMI individuals, therapeutic workers and professionals might be able to approach the management and provision of transitional care in ways that do not cause narrative injury in service to existing master narratives.

Tracing the historical assertions of narratology: Characters' actions organize narratives.

The following section will now describe special considerations taken in the narratological analysis of the data gathered through interviews with i-SMI research participants.

Aristotle's *poetics* and *rhetoric* grounds narratology. The actions of the protagonist, or main character, organize a three-part-plot sequence: the beginning reveals the trouble that the protagonist finds himself or herself in, the middle is about self-realization, and the narrative's ending is about turning their misfortune around; thus they transform themselves. However, inside the protagonist's space, the sphere of transformation — a cluster of mechanisms cultivate his or her own freedoms. Germane to this work, in particular, often a theme in this sphere is the individual's own human nature as influencing his or her agency and awareness of morality, which may be in conflict with social groups, and as well as economic and political systems (Barry, 2009; Hoffe, 2003).

In Propp's (1928) exploration of Russian folktales, the analysis of narrative function builds on Aristotle's initial thinking, and is more complicated: the characters in the tale each have an individual "sphere of actions" (pp. 79-80) or stereotypical behaviors that play an important role in what determines the narrative sequence in which the main character's troubles are experienced in a variety of ways. After introducing the main character, in the beginning, the folktale's middle part can then take on many forms which shape the main character's transformations, such as the villain, the false hero, the enabler or the helper and how they interact with the protagonist's situation(s) along with its linear format until the ending — often leading to a moral message.

Aristotle and Propp have informed the way readers have come to a formal understanding of the character's intuitive actions and knowledge, as they have strongly colored what constitutes a competent form of communication through a logical paradigmatic and formal plot, character typology and the resulting expected actions (Barry, 2009; Frank, 2010; D. Herman, 2009). Often highly prescriptive, these traditional narrative elements are a foundational part of what formulate overarching and pervasive metanarratives. For the purposes of this project, these are akin to Lindemann-Nelson's (2001) understanding of the Master Story.

In the context of this work, using narrative repair theory in revealing the experience of transitional care for the individual with SMI is grounded in one key question: *What happens if the character is severely mentally ill and has a different narrative form of sequencing?*

Genette's (1988) groundbreaking work is about how stories are told, specifically about the contrast between *mimesis*, the parts of the narrative where the speaker's direct speech describes or dramatizes the performance about their actions of a situation, and *diegesis,* the other parts of the narrative in which the speaker tells or links the information about what happens rather than showing as it happens (Barry, 2009; Vittorio Gallese, 2009). How stories are told highlights a character's perspective, which reveals the personal history and the possibility of telling it from someone else's perspective, or using flashbacks and flash forwarding scenarios though time, or even a story within a story that includes one's 'mood' and unique choice of words (Barry, 2009; G. Genette, Ben-Ari, & McHale, 1990).

Patients can attempt to mimic life in emergent sense-making stories (Mattingly, 2000) which tentatively reveal the speaker's underrepresented narratives as *small stories* (Georgakopoulou, 2006), and whether stories are literally seen and understood by the individual (e.g., descriptions of traumatic experiences) as a series of visual images (Grossman, 2002; Hoffman, 2012, 2013). In the context of this work, these often are expressed as cultural-based idioms of the body and mind during clinical encounters (Kirmayer, 2000, 2006), or to serve as narrative identifying (Frank 2010, pp. 48-49), a speaker's process for interweaving identity and in a story that teaches the individual with SMI who they are, in relationship to the community at large.

These "small stories" are important and must be teased out and explored, as they are often representative of a power differential, be addressed. According to Luhrmann (2001), "When psychotherapists tell stories, they are learning to explain the way people in the story relate. Telling the story well demonstrates mastery" (p. 7). Kirmayer (2000) offers additional insight: during the health professional-patient encounter, there is a social power differential, which informs interpretation. For the health professional, the interpretative aim is "to subdue, or settle the issue, seeking coherence" and norms, and for the patient "to break through, seeking relief" (p. 175).

Lindemann-Nelson (2001) argues within her framework of Narrative Repair that to "re moralize" an individual's oppressed state of personal agency is to restore their identity with the telling of what she refers to as a "counterstory" — *told for the purpose of resisting a socially shared narrative that purports to justify the oppression of a social group* (Lindemann 2015, p. 98). In the context of this work, identifying the existence of a counterstory is a deep analysis of interviews uncovering the experience of the i-SMI, in their verbal descriptions of experience, or "stories."

Following is an exemplar of existing literature to demonstrate how such a narratological analysis employing the theory of Narrative Repair (Lindemann Nelson, 2001) might operate. Let us examine the groundbreaking autobiography by Beers (1908), *A Mind that Found Itself*, eventually accepted by the psychiatric community and served to champion the Mental Hygiene Movement in the early 1900s in the United States and Canada. Beers' experience brought public health awareness and oversight of practice therapeutics' and new standards, such as pre-screening methods and make improvements to treatment services in mental hospital environments (Grob, 1983; Parry, 2010; White, 1930).

Beers' personal experience brought insight that one could recover from a mental illness, and his account served as a source of research for prominent psychologists and psychiatrists predating the DSM-III era, such as William James and Adolph Meyer. From a psychobiological standpoint, they concluded: "the environment as a whole—within the institution and without—influenced the psychology of the individual" (Arias, 2015, p. 21).

However, Beers' autobiography is *not* representative of the success of the counterstory in changing the mindset of care oriented to *the art of living* (White, 1930) as Beers had envisioned for SMI populations. Sadly, Beers himself had a relapse of severe depression and suffered without treatment which contributed to a short life (Arias, 2015).

When an individual identifies him/herself with a group, the individual will adopt the group's goals and attitudes, creating a safe social niche (McAdams, 2015). In populations of the severely mentally ill, this adoption often is aligned with what the individual with SMI may *think* is perceived by the larger society as "normal." Luhrmann (2007) argues this does nothing to ameliorate the conditions of the P-SMI's social experience and the experience of the illness itself, referring to what the individuals with SMI experience as "social defeat" (Luhrmann & Marrow, 2016, p. 202). The negative beliefs of society about individuals with SMI affect their social experience – psychosomatic responses result due to social defeat, adversely affecting the body and brain, potentially making their psychosis worse, and leading to cycling in the "institutional circuit" (Luhrmann, 2016, p. 153).

Lindemann-Nelson's work (2001) would suggest that narrative repair is the only way to address the i-SMI's tendency to hide behind accepted metanarratives, which may contain oppressive societal norms and practices that adversely affect the i-SMI's ability to progress on the journey to recovery. For a counterstory to unseat the master narrative it must be able to repair the patient's identity in a therapeutic space and as well as change the way care is operationalized — these reparative keys are located in the subject's stories and provided by themselves.

In sum, narratology provides an epistemological approach that allows the analysis of subjects' stories that can help identify any character transformations as indicated as stories order characters in space and time and present a format for examining character transformations (Barry, 2009; Todorov, 1971). The sequential development of the narrator's experience and the speaker's position in the narrative reveal his or her identity, giving the project insight into the SMI individual's lifeworld (recall Husserl from Chapters One and Two). Guided by sensitizing concepts to identify core aspects of the subjects' environmental or ecological experience in transitional care, the theory of narrative repair (Lindemann-Nelson, 2001), then, not only enables this study to explore the i-SMI's experience but to hear the multiple levels of the stories within that could lead to suggested transformations in the care of the i-SMI.

Qualitative Research Design

Purposive sampling. A non-random, purposive sample of individuals with SMI best provided the insight into the complexity of being mentally ill and as well the potential for making improvements in this population's experience of transitional care. These individuals holding this experience, are considered representatives of phenomena which this research study seeks to explore.

Sample selection and inclusion criteria. The study's participant sample consisted of five individuals with SMI between 18 to 50 years, discharged to the community from a psychiatric hospital whose experiences and insights would address the research questions about transitional care. For this study, discharge to the community is in the prior 3 and 6 months.

This sample included participants with a likely diagnosis of schizophrenia, depression, or anxiety and who were capable of making decisions on their own, as determined by the discharge care team coordinating services for their outpatient clientele associated with the clinic. Out of concern to reduce psychological risk, this study followed a safeguarding protocol (Koivisto, Sirpa, Eila, & Leena, 2001), which allowed the participants to have their caregivers present for emotional support during the interviews.

Exclusion criteria. Non-participants were considered outpatients who have developmental conditions (i.e., mental retardation) or are undergoing treatment for substance abuse. Mental health outpatients with developmental and substance use disorders were not considered as part of the population with SMI based on the clinical criteria established in the broad working definition for people with SMI as defined in the Federal Register (1993, pp. 29422-29425) and the revised clinical criteria of the Federal Register (2010, pp. 71632-71635). Non-participants are also the professional caregivers that were present during the interviews.

Sample size. Because of the intense work of the study, a small sample of five individuals with SMI was sought and considered sufficient to provide the depth and breadth of the phenomenon. For this dissertation, the generation of raw data from a sample of five participants, and subsequent analytical processes was considered sufficient for single researcher management.

Setting. The interviews were conducted in two outpatient clinics, which are in a large urban area in the southwestern US. The clinics are under the administration of one recovery facility.

Interview length. The exploratory work involved two interviews: the initial interview explored participants' experiences in the context of transitional care, and the second interview involved Peer Debriefing, no more than one month after the first interview that took place with each participant. The duration of these interviews was approximately one hour.

Recruitment procedures and methods. This work began by introducing the research project to the administrative decision-makers. First, a formal letter was electronically delivered to introduce the project and myself. Next, an exchange of telephone calls ensued to discuss more details of the study and to set up face-to-face meetings with the CEO and staff. The organization did not have its institutional review board (IRB); therefore, Arizona State University's IRB reviewed the protocol of this study.

Ethical concerns. After reviewing the literature regarding ethical concerns in the recruitment of people with mental illnesses as research participants, I chose to follow Koivisto, Janhonen, Latvala and Visanen's (2001) safeguarding recommendations; (1) researchers should establish a connection with the mental health organization's care coordination team, and (2) researchers should be sensitive to participants' verbal and non-verbal signs of discomfort during the interviews. I began corresponding with the leadership of the recovery center, first to introduce myself and the research proposal. Next, I set up a meeting to present the project to the staff members. This helped me establish a working relationship with the staff and to develop the *Information Letter* (see Appendix B) and align the safeguarding items as mentioned by Koivisto et al. (2001) above.

Initially, my recruiting protocol was a two-step process: (1) screen the potential participants via telephone, and (2) arrange to meet with them at the clinic. However, following my successful meetings with the CEO and staff, we developed a more effective, patient-focused recruitment strategy: the discharge team would identify potential participants who were assessed as being able to make their own decisions. The team would then introduce the *Information Letter* and go over the details of the project with their clients (potential participants). The discharge team members also volunteered to help me schedule the interviews at the clinic. As the final step in the recruitment, at the first scheduled interview, I reviewed the *Information Letter* with the participant, and then I obtained their consent.

Data collection, privacy and confidentiality. No identifiers were collected that linked personal information related to the participants; instead, pseudonym IDs were assigned to ensure privacy and confidentiality. Fictitious code names and identifiers were used during the collection of the data to ensure participant anonymity and were also used to perform analyses, including any form of information sharing between the research team members. When the consent forms were signed and collected, at that time, these fictitious code names and identifiers were used during the interview digital audio recording, for notetaking and for identifying diagrams and the drawings generated in the field. Also, these made-up code names and identifiers served a master list to corollate the interviews, linking the participant's first and second interview in order to generate a consistent and accountable record of the project's analytic process involving basic coding, categorical and axial analysis, and identification of the components necessary to apply the theory of narrative repair. Digitally recorded interviews were alphanumerically labeled and dated; to link participants' fictitious code names to their respective interviews, ensuring that no personal information identified the participants.

The digital voice recording device Olympus WS-700M was used to collect interviews. The electronic master list was stored on a separate external hard drive apart from the digitally recorded interviews. The electronic storage chip belonging to the device that was used to collect the audio files, including the electronic master list of participants' code names, was physically removed from the device and then stored apart from the external hard drive device for further safeguarding of data. The two physical storage devices, as mentioned above, the removable Olympus WS-700M storage chip, and the external hard drive (containing the electronic master list) were secured in a locked filing cabinet located in the researcher's office at Arizona State University.

All electronic files transferred to committee members' computers to perform debriefing and analyses also employed the assigned codes (alphanumeric labels and dates of the interviews; linking participant's fictitious code names) contained in the master list system to ensure participant anonymity and to maintain participant's de-identification. In addition, any transmission and sharing of electronic records that came out of this study employed password protection in order to access the electronic information that was stored.

For the duration of the research study, the signed consent forms were securely locked in a filing cabinet located in the principal investigator's office at ASU and retained in a sealed envelope for three years after the close of the study. Beyond three years, the signed consent forms will be destroyed. The interview audio recordings were deleted immediately after the raw data was transcribed and verified for clarity.

Collaboration with facility staff ensured safeguarding the SMI participants by first enlisting their help with convenience sampling to reduce harm. Second, the selected participants were free to stay or leave the study without consequence to their treatment. Third, staff members were present in the interview room for emotional support. Lastly, the staff helped the researcher to remind the participants that pseudonyms and encrypted codes were used to protect sensitive information collected during interviews and in performing the analysis afterward.

Informed consent process. As the researcher, I was responsible in reviewing the *Information Letter* with each of the participants at the facility. The staff was present when I handed out copies of the *Information Letter* to the participants, and then I obtained their signed consent.

Compensation. Following Kiltzman's (2013) guidelines, the strategy for determining compensation for costs of time and travel for study participation. We employed two assessment models - wage payment and reimbursement. The amount of $24.50 is a cash reimbursement for each single interview session. The total amount possible for participation was $99.00. These estimates were based on the following: Acceptable Listing of Compensation from Virginia Tech (see http://www.irb.vt.edu/documents/Acceptable_Listing_of_Compensation.pdf) and reasonable compensation for participants' travel residing in the local [Name of city] area, and a basic meal.

- Hourly rate at $10.50, 1 hour for round trip travel and 1-hour interview time ($21.00) (per Minimum Wage calculation in Arizona in 2018)
- [Name of City]/Public transit 1-Day rates/local bus & light rail $4.00 and/or Express/RAPID $6.50 ($10.50) (per transit fare calculator)
- The price of a basic lunchtime meal served in an inexpensive [Name of city] restaurant is $14.00 (per average restaurant meal calculator)

In consultation with the university IRB, the above compensation strategy determined the reasonable total amount, and of which did not present undue influence. After reviewing the above cash compensation strategy with the CEO of the recovery center, the researcher followed the CEO's recommendation to distribute Walmart gift cards after each interview, as participants could manage gift cards better than receiving cash. For this compensation, the researcher used personal funds.

Risk to participants. The researcher anticipated that participants might find it difficult to talk about their experience of transitional care, and they were informed of the discomfort that may arise during interviews. This project employed the Common Rule criteria [(45 CFR 46, Subpart A (Protection of Human Subjects 2018)] to guide the following statements and disclosed these in all forms of communication procedures and used them in materials related to this study (see Appendix B):

> You are free to answer any question that you like during the interview and give as much information as you are comfortable talking about. It is possible you may find it difficult to talk about some of your experiences.
>
> If you decide not to participate or if you wish to leave the study before it is completed, you are free to do so with no effect on your future care.

In anticipation that the participants would find interviewing stressful, they were free to invite a caregiver from their mental health care team to be present. For this study, mental health staff were considered non-participants and did not answer interview questions for the participant, as they were present for emotional support only. Participants were free to leave the interview to talk about the stress related to being interviewed with their mental health support team.

Training. The researcher and committee members are all affiliates of Arizona State University and hold a valid certificate of completion in the "Training for human participants" from the Collaborative Institutional Training Initiative program (CITI). In addition, the researcher obtained a certification in Mental Health First Aid (see MHFA certification www.mentalhealthfirstaid.org/).

Interview as Context and Method

The interview design consisted of two semi-structured interviews (Brinkmann & Kvale, 2015; Seidman, 2013). The first interview focused on the individual's life history and perception of personal strategies and problems encountered; these are aspects of a paradigmatic approach (Polkinghorne, 1995). This strategy enabled the researcher to begin with the formal narrative structure regarding the situation of the i-SMI's personal experiences. In line with the requirements of narratology, the first interview followed a phenomenological methodology (see Table 2., p. 66) and used a semi-structured approach to ask participants open-ended questions (See Topic and Interview Guide, p. 59), about their lived experiences in transitional care (Bevan, 2014; Stuckey, 2013). This way, for this study, informational responses from i-SMI's could be collected reliably - understanding the way these individuals see themselves during their transition and how they understand transitional care. The second interview employed a narrative approach to clarify and unify the storyteller's details of personal actions, events, and happenings in order to construct the i-SMI's narrative structure (Dreier, 2000; Seidman, 2013).

Tailoring a semi-structured interview design in the context of narrative repair.

The semi-structured interview method essentially enables the investigator's scope of questioning to gain deeper insights into the interviewees' lived-world experiences. The design of the interview integrates ethical concerns regarding recruitment of participants, such as confidentiality, consent, options to withdraw, and use of and scope of the results, and as well as moral concerns about inviting individuals with SMI soon after their discharge from a psychiatric hospital. The IRB and my mentors raised caution, first and foremost, gaining access to these vulnerable individuals and addressing unforeseeable harm. Second, inside these interviews, maintaining 'focus' and being 'present' to what is being communicated – this occurs as research-topic questions guide individuals to reveal themes as their story unfolds, the capture of their own words, and with the follow up probing questions to get to their meanings. This semi-structured interview approach follows the recommendations of Kvale (1983) in keeping with the *phenomenological and hermeneutical* mode of understanding, "ordinary people are able to describe their own life-world, their opinions and acts…the interview makes it possible for the subjects to organize their own descriptions, emphasizing what they themselves find important" however[3], "to explore deeper than common sense, this may be politically threatening" (Kvale, 1983, p.173). In this study, a glimpse into interviewees' reality may challenge aspects of the transhistorical master narrative of Medicine, which is foundational to institutionalized health care and as well to deinstitutionalized caring operatives.

Accessing individuals with SMI.

In my pre-planning processes of the research design, accessing individuals with SMI involved training in Mental Health First Aid and enlisting the help of professional staff and relying on our collaborative efforts. As i-SMI's leave psychiatric hospitals, health professionals consider them stable and able to take their medications and try adjusting psychologically and socially. With this group of outpatients, there exists a professional understanding that they can make their own decisions, even though a swath

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[3] " (6) A somewhat different explanation of the uncleared status of the [qualitative] interview may be that here *ordinary people* are able to describe their own life-world, their opinions and acts, in their own words. In contrast to the multiple-choice questionnaires with questions and answers already formulated by experts, the interview makes it possible for the subjects to organize their won descriptions, emphasizing what they themselves find important….This literature, which rarely stems from professional psychologists, may function politically as consciousness raising by reflecting the repressive aspects of the social situation for large groups,"; (7) An extensive open interview may go beyond a surface understanding of the world of the interviewees, with a possibility that an interview might come *beneath the surface of society*, to explore deeper that common sense. This may be politically threatening" (Kvale, 1983, p. 173).

of studies show the trend of people with SMI frequently become unstable and go back to the hospital. According to Koivisto et al. (2001), these mainstream studies about P-SMI cycling through hospitals influence researchers' perceptions, and thus outpatients altogether lack opportunities to get involved in the research.

Including facility staff in the process.

Hence, in consideration of ethical and moral concerns as mentioned above, this study followed Koivisto et al. (2001) safeguarding suggestions: First, establish a connection with the mental health organization's care coordination team. With the involvement of staff, I gained their expertise and their trust as I was developing a protocol for this study, but more importantly, making it easy for me to recruit the volunteers and gain their trust. Second, by having staff present during the interviews, this helped me pay attention to participants' verbal and non-verbal signs of discomfort and extend to participants' emotional comfort. As a result, the pre-field work, as discussed above, was included in the *Information Letter* for this study. The example below (see also Appendix B).

> It is possible that you may find being interviewed stressful. You are free to invite a person from your mental health care team to be present in the interview. If you wish to do so, the person from your mental health care team may not answer the interview questions for you; they will be present for emotional support. You can always choose to leave the interview to talk about the stress related to being interviewed with your mental health support team.

Although the caregivers were a necessary part of the interview design, they were not directly involved in their clients' interviews, but to some degree, their presence was most likely indirectly influencing non-verbal communication. Also, I had the benefit of casual conversation outside of interviewing, which grounded my understanding of the interview-situation. Moreover, within the context of this interview design, equally noteworthy is that these interviews took place in a community recovery-oriented care setting.

Obtaining nuanced description and meaning.

Inside these semi-structured interviews, Kvale (1983) insists that it is necessary to "listen to the directly expressed descriptions and meanings as well as "what is said between the lines," and then seek to formulate the "implicit message" and "send it back" to the interviewee" (p. 175). To understand this better, I practiced face-to-face mock interviewing with mentors and peers. Interviewing proved to be challenging, all at once it requires moving the research-directives forward and listening and observing interviewee's gestures and paying attention to apparent interactions in the given setting[4]. As a result, conducting mock interviews proved indispensable, understanding the role of the investigator inside the research-setting which resonates with Lincoln and Guba's naturalistic paradigm "such a contextual inquiry *demands* a human instrument, one fully adaptive to the indeterminate situation that will be encountered" (Lincoln & Guba, 1985. p. 187), and of the experience with participants. Kvale highlights the importance of Lincoln & Guba's (1985) recommendation, that the interviewer (human instrument) should remain "presuppositionless" – leaving behind "ready-made categories and schemes of interpretation" and keeping "openness to new and unexpected phenomena" (1983, p. 176). This includes putting aside all preliminary sensitizing concepts, as previously mentioned in Chapter Two regarding the conceptual framework. (Sensitizing concepts sensitize the researcher for the analytic aspect of the research, not the gathering of data.)

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[4] These resonate Lincoln and Guba's (1985) recommendations that a 'naturalistic inquiry' demands a natural setting, "The human instrument builds upon his or her tacit knowledge as much as if not more than upon propositional knowledge, and uses methods that are appropriate to humanly implemented inquiry: interviews, observations, document analysis, unobtrusive clues, and the like" (p. 187).

Interview research-directives and focus.

From the perspective of Lincoln and Guba's (1985) naturalistic inquiry, "[that it] must be carried out in a natural setting because phenomena of study…*take their meaning as much from their context as they do from themselves*" (p. 189), and I've taken this to mean that the 'natural setting' *is within the contextual experience* of individuals' going through personal adjustments during transitional care. Thus, following Kvale's (1983) qualitative interview-directive I sought to gain as much insight into the factual aspects of participants' experience, i.e., for the i-SMI, the business of accessing health services, and the meaning of those experiences.

Interviewing individuals with SMI two times.

Kvale (1983) insists that the objective of the qualitative interview is to obtain "extensive and rich descriptions of specific situations" (p. 176) as the interviewer and interviewee talk about the research topics in asking and about the themes that are arising. Kvale (1983) claims that a second interview makes it possible to better understand the ambiguities that may arise about meaning, and interpretation, "the contradictions of the statements of an interviewee…may be adequate reflections of objective contradictions of the world he lives in" (p. 177). These aspects of Kvale's guidance for qualitative interviews were especially aligned to the analysis using Narrative Repair theory (Lindemann-Nelson, 2001). In addition, Lincoln & Guba, Kvale, and Seidman (2013) agree that the second interview improves intra validity 'credibility' by reinforcing the gaining of participants' approval. For example, the statement below was included in the approved IRB protocol *Information Letter* as part of the design to move the research-directives forward.

> The follow-up interview will give you the opportunity to review the transcript made from the first interview and allow me to understand your story better. During the follow up interview, you are also free to help me map out some of the details; this is to clarify your story through drawings (See Appendix B).

Methodology Employed for the Two Interviews

Hence, this interview-design employed an initial (first) interview and a follow-up (second) interview to give the participants more opportunity to talk and as well as to use drawing media to explore further any illustrated experiences. The interview topic guide in this study followed both Kvale's (1983) Sideman's (2013) phenomenological themed guidelines: the goal of the first interview is to explore the temporal nature of the human experience, and the second interview seeks to clarify; 'whose understanding is it?' regarding the experience and emphasis on meaning to regarding experience-based themes that arise in the individual's story. As mentioned earlier, the semi-structured interview is a method that bridges the philosophical underpinnings of *lifeworld* (recall Husserl) as themes are used in narrative methods and analysis in the development of stories (Kohler-Riessman, 2008a; Kvale, 1983; Seidman, 2013).

By inviting participants in the follow-up (second) interview to use drawing media, whether they choose to write for themselves or draw or talk and use more gestures, the research-interview directive sought a deeper understanding of themes and multisensory self-narratives. Treadaway, Prytherch, Coles and Millman's (2013) method of 'walk and draw' methodology helps to understand the way individuals can relate words and senses to their environment with the drawings that they produce - another dimension for this project as regards understanding participants' emotional, physical, and aesthetic space. Although Treadaway and colleagues' participants walk about the environment, in this study, participants remained inside the interview room.

In the following section, topics and questions of the interview guide follow the methodological principles as mentioned above; the first interview topics A, B, and C focused on the temporal nature of the human experience, and the second interview topics D, E and F asked of the participants to clarify the details of the lived experience, meaning and meaning in context. These topics and open-ended questions and general prompts and questions, as they appear below were approved by the ASU's IRB.

Topic and Interview Guide.

The focus for the first semi-structured interview and open-ended questions are outlined below:

A. ***Topic***: The journey from illness-to-wellness as individuals' transition from a psychiatric mental health experience back to their neighborhood and home.

  a. *Tell me about your experience of your journey into mental health recovery.*

  b. *What is it like to move out of psychiatric care and move back to home (or back to your neighborhood)?*

    i. *Could you describe what it's like moving from one place to another place?*

B. ***Topic***: What the individual understands of themselves as personal changes take place, such as resuming their role in society and imagining what their ongoing healing experience will be like.

  a. *What do you value about your mental health experience?*

  b. *What is it like to manage both conditions related to illness and recovering?*

  c. *What activities do you like doing with other people?*

C. ***Topic*:** The individual's experience of the interface of the physical and emotional space and how we can design healthcare systems and processes in response to this population's needs.

a. *What would you like your care team (or family members) to know about your experience from the time you began psychiatric care to the moment you started your transition back to your home?*

  i. *Give me an example of…*

    1. *Who are the people involved?*

    2. *Can you describe the place (where, when)?*

  ii. *Imagine making changes to…*

    1. *Describe what it would (look or feel) be like if…?*

The focus for the second semi-structured follow-up interview with prompts below, are to clarify details, themes or meanings that will come of his or her initial interview.

D. ***Topic*:** How he or she perceives the master narrative to be, in terms of living in or out of the transitional care framework (i.e., expectations based on the established clinical narrative, expectations based on the social narrative regarding re-socialization).

E. ***Topic*:** The emphasis on how he or she identifies themselves within their experience narrative, (i.e., unique plot organization, persona, character perspectives and events).

F. ***Topic*:** Using his or her personal meanings to map out the narrative, emphasis on visualization and/or co-constructing drawings.

General prompts and questions:

- *Tell me what happened next*
- *Could you give an example?*
- *Could you describe what* ________ *(looks, feels) like?*
- *Help me understand what* ______ *means*

First interview.

Data collected from the first interview and subsequent transcription enabled a preliminary 'thematic analysis' (Corbin & Strauss, 2015b; Kohler-Riessman, 2008b), a necessary process to discover emergent questions that pertain to participants' responses to both social and physical conditions (Lincoln & Guba, 1985a). For instance, how space is perceived? how is space constructed? meanwhile teasing out what constitutes the 'spaces' of the clinical experience that is operationalized in the i-SMI's experience of transitional care. After transcribing the first interviews, traditional qualitative comparative analysis was applied to produce open codes, followed by the second interviews to identify the emerged themes. This level of analysis served to familiarize the researcher with the overall nature of the data.

Second interview.

As mentioned above, the second interview takes a narrative approach and clarifies personal actions, events, and happenings to construct i-SMI's narrative structure (Dreier, 2000; Seidman, 2013). In this instance, the chosen strategy for the second interview is to clarify the details of participants' experiences and reflections as they appear in the transcribed narratives. Combining themes and thinking interpretatively opens possibilities to choose which most appropriate form of interpretation best acknowledges the storyteller and their story (Garro & Mattingly, 2000; Kohler-Riessman, 2008b). In line with the requirements of narratology, the second interview uses narrative methodology (Kohler-Riessman, 2005, 2008a; Stuckey, 2013), in the sense of discovering provisional themes based on the preliminary analysis which serve as a starting point, while verifying with each participant their own responses and asking further detailed questions. This is planned so that the researcher can gain further insight into the way individuals choose to tell their stories, as it colors illness-to-wellness experiences and orders social and physical spaces narratively. All above processes generated code clusters of themes and categories in preparation for the application of Lindemann-Nelson's narrative repair theory.

Anthropologists studying patients' narratives avow that: "during transition, a person enters *as one kind of person* and emerges altered in some essential way" (Becker, 1997, p. 119) and that, "in the illness stories what begins as the breakdown of narrative — life's interruption by illness — is transformed into another kind of narrative" (Frank, 2013, p. 164). This underscores i-SMI participants' vulnerability, and the interviews focus on talking about their illness-to-wellness experience regarding transitional care. It is for this reason that I have structured the interview process, as I have, explained above.

Sensitizing Concepts Applied Cyclically to First and Second Interviews

A typical approach within qualitative research methods is to incorporate sensitizing concepts in a granular way as aligned with the tools of analysis, such as interview questions (as listed in Table 1, below). Within this foundational sensitizing concept of *Homeworld* were other chosen sensitizing concepts for this project *Genius loci*, *Ekistics, Attunemen*t, and *Epimēleia heatou* based on philosophy and architecture, which considers design as unifying human experience. These guide the inquiry of the participants' meanings with sub research questions seeking "truth values" (Lincoln & Guba, 1985b).

Overview: adapting interview methods and sensitizing concepts for coding. Table 1 below is an adaptation of Bevan's (2014) descriptive phenomenology approach, which underpins the two key concepts of Homeworld (lifeworld and natural attitude) include Woods, Priest, and Roberts (2002) strategy to formulate semi-structured questions for this study. An adaptation of Mojtahed, Nunes, Martins, and Peng's (2014) decision mapping tool, provided a strategy for the second interviews when the participants were invited to use drawing media. Table 2 shows how the sensitizing concepts provided the foundation for the initial analysis and the focus codes that were selected to conduct simultaneous coding. This was done to "to understand and define phenomena in abstract terms…relationships between phenomena" (Charmaz 2014, p.161) and to view the developing thematic codes from the data (Bowen, 2006).

Table 1

Structure for a Phenomenological Interview

Sensitizing concept	**Researcher approach**	**Interview structure**	**Method**	**Semi-structured/open ended questions**
Phenomenological attitude: Husserl's ***Homeworld*** combines the key concepts: ***lifeworld***, the meaning of being-in-the world, and the ***natural attitude*** related to the unconscionable responsiveness what as individual does when performing daily activities.	*co-participant/ opening research statement – dialogic co-constructed meanings – employ the "decision making map" tool *Mojtahed, R., Nunes, M. B., Martins, J. T., & Peng, A. (2014)	Contextualizing: enabling a person to reconstruct and describe their experience in the form of a narrative (addressing the lifeworld in natural attitude)	Descriptive narrative context questions	1. "Tell me what happened when you left the psychiatric hospital" 2. "Describe the differences, from being in the hospital to where you are now…where is *home*"
	Phenomenological interpretive and hermeneutic processes below (employs 3 principles of reduction): 1. Explore *lifeworld* inside the *natural attitude* 2. Critical-self line of questioning maintain sensitivity to participants' description of their world. 3. Active listening	Apprehending the phenomenon as it appears in the participant's natural attitude	Descriptive and structural questions, interactions as they appear in the situation or event	3. "Tell me about your typical day at home" or (…school, work, visiting friends, etc.) 4. "Tell me what you do to get ready for the next professional therapeutic appointment" 5. "Tell me what transitional care means for you"
		Clarifying the phenomenon, exploring meaning through making imaginative changes	Imaginative changes, varies the structure of questions	6. "What would please you more about making any sort of changes:" *Examples*: "if you could bring, familiar things or people along to clinical settings" *or* "things or people home from the hospital what/who would you bring" *and follow-up* "What would that be like" 7. "If you could draw what an ideal place should look like where you receive your treatments, what would it look like" *or* "where you would like to be instead" *and follow-up* "what would that experience be like"

After obtaining the data from the first interview, simultaneous codes were used to capture the i-SMI's complex Homeworld. According to Saldaña (2013) and Miles, Huberman, and Saldaña (2014) simultaneous codes are the use of different codes of the same data at the same time, in order to apprehend rich overlapping meanings and are selected by the researcher to explore different research interests in a study. Table 2 (as mentioned above) illustrates how the sensitizing concepts underpin this project's aims and rationale for selecting first cycle codes. As Saldaña (2013) suggests, the qualitative tradition of the bundling of different codes applied to the same qualitative datum is useful in first cycle coding to explore thick, rich descriptions to generate units of code. Whereas, second cycle codes are processual analytic strategies, taking the units of code generated from the first cycle and employ axial coding (Corbin & Strauss, 2015a) or pattern coding (Miles, Huberman, & Saldaña, 2014b) methods to achieve overarching themes.

Thus, the application of these first cycle and second cycle coding methods facilitates a preliminary analysis in trying to understand the way individuals with SMI see themselves both during their transition and how they understand 'transitional care,' applying a systematic method after the first interview to achieve a preliminary 'thematic analysis.' It is the most common method in the narrative analysis used in nursing and in other health-related research, to uncover and categorize patients' experiences — i.e., what was said during the interview (Kohler-Riessman, 2008b; Stuckey, 2013). The preliminary analysis enables the preparation of the second interview processes and as well provides a systematic format to both develop and align the codes (develop the codebook) of transdisciplinary perspectives in this work (D. Herman, 2007).

Table 2

Sensitizing Concepts Applied to Coding Method Selection

Sensitizing concepts/sub-research questions underpins the drivers of purpose of this study (See also Charmaz (2014), theoretical sensitivity pp. 160-161).	**Simultaneous code bundle selection** (Focus codes)
Attunement: Explores participants' emotional contours of experience and perceived affect in temporal and spatial references in an environment, such as visual and auditory responses to the physical environment that affect mood. ● What influence does the environment have in shaping an individual's habit – in support of their daily routine or cue in human senses (architectural experience) to initiate a change in behavior? ● What happened overtime in caring for the SMI which currently neglects aspects of the human process related to attunement)?	**Process:** Explores individual's **actions which reflect responses to a situation**, an awareness to act—codes typically capture gerunds (words ending with 'ing'). ● e.g., The way in which individuals with severe mental illness (i-SMI) handle ongoing problems.
Genius loci: Explores interrelationships to places/settings, connecting symbolic meaning, oral tradition, spirituality, myth and legend. ● What meanings are associated with a place that centers one's cultural outlook or make it memorable? ● What does an individual need to do, to transfer 'spirit of place' in the proximity of where they live?	**Emotion:** Explores **affective experiences, in response to core motives in human action** — feelings related to intrapersonal and interpersonal relationships in different settings, enables the investigator to code vocal nuance in recordings and combine non-verbal observations about interviewee's perceptions. ● e.g., How emotions can impact i-SMI health orientation - responses related to support staff in the hospital and with family members at home, and perceptions about significant places.
Epimēleia heatou: Explores personal philosophy in cultivating one's agency 'taking care of the self' integrates mind, body, the spiritual and social experience. ● What kind of personal skills and interpersonal relationships are needed to co-create spaces that support healing? ● What keeps the protective 'therapeutic sphere intact?	**Versus**: Explores conflict or competing goals, **social powers of domination**, such as organizational (professionals) vs. individual (agency) and non-professional. ● e.g., What do i-SMI do as they encounter conflict related to re-integrating as 'normal' members in a society or compete with clinical interpretations about their illness experience.
Ekistics: Explores creating an 'optimal' personal space across networked system of spaces (such as, the space of one's room to places in the community). ● What do stakeholders need to address in optimizing the personal unit of space, before making community spaces available during one's mental health crisis?	**Value:** Explores the personal system, the way in which an **individual integrates values, attitude and beliefs** — the attributes follow: *value*, what is significant, *attitude*, the way one thinks and feels, and *belief*, by combining value and attitude this reflects one's knowledge and ability to make interpretations. ● e.g., I-SMI's life history, illness experience or imagination, what influences their identity, social reality or choice of needs and wants.

Overview: first and second interview analytic considerations and procedures. The tables 3 and 4 below correspond to the proposed applications of two analytical methods applied after each interview, which delineate the processes employed to perform a thematic analysis in understanding what is said [by the i-SMI participants] and followed by an interpretative narrative analysis to understand *h*ow it is said [by the i-SMI as storyteller]. Guided by the aims of this work, and between the two planned interview research processes, this works cumulatively toward uncovering the i-SMI's counter narrative under the prevailing master story.

Table 3 Applying Thematic Coding Methods After the First Interview

Taped interviews are transcribed and electronically managed [MAXQDA] of which begins the audit trail, e.g. tracking procedural codes (first and second cycles) and the development of the codebook.

1 Transcription	**2** Analytic memo writing	**3** Thematic analysis	**4** Codebook
Each interview transcription is separately coded, one participant at a time Constant comparison systematically applied: code to code, theme to theme, category to category	Document and reflect: ● Field notes, *e.g.* observations from the interview ● Dialogic co-constructed meanings in line with the semi-structured questions to track *what is said* employ the “decision making map” tool Mojtahed, R., Nunes, M. B., Martins, J. T., & Peng, A. (2014) Personal and professional memos are entered in a separate field journal	Identify meanings to ‘patterned’/repeated topics which unify the basis of the experience/theming the data *e.g.,* ● Character actions ● Organizational interactions ● Interactions with physical places	Manage codes use tags/theme/ categories: *e.g.,* ● Character identity ● Transitional care ● Physical environment ● Social environment Use time stamp in voice recordings to locate unique expression, *e.g.,* ● Tropes ● Meaning ● Mimetic schemes
First cycle codes		**Second cycle codes**	
Simultaneous codes are applied to the same qualitative datum, as transcribed content may have multiple meanings	● Process ● Emotion ● Versus ● Value (See Table 1, p. 64, for code explanations)	Apply **situational mapping** method (Clarke, 2005) to reorganize data from first cycle codes and focusing on interrelationships ● **Pattern** (meta-coding) develop major themes ● **Causation** Participant in vivo statements reveal reasoning and beliefs, story elements such as metaphors and idioms, character identity	**Integrative memo**: document reorganized and reanalyzed data **Emergent questions**: *e.g., “when that happened, then what happened…”* *e.g., “If you could draw your ideal space what would it look like?”* Employ to structure the second interview approach/ clarify details and unify the storyteller’s details, related to personal actions, events and happenings

Table 4 Applying Narrative Analytics/Interpretive Methods After the Second Interview

Taped peer review interviews are transcribed and electronically managed [MAXQDA] codes & memos

1 Transcription	**2** Analytic memo writing	**3** Interpretive analytics	**4** Codebook
The storyteller's details of personal actions, events and happenings clarify details – added to the existing first interviews as extended columns Each interview transcription is separately coded, one participant at a time	Document and reflect: ● Field notes, e.g. observations from the interview ● Dialogic co constructed meanings Personal and professional memos are entered in a separate field journal	Based on the first interview, thematic analysis informs appropriate interpretive narrative analytics, ● **3A** Transcription as interpretation/ understanding the story linguistically ● **3B** Storyteller's understanding of the world includes analysist's insights ● **3C** Counterstory vs the Masternarrative	Manage literary devices, use time stamp in voice recordings to locate unique expression, code lists: e.g. *Literary devices* ● Tropes ● Meaning/idioms ● Description vignettes e.g. *Narrative structure* ● Stanzas ● Narrative sequence ● Mimetic schemes

Narrative analytic guiding question: *How do we capture the character's transformation*? (Todorov, 1971)

3A Narrative structure	**3B** Narrative Structure
Analytic interest: Understanding the i-SMI's story linguistically James Gee's (1991) theory of narrative structure (developed from his seminal work with schizophrenic patients) – socio-linguistic, focus *how things are said* - breakdown the narrative to explore ● Stanzas, typically a minimum of 4 lines which are typically topic centered and/or explore attributes of character actions ● Larger units of discourse explore tropes, or other narrative parts **Analytic interest:** Understanding the i-SMI's lived experience. Laurence Kirmayer (1992) insists that meaning through metaphor is not only a representation but meaning presents the individual's reality.	**Analytic interest:** Understanding the storyteller's—'experience' of space'— [is all that surrounds the i-SMI - dynamic and responsive to their interactions while at the same time informing them, *see also sensitizing concepts/focus codes/research emergent questions* in Table 2, p. 66] Arthur Frank's (2010) *Letting Stories Breathe*, a socio-narrative framework focuses on *how stories work for the storyteller* (pp.104-111) – paying attention to the differences/conflict/ambiguities: 1. Translate the story to into image, using thick description from the narrative 2. Translate the story from a different point of view from the characters mentioned by the storyteller 3. Attention to what happens in the story is just as important to what does not happen in the story 4. Attention to the differences between the storyteller and the interpretive analyst 5. Allow the story to emerge 6. Acknowledge the storyteller's personal power (agency) and the analyst's lessons learned

3C Counterstory vs Masternarrative
Analytic interest: Implications for future, the i-SMI's counterstory vs the Masternarrative in practice Lindemann-Nelson's (2001) **theory: *damaged identities and narrative repair***, the counterstory tentatively improving SMI's social position and changing the Masternarrative in terms of social power

Analytic interest. In summary, applying the narrative analytic coding methods after the first interview functioned to obtain thematically the 'lived experiences' from the character in the story as well as the storyteller, exploring the master narrative that keeps this population oppressed — understanding *what* is said about transitional care and the i-SMI's relationship about their care and perception about themselves. After the second interview, the aim was to develop the narrative structure — because, "the capacity of stories is to explore complications, rarely to resolve them" (Frank, 2010, p.110), e.g., character transformation (Todorov, 1971) — understanding the storyteller's way of "making earth more habitable" (Frank, 2010, p. 46) by interpreting *how its spoken,* e.g., the speaker's voice inflection and actions during the interview, can determine which points to apply narrative codes, such as tropes, the use of figurative language to express ideas and personal idioms which express special meaning rather than taking for granted the literal meaning, or mimetic schemes in which the speaker's phrases reflect how he or she imitates the real world.

Trustworthiness

Lincoln and Guba's definition of Trustworthiness consists of four components: Credibility, Transferability, Dependability, and Confirmability, all of which are the actions that a qualitative researcher takes in planning research design and in applying methods. Briefly, an explanation of these components is as follows: *Credibility*, establishes that the results of the study are believable by external reviewers, *Transferability* ensures, that the content of the study can be applied to similar settings concerning the SMI population, *Dependability* relies on, establishing a codebook to begin the processes of managing and evaluating the data which defines the audit trail. *Confirmability* combines all the research design methods and processes, such as data collection, analytic reduction and interpretation, data reconstruction, and documents that show how research decisions were made, such as reflective journals, using empirical literature to triangulate data and member checking.

I selected Peer Debriefing as a way of demonstrating credibility and, thick description as a way of demonstrating transferability. The audit trail demonstrates dependability and confirmability. Internal validity and reliability were addressed throughout the second interview process in that, conversational exchange allowed both researcher and participant to make sense of the story and as well as the primary storyteller for themselves. I kept a journal for my reflections and memos and interview codes. In addition, I worked with my committee members to review the analysis and the transcriptions and codebook materials. This way I established trustworthiness.

Lincoln and Guba's (1985) understanding of "human-as-instrument" (p. 192) completes the discussion of trustworthiness in this project. As the researcher, my preparation and training, along with extensive tacit knowledge, assured that I possessed the "characteristics necessary to cope with an indeterminate situation [as it emerges in doing fieldwork]… that uniquely qualify the human as an instrument (Lincoln & Guba, pp. 193[5]), as well as Morse, Barrett, Mayan, Olson, and Spiers (2002) insist, my actions, detailed method, and documentation were designed to "ensure rigor" (p. 1). I had set up a systematic work plan in order to maintain internal and external validity and reliable measures.

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[5] According to Lincoln and Guba (1985b) in conducting field work, the "human-as-instrument" characteristics include the following: (1) Responsiveness, (2), Adaptability, (3) Holistic emphasis, (4) Knowledge base expansion, (5) Processual immediacy, (6) Opportunities for clarification and summarization, and (7) Opportunity explore atypical or idiosyncratic responses" (pp. 199-194).

Strengths and weaknesses.

Table 5 below is an overview of the strengths and weaknesses of this study. I have consulted the work of Brinkmann and Kvale (2015), Cannella and Lincoln (2010), Lincoln and Guba (1985b), Miles et al. (2014c), Seidman (2013), and Taylor and Bogdan (1998).

Table 5

Overview of the Strengths and Weakness of the Research Design

Criteria Area	**Characteristics** – Strengths (S) and Weakness (W)
Sample	(1) In determining the sample size of 5 participants for in-depth (face-to-face) interviews (a) difficulty in recruitment (W) (b) quality of the data collected (S) (c) possibility of a secondary interview with the same participants (S)/ different participants (W) (d) constraints of the first and second interview timelines (W)
Research Aims	(3) Scope of research aims are too large for this initial study (W) (a) Narrowing the focus on participants' stories (S) (b) Achieving the "counternarrative" needs future studies (W)
Research Design	(2) Considering the emergent nature of the research, in returning to the field to conduct the second interview, [after generating a preliminary (thematic analysis)] seeking an interpretive "habitable storyline" Frank (2010) to address the gaps and expand participants' narrative – serving to scaffold the participants' emergent short stories. (a) difficulty in cooperation with participants (W) (b) confirming results with participants (S) (c) investigators' inexperience in conducting field interviews (W) (d) secondary IRB applications/extensions (S/W) (e) extends the 4-month work plan timeline (S/W)
Data Collection	(4) Integrating additional methods of data collection other than digital recordings, listed below: improves the quality of the data (S)/extends project timeline (W) (a) field notes, jottings and diagrams (b) observations (c) casual conversations (d) reflexive journal
Data Analysis	(5) Working within a transdisciplinary framework (a) critique with various disciplinary perspectives (S/W) (b) discover new methods in doing the work (S) (c) Managing complex data with computer software MAXQDA (S)

Conclusion

This project sought to address perceptions of what is needed in caring for the P-SMI from a transitional care perspective. Understanding the i-SMI participant as both a character in a story and the storyteller, ultimately seeking a better understanding of the i-SMI*'s* perceptions of their illness-to-wellness journey, and perhaps, uncover a counterstory able to close this gap.

Chapter 4

THE FINDINGS OF NARRATIVE REPAIR AND COUNTERSTORY

In the previous chapter, Narrative Repair theory was proposed as a tool to better understand how master narratives can damage identities, arguing that a counterstory more aligned with the participant's experience may arise through the qualitative analysis process. In this chapter, the results of that analysis are presented. Zoie, one of the participants in the study, serves as representative of the P-SMI's experiences, with findings from other participants shared throughout the analysis, providing additional insights here in the presentation of results. As mentioned in Chapter 3, the sensitizing concepts for this project provided an *a priori* lens through which to look at the data. A detailed alignment of these concepts to what emerged in the coding manual was provided (detailed in Table 1: *Structure for a Phenomenological Interview* (p. 64) and, Table 2: *Sensitizing Concepts Applied to Coding Method Selection* (p. 66) in Chapter 3); we can see tracings of these relationships throughout the results section as well. Cross-disciplinary examination of the data draws from the literature, simultaneously tracking the discussion. The presentation of results will address these research aims and questions:

1. Understand the transitional care experience from acute care hospitalization to the community for individuals with SMI.
    Research question 1a. What is the experience of the P-SMI?
    Research question 1b. How do we understand the i-SMI within the larger context of transitional care?
2. Propose how this experience may be used to create a new story of transition that empowers individuals with SMI, through a better understanding of their "Space."
    Research question 2a. How do individuals with SMI perceive the making of their space, related to their experiences of transitional care?
    Research question 2b. How do we respond to their needs throughout the transitional care?

This chapter begins by briefly revisiting Lindemann-Nelson's framework for Narrative Repair and then branches off into three sections to present the results. The first section asks of the data - *Whose story is it?* Included here is the researcher's perspective, what I have learned from the participants' framing of their own overarching story, triangulated with Zoie's insights. Section I used this project's codebook category, *Meaning and Metaphor* to drive the analysis, aligned with Kirmayer's assertion that metaphor is not only a representation, but represents the i-SMI's reality. In keeping with the narrative repair framework, introduced in Chapter 1 and detailed more here, metaphor-as-reality is used to move through the presentation of results: identification of narrative ruptures, followed by narrative injuries, the opportunity for narrative repair, and finally coaxes forth the narrative elements.

The second section looks at the potential of transitional care itself, shown in the data as an opportunity for the i-SMI to make gains in their own journey. Challenges remain regarding addressing power differentials, and three codes emerged from the data to denote this: overcontrolling, equitable, and uncharted relational dynamics. As section II unfolds, the need to examine ruptures and injuries falls away after the overcontrolling relational dynamics are addressed - the data show that equitable relational dynamics are the point at which recovery *in* mental health begins - detailed in section II. Here, as Lindemann-Nelson says, a "tapestry" begins to form within the data, evidenced by the building of the narrative elements upon one another. This section concludes with a presentation of uncharted relational dynamics, which highlight yet another important set of insights. Here, the counter story can begin to emerge, alongside the narrative elements that comprise it.

Section III concludes the presentation of results, detailing the narrative elements that emerged from the data, which begin to weave together and bring forth the counter story. It then broadens its scope to a more general sense to inform how the metanarrative might eventually spring from the counter story and be brought to life, highlighting the overarching themes that were identified in the work: *Uncovering + Discovering, Placement + Place*, and *Protection + Atmosphere*.

Applying Narrative Repair Principles/Revealing the Counter Story

In Chapter 1, I introduced my interpretation of Lindeman-Nelson's theoretical framework: *Damaged Identities and Narrative Repair* to illustrate how I would apply narrative repair principles (see diagram below) in analyzing the data for this project. In Chapter 3, Narrative Repair theory was presented, situated in the broader context of the work in narratology, specifically the narrative elements which define the master story, the counter story and finally the metanarrative, defined by Lindemann-Nelson (2001) as the final product that narrative repair seeks wherein all parties support the new vision that has emerged from the counter story. This chapter delivers the participant's (storyteller) experience; its focus is to present the study's results following application of narrative repair to reveal counterstory narrative elements and the potential for a new metanarrative.

Before I begin Section I, it is worthwhile to review the analytical approach in examining narrative elements - consisting of narrative injuries, narrative ruptures and emerging narrative elements that arise from examining the participant's (story) experience. An illustration is immediately below.

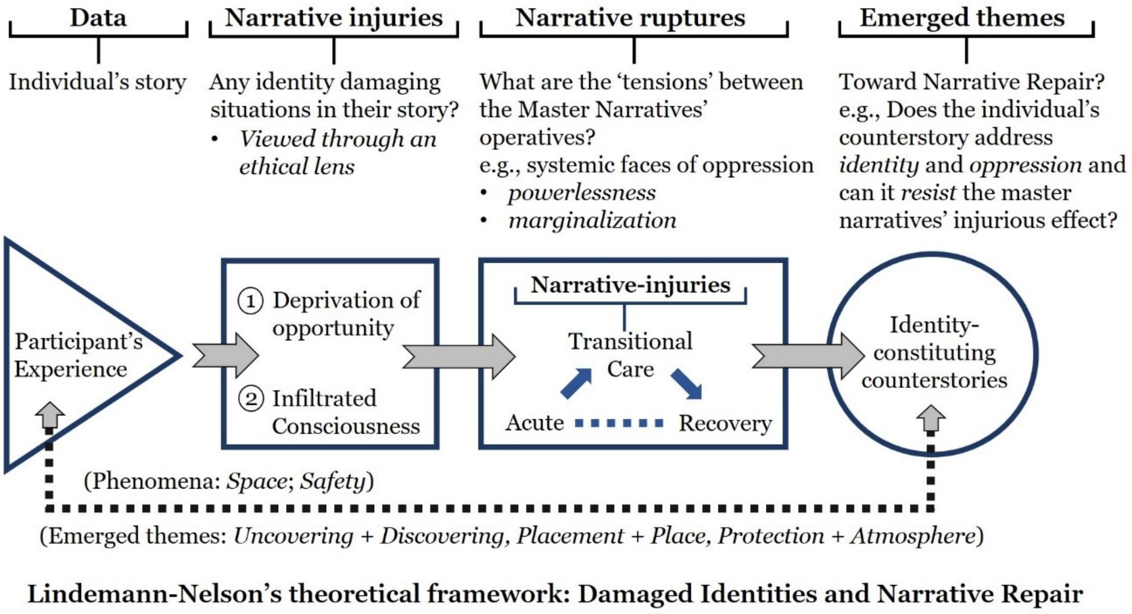

Figure 1. Lindeman-Nelson's theoretical framework: Damaged Identities and Narrative Repair

Section I: Whose Story is It?

While I set the stage with my first interview question, *what was it like to leave the hospital and get back to living in the community*? the participants' collective response — *can I first tell you about what I experienced in the hospital*? produced a broader framework to encompass phenomena of the acute-recovery cycle. The analytical work below follows participants through these 'cyclic' events. In this instance, the storyteller's insight changed my assumptions about transitional care. The data provided me with insight into participants' experiences in ways I had not anticipated: specifically, I was guided by participants' responses to draw from the literature about hospital readmission, and to return to chapter 2 to include it, as well as to question[6] in this chapter what it can mean to go through multiple transitional care experiences.

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[6] Field note memo: The ambiguity experienced by people with SMI, trying to understand who they are and what they can be doing, regaining short- and long-term care (includes (continued on the next page)

The researcher's perspective

Recalling Kvale's (1983) interview methods described in chapter 3, the first interview, or *life-world* interview, is about the individual's relationship to the world. Here, the interviewer and interviewee talk about the participant's prevailing social situation. In this project, this situation would be transitioning from acute care back to the community. Central to capturing this experience is seeking meaning from participants' detailed descriptions and achieving a better understanding of what was said "in between the lines" (Kvale, 1983, p. 175). For the purpose of this project, this involved not only listening to the participant's verbal response, but paying attention to vocalization, observing facial expressions, and body gestures. I took note of these during the first interviews without interpreting participant actions and meanings. I investigated the potential of these messages prior to and during the second interview, which per Kvale (1983) explores meaning within central themes of the first interview. Here, I also encouraged participants to draw their surroundings.

Following the analysis process laid out in Chapter 3, I began to learn that Zoie's insights were representative of all participants within the study, and I was able to rely on her thoughts to drive the analysis. However, to ensure the triangulation of findings, the chapter concludes with an in-depth exploration of the insights of William and Sophia,

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the current re-hospitalization experience): Although the interview question regarding transitional care, -*what was it like to leave the hospital and get back to the community, to your home* [*living*]?- the participants indicated that personal transitions are ongoing, and that transitional care is understood through terms based on their own experiences. In addition, my casual conversations with staff corroborated participants' concerns, as their clients' past issues regarding personal transitions remain problematic. Transitional Care staff see that their client's requests about their diagnosis and medications is sporadically addressed by the health professionals on their mental health team without giving satisfactory explanations going forward.

two other participants in the study, in a sort of dialogue as the conclusion of the work is presented. (Their demographic information is provided at that point in the chapter).

Framing the presentation of results

I will employ Zoie's own words, gestures, and graphic illustrations to examine narrative injury and ruptures, in keeping with the tenets of the framework for Narrative Repair. Mainly focusing on *in vivo* statements, these provided a wayfinding system through her acute-transitions-recovery story and helped to identify emerging, overarching themes as well as the narrative elements to begin reconstructing the counterstory.

Table 6 below, Framing the Results provides a visual of the codebook used in the analysis; the results are presented in sections I, II, and III below. The headers within the visual denote what will be presented in sections I (metaphor theme, drawn from *in vivo* statements) and II (relational codes). The first narrative element to emerge, denoted by interview excerpt (IE) 1 is listed in the visual as well, as this provides a grounding point to establish Zoie's experience and to open the analysis for additional narrative elements to emerge. (Note: Bolded text and boxed highlights are used to unfold of the story, in the presentation of the results below).

Table 6

Framing the Results

Codebook Category
Section I/Narratological considerations Coding Category: **Meaning and metaphor**

(metaphors provide the organization of the small stories and a system to track emerged narrative elements)

Interview Excerpt (IE) following Zoie's story (readmission + discharge experiences/small stories)		**Applying Narrative Repair Principles** (NRP)		
Narrative Element	**Power Related Dynamics**	**Narrative Ruptures**	**Narrative Injuries**	**IE - Emerged Narrative Elements** (NEs)
IE 1 Metaphor • "*go through the runaround again*" • "*picking up the broken pieces*" *Body and language are inseparable	***Section I code** Metaphor establishes Self-evidence	(Chapter 2) Master Story Historicity: *Overcontrolling*	Operative inconsistencies in Acute and Community care settings	***IE 1 (a)** *Meaning can repair or change the direction of personal transition*
	Section II codes • Overcontrolling (applying NRP/IE-NEs) • Equitable (emerging IE-NEs) • Uncharted (emerging IE-NEs)	**Dominance** *Nosology* *Pathology*	**Effect on the i-SMI's** *Powerless* *Marginalized* *Violated*	

The participants

Zoie is in her mid-twenties and lives at home with her mother. Currently, she is unemployed and dependent on ride-share transportation to various day programs, clinical appointments, shopping for groceries, and sponsored recreation. Her mother's home is in a rural area, and the usual one-way trip into the city takes about forty-five minutes to one hour. Also, her mother's home is on the same street as her sister's home. During the transitional time frame, Zoie is regaining access to day programs and contacting members of the managed care team and is trying to secure educational funding. Her goal is to build a career in early childhood education and psychiatry. Her favorite hobbies include creating artwork and poetry and working with children. Zoie's general diagnosis is schizophrenia, she suffers from depression and bulimic episodes and is challenged with suicidal thoughts. However, she told me she wishes to become successful in different social roles, i.e., wife, student, having a professional career.

The participant's perspective

We see how Zoie's *in vivo* statements allow her voice to stand out (and bolded text). In keeping with the methodology of this work, we can expect to see various textual meanings emerge from the interview excerpts. As Kvale (1983) suggests, reading in between the lines, Zoie says of her illness and transitions from acute to community settings that she is "picking up the broken pieces," a sentiment also observed through her body gestures [*gulps in a breath, eyelids opening up and down rapidly and voice stuttering*] and following narrative threads that weave in personal notions and institutional expectations and adjustments being made in the context of health care services. Zoie's "whole cloth" explanation is provided in the box below, the presentation of results follows, with elements from the literature fleshing out the interpretation.

Interview excerpt (IE) 1: Narratological considerations: *metaphor and meaning* — following Zoie's story (readmission + discharge experiences/small stories)

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*Z: I didn't want to go back to the hospital, **I didn't want to** – **go through the runaround again**, with going back in the hospital, getting better and having to pick yourself back [*gulps in a breath, eyelids opening up and down rapidly and voice stuttering*] **and – to – pick – the pieces up – that you had broken.** And, so, I fought with [my sibling] for a little while, and then [my sibling] took me to the ER.

*I: Help me understand, what do you mean by, 'picking up the broken pieces?'

Z: I feel like, when I go the hospital, like I'm broken. And, then I go to – I go to into the hospital and its – I perceive the hospital as it can be a good thing at times – but, I feel like a – like you're going backwards, it is taking a few steps in your recovery, to be and to go to a hospital – It's like you're starting from day one.

*Note: The voice of the interviewee Zoie (Z), and my voice, the interviewer (I).

Picking up the broken pieces. Kirmayer argues that meaning through metaphor is not only a representation but meaning presents the individual's reality: "[t]he bodily grounding of metaphor is based in the hierarchical elaboration of sensorimotor equivalences. The social grounding of metaphor resides in the pragmatics of language where context and intention are inseparable from meaning" (Kirmayer, 1992, p. 323). Thus, the body and the text are inseparable, providing the individual experience and the means of communication. As Kirmayer suggests, these contribute to a sense of self: "even the few words... invoke a whole conceptual space or world" (Kirmayer, 2000, p. 155).

The master story is that i-SMI's are perceived as psychopathological, disordered agents, not able to put together their fragmented selves, which raises questions of morality and agency. Notwithstanding the i-SMI's experience of psychotic episodes, the research shows that others' attitudes can also alienate the individual as they try to understand their own illness and wellness realities. Mackenzie and Poltera (2010) assert that with appropriate care, support and medication, the complex process of narrative self-constitution can occur, and i-SMI's can make sense of self and disability in a meaningful way.

Frank (1993, 1997) also pays close attention to the patient's stories, as he observes that clinicians interpret patient's illness enactments as constructing *patient-with-a-diagnosis-identity* (Frank's emphasis) when in fact patients outside of clinical settings pursue *wanting-to-be-patient-no-more* (Frank's emphasis). Beyond the clinical settings, health professionals may be unprepared to see the individual's self-narrative development.

Zoie was talking, moving, gesturing, and drawing throughout the interview process, a central uniqueness of this research project in particular, the immense value of which is discussed more in chapter 5 as an implication for practice. This interview strategy addressed what Becker laments: “sensation and bodily expression are undervalued, narrative is our primary means of accessing the world of bodily experience and is essential to our understanding of that experience” (Becker, 1997, p. 26). Narrative, for this project, purposefully encompassed much more.

Narrative ruptures

Zoie, during these interviews, is currently accessing transitional care. We can see in her reflection below on being readmitted “again” (Zoie’s emphasis), that narrative ruptures arise between acute care and recovery and that inconsistency still exists: “it’s like you’re starting from day one again” (Zoie’s emphasis). In the backdrop of Zoie’s present situation, her story emerges against the historicity of healthcare master narratives. Recalling Chapter 2, and the move toward a diagnostic structure to develop a wider research base regarding causes of mental illnesses, thus deconstructing the P-SMI’s experiences.

> Z: I perceive the hospital as it can be a good thing at times – but, I feel like a – like you’re going backwards, it’s taking a few steps in your recovery, to be and to go to a hospital – It’s like you’re starting from day one.

At this point in her story, Zoie talked about “picking herself back up again” as she is describing herself as “picking up the broken pieces,” it is important to realize that her actions involve relational dynamics between various professionals (providers) and nonprofessionals (herself, the i-SMI) and that these activities correlate to physical locations - the “hospital” or “recovery clinic” or “home” and other places in the community.

Narrative injuries

Zoie's story represents the phenomenon of transitioning from acute to community settings. Tracking meaning and metaphor in Zoie's statement in the above interview excerpt (Interview excerpt 1: Narratological considerations: *meaning and metaphor*), Lindemann-Nelson's theory frames reconstitution of identity as the work involving the storyteller's intent to reestablish moral agency. Zoie's challenges emerge in the actual telling of her story, specifically in obtaining degrees of professional endorsement for her to reconstruct her own moral agency as she moves from acute to community setting. As observed in the master narrative presented in chapter 2, P-SMI are excluded from choosing a direction regarding where they can go to get help and how they are viewed by others. Mackenzie and Poltera (2010) emphasize that others' responses can reinforce the existing structure of vulnerability, and adversely impact the i-SMI progress toward reconstitution (described in Lindemann Nelson's framework as resulting in *infiltrated consciousness*).

Zoie shows us that the i-SMI seeks social interaction and a connection across and within body and mind. Reductionist trends in understanding these individuals can enable this population's disempowerment via narrative injuries on multiple levels caused by the separation of the body and mind. This can deconstruct the i-SMI identity in the larger context of transitional care. As Zoie reports: she experiences "[G]going backwards" (Zoie's emphasis) while in acute care and in "a few steps in [my] recovery" while in transition to managed care.

Narrative repair: identification of the first narrative element

Recall the literature from chapter 2: there are different ways to identify individuals with or without a mental illness and these can create relational tensions beginning with acute care and as i-SMI's transition and access various community care settings. “We define illness identity as the set of roles and attitudes that people have developed about themselves in relation to their understanding of mental illness” (Yanos, Roe & Lysaker, 2010, p. 74). For Zoie, there is an important distinction between what the literature describes as the biomedical interpretation of recovery “from” mental illness as complete remission of illness and returning to an original state without symptoms, and recovery “in” mental illness, managing symptoms and being mentally ill (see Lysaker, Roe, & Yanos, 2007; Yanos, Roe, & Lysaker, 2010).

Against this backdrop of narrative ruptures, we can expect to see a ‘cyclic’ complexity with degrees of narrative injury, for example, assumptions about whether an individual must recover *from* mental illness or whether a recovery *in* a mental illness is possible. The meaning of recovery and the possibility of these two different orientations — *from* or *in* mental illness — impacted Zoie’s self-constituting efforts. When Zoie was able to acknowledge that she continues to suffer from a mental illness and can function within that context in a positive way, rather than holding herself accountable to recovering entirely from that illness, her view of her transitions changed. Here, the first narrative element appeared in the data: the data showed that (a) *meaning can repair or change the direction of personal transition.* Throughout the presentation of results, emergent narrative elements are identified by the letter that denotes them in the coding manual (visuals of this manual are presented throughout the results) and are italicized.

Conclusion

This section has discussed narratological considerations, the researcher’s perspective, and employs what I have learned from the data. Zoie’s *in vivo* statements coupled with the literature, helped to move toward narrative repair and uncovered the first narrative element, *meaning can repair or change the direction of personal transition.* Using the process, examining narrative ruptures and their injurious effects lead to this important narrative element in the context of Zoie's choices about recovery *from* or *in* a mental illness.

Section II builds from the IE 1/Narratological considerations *metaphor and meaning* and examines Zoie's experiences of transitional care, what are categorized in the data as "overcontrolling," "equitable," and "uncharted" relational dynamics, these emerging inside two themes from the codebook: *Demeaning Experiences* and *Meaningful Inclusion*. Following Zoie down through this section, the codebook category *Constructs of personal transition as narrative self-evidence* prepares the reader to hear Zoie's thoughts on her transitions. We can expect to see how she lives in the moment – integrating gestures and textual elements.

Section II: Transitional Care - a Time to Consider Potential Gains

As asserted in section I, Zoie sees a recovery *in* mental illness. She is acknowledging her care transitions will continue and is accepting of herself managing her disability and symptoms, seeking reconstitution: "I've been more understanding and accepting of being labeled SMI. Because, SMI doesn't mean a bad thing, like I get more resources …I have a lot more struggles and challenges to get through to be able to do the things that everyone else does" (Zoie's emphasis). Her mainstay orientation is about gaining a "sense of self …within myself"[7] (Zoie's emphasis) and is partly co-constructed with the professionals[8] supporting her. First, her orientation is dependent on

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[7] Field note memo 7: The participants of this study expressed interest in finding opportunities to tell their stories to peers and their caregivers. The data also showed the development of the self-narrative itself to be instrumental in collective decision-making processes involving health professionals.

[8] Woltmann and Whitley (2010) posit, "The tendency of consumers to either verbally defer to their case manager when a disagreement arises or interpret past disagreements as arising from their own failings in judgment may be due, in part, to truncated social networks and the natural desire of individuals to check the validity of decisions with (continued on the next page)

professional endorsements to gain degrees of agency and partly accepting the definition of SMI in order to access programs. Second, her orientation relies on her diverse experience, aspects of her social relationships and physical connection to places, to develop her own space. As Zoie puts it: "[t]hey support me in the direction that I choose, and they give me the room to be creative and be – to express myself" (Zoie's emphasis).

Zoie reports that she has revisited her concerns with health professionals because early on these were not in alignment with her recovery orientation and/or failed to resolve them from previous hospitalization. In this respect, Zoie may seek recovery "differently" according to the context of transitional care, and in relation to her times of personal adjustments, e.g., Zoie reports that she is now considering her own education (taking on the role of the student) and accepting accommodation for education.

Unexplored transition potential

At this point in her recovery-oriented timeframe, Zoie is looking forward to re-establishing moral agency and autonomy. Recently endorsed by the acute care team, the clinical narrative asserts that she's stabilized with medications and is not a threat to herself or to others. In effect, the clinical directive is an authorized discharge agreement between health professionals. Thus, diagnostic understandings of Zoie are transferred to case management in community care. However, Zoie's transition potential had not been addressed at the time of discharge — "It's just the case management team kind of looks down upon (name of TC /recovery-oriented provider)" (Zoie's, emphasis). Zoie's

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trusted others. Another explanation may be that consumers have been deprived of agency and self-efficacy by previous encounters with the mental health care system and therefore are unaccustomed to making decisions independent of clinicians" (p. 34).

personal adjustments are necessary to gain autonomy[9] after restoration of moral agency. It is important to realize Zoie's concurrent adjustments consist of balancing medication and side effects while earning degrees of freedom, these occurring in different places in the community. Also, important to note is the power differential inherent in health professional relationships, and how these can inform the i-SMI's experience of transition, discussed further as an implication for practice in chapter 5.

Unaligned personal transitions

After leaving the psychiatric hospital, Zoie is in a transitional time frame of three months, determined by health insurance policy. Inside my analysis of this timeframe, codes identifying relational power dynamics emerged, and are reflected in a piece of the project's codebook: Overcontrolling, Equitable and Uncharted, as they describe Zoie's personal transitions related to the first narrative element, (a) *meaning can repair or change the direction of personal transition*. Guided by this understanding, a presentation of results related to the category *Constructs of personal transition as narrative self-evidence* is discussed below under the sub themes of *Demeaning Experiences* and *Meaningful Inclusion* from the code book. Between these contrasting power relations, we can expect to see what Zoie does to resist what she perceives as an oppressive influence.

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[9] See Laor (1984) "For no matter how clearly autonomy is defined and no matter how limited is the defect-in-autonomy the conscientious individualist, whether his concern is with mental health, with legal practice, or with philosophy, has to choose between prevailing intuitions which permit, at times, imposition of psychiatric treatment on the mentally ill, at times, no imposition at all" (p. 334). "Modern psychiatry clearly deals with the distinction between the autonomous and the defective in autonomy. Thus, as the natural next stage of inquiry, psychiatric diagnosis is to be considered as a case-study of ethics in general and of medical and psychiatric ethics in particular" (Laor, 1984, p. 345).

Overcontrolling Relational Dynamics

Following Zoie’s movements down through readmission inside the coding category of overcontrolling relational dynamics, a narrative element regarding Zoie’s experience of place-related access to health services emerged. A visual of the slice of codebook aiding in the analysis of Zoie’s experience within the hospital ER intake and care unit, psychiatric care unit, and psychiatric intake unit is provided below (Table 7 shows a preview of emerged narrative elements correlated to place-based health services). Although one would assume that logically, presentation of intake experiences should precede care experiences, Zoie's discussion of her own experiences unfolded in the order above. In order to remain true to the way in which she understands her own experience the data are presented in this order. The literature on agency and physical space helps us to unpack what she experiences in these settings, showing that a place of therapy is controlled beyond the physical confinement of an acute care facility; this control extends to transitions to and within community settings in terms of access to services, as well. Albright (2015, 2018) takes into consideration the scholarship that suggests a neuroscience for architecture and asserts that the effects of the physical environment not only influences social organization but considers that the built environment can actually dictate outcomes: “elicit[ing] internal states that benefit sensory, perceptual and cognitive performance, and behavioral outcomes” (Albright 2018, slide 129).

Table 7

Overcontrolling Relational Dynamics

Codebook Category: Interview Excerpt (IE)/
Sections I & II/Constructs of personal transition as narrative self-evidence

Emerged Narrative Elements

	Codebook Theme: **Demeaning Experiences** (DE)	**Place Related**		Codebook Theme: **Meaningful Inclusion** (MI)
IE 3 (c)	*utility of physical space in places of therapy undermine one's efforts to maintain agency*	Hospital ER at intake and exam room	**IE 2** (b)	(in the context of diminished agency) *performing identity triage* • Patient's narrative co-constructed (MI) • Patient's narrative used for clinical assessments (DE)
(d)	*diminishing moral agency + identity in mental illness:*			
(d.1)	*"I walked into the ER, um – someone had asked me why I was there, and I said that, "I am suicidal." And the looks on her face was like, "okay what do I do?" – this was the intake person, she had this look like "why?"*			
IE 5 (e)	*Unresolved health professional power that suspends agency*	Psychiatric acute care intake	**IE 5** (f)	*"it would have helped if I had a little more — compassion or empathy of what I was going through, [lowers hands and rests both palms flatly on top of the drawing*] ***because it should be focused on the patient**."*
(e.1)	"*it's probably more convenient for them to do it the way that they are doing it, but they need to — know tha t — whatever they are doing its* ***it's TEN TIMES harder on the people going through, with whatever they are going through***"			
IE 6 (h)	(in the context of discharge) *untapped i-SMI's experience-based narrative*	Psychiatric acute care unit	**IE 4** (g)	(in the context of therapy) *Personal space of safety* ["**Safety bubble**" combines social and physical spaces] and (in the context of self-evidence: mapping-emergent narratives and boundaries)
(h.1)	*"But I felt very – like thrown under – like –* ***thrown under the rug****. They didn't want to deal with me anymore. So, that they were just sending me to an ACT team."*			
(h.2)	*"They decide what's going on. Kind of like – a jury, coming up with – guilty – or not guilty. Like they decide my fate. It's kind of how that feels sometimes – is* ***I'm out of the loop***."			

Hospital ER. While Zoie was admitted in the hospital ER immediately after a relapse, she waited five hours before the crisis prevention and response (CPR) worker arrived to make an assessment. She and a CPR worker co-created a narrative based on Zoie' s verbal account. Based on the data, it could be argued that this was Zoie's first opportunity to tell her story during a stressful time (boxed highlight). In the situation below, a form of *narrative triage* (my emphasis), a concept that emerged from the data and that is talked about more in chapter 5, delivers a glimmer of hope for Zoie to preserve "be WHO I am and just–be" (Zoie's emphasis).

IE 2: Constructs of personal transition as narrative self-evidence: **Emergence of *performing identity triage*** (my emphasis)/*Meaningful Inclusion*

Z: The CPR worker got there about nine – at night. She had asked me; "*what happened that day; how I was feeling*." The CPR worker, **I felt like she was very thorough with the way that she was asking the questions, she was comforting, she was understanding, she was personable. She actually really helped me calm down a lot and be able to explain to her what was going on – before that I got to the hospital.** And she had told me that her recommendation was for me to; "*go to inpatient*" – to – "*a hospital,*" and asked me if I was, "*going to voluntarily going to do that*," I said, "*Yes*." So, that meant that she was going to send my packet out to different places so that I would be able to go to be inpatient.

I: What did you think of her assessment of you?

Z: Um – her assessment did made sense to me. Um – she actually wrote down what I wanted her to write down, like she asked [*eyelids open and close rapidly*] – is like [*stutters*] – she would repeat what said to her, so that, she [*eyelids open and close rapidly and stutters*] – she – I knew what she was going to write down. It was all my words, and I felt that – that was really good.

The CPR worker's assessment fulfilled the design of its purpose, to convey Zoie's narrative, informing the clinical team. By volunteering to get treatment at a psychiatric hospital, Zoie kept herself out of court-ordered treatments and the legal system and did this purposefully. Zoie's volunteering is positive in the sense that she was able to talk with the care team regarding pathology, disability, and impairments rather than becoming mired in legal aspects that may not have addressed her problem with such immediacy or delayed her in her journey to recovery. In this situation, (b) *performing identity (narrative) triage* was identified as a narrative element - it serves as a brief opportunity for Zoie to regain personal control and chronicle trauma with the CPR worker. This is in stark contrast to her ER intake experience below.

Hospital ER intake. In this situation, we can begin to see how demeaning experiences are socially dismissive (boxed highlight 1), Zoie's moral agency is diminishing against a backdrop of professional protocol, setting up examinations (boxed highlights 2, and 3). In this example, we can also realize how the (c) *utility of physical space emerges as undermining one's efforts to maintain agency*. The literature is useful in exploring what Zoie is experiencing below. Place-based experiences are shown to shape what individuals see themselves doing in those places (Low, 2003; Low & Altman, 1992). In Zoie's case, the physical space informed her experience and her understanding of her illness at that particular juncture. She talks below about how the care team removed anything in the room that she might have used to harm herself, and while she understood why, it was still a negative experience for her. Her placed-based experience shaped even her words in the interview - "It was cold, and they had asked me to take everything off…everything was taken from me" her body experiences this directly. Grange (1985) would agree with this close connection: "without place, there would be neither language, nor action nor being as they come to consciousness…" (p. 71). This way, place-based experiences are embodied by individuals and share the symbolic meaning of the architectural form, in Zoie's case an empty "gutted" room. Zoie's experience in the ER the data show that the system and its physical aspects may have negatively influenced her ability to maintain her agency. These combined have a devastating effect on Zoie.

IE 3: Constructs of personal transition as narrative self-evidence: **Emergence of *the diminishing agency*** (negative effects combine social and physical characteristics)/*Demeaning experiences*.

I: Walk me though that experience, when your [sibling] took you to the hospital-ER.

1 Z: I walked into the ER, um – someone had asked me why I was there, and I said that, "*I am suicidal.*" And the looks on her face was like, "*okay what do I do?*" – this was the intake person, she had this look like "*why*?"

I: Where were you when you come across this intake person – in the ER?

Z: Um – I had walked into the ER, and because it was after hours so we couldn't go through the hospital part [*begins gesturing using both hands, hovering over the surface of the table, creates shapes using fingers to trace the movements of herself walking through the hospital*] – so I walked in to the after hour side [*stutters, eyelids moving up and down rapidly*] – which was the ER, and [my sibling] was next to me, and they just told me to sit in a chair – like right in front [*stutters*] cuz, this is a small hospital.

So, I sat in the chair, and they got, [*stutters, eyelids moving up, down, rapidly*] they got a room. And, they – [my sibling] had said that [they'd], "*had never seen them gut a room like that*" – they took all the wires, they took all the equipment, they took all the oxygen wires, all the – everything that I can hurt myself with was taken out of the room – by the healthcare professionals. And they…

I: What did it feel like to be in that gutted room?

Z: **It was cold, and they had asked me to take everything off**, and just wear a gown. So, I had to wear a gown. They – they – asked for all my jewelry, all my – cell phone, everything was taken from me.

I: Do you recall what you were thinking or feeling about how everything was taken from you?

2 Z: **It was kind of demeaning**. It was kind of like, I understand that they had to because of health and safety reasons, but the way that they did it was kind of un – they weren't very personable about it – comforting.

I: What do you imagine telling the health professionals to make any sort of changes?

Z: Well if – if they have to gut the room, maybe talk to you and tell you why they are doing it, and probably – like explain what they are doing as they are doing it, instead of just [*stutters, eyelids moving up, down, rapidly*] gut – like – the way they did it was very quick – and very – [*gestures with hands, fingers held tight against stiff solid palms, making chopping movements in the air*] – like very strict – like, "*we gotta get this done before we bring her in here.*"

3

And we could see them just taking all of the gloves out, all – everything that was in the room got taken out. So, going back – they had, [*stutters, eyelids fluttering up and down rapidly*] they escorted me into the room, and the room was like [*gesturing using both hands, hovering over the surface of the table, using fingers to trace walking through*] right by the nurse's station.

So, when I was on the bed, I could see out – and they kept the curtain open, so I could see them. And um – my [sibling] was talking – they – just left me alone in there – like my [sibling] was there, but they had to keep the curtain open a little bit, and I was just alone with [my sibling], they didn't come in to – the doctor didn't even come in for – a good hour.

Psychiatric acute care. This part of this story may seem out of sequence, as we would expect to see next after hospital intake, Zoie transported via ambulance over to psychiatric acute care intake and finally placed into psychiatric acute care. In this case, it was important for Zoie, and for us to see first how placed-based intake experiences can be different. While an inpatient in the psychiatric unit, Zoie reveals that she develops her personal space of safety - what she refers to as "the safety bubble." She incorporates the helpful relationships of the staff members and integrates these with her experience of the built environment – "a sense of self…within myself" (Zoie's emphasis). It is noteworthy that Zoie is developing a space of her own which is underreported. This remains unnoticed even at the time of discharge.

IE 4: Constructs of personal transition as narrative self-evidence: **Emergence of a *personal space of safety*** (combining social and physical spaces, mapping-emergent narratives and boundaries)/*Meaningful Inclusion*.

I: So, what happens with your safety bubble — do you want me to guess that it keeps moving with you being at its center?

Z: [*looks up from the drawing with a grin and catches I's gaze which is focused on the diagram*] Uh-huh (humming) — [**S looks over momentarily to where the crayons, colored pencils and markers had rolled away and asks I, "do you have that?" I responds: "I think we do." I then gently pushes all of the drawing instruments and rolls them along the table surface towards Z. Z then picks up a green colored marker and begins to make tight circular-like markings as she describes being in the different areas/locations.*]

*Note: Stanley (S), pseudonym for the health professional present in the interview room.

> So, usually ME would be right here, or right here — so, I'm right next to um — the nurse's station — but, I also liked being at the pool [*makes a tightly-swirled mark on the paper*] and um — they would bring animals, so I REALLY liked the animals, that was really — that was really — comforting and helpful [*voice is melodic almost singing. Z creates an open circle.*] they had horses [*makes a few arcing lines by stroking away from the circle's perimeter-outline-edge*], um dogs, they did horse therapy, equine therapy. So, I felt safe within this WHOLE — like this is the unit safety level [*points using the marker holding it tightly with her right-hand and gestures with a circular movement over the Name of space (theme 1) area which is already drawn*], and then the whole [*pointing using the marker holding it tightly and with her right-hand making a wider circular gesture to encompass the entire drawing*] hospital is still a big safety level. Like [*silence over 5 seconds*] they take extraordinary measures to make sure that you're safe. (See below, figure 2)

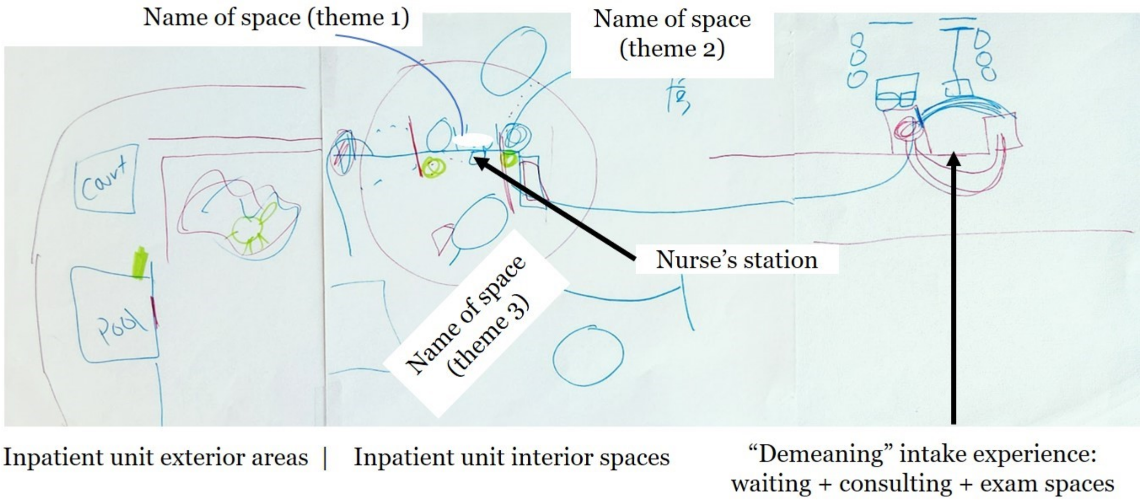

Figure 2. Map of an emerging personal space of safety during psychiatric acute care. (Memo: The utility of the second interview provided peer review: Learn more about the emerging themes, clarify details, obtain i-SMI's descriptions and meaning.)

Tracking Zoie's experience with the literature, Abroms (1969) posits psychiatric treatment sets limits on the individual's symptomatic behavior and learning basic sets of psychosocial coping skills. Milieu Therapy (MT) is intensely focused on the individual's capability, setting up personal goals in order to modify destructive social behaviors. Unique to MT, is that the individual's threshold is tested inside highly structured social boundaries and the physical setting is manipulated as a means of experiencing the lived reality.

Thus, MT can be extended to a therapeutic community, as the individual can learn occupational and recreational skills:

> [Orientation] – According to the conventional medical model, a patient is either fully oriented as to time, place, and person, or he is not usually because of altered brain function. Viewed as a social skill, however, orientation can be learned and is susceptible to gradations almost without limit. [Assertion] – As these pathological expressions are limited, the patient must replace them with more direct and regulated means of asserting his needs and wishes…he must learn directly to assert his aggressive energy without annihilating or disconfirming those on whom he depends for social relatedness (Abroms, 1969, p. 554).

Mahoney, Palyo, Napier, and Giordano (2009) point out that MT was traditionally thought of as a costly unit-bound/program-based environment which focuses on patient safety. I-SMI's typically stay in acute care for a short period of time, and MT does not translate successfully into community care settings. (Recalling chapter 2, current practice is reduced to safety and its focus is on symptom reduction and cost containment). On the grounds of integrating the patient-centric movement, Mahoney et al. (2009) suggest that a reconceptualized therapeutic milieu is to develop a negotiated network of human-to-human and human-to-environment relationships. This is an untapped area of potential development, the opportunity to use the i-SMI's narrative and understand how self-evidence informs the personal habit.

The scholarship in this section suggests that the intense therapeutic work is based on the MT tradition. In the IE 4 story, Zoie revealed how she had developed her personal space of safety while in the psychiatric hospital. She explains more about this in IE 5: "Once you get onto the unit — then they help you to create the [safety] bubble, they ensure that you are safe" (see in IE 5, below Zoie's emphasis). In her quest to describe how she and the staff used different spaces within the psychiatric facility, Zoie was compelled to draw a map - integrating her words with body gestures, and mood [voice is melodic almost singing].

She deliberately used different colors in what appeared to show a hierarchy of meaningful relationships. In this context: Green represented herself, placing and mobilizing personal use of space; Red, seemed to represent critical areas and features, such the nurse station and locked doors; Blue, to indicate the physical limits of spaces, such are the boundaries of a room, larger areas of the pool or small features such as chairs in the intake room. (See *Figure 2.* above).

> **e.g.**, Z: So, usually ME would be right here, or right here — so, I'm right next to um — the nurse's station — but, I also liked being at the pool [makes a tightly-swirled mark on the paper] and um — they would bring animals, so I REALLY liked the animals, that was really — that was really — comforting and helpful [*voice is melodic almost singing. Z creates an open circle.*] they had horses [*makes a few arcing lines by stroking away from the circle's perimeter-outline-edge*], um dogs, they did horse therapy, equine therapy.

However, the psychiatric acute care intake event below is in stark contrast with Zoie's experience inside the psychiatric acute care unit ("it's ALL-IN limbo because you don't know if you're getting admitted or not" (Zoie's emphasis)). Again as a reminder to the reader, the psychiatric acute care intake below does not follow the order of getting an i-SMI admitted [e.g., the order that one would expect; from hospital ER intake, then transported to psychiatric acute care intake and at last admitted to the psychiatric acute care unit]. Rather, these out of sequence IE's indicate the sort of activities that Zoie embodies from place to place, as she 'picks up the pieces' and tries to prolong agency. In the example above, we can see that she recalls placing herself next to the nurse station. It is in this sense that Zoie's experience includes Orientation and then Assertion (see Abroms explanation above). As she describes her experience next to the nurse station, her voice was melodic, and she was gesturing with her fingers, stroking the paper, and lightly gripping the marker. As she describes her demeaning experience during psychiatric intake, the tone of her voice got taught, and her body reacted. She applied a tighter grip on the marker and occasionally formed a fist to knock on the table to emphasize the words. (See IE 5 below).

Recall the statement at the outset of this section talking about the way in which Zoie ordered her experiences in her interview. Although this may run contrary to what one might assume to be a more "logical" order of ER intake, psychiatric intake and psychiatric acute care, this section concludes with Zoie's experience of psych acute care intake because that is how she spoke to her experiences in the interviews. Remaining true to this order is central to the methodology.

Psychiatric acute care intake. The IE 5-Emergence of the narrative element *unresolved health professional power that suspends agency* is a story that is like the Hospital ER (IE 3) experience. The difference is that Zoie travels between two specialized places of therapy, a hospital and psychiatric hospital, each place with distinct health professional orientations and services, and as well the experience of safety. (The reader should keep in mind; Zoie's emotional trauma had started at 4:00PM (hospital ED) until she arrived 12:00AM (psychiatric hospital). After she had a positive experience with the CPR worker *performing narrative triage* she was then transported in an ambulance to the psychiatric hospital). The notion of Zoie developing a personal space across this stretch of time is absent (boxed highlight 1) until she gets admitted (boxed highlight 2).

> **IE 5**: Constructs of personal transition as narrative self-evidence: **Emergence of *unresolved health professional power that suspends agency*** (a separation of social and physical spaces/untapped development of personal space)/*Demeaning Experiences.*
>
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>
> I: I would like to bring into this conversation is what you told me earlier — safety bubble. You told me that is takes you a long time to build it and that it holds a certain level of comfort for you — do you think that with this movement [*points to the intake room and then points to the consult/evaluation room on the diagram*] and as you are in "limbo" (Zoie's emphasis) — that health professionals understand what you are going through?

1 Z: When you are in this intake room, I feel that they are not concerned about your comfort level. I feel that they are concerned about getting their paperwork done and getting you either out the door or on the floor [*pointing to the Name of the unit/space on the diagram*] — Like that's their only concern, they're not worried about if you are cold, [*knocks on the drawing/table top with the butt end of the marker on the location of the intake room*] or if you're uncomfortable, or depressed, or if you need someone to talk to — they just leave you in this room [*places the marker down on the table surface and with the right-hand forefinger makes sweeping arc-like gestures touching the diagram where the consult/evaluation room was drawn*] and they get there questions and everything done and they get you here [*points to the inpatient rooms*] as fast as they can.

I: What would you like to tell the health professionals to change with this kind of situation?

Z: **They're process — is yes, it's probably more convenient for them to do it the way that they are doing it, but they need to — know that — whatever they are doing its TEN TIMES harder on the people going through, with whatever they are going through** [*right-hand forefinger makes sweeping arc-like gestures touching the diagram where the intake room was drawn*] in this intake room.

Like the people in the intake room are — like for me I was completely out of it [*looks directly into I's face*] I was not myself [*looks down on the drawing and with both palms and fingers spread out flat Z touches the paper then raises hands slightly up in the air to hover momentarily over the drawing*] and it would have helped if I had a little more — compassion or empathy of what I was going through, [*lowers hands and rests both palms flatly on top of the drawing*] **because it should be focused on the patient**.

I: [*looking at Z's hands resting flat on the drawing*] Help me understand this better, [*I looks directly into Z's face*] with your situation in here, you didn't feel that they helped you to create your safety bubble? (psychiatric intake event).

2 Z: Once you get onto the unit — then they help you to create the bubble [*forms a fist with her right hand and knocks with her knuckles loudly on the drawing/table surface twice*] — and they um, ensure [*knocks with her knuckles loudly on the drawing/table surface once*] — they assure you [*knocks with her knuckles loudly on the drawing/table surface twice*] that you are safe.

But when you are here [*picks up a maker in her right hand and uses its butt end to trace a circle around both the intake and consult/evaluation rooms*] **its ALL-IN limbo because you don't know if you're getting admitted or not.** You don't know if you're getting admitted until, like until they're ready to almost take you to the unit. Like you're in the same intake room for maybe another twenty to thirty more minutes after they've actually said, yes, you're actually being admitted.

Revolving acute care discharge. Zoie has had this hospital-ER-to-psychiatric-hospital-and-back-again experience repeatedly: discharge experiences that were dominated by the collaboration between acute care and the management care team, exclusive of Zoie's and the TC/recovery professional's orientations. As a result, a continual omission of her personal recovery orientation occurs, notwithstanding Zoie's deeper sense of an embodied self-narrative, being reconstructed and constructed.

> **IE 6:** Constructs of personal transition as narrative self-evidence: ***Emergence of untapped i-SMI's experience-based narrative*** (continuance of unresolved health professional power that suspends agency)/*Demeaning Experiences*.
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>
> Z: I was on an ACT [*assertive community training, an intensive reintegration program*] team before. But I felt very – like thrown under – like – **thrown under the rug** (metaphor element) – like – like they didn't want to deal with me anymore. So, that **they were just sending me to an ACT team**.
>
> I: How, did the clinical team decide to tell you that you needed ACT care?
>
> Z: Um – they told me about it in one sitting. They had talked – they had talked – like **the case managers talk with each other**, and then – when – they sent one person to tell [*eyelids rapidly moving up and down and voice stammering*] – me – what – their – **their verdict was, or their – decision**. And **I was just upset, too upset to just even talk to them**. So, I'm like okay. Um when –
>
> I: – What did you mean by verdict?
>
> Z: Well, I feel with this particular team that I'm on, they – they have – they talk about – talk about – [*eyelids rapidly moving up and down and voice stammering*] what's going to happen with me to each other – like **they decide what's going on**. Kind of like **– a jury, coming up with – guilty – or not guilty**. Like they decide my fate. It's kind of how that feels sometimes – is **I'm out of the loop** (metaphor element), so, I'm not – it's – like, **I have to go with what they say.** When I was ready to leave – well **in the hospital, they had said that it's my right** to go to (name of transitional care (TC) recovery-oriented (RO) provider), as an SMI – **as being an SMI**.
>
> And, being already enrolled in (name of TC/RO provider), and already – they should not **– my case manager should not have kept me from going to (name of TC/RO provider), because it was my choice.** (continued on the next page).

> Z: And, when I, I had called, um – that, that day – I had called my case manager, cuz they were getting ready to send me home [*inhales deeply*] – um, I called my case manager and I – expressed to them like; "*this is my choice*" and; "*I feel that you are working against me and not for me,*" and; "*I want to go to (name of TC/ recovery-oriented provider – I feel like (name of TC/RO provider) is the best for me right now*" – I don't – I just want; "*do you want me to – do you want to set up transportation for me when I get out? Or, do you want me to call (name of preferred TC/RO provider) for them to set up transportation?*"

In this situation, divergent services with what feels like no end (as revolving) to them suspend Zoie's personal transition. Zoie repeated this transition from acute care, where the health focus was on illness and medications, to a community care system where health focus shifted to behavioral involving psychosocial or rehabilitation programs. As shown above, Zoie determined she was going to recover *in* mental illness, but the complexity remains for her in terms of accessing and interfacing with a system of mental healthcare. Zoie must also consider the reconstitution of a basic agency with having a disability, thus needing a social prosthesis (in this context, supported by a psychosocial program to rebuild coping skills), or in the instance of impairment and constructing agency, the social prosthesis is gaining access to a place-made-to-order (in this context, rehabilitation that involves occupational training and education). Notwithstanding, the level of agency endorsements clinically determined and Zoie's untapped narrative.

Zoies' experience reveals are that places-made-to-order is about settings that contain organized activities, and she already has a preference, but she does not have access to a self-narrative, to talk through, talk with, health professionals. In sum, her use of metaphors in the IE 6 story embodies (what she is telling us "[t]hey decide what's going on,") and her physical body (basic agency arises from experience, self-evidence) feels it, and she says "like thrown under the rug…I'm out of the loop," and her case manager is unaware of Zoie's deeper sense of development; thus another narrative element emerges: *untapped i-SMI's experience-based narrative.*

Narrative ruptures

Recalling the context of Zoie's story, "I didn't want to go back to the hospital, I didn't want to – go through the runaround again, with going back in the hospital, getting better and having to pick yourself back" (IE 1), these *Overcontrolling relational dynamics* occur in Zoie's experiences of getting admitted and readmitted. First, they point to the unresolved perspectives on health and healing between health professionals, discussed further in chapter 5. Second, unintended negative effects born out of dismissiveness toward Zoie's attempts to voice her concerns that cause her various setbacks –"I feel like, you're going backwards, its taking a few steps in your recovery, to be and to go to a hospital – it's like you're starting from day one" (Zoie's emphasis). Together these repeatedly limit Zoie's recovery progress.

She is not able to combine treatment and therapy rehabilitation in her efforts to obtain degrees (prolonged endorsements from professionals) of her agency. As a result, Zoie cycles through this process, trying to re-identify herself against the backdrop of a master narrative that is orientated toward pathology, impairment and disability. The dominating acute care operatives set the direction for community care services and created ruptures in Zoie's efforts to understand herself and in recovery-oriented care coordination.

Recall the statement at the outset of this section talking about the way in which Zoie ordered her experiences in her interview. Although this may run contrary to what one might assume to be a more "logical" order of ER intake, psych intake and psych acute care, this section concludes with Zoie's experience of psych acute care intake because that is now she spoke to her experiences in the interviews. Remaining true to this order is central to the methodology.

Narrative injuries

The codebook sub theme *Demeaning Experiences* highlights systemic occurrences identified in the data that arise from health providers just following the rules that are part of doing their jobs, but these day-to-day activities adversely affect i-SMI's. Zoie pointed these out (*see* Table 7., p. 90) Codebook theme*: Demeaning Experiences/* IE 3, IE 5 and in IE 6) "going backwards" setbacks as violating "steps" of personal transitions in recovery. These narrative injuries indicate inadequate understandings of the i-SMI's *Homeworld*. (Examples from Zoie's story are again listed below). From the moment Zoie experienced an emotional trauma, the event overwhelmed her personal balance of control. (The reader should be aware that prior to this event, there were other points of contact with crisis prevention and family members. And even before that, Zoie was not able to gain access to a rehabilitation program). Zoie and her sibling arrived at the local community (general health) hospital.

> **IE 3: Emergence of *diminishing agency*** – This story thread continues with the progression of disempowerment/*Demeaning Experiences*.
>
> ***e.g.*:** I walked into the ER, um – someone had asked me why I was there, and I said that, "*I am suicidal.*" And the looks on her face was like, "*okay what do I do?*" – this was the intake person, she had this look like "*why*?"
>
> ***e.g.*:** I had walked into the ER, and because it was after hours so we couldn't go through the hospital part [*begins gesturing using both hands, hovering over the surface of the table, creates shapes using fingers to trace the movements of herself walking through the hospital*] – so I walked in to the after hour side [*stutters, eyelids moving up and down rapidly*] – which was the ER, and [my sibling] was next to me, and they just told me to sit in a chair – like right in front [*stutters*] cuz, this is a small hospital – so I sat in the chair, and they got, [*stutters, eyelids moving up and down rapidly*] they got a room. And, they – [my sibling] had said that [they'd], "*had never seen them gut a room like that*" – they took all the wires, they took all the equipment, they took all the oxygen wires, all the – everything that I can hurt myself with was taken out of the room – by the healthcare professionals. And they…
>
> ***e.g.*:** It was cold, and they had asked me to take everything off, and just wear a gown. So, I had to wear a gown. They – they – asked for all my jewelry, all my – cell phone, everything was taken from me.

> e.g.: It was kind of demeaning. It was kind of like, I understand that they had to because of health and safety reasons, but the way that they did it was kind of un – they weren't very personable about it – comforting.

In the emergence of the *diminishing agency* story above, Zoie goes through the deconstruction of her identity and physical agency. Both social and physical characteristics of the hospital environment amplify the trauma. As mentioned above, the scholarship in this section tracking this insight suggests that the intersection of social and physical boundaries in places of therapy are underdeveloped for persons with SMI.

Zoie arrived at the psychiatric hospital with her dignity and sense of self demeaned. Her attempt to maintain physical ownership of her body was thwarted. Notwithstanding that an assessment packet had been put together for the health professionals, Zoie does not understand what the content of the packet contains and how it will be part of what happens to her next.

> **IE 5: Emergence of *unresolved health professional power that suspends agency*** (a separation of social and physical spaces/untapped development of personal space)/*Demeaning Experiences*
>
> ***e.g.*: When you are in this intake room, I feel that they are not concerned about your comfort level. I feel that they are concerned about getting their paperwork done and getting you either out the door or on the floor** [*pointing to the Name of the unit/space on the diagram*]—Like that's their only concern, they're not worried about if you are cold, [*knocks on the drawing/tabletop with the butt end of the marker on the location of the intake room*] or if you're uncomfortable, or depressed, or if you need someone to talk to — they just leave you in this room [*places the marker down on the table surface and with the right-hand forefinger makes sweeping arc-like gestures touching the diagram where the consult/evaluation room was drawn*] and they get there questions and everything done and they get you here [*points to the inpatient rooms*] as fast as they can. (See Figure 2 above).
>
> ***e.g.*: They're process— is yes, it's probably more convenient for them to do it the way that they are doing it, but they need to—know that—whatever they are doing its TEN TIMES harder on the people going through, with whatever they are going through** [*right-hand forefinger makes sweeping arc-like gestures touching the diagram where the intake room was drawn*] in this intake room. (continued on the next page).

> Like the people in the intake room are — like for me I was completely out of it [*looks directly into I's face*] I was not myself [*looks down on the drawing and with both palms and fingers spread out flat Z touches the paper then raises hands slightly up in the air to hover momentarily over the drawing*] and it would have helped if I had a little more — compassion or empathy of what I was going through, [*lowers hands and rests both palms flatly on top of the drawing*] **because it should be focused on the patient**.

"It would have helped if I had a little more - compassion or empathy of what I was going through…because it should be focused on the patient" (Zoie's emphasis). Clearly, there is a gap in knowledge about the way i-SMI's incorporate experience and develop a personal space of safety. Zoie's burden is highlighted by the emerged code *over controlling power dynamics*: "it's probably more convenient for them to do it the way that they are doing it, but they need to — know that — whatever they are doing its TEN TIMES harder on the people going through, with whatever they are going through."

In the IE 6 story below, with the emergence of the narrative element, *untapped i-SMI's experience-based narrative* we can see how this knowledge gap bleeds into the community care arena and is paired with *overcontrolling power dynamics*. It is important to realize that health professionals continue to dominate the discharge event, as evidenced by Zoie's comment: "I'm out of the loop…they decide what's going on…[k]ind of like a jury, coming up with — guilty — or not guilty." This is a vulnerable time for Zoie as she is being discharged from acute care and is transitioning to community care settings.

In Zoie's recovery-orientation to develop her sense of self, a professional decision - "the verdict" - decides for her to continue with an illness identity. Zoie's self-narrative that was taken by the CPR worker at intake holds its value as an illness thread but is not recognized as a personal chronicle from which to build an ongoing story. In this sense, she is deprived of this opportunity and is denied the development of a personal space. She says: "I felt very – like thrown under – like – thrown under the rug."

Exploring this metaphor briefly reveals the violence that she feels she endures. She is stepped on and hidden under a rug; the space between the underside of a rug and the floor is dimensionally uninhabitable for a human being, lest they reduce the self to one-dimension, and "flatten" their being.

> **IE 6: Emergence of *untapped i-SMI's experience-based narrative*/***Demeaning Experiences*
>
> ***e.g.*:** I was on an ACT [assertive community training, an intensive reintegration program] team before. But I felt very – like thrown under – like – **thrown under the rug** (metaphor element) – like – like they didn't want to deal with me anymore. So, that they were just sending me to an ACT team.
>
> ***e.g.***: Well, I feel with this particular team [ACT, assertive community training] that I'm on, they – they have – they talk about – talk about – [*eyelids rapidly moving up and down and voice stammering*] what's going to happen with me to each other – like they decide what's going on. Kind of like – a jury, coming up with – guilty – or not guilty. Like they decide my fate. It's kind of how that feels sometimes – is **I'm out of the loop** (metaphor element), so, I'm not – it's – like, I have to go with what they say. When I was ready to leave – well in the hospital, they had said that it's my right to go to (name of Transitional Care (TC)/recovery-oriented (RO) provider), as an SMI – as being an SMI. And, being already enrolled in (name of TC/RO provider), and already – they should not – my case manager should not have kept me from going to (name of TC/RO provider), because it was my choice.

Conclusion

In this section, it can be argued that in the context of an i-SMI's relapse, they are in a very fragile state and in need of acute care "... it should be focused on the patient," Zoie asserts - but the data and the literature show that a knowledge gap exists about the way i-SMI's integrate physical and social space in care settings and in transition to and from those care settings.

Physical space. The data show that the built environment impacts the experience of the individuals. From the standpoint of health professionals, utility and efficiency is essential. Canter and Canter (1979) assert that specially designed places such as a place of therapy support professional services and should benefit the patient's healing experience. In Zoie's hospital intake events, we could see how the spaces of the exam and consult rooms facilitate the actions of the staff when they are administering health services. However, Zoie's experience of their utility was stressful, emotionally and physically. Zoie's experience in the psychiatric acute care unit was different in the sense that the space instead, according to Zoie, felt enhanced to foster social interaction and to reduce emotional stress.

The literature in environmental psychology, social psychiatry, and therapeutic narrative techniques share a common philosophy in that the individual's words hold meaning and that descriptive language binds the experience of the social space and the physical spaces. Likewise, the literature in neuroscience for architecture suggests that the physical spaces offer the individual sensory opportunities for their bodies to experience orientation in the three-dimensional world, therefore shaping newly acquired habits, modifying or reinforcing habits already learned. In this regard, we consider the fact that places impact people and the evidence base regarding human factors that is used by other health practitioners to plan and build our fixed social experiences.

Vision is a powerful sense which provides people the ability to construct unique spatial coherence. The brain is organically hardwired to help navigate our bodies and to respond to a dimensional physical world (Groh, 2014). The sense of agency, or the control of actions, depends on an ecological sense of one's own self-movement. This ecological sense of moving through the world not only involves a visual awareness of our pre-reflective experience that is stored and used by our working memory, it also includes the things that we don't readily get to observe. We tap into our pre-reflective experiences to make up our mind about our conscious efforts to use our knowledge about the world and then use it with our own voluntary capacity to take action (Gibson, 1979, 2014).

In this sense, this is how our body can shape the mind. We can experience a multisensory three-dimensional world but then we get to decide what we need to with our bodies to live and function in the world (Gallagher, 2012; Merleau-Ponty, 2014b). This way we can begin to put together the physical tools and objects that assist our activity (Heidegger, 1971; Vygotsky, 1978) and in this regard attach meaningful sentiment to material objects (Malafouris, 2013).

Emotional sensory information is evaluated and translated into action, this in effect normalizes the relationship between the individual and the triggering event. For example, if the stimulus event is identifying oneself as a member of one's group, then the cognitive corollary is friendship. Thus, the feeling state of friendship is acceptance, and the overt behavior is related to the concept of grooming (taking care of each other) and the overall effect is mutual support (Plutchik, 2001). As Zoie indicated, as soon as she was admitted in acute psychiatric care (the text in IE 3 and illustrated in Figure 3). The spatial human experiences are thus affected by the working human relationships in a place, for instance the architectural design of the nurse station may inhibit or improve the way patients interact with staff (Andes & Shattell, 2006; Shattell, 2013; Shattell et al., 2014; Thomas, Shattell, & Martin, 2002). The social activities related to an individual's involvement in potential events; can influence how he/she evaluates him/herself related to terms of engagement and that of the norms of the social group (Burge, 1979). In some instances, social isolation or disengagement can disrupt one's emotional development (Vygotsky, 1978). Taken together, people are apt to develop emotional attachments across the collective experience of the urban and natural landscape (Hashemnezhad, Heidari, & Mohammad Hoseini, 2013). Even the objects that we see in places, such as works of art in a museum or mounted on a wall in one's bedroom can trigger one's imagination and evoke an emotional experience (Pallasmaa, 2015). The history of our built environments can also shape our thoughts about how we want to go to places (Mallgrave, 2015). This way psychological-social-physical spaces become the context of the individual's multisensory experiences and those performed with our bodies and attuned linguistically (Pérez-Gómez, 2016a). Thus meaning, atmosphere and mood deliver the quality of an experience (Pallasmaa, 2016; Pérez-Gómez, 2015).

Social space. Health professional perspectives identify illnesses and correlate strategies to help the patient manage their symptoms. It appears that Zoie was treated to a form of MT, in at least two re-admissions while she was in a short-term psychiatric acute care unit. In her emergent narrative, she reveals that she used these MT experiences to strengthen a base of self-evidence.

Moos (1968) claims that in a given therapeutic community, the milieu of the setting can elicit "modes of responses," depending on the organized social strategies, and as well the interactions between staff and patients (p. 49). In addition, Moos (1979) claims that an individual's system of adaptation to a physical environment is health-related. The literature shows this adaptation is dependent on the variables of the physical elements and spatial constraints; for example, crowded settings can adversely affect stress levels (Moos, 1979). Evans echoes Moos' assertion: "The built environment can indirectly impact mental health by altering psychosocial processes with known mental health consequences" (Evans, 2003, p. 536). However, Moos' and Evans' social-ecological perspective focuses on population use of urban and institutional settings, and not on the individual's self-oriented creation of space.

Zoie asserts that her personal space of safety arises from this experienced-based evidence, but she reports that she still needs endorsements to reconstitute her agency and help to build a better identity, as well as the spaces to work on her story. Her self-evidence, then, is still somewhat precarious, as it relies on provider support and verification - when sometimes, even the providers are embroiled in their own power differentials, which the data showed adversely affected Zoie's own journey.

Recalling the first narrative repair element: (a) *meaning can repair or change the direction of personal transition,* we can see a textual meshing taking form in Zoie's quest to change *Overcontrolling Relational Dynamics*. The narrative ruptures show their injurious effects by lacking understandings of the patient's (d) *diminishing moral agency + identity in mental illness*. Table 8 below provides a snapshot of the codebook, illustrating the category and associated themes that emerged from the data. Importantly, the table highlights the narrative elements that have emerged as we begin to piece together the Counter story.

In the next section we follow Zoie as she seeks recovery-oriented care concurrently with managed care and makes personal adjustments. She believes that she will pursue the growth of her own personal space of safety and set goals to pursue professional education.

Table 8

Applying Narrative Repair Principles (NRP)

Codebook Category: Interview Excerpts (IE)/
Sections I & II/Constructs of personal transition as narrative self-evidence

Following Zoie's story (readmission and discharge experiences/small stories/micro-experiences)

Section I		**Section II**		
Codebook Category Narratological considerations: **Metaphor and meaning** ***IE 1 (a)** NRP-NE Establishes self-evidence		Coding Category **Over Controlling Relational Dynamics** Sub-themes: **Demeaning Experiences** (DE) **Meaningful Inclusion** (MI)		
Narrative Element	***IE-Emerged Narrative Element** (NE)	**Narrative Ruptures** Related to Master Story	**Narrative Injuries** Showing gaps Emerged Narrative Elements (NEs)	**IE - Emerged Narrative Elements** (NEs)
IE 1 Metaphor • "*go through the runaround again*" • "*picking up the broken pieces*" *Body and language are inseparable	***IE 1 (a)** *Meaning can repair or change the direction of personal transition* **Section I code:** Metaphor establishes Self-evidence	Inconsistent operatives and dismissive of the patient's attempts to voice concerns (DE) Limited access to recovery (DE)	**IE 3 (c)** *utility of physical space in places of therapy undermine one's efforts to maintain agency* (DE) **IE 3 (d)** *diminishing moral agency + identity in mental illness* (DE) **IE 5 (e)** *Unresolved health professional power that suspends agency* (DE) **IE 5 (e.1)** *"they need to — know that — whatever they are doing its* ***it's TEN TIMES harder on the people going through, with whatever they are going through"*** (DE) **IE 6 (h)** *untapped i-SMI's experience-based narrative* (DE)	**IE 2 (b)** *Performing identity triage* • co-constructed narrative (MI) • narrative used for clinical assessments (DE) **IE 4 (g)** *Personal space of safety* • (in the context of therapy) combining social and physical spaces (MI) • (in the context of self-evidence: mapping-emergent narratives and boundaries) (MI) **IE 5 (f)** "*It should be focused on the patient"*(MI)

Equitable Relational Dynamics: The Potential Gains of Narrative Elements as Self-evidence

As mentioned in the introduction, this is the place in the presentation of results where we begin to let go of the narrative injuries and ruptures and we focus most on the narrative elements that comprise the counter story. These injuries and ruptures can begin to fall away because, as Lindemann-Nelson (2001) insists - the narrative elements begin to weave a tapestry of their own, building on one another, while at the same time using previous ruptures and injuries as a jumping off point of sorts. From this point forward in the presentation of results, it is the narrative elements that we track, as we continue to move toward the counter story.

In this section we trace Zoie's movements in *places related* to health services in the community. Table 9, below, is a visual slice of the codebook exploring the emerged code of equitable relational dynamics and its associated narrative elements. The data showed that health professionals coordinate care strategies guided by the discharge agreement meanwhile Zoie's efforts are applied to her own meaningful system of personal transitions. First, the reader will preview the emerged narrative elements, listed under the coding categories *Potential gain/loss* and *Re-identification and self-orientation*. This begins Zoie's work toward identity constituting roles and agentic progression which she believes will allow her to access *all places*, then to community care places where professionals coordinate services to where Zoie must travel, and finally to home. Afterward, the reader is treated to Zoie's stories which will amplify her own meaningful system inside the (g) *personal space of safety*.

Table 9

Equitable Relational Dynamics

Codebook Category: Interview Excerpts (IE)/
Sections I & II/Constructs of personal transition as narrative self-evidence

Emerged Narrative Elements

Coding Category:	**Potential gain/loss**	**Place Related**	Coding Category:	**Reidentification and self-orientation**
IE 7 (j)	**Gain:** "I want to be getting - graduating, getting my bachelor's degree, and - and, planning on my master's."	Future access to all places	**IE 7** (i)	"That's what I WANT is to see myself be my own safety bubble and carry it out to wherever - wherever I go." (*reconstituting identity + personal space of safety + social agency*)
IE 8 (k)	**Gain:** "Because I - this diagnosis, I just need a little more help and a little more time to be able to be a functioning adult."	TC recovery - (orientation inconsistencies Managed care)	**IE 9** (*l*)	*Advocacy involves disentangling what healing orientation means*
E 8 (k.1)	**Gain:** "To have control over my treatment and decide where I want to go. So, that really helped me a lot because it gave me a sense of control- a sense of belonging within myself."		**IE 10** (m)	"At the members' meeting last week, I got to read my poem." *Self-evidence + meaning and place*
IE 10 (n)	**Gain:** "They, they support me in what I want to do with my life. They support me in the direction that I choose, and they give me the room to be creative and be – to express myself."	TC recovery	**IE 11** (p)	*Meaningful stories can be made socially accessible and unlocked by the i-SMI's recovery-orientation.*
IE 12 (q)	**Gain:** continued *personal space of safety* the "safety bubble" is critical in placement: *combining social spaces as enabling + self-orientation + places organized with supportive activities*	TC recovery- (orientation inconsistencies) Managed care/ Future access to all places	**IE 11** (p.1)	"be WHO I am and just - be." *Reidentification in mental illness + orientation + meaning and place + agentic endorsement*
IE 12 (q.1)	**Loss and Risk:** cannot access/uncover self-orientation + discover/reconstruct the personal space of safety		**IE 11** (p.2)	*Potential gains of narrative meaning and places*
IE 13 (r)	**Loss and Risk:** Personal space of safety could not transition to home	Home	**IE 11** (p.3)	Uncover self-orientation + self-evidence + *narrative in a mental health system of care*
IE 13 (r.1)	**Loss and Risk:** "I'm trying to show you the potential NOT safe - areas…all of this which is NOT at the hospital."			
IE 13 (r.2)	**Loss and Risk and Gain:** "It's' a LOT different than the hospital, because this is already made for you. The safety bubble at home you have to create yourself And, it's really hard to do so, if you do not have the support or the KNOWLEDGE to do so."		**IE 13** (s)	"It's taken a long time for me to be able to build this bubble." *Self-evidence + orientation + agentic endorsements + identity in mental illness + social agency i.e., student*

Orientation in healing mentally. Zoie reveals that her 'transition potential' was/is not adequately realized with revolving discharge agreements in the past few times as they primarily focus on diagnosis and pharmacological treatment and little emphasis on Zoie's orientation to align her own work and rehabilitation. Here, the narrative elements (a) *meaning can repair or change the direction of personal transition* and (c) *utility of physical spaces in therapy undermine one's efforts to maintain agency* come together to help us understand Zoie's departure from the hospital, and build to form an additional narrative element: the (p.2) *potential gains of narrative meaning and places*.

> **IE 7:** Constructs of personal transition as narrative self-evidence: **Emergence of *reidentification and orientation*** – (reconstituting identity + personal space of safety **+ social agency**) "be WHO I am and just – be."
>
> Z: I want to be getting — graduating, getting my bachelor's degree, and — and, planning on my master's. So, I want to be proactive — I want to be, [*4 seconds silence*] I want to be even more safe within myself, to where I don't need all of the safety net that I have — the safety bubble that I have — I'm able to be just my own safety bubble. That's what I WANT is to see myself be my own safety bubble and carry it out to wherever — wherever I go.

Zoie is seeking to align resources and to gain a better understanding of her diagnosis. In all probability, Zoie with Stanley's help (pseudonym for the TC recovery caregiver present in the interview room) *wanting-to-be-patient-no-more* (Frank, 1993, 1997). In this regard we will keep following Zoie on down through this section, specifically how she perceives the making of her space related to her transitional care experiences "That's what I WANT is to see myself be my own safety bubble and carry it out to wherever — wherever I go."

IE 8: Constructs of personal transition as narrative self-evidence: **Emergence of *reidentification and orientation*** – (reconstituting identity + personal space of safety **+ diagnosis**) “be WHO I am and just–be.”

Z: –“Because I, – this diagnosis, I just need a little more help and a little more time to be able to be a functioning adult. And, resources like vocational rehabilitation and (name of TC/recovery provider) actually help me do that. It’s just the case management team kind of, looks down upon.”

Orientation in mental health. Recalling that this is a time where Zoie is going through a few turning points, where she will continue to consider getting better *in* mental illness and *in a mental health system*, as she manages the pharmacologic treatment. In addition, with consideration for agency (Anthony, 1993), Zoie needs to understand health with professional input and provider endorsement to move through psychiatric rehabilitation and a supported journey through her own processing of the perceived negative impact of being an i-SMI: impairment (managing symptoms), dysfunction (social and work skills adjustments), disability (unemployment) and disadvantaged (discrimination and poverty).

IE 9: Constructs of personal transition as narrative self-evidence: **Emergence of *reidentification and orientation*** – (reconstituting identity + personal space of safety + diagnosis **+ self-orientation**) “be WHO I am and just – be.”

I: [*I and Z glance at the post-it notes. I rests forearms on the table surface and leans in closer towards Z*] — Well what’s remarkable about — all your transitions, you go from place to place to place — how do you feel emotionally about having to do so — on this journey towards your recovery? How does this come across for you? [S *leaves the room and closes the door quietly*].

Z: Sometimes it’s a little confusing.

I: Is it?

Z: Yeah, like — difficult to adjust.

I: How do you deal with — what do you do to manage making…?

Z: …I don’t kno— [*looks into I’s face, leans with forearms on the table surface closer towards I*] I just — I feel like [*inhales calmly*] that I’ll find what I AM in control of — and — take hold of THAT and not focus so much of what I’m not in control of.

> So, I have a real — real problem if I feel that I'm not in control. So, like recently I've noticed that I need to find like something that's in my control and just focus on that. When **I feel that all of this is just flying** [*picks up both hands in the air close to her ears, then gestures two intersecting circles in front of her face, with open palms and spread out fingers*] **around me** — like **my treatment, my recovery all of it** [*lowers arms, with palms open flat and fingers spread out, pushes hands upwards over her head*] — **is just up, up in the air**.
>
> **I have to find something that's in my control** — like taking my meds or — um, being at (Name of TC recovery) that's in my control — like my case manager doesn't like it so much, that I'm at (Name of TC recovery provider) so much — but, that's in my control I choose to go there (Name of TC recovery provider and location of place) — [*eyes blinking*] to be here (Name of TC recovery provider and location of place). ACT (actions): [*S re-enters the room quietly, whispers: "Sorry", sits back down and places cold water bottles on the table. Z responds: "Thankyou" and take a sip of water, I responds: "Thanks I've got mine over here."*]
>
> I: How would you define that for yourself — taking control — what does that mean to you?
>
> Z: I am — like, in charge of it, I get to decide the outcome — I get to decide — um, [*inhales*] if I'm going to help myself or not.
>
> I: How do you tell this to the health professionals that you come across — like, your case manager who was confrontational with you?
>
> Z: Um — the second time that I was in the hospital I've gotten told that it's my right, to — **to have control over my treatment and decide where I want to go**. So, that really helped me a lot because it gave me a sense of control — **a sense of belonging within myself.**
>
> So, I was able to advocate for myself to my case manager and I just told her — well my case manager is on vacation, and I told another case manager that — I, choose to go to (Name of TC recovery) and "*I need to know if I have to start-up transportation or you?*" — because, um — I didn't feel like having an argument or a confrontation with [*breathes in sharply*] — the case manager again, so I was just saying; "*this is what I'm doing, are you going to help me to not?*"

In this transition from hospital to community care, Zoie learns to advocate for herself and gains the support from the TC recovery provider. In this situation the TC provider is also endorsing Zoie's graduated "moral" agency (recall that the clinical team has already endorsed the treatment of stabilized medications and behavior) and supports her efforts of reidentifying herself and obtaining autonomy (in terms of managing medications *in* mental illness) and helps with setting long terms goals to achieve agency (in terms of setting up rehabilitation, i.e., “getting my bachelor’s degree” (Zoie’s emphasis)). Advocacy is critical for i-SMI’s to secure before they can even move in the direction of, as Zoie says, “be WHO I am and just – be” (Zoie’s emphasis). It is here that another two narrative elements emerged: (p.1) *be who I am,* and (l) *advocacy involves disentangling what healing orientation means.*

Recovery-oriented transitional care. It is at this juncture of the story that Stanley enables Zoie to access her own lived experiences. Zoie is encouraged to develop her own story (boxed highlight below); she prefers creating artwork and poetry “they support me in the direction that I choose” (Zoie’s emphasis). TC recovery-oriented caregivers invited to share her work with peers. Zoie draws from lived experiences to begin her re-identification: “*be WHO I am and just – be*” (Zoie’s emphasis). She reveals that her health orientation emerges through exploring “sense of self – is belonging with myself. ”

> **IE 10:** Constructs of personal transition as narrative self-evidence. **Emergence of *reidentification and orientation* —** (reconstituting identity + personal space of safety + diagnosis **+ equitable support**) “be WHO I am and just – be.”
>
> I: In which way has (name of this TC recovery provider) supported you tremendously?
>
> Z: They, they support me in what I want to do with my life. **They support me in the direction that I choose, and they give me the room to be creative and be – to express myself** and to, um – like at the members’ meeting last week I got to read my poem. And the poem that I wrote, I didn’t think was very good.
>
> And then I’ve read it to Stanley, and – he made me feel like it was good. He made me feel like I did something that – could help other people. And, I just – for me it was just me getting the way I was feeling onto paper, and it made me realize that – what I’m going through, and what I think – and what I feel – can be beneficial if I express it.

It is important to note that for the first time, sitting in on the interview, Stanley gains access to Zoie’s deeper narrative and sees untapped meaning emerging from the larger context of Safety and Space. It is likely the first time Stanley has been privy to Zoie's information (boxed highlight 1 below in IE 11). because outside of these interviews in their day-to-day work, *health providers cannot ask of their clients' direct personal questions about themselves and their treatment*. This is an ethical protocol, reducing i-SMI's risk and not violating doctor-patient consent. Likewise, in this study, I'm also following the IRB protocol. Much of the health provider's questions are related to client needs and coordination of professional services.

Uncovering self-oriented space in a place of safety. Next, we can expect to see how Zoie pivots her sense of self, transitioning from an acute place of therapy to a recovery-oriented place of therapy in the community — "they give me the room to be creative and be — to express myself" (Zoie's emphasis) with the support of professionals and nonprofessionals (i.e., family members and peers).

IE 11: Constructs of personal transition as narrative self-evidence: **Emergence of *potential gains*** – (reconstituting identity + personal space of safety) "be WHO I am and just – be."

I: About your current safety bubble, you told me that the art chest helps you to manage being in the present by involving yourself in art works, how does artwork help you to build that safety bubble toward the future? (See Figure 3 below).

Z: [*Z snaps the blue colored marker cap off and on a couple of times*] For me, when I get—when I get a canvas [*the sound of the commuter train bell wafts into the room through the exterior windows*] — and I just — look — at it and — figure out — and look at it — it makes me feel [*5 seconds silence*] for one, in control. Because, I can put ANYTHING THAT I WANT on that canvas — for two, I feel inspired—by whatever—by whatever I'm feeling that day I can put that on the canvas and that's just — and that's okay, because if I mess up and don't like it I can just re-paint it. Because, there's NO mistakes in art. **In art, I've been told that — for years, that there's NO MISTAKES in art, art is art — no matter, one person might like it and one person might not — but, art is art**.

And, **for me it's just FREEING**, like — oh! [*tilts head downwards*] "I don't know if liberating is the word for it?"— okay; liberating to just [*4 seconds silence*] KNOW that whatever I put on this canvas or whatever I draw on this paper [*points to the sheets of drawings/diagrams on the table surface —*

3 seconds silence] it's okay, **because there's NO WRONG, TURNS** [*uses the marker to knock on the table top once*] — there's nothing, **NOTHING I COULD DO wrong, because art hasn't any wrong.**

I: Could you tell me if the artwork that you make, have you saved any of it or have it on display in your room anywhere?

Z: Actually, I had moved. Actually, a lot of it got thrown away, because I had left it at the old house and I didn't bring it with me [*slowly rocks back and forth in the chair, the table creaks*] so —

I: — How did that make you feel?

Z: Hmmm…kind of disappointed in myself, but **I know I can just make more** [*snaps the marker cap off and on*].

I: So, the artwork that you do have, where do you keep it in your space?

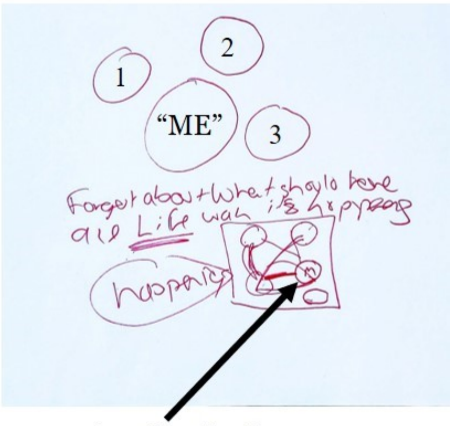
Z: I have like a drawing that I did, its actually poems that I did [*starts tapping on the tabletop with the butt end of the marker*] — and there's some things drawn on it. I have that hanging up and I have um, I actually I made — a [*stares at blank sheet of paper on the table surface*].

I: What sort of drawings do you create that are poems?

Z: Oh, poems? **The one that's on my wall is about feeling more confident after a breakup. I—I have different personas** [*left hand holds down a blank sheet of paper and draws with right hand (uses red colored marker*] and this is Name 1 [*draws a circle*], and this is Name 2 [*draws a circle next to Name 1*], and this is Name 3 [*draws a circle above Name 1*] and they're all a part of me [*draws a larger circle under Name 2*] but — like on a daily basis—I made this art work where I drew, I painted them—but [*tilts head downwards*] — **how — to —explain them, is like — you're in a car and this is the — you're looking down** [*draws a rectangle shape*] — like, **the roof is off and you're looking down** [*points to the rectangle representing the car*] — **so there's the steering wheel** [*draws a bolded line onto a portion of the rectangle*] **and this is me** [*draws a small circle, inside the car in front of the driver*].

There's the back seat, and there's two back seat drivers [*draws two circles behind the driver*], and there's [*the sound of people talking outside in the lobby area wafts into the interview room, a random voice is heard: "…oh no, no, no!"*] one in the driver's — [*Zoie is slowly nodding her head from side to side*] in the passenger seat [*draws a circle*].

“ME” and the 3 personas



“ME” as the driver

Figure 3. Map of “ME” identity reconstitution and working with internal voices

1 Z: So, [*3 seconds silence*] when it’s me [*points to the driver*], so this person can influence me [*draws a line connecting the back seat driver (located behind the driver) to the driver behind the steering wheel*], this person can influence me [*draws a line connecting the back seat driver who is located being the passenger, over to the diver*] — but the person in this seat [*draws a bolded line connecting the passenger to the driver*] is REALLY, REALLY influencing me.

So that’s — when you are in a car, the passenger is more influential than people in the back — but, so for me it gets really confusing because — there’s sometimes — people — these two [*uses the butt end of the marker to trace over top the diagram while explaining*] will fight over THAT seat, or this person [*using the marker Zoie traces over the passenger (circle) and over to the diver (circle)*] will fight to be in this seat — or this person will, want to just jump into that seat, or jump into that seat like its — sometimes in my head, [*exhaling a soft chuckle*] this is what’s happening. So, it’s just, confusing.

I: As driver in this artwork — what is its poetic meaning?

2 Z: Um, **it has a saying, it says** [*writes on the drawing and narrates*] — “***forget about what should have happened and live what is happening***” — so, **that means a lot to me** about, um this particular [*underlines the word ‘live’*] thing because, this [*uses the butt end of the marker to point on the words ‘live what is happening’ while tapping softly on the table top two times*] is like — I can’t control the past, I can’t — sometimes I can’t even control the present, but I can ALWAYS [*uses the butt end of the marker to point on the words ‘live what is happening’ while tapping softly on the tabletop three times*] — just be here, be in the moment, **be WHO I am and just — be**.

> And, **I can just let it happen and just LIVE** [*swipes the word 'live' on the paper with right forefinger*] what is happening [*draws a circle around the word 'happening'*]. And, not put SO much effort into what I should have done, or what somebody else should have done — or what should have happened in my life, but I can't control anything that SHOULD have happened, I CONTROL what is happening — that's basically what I can control [*points to the driver in the drawing*].
>
> I: So, I gather from your poetic driver's wishes, that you wish to drive into spaces that let you build a life for yourself?
>
> Z: Yes.

In the IE 11 context, Zoie uses the metaphor of driving a car to understand her internal power struggle with three personas (her internal power struggle was shown in the data to be her dealing with her hallucinations - what she understands as her identity in mental illness). It is important to realize that she felt safe and supported in the interview, and she decided to engage both me and Stanley, as she (h) *uncovered self-orientation* (boxed highlight 2 above, in IE 11). It can be argued by psychologists that Zoie is trying out her sense of self in the real world. In this situation, the complexion of her identity is related to uncovering moral agency – the role of the driver as a responsible free agent. In addition, we may discover the 'tools' that are necessary to help Zoie feel to a lesser degree the impact of her illness (see Anthony, 1993), impairment, dysfunction, disability and disadvantaged). At this point of the story, one of the tools happens to be a car that she can drive. Currently, Zoie does not drive and does not own a car. She claims it is too stressful and relies on family members and the rideshare contracts that are set up by the case management team.

Hall (1990b) (mentioned above after IE 3 in Section I) writes about places that hold "fixed-featured spaces," places that are organized around the activities that people do and to govern human behavior. The spaces in them, such as in a building, contain rooms that are specially organized to develop social behavior, i.e., eating, sleeping, food preparation and so on, also contain artifacts - ‘tools’ or objects that are associated with these activities. These also can be transferred to other spaces and people continue such activities to form habits using such artifacts. Furthermore, Hall (1990b) insists that the sense of space and distance, between rooms, or buildings or going from one place to another is not a static situation. He writes: “[human] perception of space is dynamic because it is related to action — what can be done in a given space — rather than what is seen by passive view” (p. 115).

According to Hall, regardless of these distance sensing spatial and emotional cognitive processes, “If we can rid ourselves of the need for a single explanation, and if we can think of [humans] as surrounded by a series of expanding and contracting fields which provide information of many kinds, we shall begin to see [him/her] in an entirely different light. We can begin to learn about human behavior, including personality types. ...but each one of us has a number of learned *situational* personalities. The simplest form of the situational personality is associated with responses to intimate, personal, social, and public transactions”(Hall, 1990b, p. 115).

Zoie’s self-evidence

As has been the strategy throughout the presentation of results, the literature has been used to illuminate the data and to show where research and data converge and where they may diverge based on these results. In this section, we use Hall (1990) to examine Zoie's self-evidence. So far, the scholarship suggests that Zoie is transitioning her (g) *personal space of safety* back to the community, and the data that her potential counter narrative converges on realizing situational health orientation — these emerging in helpful relationships.

In the context of IE 11, these point to uncovering what experiencing mental illness can mean to the i-SMI, a personal transition hidden in the texture of the metaphor. Zoie is seeking professional help. This is a complex intersection: first, gaining clinical moral endorsements of moral agency, then trying to intersect agency and characteristics of autonomy (i.e. managing diagnosis and treatment), and finally achieving the role of the student (free agent, yet to be experienced). Previously emerged narrative elements: (a) *meaning can repair or change the direction of personal transition*, and (p) *meaningful stories can be made socially accessible and unlocked by the i-SMI's recovery-orientation* help us to understand how Zoie seeks to gain agency and what she needs in order to do this successfully from the healthcare provider and herself.

In the IE 13 context below, Zoie reveals what happens when she transitions from the hospital. As we saw in section II, narrative injuries, in *Overcontrolling Relational Dynamics,* at the time of discharge health professionals have various recovery-orientations and Zoie's situational self-orientation moves in the direction of seeking to (h) *uncover self-orientation + discover placement of social spaces,* and growth of her personal space of safety. Recall that the discharge agreement granted Zoie access to case management services, strong support with medication treatment and prevention of relapse. However, there's still a gap in knowledge about the way i-SMI's incorporate experience and develop a personal space of safety. Below, we can track this experience of the knowledge gap, how this appears at time before Zoie's Hospital ER visit in the context of IE 12, and afterward in the context of IE's small story.

Unattuned self-oriented space reinstitutes risk and loss of agency.

Taking into consideration emerging counter narrative elements in above, that were highlighted in the context of the coding category *Overcontrolling Relational Dynamics*, and Zoie's emerging counterstory in the section exploring the category *Equitable Relational Dynamics*, her narrative as self-evidence remains an untapped source. At a time even before her emotional trauma, Zoie had described her experience of mental illness as a storm of sorts, not just assuming the condition of her internal power struggle with personas but as a condition that exists in the space of her home. While Zoie is presumably trying to (h) *uncover self-orientation*, there exists operational tension regarding the direction of health coordination and Zoie's personal transition, we notice the (i) *potential loss of agency and risk*.

> **IE 12:** Constructs of personal transition as narrative self-evidence: **Emergence of *potential loss of agency and risk*** (the mapping of metaphor as reality), (See Figure 4 below).
>
> ---
>
> Z: So, um – I met with the peer mentor for about two or three times a week. Um – but I felt like – I wasn't [*Z gestures with both hand in the air, with tumbling motions hand over hand*] – it was just arts and crafts, we were just me, and do arts and crafts or we would go to the food bank, like she took me to the food bank [*inhales deeply*] and she um, took me to my doctor's appointment and stuff like that. And then, they had set me up with the day program that I was in, they had a branch in [Name of clinic and location], but they had um, **they only had a worker there for a few hours a day to where I'd go to a few groups and go home. And, when I was at home there was a lot – I thought too much, I was just wrapped up in my own thoughts, uh – there wasn't much for me to do,** um –
>
> I: How did that make you feel being wrapped up with too much in your thoughts?
>
> Z: It felt, it felt, [*eyelids rapidly opening and closing*] very – **like if you were in a tornado, it was scary, it was um – like, heart racing.**
>
> I: When that was happening, where were you – I'm guessing that you were in your home at that
> time?

> Z: Yeah – it was like I was alone, I had no – I've felt like I had not outlets. I had no – because, my case manager would get mad if I called [Name of TC recovery provider] and told them how I was doing. I guess [Name of TC recovery provider] was communicating with my case manager and my case manager didn't want me to go to [Name of TC recovery provider] and they wanted me to do what I was. So, after [*suddenly stops talking*].

In the context of IE 12, the psychosocial program that Zoie was already part of did not leave her room to (h) *uncover self-orientation* + *discover/reconstruct the "safety bubble."* Plutchik (2001) would insist that Zoie's emotional reaction to this situational orientation would be fear "it was scary… it was heart racing." Because the stimulus event imposes a threat, as Zoie is aware of the dangerous effect, "I thought too much, I was wrapped up in my own thoughts." So, it seems in this situation, Zoie would prefer escaping to a safe refuge.

Thus, if this gap in knowledge related to the intersection of agency reconstitution (mentioned above) goes unnoticed with another hospitalization, Zoie will be caught experiencing a closed feedback loop - "starting from day one" (Zoie's emphasis). These strengthen the argument of recovery *in* mental illness "picking up the pieces that I've broken" (Zoie's emphasis) that Zoie has decided to undertake. Upon leaving the psychiatric hospital, Zoie explains in IE 13 how it is a critical time to attune her personal space of safety and adjust in her home. These adjustments that she recommends are not only centered on the physical utility of the home but ensuring that the space of her room is re-discoverable to include her situational orientation.

In the context of IE 13 below, Zoie argues that a continued personal space of safety is critical placement, combining social spaces as the following narrative element: (q) *enabling* + *self-orientation* + *places organized with supportive activities*.

The literature supports this; Bandura (2006)[10], Gallagher (2005)[11], Hall (1990) and others believe that an i-SMI is able to experience the physical world, and with support and tools, realize for themselves a unique self-orientation during and across transitions.

Notwithstanding the conversation between these scholars, Zoie interweaves all their notions in the creation of Figure 4, below. This, for her, is what it is like to leave the psychiatric hospital and get back to the community and back to home and to have concerns about personal transitions and potential loss of agency and risk. We can expect to see Zoie's gestures and language and coordinated breathing that embodies a deeper understanding of transitional phenomena.

IE 13: Constructs of personal transition as narrative self-evidence: **Emergence of *potential loss of agency and risk*** – (transitioning a personal space of safety across the settings).

I: So, when you transitioned home — how do you transition a safety bubble home?

Z: Well, at home it's a lot — [*reaches for the paper pad and rips out a few new sheets and then table squeaks and shakes. Z shuffles the loose sheets and arranges a single sheet of paper in front of her as the table comes to rest*] — and then — so, this is the drive home [*with a blue colored marker draws an*

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[10] Bandura (2006) claims social cognitive functions of agency interweave "core agentic capabilities of intentionality, forethought, self-reaction and self-reflection [and] operate as hierarchically organized determinants" (p. 167.) — psychological framework makes sense of hierarchical thought processes and interpersonal interactions including the ways in which our body engages the world - resulting in what he calls the *physicality of agency*.

[11] Gallagher (2005) notes that for people who have an altered body-schematic, such as problems with visual perception coupled with movement of their own volition, even "voluntary action…includes a sense of agency for the action, generated in the processes that lie between intention and performance" (p. 176). Thus, individuals tend to override or self-correct, for instance, compensating for their lack of ability. However, people experiencing schizophrenic delusions of control, "experience a loss of agency but not a loss in sense of ownership," for example, "I know that it is my body that is moving, but I do not have a sense of agency for the movement" (Gallagher, 2005, p. 178).

uninterrupted long bold stoke from one end of the paper to its other end] ALL upward — and then I get home, [*with a red colored marker draws a parallel line next to the blue line. Using her left palm, touching the paper surface, swipes quickly in a smoothing gesture forward and backward and forward*]. I get home, say this is my home [*terminates the straight red line (right-handed) by outlining a rectangle shape (indicating home)*].

Um — so, the case manager's car, [*with the red colored marker, draws a half-circle with two circles directly touching the edge of the half-line of the circle*] and um—we both walk in the gate and walk into the house [*Caps the red marker and puts it down on the table surface.*]

My home — [*picks up the blue marker and uncaps it. Draws bold line by stroking back and forth and back again, overlapping the red line on the one side of the rectangle shape*] — there's always a locked door — the front door. There's always — there's my mom's bedroom. I'm trying to show you the potential NOT safe areas.

So, the front door — [*makes a single bold-blue-colored-line by making a continuous stroke, back and forth and back again. The bold line is drawn down along the same line next to where the front door location was marked*] — um, medicine in the kitchen, um — knives in the kitchen [*makes a single bold-blue-colored-line by making a continuous stroke, back and forth and back again, further down along the same line next to where the medicine location was marked*] um, all of this which is NOT at the hospital.

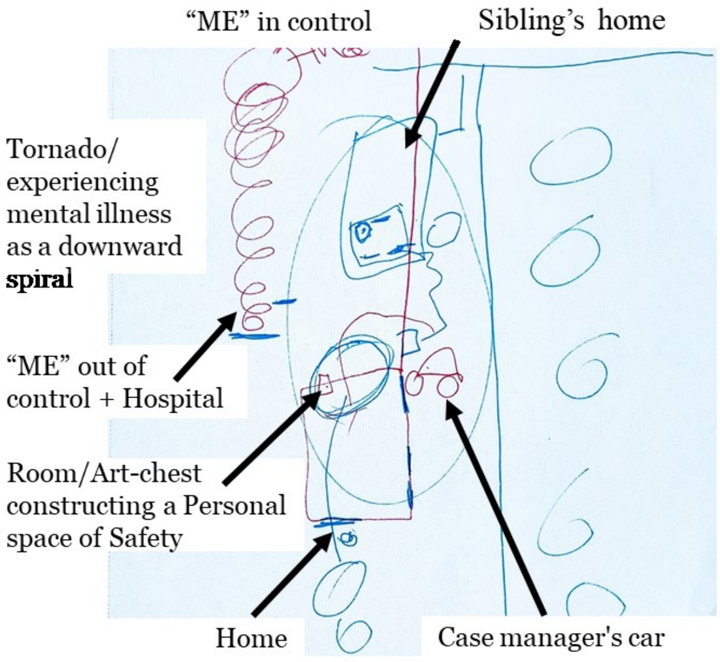


Figure 4. Map of the tornado/spiral metaphor and home and family support and neighborhood. (Transitioning a personal space of safety across the settings).

My room is right next to the front door so, — like — I consider this now as **my safety bubble, because I choose what goes in there** [*draws an outline in the shape of a closed circle*]. I choose if — [*taps marker three on the table times pointing to a spot within the circle (room)*] — if I don't want medicine in there [*draws another concentric circle over top first circle*], or If I don't want [*inhales deeply and exhales slowly*] — if I don't want to have sharp objects in there [*draws another concentric circle over top the second circle*] — **or I create my own safety bubble** [*using her left palm, touching the paper surface, swipes quickly in a smoothing gesture forward and backward and forward*] **within my room.**

Its' a LOT — it's a lot different than the hospital, because this is already made for you [*uses her right hand to hover over the diagram of the hospital*]. But, the hospital — **the hospital safety bubble is already made for you** (inhales sharply) **the safety bubble at home you have to create yourself** (exhales). **And, it's really hard to do so, if you do not** [*uses the butt end of the red capped marker in her right hand to knock on the table surface*] **have the support or the KNOWLEDGE to do so** [*uses the butt end of the red capped marker in her right hand to knock on the table surface*].

Like for me I have [Name of TC recovery-oriented provider] support, and I have um — like the peer mentor is sometimes is really supportive — but, me and only [Name of TC recovery-oriented provider] — like — **if I have an issue at home** that I feel that I'm uncomfortable with, like **I can talk to them** [Name of TC/RO provider] **and they could help me make a game plan or another safety measure to go in my bubble** [*S briefly looks at Z and jots down notes*].

Like, um—for an example, I'm going to be home alone the weekend of the tenth [*S briefly looks at Z and jots down notes*]. So, I told [Name of TC recovery-oriented provider] staff to help me a—make a plan, to where I'm still in my safety bubble, and I don't feel that's it's been popped.

I: What would it feel like if it did pop? [*S quickly glances over to study Z' face and inhales slowly, looking over to meet with I's gaze. I observes Z*].

Z: [*5 seconds silence*] Overwhelming [*S exhales as he widens his eyes while anticipating Z's answer, and quietly says out loud: "Wow!"*]. Scary — um [*8 seconds silence*], like for me it takes — like **it's taken a long time for me to be able to build this bubble.** If I feel like it's been popped, and I just can't fix it—like can't patch it or can't fix it, then I start to feel — [*Z repositions the paper of the diagram with her home on it, uncaps the red colored marker then draws an outline of a closed circle at the top edge of the sheet, and writes (me) next to it connected by a single line*].

> Okay, this is me and then **if the safety bubble pops — I feel like I'm in a downward spiral** [*Z leans on the table and rests both arms on the surface. Z lifts her right hand with her arm at rest and draws a single continuous-spiraling-line moving vertically halfway down the sheet of paper. Z stops leaning on the table, and the table creeks as she sits straight up in her chair*].
>
> So like, I'm here now — [*makes a bold line with a continuous stoke, back and forth and back again, which intersects the outline of the circle*] — and if, like I can't catch — if it gets popped and then I can't catch it here [*makes an outline of a closed circle which intercepts the circle that she just drew over the spiral*] — or here [*makes another outline of a closed circle further down along the spiral*] — then just keeps going down and I lose more and more of my safety bubble. And um — **so it's a lot of responsibility on ME to catch it and fix it**. [*eyelids open and close rapidly then stutters*] But — I'm — like —**I can't** [*taps twice on the table with the butt end of the marker in her right hand*] **always fix it by myself, so I need to reach out and get the help that I need to fix it** [*Z puts the marker back on the table surface and rests her hands in her lap*].

The Counterstory

"The proper target of a counterstory is a master narrative that has been generated by an abusive power system to impose on a particular group an identity the system requires" (Lindemann-Nelson, 2001, p. 155). Below is the counterstory "*told for the purpose of resisting a socially shared narrative that purports to justify the oppression of a social group* (Lindemann, 2015, p.98). In this project, the counterstory has been identified as a resistance to the Overcontrolling Relational Dynamics identified within the data - and focused instead on Equitable Relational Dynamics that are best able to attune social space, the physical environment, and meaning for the i-SMI. Also uncovered was what Lindemann-Nelson (2001) calls "gaps…tensions within" (p. 165) the "tissue" (p. 187) - a piece of a story that has emerged from the data that is not exactly part of the counterstory, but not exactly *not* part of it either. This was encompassed within the coding category Uncharted Relational Dynamics, presented following the counterstory. First, the presentation of Table 10 summarizes the narrative element findings, then the counterstory follows.

Table 10

Summary of Emerged Narrative Elements

Codebook Category: Interview Excerpts (IE)/
Sections I & II/Constructs of personal transition as narrative self-evidence

Section I/ Narratological considerations Coding Category: **Meaning and metaphor**		**IE 1 (a)** *Meaning can repair or change the direction of personal transition*	
Section II/Coding Category: **Overcontrolling Relational Dynamics**		**Section II**/ Coding Category: **Equitable Relational Dynamics**	
Codebook themes		Counter story coding categories	
Demeaning Experiences (DE)	**Meaningful Inclusion** (MI)	**Potential Gain/loss**	**Reidentification and Self-orientation**
	IE 2 (b) (in the context of diminished agency) *performing identity triage* • Patient's narrative co-constructed (MI) • Patient's narrative used for clinical assessments (DE)	**IE 7 (j) Gain**: "I want to be getting - graduating, getting my bachelor's degree, and - and, planning on my master's."	**IE 7 (i)** "That's what I WANT is to see myself be my own safety bubble and carry it out to wherever - wherever I go." (reconstituting identity + personal space of safety + social agency)
IE 3 (c) *utility of physical space in places of therapy undermine one's efforts to maintain agency*		**IE 8 (k) Gain:** "Because I - this diagnosis, I just need a little more help and a little more time to be able to be a functioning adult."	
IE 3 (d) *diminishing moral agency + identity in mental illness:*		**IE 8 (k.1) Gain:** "To have control over my treatment and decide where I want to go. So, that really helped me a lot because it gave me a sense of control— a sense of belonging within myself."	**IE 9 (*l*)** *Advocacy involves disentangling what healing orientation means*
IE 3 (d.1) *"I walked into the ER, um – someone had asked me why I was there, and I said that, "I am suicidal." And the looks on her face was like, "okay what do I do?" – this was the intake person, she had this look like "why?"*	**IE 4 (g)** (in the context of therapy) *Personal space of safety* ["Safety bubble" combining social and physical spaces] and (in the context of self-evidence: mapping-emergent narratives and boundaries)	**IE 10 (m) Gain:** "They, they support me in what I want to do with my life. They support me in the direction that I choose, and they give me the room to be creative and be – to express myself."	**IE 10 (n)** *"At the members' meeting last week, I got to read my poem."* *(Self-evidence + meaning and place)* **IE 11 (p)** *Meaningful stories can be made socially accessible and unlocked by the i-SMI's recovery-orientation.*

Table 10 continued

Summary of Emerged Narrative Elements

Section II/Coding Category: **Overcontrolling Relational Dynamics**		**Section II**/ Coding Category: **Equitable Relational Dynamics**	
Codebook themes		Counter story coding categories	
Demeaning Experiences (DE)	**Meaningful Inclusion** (MI)	**Potential Gain/loss**	**Reidentification and Self-orientation**
IE 5 (e) *Unresolved health professional power that suspends agency*			**IE 11 (p.1)** “*Be WHO I am and just – be.*” (Reidentification in mental illness + orientation + meaning and place + agentic endorsement)
IE 5 (e.1.) “*it’s probably more convenient for them to do it the way that they are doing it, but they need to — know that — whatever they are doing* ***it’s TEN TIMES harder on the people going through, with whatever they are going through*****”**	**IE 5 (f)** “*It would have helped if I had a little more— compassion or empathy of what I was going through,* [*lowers hands and rests both palms flatly on top of the drawing*] ***because it should be focused on the patient***.”	**IE 12 (q) Gain:** continued *personal space of safety* the “**safety bubble**” is critical in placement: (combining social spaces as enabling + self-orientation + places organized with supportive activities)	**IE 11 (p.2**) *Potential gains of narrative meaning and places* **IE 11 (p.3)** *Uncover self-orientation + self-evidence + narrative in a mental health system of care*
		IE 12 (q.1) Loss and Risk: Cannot access/uncover self-orientation + discover/reconstruct the personal space of safety	
IE 6 (h) (in the context of discharge) *untapped i-SMI’s experience-based narrative*		**IE 13 (r) Loss and Risk:** Personal space of safety could not transition to home	
IE 6 (h.1) “But I felt very – like *thrown under – like – thrown under the rug. They didn’t want to deal with me anymore. So, that they were just sending me to an ACT team.*”		**IE 13 (r.1) Loss and Risk:** “*I’m trying to show you the potential NOT safe—areas… all of this which is NOT at the hospital.*”	
IE 6 (h.2) “*They decide what’s going on. Kind of like – a jury, coming up with – guilty – or not guilty. Like they decide my fate. It’s kind of how that feels sometimes – is I’m out of the loop.*”		**IE 13 (r.2) Loss and Risk and Gain:** “It’s’ a LOT different than the hospital, because this is already made for you. The safety bubble at home you have to create yourself. And, it’s really hard to do so, if you do not have the support or the KNOWLEDGE to do so.”	**IE 13 (s)** “It’s taken a long time for me to be able to build this bubble.” (*Self-evidence + orientation + agentic endorsements + identity in mental illness + social agency, i.e., student*)

On the quest to find a place of refuge through readmission, Zoie found her *moral agency diminished* and questioned her *identity in mental illness*. Going through an emotional trauma, her sense of self intimately links understandings of identity in mental illness and her body's attunement to the physical surroundings showing that *meaning can repair or change the direction of personal transition* – she arrived with these already meshed together. In the *places related* to acute care, health professionals are trained to implement safety protocols and reduce risk. In Zoie's experience, professional movements pivoted the institutional social space without realizing that she's already stitched herself a system of emotional-body-meaning through self-evidence, but instead focused on movements in keeping identity in mental illness; as such are aspects of over-controlling relational dynamics. From Zoie's perspective, the social space created in *places related* to acute care *suspends one's self-orientation* toward recovery except for the psychiatric acute care unit where MT was employed. The data show that *performing narrative identity triage* (a form of 'identity' triage) was comforting and empowering for Zoie. Even its brevity, the co-constructed assessment summoned up her story, threading together elements of emotional-body-meaning. In addition, Zoie's *personal space of safety* flourished when the physical surroundings were combined with professional safety protocol, but not until she could access the real spaces inside a purposely built psychiatric acute care unit. Zoie told me that other i-SMI peers have not had the benefit of experiencing MT in a psychiatric acute care unit, and that this is not the norm, because mostly: *utility of physical space in places of therapy undermines one's efforts to maintain agency*.

Recall the narrative element: *meaningful stories can be made socially accessible and unlocked by the i-SMI's recovery-orientation* — the emphasis here is that Zoie's self-orientation is about reconciling meaning "It's taken me a long time for me to build this bubble.” However, the value of realizing the hidden potential of Zoie's stories coming to life and co-joining the recovery-oriented professional fell outside of the provisional discharge agreement. The narrative triage of sorts served the clinical care team. In repeated attempts to voice her concerns, Zoie together with TC recovery-oriented professionals realized that *advocacy involves disentangling what healing orientation means*, and in terms of finding equitable potential gains. As mentioned above, real spaces are those inside a highly structured psychiatric acute care unit, where Zoie’s moral agency gains a fundamental endorsement so that she can get back to living in the community and over emphasis on identity in mental illness. Zoie’s immediate concern is to reconstruct that emotional-body-meaning quickly, these meshing of threads, but to go little further than the last readmission, as she explains “I’m not the same person that I was when I went to the hospital” is fraught with *unresolved professional power that suspends agency*.

We begin to see the *personal space of safety* grow out of the utility of safety: i.e.*,* (in the context of therapy) combining social and physical spaces *(Meaningful Inclusion),* and in the recovery-oriented place *“they give me the room to be creative and be – to express myself.”* Her stories are *socially accessible,* during this transitional time frame equitable relational dynamics support, *“a little more help and a little more time to be able to be a functioning adult.”*

What emerged, in this study *(in the context of self-evidence: mapping-emergent narratives and boundaries)*. Zoie *uncovers self-orientation* (i.e., narrative elements*: uncover self-orientation* + *self-evidence*) with a deeper understanding of her identity in mental illness. In the short story about driving the car, that metaphor brings to light what she is ultimately seeking, “be WHO I am and just-be… I WANT is to see myself be my own safety bubble and carry it out to wherever I go." Ultimately, Zoie is after the *potential gains of narrative meaning and places*, as she exclaimed:

> It's' a LOT different than the hospital, because this is already made for you. The safety bubble at home you have to create yourself. And, it's really hard to do so, if you do not have the support or the KNOWLEDGE to do so.

There are still unresolved problems with sorting out mental health services and services for people with SMI, regarding the different strategies about health and healing. Access to programs are limited and Zoie's self-evidence remains untapped. The divided perspectives between her managed care team and the TC recovery-oriented professionals partially engage Zoie's personal space of safety. In the story regarding *potential loss of agency and risk*, from the standpoint of the utility of safety, the experience was not the same as it was in the hospital, and her home was not safe when she transitioned home. There is a gap in understanding how Zoie's narrative meshes emotion-body-meaning to reconstitute a functional identity (gaining social agency and autonomy with managing treatment) which could develop in parallel to identity in mental illness (*safety bubble*). In the story about gaining access to TC recovery-oriented care, this was achieved through advocacy. Then Zoie's social space could be explored with peers and help with setting future goals.

In this section, the counterstory arose as grounded in equitable relational dynamics, empowering Zoie to explore her own story, and strengthen her social space with peers. This way her experience, her story, is made socially accessible and meaning can be explored. Without health professional endorsement and advocacy of Zoie's mental health orientation, her voice was lost against the backdrop of overcontrolling relational dynamics in acute and managed care. However, there remains a gap in understanding Zoie's orientation regarding her narrative that binds the development of a personal space of safety across the settings.

Gaps and Tensions within the Tissue of Unfolding Stories

As noted in the introduction to this last section, what follows does not seem to be part of the counter story, but is not *not* part of it, either. As Lindemann-Nelson (2001) asserts, there can be gaps and "tensions within" (p. 165) the "tissue" (p. 187) of an individual's unfolding story: pieces of the story, or knowledge, that is potentially, or perhaps always, missing. Glimmers of these missing pieces may be identified in the data and we track and record them, but acknowledge that they are perhaps not part of the counterstory as it emerged initially. It is important to remain mindful of this as Lindemann-Nelson asserts: "counterstories come into being through a process of *ongoing* (my emphasis) engagement with the narratives they resist" (2001, p. 169), in a dynamic dialogue.

At this point in the analysis, Zoie's experience seemed to spin off into a mysterious, corollary story we don't yet understand. In the presentation of results here in Chapter 4 we see it as her experience of travel (coded in the code book as a "micro experience" and the importance she places on physical possessions that she can rely upon during transitions). Without further opportunity to talk with her about it in the contexts of additional interviews, we can only begin to examine these. I have coded these as uncharted relational dynamics, as they clue us in to the fact that opportunities for additional exploration and mapping in collaboration with the persons with SMI, remains, in order to better understand their experience. As stated above, they are focused primarily on travel and personal possessions.

Table 11

Uncharted Relational Dynamics

Codebook Category: Interview Excerpts (IE)/
Section II/Constructs of personal transition as narrative self-evidence

Emerged Narrative Elements

Sub Coding Category:
Defining Space in Micro Experiences

IE 14 (t) **Physical presence of possessions** *personal affect (agency) in micro experiences without fixed spatial boundaries*

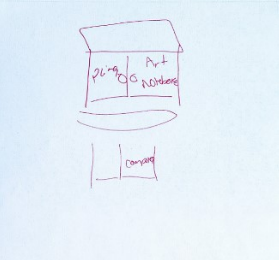
IE 15 (u) **Limits of possession and meaning**

(u.1) *Suspended agency* "Everything in up un the air, there's no steady ground": *ownership* + *identity*

e.g. "Because when you're not in your clothes, you feel NOT yourself, you've got out of sorts, like I feel — just like in limbo. Like, just no steady ground — you know."

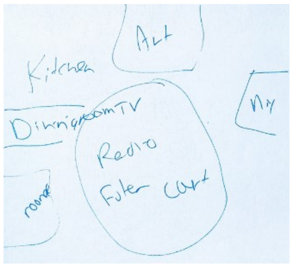
IE 16 (v) **Meaning of place** [sense of self + fixing spatial boundaries [strengthening the social space] + *imagining free social agency* (in the context of community care settings, home and accessing all places)

(v.1) <u>A Triptych</u>: (v.a) uncovering identity in mental illness + discovering a functional social identity
(moral agency + rehabilitative endorsements + biological adjustment)
(v.b) equitable relational dynamics and developing the personal space of safety
(v.c) personal transitions: mapping the situational orientation



(v.c.1) Meaningful
personal effects
(body + meaning + social spaces)

(v.c.2) Sensory placement
(meaning mapping/
self-evidence)



(v.c.3) Placement
of the body
(body + habit + healing)

(v.2) Zoie: Um, I think…free and love and understood [*making rotating gestures with right wrist hovering over the table top and holding the marker*] — I think — that if I'm in a house all by myself, then I would want an animal [*writes word*] so that I feel loved. Um — I want to feel — free to be — as, unique as possible, like I want to — fear no judgement — in my environment. Um, be free to be just who I am — no — boundaries, no walls, just completely who I am. But that would be the ideal environment for me to be — just — be who I am, and no fear of judgement, no fear of criticism, no fear of — [*takes a deep breath, looking at the written words on the sheet of paper*].

Throughout the data there are many instances of Zoie undertaking travel of some kind - ride shares, ambulance rides, taxis to and from home, what are referred to in the table above as “micro-experiences.” We must consider vulnerability to external sources (a la Gallagher), specifically the inherent fluidity of the short-lived micro experience (the journey between places) when the individual is relying upon their own thoughts and strategies for personal transitions (important to gaining sense of self) in a rapidly changing environment, as well as the meaning of possessions. Table 11 above provides a previewing of the emerged narrative elements, these appearing under the sub coding category: *Defining Space in micro experiences*.

Personal affect in micro experiences. In the small story below we consider what Zoie goes through during travel, the positive effect of performing *triage narrative* helped her get to the next place of therapy, the psychiatric hospital. However, the negative effects of discomfort were not only tied to body sensation (feeling cold) but Zoie’s sense of self wearing a hospital gown and the uncertainty of her situation. These *micro-experiences* (my emphasis) are part of her journey and uncharted, she is not in control of what can happen next “[W]hen I’m in the hospital and they take all my stuff that I’m wearing and when I’m gowned — I’m safe. But, I feel vulnerable and I don’t know if everything is going to be okay. Everything is just up in the air, like there’s no steady ground” (Zoie’s emphasis).

IE 14: Constructs of personal transition as narrative self-evidence: **Emergence of *personal affects*** (my emphasis) — (Physical presence of possessions + suspended ownership)/Suspended: *“everything is just up in the air”* (Zoie’s emphasis).

I: Can you describe what it was is like to leave that ER room, and get transported by ambulance?

Z: I was actually – **I felt relieved leaving that cold – ER room**, but – I’d gone to places before in an ambulance, so it wasn’t, like a big drastic change for me, but –

I: – can you describe what that ambulance ride is like?

Z: Um – since I'm coming from [Name of town] its very long, very bumpy and very – [*lowers voice tone and whispers to herself*] "I don't know the word"– um – especially **if you have an ambulance driver that does not talk to you, it's very long and boring and you think a lot the entire way. You think about why you're going, why – [*with open palms and spread out fingers, gesturing hands create open circles articulated by wrist movements twice*] – why you have to go – what could you have done to not go**.

I: Where are you inside this ambulance?

Z: I was in the back – um, this specific ride I was – **I felt that I was by myself because I was in the ambulance facing rearly,** and the – the paramedic was um – behind me in the seat, [*sits up straight in the chair, arcs her head turning twice three-quarter ways towards the left shoulder*] **so I didn't see him**, I didn't talk to him, um – the entire ambulance ride was basically quiet.

I: Help me understand, so, basically it was just you in the back and the ambulance driver up front?

Z: No, the driver was driving – and then um – in the ambulance [*waves both arms around to demonstrate where she has sitting in the ambulance in relationship to her body as the reference point*] there's like a seat with a seat belt [*moves arms and uses hands to demonstrate the movements correlated to pulling on a seat belt and fastening the buckle*] behind the driver, where the – the – other EMT can see me, but I couldn't see him [*sits up straight in the chair, arcs her head turning twice three-quarter ways towards the left shoulder*]. **I had asked a few times to change the air conditioning, but that's basically all – that we talked about.**

I: How long was this ride?

Z: About forty-five minutes.

I: That's quite a ride: what do you recall thinking about, not talking much to the EMT while on a forty-five-minute bumpy ride?

Z: Yeah. [*lowers voice tone*] Yeah. [*focusses momentarily on the floor, looks straight into I's face*] It was – **I just thought a lot about how, I got into that situation, how I was feeling before**, I um – [*sits up straight in the chair, arcs her head turning twice three-quarter ways towards the left shoulder*] **went to the hospital before I went – before, because, I had just [*sits still for 3 seconds, breathing shallow*] changed automatically from being okay to – devastated, like completely flipped [*eyes widened*].**
And, um – when I go to the hospital, um – it was after hours so like they had me get off the gurney um – outside and then I had to walk with the person who was going to do my intake.

I: Can you explain, what did you do to get off the gurney?

Z: Yeah, they [EMT's] had just lowered it [*uses right hand, with a tight-fingered-palm hovering over the surface of the table to demonstrate the lowering of the gurney*] like – um **– they helped me get off the gurney and they gave me – my stuff to the person who came to the door,** cuz it was late at night – so they had to unlock it and um – have someone come down – they've rung a bell and talked to them, and they had someone come down and get me. Um – they came and got me, and I sat in, um – it was like an intake room.

I: Can you explain what that intake room was like?

Z: Um – **it was a lot quicker that it usually was – but, I was – in the intake room and they took me to do my medical assessment, and they brought me back.** Um – and **they took me to do my** psych – **my psychiatric assessment, and they brought me back**. And then I –

I: – Help me understand, you kept going in and out of this intake room, while you were going to other rooms for different assessments?

Z: Yeah. There was a tech sitting at the desk, and then I was the only one sitting in the intake room – but there's like several chairs and two couches and chairs on the other side [*picks up both rested arms in the air hovering over the table and articulates using hands and fingers shaping the objects in relationship to their placement within the intake room*]. So, it was just me just sitting in the intake room with the tech sitting at the desk. Um – **when they said that they were going to admit me –** um they, I did my – [*eyelids open and close rapidly while stammering*] I went through my stuff with – well I didn't have any stuff.

I: What do you mean by stuff?

Z: Like **my belongings**, like um **my clothes**, my um – my – wallet, my everything. They, they said they had to take my jewelry [*right hand wraps on the table surface with knuckles and fingers forming an open fist*], they had to lock up my wallet [*right hand wraps on the table surface with knuckles and fingers forming an open fist*], they've locked up my phone [*right hand wraps on the table surface with knuckles and fingers forming an open fist*], they had to lock everything up [*right hand wraps on the table surface with knuckles and fingers forming an open fist*]. And, then **I could have my clothes, um – that's basically all they let me have is my clothes.**

I: How did you feel about getting back your clothes at that point?

Z: **Like myself – comfortable.**

I: What ever happened to that packet that you mentioned before?

Z: It wasn't given to me the packet was given to the EMT's – they – they had a folder and they gave it straight to [Name of psychiatric hospital]. Um, I never

> saw what was in the packet – like **I don’t know what** – like **they say, that they give them a packet, but [*eyelids open and close rapidly while stammering*] – I don’t – I’ve never really have known what was in the packet [*gulps down a deep breath*] like every time that I’ve gone to the hospital**. Um, [*looks momentarily on the floor*] when I finally got back to the unit, um – I couldn’t sleep.

During the first interview, Zoie reveals that she relies on repeat experiences concerning the ‘packet’ as part of getting admitted, but as she is traveling, she feels uncertain how the information that it contains will be used (IE 14 immediately above). Her possessions are also traveling with her, also packaged, and are not accessible (suspended ownership). Also, relying on the valuable experience with the CPR worker as she is not able to talk to someone during the ambulance ride, Zoie uses the opportunity to think about the turning points contained in her self-narrative (personal affect).

> Z: I felt that I was by myself because I was in the ambulance facing rearly, and the – the paramedic was um – behind me in the seat, [*sits up straight in the chair, arcs her head turning twice three-quarter ways towards the left shoulder*] **so I didn’t see him, I didn’t talk to him, um – the entire ambulance ride was basically quiet.**
>
> Um – since I’m coming from [Name of town] its very long, very bumpy and very – [*lowers voice tone and whispers to herself*] “I don’t know the word”– um – especially if you have an ambulance driver that does not talk to you, it’s very long and boring and you think a lot the entire way. **You think about why you’re going, why – [*with open palms and spread out fingers, gesturing hands create open circles articulated by wrist movements twice*] – why you have to go – what could you have done to not go.**

Zoie is aware of her own body sensations, “I felt relieved leaving that cold — ER room, but – I’d gone to places before in an ambulance, so it wasn’t, like a big drastic change for me,” and “I had asked [the EMT] a few times to change the air conditioning, but that’s basically all – that we talked about.” What emerges is a narrative element, but outside the counter story: (related to hidden interpersonal dynamics and Zoie’s personal transition), the (t) *physical presence of possessions*, e.g., the meaning of wearing the hospital gown and the EMT’s delivery of the hospital packet gave her cause to think and feel differently about herself and the future. The interview excerpt 15 below, continues the above conversation supplied by the second interview. (Note: based on the data in the boxed highlight above in IE 14, the second interview explored the meaning of *physical possessions,* i.e., clothing and packet, and their effects on agency. In the boxed highlight below, Zoie supplies details of the dynamics obtaining control of her possessions).

> **IE 15:** Constructs of personal transition as narrative self-evidence: **Emergence of *personal effects*** (my emphasis) — (Physical presence of possessions + controlling ownership)/Suspended: *"everything is just up in the air"* (Zoie's emphasis).
>
> I: Going further back in your story, can you recall what sort of person you felt like at the time when you were in the ER and they had you wearing a hospital gown— you told me that you felt cold and that they took everything away.
>
> Z: Yes, they did. They took everything away.
>
> I: Help me understand, [*I uses both hands to gesture explaining moving from location to location*] as you were then transported still wearing that hospital gown in the ambulance, and by the time you finally got to [*name of psychiatric hospital*] intake room — what sort of person did you feel like when you got your clothes back?
>
> Z: **A sense of comfort and a sense of — clothing — like when you're in the hospital — like for me [*picks up right hand and touches chest with her palm*], when I'm in the hospital and they take all my stuff that I'm wearing and when I'm gowned — I'm safe.**
>
> **But, I feel vulnerable and I don't know if everything is going to be okay. Everything is just up in the air, like there's no steady ground.** Well like when you get — when I got to [*name of psychiatric hospital*], and **I finally got to put my clothes back on** [*inhales deeply*] I felt like I [*3 seconds no talking, and as Z's arms push against the table then sits up straight in the chair, the table creaks*], **I — was in my spot**. Like **I knew that I was being able to move forward**. That I was going to — that I was (slowing voice pitch) going — to — be — more — (fast voice pitch) **I was going to have help getting better**.
>
> I: Help me understand this better, putting your own clothes back on made you feel grounded as a person?
>
> Z: Yes. Because **when you're not in your clothes, you feel NOT yourself, you've got out of sorts, like I feel — just like in limbo. Like, just no steady ground — you know**.

We take into consideration that Zoie goes through several micro-experiences "up in the air" and "in limbo" often with each admission. In this situation, until she is given her clothes to put back on, she is not herself as she claimed, “there is no steady ground.” The limbo metaphor helped Zoie see that the hospital “packet” was instrumental with the intake assessments. Zoie was beginning to feel that, “I was in my spot…like I knew that I was being able to move forward. That I was going to — that I was (slowing voice pitch) going — to — be — more — (fast voice pitch) I was going to have help getting better.” Although she exchanges a hospital gown to wear her own clothes while inside the psychiatric hospital, Zoie’s journey is not over. Thus, notwithstanding the dynamics of ownership regarding “clothing” or “packet,” both are tools used to make decisions, we see the narrative element emerge (u) *limits of possession and meaning*.

In Becker’s (1997) work with recovering patients, the limbo metaphor is often used to reestablish a sense of order, “by placing boundaries around it” and “separate the time of limbo from a future time when life would return to “normal”” (p. 120).

Ybema, Beech and Ellis (2011) consider the anthropological notion of liminality, a temporary ‘suspended’ and transitional state bound in space and time. They extend this notion to the possibility of transitional and perpetual liminality – a condition of how social actors move in, and out of old, and acquiring new identities. They considering the time or phases between two identity positions, regarding two different social contexts “(i) actors who experience going through a transformational change from one identity position to another, and (ii) actors’ sense of being in-between two identity positions for a prolonged period of time” (p. 21).

Consider the combined short stories mentioned earlier, IEs 4 and 5, eventually Zoie will return to the community and will seek help in disentangling personal transitions, with and without mental impairments. Zoie is not assured of returning to “normal.” She will also engage with professionals and non-professionals and go through micro-experiences surrounding the physical presence of possessions and their limitations, as ownership and decisions shift between relational dynamics. In this sense, Zoie will continue her combined quest to sort out her identity against the larger context of her disability punctuated by meaning-making collaboration.

In a final vignette from the data, Zoie's "art chest," and its centrality to her experience, is presented below. This exemplar serves to illustrate the foundational nature of physical possessions during transition - the importance of which will be discussed further in chapter 5. According to Stahl (2003) "There is a dynamic relationship between shared meanings and individual interpretations: In order to engage in collaborative activities, people must come to recognize meanings of artifacts, and interpret these meanings from their own perspectives" (p.1). As Zoie indicated before: "I'm able to be just my own safety bubble. That's what I WANT is to see myself be my own safety bubble and carry it out to wherever — wherever I go."

IE 16: Constructs of personal transition as narrative self-evidence: **Emergence of *Meaning of place*** (fixing spatial boundaries + imaging free agency).

I: I want to take you back to what you said about building your safety bubble [*Z catches I's gaze looking at the diagram of home and spiral drawn on it*] — can you recall what you were thinking about the supportive environment [*I points to the hospital diagram*] you had talked about how the hospital always has a readymade safety bubble, but when you are at home you have to recreate it on your own [*I points to the diagram of the home and spiral drawn on it*]. How would you recreate that? [*Z studies I's face and smile*].

Z: Um — **I recreate it** like — I, **in my room** — like **for me**?

I: Uh-huh, of course.

Z: [*picks up the red colored marker*] ...**I have this little chest of drawers** [*draws a small rectangle inside the three-blue concentric circles that were previously drawn to represent her room*] — chest of stuff. And I have, art and I have — like — my computer and everything is in that chest. So, **I feel like that's part of my** [*uses the tip of the red colored marker, to create a dot in the middle of the rectangle which represents the chest*] coping skills, my um — that's part of my **safety bubble**.

I: **Tell more about that chest.**

Z: Um — [*Slides a new sheet of paper over top the home diagram. With the red colored marker begins to draw*] So, there's the chest. It's actually two night stands on top (giggles) of each other. Alright there's the top of it, and then there's doors. There're doors here and then there's another nightstand below it, and there's doors here. And for me, I put all my art, supplies [*writes and says the word*] art, [*writes and says the word*] painting, um [*writes the says word*] notebooks [*lowers head speaks to the paper*] "*there must some writing in there,*" um and, that's my art supplies a home. I. In this one, I have um — my [*writes and says the word*] computer and um — most of my, like my rehab is in there. So that I, [l*eans on table and the table creaks*] like when I go into this chest — when I'm — usually it's just like — cuz, I'm waiting on going to rehab.

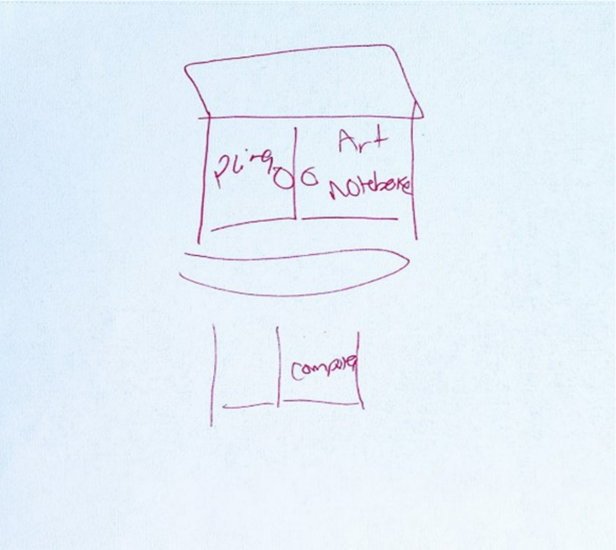


Figure 5. Meaningful personal effects (body + meaning + social places)

Z: So, when I go into this chest, it's to help me LOOK forward to the future. Like this chest [*points to the word, computer on the diagram*] helps me know that I'm not sitting still — I'm not — like a sitting duck. You know, like when they say that you're a sitting duck? [*cheerfully giggles*]

I: Well I've heard people say that [*giggling*], but what meaning does it hold for you?

Z: Okay, like for me [*10 seconds no talking. S continues softly clacking on his mini laptop keyboard, and with each downstroke, the wooden table slightly vibrates. Z quickly breathes in and exhales*] — like I'm vulnerable [*8 seconds silence*] — um, now I totally forgot [*laughing*] what I was talking about.

I: ...oh, you're good. You were explaining how the chest in your room is part of your safety bubble, and how you have this [*points to the word, computer on the drawing*] and how this is...? [*pointing to the words, painting, art, and notebooks on the diagram*] ...

Z: ...the coping skills. But — [*4 seconds no talking and the sounds of keyboard strokes and slight table vibration*] — oh ya, it lets me know that I'm not just vulnerable, that I'm not just not doing anything in my life. I am setting goals [*with both hands in the air hovering over her lap and with palms facing towards her body, gestures hand over hand, cycling making circles*] making strides. Um — being as proactive as I can.

So, that reminds me that this could be a big part of my safety bubble, because its [*7 seconds no talking and the sounds of keyboard strokes and slight table vibration*] — it's a reminder or a — basically a reminder, but I'm not the same person that I was when I went to the hospital.

I: [*I is smiling*]...Potentially this could be the fun part of our conversation [*Stanley looks up from his mini laptop and hums. Zoie smiles.*] — imagine what your dream environment would be like — imagine being immersed in such a place [*Zoie giggles*] — what would it look like, smell like...

Z: ... [*cheerfully laughing*] out of my imagination

I: ... **Use any words that can describe what your imaginary environment**...

Z: ...[*Z picks pulls out a new sheet from the pile of paper that she had previously arranged, and writes words beginning at the center of the page, uses a blue colored marker*] — um, **safe**, **comfortable** — there is this scent from um, — [*uses the butt end of the maker to knock on the drawing/table top 2 time*s] Scentsy that I really like it's called, **Jamni time** [*writes words*] and its basically just **lavender** — [*looks directly into I's eyes*] that's the scent that's really more comforting to me. Um — [*looks down on the sheet*] safe, comfortable — understood [*writes word*] — I will say what comes with **understood** is, um — free [*writes word then 7seconds silence*] — **loved** [*writes word, then 10 seconds passes, leans on the table edge and the table creaks*] — we have to have **popsicles** [*Z cheerfully laughs, writes word. Stanley and Interviewer join in with cheerful laughter. Everyone laughs for 10 seconds*].

I'm sorry, [*Z is smiling and giggling*] for some reason, like — for some reason I always just — like — like, my mom keeps popsicles in the freezer, because I like to crunch — crunch — ice [*knocks on the table using the butt end of the marker*] um — it's cold it, sometimes hurts your teeth — like with the popsicles that I have there, they're kind of oversized otter-pops, they have the plastic on them and I crunch it [*laughing*] in the plastic and then eat it.

I: What other things would you include in...?

Z: ... [*exhaling a chuckle*] an **art room** [*writes words*]. I want my own art room! Um, [*drumming on the tabletop with one marker, by making rotating gestures with right wrist*].

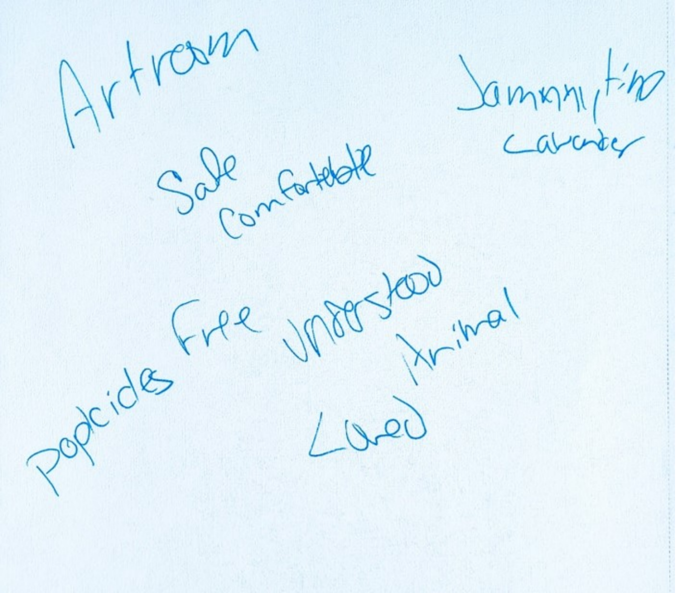


Figure 6. Sensory placement (meaning mapping /self-evidence)

I: …[*cheerfully laughing*] Care to venture how all these words put together can help define how you could live in such an environment?

Z: …[*cheerfully laughing*] Um, I think…**free and love and understood** [*making rotating gestures with right wrist hovering over the table top and holding the marker*] — I think — that if I'm in a house all by myself, then **I would want an animal** [*writes word*] **so that I feel loved**. Um — I want to feel — free to be — as, unique as possible, like I want to — fear no judgement — in my environment. Um be free to be just who I am — no — boundaries, no walls, just completely who I am. But that would be the **ideal environment for me to be — just — be who I am, and no fear of judgement, no fear of criticism**, no fear of — [*takes a deep breath, looking at the written words on the sheet of paper*].

I: — **At the moment, how do you imagine seeing all that coming together in an ideal living situation? — what sort of boundaries or walls would you have or not have in place?**

Z: Well, I don't mean literally by having no walls, I meant — like, having EMOTIONALLY no walls. Um — [*6 seconds silence*] if I picture like my perfect environment — I'm coming home, [*sucks in a sudden deep breath, exhales slowly*] sit on the couch, my puppy jumps in on my lap, and just lets me pet her — um, I have a friend or a significant other that — comes out — and greets me — and we just — TALK.

Like I don't — I'm not a big TV person, I'm a big radio person. I like music playing. Like — maybe even — like coming from the art room just always music playing, like some sort of music just keep the radio on.

I: What else do you see here in...? [*holds hands in the air with palms open and fingers stretched out hovering over the edges of the drawing with Z's written words on it*].

Z: ...And, um — I'd like to see greens and blues, and — I can draw — I can — I want my — to be able to — have like a — chalkboard wall [*stretches her arms up over her head and lowers them spanning out with palms open and fingers spread-out*] or a white board wall [*uncaps the blue colored marker in her right hand*] — so that I can draw ANYTHING that I want on my bedroom wall so that — [*uses the uncapped marker to draw in the air with her right hand, gesturing the scribbling of shapes and lines*] — [*lowers arms and rests hands in her lap, with right hand poised holding the uncapped marker*] whatever that I'm feeling THAT week, or THAT day or WHATEVER that's how — I can have THAT done. Is that I can — put — ANYTHING — like if — cuz, sometimes — I want a rainbow — and stars — and butterflies — and then sometimes I just want — finding — a storm drawn on my wall, like [*the sound of people talking outside in the lobby area wafts into the room*] um, I want to feel free to be able to EXPRESS — how — how I'm feeling — and how I'm — what I feel and who I am at THAT MOMENT because, like for me it's — its — I'm maybe — THIS WAY [*picks up palms and sways hands (right hand still holding the marker) in the air simultaneously to the right*] one — minute, and then completely — [*sways hands simultaneously to the left. Lowers hands to rest in her lap. The right hand still holding the marker puts the cap back on and places it on the table surface in front of her*] the next, the NEXT minute — and [*takes a deep breath and exhales slowly*] I want to feel that's okay.

I: Should I guess that is what you meant by wanting to be free?

Z: Uh-huh. I mean, within limits [*smiling and laughing*] like I can't just do it if I want.

I: [*laughing*] why not what stop...?

Z: [*laughing*]... cuz, there's things that I have to pay attention to — I just want to be able to express myself uniquely — and — creatively and just — be who I am. And—I think—in my environment right now — it's just — it's comfortable, but it's not — I don't feel free or understood. I feel loved, um — I have — I don't have an art room, but I have art supplies — like, I have some of what — I want — in my ideal home — and — with me in my home, but there's more — that could — help that.

I: You brought this up before, about art being a big part of your recovery experience in our conversations — you told me that the art rooms at [*Name of TC recovery provider and location*] are one of your favorite spaces to be in, and you also mentioned the '[*Name of area*]' (multipurpose room) over at [*Name of recovery provider and location*]. Can you be more specific about how that fits in YOUR ideal home environment?

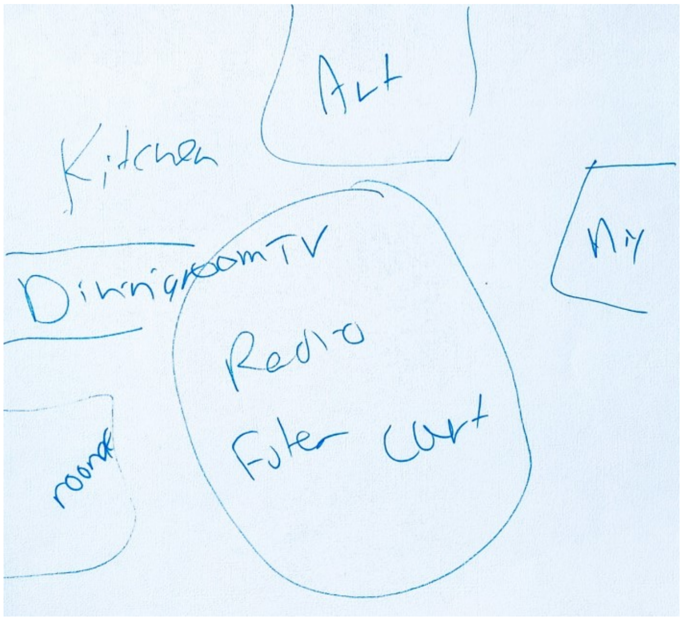


Figure 7. Fixing spatial boundaries, the placement of the body (body + habit + healing)

> Z: Yeah! [*clears throat*] — like— [*tears out a new sheet of from the paper pad and picks up the blue colored marker in her right hand. Uncaps the marker with left hand, and uses the hand to hold the sheet of paper steady dome on the table surface as she begins diagraming shapes and writing words*] like — if I were to have a house [*pointing downwards with her right index finger hovering over the sheet of paper (while still holding the maker tip downward) gesturing a circle shape, circumscribing in the air around the four edges of the sheet of paper*].
>
> I would want my room, to be on the end of the house [*draws a three-sided rectangle (the fourth side of the rectangle is the paper's edge), and writes the word 'my' inside of it*] — and then maybe, my roommate or my friend or whoever has their own particular room at the end of house, and that's [*draws another three-sided rectangle on the opposite side of the page, and writes the word 'roomae' inside of it*] there, our spaces — like this, I can do [*Stanley's mobile phone vibrates loudly and the table top shakes and creaks as he gets to leave the room*] like I could move my — I could draw whatever I want on the walls and — maybe — like an art room like in the middle [*draws another three-sided rectangle at the top on the page and writes the word 'art'*] and then — so my room, roommate or, even if I had a significant other I would want them to have their own space.
>
> Um, art room and then maybe a kitchen — but, I would want the kitchen on the other side of the house then where I'm at, because sometimes I have a hard time with food. So. I'm bulimic, so I have a hard time with my relationship with food. So, my ideal kitchen would be on the other side of the house [*writes the word 'kitchen' on the left of art room*], that I can control it.

> And then we have this whole space – [*draws a large circle in the middle of the sheet*] we could have a TV [*writes word*], um radio [*writes word*], futon [*writes word, 'futen'*], couch [*writes word, 'cart'*], um — maybe even like a pin ball machine or something, like something — that — can just distract — um — and then what's important to ME is a dining room [*draws two horizontal lines, one line above the roommate's room and the other line under the work kitchen. Then and writes the words 'dining room' in between the two lines*] — cuz, when I eat, I do not feel comfortable eating alone, so I'm — ten times — nine times out of ten — I will NOT eat if I'm alone. So, the dining room is — I never — like, growing up we never had a dining room we always — ate — in the living room, but I feel it's important to at least eat dinner in the dining room [*uses the maker to point and tap on the word, dining room*].

Conclusion

The results presented above serve as additional information about Zoie's experience but remain outside the counter story, Lindemann-Nelson (2001) suggests, gaps and narrative tensions weave "tissue" (p.187) of one's unfolding story. In this piece of the findings tells us about liminality, and three narrative elements were identified: the (t) *physical presence of possessions*, (u) *limits of possession and meaning* (sentimental) and (v) *meaning of place*. All of these define a sense of place and micro experience and speak back to the personal space of safety and its utility in solidifying identity and movement forward.

Section III: Whose Recovery Is It?

This section takes a closer look at the meaning of recovery and considers that systematic barriers remain hidden in the cloth of the counterstory, knowledge gaps which unintentionally cause i-SMI's limbo-state experiences. First, there is not a shared understanding of what recovery means between health professionals and persons with SMI (Ellison, Belanger, Niles, Evans, & Bauer, 2018; Piat et al., 2009). Second, the constructed definitions and ways of diagnosing mental illnesses explain internal pathology or the terms of social behaviors and disorders (Horwitz, 2009, 2020). In this regard – whose recovery is it? – looks at differences, how health professionals operationalize safety for persons 'recovering' with SMI and persons' with SMI experience of safety while constructing agency for themselves.

Residual narrative ruptures as recovery-oriented meanings

There remain residual narrative ruptures as participants in this study experience uncertainty with re-transitioning from acute care across recovery-oriented care settings. As previously realized in section II, these 'residual' elements remain as systemic barriers primarily due to [IE 5 (e)] *unresolved health professional power that suspends agency*. Davidson and Roe (2007) suggest that there are inconsistencies with the meaning of recovery, as medical perspectives focus on remission of illness conditions or progressive deterioration, and the Mental Health Consumer movement refers to the individual's right of self-determination and reintegration to the community even though they have a mental illness. Moreover, others claim there are "limits of scientific authority… applicability of knowledge" (Porter & Zachar, 2012, p. 206) that rehabilitation may not tie into the subject's reasoning, as it should explore narrative understandings of 'health orientation'[12] (Thorton, 2012).

Becker (1997) reminds us that an illness trajectory causes patients' uncertainty over a long time. Such as, in this study linking i-SMI's readmission experiences across time and distance and places (recall these are cyclical) they increasingly become aware of their limbo-like state (see *uncharted relational dynamics* examples in Table 11 above),

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[12] "Narrative understanding contrasts with the nomological or law-like explanations that are found in the natural sciences, and to which a biomedical view of psychiatry aspires because its normative. Narrative judgements thus answer to a different kind of internal logic to non-normative nomological accounts. In the vocabulary that John McDowell has developed from Sellars, they belong to the "space of reasons" rather than the "realm of law" (McDowell, 1994)" (Thorton, 2012, pp. 248-249). See also Thorton's references: McDowell, J. (1994). *Mind and World*. Cambridge, MA: Harvard University Press., and Sellars, W. (1963). Philosophy and the scientific image of man. In: *Science, Perception and Reality*. London: Routledge and Kegan Paul).

vis a vis disparity between the "voice of their body and the voice of society" (p. 193). In addition to healing emotionally and mentally, participants' micro-experiences, are included in their healing process, thus delaying reconstitution.

With Zoie's forwardly focused narrative "[T]hat's what I WANT is to see myself be my own safety bubble and carry it out to wherever go," there is a remarkable correlation with the pursuit of developing a personal space of safety across the settings. As Lindeman-Nelson's (2001) says, that the individual's unfolding 'forward' story "creates a moral track record that commits her to certain values for the future" (p. 16). Therefore, we should consider Zoie's concerns of re-transitioning, the narrative element (k.1) [T]*o have control over my treatment and decide where I want to go… that really helped me a lot because it gave me a sense of control — a sense of belonging within myself* – resonates with participants' needs to *Discover* better health-oriented opportunities and *Uncover* aspects of their illness identity, thus arises the theme of *Uncovering + Discovering*.

Zoie's efforts are focused on maintaining and prolonging a personal space of safety as her identity continually changes. These efforts developed through the narratives of self-evidence: personal experience of the social and physical effects of the environment. From the professional perspective, the utility of safety moves through an array of limited maintenance/managed services (i.e., medication compliance) and prevention of relapse (i.e., medication adjustment, symptoms screening). Between Zoie's continuous efforts and professional utilitarian movements, there is a disconnect of the patient-centric experience of safety.

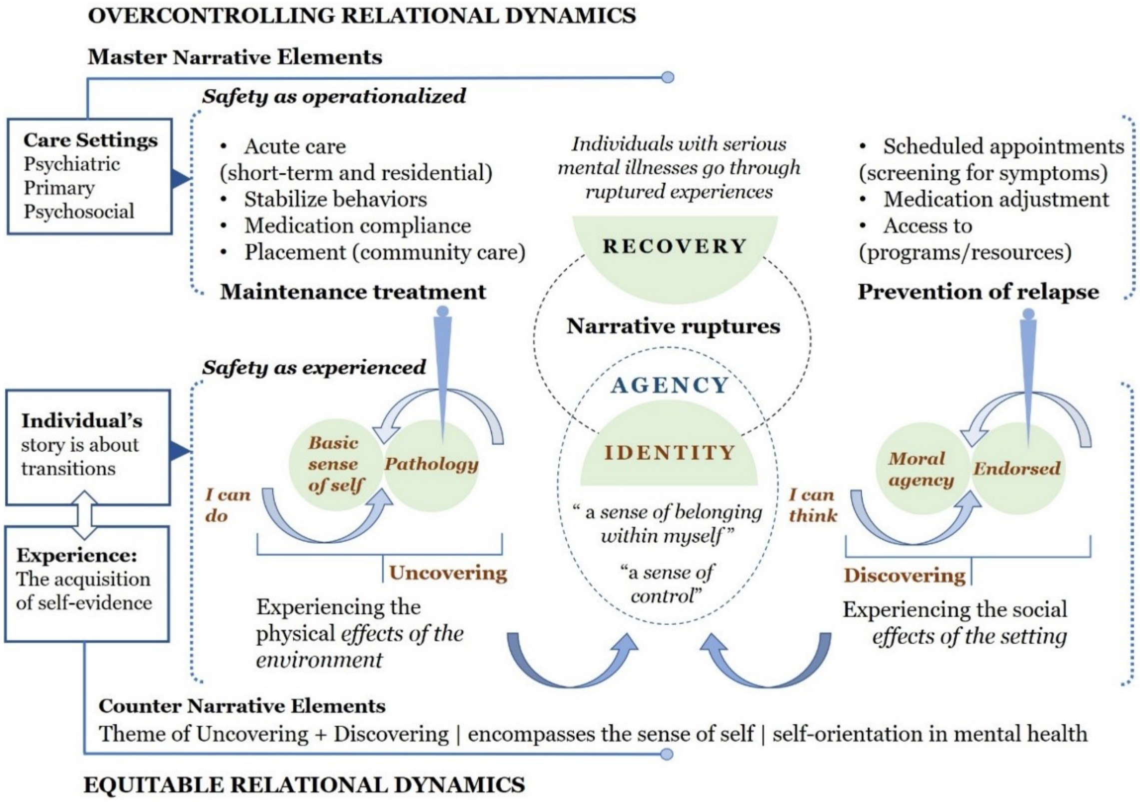

Figure 8. Overview: Map of Whose Recovery Is It? This overview illustrates the dominant systematic overcontrolling relationship dynamics, which contribute to i-SMI's adverse residual effects (*deprivation of opportunity* and *infiltrated consciousness*) as health professionals utilize different recovery-orientation strategies (see Mechanic & Olfson, 2016). Per the emerged Counterstory narrative elements, i-SMI's pursue Equitable relationship dynamics to gain moral agency and the bundling together of a diverse experience base.

Transition potentials of safety need more than the utility of referrals

It is useful here to bring in two other participants' insights to further the discussion, as mentioned above. These recommendations that come from William and Sophia, show how they are missing elements of support at a critical time of being discharged, as they focus on their transition potential of safety while health professionals focus on the utility of referral mechanisms.

William's re-transition.

William has been accessing mental health services since his adolescent years and has gone through many years of readmission, medication adjustments, and various inpatient programs that include forms of MT. Now an adult, [i-SMI] William, claims that his most current diagnosis may not reflect what he feels about his illness identity. William is a songwriter and musician currently has no family support and lives alone. He is unemployed and is looking forward to completing his high school education. Besides wishing to work and live independently, plan a nursing career specializing in occupational therapy, and become an educator. He believes that his experience with the mental health/illness care systems can provide insight in putting together programs to help adolescents. William suffers from aspects of bipolar and depression, and recently his diagnosis includes borderline personality disorder. He claims that a recent diagnosis was not explained in a way that he could trace it to a sense of the self. He fears that if he inquires how health professionals see his illness identity, that involuntary strategy may transpire.

Sophia's re-transition.

Sophia is a retired health professional in her late-40s. She excelled in competitive sports in her college years, currently is divorced, has two adult daughters, and lives independently apart from all family members. She enjoys the big family get-togethers, holidays, and cultural tradition. Sophia has strong support from her family members and visits with them/ her every weekend. She enjoys getting involved in a variety of social activities with peers across community care settings. Some of her hobbies include cooking, artwork, and educational programs. Sophia has set up for herself highly structured routines so that she will not suffer the consequences of her depression and allow suicidal thoughts to creep in. She feels that managing her bipolar diagnosis and following up clinical appointments is a full-time job. So, she decided to move to an apartment, that is just a fifteen-minute walk to the general hospital, the pharmacy, and grocery stores.

Re-transition experience gives rise to sub-themes of Placement + Place and Protection + Atmosphere.

In both William's and Sophia's stories, the omission of the (g) *personal space of safety* is an injurious result caused by the residual narrative rupture. During this transitional care timeframe, readmission was for medication readjustment and psychiatric revaluation. At discharge, they sought to re-transition prior micro-experiences and begin reconstituting agency (e.g., recall Zoie's metaphor "picking up the broken pieces"). Under the sub-theme of Placement + Place, in Williams's situation; he must find a place to live (e.g., recall Zoie's story, not all psychiatric units are purpose-built with an architectural ordering that supports the re-development of physical agency, an aspect gained from intensive (milieu therapy) MT work). As in William's discharge event, we can expect to see in Sophia's that meaning of recovery was not addressed.

Under the sub-theme of Protection + Atmosphere, Sophia's story is another example next to Zoie's development of "sense of control" and "a sense of belonging within myself." These results show, first establishing the self-narrative and then tying into a self-evidence obtained from experiencing the physical and social environments. (Examples from Zoie's story see figure 5., p. 144; figure 6., p. 146; figure 7., p. 148).

Both William and Sophia's personal space of safety is a self-oriented recovery *in* mental illness. They are involved in identity reconstituting activities, what it means to be recovering with a mental illness. Having gained moral agency of sorts after leaving the hospital, they are now seeking to regain skills, which was identified in the analysis as a strengthening of their autonomy, and to rekindle social connections with family members and friends, while re-constructing social agency. In the context of seeking equitable relational dynamics, the dominant narratives related to managing mental illness (maintenance treatment and preventing relapse) control the way i-SMIs' obtain autonomy, which overrides the i-SMI's employment of meaning (see Young, 1990)[13].

In William's (IE 17) short story, the utility of placement and safety is a system of service referrals and managed care. The physical placement of himself is without a place to live in and with no easy access to a telephone. (From Table 11: (t) *physical presence of possessions*, there are (u) *limits of possession and meaning—suspended agency* "everything is in up in the air, there is no steady ground": adverse effects from Zoie's in vivo statement that is related to master narrative ruptures, and William is still seeking (v) *meaning of place*). The results show that William cannot maintain physical Protection, a la Becker's assertion of prolonging "limbo-like" experience, uncertainty in the sense of re-transitioning an experience of Safety for himself. Such as prior familiar feelings of comfort, feeling supported, and in a place that aligns with his needs[14].

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[13] "Autonomy is a closed concept, which emphasizes primarily exclusion, the right to keep others out and to prevent them from interfering in decisions and actions. Autonomy refers to *privacy*, in just the sense that corporations are private in our current legal system. It should be distinguished from *empowerment*, which I define as participation of an agent in decisionmaking through an effective voice and vote. [Social] Justice requires that each person should have the institutionalized means to participate effectively in the decisions that affect her or his action and the conditions of that action. Empowerment is an open concept, a concept of publicity rather than privacy. Agents who are empowered with a voice to discuss ends and means of collective life, and who have institutionalized means of participating in those decisions, whether directly or through representatives, open together onto a set of publics where none has autonomy" (Young, 1990, p. 251).

[14] Field memo: William's personal space of Safety involves creating lyrics setting these into songs, processes of recording and live musical performance. For William, it's about developing public awareness regarding what i-SMI's go through. He intends to deliver positive messages for others who are going through a mental illness. During interviews, William would often make use of his singsong voice and tap the tabletop as if drumming up a rhythm. **Interview Excerpt**. Interviewer: What are you experiencing in this space, (continued on the next page)

For example, inconsistency in health strategies and being dismissive of the patient's attempts to voice their concerns (coded as a *Demeaning Experience*).

> **IE 17: Theme: Uncovering and Discovering | sub-theme Placement + Place** (pursing a personal space of safety + lack of physical space + lacking for communication).
>
> ---
>
> I: So — when they [*health professionals*] discharge you, is there a set time limit that you have to do this in (the conversation was about finding a place to live)?
>
> W: If you're feeling safe, and you're stable they're gonna discharge you even if you don't have a placement. They don't help you with placement, unless — you're — still feeling unsafe. So — on the kid's side it's different. They LET you stay until you have a placement. On the adult side it's different. they leave you to [*Shelter Services*] is a homeless shelter and most of the time you're sleeping outside — cuz, it's so crowded. You are sleeping on the street. They can connect you with counseling and like at a clinic, but — if you don't have — a place to live — or, if you don't have a phone, how are you going to get a ride? [*to the clinic*] — so? [*shrugs his shoulders*].

We can expect to see in Sophia's stories below (IE 18 and IE 19), how she employs her self-orientation of wellness to develop self-narrative (see Thorton, 2012). She suggests that the discharge agreement dismisses a critical aspect of the way persons with SMI encapsulate their prior transition movements toward the development of a (g) *personal space of safety*. Thus, it reveals the power of the decisions made by health professionals and as well as the knowledge gap related to what recovery means.

---

how are you experiencing it…?*William*: …I don't even really notice it — [but] I think you have to be able to live with it [space between yourself, even though it's your place be in, it's what you make of it] (William-09 19 2018, Pos. 535-537 in MAXQDA). *Interviewer*: So, what can you tell me about what you think, or feel about that space of music? *William*: It's actually both — to be honest, because I'm thinking about what the lyrics mean when I hear it, and then when also I'm feeling how they are feeling, also (William-08 29 2018, Pos. 461-462 in MAXQDA). *William*: — I hope that they [*the audience*] feel, that they're not alone and, that there's actually people feeling the same way that they feel, and that as I'm trying change — and they should too (William-08 29 2018, Pos. 466 in MAXQDA).

IE 18: Theme: Uncovering and Discovering | sub-theme Placement + Place (pursing a personal space of safety + discharge agreement suspending the meaning of personal transition).

I: What advice would you give to health professionals when they are preparing people to go home from hospital, or preparing people to get therapy…

S: …I'd say give them some markers [*waves right hand over the markers on the table*] and give them some paper — [*moves body forwards toward the edge or her chair and looks straight into the investigator's eyes and smiles*] like this — [*waves right hand over the stack of papers on the table and voice tone rising cheerfully*] and have them DRAW—with anything that they feel like drawing and let their imagination run off with them. That's what I say.

I: How about after people would draw…

S: …Uh-huh…

I: …How should health professionals follow up with them—do you have any further advice for them…?

S: … No—no not really…

I: …So, what would happen, what would you tell health professionals to…?

S: …Tell them to draw whatever they wanted — whatever they feel like drawing, a dog, a cat, a house, a bike, a car — [*chuckling*] whatever they feel like drawing [*cheerful voice*] — just let them DRAW and they'll SEE how relaxed they will be when they're doing that, cuz they'll forget all about their problems.

I: For me that makes sense… [in this context, Sophia created drawings over the course of the interviews]

S: …Yeah, yeah it does …

I: … And then after you draw, do you want them (health professionals) to see what people are drawing …?

S: … [*rising voice tone above the investigator's voice*] YEAH…

I: … Do you think that it would …?

S: …TALK about you're drawing [*right index finger points to the dream house drawing and the gesture continues as Sophia's finger lands on the wooden table surface hard making a knocking sound*] what it MEANS to you [*as above repeats gestures*] WHY YOU DREW IT [*as above repeats gesture and lowers voice*] what it signifies [*flips up both hands with palms open and finger spread out, then turns hands over to rest gently on tip of the drawing*] — yeah. [*sits straight up in the chair*] Yeah, that's what they should do.

In Sophia's next short story below (IE 19), the findings show that she must be engaged in self-constituting activities, or she will put herself at risk. Fundamentally, the realization from creating abstract drawings (IE 18) in order to develop a self-narrative, Sophia re-transitions lived spatial movement[15] and human interaction[16]. Sophia's personal space of safety develops as she continues to create, collect, and share artwork, bringing artifacts into her home that are meaningful. She uncovers emotional healing potential, as these artifacts remind her of what she has accomplished, and she acknowledges that there is a discoverable 'protective' and 'higher' spiritual power.

> **IE 19: Theme: Uncovering and Discovering | sub-theme Protection + Atmosphere** (pursing a personal space of safety + fixing supports in physical and social spaces + self-orientation).
>
> I: Help me understand what large rooms have, that you like to see—artwork in them?
>
> S: I like pictures on the walls (*giggles*) that I like to see, like these pictures on the walls here in this room, ha, ha, ha.
>
> *D: Perfect. Perfect. Ha, ha, ha (*the caregiver interjected here momentarily during the interview in order to support Sophia's emotional level of comfort).

---

[15] Cognitive sciences subscribe to Husserl's work, See Moran (2011) "Habit… for Husserl, is intimately involved in the constitution of meaningfulness (Husserl's *Sinnhaftigkeit*) and forms of sense (*Sinnesgestalten*) at all levels, from the level of perceptual experience, through the formation of the ego, to the development of society, history and tradition, indeed to our whole sense of the *harmonious course of worldly life* and to the genetic constitution of world hood as such. Habituality, furthermore, is a key structural principle in the genetic constitution of the transcendental ego itself, as it unfolds as a concrete living and acting person in an intersubjective, cultural and historical world" (p. 53). See also Moos (1979), *Social-Ecological Perspectives on Health*, and Gibson (1979) *The Ecological Approach to Visual Perception*.

[16] Field note memo: After several hospital admissions and getting her medications adjusted, Sophia, during this transitional time frame, is working on fixing spatial boundaries. As she is mostly feeling comfortable in "large rooms" the interview room that we are presently occupying is not considered large. My understanding of Sophia's concern is that small physical spaces with people she doesn't know makes her feel very anxious. Thus, most likely indicates that the meaning of artwork in any room engages her prior experience.

I: Can you give me more examples of the things that you like to see in such rooms? Describe in detail some of the physical things that you like to see in the rooms?

S: [*looking around the room*] I like to see phones, ha, ha, ha – you know that you have communication with the outside world – ha, ha, ha.

I: Pictures and phones, is that it?...

S: ...People. Not large crowds. Yeah, ha, ha, ha.

I: Can you describe in detail, what are some of the things that you have in your apartment?

S: Oh, sure! Yeah, in my apartment – well you see at [*Name of TC recovery-oriented center]* here, and at [*Name of a second community care provider*] and at [*Name of a third community care provider*] there is art. So, we get to work on paintings, we get to draw, make things with ceramics.

And at home I have a collection of art pieces. So, that makes my home more colorful and cheerful. I have a big nice long couch. I have a little table. I have my artwork on the walls and on the table. It makes me feel comfortable, cuz it reflects what I do on a daily basis – and – it helps me remember all the happy times that I've had outside my apartment.

I: Tell me more about your experiences with your art activities...

S: ...I bring them home with me [*cheerful laugher*]

I: Oh, that's...

S: ...Yeah...

I ...That's wonderful, you bring them home...

UNCOVERING: (experiencing the physical effects of environment)

S: Yeah. It helps me connect – it makes me feel, okay. This is what I've been doing – see, this is what I've accomplished. I have this art piece at home, and I look at it at home, and what did I do; well I made that! Huh, ha, ha, ha (*cheerful laughter*). Yeah.

I: Do you do art activities in all the places that you go to?

S: I do a lot of artwork, yeah. Yeah, I do.

I: So, you are a collector of art?

S: A collector, yes indeed. Ha, ha, ha.

I: So, can you tell a story about the things that you collect?

S: Yes, I can.

I: Can you tell more specifically about the things that you collect; does it remind you of…?

S: Yes, it does. It reminds me not only of the day and the time that I've spent with other people when they were with me. So, it CHEERS me up, ha, ha.

I: Do you have other memorabilia that…?

S: Yes, I do. I have collections that other people have given me. I have a friend here that gave me a little bunny rabbit that she made with cardboard [*gestures with her hands, continues to shape up a bunny rabbit outline with her fingers*]; it's made out of yarn, and it's got two buttons for eyes and ears – it's really cute, ha, ha.

I: That is fantastic. What other things can you tell me from the activities…

DISCOVERING: (experiencing the social effect of the setting)

S: Let me see – [*thinking about what to say*] well – there's art basically what I do. There's uh, a spirituality group which I like a lot, and we talk about God. Whatever keeps you going, for me it's my higher power – that means a lot to me. I have faith in God, he's helped me through a lot of trials and tribulations in my life. So, I love going to spirituality class here at [*Name of TC recovery-oriented provider*].

I: Is this spirituality class only at [*Name of TC recovery-oriented provider*]?

S: Yeah, I get it here.

I: How do you bring that home?

S: I read my bible a lot. Uh-huh, I read my bible a lot. And um – I'm a cancer survivor, I'd like to share that with you.

Conclusion

Taken together, the narratives of William, Sophia and Zoie, presented in section II, as well as the emerged Counterstory, and remaining narrative elements that are “tensions within” (Lindeman-Nelson, 2001, p. 165) the “tissue” (p. 187) of an individual’s unfolding story, show that *recovery* is a term that serves the utility of mental health recovery-oriented services, and services for mental illnesses. There remains (e) *unresolved health professional power that suspends agency* and it is in this limbo-like uncertainty experienced by the i-SMI a delay of development of self-oriented healing occurs. It can be argued that the emerged counterstory, *Equitable relational dynamics attune social space the physical environment and meaning,* does not replace the meaning of recovery within the master narrative’s operatives. Perhaps only through advocacy can i-SMI’s find portions of equity with micro power arrangements. This suggests narrative repair may be achieved if professionals replace the biological recovery term *recovery* with the notion of Pérez-Gómez’ *attunement*: addressing the importance of the I-SMI’s relationship to their environment, both neurologically and phenomenologically - with architecture and the built environment as a trigger for empathy regarding atmosphere and mood.

Chapter 5

THE JOURNEY TOWARD NARRATIVE REPAIR

This project sought to examine the current state of transitional care for those who have a severe mental illness to find a better way of creating and maintaining continuity in their understanding of themselves while functioning in the world. Most important to this work is an inclusion of the experience of the individual with severe mental illness (i-SMI) as they transition from acute to community settings, and the insights that their experience could provide in healing the fractured transitional care system.

This project strived to answer the following research aims and questions posed in Chapter 1, Aim 1: Understand the transitional care experience from acute care hospitalization to the community for individuals with SMI (1a) What is the experience of the population with severe mental illness (P-SMI*)* (1b) How do we understand the individual with a severe mental illness (i-SMI) within the larger context of transitional care? Aim 2: Propose how this experience may be used to create a new story of transition that empowers individuals with SMI, through a better understanding of their "Space." (2a) How do individuals with SMI perceive the making of their space, related to their experiences of transitional care? (2b) How do we respond to their needs throughout the transitional care process and journey to recovery? Chapter 2 provided the historicity of the two most influential threads and how they shaped transitional care for this population. These threads were the institutionalization and deinstitutionalization of people with SMI over the last several centuries and the psychiatric nosology that has dominated the ways the P-SMI are perceived, thus establishing the master narrative elements and the ways in which transitional care responds to their needs. Chapter 3 outlined the qualitative research methods and the steps taken to interview i-SMI's in obtaining their narrative experience. Chapter 4 presented the findings with examples of the codebook and interview excerpts of the emerged narrative elements to showcase the findings in the counterstory. Also uncovered were additional narrative elements that emerged as gaps in the cloth of the counterstory, which will be discussed further in this chapter.

Summary of the Findings

Utility of narrative repair as a theory to understand the experience of i-SMI

Narrative repair realizes the counterstory as 'resisting' narrative injury, and it seeks to insert new themes based on insights gained that propose a metanarrative more suited to the actual experience of the individual. The theory of narrative repair in this project examined participants' stories for these active narrative effects: *ruptures* within healthcare narratives operatives, *injuries* that are harmful to i-SMI's reconstitution efforts, and *resistance* to uprooting the harmful narrative effects. The latter informs the direction of the counter narrative.

The Master Narrative and the Counterstory

Master Narrative. The master narrative in the data was coded as *Overcontrolling Relational Dynamics*. The established master narrative operatives that showed up in this study are related to the utility of safety in place-based acute care facilities and the clinical story encompassing the patient's pathology, disability, and impairment deficits, informed by deep-seated reductionist assumptions in managed care and the protective structures of care coordination.

Narrative ruptures in this study show up as the basic limits for treatment maintenance that the patient must follow to access services, that reinforce the medical perspective (vis a vis medication compliance, symptoms screening, and setting up ride-share contracts to authorized clinics and programs). In the community settings, there are three systems of care that the participants access: general health/primary care services,

services for mental illness (acute psychiatric care, programs for people with SMI (p-SMI) such as ACT), and services for mental health (psychosocial and rehabilitative programs). Between the systems of care for mental illnesses and mental health services, distinct power differentials between health professionals were identified in the data. These power differentials also had an adverse effect on participants, coded in the data as *unresolved health professional power that suspend i-SMI's agency*.

Narrative injuries in this study show up under the coded theme of *demeaning experiences* that the i-SMI's in this study reported as a dismissive attitude on the part of providers. This impacts identity in mental illness, which adversely affects the i-SMI's efforts to obtain/prolong moral agency, gain autonomy, and maintain hope in achieving social agency. Participants reported that the omission of their voice in the discharge agreement lowered self-esteem which launched an adverse cascade that undermined the development of their core sense of self, and restricted the uncovering of a 'getting better' orientation which moves in the direction of developing, as coded in the data, *personal space of safety*. The combined narrative ruptures and injuries move toward the counterstory and can set in motion transformation in the way that i-SMI's experience transitional care as well as change in the master narrative.

Counterstory. The counterstory in this work, coded in the data as *Equitable Relational Dynamics attune social space, the physical environment, and meaning* – encompasses health professionals' empowering of the i-SMI's continued efforts, by enabling the telling of their stories and supporting their clients in realizing potential gains to reduce loss. In this study, these were derived under the coded theme of *meaningful inclusion*. The value of this counterstory is based on the coded notion of *meaning and metaphor* to bring forth the voice, the participant's embodied experience. The first emerged narrative element set forth the direction of narrative repair, coded as *meaning can repair or change the direction of personal transition*, interweaving the rest of the resistive pieces of the emerged narrative elements of this journey: pick-up-the-broken-pieces and go through readmission-community-home and imagined future. These resistive narrative elements, thus, are combinations comprised of the emerged narrative elements from the analysis and are used to propose new stories (see Table 10. *Summary of Emerged Narrative Elements*, pp. 130-131).

Discussion: Key Findings and Conclusions

Narrative repair analysis uncovered narrative (elements) keys from i-SMI's stories and, thus, the discourse for the counterstory, which calls for the redistribution of power dynamics across the care settings. Counterstory's discourse considers that p-SMI pursue equity in getting better; the narrative keys propose to unlock traditional master narratives and repair overcontrolling effects.

We found several narrative keys that are specific to place-based events, and these are between health professionals' operatives that make up the i-SMI's readmission-discharge-care transition journey. Therefore, professional health agents making common any sort of equitable endorsement would require a systematic collaborative undertaking, to replace or revise demeaning strategies related to health service delivery. The participants' counterstories maintained this emerged narrative element (a) *meaning can repair or change the direction of personal transition*, a common thread interweaving the 'tissue' (Lindemann-Nelson) of short stories – at any point of the readmission-discharge-care transitions journey — underpinning the features of the seven key narrative findings, as in the discussion that follows below.

1. Performing narrative triage

Performing narrative triage first emerged during the time of relapse, in the general hospital ER setting and was part of the participant's intake journey to gain admission in acute psychiatric care. The techniques performed by a crisis, and prevention and response (CPR) worker were useful in the sense of talking to Zoie, getting her words, compiling and reviewing a short story about her relapse event. The act of narrative triage gave Zoie a brief opportunity, re-centering a sense of "calmness" within herself. The act of gathering information was useful for the preview of the intake staff, part of the admissions process. Problems emerged later when Zoie prepared to leave the acute psychiatric unit, how clinicians' interpretations that came out of her relapse-story, decisions explicitly about treatment, how therapy moved in the direction of managed care exclusive of her active input. There was little opportunity to hear the clinical narrative as i-SMI's leave the hospital. This finding suggests that the act of compiling and reviewing a short story proved to be equitable, empowering, essential as i-SMI's pursue the development of self-narrative.

2. Untapped i-SMI's experience-based narrative, and
    a. Health professionals in the community care settings may not be able to ask of their clients' direct personal questions

The paring of these narrative keys (2) and (2.a), shows the problems that keep re-emerging, specifically at the time of discharge, making the experience of the relational dynamics more complicated for the participants and the recovery-oriented mental health professionals. Both narrative keys indicate that there is an overlapping effect, the absence of compiling and reviewing i-SMI's self-narrative. The data show that the participants need to develop a forward-looking story with support from mental health recovery-oriented services.

To reiterate (2) above, when Zoie left acute psychiatric care, there was little opportunity to revisit her relapse story and to pursue creating a personal narrative – "it's taken me a long time to build my safety bubble" (Zoie's emphasis, in this context, integrates the social and physical spaces that emerge from the self-narrative). William and Sophia had similar repeated past experiences with omissions of their personal story. In the recent discharge event, William preferred learning more about his new diagnosis and how the effect of the medication impacts his illness identity – "I had no one to talk to" (William's emphasis). William was not well prepared to leave the hospital and did not have the means to articulate his concerns. Sophia applied her caregiver's skillset to reconstruct a sense of self, develop a routine that would later prove to integrate her illness identity, and help her develop increments of autonomy. Participants repeatedly have experienced delays, in obtaining a self-oriented healing, not having the necessary tools to transition into the next setting. Because Sophia's experiences combine health professional training and living with a mental illness, she suggested that the discharge plan should include the space for i-SMI's self-narrative, in her words:

> [*health professionals should*]...TALK about your drawing, what it MEANS to you, WHY YOU DREW IT, what it signifies. Yeah, that's what they should do.

Furthermore, the data obtained from the researcher's field notes outside of these interviews, show that health professionals outside of the acute care setting, triangulate the i-SMI's experiences – gaps and tensions within the tissue of the unfolding story (Lindemann-Nelsons' emphasis) – (2.a) *they could not ask of their client's direct personal questions about their diagnosis*. Underpinning this issue are ethical guidelines regarding patient privacy and doctor-patient confidentiality. There are different protocols for community health workers to consider, what comes with coordinating health services and finding resources, and what comes with identifying risk at point of care and reporting to health professionals in acute care and across the settings.

3. Utility of space in places of therapy can either undermine or enhance one's efforts to maintain agency

In the above narrative findings, (1), (2), and (2.a), we find this overlap with the crucial development of the self-narrative. Of equal importance is i-SMI's intertwining of the physical experience of places that comes out of the self-narrative. Hence, the narrative finding (3) — shows how identity and agency come together, specifically, the process of familiarizing one's body with the physical routines that we learn, by doing what we need to do in order to feel safe in each setting — results show constructs of physical agency.

Zoie's stories show how purpose-built care settings, impacts how i-SMI's interact with the physical settings to construct physical agency. She reported going through negative experiences: e.g., the case manager did not check her home for potential physical harm, e.g., in both hospital intake experiences the hospital spaces were organized around the activities of the health professionals, and positive experiences, e.g., the spaces in the acute care psychiatric unit were organized to include patient activities, e.g., the art rooms located in the community care settings.

It is in this regard, Zoie's core sensibilities of a *personal space of safety* (see also the key narrative finding (6) below), integrates physical space (pp. 106-109) and social space (pp. 109-110) and in Zoie's words, the "safety bubble."

> It's a LOT different than in the hospital, because this is already made for you. The safety bubble at home you have to create yourself. And, it's really hard to do so, if you do not have the support or the KNOWLEDGE to do so…[i]t's taken a long time for me to be able to build this [safety] bubble.

The integration of the such spaces – characteristics that defines the bubble – was described in detail, making use of linguistic features such as metaphors and body gestures and drawing media (from IE 6 story (pp. 94-95) figure 2 appears below).

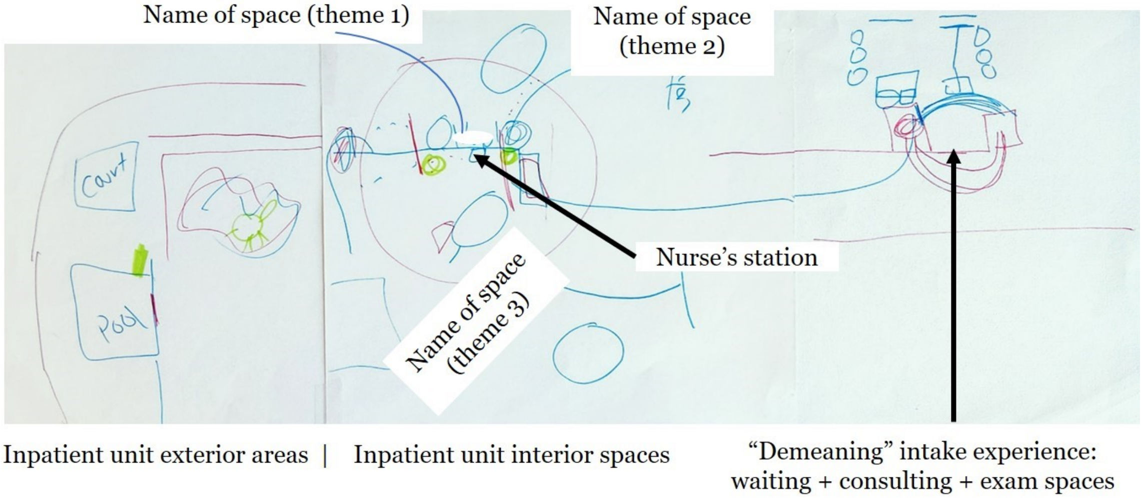

Figure 2. Map of an emerging personal space of safety during psychiatric acute care. (Memo: The utility of the second interview provided Peer review: Learn more about the emerging themes, clarify details, obtain i-SMI's descriptions and meaning.)

This finding uncovered more in-depth phenomenological pieces of the counterstory, which interweaves the i-SMI's *homeworld* ecology; these are the hidden aspects of getting better, which involves the way one's perception and body, such as intentions and adaptations, experience the physical reality of a place. It is in this sense; how constructing one's physical agency informs i-SMI's autonomy. Furthermore, the literature on architectural designs that employed evidence-based research, show that purpose-built environments benefit patient-centrist healing outcomes. Neuroscience goes a little further with the discussion on evidence-based design, how the outside world stimulates the human condition and the importance of using visual and emotional triggers in multisensory design interventions to enhance psychosocial outcomes.

4. Unresolved health professional power that suspends agency, and
    a. Advocacy involves disentangling what healing orientation means

The pairing of these (4) and (4.a) narrative findings, braids the problematic outcomes related to (2) and (2.a) noted above. However, in its narrative braiding, the complexity surrounding the i-SMI's self-orientation (e.g., how physical agency comes out of the self-narrative as (3) discussed above) and seeking advocacy from the recovery-oriented health professional group subordinate to the discharge planning group in acute care. In sum, the braiding intertwines these dynamics: redistribution of power and disentangling the healing orientation between health professionals and making decisions that impact i-SMI's moral agency (e.g., *health agents making common any sort of equitable endorsement would require a systematic collaborative undertaking, to replace or revise demeaning strategies related to health service delivery*).

Moreover, the power differential between services for mental illness (pharmacological treatment) and services in mental health (psychosocial therapy) was observed both in the historicity of the master narratives and in the experiences of the participants (chapter 2), controlling one's "fate" (Zoie's emphasis) in health orientation.

> They decide what's going on. Kind of like – a jury, coming up with – guilty – or not guilty. Like they decide my fate. It's kind of how that feels sometimes – is I'm out of the loop (Zoie).

To reiterate the findings (2) and (2a) show the omission of the SMI's self-narrative, (4) and (4 a) shows the tensions between health professionals deciding the course of health strategies. Meanwhile, i-SMI's pursue meaningful healing without having earned – a formative vocal status — revealed the need for an advocate champion.

> I called my case manager and I – expressed to them like; "*this is my choice*" and; "*I feel that you are working against me and not for me,*" and; "*I want to go to (name of transitional care(TC)/ recovery-oriented (RO) provider – I feel like (name of TC/RO provider) is the best for me right now*" – I don't – I just want; "*do you want me to – do you want to set up transportation for me when I get out? Or, do you want me to call (name of TC /RO provider) for them to set up transportation?*"

A polarized medical strategy is downplaying the i-SMI's self-orientation and recovery with overcontrolling power dynamics – "the verdict" (Zoie's emphasis) — delays the development of the core "sense of belonging within myself" (Zoie's emphasis), thus, learning more about illness and medications and uncovering civil rights in order to gain access to treatment and other programs.

5. Meaningful stories can be made socially accessible and unlocked by the i-SMI's recovery-orientation, and
    a. "Be WHO I am and just be,"
    b. Potential gains of narrative meaning and places, and
    c. Uncovering self-orientation, building a self-evidence by developing a narrative platform in a mental health system of care

The above narrative finding and its emerged sub-narratives — arise as resistive characteristics in weaving together the "tissue" (Lindemann-Nelson) — of the Counterstory: *equitable relational dynamics attune social space, the physical environment, and meaning for the i-SMI.* Their resistive characteristics counter the effects of the previous findings related to overcontrolling master narrative elements.

As mentioned previously, when i-SMI's leave the hospital, there are few opportunities to continue developing a core sense of self, in the sense of using personal experience to inform health orientation. The interviews for this study provided the participants with more opportunities to tell their stories in a 'familiar' safe environment.

The utility of the interview strategy, as mentioned in chapter 3, was not only fruitful for the participants and me but also for the silent caregivers that were present. For example, Zoie explored her illness identity, through the metaphor of driving a car (5. a.) "*be WHO I am and just be,*" and through subsequent small stories, that emerged in the act of Zoie telling her story and she developed personal maps that show (5. b.) *potential gains* [exploring] *narrative meaning and place.* These emerged sub-narrative elements above, and (5. c.) *uncovering self-orientation, building self-evidence* move in the direction of getting health professional help, with development and charting the self-narrative. In sum, these findings suggest filling the gaps — omissions, as noted in the previous findings (2.) and (2.a.) above. Zoie was encouraged by recovery-oriented professionals — equitable relationships – develop self-narrative and shared experience with peers. The findings suggest the development of a patient-centric narrative platform empowers i-SMI's to establish themselves into the community quickly.

6. Personal space of safety, and
    a. Physical presence of possessions,
    b. Limits of possession and meaning, and
    c. Meaning of place

We see overlap from (3) discussion, further developed here from the i-SMI's perspective. The participants reported that personal space arises from a core "sense of self…belonging within [oneself]" (Zoie's emphasis) which combines understanding themselves and how they can relate to the world. In this regard, i-SMI's lived experiences incorporate emotion-body-mind, "feel more safe within myself and to have control…I am able to be my own safety bubble" (Zoie's emphasis) and integrates the psychological-social-physical.

When I asked Zoie how she can bring the safety bubble home, in the IE 16 story (pp. 143-149), she had produced a series of three maps, and her detailed descriptions indicated how safety and space is simultaneously a social and physical experience. For example, (6. a) *physical presence of possession* holds meaningful sentiment. In Zoie's example, it is the 'art chest' that helps her bundle together the personal effects of emotion-body-mind, related to a positive experience of safety as she works on building social skills and learning new computer skills. Zoie's goal is to access to rehabilitation. In the example with Sophia, she is an art collector of sorts.

> It helps me connect – it makes me feel, okay. This is what I've been doing – see, this is what I've accomplished. I have this art piece at home, and I look at it at home, and what I did do; well I made that! (Sophia).

It is in this sense that — emotion-body-mind — the core *sense of belonging within oneself* (participant's narrative thread); that an individual's act of storytelling "bundles"[17] their inner world, and the psychological-social-physical external world (Husserl's *lifeworld*). From the data, an example of the psychological-social-physical adaptation (6.b) *limits of possession and meaning* arise at a time when Zoie's agency was suspended, wearing a hospital gown; she did not "feel like herself" until she could wear her clothing again. The decisions setting limits of personal re-possession of belongings (e.g., Zoie's clothing) prolongs physical agency. The example above is complicated, as being admitted to acute care involves authorities' permissions and not one's freedom of choice. Zoie's maps pieced together the (6.c) *meaning of place*, and she described the elements that would engage in feeling safe and physical safety. She sought recovery-oriented therapy to gain emotional support for her issues with bulimia and took it a step further – a forward-looking story – thinking about changing habit by creating a formal dining-room experience in the existing space of her home (a proposal to change the way she would physically do things in her envieronment).

7. The theme of Uncovering + Discovering [sub-themes of Placement + Place and of Protection + Atmosphere] addresses the gaps in the cloth of the Counterstory (see figure 8. reinserted below)

This themed narrative key acknowledges that the participants' continuous efforts show resilience, a direction towards *Uncovering* what it means to get better and *Discovering* how to get better. It examines the gaps and tensions in the "tissue" of the counterstory, specifically the knowledge gap – what is? — health orientation and being

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[17] Luhrmann (2001),"When psychotherapists tell stories, they are learning to figure out the emotion-motivation-behavior bundles that (as they would see it) explain the way people in the story relate. Telling the story (convincingly) demonstrates their mastery" (p. 72). It is in this sense, that i-SMI are understanding themselves regarding their illness identity as they trying to adjust living in the community. See also Plutchik (2001) regarding emotional response, "Predicting the characteristics of environments enables organisms to prepare for those environments….[t]he human brain, which has evolved as an adaptation to changing environments, has now helped the very environments to which it must continue to adapt" (p.347).

mentally disabled. There is also overlap from (4) and (4.a) discussion, the themed finding with its sub-themes (7) move into the larger context of equitable relational dynamics, picking up the *Uncharted* relational dynamics that pertain to participants' re-transition experiences and the residual effects caused by systematic narrative ruptures.

To reiterate (from chapter 4, Figure 8., reinserted below), an overview of the systematic narrative tensions related to overcontrolling (residual narrative ruptures) and i-SMI's acquisition of self-evidence, pursing equitable relationships.

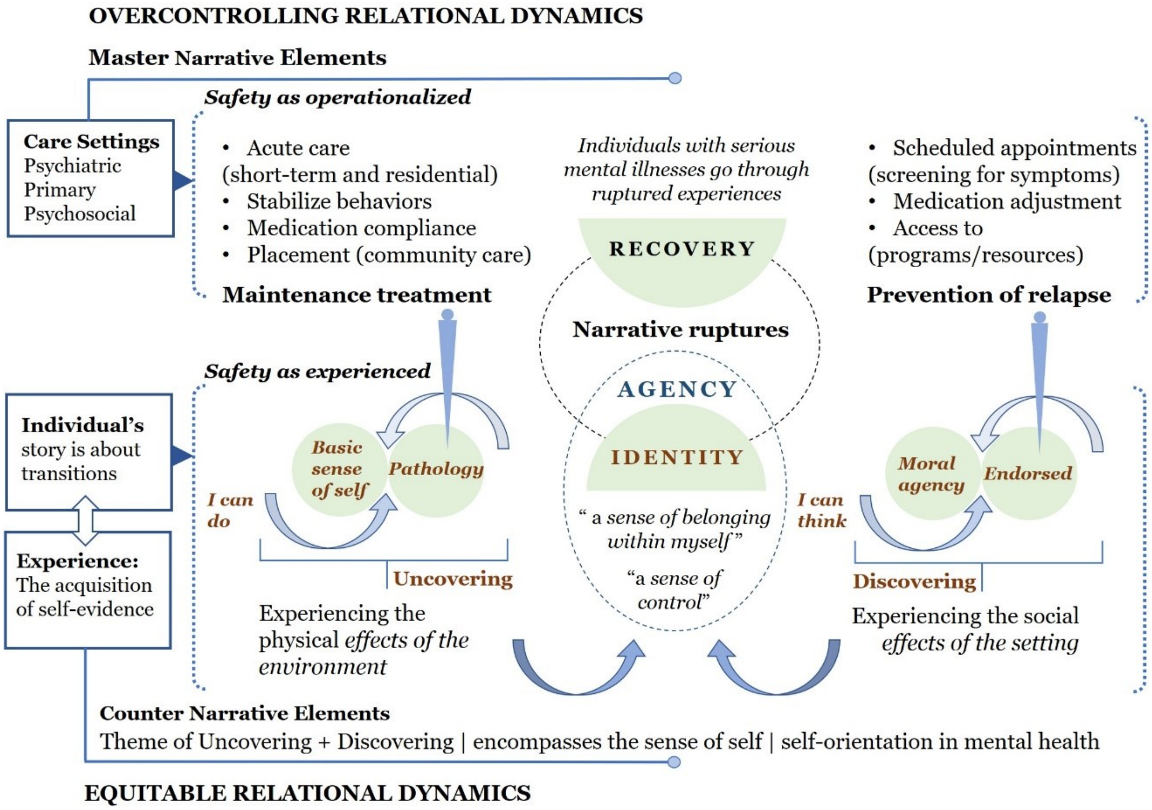

Figure 8. Overview: Map of Whose Recovery Is It? This overview illustrates the dominant systematic overcontrolling relationship dynamics, which contribute to i-SMI's adverse residual effects (*deprivation of opportunity* and *infiltrated consciousness*) as health professionals utilize different recovery-orientation strategies (see Mechanic & Olfson, 2016). Per the emerged Counterstory narrative elements, i-SMI's pursue Equitable relationship dynamics to gain moral agency and the bundling together of a diverse experience base.

Thus, the finding (7) elicits a new research question: whose recovery is it? It cannot be answered in the context of this project's counterstory, which leads to a further discussion of the counternarrative in the next section below and afterward recommendations follow.

The way in which identity and agency come together

Based on the findings of the counterstory, participants in this study indicated that the constitution of a *personal space of safety* is a vital component of their patient-centric experience. This space of safety was defined by participants as a place where they could "just be" – desiring others' full and genuine acceptance of who they are, and an acknowledgment of their self-evidence in recovering "within" their mental illness.

Synthesizing these experiences, participants' narratives show a long process of reconstructing their own identity, and within that identity – finding self-worth and a means of contributing more broadly. In the context of their mental illness, participants sought to understand themselves and the effects of illness, within this process, participants desired restoration and retention of their moral agency while pursuing functional autonomy in their contribution to personal and larger spheres of society.

This autonomy was considered by the participants the ultimate achievement, such as becoming independent in managing the effects of mental illness, which they reported leads to hope in constructing social identity, such as becoming employable or getting a career, or being accepted as a student or a son/brother once again by loved ones.

Narrative and personal space intertwine. As in the discussion above, the participants reported that the personal space arises from acceptance, support, and a core "sense of self…belonging within [oneself]." However, this project has found that there is more to this *personal space of safety*: tracking the i-SMI's process toward "getting better" we see that for this population, bound together are a core sense of self, mental, emotional, and embodied, engaged in psychological-social-physical activities where intention and agency intersect.

In a continuous effort to braid the internal-external experience, Zoie said "It's taken a long time for me to be able to build this bubble [*personal space of safety*] " Included in this space, for all participants, was the micro experiences of feeling that they were in limbo – and seeking to understand their illness identity, restore and retain their moral agency, and solidify their autonomy. For example, recall that Zoie chose to confront the clinical team, so that she could gain access to a meaningful place-based care setting. She did, and reported:

> They, support me in what I want to do with my life. They support me in the direction that I choose, and they give me the room to be creative and be – to express myself … at the members' meeting last week I got to read my poem.

Her personal space of safety enabled her to do much more than simply stay out of harm's way – it facilitated her internal and external relationships with those people and places around her and helped her to solidify her identity, agency, and autonomy. (These identity reconstituting activities include key finding 6).

For the purposes of continuing to better understand and advocate for those suffering from severe mental illness, acknowledging the foundational nature of the personal space of safety is crucial. Coupled with the assertions in the sections above that until the meaning of recovery is co-defined by the i-SMI and healthcare professionals, there will be no social justice for the SMI community, the necessity of looking closely at the intricacies of the space of safety is paramount.

It is here that this work suggests that there is a way to draw out the interactions experienced by the i-SMI between the core sense of self and the external environment – enabling research, policy, and advocacy to more closely examine the complexity.

This project proposes a new term that describes the environment in all its richness, and asserts the importance of understanding its infinite complexity: the Ecosystem of Space

Ecosystem of Space

This project suggests that the way in which identity and agency come out of a personal space of safety lends itself to a new way of understanding the needs of the p-SMI in their journey toward recovery, or even more so, attunement. Having reached the conclusion of this project, I would suggest that a counternarrative can be generated from the insights of participants in this study, setting the stage for deep and meaningful work with p-SMI to uncover insights and attune their healing environments to them, through their stories and experiences. I've called this framework the Ecosystem of Space, emphasizing that the i-SMI's development of agency has an intimate relationship with experiencing Space, including the social and physical environment, and describe this as an ecosystem to emphasize the complex ways that the i-SMI's personal space of safety, in its greatest authenticity, is born from their narratives, their way of healing, and a retention and sustaining of their moral agency.

Recall from chapter 4 in section II, Gibson, Moos, and Evans certainly get us partially there with the understanding that environments contain structural features that affect the way that we think and live. Sense of agency depends on our visual awareness, the way we use our memory, and take voluntary action primarily, an ecological sense of one's self-movements, picking up cues that are available in the physical world (Gibson, 1979, 2014). Alternatively, Moos (1968, 1979) and Evans (2003) suggest that the social-ecological experience across urban and institutional settings, the physical experience of the social settings are organized in a manner to elicit "modes of responses" and, thus we need careful consideration when developing the built environment.

Let us go one step further in my proposal of an Ecosystem of Space. I would offer Zoie's re-transitioning exemplar as proof of the need for this next step. Recall figure 3 (p. 120); she begins with a short story to understand the personas that make up her identity in mental illness. She then develops a forward-looking story, imagining obtaining free agency. She does this by using metaphors (i.e., driving a car responsibly) and relies on embodied self-evidence. She builds a series of short stories, to create a container of sorts "a bubble" that resonates with sensibilities akin to experiencing Safety (Recall footnote 15, Moran (2011) on Husserl: *Habit… is intimately involved in the constitution of meaningfulness and forms of sense at all levels…*). The bubble permits systems of spaces (see Hall, 1990) — Zoie's narrative is so much more; it is imaginative and tactile so that it constitutes personal power (Recall footnote 12, Thorton, 2012): *Narrative understanding contrasts with the nomological or law-like explanations that are found in the natural sciences…*).

Zoie's ***Ecosystem of Space*** can be interpreted as an ***architecture for healing***; it moves beyond the utilitarian scope of experiencing the built environment. She demonstrates this with *the tryptic* drawings (see Table 11, p. 136, IE 16 (v.1)), placing her *personal space of safety* into the community and at home. Her architecture consists of three fundamental things: an art chest that contains tools to help her imagine and remember experiences and tools to develop new skills, a list of meaningful words that define a hierarchy of valuable experiences[18] , and a relationship diagram of spaces that

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[18] (Zoie-07 25 2018, Pos. 252-253 in MAXQDA) *Interviewer*: [*cheerfully laughing with Zoie after she mentioned the word popsicles*] Care to venture how all these words put together can help define how you could live in such an environment? [See Table 11, p.136, code IE 16 (v.2)]. *Zoie*: [*cheerfully laughing*] Um, I think…free and love and understood [*making rotating gestures with right wrist hovering over the table top and holding the marker*] — I think — that if I'm in a house all by myself, then I would want an animal [*writes word*] so that I feel loved.
(continued on the next page)

can potentially heal negative behaviors by forming new psychosocial habits — for example, setting up a formal dining area so that she can deconstruct the problems related with her bulimic conditions.

Thus, the journey toward narrative repair from the perspective of i-SMI's uncovers a deeper counternarrative, ***Ecosystem of Space***: the manifestation of a personal architecture for healing, making a systematic organic-space-experience for the core sense of self to transition and flourish.

I propose that the Ecosystem of Space not only encompass physical space, but also reflects the richness of Zoie's insights, and the insights of others suffering from severe mental illness who may seek a space of safety for themselves, tailored personally to them and their needs. It is through the individual's understanding of their own valuable experiences, their ability to attune their space to purposefully create new habits, their insight into their core sense of self, and their desire for a moral agency that the Ecosystem of Space may arise, reflective of the insights and desires of those who have a severe mental illness.

This project shows that gleaning these insights is indeed possible, and with the theories of architecture, neuroscience, and transitional care as a foundation, I believe that an Ecosystem of Space can be a reality.

Um — I want to feel — free to be — as, unique as possible, like I want to — fear no judgement — in my environment. Um be free to be just who I am — no — boundaries, no walls, just completely who I am. But that would be the ideal environment for me to be — just — be who I am, and no fear of judgement, no fear of criticism, no fear of — [*takes a deep breath, looking at the written words on the sheet of paper*].

Recommendations

The key findings in this research are used to guide recommendations for collaboration between health professionals, the value of the qualitative research methodology, and further research and policy. Each of these discussed below.

Recommendations for collaboration between health professionals

In the attempt to answer the research questions for this study, the utility of narrative repair addressed the experiences of the i-SMI's against a backdrop of the relational power dynamics that arise in the health care master narratives' operatives. The master narrative's overcontrolling operatives indicated that there remains a deep-seated dismissiveness towards i-SMI's which had a damaging effect on identity and the indication that there are remaining barriers between health professionals' orientation regarding service for mental illnesses and service for mental health. At the same time, it should be noted that collaboration between health professionals already exists. Therefore, some of the following recommendations may already be in place. The value of the i-SMI's experience and the counterstory seeks to redistribute power dynamics, coded as *Equitable relational Dynamics attune social space, the physical environment, and meaning*. The recommendations put forth ways in which to reinvent getting better, such as – implementing a narrative platform that empowers i-SMI's to develop their stores with the help of health professionals beyond the clinical narrative – include i-SMI's in the discussion of the treatment plan and the discharge agreement so that they may understand their illness identity better as they continue to reconstruct agency in the community care settings. These recommendations include key findings (4), (5), and (6) as listed above.

Priorities for collaboration between health professionals in the study include:

1. Revisit how recovery is interpreted and operationalized in order to reduce professional inconsistencies. The decision-makers should consider including the i-SMI's potential gains in services for mental illnesses (acute care) and services for mental health (community care settings and managed care) to make any enhancements that would create equity in treatment and therapy. (Include key finding 4).

2. Consider a policy change that addresses the development and implementation of formal training in (1) *performing narrative triage* outside of the clinical setting. In this project, the CPR worker had assessment techniques to obtain i-SMI's story in a meaningful way. Introduce an education platform for patients' narrative continuity by extending professional assessment tools to capture patient's emergent narratives. (Include key finding 5).

3. In addition to introducing a platform for narrative continuity, consider addressing i-SMI's potential gains that are of therapeutic value related to *personal space of safety* in clinical settings and outside of the clinical settings. In this project, participants recommend that the discharge assessment should include their potential experience of transition so that identity reconstitution is part of the discharge agreement. Include health professionals in the community care settings so that ongoing professional endorsements of agency support the i-SMI's self-orientation. Development of the personal space of safety includes assessment tools to determine and support i-SMI's self-orientation of a therapeutic environment – social and physical adaptations. (Include key findings 3 and 6 and the discussion *the way in which identity and agency come together*).

4. Become knowledgeable about the research methodology related to the key finding (6) *personal space of safety*.

Recommendations for research methodology

Chapter 3 discussed the utility of Kvale's (1983) qualitative interview method in acquiring information from participants' lived experiences, and thus borrowing philosophical concepts from Husserl's *Homeworld* (see Chapter 2, sensitizing concepts). It should be noted that these philosophical underpinnings are widely used in a variety of psychoanalytical and other therapeutic encounters with the taking of one's story and are examined through a diagnostic lens. For this reason Hall's assertion, "if we can think of [humans] as surrounded by a series of expanding and contracting fields which provide information of many kinds, we shall begin to see [him/her] in an entirely different light" (Hall, 1969, p. 115) can be used objectively to ask of the P-SMI questions related to experiencing space with or without fixed boundaries.

Although there are other phenomenological research methods available, in this project, the viability of Kvale's (1983) semi-structured interview and topic guide was useful in reminding me to follow an ethical line of questioning and to focus on the research objectives. It should be noted that this interview process was not only fruitful for the study, but it was a meaningful exercise for me for the individuals being interviewed and for the silent professionals that were present.

Recalling that the participants were interviewed two times: First to take note of the context of their experience, observe gestures, facial expressions, and acquire what they say. Second, to follow up on emerging themes and verify what they said and obtain participants' thoughts and feelings and imaginings perceived as connected/connecting to the world. The preliminary results were tested during the second interview-situation, which pertains to Kvale's (1983) proposition "positive experience" (p. 178) that a qualitative research-interview is an extraordinary and enriching experience for the interviewee as knowledge is being generated and exchanged in conversation.

I am accustomed to using a variety of media to develop architectural concepts of three-dimensional spaces and thought that it would be helpful to invite participants to use their own process of drawing/diagramming/writing as they tell their story. With this hybrid research model of engagement and in keeping with narratology, I considered Kirmayer's assertion that body and language converge upon the use of metaphors (idioms, expressions) not only as a narrative element of representation but representing the i-SMI's reality. Therefore, combining the semi-structured interview with media for which to engage interviewees, this tactile opportunity engaged the participant's mind and hands to augment the story. It realized that more than one interview is necessary to reach a positive (Kvale, 1983) interpersonal conversation, to uncover the embodied meaning of the participant's mannerisms. Put together; these define the characteristics of Space and meaning of Safety that would integrate their narrative of a *personal space of safety*, which is at its core, the value of the i-SMI's understanding of themselves and the notion of building themselves into the community. (Recall: "Stories are a way of redrawing maps and finding new destinations" (Frank, 2013, p. 53)).

Hence, the following recommendations extend this form of experience-based research methodology related to i-SMI's quest for equity in treatment and therapy and with equitable relationships:

The i-SMI's transition potential could be realized by the design of semi-structured interviews, open-ended questions surrounding the i-SMI's self-orientation. A broad approach, regarding the 'complexity' of i-SMI's lived experiences and the taking of emergent stories are not currently in the scope of diagnostic assessments or interview-situation of analysis. This approach will most likely be crafted surrounding the individual's use of metaphor related to their micro-experience. Such as Zoie's exemplar with 'picking-up-the-broken-pieces' with each of these pieces/stories tied to meaningful aspects of her narrative indicated how she was bundling social and physical aspects of agency. Uncovering the value of agency within these narratives moves in the direction of understanding how i-SMI's can bundle together a therapeutic experience.

As discussed in chapter 4 (regarding spaces: physical (pp.106-109) and social (pp. 109-110)), including the key findings of 3 and 4 above, there exists evidence-based research on improving the human environment. We can review this work in Zoie's maps and related stories when she attempts ways to bring her personal space of safety home from the hospital. This sort of work will generate relational dynamics and perhaps equity by comparing health meaning ontologies. This methodology will contribute to furthering the research on Ecosystem of Space.

Limitations of the study

The key limitations for this study include the discussion on bias and future research:

The possibility of bias existed since I have a professional background in architecture. However, I have been transparent with my views regarding the phenomenon of Space and the sensitizing concepts. This is not unreasonable. As Blumer (1954) asserts: "the structure of science may emerge in place of mere assemblage of disconnected actions" (p. 522). In the case of this work, the actions are those of the i-SMI, seemingly nonsensical or unacceptable in mainstream thinking, but rich data and central to this project. This assertion of Norberg-Schulz is aligned with my belief in uncovering the ecosystem of space for the SMI, and "building" to their reality in a responsive way.

Another possibility of bias existed since I have family members with severe mental illness. However, I have also been transparent about my foundational understanding that we cannot rush to conclusions regarding the needs of i-SMI's. My intimate involvement with my siblings and experience of caregiving combined interview practice with peers, I believe, connected my awareness and acquired skills to ask of the participants probing questions. (The transcripts contain their rich descriptions of the gestural observations, including characteristics of the interview surroundings; in fact, it allowed participants the freedom to talk a little more about what they considered essential and be more direct about their diagnosis and emotional discomfort even though their caregivers were present).

This exploratory study was conducted in places of therapy, and interviews were retrieved during the three-month time frame of transitional care. This suggests a future research direction in tracking i-SMI's potential gains across other places in the community and over a longer period.

Recommendations for future research and policy

In the case of this project, the theme of Uncovering and Discovering proposes the next research question: whose recovery is it? The data show participant's resilience, continuous efforts in uncovering what it means to get better and discovering how to get better. The "tissue" of the counter story shows a knowledge gap in realizing i-SMI's self-orientation, and health orientation between health professionals, including the discussion: *the way in which identity and agency come together,* vis a vis *the personal space of safety*. The data showed that the built environment shapes i-SMI's experience of acute, transition, and community health situations. Special consideration is needed in planning and realizing the impact of place-based experiences. Based on the discussion: *the way in which identity and agency come out of space of safety introduces — a counternarrative for an Ecosystem of Space.*

In light of this work, narrative repair considers i-SMI's recommendation for equity in treatment and therapy and operationalizing equitable relational dynamics. In this project, this was achieved through the role of health professionals acting as advocates. Therefore, the following recommendations should be considered:

1. Based on the limitations of this study as mentioned above, consider extending this research to track i-SMI's potential gains across settings over a longer period. This research should be undertaken in partnership with professional community services.

2. A further study using the same line of inquiry and utility of narrative repair should be undertaken for health professionals' narratives to extend the spectrum of findings with P-SMI's. This research is necessary for making realistic recommendations for policy changes regarding equity in special services and access to facilities. This future work can explore the Americans for Disabilities Act (Title II and Title III Amendments Act 2014) to expand the definition of specialized services and access to facilities that could be equitable for P-SMI.

Researcher's Reflection

Based on the value of the data given by those in this study, it is relevant to develop tools and educational materials for the development of a patient-centric narrative platform, moreover, in consideration of maintaining a narrative playbook of achievements agency. This work is necessary to uncover ways of communicating the architecture of transitions of i-SMI's and address the need for establishing a resource of their experience-based platform to integrate the work of the clinical narrative.

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APPENDIX A

IRB APPROVAL NOTICES

ASU Knowledge Enterprise Development

APPROVAL: EXPEDITED REVIEW

Gerri Lamb
CONHI: Research Faculty and Staff

Gerri.Lamb@asu.edu

Dear Gerri Lamb:

On 4/29/2018 the ASU IRB reviewed the following protocol:

Type of Review:	Initial Study
Title:	Stories as told by individuals who are experiencing mental health care
Investigator:	Gerri Lamb
IRB ID:	STUDY00008168
Category of review:	(6) Voice, video, digital, or image recordings, (7)(b) Social science methods, (7)(a) Behavioral research
Funding:	None
Grant Title:	None
Grant ID:	None
Documents Reviewed:	• ZV-Tsikopoulos_Consent Form 04 19 2018.pdf, Category: Consent Form; • citiCompletionReport1917089.pdf, Category: Other (to reflect anything not captured above); • ZV-Tsikopoulos_Intital and follow-up interviewing script 04 19 2018.pdf, Category: Participant materials (specific directions for them); • ZV-Tsikopoulos_Interview Topic Guide 04 11 2018.pdf, Category: Participant materials (specific directions for them); • ZV-Tsikopoulos_Telephone Recruitment Script 04 12 2018.pdf, Category: Recruitment Materials; • G_Lamb-Z_Tsikopoulos_HRP-503a-TEMPLATE_PROTOCOL_SocialBehavioral-Tracked Changes.docx, Category: IRB Protocol; • citiCompletionReport1917089 (1).pdf, Category: Other (to reflect anything not captured above); • ZV-Tsikopoulos_Consent Form 04 19 2018.pdf, Category: Recruitment Materials; • Relias - Oracle - Mental Health First Aid course outline.pdf, Category: Other (to reflect anything not captured above);

ASU Knowledge Enterprise Development

APPROVAL: CONTINUATION

Gerri Lamb
CONHI: Research Faculty and Staff

Gerri.Lamb@asu.edu

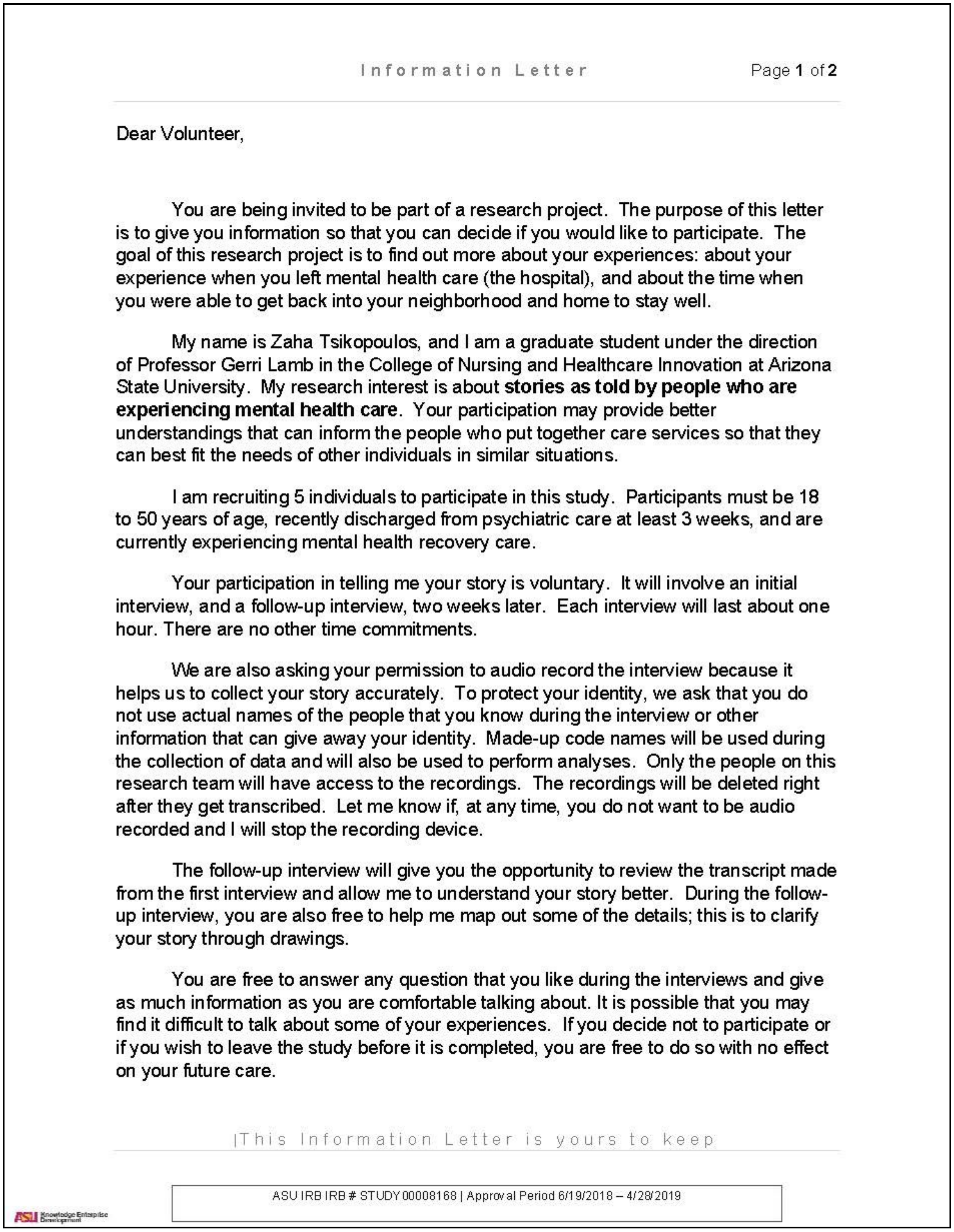
Dear Gerri Lamb:

On 4/1/2019 the ASU IRB reviewed the following protocol:

Type of Review:	Initial Study
Title:	Stories as told by individuals who are experiencing mental health care
Investigator:	Gerri Lamb
IRB ID:	STUDY00008168
Category of review:	(6) Voice, video, digital, or image recordings, (7)(b) Social science methods, (7)(a) Behavioral research
Funding:	None

APPENDIX B

IRB APPROVED INFORMATION LETTER



Dear Volunteer,

You are being invited to be part of a research project. The purpose of this letter is to give you information so that you can decide if you would like to participate. The goal of this research project is to find out more about your experiences: about your experience when you left mental health care (the hospital), and about the time when you were able to get back into your neighborhood and home to stay well.

My name is Zaha Tsikopoulos, and I am a graduate student under the direction of Professor Gerri Lamb in the College of Nursing and Healthcare Innovation at Arizona State University. My research interest is about **stories as told by people who are experiencing mental health care**. Your participation may provide better understandings that can inform the people who put together care services so that they can best fit the needs of other individuals in similar situations.

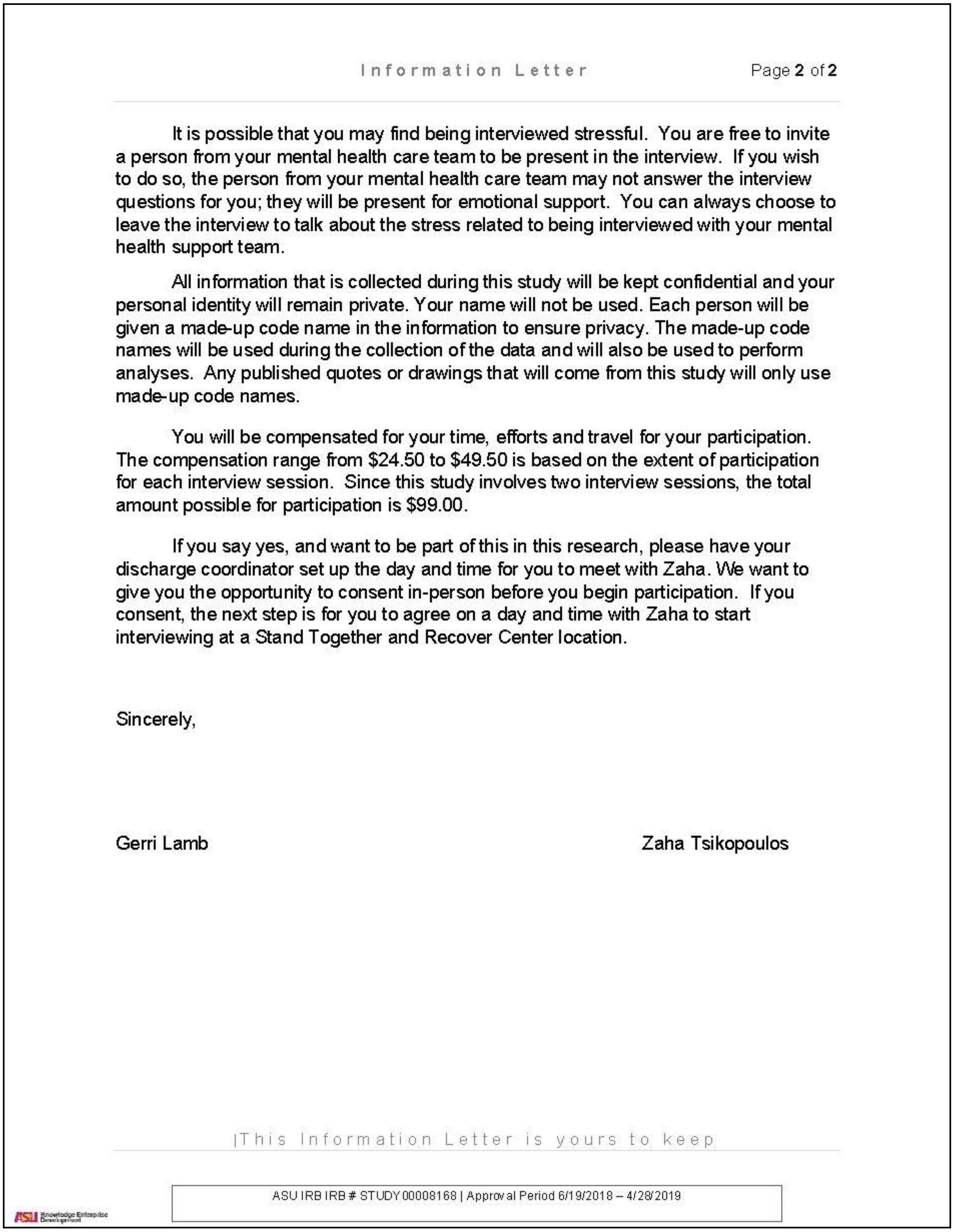
I am recruiting 5 individuals to participate in this study. Participants must be 18 to 50 years of age, recently discharged from psychiatric care at least 3 weeks, and are currently experiencing mental health recovery care.

Your participation in telling me your story is voluntary. It will involve an initial interview, and a follow-up interview, two weeks later. Each interview will last about one hour. There are no other time commitments.

We are also asking your permission to audio record the interview because it helps us to collect your story accurately. To protect your identity, we ask that you do not use actual names of the people that you know during the interview or other information that can give away your identity. Made-up code names will be used during the collection of data and will also be used to perform analyses. Only the people on this research team will have access to the recordings. The recordings will be deleted right after they get transcribed. Let me know if, at any time, you do not want to be audio recorded and I will stop the recording device.

The follow-up interview will give you the opportunity to review the transcript made from the first interview and allow me to understand your story better. During the follow-up interview, you are also free to help me map out some of the details; this is to clarify your story through drawings.

You are free to answer any question that you like during the interviews and give as much information as you are comfortable talking about. It is possible that you may find it difficult to talk about some of your experiences. If you decide not to participate or if you wish to leave the study before it is completed, you are free to do so with no effect on your future care.



It is possible that you may find being interviewed stressful. You are free to invite a person from your mental health care team to be present in the interview. If you wish to do so, the person from your mental health care team may not answer the interview questions for you; they will be present for emotional support. You can always choose to leave the interview to talk about the stress related to being interviewed with your mental health support team.

All information that is collected during this study will be kept confidential and your personal identity will remain private. Your name will not be used. Each person will be given a made-up code name in the information to ensure privacy. The made-up code names will be used during the collection of the data and will also be used to perform analyses. Any published quotes or drawings that will come from this study will only use made-up code names.

You will be compensated for your time, efforts and travel for your participation. The compensation range from $24.50 to $49.50 is based on the extent of participation for each interview session. Since this study involves two interview sessions, the total amount possible for participation is $99.00.

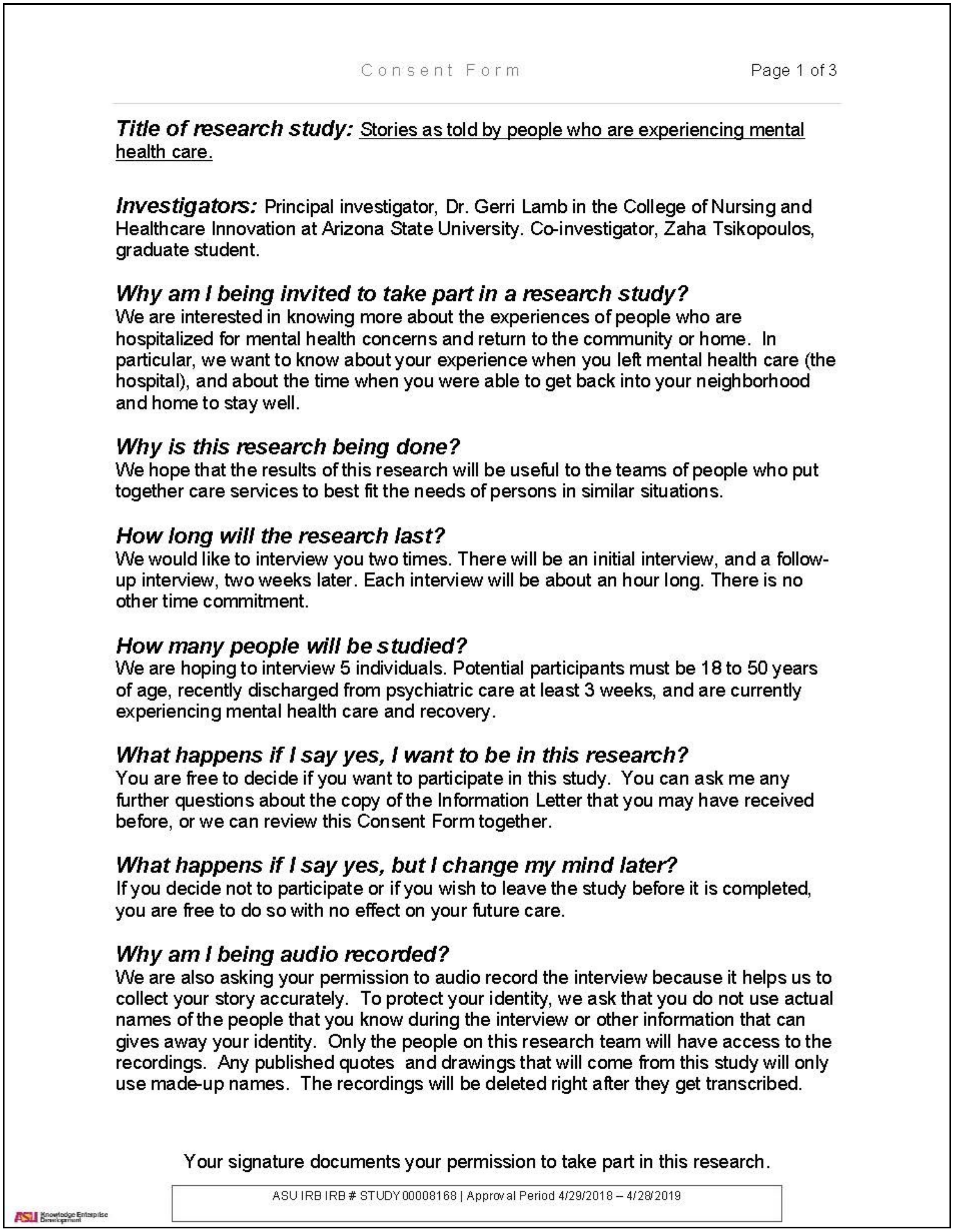
If you say yes, and want to be part of this in this research, please have your discharge coordinator set up the day and time for you to meet with Zaha. We want to give you the opportunity to consent in-person before you begin participation. If you consent, the next step is for you to agree on a day and time with Zaha to start interviewing at a Stand Together and Recover Center location.

Sincerely,

Gerri Lamb Zaha Tsikopoulos

APPENDIX C

IRB APPROVED CONSENT FORM



Title of research study: Stories as told by people who are experiencing mental health care.

Investigators: Principal investigator, Dr. Gerri Lamb in the College of Nursing and Healthcare Innovation at Arizona State University. Co-investigator, Zaha Tsikopoulos, graduate student.

Why am I being invited to take part in a research study?

We are interested in knowing more about the experiences of people who are hospitalized for mental health concerns and return to the community or home. In particular, we want to know about your experience when you left mental health care (the hospital), and about the time when you were able to get back into your neighborhood and home to stay well.

Why is this research being done?

We hope that the results of this research will be useful to the teams of people who put together care services to best fit the needs of persons in similar situations.

How long will the research last?

We would like to interview you two times. There will be an initial interview, and a follow-up interview, two weeks later. Each interview will be about an hour long. There is no other time commitment.

How many people will be studied?

We are hoping to interview 5 individuals. Potential participants must be 18 to 50 years of age, recently discharged from psychiatric care at least 3 weeks, and are currently experiencing mental health care and recovery.

What happens if I say yes, I want to be in this research?

You are free to decide if you want to participate in this study. You can ask me any further questions about the copy of the Information Letter that you may have received before, or we can review this Consent Form together.

What happens if I say yes, but I change my mind later?

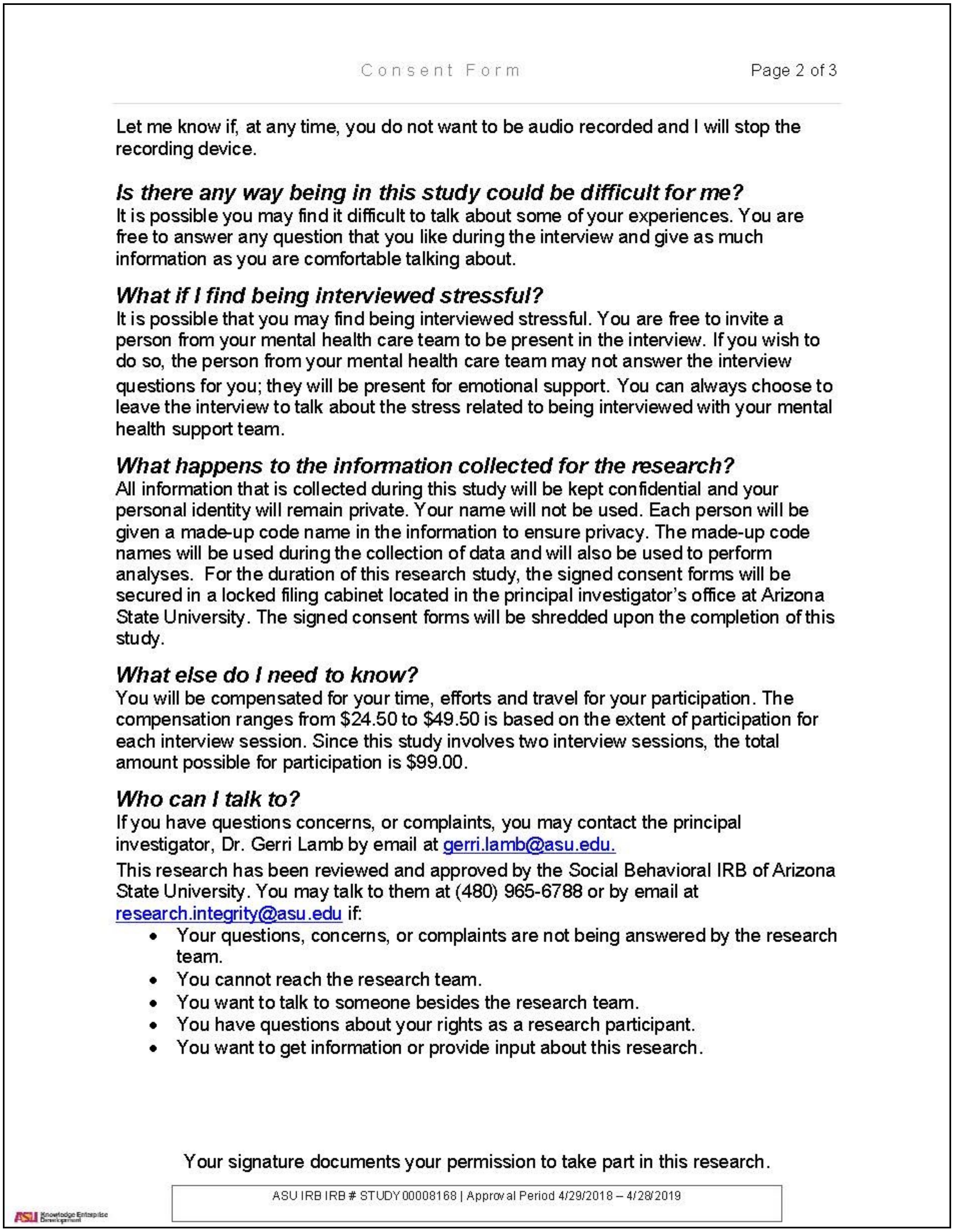
If you decide not to participate or if you wish to leave the study before it is completed, you are free to do so with no effect on your future care.

Why am I being audio recorded?

We are also asking your permission to audio record the interview because it helps us to collect your story accurately. To protect your identity, we ask that you do not use actual names of the people that you know during the interview or other information that can gives away your identity. Only the people on this research team will have access to the recordings. Any published quotes and drawings that will come from this study will only use made-up names. The recordings will be deleted right after they get transcribed.

Your signature documents your permission to take part in this research.

ASU IRB IRB # STUDY00008168 | Approval Period 4/29/2018 – 4/28/2019



Let me know if, at any time, you do not want to be audio recorded and I will stop the recording device.

Is there any way being in this study could be difficult for me?

It is possible you may find it difficult to talk about some of your experiences. You are free to answer any question that you like during the interview and give as much information as you are comfortable talking about.

What if I find being interviewed stressful?

It is possible that you may find being interviewed stressful. You are free to invite a person from your mental health care team to be present in the interview. If you wish to do so, the person from your mental health care team may not answer the interview questions for you; they will be present for emotional support. You can always choose to leave the interview to talk about the stress related to being interviewed with your mental health support team.

What happens to the information collected for the research?

All information that is collected during this study will be kept confidential and your personal identity will remain private. Your name will not be used. Each person will be given a made-up code name in the information to ensure privacy. The made-up code names will be used during the collection of data and will also be used to perform analyses. For the duration of this research study, the signed consent forms will be secured in a locked filing cabinet located in the principal investigator's office at Arizona State University. The signed consent forms will be shredded upon the completion of this study.

What else do I need to know?

You will be compensated for your time, efforts and travel for your participation. The compensation ranges from $24.50 to $49.50 is based on the extent of participation for each interview session. Since this study involves two interview sessions, the total amount possible for participation is $99.00.

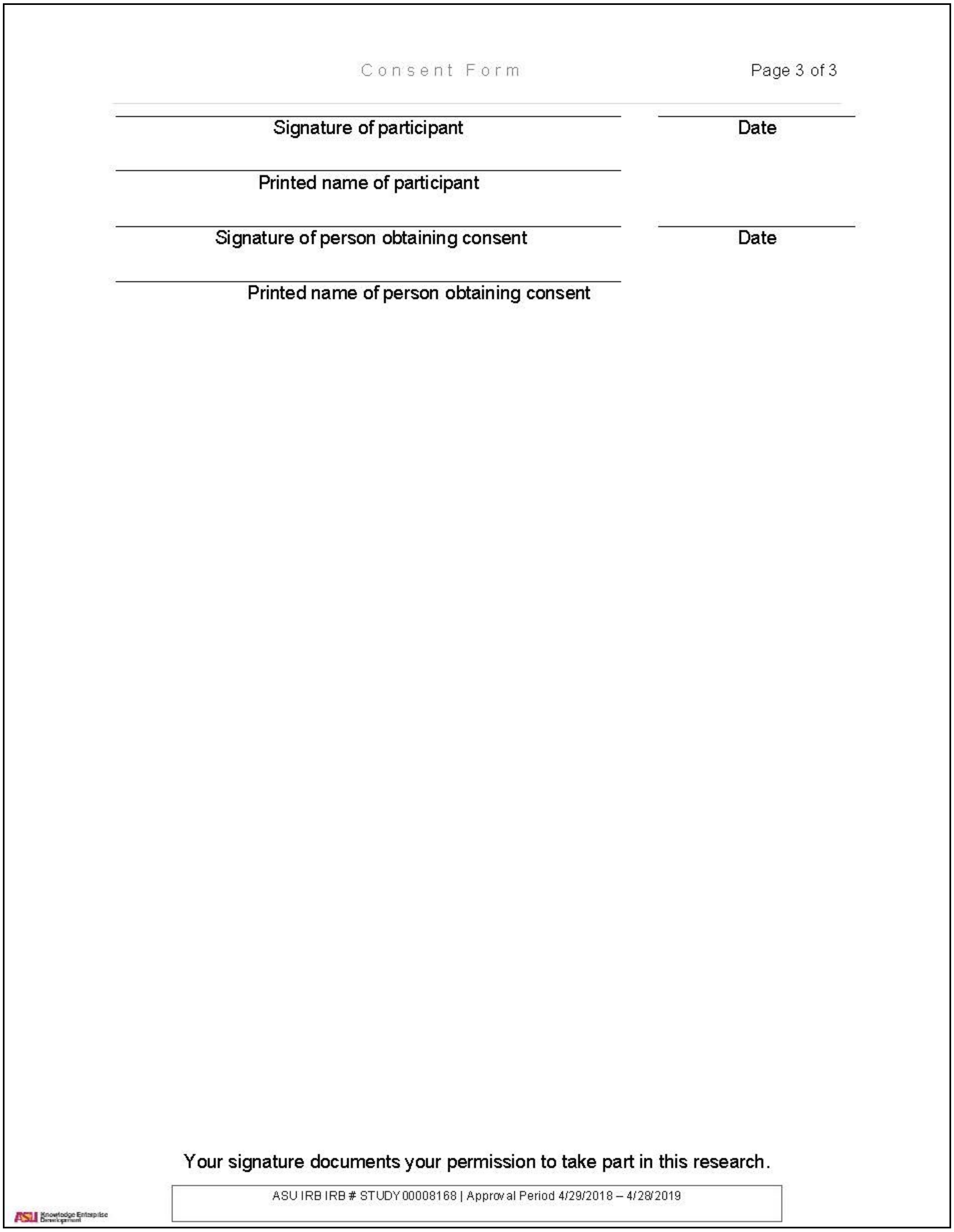
Who can I talk to?

If you have questions concerns, or complaints, you may contact the principal investigator, Dr. Gerri Lamb by email at gerri.lamb@asu.edu.

This research has been reviewed and approved by the Social Behavioral IRB of Arizona State University. You may talk to them at (480) 965-6788 or by email at research.integrity@asu.edu if:

- Your questions, concerns, or complaints are not being answered by the research team.
- You cannot reach the research team.
- You want to talk to someone besides the research team.
- You have questions about your rights as a research participant.
- You want to get information or provide input about this research.

Your signature documents your permission to take part in this research.



Signature of participant — Date

Printed name of participant

Signature of person obtaining consent — Date

Printed name of person obtaining consent

Your signature documents your permission to take part in this research.

ASU IRB IRB # STUDY00008168 | Approval Period 4/29/2018 – 4/28/2019

APPENDIX D

LEGEND OF REFERENCES AND ABBREVIATIONS FOR TABLE 12

&

TABLE 12. SUMMARY OF NARRATIVE STRUCTURES IN THE FINDINGS

Legend of References and Abbreviations for Table 12

IE	Interview excerpt
(x)	Emerged narrative elements (see Table 10)
	Power Dynamics
SE	Self-evidence
SO	Self-orientation
ORD	Overcontrolling relational dynamics
ERD	Equitable relational dynamics
URD	Uncharted relational dynamics

Table 12 Summary of Narrative Structures in the Findings

Systemic Narrative Structure	**Narrative Repair Principles** Narrative Effect: Ruptures › Injuries › Resistances	
Narrative Characteristics	**Narrative Operatives**	**Effects on i-SMI's**
MASTERSTORY **ORD/Dominance:** Nosological labeling, correlating pathology, disability and impairment deficits develop the clinical story of the patient. **Professional domain:** Authority is transferred to the community of practice via the discharge agreement, binds clinical treatment and patient decisions.	**Established:** Utility of safety related to place-based delivery of services treatment in acute care and in community settings: • Pharmacological readjustments • Psychiatric reevaluations, prevention screenings, follow up clinical appointments • ***Ruptures*:** Determine health policy, sets up basic limits in programs and access to services • ***Ruptures*:** Reinforce the medical perspectives on intervention outcomes	***Injuries:*** Dismissive dynamics impact i-SMI's identity *in* mental illness and in obtaining/prolonging perspective on moral agency and agentic endorsements (related to disability/autonomy): 1) ***Omission*** of i-SMI's (experience-based story) concerns regarding treatment and understanding of themselves related to diagnosis; 2) ***lowers*** self-esteem enabling barriers to SE, 3) ***undermines*** the pursuit to obtain "sense of self," 4) ***restricts*** bundling aspects of SO/ development towards a personal space of safety
COUNTERSTORY ** **ERD/supportive:** Per authorized utility of safety discharge agreement incorporating client needs and choices. Professional domain: Maintaining medical orientation toward patient outcomes related to community services. **Patient's domain:** Bridging medical perspective related to agency endorsements in recovery-orientation. **Unexplored Transition Potential URD's** [see Table 11 p. 136]. Gaps in knowledge below translate across the settings: **(c)** *Utility of physical space in places of therapy undermine one's efforts to maintain agency* **(e)** *Unresolved health professional power that suspends agency,* **(h)** *Untapped i-SMI's experience-based narrative* **(p)** *Meaningful stories can be made socially accessible*, and **(p.1, p.2, p.3)**	**Coordination**: Protective structure related to utility of safety based in discharge agreement presents barriers to i-SMI's personal transition potential **Mental Illness** *Establish endorsements* • Identity limited to psychiatric impairments/disabilities • Identity and agency reconstitution related to patient's clinical story in determining community reintegration • Health providers cannot ask clients about themselves ** **(a) Meaning can repair or change the direction of personal transition** **Mental Health** *Advocacy establishing Relationships* • Endorse i-SMI's self-orientation and health professional partnerships ++**(*l*)**	***Remaining injuries***: i-SMIs missing partnership with mental illness team related to identity in mental illness. • Limits in **(b)** *performing identity triage* • Limited MT in place-based acute care **(g)** *personal space of safety* • **Loss and Risks**: **(r)** *Personal space of safety could not transition home* **A Time to Consider Potential Gains** **Resistances:** Arising ERDs ** attune social space, the physical environment and meaning. *Advocacy involves disentangling what healing orientation means* ++**(*l*)** 1) **Empowering** i-SMI's SE/SO perspectives: place-based social space + physical environment 2) **Potential gains related to Gaps** [See Table 9, p.112] **(i), (j), (k), (k.1), (m), (n), (q)**

Table 12 Continued

Summary of Narrative Structures in the Findings

Systemic Narrative Structure

Narrative Characteristics

SELF-NARRATIVE

URD/Self-evidence:
- Reidentification, identity in mental illness
- Identity construction related to obtaining/prolonging agency **(h)**, **(p)** and **(p.1, p.2, p.3).**

Transitional care experience: IE-1
****(a)** Meaning can repair or change the direction of personal transition

Metaphor as reality

Z: "I didn't want to go back to the hospital, I didn't want to – **go through the runaround again**, with going back in the hospital, getting better and having to pick yourself back [*gulps in a breath, eyelids opening up and down rapidly and voice stuttering*] and – to – pick – the pieces up – that you had broken. And, so, I fought with [*my sibling*] for a little while, and then [*my sibling*] took me to the ER.

I: "Help me understand, what do you mean by, **picking up the broken pieces**?"

Z: "I feel like, when I go the hospital, like I'm broken. And, then I go to – I go to into the hospital and its – I perceive the hospital as it can be a good thing at times – but, I feel like a – like you're going backwards, its taking a few steps in your recovery, to be and to go to a hospital – It's like you're starting from day one."

Narrative Repair Principles
Narrative Effect: *Ruptures › Injuries › Resistances*

Narrative Operatives

Establishing: Integrating the experience of safety related to place-based utility of safety
- Pharmacological readjustments
- Psychiatric reevaluations, prevention screenings, follow up clinical appointments
- ***Resistances*: (g)** *Personal space of safety*

  Advocacy involves disentangling what healing orientation means **(*l*)**, related to gap **(i)**#

(g) Personal space of safety *mapping emergent narratives and boundaries*

Acquiring Self-evidence [See Fig. 8, p. 174, Overview: Map of *Whose recovery is it*?]

Theme: related to SE
1) *Uncovering + Discovering*

Pursuing the personal space of safety [see Table 11, p. 135 *Defining Space in Micro Experiences*]

Sub-themes: related to SO
2) *Placement + Place*
3) *Protection + Atmosphere*

(t) *Physical presence of possessions*
(u) *Limits of possession and meaning*, **(u.1)**
(v) *Meaning of place,* **(v.1)**, **(v.2)**

Effects on i-SMI's

***Remaining injuries*:**
- Masterstory related/dismissive dynamics
- *Omissions related to gaps*: **(c)**, **(e)**, **(h)**, limited **(b),** limited **(r)**

***Ruptures*:** Redefining patient-centrism

***Resistances*:** Advocacy
- Counterstory related empowering/Arising ERDs ****attune social space, the physical environment and meaning.**
- *Potential gains related to gaps,* **(i)**#**, (j), (k), (k-1), (m), (n)**