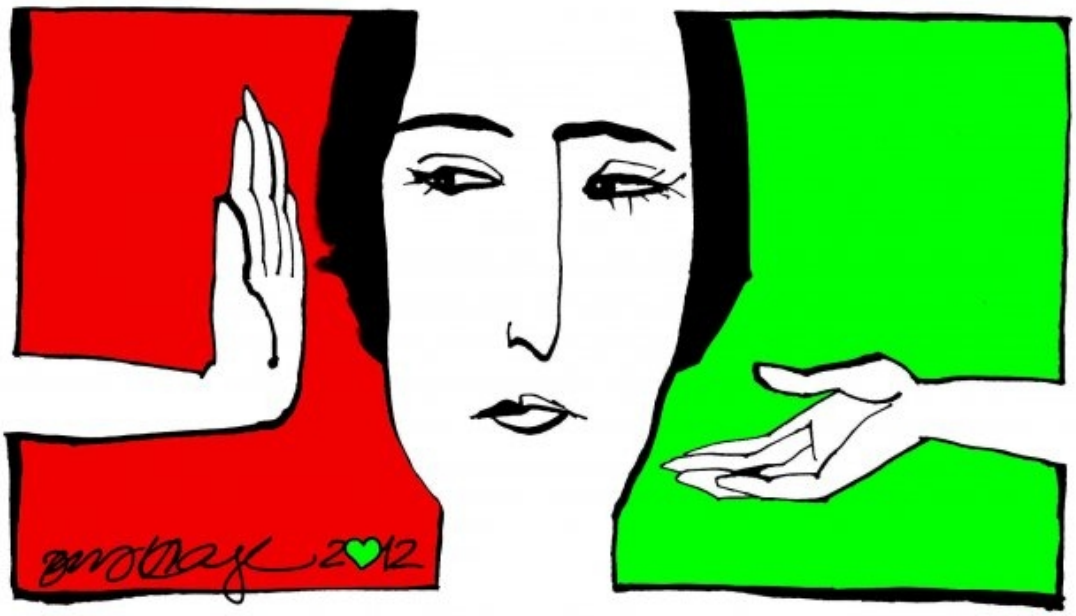

A narrative analytic study of the meaning of home

The case of Danish psychiatric outpatients

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Forord

Med disse linjer vil vi gerne sende en stor tak til vores deltagere, der har været åbne, modige og venlige nok til at åbne deres hjem og hverdag for os – jeres hjælp har været uvurderlig! Derudover skal der også lyde en stor tak til vores utrættelige vejleder, Nikita A. Kharlamov, der har hjulpet med både gode råd og store mængder af tid, engagement og sparring. Endnu en tak går til Landsforeningen SIND, der har været en stor hjælp i at formidle kontakten til vores deltagere.

Sidst, men ikke mindst, takker vi hinanden for stor gensidig tålmodig undervejs i processen!

Claudia Gallas & Casper Andersen
Aalborg Universitet, maj 2015

Foreword

With these lines we would like to say thank you to our participants, who have been open, brave and friendly enough to open their homes and everyday life to us – your help has been invaluable! Furthermore, we would also like to say a resounding thank you to our tireless supervisor, Nikita A. Kharlamov, who has helped with both good advice and great amounts of time, commitment and sparring. A further thanks goes also to Landsforeningen SIND, who has been a great help in facilitating the contact to our participants.

Last, but not least, we thank each other for great mutual patience during the process!

Claudia Gallas & Casper Andersen
Aalborg University, May 2015

(The picture on the cover is from: http://www.b.dk/kronikker/noget-er-raaddent-i-psykiatrien, downloaded 4th of May, 2015, 9 pm)

Summary

In this thesis, we use a narrative analytical approach with a focus on small stories and everyday life to look at how five Danish psychiatric outpatients across the Jutlandic peninsula construct their meaning of home in relation to their treatment and diagnosis. In recent and coming years, there has been a push for further outpatient based treatment in the Danish Psychiatric System, due to a variety of reasons both humanitarian and financial. As such, home and the everyday life context seem to become increasingly important as sites for, and aspects of, treatment, with inherent repercussions; both potentials and complications. A further understanding of how people within this group relate to and understand their home and everyday life therefore seems needed, of which this thesis is a small contribution.

The thesis was written as an independent article and a surrounding framework that detailed our theoretical and methodological approach, as well as summarized our process, expanded our analysis and discussion, and allowed us a place for reflection.

The existing literature from the field of home-meaning contributed to an understanding of the multi-faceted concept of home and how it has been envisioned through a variety of studies as largely static and generalizable lists of decontextualized meanings. Through applying a transactional approach, we argued for a conceptualization of “home” as an active and interdependent relation between person and environment grounded in everyday activities emerged. To study this meaning-making process, a small story analytical approach was chosen and used to focus on exactly the everyday aspects of home making and the way people create their meanings in talk.

The analysis revealed how home was very much a transient and ambivalent, but also essential aspect of people's recovery process, being a site for many of the activities and sources of identity work that are crucial for people trying to recover from a psychiatric disorder. At the same time, the move of treatment into the home context was an ambivalent transition, potentially pathologizing everyday activities and creating a constant negotiation of how to manage treatment and maintain a sense of self beyond that of a patient.

In our discussion, we elaborated on how our participants used their home as a

resource in illness management and how our findings related to the general field of home-meaning, carving out a space for further research on home as something that we “do” instead of something we have. On the basis of these findings, we argued for a strengthened focus on exactly the everyday life and home as a physical and social arena for clinical intervention, seeing promise in an approach that sees treatment as less to do with treating abstract symptoms, but more of management of everyday issues from the complexities of social relations to the trivialities of paying bills. Further research is needed in how to both utilize the everyday in treatment in an a more integrated and ethical fashion and transform the bond between practitioners and patients into a partnership.

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1. Introduction

> "[home] is a place where you understand everything, without having it explained. Where you don't run the risk of things meaning something else than what you think"
>
> (Højlund, 2006, p. 98, quoting Anne Knudsen, Danish Anthropologist, on the topic of "home", our translation)

Anne Knudsen's assertion of what "home" means, shows succinctly how implicit and commonsensical the meaning of home is for people – and also how difficult it is to study. Both simple and complex, it is a multi-faceted social, physical, emotional and cultural construct that is often taken for granted (Højlund, 2006, p. 99f). Implicitly and explicitly, it is often cast in a positive light as a place of restorative power for people (Borg & Karlsson, 2013, p. 105f). Increasingly, through an ongoing political and medical push for more treatment on an outpatient basis in the Danish Psychiatric System in favor of longer term hospitalizations (inpatient care) (Danske Regioner, 2008, p. 3, 5), the community, home and everyday life appear to take on a focal role in the treatment of psychiatric patients (Regeringens udvalg om psykiatri, 2013, p. 35, 92-98).

Looking at this trend as psychologists and home makers, we asked ourselves how Danish outpatients react to and understand its impact in their everyday context, as well as what "home" means for them and what role it plays in their subjective recovery trajectories? Is home truly a place of restorative power or is the reality more ambivalent – more complex? Referring back to Anne Knudsen's words (Højlund, 2006, p. 98), it struck us how the transition of psychotherapeutic and pharmaceutical treatment into the home and everyday context might change this relation to home and their lives there by making it a more explicit concept, something to be suddenly negotiated in light of treatment (Angus et al., 2005; Borg & Davidson, 2008; Curtis, Gesler, Priebe & Francis, 2008; Musaeus & Brinkmann, 2011). We spent our 9th semester project finding out more about the field of home-meaning, seeing how it had been richly studied with a variety of groups, such as elderly (e.g., Moloney, 1997; Molony, McDonald & Palmisano-Mills, 2007), general populations (e.g., Mallet, 2004; Moore, 2000; Sixsmith, 1986), psychiatric patients living in more

“home”-like ward environment (e.g., Gross, Sasson, Zarhy & Zohar, 1998; Thibeault, Trudeau, d’Entremont & Brown, 2010) and psychiatric patients in supported housing (e.g., Borg et al., 2005; Lindström, Lindberg & Sjöström, 2010). Still, as both Borg & Davidson (2008) and Ulfseth, Josephsson & Alsaker (2014) assert, there is still a relative scarcity of studies that deal with the everyday life of psychiatric patients (Borg & Davidson, 2008., p. 129; Ulfseth, Josephsson & Alsaker, 2014, p. 2); just as the transition of treatment to the everyday context of home warrants further attention, for both somatic and psychiatric outpatients (e.g., Angus et al., 2005; Borg, 2007; Borg & Karlsson, 2013; Healey-Ogden, 2013). The act of home-making involves challenges, demands and difficulties (Douglas, 1991, p. 303f) implicit in the everyday chores (e.g., washing dishes, keeping order, etc.) that may be the same for every home-maker, but can be seen in a continuum from “normal” to “pathological”. People with psychiatric disorders might find these challenges aggravated in a myriad of ways, due to their specific conditions and extra factors such as entering and undergoing treatment, where everyday life actions become a site for treatment.

As such, understanding more about the meaning of home and everyday life for psychiatric outpatients seems important, both as a basis for how they construct their sense of identity, but also because the home and the routines of everyday life afford the agentive arena for people's lives, where their disorder first becomes prominent, and where they deal with it and their treatment process on a daily basis (Borg & Davidson, 2008, p. 130). The management of the social and physical routines and contexts of everyday life seem to be a potential source of many issues for this population, with a tendency for increased risk of suicidal, maladaptive behavior and stress due to, e.g., stigma, daily hardship in managing both routines and treatment, and ultimately even psychiatric admissions (or readmissions) (e.g., DSI & SFI, 2010; Madsen et al., 2013; Mortensen et al., 2000; Rasmussen, 2014). All too often, these difficulties are somehow seen as manifestations of the given disorder or as detached from everyday life issues that we all may face, both casting the patient as dangerously close to “being” their diagnosis and decontextualizing the treatment process from the context of people's lives (Borg & Davidson, 2008, p. 129f).

From all of these considerations, we argue for a need for a firmer understanding of what home means for Danish psychiatric outpatients, with a particular focus on exactly these everyday life issues that seem to be such an integral part of their experiences of both treatment and life in general. In response, we used our 9th semester to conceptualize a study, which served as the rudiments of the present thesis. Through a narrative analysis of five in-depth home-situated interviews, this study attempts to broaden the understanding of the meaning of home in everyday life of five Danish psychiatric outpatients across Jutland, with a particular interest in its relation to their diagnosis and treatment. Many of our thoughts and considerations from the 9th semester project have been brought along into this work and expanded upon with our newfound empirical experiences and analytical findings, along with our reflections on many of the aspects of this ongoing process.

1.1. Research question

Dwelling on all of these above thoughts, we have attempted to summarize them into our research question which goes as follows:

“How do some Danish psychiatric outpatients, when telling stories of their daily chores and routines, construct a meaning of home in relation to their diagnosis and treatment?”

1.2. Clarification of concepts

Naturally, a research question like this begs several questions. Chief among them perhaps, what we even mean by “home”? As we stated in the beginning of the introduction, there is no real simple answer to that, especially when it comes to research. Højlund (2006) argues that a strict definition of “home” prior to a study might do more harm than good. Instead, the concept should be approached in a broad manner, and therefore researched as such, as both a social, physical, cultural, etc., concept (ibid., p. 100), which we both argue throughout the thesis and attempt to study with our narrative approach. Another concept with a multitude of different understandings and definitions is meaning. To us, coming from a narrative

framework, meaning is inherently something that people “do”, in the sense that it is constructed through talk. One way of researching this process is by looking at narratives, which we define as temporally organized sequences of events that people construct and use in talk in an effort to make and communicate a sense of a particular topic, e.g., “home” (Bamberg, 2011, p.17), such as when relating about the small stories of everyday life, like when P3 talks about his everyday walks before and after starting treatment (P3, 397-401, Claudia (R1), Casper (R2), Danish version, *11.1. Appendix A*):

R2: mhm mhm. But this about going for walks that was a bit of a common denominator

P3: yes, it was, yes, I have always, I have always loved, I have always done, I have always loved to walk, I mean, and get out and get some fresh air or I mean it... yes

R1: yes

P3: but again the difference is now that where I used to walk and hide before now I go for walks in the city centre and yes

R2: mhm

As we focus on narratives, we focus on the stories that our patients tell and pay attention to which functions and positions these stories serve and elicit in talk, both in our interview session and within a larger social framework. Grounded in an understanding of the person and its relation to the world as something actively constructed, we turn to environmental, ecological and cultural psychological concepts to argue that this relation between person and environment is exactly constitutive of and constituted by everyday transactions. As such, we see the physical and social environment as entwined in time and context in an emerging process (Werner, Brown & Altman, 2002, p. 203-206). This tacit, activity-based relation to home can then be researched, we argue, by including *spirality* and *levels of organization* into our thinking (Biberce & Kharlamov, 2013; Laird, 2007). Through these, the psychological functions (“meaning-making”) that are used in a dialogue with us are understood as functioning implicitly and dynamically with other “lower” level functions, such as neurons firing. Choosing the interview as our preferred method, we do not, and cannot, ever have access to the the entirety of the embodied experience of being, living and acting in a home context, but we can nevertheless create an observable and shareable space for our participants to unfold the semantic

and semiotic aspects of the meaning-making process. We do this through a particular focus on the everyday activities of managing and acting in the home setting (Douglas, 1991, p. 287f), to situate ourselves further in this context, seeing home and everyday life as so inextricably bonded together that to understand one, one needs to pick apart the threads of the other (Lefebvre & Levinch, 1987, p. 9).

As a Danish psychiatric outpatient, one then belongs to a group with vastly different trajectories, such as having gone through one or multiple stays in psychiatric wards as an inpatient, followed by outpatient based treatment, whereas others are only treated on outpatient based care throughout. What this diverse group has in common is exactly how their treatment is connected to home and everyday life as an arena for negotiating their identity, diagnosis and treatment in a person-environment relationship.

1.3. Aim of thesis

The present thesis aims to further the understanding of what home and everyday life mean for five Danish psychiatric outpatients across Jutland as a contextualized and situated process, attempting to explore their construction of managing their disorder, diagnosis and treatment when they negotiate these processes in talk. In doing so, we hope to contribute to the literature concerning the meaning of home in general and, hopefully, bring to light aspects of this relationship that can be beneficial for practitioners in treatment, emphasizing home meaning, treatment and everyday life as a process taking place across a wide range of social, physical and psychological arenas, with one possible focal point being the home in everyday life.

1.4. Structure of thesis

Following this introduction, the thesis essentially consists of two core parts:

- A self-contained *article* which attempts to answer the questions raised in the introduction and succinctly detail our theoretical and methodological background, as well as provide analysis and discussion of our interviews and findings.

- A *surrounding framework* that primarily serves as a backdrop to the article, allowing a space for reflection on and exploration of the myriad of facets inherent in the process of producing both article and thesis, further trying to contribute to an understanding of our research question.

The article is also written with a particular audience in mind, namely as a draft for publication in the journal Nordic Psychology, a choice and process which is further elaborated and argued for in *7.2. Writing with Nordic Psychology in mind.* Our choice of writing the thesis as a two-parter like this was done in an effort to further our professional skill repertoire.

1.5. Outline of thesis

Chapter one, *Introduction*, sets the stage for the entire thesis, explaining our interest and aims in this particular field, our research question as well as the essentially two part structure of the thesis and its general outline.

Chapter two, consists of our self-contained *article* based on our empirical work with five Danish outpatients. It briefly introduces the issue of outpatient based treatment, the concept of home and how it has predominantly been studied, followed by our argument for an alternative approach that utilizes narrative interview methods with a focus on small stories grounded in everyday life. Our methodology, participants and procedure are briefly elaborated before we turn to analysis of the interviews and our discussion of these.

Chapter three, *Foundation of study*, expands on the theoretical and methodological basis and considerations behind our article and study. First, it details how our literature review was established and conducted and grounds us in the current Danish Psychiatric System context and its shift towards recovery-oriented practice. After this, it delves into the home literature, before further explaining our environmental, ecological and cultural psychological foundation and introducing our argument for a more active, interdependent view of the person-environment relation. From there, we make a case for a narrative study of an otherwise highly embodied process through the conceptualization of it as one in multiple, interdependent levels,

shareable in talk. The chapter concludes with some of our thoughts on our methodology, as well as a discussion of how we have attempted to ground it in both a transactional framework and the existing home studies.

Chapter four, *Gathering and working with participants*, details the process of setting specific requirements for participants and how we both initially got in contact and stayed in contact with them, as well as reflections on anonymization and legal and ethical status of our participants and, finally, short summaries of our five participants.

Chapter five, *Empirical work*, expands on our empirical process from the formulation of an interview guide to its evolution on the basis of our pilot interview, as well as our reflections about aspects of the interview process, such as interview context, relation, setting and participant group.

Chapter six, *Analysis and findings*, expands our analytical process and general analysis, which was already introduced in the article. The chapter is concluded with a further discussion of our findings and new avenues of research and analysis.

Chapter seven, *Writing process and evaluation*, provides a space for some of our thoughts about writing the thesis as a two-parter, writing the article with the journal Nordic Psychology in mind and the balancing act of writing both an ethically and professionally sound piece of work for both ourselves, our participants and others.

Chapter eight, *Conclusion*, naturally enough concludes our thesis by summarizing our main points and succinctly presenting our main findings and reflections on how these might possibly be of use to both the field of home meaning, practice and ourselves.

2. Home as an arena for treatment:

Danish psychiatric outpatients' meaning of home in everyday life and treatment

2.1. Introduction

P2: *ehm... and it has also taken up a lot because... well how do I feel today and how do I feel now and how do I feel now and how do I feel now and the last time I was with her [her psychiatric nurse], I said "simply so freaking tired of having to decide how I feel all the time"*
R2: *mhh*
R1: *mh*
P2: *I mean, you get completely freaking crazy by having to go "how, what is this feeling, why?"*
R1: *mhh*

(P2, 745-749, on the topic of treatment being part of everyday life, Danish Version, *11.1. Appendix A*)

In recent years, in light of both an increased number of psychiatry users overall and recovery-driven initiatives and humanitarian and practical political sentiments, there has been a surge in the use of outpatient based treatment by the Danish Psychiatric System instead of hospitalizations (inpatient based care) (Borg & Karlsson, 2013, p. 105f; Danske Regioner, 2008, p. 3-5; DSI, 2011, p. 62f; Eplov et al., 2014; 938f). This trend is likely to continue, potentially resulting in patients increasingly staying at home in the community while being treated – home and the everyday taking on a focal role in treatment (Borg & Karlsson, 2013; Curtis, Gesler, Priebe & Francis, 2008). The process of treatment thus becomes a more integral part of everyday life, which has been lauded due to the restorative power of "home" in recovery literature, as Borg & Karlsson (2013) relates: "It was claimed that «all» people feel best in their own homes with their family, friends and neighbors in their vicinity. Home was defined as a health promoting arena through the powers and potentials that are situated in it and by doing everyday activities" (2013, p. 105f, our

translation). Like our introductory excerpt from our participant P2 accentuates, however, this is not necessarily a seamless, neutral and non-ambivalent process.

Home is a notion that has received a great deal of attention when it comes to the general population (Mallet, 2004; Manzo, 2003 & 2005; Moore, 2000), yet less attention has been granted to psychiatric outpatients, particularly Danish ones.

A range of international and Nordic academic literature has dealt with the transition of treatment from ward to different forms of home-environments for both somatic (Healey-Ogden, 2013; Lindahl, Liden & Lindblad, 2010) and psychiatric patients (Andvig, Lyberg & Thorsen Gonzales, 2013; Borg & Karlsson, 2013; Lindström, Lindberg & Sjöström, 2010) especially from a nursing perspective (Rossen, Tingleff & Buus, 2009), as well as the effect of different outpatient treatment services (Ulfseth, Josephsson & Alsaker, 2014) and what the everyday process of recovery means for outpatients (Argentzell, Håkansson & Eklund, 2012; Bartova, 2014; Borg, 2007; Borg & Davidson, 2008). To provide a sense of outpatient based treatment in the Danish Psychiatric System, a brief overview of possible treatment trajectories and the Danish System is found in *11.2. Appendix B.*

An assertion that recurs is a need for a greater understanding of what home means to people in psychiatric outpatient treatment and how it, and their treatment, translate into everyday practices in their environment. This article delves into how five Danish psychiatric outpatients living in Jutland construct their individual meaning of home in everyday life, as well as how they relate to treatment as a part of this process. As such, it is an attempt to contribute to the general field of home meaning where the meaningful, contextualized relation between the physical home, the social environment and the embodied person in everyday life seems to have been the least examined (Moore, 2000, p. 213). Furthermore, we hope that it may serve as an inspiration for further studies that consider how treatment and recovery are not individual, internal processes (Borg, 2007, p. 14, 20) and how home is not just a neutral repository for treatment or psychological intervention (Angus et al., 2005, p. 182f; Borg & Karlsson, 2013, p. 113; Musaeus & Brinkmann, 2011, p. 61f), but a rich social, physical and value-laden arena on its own (Douglas, 1991), with implications for both practitioners and patients.

2.2. Home as a contextual, embodied process

The meaning of home as both a personal concept and a socio-cultural norm has seen a great deal of research over the years, as many have attested to before us (Mallet, 2004; Manzo, 2003 & 2005; Moore, 2000; Sixsmith, 1986), its deceiving simplicity and great complexity spawning a plethora of different understandings. At the center of this discussion, however, one finds a notion of home as a distinctive and important place for people that elicits and contains an abundance of meanings, e.g., happiness, prison, continuity, family, control, isolation and many, many more (Easthope, 2004, p. 134; Moore, 2000, p. 207ff).

Running counter to our interest in home in the everyday life of patients and in understanding the role of treatment in this context, however, is a pervasive tendency to essentially collect lists of these meanings with little emphasis on activities and the context in which these are situated; casting them as static constructs that can meaningfully be generalized and claimed as universal (Hauge & Kolstad, 2007, p. 237f; Moore, 2000, p. 210). While norms for both conduct and social and physical aspects certainly permeate such a socio-culturally embedded notion as home, making it essentially commonsensical to many (Højlund, 2006, p. 100f), we argue that "home" is a deeply individual and complex process, especially in the context of patients, where everyday activities are an essential aspect of both their illness and recovery processes (Borg, 2006, p. 246f; Borg & Davidson, 2008, p. 139; Lindström, Lindberg & Sjöberg, 2011, p. 288).

Instead, we conceptualize the relationship between person and environment as an active, interdependent and multi-level transaction where meaning and sense of place emerges and changes in a relational process founded in activity and necessitating a focus on the individuality of the process behind the emergent meaning. This emphasizes an understanding of the processes behind this emergence rather than the product (Coolen, 2006, p. 186f; Heft, 2013, p. 14f, 60f; Seamon, 1982, 131f, 135). With this approach, we try to get a glimpse of "how people, psychological processes, settings, and time are mutually defining and inseparable" (Werner, Brown & Altman, 2002, p. 210). This conceptualization of phenomena as multifaceted is essential to both our approach, our methodology and our presentation of data, enriching our understanding of the processes behind meaning-making.

In this conception, people's relation to and meaning of home is in continuous negotiation, change and emergence, based in use and mobility, becoming something we "do" as we act in the world, or, as Mallet (2004) eloquently phrases it, "[h]ome then is not simply a person, a thing or a place, but rather it relates to the activity performed by, with or in person's, things and places. Home is lived in the tension between the given and the chosen, then and now, here and there" (p. 79). Home is therefore not bound to a specific site, but is an activity, and the meaning of it is something that emerges in transaction with the environment. Essentially, "our residence is *where* we live, but our home is *how* we live" (ibid., p. 83, emphasis added).

Dwelling on this argumentation, our research is thus guided by an interest in understanding more about the person's relation to the social and physical surroundings and how these and everyday activities play into how our participant's construct their meaning of home, particularly in relation to treatment.

2.2.1. Exploring embodied meaning in talk?

As we have argued above, to make meaning out of one's experiences through life is a highly habitual and ordinary process, yet also highly complex, and it never takes place in a vacuum. This holds true on a very basic level of being in the world and stretches to the higher psychological levels in talk; a process that Biberce & Kharlamov (2013) and Laird (2007) envision as *levels of organization in a spiral-like manner*, with "each higher level [...] constituted from the elements of the lower level" (Laird, 2007, p. 212), spiralling towards greater expanse and complexity of differentiation and integration, yet maintaining the interconnection and wholeness with the ''lower'' processes of psychological functioning (Biberce & Kharlamov, 2013, p. 454, 458; Laird, 2007, p. 210-212).

Seeing these levels as constantly working together in the background of our interview, we argue for an understanding of the narrative construction that people do in an interview as implicitly constituted by and constitutive of them. Following this outline, we create a space for the meaning-making processes to be unfolded and researched by focusing on how people actively negotiate a narrative of "home" in reference to their everyday life; using the higher and more reflective levels of

psychological functioning as our entry point, since these function verbally and can thus be shared.

2.2.2. Narratives with a penchant for the mundane

Essentially, narratives serve as mental and social tools to organize our experiences and memories in both thought and talk, creating and communicating meaning, by temporally organizing events according to certain social standards, providing coherence of self and one's history, as well as a means to render one's experiences intelligible and relatable to others. Through this process, we actively "do" our identity and "do" our relation to, e.g., home, as a communicative act (Bamberg, 2011; Bruner, 1991, p. 4; Taylor, 2010, p. 32). Humans do not, however, freely construct these narratives, but more or less adhere to (or rebel against) certain socio-cultural norms for doing a particular narrative, many of these being commonsensical to the point of truisms (Esteban-Guitart, 2012, p. 175; Taylor, 2010, p. 32), e.g., everybody implicitly knowing what a Danish "home" is somehow supposed to entail, as shown by Højlund (2006, p. 98). In this way, narratives serve as resources, or master narratives or public discourses, which are "collective stories that govern the existence of a collective subject, or group, in such a way that they shape the 'personal' identities and narratives" (Esteban-Guitart, 2012, p. 175). One evocative example of this could be exactly the implicit normalizing demands of a "Danish home" or of psychiatric diagnoses reflecting madness and disability (Baldwin, 2005, p. 1027), both of which our participants negotiated in their narratives.

To us, the method of exploring the meaning making processes behind our participants' meaning of home is thus to look at how they construct and use narratives of it (Taylor, 2010, p. 36). To further emphasize the everyday and its activities as the site for this construction, we make explicit use of the small story approach (Bamberg, 2011; Bamberg & Georgakopoulou, 2008; Sools, 2012). This approach sensitizes us to the remarkable in the mundane and the mundane in the remarkable of our participant's stories (Silverman, 2007, p. 18f), favoring negotiations of events still in progress, future or even hypothetical events, fragmented everyday dialogue, implicit and knowingly related stories or downright

refusals to tell and many other easily overlooked stories that people tell (Bamberg & Georgakopoulou, 2008, p. 381; Georgakopoulou, 2006, p. 123). This approach excels at the analysis of the construction behind how stories are told and how people actively use particular structures, words, omissions and so on to steer the course of dialogue, and arrive at a particular narrative structure through negotiations and revisions between the actors involved. It follows that identity construction is also seen as an ambivalent, mutable process in action in this approach, which we explore by offering the center stage to everyday life and the activities and routines that people conduct there. As such, much of our analytical attention centers on the here-and-now context, as well as the co-constructive process between actors in the interview setting, deferring from making claims of what people might “feel” as some absolute product, but rather exploring the continuous processes behind its construction in talk (Bamberg & Georgakolpoulou, 2008, p. 378f; Georgakopoulou, 2006, p. 123, Sools, 2012, p. 95, 99).

2.3. Methods

We employed a narrative approach following an in-depth semi-structured interview style and a comprehensive interview guide (Tanggaard & Brinkmann, 2010a, p. 37f), focusing on participant's experiences, physical and social situations, actions and choices in regards to home and treatment. All interviews took place in the apartment of the participant, with an active use and exploration of these surroundings, taking inspiration from Holton & Riley's (2014) and Kusenbach's (2003) contextual and involved interview-style. Here, the interview takes on an experiential character for both us as interviewers and the participant, affording spontaneity for the interaction and a more discussion-like character to the interview, fitting well with the more active and assertive interviewer of the small story approach (Holton & Riley, 2014, p. 60; Kusenbach, 2003, p. 463; Sools, 2012, p. 95). Through this method, the use and active perception of the physical everyday home environment affects the interview itself and whatever meanings are co-constructed in the process, providing a space for prompting or allowing different possible narratives or activities (Holton & Riley, 2014, p. 61), a “show, don't tell” approach to the home

setting, which more decontextualized interview methods may not afford us (Kusenbach, 2003, p. 462).

Initially, we conducted an interview pilot, which led to changes in our interview guide, emphasizing a structure of overarching themes and digging into details afterwards, where the previous one had placed too much focus solely on the physical context of home. The structure of the interview guide consisted of a series of questions that provided space for improvisation and other interesting avenues of conversation, within the greater theme of home, everyday life and treatment. Our initial questions concerned daily life, treatment, home meaning and our follow up questions were oriented to elicit further information, encouraging stories about everyday life and routines. Overall, we attempted to elicit overarching themes and bigger stories as our framework with subsequent questions exploring the context and details of these (Sools, 2012, p. 94f, 106). During the interview, it was important for us as researchers to allow a space for open discussion, which in turn meant a certain openness on our part to share bits of ourselves to create an atmosphere of sharing (Kvale & Brinkmann, 2009, p. 32; Taylor, 2010, p. 6).

Both of us acted as interviewers, one being primary interviewer, the other being observer. Broadly speaking, the observer's role was to make a sketch of the essential layout of the residence, write down basic information like type of home, impressions of décor, how the interviewee acted in relation to the surroundings while we were there, what the atmosphere and interview context was like, as well as being attentive to possible to follow-up questions. We also took photos at the end of each interview session, and wrote down post-session notes concerning context, situation and personal reflections. All these different materials were used to aid us in resituating ourselves and remembering the unique interview encounter prior to and during analysis.

2.3.1. Participants

Five people participated in this study, one man and four women, ranging in age from 29 to 45 years, with a wide range of psychiatric diagnoses and treatment histories, as well as current treatments. They lived in various places throughout the Jutlandic peninsula, all in their own apartments, except from our pilot interview

participant, a woman who lived in institutional housing. The interviews ranged in length from little over one and a half hours to well over three hours. All data was handled confidentially and was anonymized as part of the transcription process.

2.3.2. Interview Procedure

Our pilot participant was found through word of mouth, while the remaining four were found through an official notice on a social media-page of Landsforeningen SIND (a major Danish NGO for people with a mental disorder and vulnerability, their relatives and professionals, with a variety of offers and roles. For further information, please refer to www.sind.dk). Inclusion criteria focused on current psychiatric outpatients (who may or may not have been previously admitted), between the legal age of 18 to 65 years of age, who have lived in their current domicile for at least half a year. Initial contact was handled through emails, both in the case of acceptance and rejection, which was based on geography, focusing on the Jutlandic area.

Each interview started with a brief introduction to the study and various small talk. After getting consent from each participant, audio recording began. Through our interview guide, we explored many themes, e.g., how our participants experienced their everyday life prior and during both therapeutic and medical treatment, what home meant to them in general, as well as different aspects of their everyday lives, such as social relations, jobs, education or unemployment. Where relevant, inpatient treatment was also explored and put in relation to their lives in their homes now.

After the interview, we further spoke with our participants about the aim of our study, gave them a chance to flesh out things we had discussed and rounded up the interview, along with photographing the residence. Shortly after the interview, impressions about the interview and the home context were written down by both interviewers.

2.3.3 Analytic method

Using our small story approach, we focused on narratives, which we defined as a temporally organized sequence of events that people construct in talk. To organize the narratives in our interview data, we followed a grounded theory

approach in the sense that we let our data guide the process of categorization and coding for what kind of stories are told and in what fashion (Boolsen, 2010, p. 207f). Due to our research question, we were focusing on some connection to home and everyday life or/and treatment in these narratives to qualify for further scrutiny.

Our analysis rests on working with indexical, or deictic, expressions, i.e., expressions that rely on direct or indirect references to something else, or on the context and the pragmatics of their production, to attain their full meaning. i.e., meaning is not just semantic or what the dictionary says. The idea of indexical expressions goes back to C.S. Peirce's semiotics (Atkin, 2010) and a classical example might be: “It is raining”, or one from our interview: “taking sleeping pills”. Understanding the actual meaning of such an expression requires knowing who uttered it, where it was uttered and whether it was uttered in due faith. This information is not contained in the expression itself, and typically requires examining it as part of a sequence (Silverman, 2007, p. 61f, 71f), and on top of that locating that sequence itself in its proper context, e.g., in the middle of an interview session relating to home and treatment in people's homes.

Our tools for analyzing the narratives included in the different categories were informed by Silverman (2007, p. 71f) and focused on sequences, emotional valence of talk and use of references to home, everyday life and treatment, which again was informed by our theoretical and methodological process. Furthermore, as we have argued earlier, the construction of narratives is closely linked to identity work, an analytical tool to understand and explore these process and connect the different function of narrating is found in the *levels of positioning* by Bamberg & Georgakopoulou (2008, p. 380, 385):

(1) *Level of “the talked-about”*: how the characters are positioned within the story.

(2) *Level of “the here-and-now”*: how the narrator positions him/herself (and is positioned) within the here-and-now situation of the interview.

(3) *Level of “the global situatedness”*: how the narrator positions a sense of self and identity with regard to dominant discourses or master narratives beyond the here-and-now.

From this, our overall analytical process is summarized in the following steps:

(1) Several close and repeated readings of the transcriptions to get an overview of the material, together with our post-interview write-ups, photos and notes done prior and during the interview. (2) Marking recurring features and patterns, both separately and across interviews, which included repeated words and images, assumed causal links, connections or sequences. (3) Generating different main categories from the relevant narratives considering our focus on small stories that connect home, everyday life and treatment, and sort them accordingly. (4) Rereading the excerpts of narratives included in the main categories and thus generating subcategories, where they are sorted accordingly: meaning being moved to different categories; included in more than one category, establishing a new category or simply discarded. (5) Choosing examples from the excerpts of narratives from the prominent subcategories and crosschecking these with the audio files to ensure that the transcriptions were correct, changing and editing the transcriptions for precision where needed. (6) Going through the excerpts with a small story analytical approach, focusing on type of event, valence and sequence, before turning to levels of positioning. (7) Discussing the excerpts and findings before the write up; and translating the included excerpts from Danish to English with as few obvious changes done as possible, rather sacrificing readability than linguistic precision.

This progression was not followed strictly, but was a reflexive process, going back and forth between interpretations and the material, as well as attempting to look at the excerpts with an attention to their larger context. By following a conversation-analytic/pragmatics approach to talk (ten Have, 2007), we emphasize both the turn-taking as interviewers and interviewee and the ongoing narrative construction between us throughout the interviews by trying not to “beautify” the talk, for example, include pauses, repetitions and hesitation forms, and importantly, our contributions as interviewers, both as questions, replies and remarks throughout (Bamberg & Georgakopoulou, 2008, p. 393; Silverman, 2007, p. 71; Taylor, 2010, p. 8). Nevertheless, some of these contributions are not represented in all the examples due to the length of this article.

2.4. Analysis and findings

In the process of analysis, we have conceptualized three main categories of narratives found in our transcriptions: A) “Transition of home and treatment”, B) “Atmosphere of home”, C) “Transition of getting better”; each having three or four subcategories, respectively. We also conceptualized seven other smaller categories, which we will not go further into here, but which can be found in our overview of all our categories in *11.3. Appendix C*. In the following, we present main category A with two subcategories, where the first is analyzed in-depth through an excerpt of a narrative in that category to show our analytical process and foundation for our findings. The other subcategory and main category B are only presented in general terms, meaning that the same analysis was used, but only a presentation of the reasoning behind the category and its results are included due to the scope of this article.

2.4.1. Main category A: “Transition of home and treatment”

This category might not be surprising considering our focus on precisely home and treatment, but it further supports the theoretical claims and other research findings that people and surroundings change over time. All of our participants narrated some kind of a change and transition in their life reflected in their home setting in connection to their treatment.

From the beginning, an obvious finding was the big difference between the point of origin of home for P1 compared to the other participants. P1's living setting in an institution was, in many ways, a constant manifestation of treatment, and “being home” was thus something P1 actively negotiated; how the institution accommodated or promoted a sense of “being home”. In P1's stories, this was not something clear cut, e.g., “this is not my home, it is an institution” or “it is my home, it is as I want it to be”, and doing things “as in a normal apartment”, etc., were drawn forth by P1, a negotiation of how the institution could be a home to her and provide her with what she needs. For our other participants, the “being home” was not so much a question of their apartments being their homes, but more a question of how their sense of home, daily activities and chores changed through the introduction of

treatment. Whereas in the case of P1 home moved into institution, for the others treatment moved into their homes. The latter being best represented by our subcategories of “Treatment in the home” and to some extend “Challenges and consequences of treatment”.

The stories included in the first are concrete stories of different treatment options, involving specific exercises or medicine intake, all taking place in the home environment. In the second subcategory, we gathered stories of different challenges and consequences that stand in connection to their respective treatment, the events not necessarily taking place in the home, but connected to home in everyday life. Both are elaborated on in the following sections.

2.4.1.1. Subcategory 1: “Treatment activities in the home”

What connects the narratives in this category is their focus on concrete events, where our participants have realized different treatment aspects in their daily lives at home. The stories included, among others, filling in different assessments, daily intake of medicine or managing racing thoughts before bedtime. The focus for qualifying as narrative in this category is the connection of doing these treatment activities in relation to home, both concrete in the sense that they take place in home, but also how they are related to the home as a setting for doing that. In *Table 1*, we present the used words and phrases in two participants' narratives of this category that identify both treatment activities and home as place and setting for these activities, one referring directly to home and the other referring more indirectly to it.
In both examples, the respective treatment took place at home, and as a setting it “by definition” provided them the possibility to do these activities and utilize the safety of their four walls, while treatment also introduced a change in both activities and ways of understanding them. The “by definition” of doing certain things at home refers to three related facets:

- personal habit (“I do it”): this is what is most directly reported by people, even though it is not necessarily mentioned that they do it “at home”, we can argue that it is implied, inferred by the interpreters (us), from the context in which it is uttered.

Table 1: Words and phrases used that identify treatment in their home

Direct references to home (P3, 449-456):

Treatment activities	Connection	Home as place	Home as setting
”there was some home work […] different forms” “a lot of different physical exercises, breathing exercises and such”	”should sit and do here” “there home has been used quite a bit” “especially in the beginning where it was really tough to get out and test myself out”	”here” (both as answer to the question, but also as direct reference to where the interview itself takes place)	“has been nice enough to sit with it here at home” “it was really nice to be able to be here at home [...] where there were totally safe surroundings” “home has played an important role” “when you feel good at home, it gives this surplus energy in [...] the remaining treatment”

Indirect references to home (P5, 2425-2440):

Treatment activities	Connection	Home as place	Home as setting
“I should not just let my thoughts run” “okay, now you have eaten sleeping pills two days in a row [...] it is now that you should talk to your doctor?” [said to herself] “it is some of what the psychoeducation and conversations at psych [outpatients psychiatry] have done”	“this I have learned” “it is poison for my illness... not to get sleep because then I do not have a surplus of energy the day after then I can not my routines and then the spiral hits” ”but if I get it to stop now... then I can get up tomorrow morning... and feel okay” “where my anxiety for sleeping pills actually has been reduced really a lot”	No references	Indirectly, home as a space for doing activities and proving the surroundings and objects for it: “get sleep” “sleeping pills” “my routine” “get up tomorrow morning”

- shared pattern of practice (“everybody does this at home”): we know this, since it is, in part, drawn from our shared cultural knowledge and practice in our society, where, for example, most “normal” people sleep at home and not under bridges or tents (unless camping, etc).

- normative communication, legal, and media discourse (“you must sleep at home”): there are laws regulating sleeping in public and homelessness, and there are plenty of media messages, e.g., ads that reinforce this notion (like any IKEA catalog).

In addition to how the home-setting is constructed, a transition can also be seen in how the treatment activities are related to home. In the following, we elaborate further on this, as well as the richness of this category by presenting an in-depth analyzed excerpt from the category from our interview with P4.

P4 lives alone in her apartment and is challenged under the constrains of doing everyday activities in a very strict way. The excerpt takes place about halfway through the interview, and we have just talked about how her psychologist and coach help her with different things in her everyday life, whereupon we ask her what she is struggling with and how she manages that in her treatment. Here, we cut right to her answer to these two questions (P4, 1995-2007, Claudia (R1), Casper (R2), Danish version in *11.1. Appendix A*, transcriptions symbols in *11.4. Appendix D*):

P4: ehmm... well you could say I have well (1) yes challenges in many in many areas I have a lot of stuff with me... from from earlier on that my father... sort of... has inculcated me with some... eh... routines which... eh which I have brought with me... well for instance... well as an example then I have eh... my showers ehm when I take a shower then it is eh...every other day at the most and it eh... well earlier it has been only two minute showers... well were it has been like very restrictive that is my father has been really .hhhh yes... VERY aware of the fact that you didn't use too much water

R1: mhm

R2: mhm

P4: in any case it shouldn't be warm or anything like that so I have always showered in cold water and that of course is not... well particularly nice either you can say but

R1: {mhm

P4: {yes but that is the way it has been

R2: mhm

P4: and I have been used to that after all and .hhh yes... well it is of course... how to say... it becomes of course a problem (1) that that you... how to say it can't take a shower for longer periods... I mean in the beginning when I worked with it then it was ehm... that is there I worked with I mean... the heat you know that I sort of had to turn a little up for the heat and that was also fine and... it also worked for some time but well then I could sort of hear my... father stand and shout you know and... now I work on that thing with eh (1) with the time in the showers... that I kind of that is why there is a stop watch in the bath room {[laughter]

R2: {mhm mhm

P4: that eh that I you know take... eh three minute showers... eh... have to stand have to stand in there for three minutes to like... challenge that part of it so that I no longer kind of how to say it am controlled by him

R1: mhm

P4: ehm... so that that I then sort of... how to say... that that I myself get to decide how long I would like to shower you know

R2: mhm mhm

On a general level, this is an event of working with the challenges faced by both illness and treatment at home as it is constructed by P4 through the statement of having a lot of challenges, giving a short explanation to where these challenges come from (childhood and her father), and later how she works with them, ending on a note pointing to the future of what she would like to achieve.

Looking more closely, this event is set in the home-setting, there are no direct references to the home as place on a semantic level, but several references to her everyday life and home as a setting for these challenges, both in the way they appear and how she is able to work with them. As argued before, home is a setting is where you "take a shower" and where you *can* place a "stop watch" in "the bathroom" helping you to watch the time you spent in the shower. In this excerpt, contrary to the usual feature of home where one is expected to be able to execute and have the right to be self-determinant (also connected to development of being a "grown up"), P4 is struggling with this and it can be understood as an attempt to create that space for her by working with the challenges of deciding for herself the length and heat of her showers. What marks these challenges as a prominent part of her everyday life is seen in the utterances of both the activities, like "take a shower [...] every other day", "turn a little up for the heat" and "work on […] the time in the shower", but also in the word "routines" used in the beginning, which emphasizes the regularity of her activities and challenges connected to them. References to treatment activities are more difficult to find directly in the excerpt. However, we talked for a while prior to it about what kind of help she gets from her coach and psychologist, respectively, where the connection between these home activities and their treatment function can be found, as well as our direct question to her, what she does as part of her treatment to manage her everyday life, indicating strongly that she answers on that by telling about both her challenges and how she works with them. From this we argue that her story is both placed in the home-setting and linked to her treatment activities.

On the syntactic level, the overall temporal development can be seen in both content and structure of talk, and its presentation also employs a certain causal linkage between the presented events.

Content-wise, most of what is referred to relates to the present with some indications of how it was earlier in her life. One of the statements indicate a longer temporal jump back to her childhood, which she does not refer to directly, yet seems likely from statements, like “from earlier on that my father... sort of... has inculcated me with” and “my father has been […] VERY aware of the fact that you didn't use too much water”. Childhood being a time where one's parents have the capacity to influence and be in charge of how things are running at home. This is further supported by other references during the interview later on, where we talk about her challenges and the difficulties she experiences with them, as “some things that I then eh... have got with me as a christening gift from at home” (P4, 2099). Other temporal jumps go back a little shorter in time, referring to how she has been working with the length of her showers in her own home.

Structure-wise, the temporal sequence shifts quite a lot going forth and back between the present and the past by using present, present perfect and past tense[1], ending on a statement pointing to the future. Overall, these shifts are used to explain how things are now, where they come from and how she deals with them and why. The most interesting part of it lies in her use of present perfect, which is not only used to explain something from the past, how things have been, but serves as a way to comment on these past experiences from her position in the here-and-now situation. While using present and past to state more factual things (her challenges now, how she worked with them), the use of present perfect creates a space for her to indicate causal links of their connection (e.g., “that my father... sort of... has inculcated me with some... eh... routines”) and how she deals with it on a more emotional level (e.g., “that of course is not... well particularly nice either”, “but that is the way it has been”, “I have been used to that after all”). From this we are informed of how the links to her past are structured and accomplished from her here-and-now position, which we elaborate on further down.

1 In Danish and English, tense functions the same way (Vores Fællessprog, 2008), which allow us a direct translation of our findings.

The linguistic, pragmatics and conversation analysis employed so far, is also closely linked to the valence of the story's different parts and its sequence. Overall, the story is of negative valence, mostly due to the “missing redemption”, which a story of struggle must sort of imply to qualify for being one of positive valence. When looking closer at the words used and their place in the sequence of talk, we find the word “challenges”, which we can not attribute a clear valence to yet (one could argue, we already know it is going in a negative direction due to the interview lying prior to this excerpt), followed by “in many arenas”, which indicates the impact and builds up the valence waiting ahead. The valence gets slowly revealed when she describes the reasons for these challenges, i.e., her routines that her father has inculcated in her, and when they are followed up by the examples of her challenges, in the form of these everyday activities, such as taking a shower, and also connecting the reason for that to her father's restrictiveness. Building on to that is the second example, the cold water, and its direct indication of not being particularly nice. From there, the story goes on with her telling that it is a problem, which is a word with a negative valence in itself, but by stating that she worked with it, it thus develops into a more positive valence due to the chance for change. The following evaluation of this as only going well for a while shifts back to the negative valence and is supported by the new challenges presented (hearing her father shouting, which is elaborated on further down). Then there is a break in the story, leaving unmentioned how she dealt with that and how she is dealing with it now, e.g. is she still trying to challenge herself taking warmer showers? Instead she moves on to telling how she works with the length of her showers, turning to the present and also directly referring to her home in the form of a stop watch. Ending on a more future perspective, “that I myself get to decide”, indicates a more ambivalent valence since it has not yet been accomplished, which has a negative ring to it, but also that there is hope for it and possibility to get there, which is a positive valenced reading of it. From this we are informed of the overall mood of the story; she is not just working with her challenges, it is a story of both seriousness and unpleasant challenges, although with a sort of open end to it.

All this leads to an understanding of the characters presented in the story, and how they are positioned. When looking at the story itself (level 1), P4 is the main

character in opposition to her father by referring directly to him and indicating him as the reason for the challenges presented. The home being the setting for the "freeing" from her father's rules and dictation, being at the same time the physical site for the deployment of her treatment activities. These two plot lines run together, connecting the home and everyday activities closely to her treatment. From this, her father is positioned as both being a part of home and an intrinsic part of treatment. From the excerpt itself and with some knowledge of psychiatric disorder, it might seem that she is hearing her fathers voice in a medical sense, but from the outlook of the whole interview, as she states later, she is not physically hearing her father, she is figuratively speaking (P4, 2322-2324). Another character in the story is also the common "you", where we get closer to the second level of positioning, indicating the here-and-now context of her story, directing it against an audience, not necessarily just us. The common "you" drawn upon to some extent to normalize the content of the story and to distance herself from it, e.g., "my father has been really .hhh yes... VERY aware of the fact that *you* didn't use too much water", indicating that these rules were beyond her, or "it becomes of course a problem (1) that that *you*... how to say it <u>can't</u> take a shower for longer periods".

When looking at the relation between the characters of the story and the implied or explicit agency attributed to them, it follows a sequence of a more passive involvement from P4 in terms of being the "receiver" of these challenging routines, whereas her father is given agency since he is positioned as responsible for them. Later on, P4 regains some agency in the sense that she is presented as working with them, and keeps on doing so even when it is hard. And again, home is the setting for employing this agency and gain control over her life.

Looking from positioning level 2, the story can be seen as a way for her to carve out a space of telling about, not only how invasive and hard these challenges are, but also as a way to explain herself. As a person having a disorder and being interviewed about it, this is even sort of expected from her, following a position of "the reflective patient". By linking her challenges, and to some extent her disorder, to her childhood and father figure, she is constructing a narrative to make her problems understandable, both for herself and us. We did not call it into question, because it seemed like a legitimate explanation, and also one that other participants employed

in similar ways, which suggest a certain tell-ability due to a common cultural understanding and discourse of “acceptable causes of psychiatric disorders”, following both biological and social factors (e.g., bio-psycho-social model or diathese-stress framework; Møhl & Simonson, 2010, p. 42). This can also be seen as a way to strengthen her position as a “recovering patient” in the sense that acknowledging and working with one's problems is an important step in the process of recovery and being a “good patient”. From looking at level 3, this connects to a construction by her of being strong, and as a woman who still has a lot to fight for and with, as well as look forward to in her attempt to gain more agency in her own life, reflected in these everyday activities in her home. A “recovering patient” is by definition hopeful for the future and employ self-determination (Jacobsen & Greenlay, 2001). Her narrative presented here, as well as the whole interview setting, can further be seen as both a practice and a communicative act, which reinforce or draw upon master narratives and social practices that engage in the tell-ability and interest of such narratives as P4's one. The narrative structure and the position of “reflective patient” and “recovering patient” feed into the culturally embedded master narratives of fighting illness (Bury, 2001), both on the level of somatic illness and psychiatric illness, and how to deal with that. Part of this narrative is precisely the moral stance on trying to normalize one's condition due to one's position as a patient, thereby being out of the “normal” and “general” population (ibid.).

In the next section, we further elaborate on the transition of home and treatment by drawing on the narratives of certain challenges and consequences cast on treatment.

2.4.1.2. Subcategory 2: ”Challenges and consequences in treatment”

This subcategory is based on narratives that reflect some ambivalence or articulation of different challenges in regard to treatment and what consequences that entails. These narratives are concerned with direct or implicit questions about when they have committed themselves enough to treatment and when to challenge themselves more and when to stop? It also concerns the challenges of being treated in precisely the home setting and why this can be a tough undertaking.

Common for our participants, except from P1 where the prospect of leaving

the institution cost more worries and questions of how to handle that, a dilemma was communicated, involving the prospect of treatment “moving in” or how to manage the treatment that is provided, drawing on concern, challenges and annoyances that follow this transition. But always with some sight for the purpose or demand of getting better. The narratives revolve around a negotiation or confrontation of having certain treatment options in their home setting, like how they themselves suddenly have to monitor their behavior and feelings, invite friends over as both “normal” sociability and part of treatment, or even get a social worker to help out in their home. An underlying question often being when is it enough treatment or how to handle it? In these negotiations lies an ambiguity in the sense that everyday activities potentially become pathological and at the same time a means to depathologize oneself. With a short example, presented in *Table 2*, we show one specific negotiation as a way of constructing the transition of treatment in the home-setting. The transition being expressed through how the treatment activities and options are integrated and constructed in the home context.

Table 2: Phrases used to construct the transition of treatment in their home

Treatment option	Dilemma	Consequence	Home as setting
P2, 918-943:			
“that thing about that maybe someone will come into my home […] and...] be a mother to me”	“I kind of have to make up my mind about that I probably have to do this that is incredibly hard I think”	“I worry that I will look like a total... cow […] I mean I will clearly show eeh signs of... of that borderline I mean which I know is there […] I don't like that side of me... I think it is ill-mannered and I think it is... flippant”	“now you have to... now we do the dishes or now we must vacuum or... now we settle on a plan for what you should do the next couple of days here at home”
(social worker helping in the home)	“I just don't want it to be provoked out in me […] but that on the other hand then I know also that I have to do it if I am going to learn how to control it”		(referring to what the social worker might want from her)

In this example, concerning a prospective treatment option, there are two competing storylines that make up the dilemma, one being about how the treatment

option of a social worker, who would help and support her in her home, which is something that P2 needs and would benefit from, whereas the other storyline follows how this option would provoke a side of P2 that she does not like and that she attributes to her disorder.

From a treatment perspective, what can be drawn from this story, is a general understanding of the home as a setting for self-determination, which in some ways are to be sacrificed for the benefits of getting help in the home and to learn how to control the disorder. From a developmental perspective, the comparison of the social worker potentially filling a role of a mother can be seen as drawing on the culturally embedded resource of what a mother can be be in the home-setting, precisely the one telling her child to do different things, an aspect of raising your child. This is a way of positioning herself in the role of the ill-mannered child (explained by her disorder), which she distances herself from by stating her dislike for it, and also implying her struggle of living up to "being a grown-up", both in the sense of managing her behavior towards others in this setting, but also manage her home as a "grown up would do". This shows how the negotiation of treatment in the home-setting brings together a lot of different aspects of identity that, somehow, have to be integrated. Here, this can be seen in the way P2 is sort of ranking her troubles with this treatment by stating that this very hard for her, but she has to do it, in order to move on in her treatment and get better.

In the next section, we go into the atmosphere of home to broaden the understanding of home itself, but also the context for this transition of home and treatment. Again, we only present the results of our analysis and draw forth some aspects of each subcategory on the background of the narratives in the subcategories.

2.4.2. Main category B: "Atmosphere of home"

This main category of "Atmosphere at home" has three subcategories, which all represent certain aspects of home: "Physical aspects", "Activities of hominess" and "Feeling of home". The narratives in these categories all revolve around home, obviously, and to a lesser extent on treatment itself, but more on the activities and feelings that home calls for, at times tied to treatment, but mostly a general "being" in the home. The categories are analyzed much in the same fashion as the others

already presented. Due to the length of this article, we have chosen to present our findings on “Physical aspect” by shortly showing two examples of narratives in this category, presented in *Table 3.* It is also one of the aspects of home-meaning that has been the least examined in the literature that we have reviewed (Moore, 2000, p. 213).

Table 3: Phrases used to construct different physical aspects of home

Change of room when feeling bad: “I have a chair in there […] so I actually started going in there and just sit... I've found out that... it it can sound strange but just to change the room […] then you get just kind of some new impressions” (P3, 1101-1104)	*Books in the basement:* “[the books] are all in the basement they are in.... yes three moving boxes in the very back of the basement […] and there they stand well for now […] I have always read academic literature […] I always wanted to improve myself […] that is some of what [...] I miss a little sometimes […] if I got my books up here […] I maybe then would get to think to much about education and so on” (P4, 3038-3067)

From the two examples, home is both what you do in it and how its setting provides or calls for certain activities or actions. This is evident in a physical sense as in *Change of room when feeling bad* (P3, 1101-1104), where the home-setting is cast as a site for emotional regulation by physically moving around. But home is also defined by things *not* there and activities that are *no longer* wanted or performed there, as in *Books in the basement* (P4, 3038-3067), where a choice of surrounding oneself with no books gives ways to let other aspects of identity flourish. It also very effectively shows the transition of home, observable in the indexical and syntactical structure of the narrative.

Both examples can be seen as a part of a bigger narrative of being an outpatient that has to accustom to changes both due to the disorder and the treatment. For P3 it meant to discover new ways of using his home-setting, indicating a more active use and awareness of this. For P4, this reflects more an end of her academic carrier due to the development of her disorder and a change in her everyday life due to medical side-effects of drowsiness and inability to concentrate on reading a book.

2.5. Discussion

Broadly, our participants' stories reflect home as an essential, but also ambivalent physical and socio-emotional setting that has changed in relation to the treatment transition. The meaningful relation to home is constructed as a site for doing specific actions and allowing oneself to do particular actions, as well; making it a vantage point for a variety of activities and states of being. Throughout, we also find meanings of home that align with the literature, e.g., safe, hole, nest and so on, with the crucial finding that these are very much in a constant state of negotiation and flux on both a temporal and emotional level, particularly in light of the psychological well-being and treatment. In this sense, the multi-facetedness of the concept of home has been confirmed, as a feeling that emerged as an ongoing construction through everyday activities that provided our participants with a wide range of both benefits and challenges.

Our findings suggest that home, while being a place that offers a site for activities that promote agency and safety that are touted as essential in the recovery process (Jacobsen & Greenlay, 2001), is also a place full of demands and challenges for our participants, mirroring Douglas' (1991) assertion of home as a specific site of both privileges, rights and obligations. Treatment, then, is not simply a question of dealing with abstract symptoms or diagnosis in a vacuum, but instead in the very real everyday activities and issues, things that are normally seen as trivial. In our participants' tellings, everyday activities become ambiguous in the sense that home management is both an issue in and a means for recovery, which has also been expressed in other studies regarding recovery in everyday life (Bartova, 2014; Borg, 2007; Borg & Karlsson, 2013). Their disorders are inextricably intertwined with everyday life with very real consequences, causing them distress, disappointments, educational drop outs, unemployment, financial and social issues and so on. At the same time as being the site for challenges, everyday life is also cast as the scene for the recovery process through our participants' use of various exercises, routine establishment and other, more “normal” activities in their physical and social everyday environment that were seen as more or less related to treatment. These implications highlight the need for a greater understanding of the demanding everyday aspects of recovery as more than simply symptoms of disorders, so that

outpatients can be supported further in these aspects of their treatment, necessitating a focus on the individual experiences of their lives. Essentially, this means tailoring of clinical interventions that extend to the practical aspects of everyday life, e.g., along the lines of psychiatric occupational therapy (Argentzell, Håkansson & Eklund, 2012, p. 57; Ulfseth, Josephsson & Alsaker, 2014, p. 9f). Central to this endeavor is maintaining a sight for the many facets of the person beyond that of patient. As our participants showed, a patient does not suddenly lose all other social roles and identities; rather, these experiences, skills and resources could be utilized as an intrinsic part of the recovery process: many of our participants were engaged in identity work as, e.g., home maker, mother, daughter, friend, responsible adult and so on. All of these more "normal" roles and facets of the person tie in to the everyday life and activities there, and clinicians must be aware of this and actively take them into account as both a hindrance and a benefit in the treatment transition.

Conversely, treatment must be acknowledged as a potential hindrance and benefit for these other identity works. It is not just an isolated factor in a person's life, as seen in the intertwined narratives that our participants constructed, but is an aspect of a range of activities that must be understood in a continuum between the normal and pathological, and engaged as such. This supports a restructuring of the practitioner-patient relationship, furthering the sense of active participation in the everyday life context of the patient on both sides, seeing treatment as a partnership (Hatgis, Dillon & Bibace, 1999, p19ff). Part of this, we argue, could be a strengthened assessment of everyday life competence with a thorough exploration of the ability to manage aspects of everyday life, such as job status, living conditions and physical features of home, social competences and integration with community as an integrated part of treatment in the form of social and material support (Borg & Davidson, 2008, p. 139).

Considering the Danish Psychiatric System today, our findings support the development of a more recovery- and practically oriented rehabilitation of patients. By taking treatment out of the site of psychiatry and into people's home context, the clinical intervention have the potential to focus less on individual, internal processes and more on processes nested in a social and physical environment with a success criteria of managing that. This affords a chance to discover new resources and ways

for approaching everyday issues for both the patient and the practitioners by breaking down the traditional spheres of clinical work; casting therapy as a more holistic social, material, environmental and practical process that takes place in both the extraordinary processes of self exploration and the trivialities of paying bills. Many of these offers already exist, but a greater integration of the different Danish health and social sectors working together is needed, which has already been voiced by others (Eplov et al., 2014, p. 937f).

This is not a neutral undertaking, however, and the repercussions of this need to be further studied. Angus et al. (2005) showed how a more home-based focus on treatment with somatic patients can be seen as invasive and depowering for the patient, while Borg & Karlsson (2013) elaborate how psychiatric home-based treatment is very much a case of constant negotiation between patient and clinicians, a dynamic that is so far little understood. In much the same way, our participants also showed instances of hesitance, negotiation and rejection of current, more home focused treatment offers. As practitioners, we must be aware of the power relation and systemic pressures involved in providing and receiving care in as private a setting as home and everyday life. The complexity of this undertaking, however, should not let us shy away from attempting it and doing further research to do so, since the potential of a more integrated, activity-based and person-centered approach to treatment could be highly beneficial.

2.6. Conclusion

This article has explored the meaning of home in everyday life for five Danish psychiatric outpatients through narratives. Our findings have shown how home and everyday life are an essential part of the recovery process, which, in a lot of ways, is an almost commonsensical conclusion. Everyday in its seeming simplicity risks becoming invisible, its trivialities taken for granted. However, these activities, rather than managing symptoms and diagnoses, are exactly what constitute the many small bricks on the road to recovery for our participants. On this basis, we argued for a firmer grounding in the everyday life activities of home making and management as a vantage point for clinical intervention, seeing treatment of patients as less to do with treating abstract symptoms, but more in management of everyday

issues from the complexities of social relations to the trivialities of paying bills. Further research is needed in how to both utilize the everyday in treatment and transform the bond between practitioners and patients into a partnership. The latter is essential if we are to find a path through treatment and life that is grounded in the everyday life and all of the facets of the person in recovery.

3. Foundation of study

This chapter details multiple stages of our project, starting from our searches for literature as a basis for a literature review during the 9th semester, to a brief introduction of both the Danish Psychiatric System and its current transition to adhere more fully to the recovery-paradigm. The majority of the chapter is allotted to our theoretical argumentation behind our approach to doing a study of home, something that was only glimpsed at in the article, and a methodological discussion, as well. In other words, this chapter mainly serves the purpose of providing a comprehensive grounding for the article and expand on some of our thoughts there, as well as provide a vantage point for the rest of the thesis, which will delve much more into the empirical and practical aspects of our study and thesis work.

3.1. The search for a literary grounding

Part of our initial conceptualization phase of the thesis was to look for available literature to get a broad sense of what had already been done in the field of home meaning, how it was studied and conceptualized and how these concepts and reflections might feed into our project. Beyond this, we also looked at the psychiatric system in general, the recovery movement, the person-environment paradigm and available sources on narrative research studies. This was done to ensure that we had a vantage point within the literature to determine how we might contribute something new to the field (Buus et al., 2008, p. 2).

Our first searches were deliberately broad and conducted on both Google Scholar, Scopus and PsychInfo, focusing on both establishing a general overview of the topic, as well as informing us about interesting nooks and crannies, attempting to find inspiration for a more specific research question and method to answer it. This process was continuous, our literature search informing our research question and vice versa over several iterations.

Our initial search words were divided up in different blocks to make it easier to manage and either expand or limit, going for one "contextual" block (*psychiatry/psychiatric, environmental/ecological psychology, home/house/residence /domicile, treatment/care*), one "person" block (*mental/psychological/psychiatric*

illness/disease/disorder, patient/outpatient/inpatient) and one "phenomena" block (*sense/meaning/feeling*) (Buus et al., 2008, p. 4, 6). A Danish search was also conducted with the terms: *psykiatrisk/psykiatri, miljøpsykologi/økologisk psykologi, hjem/hus/residens/domicil, behandling/pleje, mental/psykisk/psykiatrisk sygdom/ lidelse/forstyrrelse, ambulante/indlagte patienter, betydning/mening/følels*e, both searches using Boolean operators (mostly AND/OR) when appropriate and after looking at the most meaningful Thesaurus Index terms. The terms were used in both Google Scholar, Scopus, PsychInfo, with a high degree of common hits. Having made some headway into the field, slowly determining both which were the most relevant for our subject and which articles or books that were the most cited or comprehensive, tracing influential works through cross-referencing, a version of the so-called chain-searching (ibid., p. 4). We supplemented these searches with help from the staff at Aalborg University Library, who guided us through their own databases; yielding new hits, but many common ones, as well. In the same period, we also tightened our search criteria in several ways, e.g., by focusing on psychiatric outpatients rather than psychiatric patients in general. These searches served as the foundation for both our theoretical and methodological grounding, letting the different articles feed into our conceptualization of our work, a process which is expanded upon in *3.3. Our underlying theoretical discussion* and *3.4. Our underlying methodological discussion.*

Our search was primarily conducted in October-November 2014, with several following searches in order to look for contributing articles or new, interesting perspectives on both our subject matter and our emerging data as it was analyzed and new avenues for discussion presented itself. Examples of these include, with Danish versions in parentheses: *recovery, home based treatment* (*hjemmebaseret behandling*), *outpatient based treatment* (*ambulant behandling*), *suicidal risk factors* (*selvmordsrisiko og faktorer*) *in Denmark , stigma*, etc. As such, our literature search has very much been an organic process of both setting the stage for our empirical work and in turn letting our empirical work form our search criteria.

Throughout the search process, we did a continual relevance assessment of the found literature, by first looking at the title and abstract or the introduction to the book, before discarding the first hits. In the next phase, we would quickly skim the

contents of the article or book, before discarding those that did not provide new insights, references or were simply not related to our research topic upon closer inspection; e.g., somatic outpatient based treatment. The final batch was then more thoroughly read and, for the most comprehensive literature, a list was drawn up and short summaries were made for easier reference.

3.2. Contextual grounding: The Danish Psychiatric System

As we argued in our article, beside the theoretical and methodological grounding of our research, we likewise tried to ground ourselves in the Danish Psychiatric System, especially in regard to structure and policies. This was both done to get a better understanding of the Danish context of psychiatric treatment and how our study might situate itself there, as well as for us to be better prepared for the interviews with our participants, who are currently a part of this system. We have created a short overview of the Danish Psychiatric System (please refer to *11.2. Appendix B*), where we sketched out the overarching treatment possibilities and trajectories of patients, also tying these to the administrative and responsible state institutions. Furthermore, as we have mentioned briefly, the Danish Psychiatric System is regulated by relatively newly implemented policies focusing on expanding outpatient based treatment and implementing a recovery-mindset (Danske Regioner, 2008, p. 3, 5; Regeringens udvalg om psykiatri, 2013, p. 35, 92-98). This development strengthens both the relevance of a project like this in the Danish context, as well as our interest in the meaning of home for psychiatric patients, since home becomes more involved in the treatment process.

When looking at our neighboring countries, a similar development in regards to both recovery and outpatient based treatment is taking place, both building on a financial and a humanitarian argumentation (Borg & Karlsson, 2013, p. 105). The financial, in part, concern the increase of people with psychiatric illness, and therefore the need to implement a better and more effective treatment options (Borg & Karlsson, 2013, p. 105; Regeringens udvalg om psykiatri, 2013, p. 47). The humanitarian one builds more on the belief that living in one's own home and being near family and neighbors is essential to promote health in people (Borg & Karlsson,

2013, p. 106), and that the empowerment of the patient is a key element to get better (Jacobsen & Greenlay, 2001, p. 482). The recent *recovery* movement can be said to guide and realize these arguments into action as a certain refinement of the past movements, such as the *anti-psychiatry movement*, beginning in the 1960s, the *psychiatric survivors movement*, dating back to 1970s, and the *broad-based consumer rights movement* later on, melting together in the 1990s (Braslow, 2013, p. 783).

In 2013, the Danish government released a new rapport devised by *Regeringens udvalg om psykiatri* (in English: the government's committee of psychiatry), which advices on the organization and accomplishment of the effort towards people with psychiatric illnesses. Both the framework and direction of this effort puts emphasis on *recovery-oriented rehabilitation*, meaning that care and treatment should be based on people's resources and possibilities giving way to a full, independent and meaningful life (Regeringens udvalg om psykiatri, 2013, p. 96). This does not necessarily imply living without any symptoms or difficulties, but rather to adapt a focus on self-determination, involvement and hope through which it is possible to both strive for as much quality of life as possible, but also accept some new limitations, thus moving on in one's life (ibid.). In practical terms, this should lead to a very flexible organized effort by the system, including cross-disciplinary and cross-institutional collaboration; to support the person's rehabilitation and quest for recovery with a constant aim of maintaining the close relation between the person and her/his immediate environment and plan in alignment of the person's hopes and dreams (ibid., pp. 96-97).

Underlying this short outline is an understanding of recovery as two-folded: the *personal recovery process* and the *recovery-oriented rehabilitation* (ibid., p. 96), which, obviously, go hand in hand, but has to be adapted by both and thereby raising some potential concerns and problems, if this, somehow, can not be attained. Thus, recovery it is no longer just an aspiration in the psychiatric system with its main goal of supporting the personal recovery process (ibid., p. 96), but also a project for the individual patient or, also called, *consumers* (Jacobsen and Greenlay, 2001), implying both empowerment of the individual, while also mirroring the capitalistic turn of our society. It also implies a third understanding of recovery as a mental

health outcome (Braslow, 2013, p. 784), which can be measured and manufactured in different ways (Borg, 2007, p. 18). As Eplov et al. (2014) attentively stated, there is a need for a comprehensive reorganization and involvement of the existing system to be able to actually offer a recovery-oriented rehabilitation to people with a psychiatric disorders, not just a mere reformulation of it. To do so, a collaboration on an organizational level between the different sectors is needed, as well as a widespread change of culture, practices and legislation, in addition to thorough development of leaders and health professionals together with the patients (ibid., pp. 937-938). On a more societal level, Eplov et al (2014) also emphasize the need for an active fight against stigmatization and social isolation of the psychiatric patient group as part of the recovery process (ibid.). A core critique of the work done so far and the governmental outlines provided for this to be facilitated at this point, is how they seem sketchy on practical and concrete recommendations for this change to actually happen (ibid., 938); resulting in an ongoing transition with numerous differences in application and understanding of the paradigm throughout the system and the treatments our participants receive.

Having thus situated ourselves more firmly in the current context, changing paradigms and issues of the Danish Psychiatric System, we now turn to a broader discussion of our theoretical foundation, which was only briefly touched upon in the article.

3.3. Our underlying theoretical discussion

As our article briefly showed, our theoretical foundation was underlined by a transactional approach, emphasizing the relation between person and environment (physical and social world, other actors, etc.) as emergent, interdependent, reciprocal and multi-level transactions that are shareable through talk and therefore explorable through a narrative analytic approach (Bibace & Kharlamov, 2013, p. 454, 458; Heft, 2013, p. 17; Heft, 2014, p. 58; Laird, 2007, p. 210-212; Taylor, 2010, p. 36).

This argument was built on an underlying discussion within the field of home meaning studies that we expanded by drawing upon cultural, ecological and environmental psychological concepts within our 9th semester project and which is further elaborated in this thesis. In the following sections, we start by unfolding the

phenomena of home and some of all the different meanings people attribute to it, along with how different avenues of study conceive of this. In the article, we focused on the meanings and the paucity of transactional studies that have looked at home and everyday life, particularly for psychiatric outpatients. Here, we take a more in-depth look at some of this and discuss the implications for both a traditional interactional approach and our own transactional approach to this field of study. This discussion, as well as a deeper look at space and place, unfolds over the following pages, before turning to an exploration of our narrative theoretical focus and how it meshes with our conceptualization of the person-environment relationship.

3.3.1. A deeper exploration of "Home"

> "'When one speaks of a home – a childhood home – we all know what that means.'"
> (Højlund, 2006, p. 98, quoting KFBU, a Danish youth institution; our translation)

Home, as we briefly touched upon in the article, is both a simple and terribly complex notion. Simple, because it has a deceptive sense of banality to it since it is something that we all have some implicit and explicit knowledge and familiarity with (Højlund, 2006, p. 98ff). Complex, because it exists in the tension field between a socio-spatial and psycho-social entity, as well as an emotive space (Easthope, 2004, p 135; Højlund, 2006, p. 99f; Mallet, 2004, p. 65; Valsiner, 2014, p. 190).

Like many other concepts and notions, the study and conceptualization of home is also very much a child of the social and historical context within which it has been studied: the meanings of home very much center around the idea of a residence as the cornerstone of "hominess", becoming a place for identification and self-definition in the Western world in the wake of the meteoric urbanization processes of late 19th and early 20th century (Mallet, 2004, p. 72; Manzo, 2003, p. 49; Moore, 2000, p. 209f). It was a time of great social upheaval, with the everyday and home becoming sites of commonality and universality in an increasingly reference-less Western world, the regularity of home and sameness of lives providing some sense of constancy (Douglas, 1991, p. 287f; Lefebvre & Levich, 1987, p. 9).

The notion of the "normal home" emerged, strongly tied to the idea of the

middle class childhood home, becoming a place that provided a fortress and haven towards the turmoil and pressure of the outside world, being a place for growth, regeneration and joy instead (Højlund, 2006, p. 99; Mallet, 2004, p. 71, 76). As our inclusion of Borg & Karlsson (2013, p. 105f) showed in the article, as well as how other studies have shown (e.g., Mallet, 2004, p. 76; Manzo, 2003, p. 49f), this positive connotation of home still resonates within the literature and also with health services (e.g., Healey-Ogden, 2013, p. 72), yet home is also increasingly diversified, seen as a mire of chaos, mindless chores, struggles, violence, sexual abuse and isolation, and much more (Easthope, 2004, p. 134; Manzo, 2003, p. 51f; Moore, 2012, p. 212). Home is also increasingly conceived of as a more mobile construction, both spatially and temporally, and able to transcend the notion of the home as residence and thus also concern persons, feelings, identity, religion, attachment and so on (Douglas, 1991, p. 289f; Højlund, 2006, p. 99f).

To us, with our interest in people being actively treated in their home and everyday as outpatients, we still focus on the residence or community as a possible center for the phenomena of home. We do, however, align ourselves with this increasingly transient and active understanding of home, and find it problematic how much of the research on home meanings in many ways is little more than concepts without any "thickness" to them; little contextual and practical connection between people and their homes, favoring universal generalizability and applicability instead (Hauge & Kolstad, 2007, p. 237f; Moore, 2000, p. 210). This neglects that home might very well be a shared, socio-cultural phenomenon and concept with a set of relatively decontextualized norms attached to it (e.g., home as a haven), but that it, as with everything else, is a highly individual and complex negotiation that requires a sensitivity to the processes behind it (Douglas, 1991, p. 289f; Højlund, 2006, p. 100f). Taking a cue from both Silverman (2007) and Lefebvre & Levich (1987), the everyday and the constitutive activities that we do there seems a good place to start any study of home, looking at what people actually do in it and with it as a physical and social place (Lefebvre & Levich, 1987, p. 9; Silverman, 2007, p. 25, 27), taking Mallet's (2004) words to heart: "our residence is *where* we live, but our home is *how* we live" (ibid., p. 83, emphasis added). Højlund (2006), who studied a Danish youth institution and its inhabitants as they attempted to create a semblance of "hominess"

within the institution, wrote at length about how certain everyday routines and activities, such as lightning candles, gathering for breakfast in the morning, etc., were essential for this endeavour (ibid., p. 102f). Routines and activities in home, seemingly simple and personal, are both a socio-culturally established "way of doing" home and the basis for our most basic way of relating to home, serving as a way to familiarize ourselves, act within and experience our residences in everyday life (Manzo, 2003, p. 53). Some activities are implicitly and explicitly connected with home and the routine of everyday life and only "suitable" and expected there, which was also an ambivalent issue in the institutional setting that Højlund (2006) described, e.g., how social activities between inhabitants and staff were constantly negotiated as both family-like and professional (ibid., p. 118). Routines and everyday activities are often unnoticed until disrupted or cast into question , as in the case of entering into therapy or when being asked "what you do here?" in an interview session, as happened with our participants.

What emerges is an understanding of "home" as a dynamic concept that is both a socio-cultural construct with certain norms and home-activities attached to it, but also a deeply personal process of "making" and "doing" the home in a myriad of ways. In order to use this conceptualization of home for our study, however, we still needed to connect this physical and embodied relation to home to processes that we can get a glimpse of in a narrative analytic study. The question that guided us from this stage, thus became how we could conceptualize and understand the meaning-making processes of people experiencing and acting within the world in everyday life?

3.3.2. Emergent meaning: the active person-environment relation

In our article, we briefly argued for the process of meaning of home to be an emergent property of the person-environment relationship, but that begs the question of how this relationship is to be understood, since that has deep implications for our thesis. Over the following pages, we explore and discuss how the relation might be approached, after which we move from the bottom and up, from the most mundane aspects of this meaning making process through to the remarkable ease and routine

of everyday life in places.

3.3.2.1. Interactional perspectives: a series of variables

Much of the literature about home meaning stems from the *interactional* metatheoretical approach (Mallet, 2004; Moore, 2000), as this has been the predominant way to understand both the complex relation between person and environment, as well as the conception of the individual (Heft, 2013, p. 14f; Werner & Altman, 2000, p. 23). For much of the modern history of general and environmental psychology, this has resulted in a perspective of the person as essentially apart and independent from other entities, be they other persons or objects and so on, in a shared physical and social environment. This has meant a prevalence of studies that explore how various individual, environmental variables affect the person and vice versa, metaphorically casting the individual as a passive billiard ball affected by stimuli from other, independent billiard balls around him, skirting around on some decontextualized, Cartesian billiard table (Heft, 2013, p. 15f, 19, 24; Kharlamov, 2012, p. 287f; Werner & Altman, 2000, p. 23). This approach has spawned much research and progress, especially in its promotion of environment as an important field of study, and the prevalence of interactional approaches in environmental psychology is perhaps quite fitting, seeing as the discipline has historically been very focused on the assessment of behavior, performance and environment (Gifford, 2012, p. 54).

As we described in our article and the home section, however, they have increasingly been challenged by alternative conceptualizations. An approach that merely sees people “as users of environment who respond to it with more or less success and satisfaction” (Kharlamov, 2012, p. 287) and casts aside the relational aspects of the socio-cultural and physical context as merely independent variables has great difficulty answering how a painting can be beautiful or a place comforting (Coolen, 2006, p. 185ff; Clapham, 2011, p. 361; Werner, Brown & Altman, 2002, p. 204ff)? In such a world of independent billiard balls, where is the relational, personal meaning to be located and how is it to be communicated meaningfully (Heft, 2014, p. 63)?

Having explored the predominant perspective on person-environment

relation, we turned to the notion of transaction and ecological axioms of psychology for further answers.

3.3.2.2. Ecological-transactional perspectives: a possible seed?

The ecological and transactional approach offers a perspective that is radically different, seeing human meaning-making as something that emerges in the individual's active and changing relation to the embodied materiality of the environment and objects within it. This also means that the person is no longer an essential, independent part of this process, but rather just an aspect of it (Clapham, 2011, p. 363; Jacobs & Malpas, 2013, p. 289). It stands to reason that in such a constellation, objects have little to no inherent meaning, instead constantly being negotiated, discovered and re-negotiated in a relational process of human intentions, wants and desires and features of the environment, to which people continuously adjust their behavior, often changing in accordance to in-situ or long-term plans, dreams or goals (Coolen, 2006, p. 186f; Seamon, 1982, 131f, 135). As is maybe obvious by now, our knowledge of the world is then not carried and developed internally, in the cupboards of the brain. Instead, the relational process of the person acting in a particular situation and context is a treasure trove of information in and of itself. In this conceptualization of mankind, our consciousness and actions are thus seen as ongoing affective and cognitive relational processes, emerging in the actions that people do, instead of through some discrete entity within the person (Heft, 2014, p. 56f, 73).

Here lies the seed of how the meaning of home emerges as a relational process, something that *necessitates* a physical and social context to act in for the meaning to emerge. We still, however, need to develop this further, to discover how some objects can be “homes”, while others are distinctly different to us – a sign of how, while objects may have no inherent meaning, they still have a distinct range of *affordances* (Charles & Sommers, 2012, p. 8f; Heft, 2014, p. 63f).

3.3.2.3. Affordances: constrains and potentials

Whenever a person acts in a given environment or with a given object, affordances is, essentially, what that person is capable of doing in relation to these. In

this case, “doing” covers the gamut of basically anything, depending on the object or the environment. Affordances cover the range from basically physical, to social and mental objects and their uses (Charles & Sommers, 2012, p. 8f). As such, these potentialities depend both on physical, social or mental aspects of the person (e.g. having hands to use a computer and the skill to pick it apart if something goes wrong), as well as being encultured to a particular socio-historical setting (e.g., actually knowing how the computer works and how to use it – unlike a fourth century clergy man). Meaning, in this sense, emerges through a convergence of the object or environment, some ability or desire of the person and the context in which the process takes place. Correspondingly, some object has the potential to be meaningfully related to in a myriad of ways, both expanding and shaping the ways that we can and do relate to our environment (Coolen, 2006, p. 186-189; Heft, 2014, p. 57; Shweder, 1991, p. 74f). Before we delve into complete relativism, this does not mean that a box that somehow resembles a computer suddenly becomes one through sheer will of the individual. Physical, social, mental and cultural restrictions exist alongside these potentialities, and as such, most uses of objects or environment are more or less constrained by social norms or conventions (Charles & Sommers, 2012, p. 8f; Heft, 2014, p. 63), e.g., a “public square” is commonly not used as a private “home”, but might take on semblance of it during a long protest.

Here, we see the connection to some of the socio-cultural norms of home that we explored in the home-section: for some object to qualify as a potential home, despite obvious differences in aesthetics and uses, a certain physical structure within a certain social and cultural structure is necessary, most importantly perhaps its potential for providing a specific site for regularity; a situated, physical object to sleep in, go to, go to work from, make food in, as well as allowing and constraining particular social and cultural negotiations (Douglas, 1991, p. 306f; Højlund, 2006, p. 113). We still, however, need to get a sense of how this negotiation and meaning can emerge as an enduring aspect of a particular place to both the individual and society at large.

3.3.2.4. Semiotic mediation: transcending the here-and-now

Essentially, the human existence that we have drawn up so far may at first glance seem like a chaotic cavalcade of an infinite series of immediate moments with relations to environments and their social and physical objects, with little system or coherence. However, humans are always searching to make sense of the world (Bruner, 1991; Shweder, 1990; Valsiner, 2007 & 2014) and underlying this seeming chaos is a constant microgenetic process that dynamically creates a sense of a structured, sequenced connection between the person and its environment through gradual unfolding and differentiation of this relation (Werner, 1956, p. 347). What this means is that a person's being in the world becomes both a constant developmental and sequenced experience through time, as well as increasingly familiar and specific through acting in an ever-changing world; such as familiarizing yourself with a new, unknown city, learning a new skill or simply reading through a book or having a conversation. This process can last from a few seconds to hours, days, years; it is an ongoing and dynamic "acting" in and with the world (ibid.); building on the processes that we described in the above sections.

Central to our understanding of the concept is also a microgenetic emergence and categorization of experience through the use of *signs*. A sign is a mental and cultural object, to use the terminology of the previous section that encapsulate and organize an experience (Valsiner, 2007, p. 20). Using these signs (i.e. s*emiotic mediation)* creates meaning, through regulating and organizing the relation to the environment and oneself (Kharlamov, 2012, p. 290; Valsiner, 2007, p. 301), providing a means for people to interpret their environment, themselves and others, both in the split-second of moment to moment as well as much longer, more continuous experiences (Valsiner, 2007, p. 301f; Valsiner, 2014, p. 180). In a basic sense, it works by using words to label and understand our various experiences, feelings, wants, etc., such as "feeling at home", "being a mother", "being sad", etc. Language in general is a powerful resource to organize and share these signs and of vital importance to understand how human beings can create a lasting and yet transient sense of meaning to for example a place. Through the structure of language and the use of signs, it is possible for human beings to transcend the here-and-now, through an act of *psychological distancing*, which

> "[…] always includes the context within which the person is, and in relation to which the distancing takes place. The person does not 'go away' in the context […] The person creates a distance – by way of semiotic mediation – in relation to the here-and-now context. [...] This reflection – which is cognitive and affective at the same time – allows the psychological system to consider contexts of the past, imagine contexts of the future and take perspectives of other persons (in the form of empathy)" (Valsiner, 2007, p. 13).

Take our article, for instance. Our participants produced narratives of their lives, acting and reflecting upon their past, present and future through words; side-stepping the current context, but still talking from it and often returning to it from a distant past or future in their ongoing negotiation of their treatment and home, a point we will return to in *3.3.4. Our narrative analytical approach*.

While personal experience and its attributed signs may be highly individual and never capable of being "completely" covered by a sign, most of us are still enmeshed in our socio-cultural context to an extent that we use and produce culturally specific, shared expressions and signs for the same feelings and experiences, enabling discussion and somewhat accurate communication between people and with ourselves, but this personal internalization always means slight variations in the understanding of the sign (Valsiner, 2007, p. 40, 301f, 340; Valsiner, 2014, p. 180).

Far from being creatures that live solely from moment to moment, then, our potential for action and meaning-making often exceeds into more symbolic arenas instead of merely physical and momentary, and many of our actions only make sense in relation to the particular social and cultural environmental structures and contexts within which we are situated or by taking some distant future or past into account. A relevant example could be going through a long, arduous psychotherapeutic treatment in order to somehow "get better", which might, in the case of a more religious context, rather require seeking penance for some sin to reach absolution and "get better" (Heft, 2014, p. 66f; Shweder, 1991, p. 75; Valsiner, 2007, p. 40, 340).

As a final leg in our argumentation, we look at how these above reflections can be applied and understood in relation to the socio-spatial spaces that are required to situate a home: places.

3.3.2.5. Places: meaningful spaces

Human meaning-making in relation to place happens in the encounter and active organization of space; making it meaningful by putting raw, boundless space into particular temporal, cultural and spatial boundaries (Kharlamov, 2012, p. 291), like claiming a piece of land in the the name of some king, suddenly conferring an entire culture of norms, expectations and limits down upon it. As such, “places” can be anything; both private and public, both manmade and natural, both material and imaginary, like a memorial or a future dream house. What is essential, is that places depend on people to define them as such in order to exist, by being physical focal points for particular practices, intentions and meanings. This existence is both constituted by and constitutive of humans acting in accordance to these social, physical and temporal boundaries – take for instance the vast difference between the aforementioned memorial and dream house as sites for human practice and conduct (Easthope, 2004, p. 129; Smaldone, Harris & Sanyal, 2005, p. 398; Valsiner, 2014, p. 182ff).

Building on the process of semiotic mediation from above, we can understand the feeling of being “home”, of “forest”, of “museum” – i.e., a specific “sense of a place”, through a sign that is created based on previous experiences, conduct and activities and so on within a context that has been internalized by the individual as a particular “feeling” (Kharlamov, 2012, p. 307ff).

Here we come to the crux of our argument, as this sign, that is based on the feeling, in turn based on actions and experiences in a place, serves the purpose of a regulative spatial sign to “pre-emptively set the stage for feeling toward any further encounters” (Valsiner, 2007, p. 39). This constant, enduring process ensures that the setting and feeling of a particular space in the world continues to be recognized and understood as “home”, since all future encounters with a place defined through a “home” sign is organized according to this overarching feeling and meaning (Kharlamov, 2012, p. 294). Tying a loop back to our discussion of home, this process results in a schematization of the organized and regulated place; home and its “placeness” and meaning becoming commonsensical and tacit, appearing as more of a “feeling” than the highly complex constituting and constitutive process that is behind it (Kharlamov, 2012, p. 291; Valsiner, 2014, p. 190). This does not mean that

it simply becomes some essential quality: since it derives from such a complex, dynamic transaction of processes, it is highly transient and emergent and under constant negotiation. When something in the “home” context changes, like in the case of child birth, a break-in or psychotherapeutic treatment, it is re-evaluated and re-negotiated through this dynamic, embodied and social transaction we have described (Kharlamov, 2012, p. 289).

From all of this emerges a dynamic and contextualized relation between people and their environments, which, as we pointed out in our article, seems to have been the least examined (Moore, 2000, p. 213), leaving out many of the physical, social and psychological processes described above. Up until now, we have taken a step back from the brief argumentation of the article and attempted to provide a slightly more in-depth conceptualization of the general person-environment relationship, along with a sketch of how places and their meaning to human beings might be understood within this framework. In doing so, we have distanced ourselves from the more Cartesian conception of home prevalent in the literature and carved out a space for a more transactional approach. What follows is an expanded discussion of the “levels of organization” concept brought up in the article and how we used it to bridge the divide between this highly embodied and often tacit experience to the realm of something more shareable and tangible for our research methods.

3.3.3. The spiral - meaning moving from firing neurons to words

In the beginning of this project, we asked ourselves how we as researchers could get a sense of the personal meaning of home from the perspective of our participants, and retain a focus on their physical, embodied everyday aspects of life?
As we have argued above and in the article, meaning emerges through a transactional process with one' s environment in a highly habitual and tacit manner that becomes increasingly complex as one moves from the most basic being in the world to the higher psychological levels. In the following section, we expand the argument behind our reasoning for using a narrative analytical approach to study this phenomenon. We first do this by introducing the concept of the spiral as a possible bridge across the divide of the embodied experience to a shareable experience.

Linear developmental stages of increasing competence or complexity have long been all the rage within the developmental paradigm, as famously evident in Piaget's cognitive theory, Erikson's psychosocial stage theory or Freud's psychosexual stage theory (Bibace & Kharlamov, 2013, p. 457). In this perspective, psychological development is a continual transition from a fused state to one of increasing differentiation. On the other hand, psychopathology or abnormal development is signified by a regression to one of these previous, fused states (ibid.). In much the same way as we conceptualize the process of home meaning as a temporary, dynamic achievement instead of as an essential quality, Bibace & Kharlamov (2013) use the concept of *dynamic coexistence to* emphasize the same fleetingness to psychological processes, seeing them as "[...] local, context-driven distinctions and differentiations that emerge in concrete life situations out of the coexistence of all present psychological functions" (ibid., p. 457). To reiterate the central point of the approach from our article, directionality is here envisioned as a *spiral* towards greater expanse and complexity of differentiation and integration, yet maintaining an interconnection and wholeness with the ‘‘lower’’ levels of psychological functioning instead of existing independently of them (Bibace & Kharlamov, 2013, p. 454, 458; Laird, 2007, p. 210-212). What this means in practical terms is that the "lower" levels, such as neurons firing or sensory stimuli, are imperceptible and automatic to both interviewer and participants in an interview. All levels, however, are necessary for this particular feat and constitutive of one another, "lower" levels merely subordinated to more advanced levels, such as the ones utilized in dialogue (Bibace & Kharlamov, 2013, p. 454; Laird, 2007, p. 212). As Werner (1956) showed, aphasic people, without the particular lower level functioning of word recognition, were still capable of reproducing specific read words (e.g., aunt, fork, etc.) when prompted by a researcher providing the general category of the word (e.g., people, utensils, etc.), showing how the higher level functioning could temporarily and dynamically emerge in a co-construction (Werner, 1956, p. 352f).

Taking these considerations into account and conceptualizing human meaning making as a spiral-like organization of levels, we argue for the relevance of a narrative analytic approach as our method; through narratives, we can get a glimpse of part of this meaning-making process by looking at the identity construction of our

participants and how they negotiate on the basis of everyday activities in talk. By conducting an interview about the meaning of home for patients and focusing on their routines and activities within the home context, we create an observable and shareable space for the semiotic meaning-making processes to unfold and to be researched as narratives, being implicitly constituted by, and constitutive of, all aforementioned levels and processes working in the background of our interview. The following section will briefly round up the narrative theoretical part of our thesis before we turn to the methodological application and implications.

3.3.4. Our narrative analytical approach

Our narrative approach was a greater part of the article than much of the above theoretical foundation, necessitating less focus on it in this part of the thesis. As such, the following pages serve as an elaboration of the main functions of narratives for the purposes of our thesis and a discussion of our inclusion of the small story approach in favor of the big story approach that is often predominant in narrative theory (Bamberg, 2011, p. 16).

3.3.4.1. Narrative in different approaches

As we have argued in the article, narratives are one way of “doing” talk and thereby contributing to the practices of meaning-making (Taylor, 2010, p. 36). To shortly recap, we conceptualized narratives as people's construction of events in a temporally organized sequence performed in talk and by which they both create and express meaning (Bamberg, 2011, p.17). In this thesis, we operate with an understanding of narratives as having three main functions: (1) as a process of organizing human experiences and memories in talk and thought, providing an understand and have a sense of self (Bruner, 1991, pp. 4, 6). (2) as a construction in talk that enables to navigate in the local and immediate situation with a lived past and an anticipated future (Bamberg, 2011, p. 16; Sools, 2012, p. 103). (3) as a resource on the background of the socio-cultural context that form the stories that are and can be told (Esteban-Guitart, 2012, p. 175).

However, there are different ways of looking at narratives from a research perspective. In our article, we made use of a small story approach, in favor another,

more dominant approach in narrative theory: *big story* approach, also called biographical approach (Bamberg, 2011, p. 15; Bamberg & Georgakopoulou, 2008, p. 380). With the latter approach, a lot of research has informed the practices of people when constructing a more unifying sense of self, as well as a more coherent sense of identity, since the focus lies on life stories, meaning plotting a story about one's course through longer periods of life or big life events (Bamberg, 2011, pp. 15, 18). When looking at these stories, the focus lies more on the *content*, what it is about, and the way it is *structured*, often in search of certain plot lines (Sools, 2012, p. 95). Due to the focus on *what* people tell, it is necessary to be aware of avoiding the fallacy of assuming that these utterances reflect experiences and meanings on a one-to-one basis as valid data on facts and attitude of the person (Atkinson, & Silverman, 1997, p. 304, 322; Lucius-Hoene & Deppermann, 2000, p. 201f). An interview, and especially a biographical one, creates a particular space for people to rewrite their history (to some degree) in a retrospective manner, thus setting the stage for people to emphasize certain parts in relation to an outcome, e.g. being diagnosed with a psychiatric disorder, and downplay others, but without being followed up by an analysis looking to explain this "doing" (Bamberg, 2011, pp. 15-16, Silverman, 2007, p. 39).

By employing a small story approach on narratives, the focus is precisely on the "doing" of narratives, meaning "*how* the story is told and *why* it is told in this particular way" (Sools, 2012, p. 95, original emphasis), especially emphasizing the co-construction and interaction between people (Bamberg, 2011, p. 15), avoiding claims about people's "inner" thoughts and feelings (Bamberg & Georgakolpoulou, 2008, p. 378f; Georgakopoulou, 2006, p. 123; Silverman, 2007, p. 47; Sools, 2012, p. 99). Instead of looking at narratives as *representations* of the experienced world and identity of the person, as in big stories, the focus is on narratives as a *construction* of the world and the sense of identity by interactive engaging in this process (Bamberg, 2011, p. 16). This approach, contrary to what might be expected, does not toss having a sense of constancy and sameness of the world and identity away, but rather understands this as emerging from regular, repeated practices of constructing the world and identity, without adhering to them as being fixed and stable entities (ibid.). From this, it is also understandable that the approach has other names, like talk-in-

interaction, social practice approach or narrative practice approach (Bamberg, 2011; Bamberg & Georgakopoulou, 2008; Sools, 2012), precisely emphasizing narratives as a commonsensical part of our everyday life, surfacing in everyday conversation (Bamberg, 2011, p. 15). Even though our interviews cannot necessarily be seen as everyday occurrences, the data can still benefit from this approach, due to several reasons. In a research study about something as taken-for-granted in a Danish context as “home”, so much is implicit and commonsensical that there is a real possibility in merely skimming the surface of people's stories of home, losing sight of the complexity and plasticity of the individual construction and lived life behind the notion (Højlund, 2006, p. 98f). This approach has both sensitized us to this process and laid the ground work for our analysis, following our conclusion on the theoretical foundation in the article, we have to set our sights on the remarkable in the mundane (Silverman, 2007, p. 18f) in order to get just a glimpse of this complex notion.

3.4. Our underlying methodological discussion

Just as the previous sections provided a space to shed a light to some of the underlying discussions of our theoretical foundation, the following sections illuminate some of the methodological reflections that did not receive much attention in our article, where it was mostly presented as a straightforward approach. In the following, then, we expand on our theoretical foundation by considering and discussing our methodological application of these thoughts.

Initially, we discuss the interview as a research method, as well as how we used ethnographic tools as an integrated part of our interview and research process, before turning to a deeper exploration of our choice and implementation of the small story approach. Finally, we elaborate on the discussion behind our methodology in general and our attempt to apply it according to transactional standards and on the basis of previous research done in the field.

3.4.1. Practical aspects of doing an interview based study

For an interview focused study, there were several things we had to be aware of and attentive to before we began the study. One of these is a simple question of

looking at the emergence of our own profession as an example of a general societal trend: in the modern, Western context, interviewing as a social practice with a specific structure, purpose and set-up is arguably an everyday activity; something that most people have some passing familiarity with, through media, personal or work experience or through therapeutic experience, as in the case of our participants (Atkinson & Silverman, 1997, p. 309ff; Tanggaard & Brinkmann, 2010a, p. 29f). This familiarity on both sides of the interview table played a part in the setting in a variety of more or less unforeseeable ways (Tanggaard & Brinkmann, 2010a, p. 30).

From the outset, an interview is always a co-construction between the participant and the interviewer; the stories shared are emerging from that particular setting and dialogue, both before, during and after the interview (Atkinson & Silverman, 1997, p. 305; Lucius-Hoene & Deppermann, 2000, p. 201f). This does not mean that people freely construct a story, mostly it will be told on the basis of prior tellings and retellings, particularly for salient stories such as treatment in the case of psychiatric patients (Taylor, 2010, p. 8). Our participants may have had several experiences with interviews, may have had negative experiences with health professionals that, due to our own prospective status as psychologists, may have an effect on the interview, and so on. Several of our participants told us stories that indicated such experiences, but it is relatively impossible to tell the impact of that. As we have argued before, it is also irrelevant for our purposes even though other analytic approaches might deem them important; what we were interested in was less their life worlds and some abstract notion of “truth value” and more our emerging dialogue in the interview and the positions our participants used there. This meant that we were focused on how their sense of home was communicated by storytelling. In such a view, we shift our focus away from asking whether stories are somehow “true” or “false” to the story told as a valuable phenomenon in its own right. Whatever inaccessible references or connections it has to some “real reality” or “inner mind” is something we leave to other researchers (Silverman, 2007, p. 43f). For us, it was more important to get a sense of our own expectations and goals, as well as our general process prior, during and after the interview session. The reason behind this was that, as Lucius-Hoene & Depperman (2000) asserted, an interview is far bigger than merely the time used in the concrete interview setting.The initial

contact, how it was done, what was told and why, what our impressions were before and after the interview, as well as the transcription process are all aspects of the same data-gathering and initial analytic process (ibid., p. 206f, 217). A very important aspect of this was our own inherent awareness of our roles when doing a study with psychiatric patients and which also cast them in this role due to our research focus. Both as small story researchers and as nascent psychologists, it was especially important for us to be a part of opening a space within the interviews for different roles and narratives to emerge. This was a difficult balancing act for us, which receives further attention in *5.2.1. Relation between interviewers and participant.*

In order to live up to the standards set up by Lucius-Hoene & Depperman (2000), as well as our own standards of transparency, we incorporated a small range of ethnographic practices into our study (Raudaskoski, 2010, p. 81f), by using note-taking of our process, both to recontextualize the transcripts during the analytic process and to document our process more fully for this thesis. Some of the later sections and chapters show the fruits of this work.

What we actually did was to both document our initial contact and impressions, writing brief notes of these and delegated one of the researchers to the role of observer and assisting interviewer during the interview, taking notes of the context, their residences, impressions of participants and the actions of everybody involved. A more thorough explanation of this process can be found in *5.2.2. Observation, notes and taking photos.* As might be apparent from the title of that section, we also included photographs of people's homes into our repertoire, being inspired by Kloos & Shah (2009) and Rechavi's (2009) uses of the method to preserve more of the context for our subsequent analysis. After the interview, each researcher then sat down and wrote a couple of pages about impressions about the interview session (Kvale & Brinkmann, 2009, p. 150). A short example in Danish and English can be found in *11.5. Appendix E* (the rest and full length versions are not included due to anonymization concerns). In doing so, we attempted to follow the tenets of ethnographic studies and have a keen focus on how participants acted in the environment and in our dialogue, without attributing any internal processes to their actions, but rather reflecting on our own reactions and understandings of our interview, our participants and the stories told (Raudaskoski, 2010, p. 81f; Silverman,

2007, p. 42).

All of this was done to provide ourselves with the best possible premise for learning between the interviews and for resituating ourselves in the interview context during analysis.

3.4.2. Applying small story approach

Throughout the last sections, as well as in our article, we have been expressly focused on an understanding of people's relation to the world as one hinging on activities. Our argument for a small story approach in our narrative methodology seems like a natural fit, with its focus on both everyday banalities and the microgenetic processes of the interview setting itself. However, based on Sools' (2012) argument that “it is hard to find interview texts that are not hybrid in the sense that they contain both big and small story characteristics, and contain both narrative and non-narrative parts” (ibid., p. 106), we also used the big story approach within our methodological “tool kit”, using both with some flexibility in both our interview guide and the actual interview.

As Silverman (2007) cautions, the mindset and research agenda with which the researcher approaches the interview is essential to the stories collected, naturally skewing the data in a certain direction (ibid., p. 39f). To us, this meant that we were primarily focused on eliciting stories about everyday issues and were very active interviewers. This stands in contrast to a big story narrative approach, where the interviewee is traditionally given a great sense of free rein to elaborate on their own story. Our “interference” meant little since we were not looking for some objective, deep insight into the life worlds of our participants, but precisely were interested in how they developed their narrative of home in dialogue (Atkinson, & Silverman, 1997, p. 304). Our interchangeable use of both approaches was an organic process that evolved together with our interview guide, using big story-questions to set the stage with overall themes (e.g., “course of treatment”) as the natural precursor for small story-questions, hoping to elicit narratives of ambivalence and negotiation behind these bigger meanings. The interview guide process is further elaborated in *5.1. Interview guide process.*

The next section goes into the discussion behind our attempt to incorporate

both previous and transactional approaches to home meaning in our interview based study, as well as how this was meshed with our theoretical foundation established earlier in this chapter.

3.4.3. A transactionally minded study

In our article, we simply asserted how we attempted to conduct our study with a transactional approach at its core, contrary to many of the already conducted studies within the field of home-meaning, but behind this lay several methodological considerations, chiefly what *transactional* actually meant to us in practice and how we could use it actively. In addition, we also assessed previously conducted studies, looking at both the methodologies and conceptualizations used for researching and understanding home meaning, and how these could either inform our study or serve as focal points for discussing our own approach. The basis for this section was a literature review and discussion that we conducted in the 9th semester project and over the following pages, it is both summarized and expanded upon, where appropriate.

One of our main aspirations behind using a transactional approach was to avoid falling into the trap that we mentioned in both the article and *3.3.1. A deeper exploration of "Home":* ending up with treating the phenomena of meaning of home in a more or less decontextualized manner, merely adding more "meanings" to the list (Mallet, 2004, p. 68f; Moore, 2000, p. 212). We attempted to ensure that through both our theoretical exploration and foundation; by seeing meaning as a more emergent, embodied and contextual phenomena and by structuring our thinking and research along transactional lines. In practice, "transactional lines" mean to be continuously sensitive to studying the phenomena as multifaceted when conducting research (Oxley, Haggard, Werner & Altman, 1986., p. 642), meaning that we had to repeatedly consider both *social milieu*, *psychological processes*, *physical environment* and *time* in our conceptualization of our study, instead of merely focusing on one particular aspect or attempt to isolate a specific "factor" of the phenomenon (Werner, Brown & Altman, 2002, p. 203f). This is also very much in line with Højlund's (2006) argument for studying home as exactly a multifaceted, interconnected phenomenon (ibid., p. 100).

Initially, we looked at the studies that seemed to be the furthest from our interview approach by being purely survey, scale and questionnaire based (Charleston, 2008; Droseltis & Vignoles, 2009; Hauge & Kolstad, 2007; Kaltenborn, 2009; Raymond, Brown & Weber, 2010; Stedman, 2002), e.g., using Likert-like scales to rate how strongly people identified with a place (Droseltis & Vignoles, 2009, p. 27), while others used more of a mixed method approach by including short, written descriptions along with the scales (e.g., Rollero & De Piccoli, 2010; Korpela, 1989). Far from tossing aside this type of research simply because of its methodology, we instead looked at some of the factors and variables they had included. Even though these studies were mainly focused on producing replicable and universal results, they could provide valuable clues to us, since the transactional approach in many ways is essentially eclectic, using the methods that is most appropriate for the phenomenon studied. At its core is an understanding of phenomena as ever-changing and contextualized, but studies that look for replicability or universality may still provide new insights for the prospective researcher (Oxley, Haggard, Werner & Altman, 1986., p. 642).

By using their conceptualizations, we for example understood how specific physical and particularly social qualities (type of place, scale of it, size, associated people and so on) were a meaningful part of what make people relate to a place, through both identification and attachment (Droseltis & Vignoles, 2009, p. 33; Hidalgo & Hernandez, 2001, p. 279; Kyle & Chick, 2007, p. 220f; Raymond, Brown & Weber, 2010, p. 433). Important for our study, where we see the relation to space as an emergent process that changes through time, it becomes an interesting finding that people who are relatively new to their residences seem to relate more heavily to it through physical qualities, whereas more settled people favor social qualities (ibid., p. 497). While we can hardly do what some of the studies have done, e.g., do repeat studies months apart (Chow & Haley, 2008; Gustafson, 2001; Manzo, 2005; Smaldone, Harris & Sanyal, 2005, 2008), we can nonetheless use these findings to emphasize before/after transitions, for example in regards to treatment. Lewicka (2010) also showed how a wide range of different personal factors influence the relation to place, factors that could help inform our later questioning; a process which can be seen more explicitly in BOX 1: Interview Breakdown, in chapter five.

To us as transactionally oriented researchers, none of these variables could somehow be seen as causative for people's meaning of home. Instead, people's meaning of home emerges as a complex pattern of relationships between all these countless aspects of the phenomena, where no single factor is causative for a certain outcome. The process of meaning of home and its change can therefore occur on several levels, which can only be further specified by an interest in the individual's relation to this process (Oxley, Haggard, Werner & Altman, 1986., p. 641), a process that is central to our narrative analytic approach. It did, however, make sense for us to use these studies to get a clearer picture of the aspects involved in the pattern and how we might use them in an interview based study. In our framework, this meant looking at the phenomena of home-meaning for our participants as a narrative construction through everyday experiences situated in talk with us; placing an emphasis on both the social, physical and temporal aspects of this construction with an assumption of underlying psychological processes being essential to the construction process. The question still remained, however, how to further implement these aspects within our thinking.

With this in mind, we then looked at how other interview studies had attempted to incorporate these aspects in their methodologies. It was a very broad range of studies (Case, 1996; Coolen, 2013; Chow & Haley, 2008; Lindström, Lindberg & Sjöström, 2011; Manzo, 2005; Rechavi, 2009; Sandhu et al., 2013; Sixsmith, 1986) that utilized the aspects in different ways.

Rechavi (2009) showed us the strength of using the personal, physical residence as an interview site, by investigating the role of people's living rooms, together with them in those very rooms, providing a more active relation and exploration of the place (ibid., p. 135f). Intuitively, we were in favor of doing much the same, due to our notion of seeing meaning-making as a relational and embodied process emerging in levels of organization, it would make little sense to conduct an interview about home in a cafe or other place, since an interview removed from the environment of interest also essentially removes the immediate physical stimuli from the lower levels of experience, making the interview more of a metaphorical exercise than an exploration of embodied experience, such as we had seen in other studies (e.g., Sixsmith, 1986). Doing the interview in the residence is even more important,

since we are studying a psychiatric patient group to whom everyday activities are an instrumental aspect of not only their home-meaning, but also of their recovery and their illness, processes which only seem to become more important as the number of outpatients increase. Home has been shown in previous literature to be perceived as exactly an important site that offers the regularity to act out these aspects of their lives (Borg, 2006, p. 246f; Borg & Davidson, 2008, p. 139; Lindström, Lindberg & Sjöberg, 2011, p. 288). Sandhu et al. (2013) showed how aspects of the household (e.g., knife, couch, window) could meaningfully relate to people' experiences of mental disorder (ibid., p. 167, 170). In addition, they also emphasized how treatment, such as medication could have an altering effect on how they conduct their daily routines or relate to home, due to physical and social side effects (Cascade, Kalali & Kennedy, 2009, p. 16f; Hodgetts et al., 2010, p. 369f), which once more shows the relevance of doing the interview in-situ and with a sensitivity towards the physical aspect of the phenomena.

At the same time, being in the houses of our participants also enabled us a chance to explore other aspects of our participant's everyday lives and social roles than if we had merely met in a cafe to discuss home and treatment in everyday life: the walls and rooms and the objects they hold serve as formative and performative aspects of identity construction, like the living room often being a showcase of important or meaningful objects, and providing an implicit, continuous sense of self through active interaction and mere presence (Jacobs & Malpas, 2013, p. 283; Rechavi, 2009, p. 137f). Items, like many of our participants related, often act as physical manifestations of social relations (like one participant who had a family picture wall) or symbols of feeling (like one participant who was a football fan and had merchandise around the apartment) (Baldassar, 2008., p. 251). By being a part of their actual house context, we or the participants could actively use some of these objects as tools in the co-construction of our narrative, relating both how they use some of these features of their environment, as well as why they might be important to them. This gave us an opportunity to explore the relational character of the home we were in, specifying actual properties of the home to their meaning making process (Heft & Kytta, 2006, p. p. 211f).

This active, relational way of envisioning people's understanding of home

also required an interview approach that favored a more active and mobile interviewer. As we detailed in *3.4.2. Applying small story approach*, we already had a focus on a more active, co-constructive way of doing the interview "talk", but we further strengthened this by looking at Kusenbach (2003) and Holton & Riley's (2014) *walking interview* and *walk along.* Their interview form, while mainly used in mobile interviews on accompanied walks in some interesting area, was interesting to us because it precisely focused on all participants as embodied and physically situated in a context that was actively used. The interview thus takes on an experiential character for everybody involved, with a looser sense of the usual question-answer rhythm, being closer to the structure of more spontaneous, everyday conversation, although still distinctively more structured (Holton & Riley, 2014, p. 60f; Kusenbach, 2003, p. 463). As such, there was room for participants to show us everyday activities or using features of the residence in talk, which also necessitates a greater degree of description and interest in what happens in the interview context. This is why we have conceptualized two roles for the interviewers; one acting as primary interviewer, while the other is both observer, note-taker and co-interviewer and also why we have conducted post-interview note sessions to remember these more vividly once we began analysis. Some of these considerations have been elaborated further in the thesis, for example in *5.2.2. Observation, notes and taking photos.*

Doing so, we have favored a conception of our interview as one primarily based in talk and activity with the actual physical and social environment, instead of the methods used by quite a lot of interview studies, such as drawing (Rechavi, 2009), photo-elicitation (Kyle & Chick, 2007; Rechavi, 2009; Sandhu, Ives, Birchwood & Upthegrove, 2013), lists (Coolen, 2006; Droeltis & Vignoles, 2009; Gustafson, 2001; Sixsmith, 1986) and pure observation (Silverman, 2007). We refrained from using them for a variety of reasons, but chiefly because these tools, while relevant in many ways, would delegate more attention to the photos, notes, etc., than to the actual physical and social environment in the interview context, running the risk of decontextualization (Hartig, 2006., p. 217). Pure observation was discarded as a method, because we, while interested in activities in everyday life, were less interested in what our participants normally visually and physically do in

their home context, as opposed to how they use these activities in their construction of meaning in talk with us.

Much like objects within the home, another aspect of our study focused on what the social relations were within and outside of it, and how all of this relates to our participants' feeling of home (ibid.). A particular social issue that we were aware of prior to our study and thus included our initial breakdown for our interview guide, was stigmatization, often resulting in various social issues in relation to family, friends media or work, which have to be negotiated as a part of everyday life (DSI & SFI, 2010, p. 7, 61). We were interested in how they used their everyday activities and home as a site for social negotiation of their recovery and disorder (Borg & Davidson, 2008; Ulfseth, Josephsson & Alsaker, 2014).

Finally, being as attentive on the context as possible did not make our study transactional in and of itself: as Lucius-Hoene & Deppermann (2000) asserts, and as we have previously noted, one's entire study is an ongoing part of the analytical process; making the final analytical approach essential to the actual output of the study (ibid., p. 206f, 217). While this seems commonsensical, we observed several instances of research (e.g., Case, 1996; Coolen, 2006; Chow & Haley, 2008; Lindström, Lindberg & Sjöström, 2011; Manzo, 2005; Sixsmith, 1986) that had often been both situated in people's residences, delved into home-meaning in a myriad ways and had people negotiating what home meant to them, yet refrained from looking at these rich negotiations as examples of emerging meanings. Instead, they used thematic analysis, ending up with lists of meanings that were detached from the everyday life from which they stemmed, instead of elaborating how those meanings were accomplished. That is not to say that these studies somehow “got it all wrong”; their approaches made sense within their respective theoretical and methodological paradigms. The important lesson for us to take to heart, however, was that our analytic approach had to reflect what we had attempted to do all along, namely conduct a study in a transactional manner and focus our analysis on the construction of the meanings that people communicated, and less on the meanings themselves.

This section has been used as a space to detail what a transactional study meant to us, as well as to discuss our methodology through previous work done in the field, while still adhering to the theoretical outline argued for in *3.3. Our*

underlying theoretical discussion. Following Højlund's (2006) advice of seeing home as a multifaceted phenomena (ibid., p. 100), we have looked at how we sensitized our interview based method to the four aspects of the transactional approach. This meant firmly grounding ourselves in the physical and social aspect by using an interview method that emphasized the relational aspects of the physical and social everyday life within the situated context of participants' residences. We considered the temporal aspect of the phenomenon by exploring the possible mutability of "home", looking for changes in time both in our participants' historical constructions of their meaning of home, e.g., in relation to prior and post treatment, but also in little differences within our interview itself. Underlying all of this was the assumption that the psychological processes were an implicit, emergent property and prerequisite of the microgenetic process of how the person relates to "home" and makes sense and meaning of it in talk.

4. Gathering and working with participants

In the following, we elaborate on the process behind gathering our participants, from formulating our inclusion and exclusion criteria on the basis of existing literature and practical considerations. Afterwards, we look at how we got in contact with prospective participants, handled their anonymity and, finally, to the legal and ethical aspects of our choice of participants, ending with brief summaries of all of them.

4.1. Initial criteria

Following our work in the 9th semester project, we had a relatively clear idea of what kind of participants we were interested in for our interviews, sticking to a very broad conceptualization. We were interested in current outpatients of both sexes, who may or many not be former inpatients. Of chief importance was that our participants were in some way going through a transition of being diagnosed and receiving institutional treatment within their home context and everyday life. Particular diagnoses were neither reason for selection or rejection; to us, their conditions are an intrinsic part of their experience of home and everyday life. What was important to us, however, was a certain length of residence within their residence, seeing as how the relation to place and home seemingly emerges as a process over time (Kyle & Chick, 2007; Smaldone, Harris & Sanyal, 2008). Due to this, we focused our attention on people who had lived in their residences for at least half a year, in order to have at least some amount of time to relate to it. Following Manzo (2003 & 2005), this is naturally an arbitrary limit to a highly individual process, where some might never come to consider their residence as “home”, but in general, as, e.g., Hidalgo & Hernandez (2001, p. 279) and Manzo (2005, p. 74) herself has shown, both attachment and identification is a product of exposure and experiences within the setting. Furthermore, we also settled on a maximum age of 65 years for our participants, due to the fact that advanced age perhaps very naturally can be seen as a physical, social and mental detrimental factor all on its own,

entailing various challenges in the relation to home (Oswald et al., 2007). Challenges that, while worthwhile to explore, were not our primary interest and, furthermore, the majority of Danish psychiatric outpatients lies within this age ratio (Det Psykiatriske Centrale Forskningsregister, 2013, Table 10).

Setting out to do our study, our inclusion criteria became current psychiatric outpatients (who may or may not have been previously admitted), between the legal age of 18 to 65 years of age, who currently have some manner of housing or residence, with which they have had a relation for at least half a year. Due to the scope of our thesis and our interest in doing in-depth qualitative interviews, we settled on a small number of interviews. Our exclusion criteria were born of practicality and feasibility in the sense that we used geographical criteria (focusing on Jutland) to settle on the final number of five participants.

4.2. Getting in contact with participants and selection

The process of getting in contact with participants took place in the early days of January 2015, while the actual interviews were mostly conducted in February, with the exception of our pilot interview in late January. The initial contact process for the pilot was facilitated by a mutual acquaintance, with whom we had briefly spoken about our project idea. In order to give the prospective participant some idea of our project, we quickly wrote down a brief introduction of our project, inviting her to take part in Master's thesis research on what home and everyday life meant to her as a psychiatric outpatient. At the same time, we also introduced us by name and as psychology students at Aalborg University, along with contact information. After the participant had read our introductory paper, she contacted us by phone, where we settled on an interview date.

Following the pilot interview, we broadened our search for participants, using email to contact both the national and local Aalborg branch of *Landsforeningen SIND* (a major Danish NGO for the mentally vulnerable people, their relatives and health professionals, with a variety of offers and roles; refer to www.sind.dk for more information), as well as *Landsforeningen af Nuværende og Tidligere Psykiatribrugere* (LAP in short; Danish NGO consisting of current and former psychiatry-users, functioning as a common organization for their interests; refer to

www.lap.dk for more information). In our email correspondence, we briefly outlined the purpose of our project, who we were and why we contacted them; i.e., in order to get in contact with outpatients either in their network or by allowing us access to their communication channels.

SIND contacted us again, promising to post a brief introduction of our study on their national Facebook page as a platform for reaching their members. In Denmark, Facebook is in many ways a perfect tool for recruiting participants in a wide variety of topics, since about half of the national population are active users there, with the majority of users being in the age ratio that we were searching for (Danmarks Statistik, 2014, p. 19). By establishing the contacts through SIND's page, we were thus connected to a particular segment of the population that might have an increased interest in both the subject and participation.

We formulated the introduction write up with our contact information along the lines of the one used for the pilot, subsequently getting it posted on their page. It was a difficult balancing act. We wanted to ensure that our participants knew what they were getting into and would not feel as if they had not been properly briefed and prepared, while also attempting to emulate a more natural conversational encounter than a rigid interview session, allowing a space for talking about a potentially difficult subject such as treatment and everyday life (Kvale & Brinkmann, 2009, p. 32; Taylor, 2010, p. 6). Our introductory write-up can be found in *11.6. Appendix F* (Danish and English version).

We were contacted by 11 prospective participants through both email and Facebook messaging. They were from all over the country, prompting us to use their geographical location as an exclusion criteria, focusing on the Jutlandic peninsula. This lowered the number of possible participants to six. One of these never replied our confirmation email, giving us five participants.

The final make up of participants was one man and four women, ranging from 29 to 45 years of age, all of them living in their own apartments. Their life circumstances, which will be elaborated in *4.6. Summaries of participants*

4.3. Contact with participants

Our contact with the participants was quite varied. In our introductory write-up, we had given the participants the option of briefly introducing themselves, if they were so inclined. Some wrote long introductions, while others kept their first words relatively few. After we had arrived at the final five participants, we sent out acceptance emails to them, whereas we informed the others that they would not be included in the present study, but also asked them if they might be willing to participate at a later date in case of any cancellations. Some agreed and were registered for possible, later use. This never became relevant. The following contact with our confirmed participants was short, mostly detailing the practicalities of the interview, but one asked for further information about our project, which we obliged. We were open to answer most questions that they might have about us or the project, since we wanted to convey a sense of openness and mutual trust that might lay the groundwork for a more equal interview situation, where we would become active co-constructors of the setting (Hatgis, Dillon & Bibace, 1999, p. 19ff; Kvale & Brinkmann, 2009, p. 33). This, however, was not relevant before the interview situation itself, which will be further expanded in *5.2.1. Relation between interviewers and participant.*

4.4. Legal and ethical status of participants and thesis

Working as we are, with a potentially vulnerable group of participants that are also part of an official system, due to their treatment regimen, it was important for us to ensure that our conduct was legally and ethically sound. Not just with our conduct in regards to participants, but also in relation to ethical issues throughout the process, from the conception of the study to its publication and possible impact (Kvale & Brinkmann, 2009, p. 80f). This meant making certain standards and living up to them throughout the process. There were two concurrent tracks in this; an official one and a more personal one.

Looking at the official track first, psychology Master's thesis projects in Denmark are not subject to application within the usual systems for evaluation of ethical and legal matters in the Danish research system, called *Videnskabsetisk*

Komite (VEK) or the local *Humanistisk Fakultets Research Ethics Board* at Aalborg University. First of all, because they are not health science projects in the sense that they are not included in the usual scope of application required projects (refer to §14, stk. 2-5 of *Lov om Videnskabsetisk behandling af sundhedsvidenskabelige forskningsprojekter;* in English: Law of science ethical evaluation of health scientific research projects; Retsinformation, 2011). Furthermore, being a student project and not officially conducted with or for the university, they count as private projects (refer to §2, stk. 3, nr. 5 of *Undtagelsesbekendtgørelsen;* in English: Exception Act; Datatilsynet, 2012), and as long as the participants expressly confirm their participation, their information may be used. This was ensured by charting up a consent form, supervised and approved by our supervisor. This was also part of our more personal ethical awareness, in that we wanted to inform our participants comprehensively about the aim and methodology of our study, both prior to and after the interview (Kvale & Brinkmann, 2010, p. 32f). The form, which can be found in *11.7. Appendix G*, briefly summed up the purpose of the study in broad terms, informed the participants of their rights in the interview context, ensured the permission to take pictures and so on, followed by signatures by both participant and primary interviewer (ibid., p. 89). All of our participants, being of legal age (over 18 years of age) are fully capable of consenting, their current psychiatric condition and treatment notwithstanding, seeing as they are outpatients engaged in recovery within their own homes. Furthermore, as another part of our own standards, we wanted to ensure that their contribution was handled confidentially and anonymously, a process which is detailed in the following chapter, as well as in *7.3. Writing ethically.*

4.5. Anonymization and handling of sensitive data

Anonymization of all of our participants was important to us for a variety of reasons, but primarily due to both personal and professional standards. On a personal, we were well aware of dealing with a potentially sensitive group (psychiatric outpatients) concerning a sensitive subject (in part, their treatment, illness and private home) (Kvale & Brinkmann, 2009, p. 91) and that we had promised complete anonymity as part of our consent form. The qualitative interview as a site for research has the advantage and disadvantage that it can provide openness

and intimacy to the extent that some things may have been said or brought up that might later cause regret for the participant, testing our sensitivity to both how far we could proceed in the interview session, but particularly in our after-session reflections (ibid, p. 92f). Some of these reflections regarding the interview session will be further discussed in *5.2. Interview context*. Throughout our transcription process, this sensitivity meant that we would continually remove names, place names or other potentially revealing information, substituting it with small comments to retain the sense of what was spoken, like [city nearby] or [childhood friend]. When our interviews had been transcribed and the transcriptions had been checked, we deleted the audio files from both computers and the phone initially used to record them. The photos and transcriptions were kept on our personal computers and exchanged between us using a dedicated USB-hard drive. Emails and Facebook messages were also deleted to the best of our ability, although contact information was retained, in order to be able to provide our participants with our article. Lastly, all of our participants had their names changed to Px (x being a number from 1-5). The reason for not simply choosing a pseudonym (like Karen, Thora or the like) was that pseudonyms are not neutral labels; like all words or names they carry sociocultural associations, like age, class and ethnicity (Silverman, 2007, p. 15f, 31; Taylor, 2010, p. 7), implicitly providing either incriminating clues or simply "noise" in our presentation. Furthermore, as Taylor (2010) muses, in relation to her own studies on identity work, "[...] a name [or category] presents the participant like a character in a play, as having an intact and already existing identity which is presented in the talk […]" (ibid, [authors' own comment]). For us, who are also doing work on identity as a fluid construction and negotiation in talk, it seems a prudent lesson to keep in mind, as it is often all too easy to fall into the trap of describing people in fixed terms and concepts. This is one of many small attempts on our part to avoid that.

4.6. Summaries of participants

The following is a short summaries of each of our participants, focusing on their trajectories as patients, as well as their current and prior sense of home. That is not to say that they are in any way complete renditions of this; just as the original

account, it is very much selective. Another pair of interviewers might have created a different account together with our interviewees; stringing different events, facts or perspectives together (Taylor, 2010, p. 8). However, that is not to say that these accounts are wholly constructive and transient, “[it] is not a project of free invention: the different positions available to her (for example as a woman in a certain life situation), the assumptions and values attached to these positions and the ways she is seen by others all limit or constrain her identity work” (ibid.). Thus, the summaries are included to give a general sense of the people that we talked to and to provide an overview of some of our background knowledge during the analytic process. Given the structure of our analysis, where different narratives were studied together, the cohesive overview of each participant might have been muddled, which we attempt to alleviate somewhat here.

P1:

A 41 years old woman, who has lived for twelve years in a group home institution. She is diagnosed with paranoid schizophrenia with a borderline personality structure and feels that the diagnosis is right for her.

Initial breakdown happened in the 90'ies, where she had been living with a romantic partner, far from home and had just finished her high school degree, while working a part time job and waiting for admission to higher education. Already suffered from an eating disorder, before being admitted due to a very low body weight and auditory hallucinations. A series of year long admittances followed, interrupted by short discharge periods in two different housing options, both insufficient for P1, who had severe issues with being alone and spent the nights at various social and community psychiatric offers. Social and professional relations would alleviate her distress for a while, but eventually she relapsed, getting readmitted. After this admittance, she got a small house that was part of a municipal offer where staff was attached in the day hours, but it still wasn't enough for her and another admission followed. After this, she got an apartment in her current group home institution, where she has lived for 12 years, interspersed with brief bouts of readmittances to the psychiatric ward. Her treatment consists of medication, psychotherapy and day to day participation in the routines of the institution and

different activities in the community. She is frequently visited by family, has many friends within and outside the institution, as well as a fiance. She relates how she is moving forward and getting better, in large part, she believes, due to the institution and its physical and social surroundings; it has become her home.

P2:

A 34 years old woman, who has been diagnosed as bipolar with anxiety and borderline traits. She is trained in the health care sector, but has not been able to work for almost six years. Currently, she is on welfare and is trying to get a place at a local day institution.

At the age of 22, she started her first treatment of psychotherapy, on and off for around 3 years due to anxiety attacks, which she also experienced throughout childhood. During her training and starting to work, she experienced some minor breakdowns, but eventually, after having a major breakdown, she began in outpatient based treatment with psychotherapy and medication. During this time, she had many failed municipal job activation attempts and more or less luck with her treatment. Eventually, she asked to be referred the local psychiatry last year. There, she got diagnosed with her current condition, and expresses it to be a great fit to her problems. She benefits well from the psychoeducation provided, but struggles more with the medication treatment.

Currently, she lives by herself in an apartment, but dreams of moving together with her boyfriend, with whom she feels that she has had her first stable, equal relationship. Her home is very much a nest to her, sometimes too much, and she is currently contemplating whether or not to invite in a social worker from the municipality as the next step of her treatment, beside the day institution.

P3:

A 29 years old man, who has been diagnosed with social anxiety and depression (due to anxiety), which he feels fits him well. He lives by himself in an apartment and is supported by welfare and holds a degree.

His symptoms started in earnest during his education, but anxiety in social contexts and feelings of awkwardness and inadequacy were stable parts of his

childhood. However, he always perceived this as ”just who he was” and had a rich social life and did well in school despite of it. During his Master degree education, where he moved to a new city and experienced many new stimuli, this changed, however, due to a variety of factors, and he sank into a depression that ended with him being stuck within his apartment in his hometown. Eventually, he sought out help and was well-received within the treatment institution, where he got an explanation for many of the issues he has experienced and was experiencing, making sense out of it as social anxiety. Currently, he attends both group therapy, medical check-ups and psychotherapy and actively uses his home as a part of his treatment, both as a social meeting space and as a place of restitution. His relation to his home has changed quite dramatically for him during his treatment, from a prison to a very positive, light place.

P4:

A 33 years old woman, who has been diagnosed with multiple diagnoses, initially diagnosed with stress, depression, anxiety, (bipolar), currently obsessive compulsive personality disorder. She lives by herself in a municipality-appointed apartment and currently receives an employment and support allowance from the municipality.

After having finished her bachelor's degree, she went on to do a Master's degree, but dropped out during the writing of her thesis due to stress, after having extended her studies for quite a few years. During this time, she sought out treatment herself at a psychologist, who eventually referred her to a psychiatrist, ending in a winter 2009-2010 inpatient psychiatric admittance for about four months, due to massive suicidal thoughts and plans. During this period, she lost her apartment and was forced to move out. Her stay at the hospital helped her with her suicidal thoughts, but did little to alleviate her basic problems and she felt let down by the staff. She was discharged to live with her sister for a while, which was stressful due to a variety of factors, before being offered municipal housing, where she currently lives. After this, she was told that her treatment options within the system were depleted, beyond the help of a social worker to help her in her everyday life. In time, the social worker helped her seek out both a social cafe for outpatients and more

treatment from the local psychiatry, where she finally got diagnosed with her personality disorder, which she feels fits quite well. Of her own volition, she has also sought out a coach, who helps with the more practical aspects of her treatment, beyond the medication and psychotherapy offered as an outpatient. For the first time in many years, she is seeing improvements in her condition, especially in her relation to her home, where she is working intensely with her everyday activities.

P5:

A 45 years old woman, who was previously diagnosed with depression, which was changed to bipolar in 2014. She lives with her youngest son in a municipality-appointed apartment. Trained in the health care sector, she currently works the night shift with special attention paid to her work hours, allowing her a good deal of free time between working days to minimize stress. This was possible through active negotiation on her part and she is generally very open about her diagnosis and treatment.

She has had depressive episodes and suicidal thoughts since being a young child and had a tumultuous childhood in general. She got married and after the birth of her first child she experienced a birth psychosis and started treatment with medicine, being treated for depression. Later on, she was divorced from her husband and shared custody of their now two children, kept on working and dealing with her everyday challenges. She had severe side effects from a wide variety of medications, which have been very detrimental to her everyday life and work. Work is her main anchor in her everyday life and very important to her. Some years ago she suffered a breakdown, where she was briefly admitted and quickly discharged herself because she felt deindividualized and powerless in her treatment there. Subsequently she has been offered outpatient based treatment and been rediagnosed with bipolar disorder and has undergone heavy medical treatment, as well as psycho-education, the latter of which she has been very happy about. To her, home is very much a shared thing between her and her youngest son who lives with her, their daily routines being an essential part of how they manage both their everyday lives and her sense of home as a positive place, quite different from what she used to feel in her old marriage and prior to treatment.

5. Empirical Work

This chapter covers a broad span of our process, from the conceptualization of our first interview guide and pilot interview to the following revisions of our guide on the basis of the pilot and the subsequent interviews. Beyond that, it delves into several complexities of our work and our thoughts on these, among them our relation as interviewers and participants, doing work in people's own homes and with a particular group of people with psychiatric diagnoses.

5.1. Interview guide process

In preparation for the interview sessions, a semi-structured interview guide was formulated (Tanggaard & Brinkmann, 2010a, p. 37), starting with our initial version for the pilot interview. After the pilot, we did a thorough revision of the initial version; the original can be found in *11.8. Appendix H*. An English version of the revised version can be seen in BOX 2, while the orignal Danish one is included in the aforementioned Appendix. The new version was tweaked and changed in small ways throughout the remaining interviews, as we gained more knowledge of what was important for our participants and how these issues and reflections might be able to provide more aspects to our analysis. These questions were added as addendums within our already established overarching themes or as slight rephrasings of our initial questions.

For the pilot, we were very mindful of the home context, keeping most of our focus on it to the possible detriment of the rest of the interview. We started out with a very brief introduction about the project, then turned shortly to the participant's treatment history, before going deeper into questions about the home context and what she did there, followed by her treatment trajectory and its influence on home. Initially, we had anticipated using a direct application of the walking method from *3.4.3. A transactionally minded study*, but had to refrain from it. Her apartment was very small and cramped, our interviewee was a heavy-set woman who had recently hurt her leg and, while it might have been interesting to explore the institution and its facilities, there were several ethical and practical implications in doing so.

Instead, we attempted to include questions that directly related to her use and

activities within her apartment, with various degrees of success. In our eagerness to avoid meaning and feeling questions, and concentrate on "doing", we emphasized the physical aspects of home without any particular context, hoping to elicit small stories or openings for broader stories, asking questions about random objects in her residence. While this provided small, interesting stories, it told us little about her relation to home or treatment and more about her fondness for particular animals. Taking a cue from Kvale & Brinkmann (2009), we struggled to provide a clear structure and sense of progression, as well as how to apply our method (ibid., p. 188f). This discussion is elaborated in *5.2. Interview context.* One example of this can be seen in P1's interview, where we have just been talking about her daily activities and we attempt to turn our collective attention towards the environment we are in (P1, 1183-1139, Danish version in *11.1. Appendix A*):

R2: I don't know if we like look a little more at the physical surroundings here I mean why have you arranged your residence the way that you have or like? Is there any particular reason that you have placed your bed over there for example or?

P1: it is because I want to [small laughter] have air when I

R2: hm

P1: I need air in the summer

R2: yes

P1: so I want to lie by the window

R1: hm

P1: so so I think, before it was standing differently then I just felt like I wanted to have it standing like this

R2: when,after after that thing about the smoke damage

P1: yes

R1: hm

The issue was in large part that we started out from the physical, activity based level, in this case the arrangement of her apartment, with too much attention paid to the objects themselves, instead of the larger context of her everyday life, treatment and home. As we moved forward to an actual interview, we found ourselves struggling with how to bridge the theoretical divide into actual questions that would work in an interview setting. This lead us to two conclusions: one, a clearer connection between theory and practice, which we have tried to convey throughout chapter three. Furthermore, we also needed a revision of our interview guide and our use of the walking method; holding onto its contextual focus, but

deemphasizing an explicit need for “moving around in the context”.

Going back to the drawing board for the remaining interviews, we tried to reaffirm what was essential for us by creating a breakdown of the different aspects and themes of home, everyday life and identity that we needed an answer to (Kvale & Brinkmann, 2009, p. 126f). This was based on the different aspects of home, everyday life and identity we had found in our review of the literature and studies. At the same time, we also detailed how we might use our methodological tools more actively in pursuit of these.

These different aspects were explored through observation and note taking (writing down what was clearly evident in the physical and social surroundings), as well as post-interview notes about personal and professional impressions about setting, interview process and personal thoughts, and photographs of the residence. Refer to BOX 1 to see the breakdown, as well as our coding system for which aspects of our methodology that were supposed to be part of answering which point.

BOX 1: ***Interview Breakdown***

Tools short term:
(ON) = observational notes
(PN) = personal notes
(PH) = photographs
(IN) = interview

Meaning of home and everyday life	**Conception of home and everyday life**	**Miscellaneous**

Derived from:
• Social environment (ON, IN)
  ○ Friends, family, work, community, other (ON, IN)
• Physical environment (ON, PH, IN)
• Affective and temporal relation (IN)
• Identity construction (IN)
  ○ sense of continuity/sense of change
  ○ important objects/places, etc (IN)
	Derived from:
	• Social environment
	  ○ social relations – frequency and inclusion in treatment/sickness (IN)
	  ○ Living situation (ON, IN)
	• Physical environment (ON)
	  ○ residence type, own/rent/offered by municipality, own/no transportation, own/borrowed furniture, layout of residence/community
		Personal information
		• age, gender, educational level, job situation, length of residence (IN, ON)
		
		Experience of treatment
		• Preparation for treatment or aid (inpatient and outpatient) (IN, ON)
		• Treatment (IN)
		• Their opinion of own treatment (IN)
		• Their opinion of psychiatric system (IN)
		• Medication (ON, IN)

• Routines and activities (ON, IN)
  ○ Work
  ○ Leisure
  ○ Chores
• Psychological process (IN):
  ○ Attachment: mutual caretaking bond between person and the home (beloved place) (connected to age, gender, education, length of residence)
  ○ Familiarity: processes by which people develop detailed cognitive knowledge of their place/environs
  ○ Identity: extraction of a sense of self based on the places in which one passes one's life
• Experience of sickness as a part of home and everyday life (IN, ON)
 	
Properties of:
• Changing as part of treatment? (both inpatient and outpatient) (IN)
• Importance (IN)
• Good/bad valence (IN)
• Home as special place (IN)
	(more??)
	• Affective relation (IN)
	• Identity construction (IN)
	• Routines and activities (IN)
	  ○ job/educational situation, transport to and from places, family life, domestic activities (chores, hobbies, subsistence, etc.) → an ordinary day? (organization, planning, negotiation, etc.)
	• financial status in everyday life (IN)
	  ○ single, single-parent, relationship, welfare payments, other support
	
	Properties of:
	• Changing as part of treatment? (both inpatient and outpatient)
		• Social consequences (IN)
		• Meaningful objects/aspects of the home (ON, IN)
		
		Experience of disorder
		• Social/physical/personal consequences (IN)
		• Diagnosis (IN)
		
		Experience of transition (IN)
		• Changes in home perception
		• Changes in self perception
		  ○ own and others
		• transition of being well/not being well
		  ○ experiences in everyday life
		• transition from treatment to home
		
		Experience of interviewing in home
		• role negotiation (IN, PN)
		• affective negotiation (PN)
		
		Other roles/identity beside being a patient? (IN, ON)

The breakdown was not meant to be “complete”, nor a comprehensive system for understanding the interplay between the different aspects, but rather to provide us with an overview of what each of our tools might be best used for, as well as what would be essential for us to seek answers to in our interviews. In this way, we could, at the very least, take measures to avoid too many of the previous pitfalls. It was an open structure, where we constantly added or tweaked smaller things as they became relevant in the different interviews – essentially helping us see the forest, as well as

the trees. This allowed us to set up a range of overall research questions that could be broken down into interview questions (Tanggaard & Brinkmann, 2010a, p. 38f; Kvale & Brinkmann, 2009, p. 152f). From this, we built a progression that we felt would encapsulate the interview points, e.g., the IN-points, while we also wrote down what the observer should be aware about in their role, e.g., the ON-points. The role of the observer, as well as the experience of doing it, is further explicated in *5.2.2. Observation, notes and taking photos.*

The questions were divided into overall themes: *Intro, Core Questions, Admittance, Outpatient Treatment, Everyday Treatment, Other Questions, Conclusion* and *Debriefing*, with several underlying questions and a series of FAQs (Frequently Asked Questions) that we used to as our "go-to-questions" for broadening bits of the interview.

For the actual interview, we settled on a booklet design, with a front page where we could write Interview Participant No, Date and Length of the Interview. For all eight pages in the booklet, the left page listed questions, while the right was left blank for observational notes, follow-up questions and small drawings of the surroundings. This was done in an effort to make it as accessible as possible and easy to go back to and find our notes in our analytical process. During the interview, it would also also provide an easy overview of our questions and our progression. It also allowed space for continual revision of questions during the interview process.

The revised interview guide can be seen in BOX 2; questions added during interview process are marked in italics.

BOX 2: *Interview Guide 2.0*
FAQ (Frequently Asked Questions): • What happened? • When did it happen? • Why? • Who was there? • Do they know anything about your treatment?
Introduction: • Role distribution • The purpose of our study • Consent form
Core questions: • Personal information (name, education, age, diagnosis) • Could you tell us what initially made you seek treatment and diagnosis?

- When did you or anyone around you notice issues in your everyday life for the first time?
- What was your life like when you got sick? How did you experience your disorder at home and outside home?
  - How were you treated?
    - Did you bring along any items while treated?
  - How are you being treated now?
    - Do you bring along any items now while being treated?
- How do you feel your treatment in your everyday life?
- *What does home mean to you?*
- *Has your treatment/illness trajectory changed your perspective on what home means to you?*

Inpatient treatment:

- What happened when you returned from your admission?
- What was it like coming home?
- How did the staff prepare you to go home and have your everyday life?
- What challenges have there been in coming home and your treatment?
  - Medicine (the consequences of it in relation to both everyday life and physical surroundings?)
  - social relations
  - routines/habits, that had to be changed/has emerged

Outpatient treatment:

- What do you do when you have to go off to outpatient treatment? And afterwards?
- What has been the most difficult in your treatment?
  - Medicine (the consequences of it in relation to both everyday life and physical surroundings?)
  - social relations
  - routines/habits, that had to be changed/has emerged
- *Has your perspective of yourself changed as part of your trajectory?*
- *How do you feel about your current treatment? That it became that?*
- *Practical considerations reg. treatment:*
  - *where is it?*
  - *how do you get there?*
  - *what does it mean in your everyday life?*
  - *how do you experience your treatment?*

Treatment in everyday life:

- What do you do before the social worker (home based treatment) comes to visit you?
- What does the medicine mean to you in your everyday life?
- Have some aspects in your residence been important to you in your treatment?
- Where do you spend the largest amount of time? When you feel good/bad?
- What is your opinion of the psychiatric system, based on your experiences?
- *How much time do you spend in your head?*

Other questions:

- What gives you the feeling of home? Is it in your residence?
- How does it emerge for you?/or not?
- What does a regular morning/day/evening/night look like for you?
- What role does your financial situation play in your everyday life? (How do you make ends meet?)

Conclusion:

- We have talked about most of what we wanted to ask about...
- Is there something you would like to expand upon/add?

Debriefing

These themes all served distinct purposes, and were envisioned in three subsequent phases. The semi-structured nature of the interview guide meant that we went fluidly between them and some questions or areas that emerged in the interview received more attention or appeared in a slightly different order than here, e.g., a deeper investigation of the inpatient admittance than planned in the guide.

- *First phase*, which encompasses "Intro" and "Core Questions", where we started out with an introduction of us and our different roles in the interview, as well as an re-introduction to the study and the signing of the consent form. A barrage of questions followed starting out with personal information and delving into broader questions regarding disorder and treatment history as well as basic feelings of home. Part of the introduction was an emphasis on their perspective and that no answer was inherently right or wrong, nor too trivial. We believed that starting out with both personal information and these bigger stories would be a good way to ensure a context for the rest of the interview, as well as allow for a familiarization to happen between interviewers and participant, alleviating stress or anxiety.
- *Second phase*, which encompasses "Inpatient/Outpatient Treatment" and "Everyday Treatment", where we delve deeper into the disorder/treatment trajectories that our participants have experienced. Here, we either focused on their inpatient experience (which was relevant for two of the four participants) before moving onto their outpatient treatment, or skipping straight to the outpatient questions. Another big part of this phase was delving into how they experience treatment in their everyday life. Part of this phase was a focus on the physical surroundings; letting ourselves be inspired by the physical context around us to shape some of our questions; e.g., noticing medicine in the living room, and framing a question around placement of medicine or talking about the kitchen and daily chores by referencing dishes, etc.
- *Third phase*, which encompasses "Other Questions", "Conclusion" and "Debriefing" was used for looking at aspects that might not have been touched upon in the rest of the interview, as well as giving space for final remarks/addendums by the participant. We concluded with a talk about the

project, our theoretical standpoint as well as smaller discussions about psychiatry or society in general. This phase varied considerably between participants. It was also the part of the interview where we would take pictures and get more thorough tours of the residence, prompting small follow-up questions.

After the interview, we would then spent about half an hour writing down post-interview notes, which is further detailed in *5.2.2. Observation, notes and taking photos.*

In all, the interview guide process was an organic, but sometimes stressful one; with big changes from the initial pilot version to the one used for the rest of the interviews, in both structure and content. Through a breakdown process of our research question, methods and the reviewed literature, we found a more solid foundation from which to build the revised interview guide, which has been examined throughout. How this worked out in the actual interview setting, as well as our relational work between us as interviewers and the participants, are elaborated in the following sections.

5.2. Interview context

The following sections elaborate on our reflections on the interview context as well as our relational work there. This is done in an effort to follow Mishler's (1986) thinking that a greater focus on the interview situation and process is an essential part of a good, qualitative study (ibid., p. 248), in order to understand our collected narratives and their underlying co-construction more fully. A few excerpts from our transcriptions have been included where appropriate.

A big part of the interview context was our own stance as interviewers and our conduct in the situation. Informed both by our own sense of respect for our participants and by Kvale & Brinkmann's (2010) wide range of quality standards for the “ideal” interviewer (ibid., p. 188f), we saw it as particularly important to be friendly and sensitive in the interview context. Both because our interviews in large part concerned both diagnosis, treatment and the everyday lives of our participants, but also because the interview took place within the context of our participants'

homes. This required a greater sensitivity to the boundaries of this public and at the same time private and intimate setting, than if we had done the interview in a nearby cafe. We wanted to ensure that they felt as comfortable as possible, reserving some time for small talk and introduction of the home setting in the pace that suited the participant, as explained in the last section.

In the following we elaborate more on these standards and our conduct when relevant and delve further into the relation between us and our participants.

5.2.1. Relation between interviewers and participant

Going into the interview context, we had already given our own role as active participants ample thought, as evinced in chapter three, but one thing is theory, another thing entirely is to actually do the interviews, a process which was evident in *5.1. Interview Guide Process.* All of these steps were done in an effort to provide a clearer structure, better questions and allow us a space as interviewers to be more comfortable and secure in our role; establishing a better interview context and session (Kvale & Brinkmann, 2009, p. 188ff). An integral part of this was the relational work constantly going on between us as interviewers and our participants. The relational work started already prior to our interview sessions, where we documented what we knew of the participants, due the to importance of giving ourselves a concrete sense of what our initial impressions were of our participants and how these impressions might both color and inform our interview process (Lucius-Hoene & Depperman, 2000, p. 206f, 217). Some had contacted us with long, concrete stories of themselves and their treatment, while others had only given the most basic personal information, their diagnosis and a confirmation of interest. We tried to refrain from expecting a particular kind of person ahead of time in cases where we only knew the diagnosis, while the “thicker” descriptions allowed us to begin building a broader understanding of the person and already consider avenues of particular questioning. One instance was P3, who had given us a very clear and lengthy description of his treatment history. This made it important for us to discover other aspects to his story ahead of time, which may be one of the reasons why his interview was also the shortest and most structured that we conducted. P1, on the other hand had been introduced with mostly a diagnosis and an institutional home as

a context, lead to a co-constructed greater focus on “just” the patient role in our questioning and a less structured interview. This is further discussed in *5.2.1.1 Interviewing people with a diagnosis and in treatment.*

Likewise, we were also conscious of the relational aspect of the interview itself: we wanted to create a looser structure for it and let it, at least to some extent, have an atmosphere of ”just being together” in the environment and talking more as equals (Holton & Riley, 2014; Kvale & Brinkmann 2009, p. 32f; Kusenbach, 2003). Particularly since we were guests inside people's houses. In doing so, we wanted to provide the opportunity to restructure the traditional power balance in the interview (interviewer as resourceful vs. participant). We did this by including our participant more in the process (Kvale & Brinkmann, 2009, p. 95; Mishler, 1986, P. 249) and potentially giving them a sense of agency and co-determination, potentially leading to quite different stories and ways of making home. This use of a looser structure worked well, in some ways, affording a more active and dynamic approach to the environment and everyday activities there, as well as a more relaxed atmosphere to explore this. One instance is where P2 starts talking about her family situation (P2, 323-334, Claudia (R1), Casper (R2), Danish version in *11.1. Appendix A*):

R1: (6) [inhalation, looks down in the interview guide] (5)
P2: do you need to know about my background where I come from family-wise and something like that I mean what
R2: I mean
R1: yes
R2: if you want to tell a little then
R1: yes
P2: oh well yes yes it was just because it might not have any relevance but it might be
R2: yes absolutely
R1: I mean it definitely has because it is also a little like how you are in relation to your family and how that affects you today also
P2: yes
R1: so but in the scope that you want to
P2: yes

This is an instance where P2 takes the lead and brings in something that might be relevant and appropriate for her in regards to this interview, where we have just been talking a little about her treatment. We followed and encouraged this direction of the interview, trying to see what might emerge from it.

In hind sight, this approach also meant that our method itself implicitly favored a particular kind of interview person, very close to the "good" interview person prevalent in the literature (Kvale & Brinkmann, 2009, p. 187; Silverman, 2007, p. 129), e.g., one able and willing to tell a story, disclose personal information and being an active part in the interview context. Thankfully, our participants were just that, perhaps due to their treatment history leading to an exposure of the practice of "telling". The interviews were all very different; while we made a point of following the interview guide for all interviews, some interviews were less stringent than others and afforded a looser structure of questions, while others followed our progression relatively tightly. Seeing as all of our participants were very talkative, we joined them in with a mixture of guidance and letting ourselves be led, without losing control as Mishler (1986) showed to be a very real possibility with some participants (ibid., p. 246).

Throughout the interviews, we, perhaps only naturally, also found a certain personal bias, finding it somewhat easier to interview and relate to the participants who were "similar" to ourselves in their life circumstances (same age, same stage in life as students and having no children, etc.), which had an effect on the questions asked and entered into our interpretation and understanding of the story told. Looking back at our notes, it was, essentially, easier to unfold alternative stories about these participants, since we used the same references and way of talking and reflecting and some of these alternative roles were more salient (Lyotard, 1982, p. 23ff, 39f). For instance, talking about student life or establishing oneself as a young adult. When our approach worked, a sense of solidarity was established between us as engaged in understanding important life experiences, like treatment (Mishler, 1986, p. 245). This also meant engaging ourselves more than in the usual interview setting, being more opinionated and also using ourselves as references, where appropriate. This was done for several reasons: we were not, as such, worried about influencing our participants in particular ways or making them self-conscious of their answers. Sometimes, we possibly shared too much of ourselves in an effort to create this solidarity, as we attempted to use aspects from our own lives to mirror or reflect something the participant said. It worked well in the cases where we were "closer" to our participants in both relation and life circumstances, eliciting further stories and

positions, such as when we talked with P4 about her hopes for finishing her degree at some point. This turned into a lenghty discussion of the Danish educational system with a great sense of back and forth between us and P4 and an implicit understanding of each other. An interesting observation is also how a valence-change seems to have been achieved within this small discussion (P4, 1331-1364, Claudia (R1), Casper (R2), Danish version in *11.1 Appendix A*):

P4: yes eh then I have to use the part of my education that I have for something later on
R1: yes
P4: I hope
R1: yes
P4: we'll have to see
R2: yeah that's it. And it is also possible to take different master courses on top of it
P4: yes yes
R2: later on and together
P4: yes yes
R2: put something together
P4: yeah that's it
R2: along the way you could say if
P4: yes, at a later date if I mean
R2: exactly exactly
P4: when the energy is there right I mean
R1: yes
R2: mhm
P4: you could say sadly you don't get very far with your bachelor's degree today
R2: not in Denmark
P4: no no
R2: that's sorta the fun thing with Denmark
P4: yes
R2: it's a little like eh
P4: a bachelor's thesis that's just sort of a basic education it isn't
R1: yes yes
P4: it's nothing special [laughter snort]
R1: yes yes
R2: yes yes
P4: no, oh no [small laughter]
R2: and in every other country where you have to pay for it then eh
P4: then the bachelor's just woooow [small laughter]
R2: yes yes yes exactly exactly
P4: just really really big right
R1: yes

The opposite often ended up in a variety of “hm”, “yes”, silence or quick shifts into other stories, like could be seen with P1, when we compared her institutional apartment with our own experiences of student housing after having talked a bit about her apartment and what she liked and disliked about it (P1, 940-961, Claudia (R1), Casper (R2), Danish version in *11.1 Appendix A):*

P1: I would like to have something bigger but I mean... I would rather be here
R1: hm
R2: hm. I think we all almost would like something bigger
P1: yes
R1: [small laugh]
R2: but.. then I will also say that this also is a little small
R1: hm
R2: it is a student apartment
P1: yes
R1: yes
R2: in a lot of ways yes yes
P1: yes
R1: yes yes that actually fits quite well yes
R2: hm hm
R1: that is there there a lot that are of our here
R2: yes
R1: friends who live in so
R2: something like this we have also lived in for the last
R1: yes I also started out in a dorm and so on
P1: yes
R1: where I could could also come out and then I also enjoyed a lot that I could just meet some people that I knew
P1: yes

Here we attempted to familiarize and perhaps even “normalize” her apartment situation with our own living situations, but it didn't really work; there was no progression in the story, and, even while we were doing it, we were aware of how there was little basis for commonality in our stories and her everyday life. After this, we quickly changed the subject to daily routines in the institution.

This level of relation work also opened up for another concern, and one of our big dilemmas throughout: how much could we ask about and how? Where did the boundary lie in regards to ethical questioning within the interview setting (Kvale & Brinkmann, 2009, p. 196)? This was particularly an issue in cases where what was expressed by our participants would possibly lead to more questioning or emotional

reaction in an everyday conversation, such as some participants relating about childhood abuse and so on. As psychologists and psychiatric patients, this was a balancing act since both we and our participants were “trained” at conversations that might cross that boundary, inviting a greater sense of intimacy than this interview setting was intended to. Across the board, all of our participants readily used psychological jargon, which was both an aid in talking about issues of treatment and diagnosis. On a conversational level, it might also have been a contributing factor to our sense of the dialogue sometimes crossing over into a more “therapeutic” setting, whether or not that was the intention of the talker involved. Mostly, we deliberately chose to refrain from exploring such instances of talk, rather moving on to other avenues. An argument could be that we might have “missed” something by refraining to delve into aspects of our participants' experiences that they chose to divulge in our course of talk, but essentially, it was a question of what we could have learned that would have been of any use to us in answering our research question if we had actually asked (Kvale & Brinkmann, 2009, p. 197). That became our guiding principle in these instances; if sensitive issues were connected to everyday life, we might explore them more, but mostly, this was not the case.

Another line in this argument might also be that we let potentially interesting avenues of talk slip through our fingers by sometimes not being challenging enough or simply “buying” the story our participants constructed with us (Brinkmann, 2010, p. 441), rather than checking for some underlying “truth” or “opening up” their innermost (Kvale & Brinkmann, 2009, p. 189). This was never our intention, as we hope has been repeatedly clarified throughout this thesis; rather, we set out to get a thorough rendition of home and everyday life, primarily using our interview role to thicken these descriptions and reflect on them together with our participants.

Having read both theoretical and practical literature about home, as well as being home makers ourselves, we were acutely aware of the potentially ambivalent threshold we were crossing through the front door. Home is a particular setting with a different power relation than most other places; a certain “tyranny” of conduct that is normatively permitted and associated with home making, such as family routines or ways of being together (Douglas, 1991, p. 287ff). In this sense, we were very much part of a routine as “guests” in their home context, where they would be hosts;

prompting us to ask for permission to do things, while they provided food and drink for us in "classic" Danish fashion (Højlund, 2006, p. 98). We also embraced our roles as guests in the sense that we brought along a little token of our appreciation for their participation, which was part of a complex negotiation of courtesy: we wanted to give them something for their participation and for the food and drink we imagined we might be getting, since we were invited home to people (several of our guests had already asked about drink preferences in the emails!). In a normal interview, we would have provided the food and drink, here it was our participants, again feeding into a different power relationship than usual. During the interviews, it was our impression that this "host"-role also afforded a sense of agency and increased power in the participant-interviewer relationship for the participant, than usually. Most of our participants seemed at ease and very ready to talk about intimate issues of everyday life and treatment or conversely to refuse to do so, to a greater degree than what we have previously experienced in interview contexts. At the same time, for us as interviewers and guests, there were certain unspoken rules in this context, which is also something that for example Borg & Karlsson (2013) touch upon in their article concerning home based treatment and the issues of doing "professional" work in as heavily personalized a setting as people's home context seem to be (ibid., p. 113).

In much the same manner, we also experienced the home context as a special site for interviewing in the sense that it afforded this seemingly greater sense of intimacy, which was both beneficial and difficult to work with, as described above, while it also blurred the boundary for what could be ethically discussed a little more than we have experienced in prior interview settings and sessions. Instead of making some sort of rigid ethical framework or guide, we tried to be pragmatic and follow our own gut feeling with the core tenet of "respect" as out litmus test for our conduct (Kvale & Brinkmann, 2009, p. 96), just as we would do in normal human interaction, although with a keen awareness that this space was something special. As we described above, this was an ongoing negotiation.

In the following, we elaborate on our thoughts on working with people with a psychiatric diagnosis and how our pilot interview was very important for our conduct within the following interviews.

5.2.1.1. Interviewing people with a diagnosis and in treatment

Interviewing people with a diagnosis was another consideration, both in a conceptual, ethical and practical sense; specifically if it would somehow affect the interview context and how, and if, we should be prepared for it? As we wrote in our initial criteria for participants, we were not terribly concerned about their various mental disorders, because they would simply be an implicit or explicit part of how that person relates to the world, e.g., how a person diagnosed with depression might experience lower self worth or lack of energy (WHO ICD-10, 2011, p. 88f), while a person experiencing bipolar episodes could be overly positive and energetic (ibid., p. 84f). To us, however, it does not make sense to put much emphasis on the disorder per se; the person who sits in front of us is instead an active co-constructionist together with us in narrating their experience of home and treatment, naturally based on whatever referential framework they might have with them in regards to treatment, experience, life and so on (Taylor, 2010, p. 7). The disorder itself is therefore not the subject of our analysis and cannot be singled out as a determining variable of some kind in their narration, even though it might be liberating to separate the disorder from the person in such a manner. To have such a discussion, however, one would both take away the agency of the person and the seriousness of the psychiatric disorder and turn to blind guess work and some normative understanding of what psychiatric disorders might be, which we do not adhere to. Rather, what we can and will say something about, is how people construct their disorder, treatment and everyday life in relation to themselves in talk. We turn to the famous Thomas-theorem for clarity: "If men define situations as real, they are real in their consequences" (Merton, 1995, p. 380). However possibly distorted, their experiences are still real to them and the basis for their construction, as much as for any non-diagnosed population, in the effect they have on their everyday life, which is what interests us.

Beyond these perhaps more abstract reflections, actually working with diagnosed people was a more visceral and complicated experience; a difficult balancing act ethically and interview professionally speaking, in the sense that we actually had to confront these thoughts and preconceived notions in our work with our participants. In *3.4.1. Practical aspects of doing an interview based study,* we

wrote about how one of our prime aspirations were to allow our participants the space to bring other roles to play than “patient”, both through actively pursuing other stories, such as everyday occurrences, and by being open in our own focus on their stories. This was not altogether easy. An example was our interview with P1, where the institutional context permeated everything, both the narrative that we co-constructed and our impression of her, her treatment and the place in general, in the sense that it drew heavily on her dependence of the place as a patient and allowed little space for alternative stories. Looking at our notes together with our transcriptions, it is difficult to pinpoint exact spots in the interview where this happened; rather it is a general sense of how the interview went and evident in the small range of alternative stories that we found. Part of the reason for this, we believe, lies in our management of the interviewer position and the somewhat unstructuredness of our first interview guide and its lack of a proper focus, as described in *5.1. Interview guide* process. In some ways, we simply had not yet figured out what our roles were and how to conduct them, which improved with our second, more focused and restructured interview guide. We attempted to live up to the standards of sensitivity and friendliness (Kvale & Brinkmann, 2009, p. 188f), but were, in a manner of speaking, caught off-guard by this treatment-oriented context. In several instances, we ended up treating her, more or less implicitly and willingly, as we would a patient, chiefly trying to make the interview a “good experience” for her and supporting her rendition of her situation. In hindsight, it is difficult to say whether or not this was the “right” thing to do; seeing as we are not dealing with any particular truth, but rather the narratives that we co-constructed, which still drew upon her everyday life and meaning of home. In a lot of ways, looking at our notes and subsequent discussions, our primary disappointment here was how easily we ourselves ended up supporting only one role in relation to patients.

With the other participants, this tendency was less evident, perhaps due to the fact that we had a better interview guide that afforded us a better foundation, but also that the interviews took place in a more domestic and more easily relateable home context. This was an important finding to us, outside of our interview transcriptions; how much the context itself meant, not just for the participants, but also for us as professionals and budding practitioners. In these interviews, a wider range of

positions and roles were laid to bare throughout the interviews. For most of our participants, however, we still acted supportive in some instances where they described difficulties, sort of trying to build them up in a manner, which we felt was "too close" to how we might act as psychologists. Such as when P2 told us about her worries of not being admitted into the day center offer that she was on the waiting list for, and where we refer back to former sequences in the interview to encourage her (P2, 2620-2640, Claudia (R1), Casper (R2), Danish version in *11.1 Appendix A*):

P2: so I think I mean yes if I don't get into that offer there I mean then I don't know what
R1: mh
P2: then probably take some days with crying bouts and
R2: mh
P2: total downer feeling but eh... then I'll have to find out what the next thing should be
R1: yes
P2: (3) but eh I have faith
R2: mh
P2: and I have been lucky
R1: yes
P2: so far
R2: mh mh and as you have also said before then... if you hold onto your stubbornness then
R1: yeah that's it
P2: yeah that is... it is damn good that it is well-developed [small laughter]
R1: [small laughter]
P2: sometimes it is bad but eh
R2: mh
R1: but exactly on that point it is probably very good
P2: think it is very good
R1: yes
R2: mh

It is difficult to say what prompted instances like this, besides our attempt to be ethically aware, friendly and slightly influenced by our educational background. As described in the last section, this was something that we were keenly aware of not doing, particularly because it, in small, subtle ways, ran contrary to our attempt at a more equal interview relation, e.g., putting us in a position of offering "help" to a patient, further reinforcing this particular role in our talk and conduct (Mishler, 1986, p. 239). At the same time, of course, we were also simply acting as we would with

any other person expressing worry. It would, for all intents and purposes, also have seemed weird within the context of the conversation not to express any support.

The participant where this supportive relation was the least evident, however, was P5, who was also the most adamant in her own use of the role of mother, employee and ex-wife, such as when she drew on some of these positions to express how she felt normal in spite of her disorder (P5, 2159-2177, Claudia (R1), Casper (R2), Danish version in *11.1 Appendix A*):

R1: [small laughter] ehm now you use a lot the word weird that is that something you yourself experience yourself weird or is it more because you have there are others who have said ”oh you're so weird” or how?
P5: ( ) both
R1: both yes
P5: when people describe me ”you're so damn weird”
R1: okay
P5: yes I am weird
R1: mh
P5: I am not like everybody else but who is really that?
R1: yeah that is exactly that [small laughter]
P5: what is normal?
R1: yes yes
P5: (no)... we can define that
R1: mh
P5: it it I mean is it normal to manage your job? Well then I am normal
R1: mh
P5: right? Is normal that you take care of your kids, yes well then I am also normal (2) eh but but if normality is that you have no swings yes but then I am not normal
R1: mh mh
P5: but in my eyes it is abnormal no swings to have... then you also have some kind of diagnosis
R1: yes [small laughter]

She repeatedly and effortlessly drew upon and used these positions throughout our talk, making the implicit power relation difference more “equal” than the others; and not, to some degree, providing us the chance to be supportive as in the other cases. Overall, we believe that this is an interesting finding, which would be relevant and valuable to delve further into in regards to contributing to research on qualitative methods and the interview context itself. However, for this thesis, we focus on some of our reflections on what the physical and ambient context meant for our relation to our participants as patients. These thoughts are briefly elaborated on

in *6.4. Findings and their use?*

In the last part of this chapter, we briefly elaborate on some of the tools that we have used throughout the interview process and which were also an implicit part of the reflection in this section: our observational notes and photos.

5.2.2. Observation, notes and taking photos

Initially, as evinced in chapter two and three, we were keen to use both careful observational notes, post-interview notes and photo-taking as tools for recording our contact with participants, their residences, the setting and the actions of everybody involved during our interviews. Our point was to preserve some of the more tacit data of the home context that might still provide an opportunity for us to gain a broader understanding for our participants and their use of their home setting (Raudaskoski, 2010, p. 81-82). At the same time, it would also attune us to that setting even further during the actual interview process and, finally, also allow us to be more firmly resituated once we started analyzing our much contextually diminished written transcriptions (Kloos & Shah, 2009; Rechavi, 2009). Part of that work can be seen in the preceding pages, where we have used some of these as focal points for our reflections. It was, however, deviously difficult to balance the observer-role and the note taking procedure in the interview setting itself, even though we had established a small guideline for it, as seen in the article. What made the balancing difficult was the additional role as a “supplementary” interviewer, sometimes tipping over when the observer got “too” engaged in talk alone. This was a continuous negotiation between the two of us throughout the empirical process. Our individual post-interview notes were a place to write down our general impressions of both the setting, the participant, ourselves and the general interview process. As previously stated, an example can be found in *11.5. Appendix E*. These were a good vantage point for our later discussions and reflections, particularly concerning our relation with the participants. The photos were primarily used as originally planned, to resituate ourselves in the context once more, especially in the many cases where we directly or indirectly made us of specific parts of the environment in our interviews.

All in all, these tools made it possible to delve deeper than we otherwise would have been able to, providing a sounder foundation for our analysis and findings, as well as a basis for further understanding of our process; providing us with a deeper learning experience. In the next chapter, we delve into the analytical process in earnest.

6. Analysis and findings

The analytical process contained several parts and methodological considerations, which were omitted in the article and which will be reviewed here more thoroughly. First, we look at some of the considerations behind our transcription process, before turning to how we approached the daunting task of starting to analyze our in-depth interviews. Afterwards, we present more analytical example to support our findings than what was possible in the article, meaning an expansion on both our main category B (“Atmosphere of home”) with some shorter excerpt from all the subcategories, and C (“Transition of getting better”) with a longer excerpt and a thorough analysis of this.

6.1. Transcription process

The important step of analysis is, in a lot of ways, the transcription process in terms of defining the possible analysis afterwards (Lucius-Hoene & Depperman, 2000, p. 206f, 217). With our small story approach, we tried to stick very closely to the spoken words and other sounds, and included all our own remarks as interviewers, which might be excluded in a big story approach. This emphasizes that there are no big or small stories prior to this process contributing to produce them (Sools, 2012, p. 98). Furthermore, we tried to include what we remembered of certain gestures and articulations made by the involved that supported the understanding of the interview context and flow. This was important to us, because our gathered records of over nine hours of interview material already were a reduction from the original rich setting to only sound, and now from sound to text.

However, sequences from the interview that were remembered with a specific understanding could suddenly seem quite different or more ambiguous when read in written form. Therefore, the transcriptions could also enhance certain doubts of our first interpretation during the interview, and thus possibly contribute to a different richness that often can not be caught in the original context due to the temporal flow and rapid movement that does not provide the necessary time for reflections about what has been said and done in the same way.

These considerations play a great part in the final analytical process, and the

different experiences between the interview setting and the transcribed versions contribute to the reflections and understandings of the gathered data. This process is difficult to be transparent about, since it ties into our memories and reflections of the interview setting, although we have tried to capture some of them by writing down notes, and for our own process, also in that we took pictures and discussed it at length with each other.

With both the limitations and the new richness of the material in mind, our first path through the recordings followed simple transcription standards, meaning that most of the focus was on the spoken words and writing them closely to the actual saying without paying to much attention to pitch, overlaps, very short pauses, emphasis on specific words and the like. We found ourselves saying “mhm” a lot, which took quite some time to describe, but we wanted to be close to what had been said, keeping in mind our own contribution to the construction of the interview (Bamberg & Georgakopoulou, 2008, p. 393; Taylor, 2010, p. 8). We worked with these first transcriptions throughout the first steps of analysis, until we found the excerpts of particular interest that were analyzed in-depth, doing justice to our small story approach by going back to the recordings, listening to it again and following the transcription standards included in the article. The following steps are elaborated in the next section.

6.2. Analytical process

When we set out to do our study, our research interest concerned how our participants construct their meaning of home in everyday life in light of treatment and diagnosis. In order to do this, we turned to our data with a keen eye for exactly these instances of narrative construction. What followed was a lengthy process of coding and categorizing these into meaningful generic categories from the narratives constructed in the interview with our participants. As we have described in our article, we followed a sequence of steps, which we elaborate on here.

Step 1 – *Several close and repeated readings of the transcriptions to get a good overview of the material, together with our post-interview write-ups, photos and notes done prior and during the interview*: This step is quite obvious in the sense of familiarizing oneself with the material. It also helped us in writing the short

biographical summaries of our participants. Our notes were used to question our overall understanding of our participants, trying to avoid settling for just one interpretation or sense of the participants and their tellings. The photos were used to understand certain references made to the interior during the interview, and remember some details about the things that were a part of their apartments.

Step 2 – *Marking recurring features and patterns, both separately and across interviews, which included repeated words and images, assumed causal links, connections or sequences:* This is were our approach is similar to a grounded theory driven approach in the sense that we really tried to let our data "talk", making these codings as we went through it, back and forth in the interviews itself and across them (Boolsen, 2010, p. 207-208). The obvious search was of course for small stories of home, everyday life and treatment. Our participants had both similar and very different indexical and deictic uses of these themes, as well as sequential or consequential links in development in time, structure and valence. For example, we found our categories by looking for different metaphors or synonyms and how they are used, e.g. home as a nest, castle, fortress, etc.; or home-activities as wearing no make up, hitting the couch, watching TV, relaxing, sleeping, making food, eating, washing up, cleaning, getting ready for things outside of home, having social get-together, etc., and look for the temporal, structural and valence development of the stories.

Step 3 – *Generating different main categories from the relevant narratives considering our focus on small stories that connect home, everyday life and treatment, and sort them accordingly*: Together with the prior step, this one encompassed a decision of cutting the tellings into smaller pieces of excerpts that contain the narrative constructed and there fitting to the category. This was difficult due to the "nestedness" of the narratives and also the continuation of them. Guiding this "cutting-process" was the interdependent process of including narratives in the categories, and the generated categories again decided, which narratives to include.

Main category C ("Transition of getting better") was quickly established due to all participants having narratives of transitioning from before the diagnosis and beginning of treatment till now where they were more "settled in" with their treatment. The valence of these narratives were mostly positive, and with some

reference of having faced hardship, becoming subcategory “progression achieved”. Others were more ambiguous in respect to the future, and thereby generating subcategory “progression-to-be”, and so on. The other categories followed a similar differentiation process: home and treatment narrated often as intertwined (main category A: “Transition of home and treatment”), and narratives of different aspects of the participants' relation to it, like valence, attachment, certain features drawn forth, etc. (main category B “Atmosphere of home”).

Step 4 – *Rereading the excerpts of narratives included in the main categories and thus generating subcategories, where they are sorted accordingly, moved to different categories, included in two categories or where new categories were generated or they were sorted out:* As described in the former step, the subcategories in each main category were generated with a sensitivity to the structure, valence or temporal development. And the reading of narratives both generated the subcategories, but also included some rearrangements or inclusion of the same narratives in more categories, since the narratives were so multifaceted. For example, some narratives about the physical aspects of home and what activities are connected to that, also could be seen as a narrative of getting better in the sense of that the participant indicated having learned new ways of seeing the environment as an active part of the treatment (e.g., P3, 1098-1130: changing rooms helps him).

Step 5 – *Choosing examples from the excerpts of narratives from the prominent subcategories and crosschecking these with the audio files to ensure that the transcriptions were correct, changing and editing the transcriptions for precision where needed:* This was done to be able to pursue our in-depth analysis of the examples included in the thesis. Due to limited space, not all examples could be included in this thesis, even though all of them would bring certain general features (since in the same category), and also contribute with smaller unique aspects of the individuality of our participants.

Step 6 – *Going through the excerpts with a small story analytical approach, focusing on type of event, valence and sequence, before turning to levels of positioning*: This step is more thoroughly described in the analytical method section in the article, and is also what drives our analytical presentation, and can be judged there.

Step 7 – *Discussing the excerpts and findings before the write up:* This is also an essential part of our analysis, though less presentable in the write-up itself. Naturally, as part of our process, we discussed our findings, working as co-writers of this thesis. This step was also important to us, because we did not want to be blind to alternative understandings of the material gathered. In a way, since we work very closely together, this blindness could of course still manage to come through without us noticing, though we feel quite competent at questioning the convictions of each others.

Step 8 – *Translating the included excerpts from Danish to English with as few obvious changes done as possible, rather sacrificing readability than linguistic precision:* This was a balancing act in itself, which can be judged for everyone themselves, since we included the excerpt in both versions, the Danish ones being in *11.1. Appendix A*. Here, we also want to emphasize that the analysis was purely done from the Danish versions. It potentially obscures our findings and the assessment of them for non-Danish speaking readers, but in working with our non-Danish speaking supervisor this is risk is reduced in a lot of ways.

In the following, we expand further on our analytical findings that we have inferred through these analytical step, and show a broader range of our analysis with the goal of strengthening and enhancing some of the points made in our discussion in the article and the discussion that follows further down.

6.3. Expansion on analysis and findings

In this section, we elaborate on our findings by grounding and contextualizing home further through including more examples of the narratives of our five participants from the category “Atmosphere of home”. Furthermore, we include our findings from our last main category “Transition of getting better”, contributing with a firmer grounding and answer to the meaning of home in light of treatment, through looking at the positions our participants take in relation to home and treatment, and the journey they are currently on as patients.

6.3.1. Contextualizing home further

Expanding on the category of “Atmosphere of home”, as argued in the article, we primarily answer our question of the meaning of home, where treatment is more or less connected to it, on the background of the narratives in this category. By going further into the examples of narratives in the subcategories “Physical aspects”, “Activities of hominess” and “Feeling of home”, respectively, we look at what home calls for in respect to activities, chores and certain feelings, and how the physical aspects can be seen as part of this construction, and contributing to an understanding of these meanings being in flux.

6.3.1.1. Physical aspects of home

Beginning with the physical aspects of home-setting, the excerpts in *Table 4* are examples of the way the physical aspects are used in the construction of having certain rights and determination to do and decide how to administrate one's home-setting.

Table 4: Phrases used about the physical aspects of home

Privacy vs. institutional life:
“if I want to be left in peace then I just go inside [her room] and close the door and if I want to be totally in peace then I just lock the door […] and then I can in return also open my door and come out […] then there are always smiling faces that ask if we can have a talk or just a cop of coffee” (P1, 83-87)

Chaos-areas:
“in my bedroom then... all my clothes lie on the floor […] and in my extra room eeh that is also storage yes there lie piles of shoes […] my two areas of chaos […] I feel best with […] structure and order […] but this is hard for myself to maintain [...] and give myself that […] it is just out of the bedroom when I get up and hurry into bed [at night] and turn off the light” (P2, 229-245)

Getting the outside inside:
“when I'm visiting them downstairs when they can sit and look out on the street [...] I would like that […] maybe in that way I miss that there is a little more... there you get a bit more of the outside inside […] it is a little too cave-like [her apartment upstairs with sloping walls]” (P2, 2263-2268)

As briefly argued in the article, P1's living situation was quite different from that of the other participants, by living in an institution with a constant manifestation of treatment, “being home” was thus something P1 actively negotiated in terms of how the institution accommodated or promoted her sense of “being home”, and provide her with what she needs. In the example *Privacy vs. institutional life* (P1, 83-87), she can be seen as using the physical door to emphasize her relation and administration of living in the institution. The act of opening and closing one's door is very normal in the sense that it is an inherent affordance of the door. The culturally embedded understanding of what a door means, and what kind of access and permeability it allows, is used in a way to emphasize the boundaries between her room and the institutional life outside, carving out a space for her to understand this place as her home in the sense that she herself has the rights and agency to decide when taking more actively part in the “outside” institutional life and her more private “inside” life. Looking at it from a Danish context, a closed door might exactly mean that someone wants to be alone, and where this barrier is not simply broken (Højlund, 2006, p. 117f). In the context of the institution, this is special in the sense that it might be more easily broken due to the rights and position adherent in being part of a treatment institution (ibid.). This information is not directly included in this story, but from what we know from other parts of the interview, and our own experience of doing the interview (staff members were checking in twice, once for coffee break and once for asking a favor), this relation was exactly something negotiated by P1, where she expressed having found a good balance and great fondness of how things are handled there. Through this narrative of her own administration of her room, she also can be seen to carve out a place for herself to be agentive in a context that might not otherwise call for this kind of interpretation and feeling.

A somewhat similar negotiation of access and permeability of home can be seen in the example of P2's story of *Getting the outside inside* (P2, 2263-2268), where the physical window downstairs is cast as a constituting relation of outside and inside, and is contrasted to the placement of her apartment on the top floor with sloping walls not having the same accessibility. In that sense the physical setting can be seen as a certain contact face that provides possibilities for meaningful actions,

and to some extent a possibility to interact with the outside without actually being outside.

The last example is also from the interview with P2, but much more in the beginning of it, where we talk about her two *Chaos-areas* (P2, 229-245). Here, the physical setting becomes more part of a negotiation of home in regard to personal responsibility and management of it. This is further reflected in her telling of her morning and evening routine, where she is sort of shutting her chaotic bedroom out by quickly go in and out. By stating her inability and trouble in providing order and structure, it can be seen as a holding a position of more helplessness and vulnerability. In a sense, this can also be seen as a temporary shaming of herself by not living up to the her wishes, as indicated, or to what is expected of management in the home (Douglas, 1991, p. 303f).

6.3.1.2. Activities of hominess

Turning to the next subcategory "Activities of hominess", we included short versions of three stories in *Table 5* that draw forth some of the activities that constituted the feeling of *being* home for our participants. These are very mundane everyday activities as in *Candles, music, friends and tea* (P1, 1632-1638), all something that fit the cultural understanding of what "doing" home is, and the Danish context, what "hygge" (English: "to 'do' cozy") is (Højlund, 2006). In the first utterances, where P1 addresses us in the interview setting, telling us of her want to light the candles and excusing for having forgotten it, she also uses a very visible and direct speech act that affirms home-doing in relation to having guests over and creating a welcoming atmosphere. The last utterance in this excerpt also again illustrates the ongoing negotiation of how her home in the institution in a lot of ways is the same as for other home-makers.

The short example of how P2 constructs her sense of hominess in *Take off make up and the like* (P2, 1325) uses the same structure of mundane activities, here emphasizing the possibility, importance and right to "let oneself go", meaning creating a counterpart to the public sphere with somewhat reversed expectations. Home can here be seen as a construction of being a "free space", where one is able to relax due to this freedom.

Table 5: Phrases used to construct activities of hominess

Candles, music, friends and tea:
"now I have forgotten it today but to light the candles candles I would have wanted to light for you sorry […] and then some good music or some good in the TV and then back to the sofa with the blanket and relax […] or get my [friend] or go over to [her boyfriend] and be cozy […] make some tea and take with me and the like as if I was in my own apartment really" (P1, 1632-1638)

Take off make up and the like:
"so my home means really a lot it must be there where... I just can... take off my make up and yes... the knittet slippers and drop the bra and walk around in old messy nightwear and... be ugly [small snort] where I can relax" (P2, 1325)

Messy but clean:
"my home... I take pride in keeping it clean […] it is messy but it is clean […] and like that it has always been […] there are no food scraps in the kitchen and the like I can't have that […] I have never smoked either […] so in that respect I'm atypical psychiatric patient […] I might make a mess but it is not disgusting […] I get food on the table […] my son feels fine and [I] look after my job […] but my home has always stood as a base" (P5, 2098-2118)

The last example is taken from the interview with P5, where the mundane activities of managing home and keeping it clean is somewhat differently constructed in terms of using it for positioning herself as responsible home-maker, atypical psychiatric patient, working and providing mother. Home-management can here be seen more clearly as a resource in identity work. In this short excerpt, P5 connects some her dominant positions that are drawn forth in the interview with us to the home-setting, and home as a central part (as base) for these different identities that come together here.

6.3.1.3. Feeling of home

From the last subcategory "Feeling of home", we included two examples in *Table 6*, these narratives convey a certain feeling of home through creating a contrast between before and now, and by using a synonym of home affording different interpretations.

The first is reflected in *Home before and now* (P3, 435-441), and very eloquently reflect the transient character of home by this telling of home as a black hole before and how light, resourceful and rewarding it is now. It is in this narrative

shift of valence that the meaning of home is constructed as this feeling of well-being. By using a strong comparison of home to be a little like a prison before, this effectively provides an impetus to strengthen the feeling of home as this positive place today. As well as, this can be understood as a way for P3 to create a space for him to contrast himself through the activities from before to now, it can also be tied to conveying a sense of agency, or getting this agency back.

Table 6: Phrases used to construct a feeling of home

Home before and now: "It is very funny to think about because I like remember it really as a black hole […] now I think eh I love to live here it is light […] it is weird because it is the same place after all […] where home earlier was a prison to me a little home is now the place where I when I have been out and do all those thing which I know are good for me then it is here I go [to and give my self permission to] relax and enjoy it and be cozy" (P3, 435-441)	*Home as a nest:* "[home] is a nest […] sometimes a little too much […] that is yes the days where I like... isolate myself or how to say it the days where I sort of don't bother other people […] which isn't as much as it has been" (P2, 1332-1340)

The last example, *Home as a nest* (P2, 1332-1340), is similar in the sense that there is the same temporal development in the story (negative to positive), but with a weaker framing of contrast. The word "nest" as a synonym for home is multi-layered in its use her, where it both affords her the comfort of being alone and safe, but also the risk of isolating oneself. In similar ways as P1 used the affordance of thephysical doors to understand her relation to the institution, here, the home as nest and overall setting is used to understand her actions of both seeking peace or distance to other and sometimes getting to much of it. Her remark on that this is not the case as much as it has been, is a way to soften this negotiation, and it can also be seen as conveying a position for P2 to be on a path of getting better. The transitional construction and movement of getting better as patient, is something we delve deeper into in the next section.

As a final comment on the subcategories in this section, we shortly want to draw some attention to the general "nestedness" of narratives in talk, from small

stories being part of bigger stories to the whole context of these communicated narratives. As one example, it can be seen in P2's stories in “Atmosphere of home” that are part of a longer story, but were divided by us into two parts. The first part is included in “Activities of hominess”, where she talks about how home is a place for her to *take off make up and the like* (*Table 5*), and being able to relax, whereas the other part is included in “Feeling of home”, where she continues with a description of her *home as a nest* (*Table 6*), and how it at times can be too much of a nest. Both stories are in themselves a continuation of each other and nested in a bigger story that together contributes to the collection of stories to understand the “Atmosphere of home” as these different aspects, together contributing to an answer of the meaning of home.

6.3.2. Considering transitions of getting better

Through our analysis, we also generated the category of “Transition of getting better”, which deals with how our participants construct a sense of getting better in talk with us. This might not be a surprising finding, considering our participants' standpoint in treatment. However, all our participants narrated some clear indications of having accomplished a change for the better in their everyday life, which is a finding in itself in the way that casting everyday life activities as a measurement of well-being, contrasting more medical explanations like reduction in symptoms. Thus, this type of narrative is another answer to our interest of how our participants construct a meaning of home in regards to their treatment. To further elaborate on this finding, we include our prominent subcategory “Progression achieved” as representative of this main category. In the following, we provide a longer analytical walk-through of this category to both show the scope of our analysis and to elaborate on the connection of home and home-management and being a “good” psychiatric outpatient.

6.3.2.1. Progression achieved

The similarities of the narratives of “Progression achieved” are found in the construction of being able to better deal with certain aspects of home and everyday

life that were a struggle before treatment. Here, our participants draw on their own development, acceptance, therapy-achievements, gain of knowledge or help from a social worker as explanation, as well as casting descriptions of struggle as a thing of the past by either uttering them in the past tense or often by using an active now-then dichotomy comparison. Furthermore, in the use of certain phrases, they refer directly to their own involvement, or lack of it, in this accomplished transition, of which some examples are shown and organized in *Table 7*.

Table 7: Phrases used about own involvement in ”getting better”

Passive involvement	Direct involvement
“somehow I moved past this”	“I have gotten much better at”
“it sometimes gets better”	“that I'm getting quite good hold on”
“he got me started”	“now I have the strength to crawl back up again”
Acknowledging involvement	“I haven taken a turn for the better”
“I just got to the point”	“I have taken what works for me”
“I got more aware of”	“I have accepted that this is the way I am”
“it works good for me”	
“I must accept it”	
“that you get out [away from home] is important”	

These different examples help us to understand the variety of ways of how this accomplishment can be framed and how this framing can create different positions to, on one hand, be able to take credit for it and convey a sense of agency over one's situation and, on the other hand, take a more passive position that conveys a sense of being lucky or unknowing of what has happened. From this, these narratives can be seen as different ways to negotiate being a “recovering patient”.

One example of this type of narrative is from the interview with P5, who lives with one of her two sons and has an overall narrative of being able to manage her life

through utilization of very strict routines when things turn rough, her routines help and save her, as she puts it. The excerpt takes place during the latter half of the interview, where we just had a longer talk about how she sees her disorder originating and how she and her son are managing at home. Here, we cut in when she evaluates on that (P5, 1897-1916, Claudia (R1), Casper (R2), Danish version in *11.1. Appendix A*, transcriptions symbols in *11.4. Appendix D*):

P5: well I can {feel=
R2: {mh
P5: =the things at home they just run... so well
R1: mh
P5: that is the conflicts are few... and those that are are short
R1: mh
P5: much shorter than they have been for many many many years and that is in spite of that I for the last half a year have been incapacitated if one can say so
R1: yes yes yes
P5: because I have simply fought a daily fight with myself that is just to get started with the routines has been... hell
R1: mh mh
R2: mh
P5: but when I had taken a shower then I also knew that then I felt a little better... when I had got my coffee you know
R2: so it was a lot like in that way... you got started with the routines
P5: yes
R2: {somehow
R1: {and motivated yourself with, on some other level?
P5: yes {because I knew that... ah when you have taken a shower then you feel=
R1: {yes
P5: =well again {right=
R1: {mh
P5: =or you feel better ”so have you got your coffee?” [said in the son's voice] {like that
R2: {mh
P5: emphasize the positive in those things there right
R2: mh mh

Overall, this can be described as an event of overcoming hardship. This is accomplished through P5 setting the stage and presenting that it has been very hard for her to realize her routines (which are so essential to her), and further by us, as interviewers, through engaging in her story and reflecting our understanding of it in our question of it being the motivational factor for her.

Looking from a semantic level, this event is set in the home-setting. This can directly be seen in the beginning by P5 statements, such as “at home”, and further along in “daily fight”, “taking a shower” and “getting coffee”, activities strongly associated with home. The coffee-drinking, when seen alone, could be taking place in

a lot of other settings as well, but through the sequence of this talk, it most likely refers to the morning coffee before starting the day, as it is a common ritual for many people. That is further supported by a little talk, which we had when visiting P5, about the importance of coffee to function through the day, a thing, we as students and writing this thesis, only know too well! It also indicates our cultural understanding of what is a fitting activity in a home, which again in connection, support each other (Douglas, 1991, p. 287f; Højlund, 2006, p. 97).

From a syntactic level, we can follow a certain temporal development in both structure and content in this excerpt. Structure-wise, the story follows a sequence of present, past and back to present. Content-wise, this is reflected in a statement of how things are now (it is going well), then drawing on the conflict-example indicating the past by stating “much shorter than they have been for many [...] years”. This contrast introduces a space for her to share our she had a “daily fight with herself” to “just get started on her routines”, and how she accomplished that and what she has learned in the sense of knowing what helps her to get them started. This is connected to the present by doing precisely what she says “emphasize the positive things there”, thus supporting, in all, her first statement. In that way, the story is created as a coherent type of story.

This example, seen as a sequence in time as before, is also closely linked to the valence of the story's different parts. The story is of positive valence in its totality, and the outcome of everything being well at home is fortified through the sequential manner of using the shift in present to past with the respective valence.

Beginning the story with a positive valence, stating how “well” things are now at home, is setting the stage for the story to come, justifying this claim. By using the word “conflict”, usually having a negative valence, but pairing it with “short”, “few” and “very few” it gives a positive valence to “having them”. This is further supported by her following statement of “having been incapacitated”, which is negative in itself, but in precisely this contrast, it functions in this sequence as elevating the positive valence of the statements before due to the indication of having to overcome that much more. The use of “I have simply fought a daily fight”, which might be negative when standing alone, gets a positive valence to it when seen in connection to the outcome of this story that has already been proclaimed, namely,

everything is well. Further on, the use of “hell” has a very negative valence, which can be seen as emphasizing the hardship of this event, but also makes the success of overcoming it even more worthy of “celebration”. After this, the positive valence of doing the daily routines were emphasized by her knowing she would feel “better” afterwards, rounding the story off with her last positive valenced statement of emphasizing “the positive of these things”.

When looking at the characters of the story, then P5 is the main character, since the story is about her struggles, with her son as a peripheral character. This we have deduce from both our knowledge of having been to her home, the recurring present of stories of her son in the interview as just prior to this excerpt presented here, as well as the argument from before that the story takes place at home, where they live together. Usually, “having conflicts” also means to be in conflict with someone, especially considering the home-setting, it would be highly unlikely that the conflicts refer to political conflicts or the like, simply because no indication of this can be found in the sequence. This is also the reason why we claim that P5 uses an imitation of her son's voice in the last section of the excerpt.

The relation presented between P5 and her son is mostly positive in the sense that they only have few and short conflicts now, and he is presented as knowing what P5 needs to get better (her coffee). In the story, P5 is positioned as the one going through hardship tied to everyday activities in the home. She takes on a big responsibility of it going so well.

All of these steps of the analysis leads to an understanding of the characters presented in the story, and how they are positioned. Regarding the story itself (level 1), we already have covered that in the above. On the second level of positioning (“the here-and-now situation”), P5 can be seen as having a strong telling of herself as a woman and mother, who has overcome some very difficult times of hardship, and carving a place for herself to present this side of her as strong and being on a way to recover in the sense that she has found a very effective way to handle even this hard period in her life. In this position also lies a very strong sense of agency that she draws on in this narrative, which can be reflected in the position of “being a recovering patient”, by definition taking control of one's life and moving forward to get better. In this movement that P5 presents is precisely the construction of

transition of getting better.

One the last level (“the global situatedness”), the tellablity of her story, as we already have indicated by drawing on the master narrative of “recovering patient”, is partly constructed around the culturally embedded understanding of fighting illness (Bury, 2001), as also argued in the article. This analysis further contributes to this understanding of how these are used by our participants to establish a sense of self, which we will discuss further in the next section.

6.4. Findings and their use?

This section offers an opportunity to dwell on some of the findings that we accumulated across the entire study, and discuss them in relation to the literature that we have reviewed in the initial chapters and our theoretical standpoint. First, we take a chance to reflect on our findings on home meaning in relation to our research question and the aforementioned literature. Then, we discuss how our participants' treatment and illness narratives can be further understood in relation to other narrative studies, particularly our participants' use of home and everyday life as a resource in this construction. Finally, we round up some of the thoughts discussed in the article, in particular the question of how to implement a possible more activity and homebased outpatient based treatment.

So, what do our findings tell us about home in relation to previous work and our research question? To briefly recap, our findings suggested that home was an essential, but also ambivalent physical and socio-emtional setting that our participants “did” through specific actions and routines, and of which treatment had become an integral part, changing the relation in different ways. They all framed the residence as a base to do “basic” home activities, such as going from/returning to, sleeping, showering, eating, cleaning (as seen in Douglas (1991)), and, in their case as patients: having privacy to take medicine or do exercises. Through tellings of these everyday activities, they attributed the home setting with many of the “home” meanings that we saw in the literature (e.g., Mallet, 2004; Manzo, 2003, 2005; Moore, 2000), such as “safety” and “nest”, etc, but also with the possibility for “isolation” and “prison”-like feelings and actions, e.g., inactivity, refusal to interact with other people and so on. Much like previous studies in the field of home

meaning, particularly Borg et al. (2006) and Lindström, Lindberg & Sjöberg (2011) who did specific studies on the importance of home for psychiatric outpatients, our participants framed home as a base from which to launch efforts towards recovery. In these studies, home was a safe, continuous place to retreat to and to act out aspects of their everyday life (Borg et al., 2006, p. 246f; Lindström, Lindberg & Sjöberg, 2011, p. 288). This is something which our study accentuates with a certain amount of ambivalence among our participants. Like Manzo (2005) showed, home was not universally seen as a good place, but rather as an ambivalent place (ibid., p. 83f), particularly in regards to treatment and its effect on the understanding of everyday activities. Contrary to other studies, our particular approach focused on the temporal and changing process of home, such as Gustafson (2001), Manzo (2005) and Smaldone, Harris & Sanyal (2005 & 2008), ours focused on the construction of this meaning and its changing character. What emerged was both a sense of change on a longer temporal scale, but particularly in their talk with us, through employment of different angles from which to approach the concept of home (e.g., different activities or social relations) or in their telling of before and after, e.g., disorder onset and beginning treatment.

What this approach showed was the deeply contextual character of the construction of meaning, breaking the mold of an understanding of home as a stable thing and opening up for an understanding of home-meaning as an negotiation both done and communicated through talk. This affirms that decontextualized words mean little in and of themselves, such as P2's reference to home as a "nest", which changed its meaning even within a short span of time, from positive to negative valence, by the attribution of actions in the home setting that were hinged on this meaning. Only by looking at the sequence of the meanings that people construct of home can we get a broader understanding of this phenomena.

Talking about meaning through everyday activities was something that seemingly made inherent sense to our participants, seeing as they effortlessly produced narratives and negotiations, contextualizing their meanings of home, e.g., the feeling of “prison” or the feeling of budding “independence”, such as in the case of P4, who constructed a sense of agency and an identity of "taking charge" through her rigorous exercises with everyday activities in home. These activities make a

residence meaningful as a "home" in being exactly a site where one can do these things, one would not be able to do in other places, constructing it as a setting where they were able and allowed to do certain actions and where certain actions were expected of them (Douglas, 1991, p. 287f). These actions resonated well with, e.g., Højlund's (2006) findings on home context, e.g., candles, chores, eating together with people, sleeping and so on. All of these things throw back to some of our reflections in chapter three, where we argued for an understanding of home as something that we "do" in a setting that affords us certain actions according to our socio-historical context and this seems to have resonated well with our findings and the narratives that we have constructed together with our participants. Being in the physical home context of our participants offered us a chance to understand and utilize the relational aspect of home-meaning, by tying their disembodied talk of actions down to specifiable features of their physical home environment (Hartig, 2006, p. 217; Heft & Kytta, 2006, p. 211). Much like Sandhu et al. (2013), who did a study on depression after first episode psychosis among psychiatric patients and how they related to their home environment, we found how objects in people's homes is both constructed as an aid and a hindrance in people's recovery efforts, e.g., in the case of P4's books, which could both be a harsh reminder of abilities lost and a physical manifestation of hope in her narratives of home and treatment (ibid., p. 170).

We argue that all of the above is relevant for a broadening of the understanding of home in relation to diagnosis and treatment, particularly now that outpatient based treatment becomes more prevalent. As practitioners, then, it becomes important to see these findings in connection to treatment and how this malleable and transient understanding of home can be explored; how can certain aspects of it be promoted and what should practitioners be aware of in their attempt to implicitly and explicitly change the home context as part of treatment? These thoughts have already been explored somewhat through the works of, among others, Bartova (2014), Borg (2007), Lindström, Lindberg & Sjöström (2010), in various ways, and will be built upon in the last part of this section.

Overall, by looking at our findings, “home” emerges as a deeply individual and complex concept, especially in the context of patients, where everyday activities are an essential aspect of both their illness and recovery processes, an observation

mirrored in other literature (Borg, 2006, p. 246f; Borg & Davidson, 2008, p. 139; Lindström, Lindberg & Sjöberg, 2011, p. 288). Having conducted a narrative study, however, we take the opportunity to dwell a little more on the meaning of home as a narrative resource, which is elaborated further in the next section of the discussion.

Our participants' use of home and activities there as a resource in the negotiation of their disorders and treatment, as well as a way to position themselves through this process, was evinced in several instances. For instance in the category of “Transition of getting better”, as well as for example P5's narrative of managing the cleanliness of home or P3's narrative of how the view of home had changed in the course of disorder and treatment.

In a broader sense, this rendition of home and treatment can be understood as an ongoing negotiation that ties into prevailing narratives of illness management. According to Bury (2001), who did a thorough review of a wide range of illness narrative studies, such a negotiation is an integral part of the illness and treatment transition, where a core concern is maintaining a sense of identity and constructing new ones (ibid., p. 264). An explicit part of entering into treatment for a person with a psychiatric disorder is often the need to suddenly restructure their narratives of themselves (Baldwin, 2005, p. 1023). One aspect of this is how to relate to being somehow ill. Being ill is, as mentioned in the analysis, often cast as a question of somehow “beating” or “fighting” the disorder, while being hopeful, self-determinant and reflective in accordance with the institutionally promoted “recovering patient” narrative (Bury, 2001, p. 279; Jacobsen & Greenley, 2001). A variant of this narrative is also found among laypeople as a sense of being offered a chance to use one's illness “successfully” by gaining new insights or values from it, paraphrasing an old Danish saying “nothing is so bad that it is not good for something” (Bury, 2001, p. 277). Bury (2001) further asserts how there seems to be an imperative to appear as a “morally competent actor” that is negotiated by framing and adhering to disorder and treatment in this manner (ibid., p. 237, 276f), or run the risk of potential alienation socially or physically from the rest of the world, which is particularly prevalent with psychiatric disorders (Hinshaw & Cicchetti, 2000, p. 560f). In this, we can recognize the process of stigmatization which seems to still be prevalent in the Danish context, despite many years of public awareness campaigns and the like (DFI & SFI, 2010, p.

13f). Perhaps not so surprisingly then, it was also evident in our participants' narratives, such as P2's use of self-stigma to partly explain her position as ambivalent towards home treatment (e.g., didn't want to show her “borderline side” to anyone) or in a negotiation of category membership in P5's proclamation of not smoking (unlike “typical psychiatric patients”). In our transcriptions, we found many other similar instances with implicit or explicit reference to stigma, mainly outside the home setting and thus not fitting within the main focus of our analysis. They can, however, be an interesting avenue for further research. An interesting indication from our impression of these parts of our data so far, is a negotiation of being ill and being “morally competent” patients in regard to two distinct narratives and how these are used and mixed, as seen in other studies as well (e.g., Adame & Knudson, 2008; Bury, 2001; Ridgway, 2001). One of these is the master narrative of disorder and treatment that has its root in a medical understanding of mental disorders. Here, the condition is something biological and individual, and treatment is predominantly seen in individual terms, as well. It is the individual that must change its behavior, undergo and deal with the consequences of disorder and treatment to achieve a sense of normalcy and removal of symptoms (Adame & Knudson, 2008, p. 157, 160f; Hinshaw & Cicchetti, 2000, p. 567f). Adame & Knudson's (2008) study of recovery-patients showed that they employed alternative narratives to this understanding of disorder and treatment; emphasizing social, political, economic and religious factors with a root in everyday life as both cause for disorder and means of treatment (ibid., p. 162f). We also observed that our participants mixed these understandings in a negotiation, which both offered them positions of “less” stigma by their disorder being “not their fault”, but at the same time also a possible clash between, e.g., the constant need for self-discipline and self-improvement when being faced with social issues. In our findings, we could see some of this in the ways our participants managed their illness and the issue of being a morally competent patient by drawing on certain justifying and normalizing standards in everyday life. In this regard, our findings mirror Bury's (2001) review, which found that the negotiation is often done precisely on the basis of “management”, both of symptoms, but also of social and practical aspects of everyday life (ibid., p. 271f, 275f). In the case of our participants, the management of home and everyday life was used as both a mark of success and

failure as persons in recovery.

From this, it seems that “home-management” thus becomes a crucial aspect of recovery in the way that it offers an opportunity to retain a sense of social and personal coherence through adherence to certain standards, both in a dialogue with others and in their personal narratives of self. This use of home-management and everyday activities by our participants as both a possible physical and narrative resource in the recovery and destigmatization process, indicate why a further understanding and utilization of these in therapy and treatment could potentially prove fruitful for the Danish Psychiatric System in general. In the article, we argued for a greater inclusion of these activities as an active part of psychiatric outpatient based treatment. However, a greater inclusion of treatment in the home context can also be problematic, as we touched upon there. Here, we develop these latter thoughts a bit more, before rounding up the chapter.

As Borg & Karlsson (2013) cautions, home is a very particular place to receive and give help and treatment, a warning that is mirrored in other studies with both somatic and psychiatric outpatients (e.g., Angus et al., 2005; Healey-Ogden, 2013; Rossen, Tingleff & Buus, 2009). If were to take treatment into a more active direction and let it have its vantage point in the home context, several considerations need to be taken into account. Angus et al. (2005) showed how home-based somatic treatment can disrupt “the intimate co-constitutive relationship between self and home” (ibid., p. 182), by imposing an institutional framework on the everyday activities of home, which was echoed by our participants, who had to consider their everyday home space and activities as an active part of both treatment and disorder. Healey-Ogden's (2013) research on well-being for chronically ill somatic patients emphasizes how practitioners acting in and upon the home context need to have a broad view of what “home” entails for the patient and their possible families for recovery to flourish (ibid., p. 72, 87), which can also be argued for in the context of the psychiatric system. This hammers home the argument for a more partnership-based treatment where the patient can gain a voice in their own treatment, utilizing the expertise on both sides of the treatment-dyad (Hatgis, Dillon & Bibace, 1999, p. 21f; Dowds, 1999, p. 180f). Being aware of the home context is essential in this process, since it is so implicit in any kind of treatment that is offered; all treatment

has some effect and grounding in the everyday and home, even though it may not be physically situated there, begging the need for a deeper understanding of what “home” entails. Musaeus & Brinkmann's (2011) study of a family in psychotherapeutic family counseling displayed some of the possible repercussions the treatment can have on the everyday social relations and dynamics of a family. The introduction of psychotherapeutic tools and discourse within the intimate home context reinforced highly asymmetrical power relations and negotiation of conflicts in the studied family, since only the parents were incorporated in the treatment (ibid., p. 60ff). The use of psychological discourse further enforced the loss of the everyday, assumptive “flow” of family life, much in the same way that direct home-based treatment did for somatic illnesses in Angus et al.'s (2005) study, in spite of attempting the opposite (ibid., 182).

We saw signs of the same in our participants' tellings of their relation to everyday activities and their social relations, most prominent in subcategory “Challenges and consequences of treatment”, or in the opening excerpt by P2 in our article. It makes sense to use the home context as the basis for treatment, as we have argued above, but too often home is still a decontextualized thing in treatment, leading to some of the issues described by Musaeus & Brinkmann (2011), Angus et al (2005) and our participants, where treatment goals are formed in the office of a clinic instead in the living room, together with the patient. Based on our own experience from our interviews, we argue for more research on what being a physical and social part of the home context as practitioners means for this process. Here, it quickly became apparent how the home context was an essential part of our feeling of seeing the person as just a person, even though this at times was also difficult, a finding mirrored by Borg & Kristiansen's (2006) study on the meaning of work for people in recovery (ibid., p. 19f). Being in the physical home with its different power relationship and its assortment of personal objects that were intrinsically formative and performative for their different identity works (Jacobs & Malpas, 2013, p. 283), opened up for possible different roles for our participants that we could engage with and explore.

This is a precarious balancing act, of course, begging the question of where to set the demarcation line between “normality” and “pathology”, potentially

formalizing the home context and setting a standard of how to live a “proper” life to maximize the possibility of recovery. One might imagine, for example taking in some of the excerpts from category “Atmosphere of home” that a consequence of such a line of thought could be a treatment-based variant of “feng shui” (for lack of a better term: “psych shui”), seeing as how many of our participants drew in the importance of physical aspects of the home environment and their management of it as part of their treatment. An assessment based on this might include some of the findings already implemented in psychiatric ward design, like standards for the physical layout of the home, maximizing aspects of it in relation to specific difficulties and so on (e.g., Gross et al, 1998; Karlin & Zeiss, 2006). This, however, is hardly what we advocate. Any kind of clinical intervention naturally hinges on a set of standards for conduct and treatment, yet rather than setting these based on some extra local management or expertise, we believe that it might be worthwhile to take a lesson from Angus et al. (2005). Their study showed how local improvisation on the part of service-providers that might run counter to health policy or economics was better able to utilize the strengths of home as a setting ground for treatment than merely imposing a regimen that did not resonate with that particular person's everyday life and values (ibid., p. 183). What is needed is further research that takes place in the everyday life of Danish and international psychiatric outpatients, where treatment is negotiated together with locally situated practitioners who also have more resources and clout to work in the particular context.

Some current Danish psychiatric offers are bridging this gap in various small ways, such as The Patient's Team (Patientens Team), which is an interdisciplinary team that works together to achieve a better, more coherent treatment for the patient (Region Nordjylland, n.d.) or the Psychiatric Outreach Team (Region Hovedstaden, n.d.), which helps a particular group of psychiatric outpatients with some of their everyday issues. Likewise, the new Danish project *”Din gode udskrivning”* (literally, “Your good discharge”), which aims to provide newly discharged outpatients with better information on what to expect when they return to their home and everyday life, and where to get further help (Projekt Din gode udskrivning, 2013-2015). In other words, work is being done, although still only for a segment of the psychiatric outpatient group. What we suggest, and what further research may provide more

substantial evidence for, is how a strengthening of the relation to the home context within the Danish Psychiatric System could prove beneficial for a far greater percentage of their outpatients.

Through this discussion, we have elaborated on certain key aspects of our findings, attempting to show how they relate to the general field of home-meaning and where we can contribute with new insights, particularly from a Danish context. There is a growing body of work that sees home and every day life as inextricably connected, which we argue is essential for a promotion of the recovery process, both as a narrative resource in identity work, but also in the minutiae of daily trivialities. This section has been used to detail some of our thoughts on the matter, but, as the studies that have inspired us, we call for further research into the home context as an arena for treatment.

7. Writing process and evaluation

Throughout this chapter, we delve into the process of writing both the thesis in general and the article in particular. The following pages are dedicated to reflections on how to write up a scientific study. When considering this process, several issues emerge that require attention, such ethical and quality standards, personal and professional goals and requirements and so on. Some of these considerations are elaborated in the following.

Overall, the writing process is an essential part of our methodology and not merely an act of objectively reporting or summarizing facts and arguments, which is often neglected in texts and articles (Tanggaard & Brinkmann, 2010c, p. 508). It has to adhere to the same conduct and spirit as the rest of the process, which to us, is focused on the "doing" of things, on exactly the process and the different steps of this. This is the reason why we have spent so much time detailing our methodology and process and touting transparency as our goal (Goldberg & Allen, 2015, p. 8, 12ff), something that will be further elaborated on in our discussion of the quality standards of our study in the following.

As another consequence of this, we also chose a particular parlance throughout most of our thesis, as well as in our article, where we used ourselves as active reference points in the telling of our project, using "we" as opposed to a more dispassionate, third person approach. We see this thesis as very much of an emergent process, where it would make little sense to dissociate ourselves from the writing process and the actions that we have chosen along the way (Tanggaard & Brinkmann, 2010c, p. 510). This is perhaps less used in the literature, but makes sense to us and our particular, activity-based perspective on things, as well as situating ourselves less distantly from both our participants and our readers (ibid.)

Initially, we had to ask ourselves who we were writing for? This is not an altogether easy question, seeing as this thesis has strings going in several different directions: it is a part of an academic process within Aalborg University, where we had to adhere to certain standards, as well as, with our article, a product primarily aimed towards a particular journal. Beyond this, there is also a consideration for our participants and the general public, who, due to the nature of the Danish educational

system, will have access to, and should hopefully, somehow, benefit from this product, especially since we wanted to be, in our small way, part of an ongoing discussion about psychiatric treatment in Denmark (ibid., p. 502). In doing do, we attempted to maintain a cohesive language and clear progression in the thesis, in order to be more “readable”, while also trying to make it more “lively” through the use of examples from participants, metaphors, summaries and so on (Goldberg & Allen, 2015, p. 13f, 17).

The status of English as a second language for the both of us presented some challenges in this ambition, seeing as how we were, at least to our minds, less capable of writing as approachable as we would in Danish. On the other hand, this was a welcome challenge for us and, potentially, opens up our thesis for a broader English-speaking, public audience.

Our choice of writing our thesis as a two-parter; a self-contained article and a surrounding piece of broader experiences, reflections and perspectives, was a challenge for us. Overall, we wanted to maintain the thesis as a coherent whole, while also writing the article as a short, precise and self-contained part of it, using the surrounding as an expansion on theory, methods and process from the article. The challenge, of course, was to avoid repeating everything and keep a natural flow throughout, as well as a connection to the article. Our reasons for choosing this format, despite the challenges, was two-fold: we wanted to practice our writing skills as part of our professional competence as psychologists and academics, as well as to write something for potential publication in a more approachable short format and for a greater audience.

Keeping in line with this thought, this meant writing our article as closely adhering to professional practice as possible, and looking for a journal for which our subject matter might be suitable. Writing for a specific journal meant informing ourselves of their guidelines for writing, submitting and reviewing articles. It did, however, also present some unique challenges in how to present and write up theory, data and other aspects of the thesis. It was difficult to pick apart of our theoretical argument and still retain its cohesiveness in the article, just as figuring out how to present our analytical process was a headache, due to its length and complexity. It did not lend itself well to such a short format, especially since we also, initially, had

wanted to include more of our participant excerpts, out of a sense of fairness for our participants, as well as presenting our findings as transparently as possible. By utilizing our surrounding thesis for some of these issues, we hope to have achieved some kind of viable synthesis.

7.1. Writing with Nordic Psychology in mind

We found our target journal in Nordic Psychology, formerly known as Nordisk Psykologi (prior to 2006), published by Taylor & Francis Ltd (for more information, refer to www.tandfonline.com/rnpy). It spans a wide range of subjects within all branches of psychology and includes qualitative studies with small sample sizes such as ours, which can otherwise be quite hard to come by (Kvale & Brinkmann, 2009, p. 318). Furthermore, it is a journal with a basis in the Nordic countries, both geographically, theoretically, methodologically and, often, empirically. In our reading, it aims to provide a space to reflect upon some of the particularities of the psychological and sociocultural practices and institutions in the Nordic countries, making it well-suited for a project aimed at understanding more about Danish outpatients in the national psychiatric health system and their treatment trajectories.

For our article, this focus means that we have attempted to mesh both the requirements from Aalborg University and those of Nordic Psychology in our conceptualization of the article. This being a thesis, we still had to adhere to the formal requirements of Aalborg University (length, style, etc). This did not mean overly much in the sense that we, having informed ourselves through the submission guidelines and reading some of the previously published articles, found several similarities in regard to structure, progression and so on. We did spend some time considering the layout and structure of the article, however, bearing in mind the advice of both Brinkmann & Tanggard (2010) and Goldberg & Allen (2015). Taking in the lessons of both, one must strike a precarious balance between “front loading” an article with a great degree of theory, to the detriment of the methodological and analytical sections, while at the same time avoid showing too *much* of our method and analysis. The latter is a common error done when thesis works are translated into articles (Tanggaard & Brinkmann, 2010c, p. 503f; Goldberg & Allen, 2015, p. 8).

This was difficult exactly because we had spent so much time emphasizing the importance of our analytical approach. We attempted to achieve the right proportion by both adhering to some of the advice provided by Goldberg & Allen (2015) about qualitative writing, as well as the input from our supervisor and our own experience from reading, by this point in our education, a good deal of various articles. It was an ongoing negotiation.

7.2. Writing ethically

Our process of writing this thesis in an ethical way has been a red thread throughout, we hope. Doing ethics, instead of making up a list of guide lines, is a very fluid thing and a constant evaluation, which is difficult to put into a formula (Brinkmann, 2010, p. 444). Throughout, we have had ongoing discussions with each other and our supervisor to determine our course of action, which we in turn have also attempted to be as transparent about as possible in this thesis. This section, as well as the next, are essentially the last bits of this process.

Previously, in *4.5. Anonymization and handling of sensitive data*, we discussed how anonymization was an important aspect of our entire writing process, since it was tied to our stance of ethical conduct. One example was that we showed consideration for our participants in our selection of data during analysis and presentation, at least the excerpts that were translated and used explicitly in the thesis and article. Beyond this practical aspect of anonymization, there was also the question of conducting and writing our analysis with an understanding of the underlying power relations and consequences in that endeavor; i.e., how our position as communicators allowed us to skew our data in a particular direction, more or less willingly and implicitly (Tanggaard & Brinkmann, 2010c, p. 501). We tried to avoid this by “sticking to the data” throughout the analytical process. Our approach was less concerned with interpretation of content, but more with understanding structure and process. We spent a good deal of both the article and chapter six, trying to explain our reasoning behind our categories and findings, as well as displaying our data material for other researchers and readers.

On a more general level, being ethical researchers and writers to us came down to the simple question of respect, treating both our participants and their

narratives with a measure of respect and veneration for the time, effort and courage they had shown and used on our behalf. This also meant that we, to the best of our ability, tried to stay true to their stories and let them speak for themselves without too much inference on our part, both in our summaries and our use of excerpts, as well as in the minutiae of how we have described and related to them throughout the thesis.

7.3. Quality standards for researching and writing

Throughout, we have aspired to conduct our study and write our thesis in adherence to certain quality standards. As opposed to the more "traditional" quality standards of generalizability, reliability and validity (Kvale & Brinkmann, 2009, p. 271f), we have instead aligned ourselves towards some of the thoughts behind doing and presenting qualitative writing described by Tanggaard & Brinkmann (2010b, p. 491-494) and Goldberg & Allen (2015). In the following, we detail each of these in turn, as well as how we believe we have lived up to it, as a concluding remark upon the thesis, before turning to the conclusion.

1) **Be transparent throughout the process:** it is important that the qualitative researcher acknowledges his or her own interests or goals with a research project and details the steps, both theoretical and methodological that are done to get an answer to that. This is done, essentially to avoid the "black box" of the method section that Kvale & Brinkmann (2009) warn about as a common occurrence: all too often these sections, along with the analytical reasoning, are omitted or neglected (ibid., p. 296f). At the core of this quality criteria is the cardinal virtue of transparency; of explaining and detailing one's outset, theory, methodology and analytical process as thoroughly and clearly as possible in order to allow for both our process and findings to be scrutinized and followed by other fellow researchers (Goldberg & Allen, 2015, p. 8, 10, 12). Throughout our thesis, we have done our very best to do just that by thoroughly explaining our process and argumentation in all the steps of our study, empirical work and analysis, as well as including examples of our interview guides, notes, transcriptions (although only for the physical versions of this thesis due to anonymization) and so on. Our analysis and our thoughts behind that has also been rooted in the data itself, which has also

been included as lengthy sequences and our categories of it that have been included for easy reference. Doing so, we believe that we have given ample opportunity for other researchers and the general public to get a sense of why we have studied the phenomena the way that we have, and judge for themselves, how our theory, method and analysis suit our phenomena and answer what we claim to investigate.

2) **Coherence and readability:** the title sort of says it all; a good piece of work has a certain coherence, progression and comprehensiveness. This criteria deals with the written aspect of transparency which means that we have to be clear in our presentation and reasoning behind our work. This is why we have included some aspects and excluded others, as well as ensure that the different parts of the thesis form a cohesive whole, both writing-wise, but also methodologically, e.g., the method of analysis corresponds to the theoretical foundation and so on. We have been acutely aware of this aspect throughout, and have created, we believe, a cohesive approach. This matters little, however, if it is not readable for the audience and clearly carves out a space for the work we have done, which in many ways is the simplest and most complex criteria to say whether we have lived up to. In an effort to do so, we have used resources like Goldberg & Allen (2015), as well as our own extensive experience of being readers, to create a thesis and article that have clear argumentation and progression.

3) **Grounded and contextualized participants:** participants should be situated and contextualized by thoroughly describing them, the interview context and how they were contacted, included and excluded and so on (ibid., p. 7). Through our summaries, explanation of methods, detailed description of interview contact and context and active use of notes prior, during and after interviews, as well as why and how we selected the participants that we did, we believe that we have done our best to live up to this criteria, too.

4) **Be aware of what you are studying and what you can claim:** it is essential to be aware of what you are looking for and what this gives you: if, for instance, we were looking for some kind of “general” meaning of home for psychiatric outpatients in Denmark, we would have to cover the gamut of

different kinds of outpatients both concerning housing options (homeless, supported housing, own house, etc) and various diagnoses and other personal criteria and so on. Instead, we were more keenly interested in specific cases, attempting to understand how these few people constructed their meaning of home in talk. What this meant was that we had to study this systematically and thoroughly, which we believe we did by thorough questioning, situating ourselves in their home context and a keen interest in the sequences of talk, instead of events (Silverman, 2007, p. 24). Certainly, this is one part of our thesis that could easily be expanded, but, as could be seen in our analytical chapter, there were several commonalities and differences evident already in our small sample, so we still believe that we have a firm grounding here.

5) **Check, check and triple-check your data and interpretation:** our categories, themes or assertions needed to be constantly scrutinized throughout our analytical and presentation process in order to ensure that they have solid grounding in the data and not just our heads (Tanggaard & Brinkmann, 2010b, p. 493). To do so, we actively used the fact we were two researchers to check each other's work by looking for categories, themes, etc., in the transcripts and then compare and discuss the results, which was also done throughout the other parts of the study. Furthermore, we also included the use of other data sources, such as our notes and photos prior and during analysis to further ascertain or remind ourselves of certain aspects of our interviews and corresponding categories, for example reflecting on our own preconceived notions and situatedness as part of our interpretation (Goldberg & Allen, 2015, p. 9). Finally, we also received feedback from our supervisor during the analytic and write-up process.

6) **Arrive at something useful:** finally, and perhaps quite demandingly, a study should not simply be made for its own sake, it should serve a purpose and be structured and conducted according to that purpose (Tanggaard & Brinkmann, 2010b, p. 495). To us, this has very much been the purpose of promoting a view of home as something extremely multi-faceted and not necessarily easily included in treatment trajectories, even though there might be great political and medical effort in doing so, as well as sound, humanitarian

reasoning, too. It has also been to show our participants as people, not only patients, who struggle and make do in their everyday life contexts and as our co-constructors in our empirical process (Hatgis, Dillon & Bibace, 1999, p. 19f). What this has meant is that we have attempted to keep our thesis and article approachable and representative of exactly this, so that they may better become some small part of this ongoing discussion.

8. Conclusion

Throughout this thesis, we have attempted to answer the both terribly simple and utterly complex question of what home in everyday life means for five Danish psychiatric outpatients (one man and four women, ages 29 through 45 years of age) across Jutland, and how they experience it in relation to treatment. We were interested in this phenomenon due to an increasing focus in the Danish Psychiatric System on providing outpatient based treatment, making the home and everyday context of outpatients an ever more important part of treatment. In the literature, home has often been cast as a good, rejuvenating and stable place for people, affording a site for recovery on the virtue of simply being “home”. At the same time, studies also showed how home and everyday life were supposedly two of the biggest stressors for people with a psychiatric diagnosis. In other words, this called for further investigation.

We used a narrative analytical approach to do just that, focusing on the small story aspect of narratives and on what people “do” in talk and how they position themselves in relation to home and treatment in everyday life. With a firm transactional mindset as our grounding, we saw people's relation to home as an active, interdependent and multi-level transaction between person and environment, where people “did” their home through specific activities there. This stood in contrast to much of the established home-meaning literature, which we hoped to contribute to by broadening and contextualizing the meaning of home. At the same time, we also set out with a goal of further contextualizing the everyday experience of being a psychiatric outpatient, since we saw surprisingly little of this in the literature.

In many ways, the results of our analysis were almost commonsensical in nature, showing how home was an essential, but also an ambivalent physical and social setting for our participants. Yet when it comes to the process of recovery, the seeming triviality of this understanding is much more complex. While our participants drew upon many of the established meanings of home, constructing it as a site for doing a range of specific actions and routines, e.g., “normal things”, like going from/returning to, sleeping, showering, eating, cleaning, or “therapy”, like

taking pills, doing exercises, etc, it is exactly in these everyday activities that many of their issues and hopes for recovery lie. Home and everyday life seemed essential to them in their recovery process, but were also full of demands and challenges that had to be negotiated, especially now that treatment had become an integral part of this context, as seen in several instances in our thesis.

Where our approach yielded a contribution to this relation, was in its focus on the contextual, transient process underlying these seemingly stable, socio-cultural understandings of home. All of their meanings hinged on everyday activities and understandings of this, often cast in relation to treatment, but always mutable and transient.

This mutability of meaning and its deep contextualization are things that all of us experience every day in conversations and interactions with our environment to the point of triviality. Yet, again, from a treatment perspective, trivalities are essential. The core of our findings lie in the understanding of home and everyday life as based in activities and management of these activities. The management of home was constructed as a site of both social and physical recovery, while the challenges of the same are a source of stress. Although based on talks with only five outpatients, the processes behind their meaning-making are exactly "trivial" enough to warrant attention beyond this small scope.

Our findings, and their implications, emphasize a need for a more general understanding of the demanding everyday aspects of recovery as more than simply symptoms of disorders, but rather as opportunities for fostering management. As such, we argue for a further extension of the clinical intervention into the practical aspects of the patient's everyday life. Here, treatment would become less a question of abstract symptom treatment, and more of facilitating and supporting material and social issues in everyday life, together with the patient. The perspective of the practitioner, working together in a partnership with the patient, would be to use this more malleable and transient understanding of home and everyday life to open up for new resources and promotion of a management of both the positive and negative aspects of everyday life. Already existing psychiatric assessment forms could be expanded with an increased focus on everyday life management, such as job status, living conditions and physical features of home, as well as social ability and

integration within the community.

At the same time, another aspect of our findings was a source of caution for us, in that practitioners must also be aware of exactly the complex and intimate context of working within and with the home and everyday life. Further research is needed in how to be a part of this partnership and new treatment arena in the most ethical and integrated fashion. We argue, however, that no matter what practitioners do, their interventions always affect and implicitly attempt to change this intimate setting, as any kind of clinical intervention naturally hinges on a set of standards for conduct and treatment. However, rather than setting these based on external health care policies or guidelines, we have used this thesis to argue for further improvisation for and strengthening of local practitioners. Being contextualized, they may be able to better use and promote the home as a site for a treatment that resonates with the particular person's everyday life and values.

These thoughts are not necessarily easily implemented in the current system, but even small steps could have a tremendous effect, changing the treatment context from primarily individual, and centered on internal symptoms, to one of understanding the patient's difficulties and treatment as a social, material, environmental and practical process. Some psychiatric offers already exist in the Danish Psychiatric System, which are based in an inter-disciplinary way of working with the patients in their context, but these are still only for smaller segment of the patient population.

What is needed is therefore more research on offers like that, and research in general that is situated in the everyday life of Danish and international psychiatric outpatients. A focus of research might be the local negotiation of the partnership between practitioners and patient, or what a shift towards a greater integration of activity-based therapy means for the patient in their local context. Mirroring our words from the article, we believe that the complexity of this undertaking should not let us shy away from attempting it and doing further research to do so, since the potential of a more integrated, activity-based and person-centered approach to treatment could be highly beneficial.

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11. Appendix

11.1. Appendix A: Excerpts in Danish

The excerpt from the original transcriptions in Danish are presented in chronological order of the thesis.

Page 4, Introduction of thesis, *1.2. Clarification of concepts*

P3, line 397-401, Claudia (R1), Casper (R2):

R2: mhm mhm. Men det her med at gå ture det var sådan lidt et fællestræk

P2: ja, det var det, ja, det har jeg altid, jeg har altid elsket, det har jeg altid gjort jeg har altid elsket og gå altså, og komme ud og få noget frisk luft eller altså det... ja.

R1: ja

P2: men igen forskellen er nu, at hvor jeg gik og gemte mig før nu går jeg ture i midtbyen og ja

R2: mhm

Page 8, Article, *2.1. Introduction*

P2, line 745-749, Claudia (R1), Casper (R2):

P2: ehm... og det har ogs' fyldt meget fordi... jamen hvordan har jeg det nu i dag og hvordan har jeg det nu og hvordan har jeg det nu og hvordan har jeg det nu og sidst jeg var op ved hende [psykiatrisk sygeplejerske], der sagde jeg "simpelthen så pisse træt af at jeg skal tage stilling til hvordan jeg har det hele tiden"

R2: mhh

R1: mh

P2: altså man bliver squ helt tosset af at sku gå "hvordan, hvad er det for en følelse, hvorfor?"

R1: mhh

Page 21, Article, *2.6.1.1. Subcategory 1: "Treatment activities in the home"*

P4, line 1995-2007, Claudia (R1), Casper (R2):

P4: øhmm... altså man kan sige jeg har altså (1) ja udfordringer på mange på mange områder jeg har mange ting med mig... fra fra tidligere som min far li'som har indprentet mig med nogen... øh... rutiner som... øh som jeg har taget med mig... altså for eksempel... altså som eksempel så har jeg øh... mine bade øh når jeg går i bad så er det øh... maks hver anden dag og det er øh... altså det har tidligere kun været to minutters bade... altså hvor det sådan har været meget restriktivt altså min far har virkelig været .hhhh ja... MEGET obs på at man ikke brugte for meget vand

R1: mhm

R2: mhm

P4: det skulle i hvert fald ik være varmt eller sådan noget så jeg har altid badet i koldt vand og det er jo heller ik... så'n specielt rart kan man så sige men

R1: {mhm

P4: {ja men sådan har det været

R2: mhm

P4: og det har jeg jo været vant til og .hhh ja... altså det er jo... hvad kan man sige... det bliver jo det bliver jo til et problem (1) at at man ik... hvad kan man sige kan bade i længere tid altså jeg kan så'n.. altså i starten da jeg arbejdede med det der var det øh... altså der arbejdede jeg med altså... med varmen altså at jeg li'som sku' skrue lidt op for varmen og det var også fint og... det gik også et stykke henad vejen men altså så ku jeg så'n høre min... far stå og råbe ik' ogs' og... nu arbejder jeg så på det der med øh.(1) med tiden inde i badet... at jeg så'n derfor er der stopur ude på badeværelset {[latter]

R2: {mhm mhm

P4: at øh at jeg så'n tager... øh tre minutters bade... øh... skal stå skal stå derinde i tre minutter for og li'som at... udfordre den del af det så jeg li'som ik længere hvad kan man sige er styret af ham

R1: mhm

P4: øh... så at at jeg så li'som... hvad kan man sige... at at jeg selv kommer til at bestemme hvor lang tid jeg gerne vil bade altså

R2: mhm mhm

Page 74, Empirical work, *5.1. Interview guide process*

P1, line 1183-1193, Claudia (R1), Casper (R2):

R2: jeg ved ikke hvis vi så'n kigger lidt mere på på de fysiske omgivelser her altså hvorfor har du indrettet din bolig som du har det eller så'n? Er der nogen særlig grund til du har placeret din seng her over for eksempel eller?

P1: det er fordi jeg gerne vil [lille latter] ha luft når jeg

R2: hm

P1: jeg trænger til luft om sommeren

R2: ja

P1: så vil jeg gerne ligge hen ved vinduet

R1: hm

P1: såh så synes jeg, før der stod det anderledes så synes jeg lige jeg havde lyst til det sku' stå så'n her

R2: når efter efter det med røgskaden

P1: ja

R1: hm

Page 82, Empirical work, *5.2.1. Relation between interviewers and participant*

P2, line 323-334, Claudia (R1), Casper (R2):

R1: (6) [indånding, kigger ned i interviewguiden] (5)

P2: ska I vide noget om min baggrund hvor jeg kommer fra af familie og så'n noget altså hva

R2: altså

R1: ja

R2: hvis du har lyst til fortælle lidt noget så

R1: ja

P2: nåh ja ja det var bare fordi at det måske ikke har nogen relevans men det kun da godt være

R2: jo absolut

R1: altså det har det helt sikkert fordi det er også så'n lidt hvordan du er i relation til din familie og hvordan det påvirker dig ogs i dag

P2: ja

R1: så men i det omfang du har lyst til

P2: ja

Page 84, Empirical work, *5.2.1. Relation between interviewers and participant*

P4, line 1331-1364, Claudia (R1), Casper (R2):

P4: ja øh så må jeg bruge den del af min uddannelse jeg har til noget senere hen

R1: ja

P4: håber jeg

R1: ja

P4: det må vi jo se.

R2: jamen det er jo det. Og det er jo ogs' muligt og tage forskellige masteruddannelser oven i

P4: ja ja

R2: senere hen og ogs' sammen

P4: ja ja

R2: flikke et eller andet

P4: jaja, det er jo det

R2: henad vejen kan man sige hvis

P4: ja, på et senere tidspunkt så altså

R2: præcis præcis

P4: når energien er til det ik' ogs' altså

R1: ja

R2: mhm

P4: man kan sige man kommer desværre ikke så langt med sin bacheloruddannelse i dag

R2: ik' i Danmark

P4: nej nej

R2: det er sådan lidt det sjove med Danmark

P4: ja

R2: det er sådan lidt øh

P4: en bachelor det er bare sådan en grunduddannelse det ik'

R1: ja ja

P4: det ik' noget særligt [latterfnys]

R1: ja ja

R2: ja ja

P4: nej, nå nej [lille latter]
R2: og alle andre lande hvor man skal betale for det så øh
P4: så er bacheloren bare woooow [lille latter]
R2: ja ja ja præcis, præcis
P4: bare kæmpe kæmpe stort ik'
R1: ja

Page 85, Empirical work, *5.2.1. Relation between interviewers and participant*

P1, line 940-961, Claudia (R1), Casper (R2):

P1: jeg vil gerne have noget større men altså... jeg vil helst være her
R1: hm
R2: hm jeg tror vi allesammen næsten vil have noget større
P1: ja
R1: [lille latter]
R2: men... så vil jeg også sige at det her også en lille smule småt
R1: hm
R2: det er jo en studenterhybel
P1: ja
R1: ja
R2: på mange punkter ja ja
P1: ja
R1: ja ja det passer faktisk meget godt ja
R2: hm hm
R1: det er der mange der er af vores her
R2: ja
R1: venner der bor i så
R2: sådan noget her har vi også boet i de sidste
R1: ja jeg startede også på kollegie og så'n
P1: ja
R1: hvor jeg også ku' ku' komme ud og og også nødt meget at jeg bare ku' møde nogen nogen folk jeg kendte
P1: ja

Page 90, Empirical work, *5.2.1.1. Interviewing people with a diagnosis and in treatment*

P2, line 2620-2640, Claudia (R1), Casper (R2):

P2: så jeg tror altså ja hvis jeg ik' kommer ind på det der tilbud altså så ved jeg ik' hvad
R1: mh
P2: så tager nok lige nogen dage med tudeture og

R2: mh
P2: total nedtursfølelse men eh... så må jeg jo finde ud af hvad det næste ska' være
R1: ja
P2: (3) men eh ja jeg har tiltro
R1: mh
P2: og jeg har jo været heldig
R1: ja
P2: indtil nu
R2: mh mh, og som du ogs' har sagt før så... hvis du holder fast i din stædighed så
R1: ja det jo det
P2: ja det er... det sku' godt den er veludviklet [lille latter]
R1: [lille latter]
P2: nogen gange er det skidt men eh
R2: mh
R1: men lige på det punkt er nok meget godt
P2: tror det er meget godt
R1: ja
R2: mh

Page 91, Empirical work, *5.2.1.1. Interviewing people with a diagnosis and in treatment*

P5, line 2159-2177, Claudia (R1), Casper (R2):

R1: [lille latter] ehm nu bruger du meget ordet mærkelig at er det noget du selv oplever dig mærkelig eller er det mere fordi du har der er andre der har sagt "årh du er så mærkelig" eller hvordan?
P5: ( ) begge dele
R1: begge dele ja
P5: når folk de beskriver mig "du squ ogs' så mærkelig"
R1: okay
P5: ja, jeg er mærkelig
R1: mh
P5: jeg er ikke som alle andre men hvem er egentlig det?
R1: ja det er jo lige det [lille latter]
P5: hvad er normalt?
R1: ja ja
P5: (ej)... det kan vi jo definere
R1: mh
P5: det det altså er normalt at man passer sit arbejde? Jamen, så er jeg jo normal
R1: mh
P5: ik'? Er normal at man passer sine børn ja så er jeg ogs' normal (2) eh, men men hvis normalen er at man ingen udsvingninger har ja men så er jeg ik' normal
R1: mh mh
P5: men I mine øjne er det unormalt ingen udsvingninger at ha... så har du ogs' en eller anden diagnose
R1: ja [lillebitte latter]

Page 106, Analysis and findings, *6.3.2.1. Progression achieved*

P5, line 1897-1916, Claudia (R1), Casper (R2):

P5: altså jeg kan {mærke=
R2: {mh
P5: =tingene herhjemme de kører bare... så godt
R1: mh
P5: altså konflikterne er få... og dem der er er korte
R1: mh
P5: meget kortere end de har været i mange mange mange år og det er på trods af at jeg det sidste halve år har været ukampdygtig hvis man kan sige det så'n
R1: ja ja ja
P5: fordi jeg har simpelthen kæmpet en daglig kamp med mig selv altså bare det at komme i gang med rutinerne har været... et helvedet
R1: mh mh
R2: mh
P5: men når jeg havde været i bad så vidste jeg ogs' så havde jeg det lidt bedre... når jeg havde fået min kaffe ik' altså
R2: så det var så'n meget den måde du... kom i gang med rutinerne
P5: ja
R2: {på en eller anden måde
R1: {og motiverede dig på, på en anden plan?
P5: ja {fordi jeg vidste at... ah når du har været i bad så har du det godt igen {ik'=
R1: {ja
{mh
P5: =eller har du det bedre ”nåh har du fået din kaffe?” [said in the son's voice] {altså så'n
R2: {mh
P5: fremhæve de positive i de ting der ik' ogs'
R2: mh mh

11.2. Appendix B: Danish Psychiatric System

This overview of the Danish Psychiatric System was done in our 9th semester project with addition of a new figure below.

Overview of the Danish Psychiatric System

Coming into contact with, and going through the Danish Psychiatric System, can have several very different trajectories for the individual patient (and their relatives), with different entry points. To qualify for treatment, guidelines from the International Classification of Diseases (WHO ICD-10) are used when admitting the prospective patient. In general, there are three different sectors in the system, each having different organization and areas of responsibility (Danske Regioner, 2008). The Danish national state is divided (geographically and administratively) into five regions, each consisting of several municipalities, making up 98 in total. Each region is responsible for the administration of the ***psychiatric ward*** placed in the hospitals for inpatients, i.e., patients admitted to stay under care, voluntary or coerced, for one or more days (ibid.). Furthermore, the regions have responsibility of the ***outpatient psychiatry***, which is made up, among others, by (ibid., p. 11-12):

- outpatient clinics (often located in the hospitals, but with no admission to the ward)
- specialized clinics in prominent diagnoses (e.g., depression, anxiety)
- community psychiatric centers (which manage longer outpatient treatment courses and
- options for home treatment)
- emergency wards (open 24 hours)

A big part of the psychiatric examination and treatment take place in the outpatient psychiatry without hospitalization (Region Nordjylland, 2014). Most people get help through their own physician, who is either in charge of treatment him/herself or refers the patient to a psychologist or a private psychiatrist. The possible downside of the latter is a long waiting list ranging from 2 weeks to 3 years, depending on geography (sundhed.dk). In cases where a more specialized examination and treatment is needed, the physician can also refer the patient to the psychiatric ward (ibid.).

The ***social psychiatry*** is most often administrated by the individual municipality, but the regions have some of the financial responsibilities as well (Danske Regioner, 2010). Under this umbrella are social services like arrangements of support in the patient's home, contact persons helping with social contacts and meaningful activities, providing sheltered residences and drop-in centres, etc. (ibid.).

Several private organizations also support people with a broad range of problems, including psychiatric disorders. Availability and services provided are very different, depending on geography.

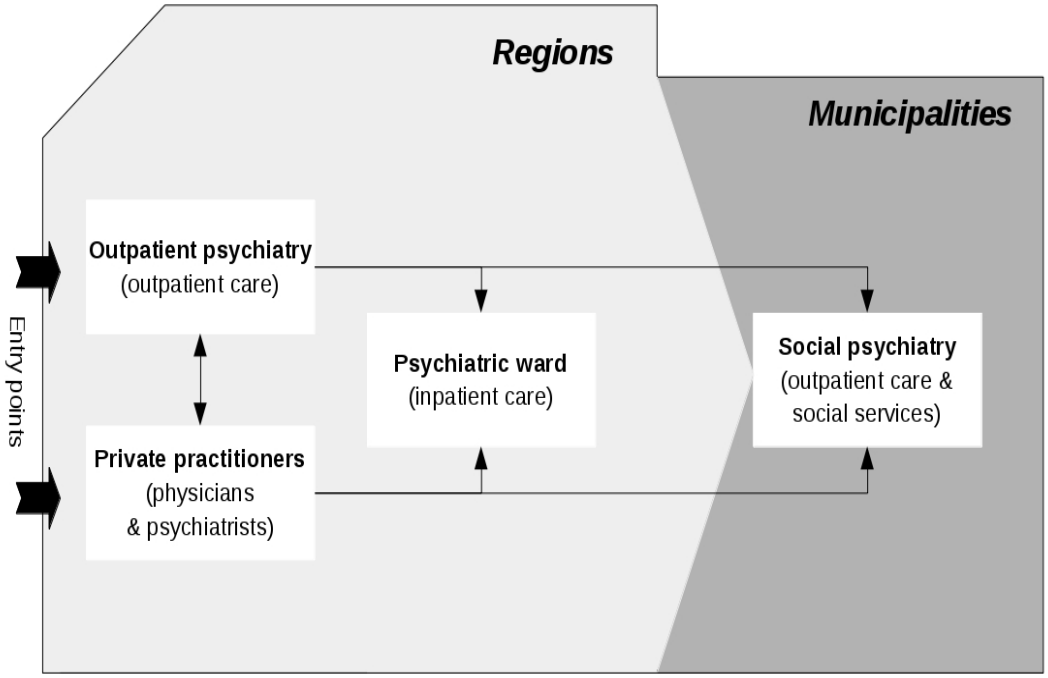

Figure 1: Illustration of the Danish Psychiatric System with the overarching trajectories for the patient, as well as the regional and municipal administration and financial responsibilities (made by the authors, 2015).

References:

WHO ICD-10 (2011). *Psykiske lidelser og adfærdsmæssige forstyrrelser. Klassifikation og diagnostiske kriterier*. København: Munksgaard Danmark.

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11.3. Appendix C: Analysis Categories

Bold	the chosen examples of narratives in that category
Italics	narratives that are included in more than one category
( )	narratives that we are uncertain its belonging in that category

Main category A: ”Transition of home and treatment”

1) ”Treatment activities in the home”	2) ”Challenges and consequences in treatment”	3) ”Home/everyday: neg → pos due to treatment”
P3 – 449-472: exercises at home, safe environment to do them (different from inpatient treatment, where one would not be able to practice them where needed) *P3 – 530-540: controlling the perfectionist (side of him)* P3 – 599-613: the first exercises done at home P3 – 754-765: taking and acceptance of medicine P4 – 1957-1982: what her coach and psychologist help her with, respectively **P4 – 1992-2026: challenges in everyday life and how she works with them, as well as her fathers impact** ***P5 – 2425-2440: learned to control her racing thoughts, maybe taking a sleeping pill, better than letting it run, talking with the physician when needed, did not know those things before***	*P1 – 2244-2285: the institutional setting helps her, she does not want to move away, they can not force her* *P2 – 165-184: experience of having a mentor before* *P2 – 474-502: dish-washing, talks with the nurse → negotiation of a explanation to why it is so difficult* P2 – 739-754: how much the treatment takes up room → changes in medicine and how do I feel now? ***P2 – 904-944: prospects of a social worker coming home to her, being ready for that vs. having to do that*** *P3 – 620-643: learning to invite people home and to feel when it is enough* P4 – 2049-2074: the father's capriciousness and impact on her days, as well as the consequences of psychological treatment, how her week looks like and where she often sits alone with her thoughts and actions *P4 – 2080-2106: an increased understanding of her condition through treatment, but it is also a very though*	P1 – 921-939: home has changed from before the institution till now in the institution, from having to do everything herself to being in protected surroundings now *P1 – 1677-1690: difficult everyday life before, easier now at the institution* *P3 – 368-413: the day now = good, healthy and structured, day before = bad, unhealthy and unstructured* *P3 – 432-448: home before = bad and dark, home now = good and light*
		4) ”Prospective treatment”
		P2 – 1193-1217: things she hopes to gain from the day center → bring about an more normal everyday life (outpatient treatment having effect on everyday life and home)

Main category B: ”Atmosphere of home”

<table>
<tr><th colspan="2">1) ”Physical aspects”</th><th>2) ”Activities of hominess”</th></tr>
<tr>
<td>P1 – 83-93: open/closeness; privacy vs. ”institutional life”

P2 – 225-252: chaos-spaces at home, how she does not succeed in giving herself structure and order even though she likes and needs that

P2 – 1312-1391 (first part): her boyfriend's home vs. her own

P2 – 1914-2004: second-hand stuff, gets many things, her bedroom and everyday life there

P2 – 2143-2209: interior decoration, family pictures, functionality, her boyfriend's home used as counterpart

P2 – 2260-2294: home as a cave, look out the window → letting the outside get ind some more, balcony → getting out without really getting out

P3 – 1015-1031: things that matter → computer, food in the fridge, pictures, personal things

P3 – 1033-1074: look and interior decoration of the apartment; rest/calmness → light and order; again trying to control the perfectionist</td>
<td>P3 – 1098-1130: changing the room and do something physical helps, the perfectionist also helps here to convince himself to do those things

P4 – 3031-3072: her books in the basement, might put to much pressure on her, because she wants to read but can not so much anymore (due to medicine)

P5 – 1918-1931: functional home</td>
<td>P1 – 1631-1639: Danish cosiness with candles/tea light, music, a blanket, her good friend, boyfriend, drinking tea → like it is her own place

P2 – 1312-1391: home as place to relax and take off the make-up and the like

P3 – 1439-1452: home means a lot, happy to live there, can invite friends and they like to visit him, drinking coffee together

P5 – 1957-1969: their home → share domestic duties, she is the grown up and therefore in charge but her son has a say to

P5 – 2098-2119: her home might be messy, but it is clean, get things done, home as her base</td>
</tr>
<tr><th colspan="2"></th><th>3) ”Feeling of home”</th></tr>
<tr><td colspan="2"></td><td>P2 – 1312-1391: home as a nest, relaxing, negotiation of one can just visit her or not

P3 – 432-448: home before = bad and dark, home now = good and light

P4 – 2336-2376: home as a place of rest/calmness, autonomy, but her father is in everything, her thoughts and actions; she has disposed everything resembling her father

(P5 – 1985-1997: it is important that they like to be at home, she has returned to her childhood city)</td></tr>
</table>

Main category C: ”Transition of getting better”

<table>
<tr><th colspan="2">1) ”Progression achieved”</th><th>2) ”Challenges”</th></tr>
<tr><td>P2 – 185-205: borderline has become better, has worked with herself, description of before and now

P2 – 428-449: about dish-washing accepts her mothers help now

P2 – 524-537: gotten better at planing her activities and having days off

P3 – 556-583: uses the perfectionist positively for implementing and accomplishing certain treatment exercises every day

P3 – 884-912: having bad days, things that can throw him off, gotten better at picking himself up and be good to himself

P3 – 1098-1130: changing the room and do something physical helps, the perfectionist also helps here to convince himself to do those things

P4 – 1642-1673: social worker → drop-in-center → starting up a ”knitting-cafe” → get outside of home</td><td>P4 – 1749-1779: help from the social worker at home with different things, reduction of time with the social worker to one hour pr week, which is fine

P4 – 3262-3296: little summary, things having changed mostly to the positive, home has become more her place even though it took a long time, but things are looking up, hopefully

P5 – 1644-1688: support from her family in regards of managing her disorder, better at managing her everyday life and at relaxing

P5 – 1897-1916: things run well at home, tough to get started with the routines, but succeed by thinking positive and about what it gives in return

P5 – 2372-2398: as much rest in her head as there can be, accepting sleeping pills if needed

P5 – 2425-2440: learned to control her racing thoughts, maybe taking a sleeping pill, better than letting it run, talking with the physician when needed, did not know those things before</td><td>P1 – 2244-2285: the institutional setting helps her, she does not want to move away, they can not force her

P3 – 530-540: controlling the perfectionist (side of him) which is difficult

P3 – 620-643: learning to invite people home and to feel when it is enough

P4 – 2080-2106: an increased understanding of her condition through treatment, but it is also a very though</td></tr>
<tr><td colspan="2"></td><th>3) ”Progression-to-be”</th></tr>
<tr><td colspan="2"></td><td>P1 – 197-230: wants to step down on medicine, feeling better now to do it, does not feel as sick anymore, schizophrenia is said to ease off a little with age

P2 – 165-184: experience of having a mentor before

P2 – 904-944: prospects of a social worker coming home to her, being ready for that vs. having to do that</td></tr>
</table>

Other categories

”rejection of treatment”	”generic day-descriptions before and after”	”stories of management”	”stories of ambivalence”
P4 – 2658-2693: impact of medicine in everyday life, rejects medicine due to torpidity/drowsiness, draws on stories of other psychiatric patients *P5 – 256-268(86): discharged herself from ward, all her personality had to included, usually her nurse-side takes care of her when things are though* P5 – 1571-1591: the whole patient has to be included, management of medicine, draws on stories of another psychiatric patient (a friend) (lack connection to home directly, instead one is to her work)	*P1 – 1677-1690: difficult everyday life before, easier now at the institution* *P3 – 368-413: the day now = good, healthy and structured, day before = bad, unhealthy and unstructured* (P5 – 505-526: description of the new everyday life of her son, close with statement of regular routines are best) (P5 – 1516-1564: acceptance of medicine, hoped to do without but can not, getting the everyday life running again) (P5 – 2063-2089: home now = castle, relaxation; home before = fortress, isolation; now she better at communicating, when she feels troubled)	P5 – 968-1007: surroundings (children, work) as indicator for how she feels, as well as how they then handle it *(P5 – 256-268(86): discharged herself from ward, all her personality had to included, usually her nurse-side takes care of her when things are though)* P5 – 1173-1213: control of alcoholism and her hobby of whiskey tasting P5 – 1226-1274: control and knowledge about her suicidal thoughts and development of plans → routines safe her P5 – 1285-1350: a bit longer story than before, medicine helps a little, but she is very medicine sensitive which has its challenges → routines safe her, always run with them, treatment encourages to stick to them	P1 – 2303-2345: ideas about what it would take for her to move away from the institution one day *P2 – 474-502: dish-washing, talks with the nurse → negotiation of a explanation to why it is so difficult* (P2 – 983-1022: shy/self-conscious in regard of (another) day center, other reasons for not getting out of her home: bicycling due to distance, hills, fitness, perspiration → medicine) (P5 – 402-428: the importance of her work and the fear of loosing it) P5 – 2831-2898: mother-role vs. patient-role

Other categories

”transition of getting diagnosed”	”narratives in opposition to current home”	”generic everyday description”
P2 – 808-870: to be understood by her psychiatrist, there is actually something wrong with her and not a fabrication of hers, happy for the diagnosis, recognizes herself in it, but not as a regular bipolar P3 – 186-194: revelation, liberation, could completely recognizes himself in the diagnosis P4 – 165-196: get a social worker to come home to her → more treatment → local psychiatry → diagnostic process for two years → understands it now, but still hard (P5 – 752-775: it is a disorder she will not get out of, psychoeducation, learning to live with it)	P2 – 1312-1391(first part only): feeling of home vs. her boyfriend's home P2 – 2301-2326: living in a big city, small apartment, not the same access to surroundings like the sea *(P5 – 256-268(86): discharged herself from ward, all her personality had to included, usually her nurse-side takes care of her when things are though)* P5 – 2591-2627: life at home with her ex-husband (the children's father)	P2 – 1218-1262: ordinary day: getting up, watch TV, cook → boyfriend P4 – 2752-2767: daily rhythm, less energy over midday one activity on a day, hopes for a light job or maybe getting of welfare P5 – 553-554 + 579-590: their mornings together, and the rest of her days at home P5 – 1416-1430: short story of eating oatmeal every morning, she gets difficulties with her stomach when being on holiday

11.4. Appendix D: Transcription Symbols

{	Left brackets indicates overlapping speech between talkers.
=	Equal signs, one at the end of a line and one at the beginning, indicate no gap between the two lines.
(3)	Numbers in parentheses indicate time of pause/silence in full seconds.
…	Three dots indicate a short pause/silence.
WORD	Capitals indicate loud or pitched sounds/talk.
underlining	Indicates an emphasis put on the word.
“text”	Quotation marks indicate citations of things being said directly in past

	talk, for example when conversations are repeated directly with who said what.
.hhhh	A dot before or after a row of h's, indicates an in-breath and out-breath, respectively.
( )	Empty parentheses indicate the transcriber's inability to hear what was said.
(word)	Parenthesized words are possible hearings.
[ ]	Angled parentheses contain author's descriptions and comments.

11.5. Appendix E: Example of post-session note

This is a shortened note from one of the interviews, Danish and English respectively, kept in the scribbly, haphazard way as it was initially written. However, personal information has been removed due to the anonymity of our participant.

Danish version:

Da vi først mødte op ved lejligheden troede jeg, at det var et gammelt faldefærdigt baghus og vi kunne ikke komme i kontakt med interviewpersonen, hvilket triggede en masse billeder af interviewpersonen som ”patient”. Dette blev dog hurtigt gjort til skamme.
Godt interview, hvor vi kom vidt omkring, både med mere overordnede ting og ned i detaljen. Interviewpersonen var nem at snakke med og meget ”vant til” at tale og reflektere over sin situation og historie.
= meget psykologfagligt lingo!
Det skulle ikke ende som sidste interview.
Nydelig lejlighed, der også passer ret godt til min egen æstetiske sans; indgød ”hygge”
→ følte mig velkommen, ikke så bevidst om ”interview”-rollen som sidst.
→ var jeg blind overfor nogle ting? Hvilken effekt kan det have?
Pillede ved hænder og hals →
Meget fokuseret på sin historie → for meget måske? (tænk på næste interview)
Følte mig godt tilpas i interviewrollen i dag, måske for meget? Ikke observerende nok!
Lejligheden var også mere ”luftig”, mere ”normal” end sidste kontekst, hvilket betød en masse for min følelse i samtalen.
Hendes ”dirty” rooms var altså ikke så slemme! Interessant observation – hvad betyder det?

- Mine forventninger: pæn pige i ren/pæn kontekst (ud fra kontakten), men diagnosen gjorde mig mere i tvivl → forventede værre → derfor måske endnu mere positiv oplevelse?
- Ikke gået nok ind i hendes papmor-rolle?

English Version:

When we first turned up at the apartment I thought it was an old ramshackle back building and we couldn't get in contact with the interview person, which triggered a lot of images of the interview person as ”patient”. However, this was quickly refuted.
Good interview, where we covered a great deal, both concerning more overall things and into the detail. The interview person was easy to talk to and very ”used to” talking and reflecting about their situation.
= a lot of psycho-lingo
Didn't want it to end like last interview.
Nice apartment, that also suits my own aesthetic sense pretty well; imbued ”hygge” → felt welcome, not as conscious of the ”interview”-role as last time.
→ was I blind to some things? Which effect could this have had?
Touched hands and neck →
Very focused about the story → too much maybe? (think of the next interview)
Felt comfortable in the interviewing-role today, maybe too much? Not observing enough!
The apartment was also more ”airy”, more ”normal” than the last context, which meant a lot for my feeling in the conversation.
Her ”dirty” rooms weren't that bad! Interesting observation – what does it mean?
- My expectations: nice girl in clean/nice context (going by the contact), but the diagnosis made me more doubtful → expected worse → maybe therefore even more positive experience?
- Didn't go enough into her step-mother-role?

11.6. Appendix F: Participant Contact Write-Up

Danish version:

Hej,

Vores navne er Casper og Claudia, kandidatstuderende på Psykologi ved Aalborg Universitet.

Vi er netop nu i gang med at lave vores speciale, hvor vi håber på at kunne lave en række interviews med tidligere eller nuværende psykiatribrugere i alderen 18-65 år, der

enten har været indlagte og/eller er i ambulante forløb. Måske det kunne være dig?

I lyset af et stigende politisk og sundhedsfagligt pres for mere ambulant behandling i psykiatrisk regi, virker hjemmet som om at det vil indtage en stadig større plads i fremtidens behandling. Men hvad er ”hjemmet” egentlig? Formålet med interviewet er at undersøge, hvordan netop du oplever, forstår og lever i dit hjem og din dagligdag.

Interviewet vil foregå i din bolig og tage udgangspunkt i, hvad hjem betyder for dig. Mere specifikt vil vi gerne snakke om din hverdag, dine rutiner og de fysiske omgivelser samt hvordan dit behandlingsforløb har været i forbindelse med netop hjemmet og hverdagen, både i form af forventninger, udfordringer, glæder, erfaringer og strøtanker. Stort og småt, alt har interesse, det er dit personlige perspektiv og fortælling, der er vigtige og interessante for os. Vores håb er, at en øget forståelse kan munde ud i en afhandling, der kan være til reel gavn for både behandlere, brugerne og deres pårørende.

Rent praktisk er vi to, der kommer ud og besøger dig. Vi forventer at interviewet i alt vil vare ca. to timer. Din deltagelse bliver gjort anonym, og alt hvad vi taler om bliver behandlet fortroligt. Resultaterne bliver brugt i vores afsluttende speciale og forhåbentlig viderebragt i en videnskabelig artikel.

Hvis vi har fanget din interesse, så kontakt os gerne på vores emails: cande10@student.aau.dk eller cgalla10@student.aau.dk. Samtidig kan du skrive lidt om hvor du kommer fra og hvad din historie er. Hvis du har spørgsmål, fx hvordan det skal bruges, de nærmere omstændigheder ved interviewet, etc., må du endelig også skrive til os.

Vi håber på at høre fra dig! :)

Med venlig hilsen

Claudia Gallas og Casper Andersen

English version:

Hello,

Our names are Casper and Claudia, Masters students of psychology at Aalborg University.

At this moment we were doing our Master's thesis, where we hope to be able to do a series of interview with former or current psychiatry users at the age of 18-65 years, who have either been admitted and/or are in outpatient based treatment. Maybe that could be you?

In light of a mounting political and medical push for more outpatient based treatment in psychiatric in-house, home seems as if it will claim an ever greater place in the treatment of the future. But what is ”home” really? The purpose of the interview is to investigate how precisely you experience, understand and live in your home and your

daily life.

The interview will take place in your residence and take its starting point in what home means to you. More specifically we would like to talk about your everyday life, your routines and the physical surroundings, along with how your treatment has been in relation to exactly home and everyday life, both in the shape of expectations, challenges, joys, experiences and scattered thoughts. Big and small, everything has our interest, it is your personal perspective and story that is important and interesting to us. Our hope is that an increased understanding can result in a thesis that can be of real use to both practitioners, users and their relatives.

Practically speaking there's two of us that will come and visit you. We expect that the interview will last about two hours in all. Your participation will be made anonymous and everything that we talk about will be treated confidentially. The results will be used in our Master's thesis and hopefully brought along in a scientific article.

If we have caught your interest, then feel free to contact us on our emails: cande10@student.aau.dk or cgalla10@student.aau.dk. At the same time you can write a little about where you are from and what your story is. If you have questions, e.g., how we are going to use it, the specifics of the interview and so on, feel free to write to us, too.

We hope to hear from you! :)

Kind regards

Claudia Gallas and Casper Andersen

11.7. Appendix G: Consent form

Danish version:

Først og fremmest, tusind tak for din interesse for at deltage!

Læs denne samtykkeerklæring for interviewet grundig igennem og stil endelig spørgsmål undervejs, hvis der er noget du undrer dig over eller mangler en dybere forklaring på.

Med denne erklæring giver du samtykke til at deltage i et interview ledet af Casper Andersen og Claudia Gallas, kandidatstuderende fra Aalborg Universitet under supervision af adjunkt Nikita A. Kharlamov (nikita@hum.aau.dk). Interviewet indgår som en del af flere interviews i vores specialeafhandling på Psykologi.

Formålet med interviewet er at undersøge, hvordan du oplever, forstår og lever i dit hjem, dine fysiske omgivelser og din dagligdag med de rutiner og forhold disse indebærer.

Interviewet foregår i din bolig og forventes at vare ca. en til to timer at gennemføre. Det bliver optaget på diktafon og senere skrevet ned på tekst. Desuden tager vi notater undervejs af interviewet, som en støtte til den senere analyse. Du giver os tilladelse til, at vi må tage billeder af dele af din bolig:

□ Nej, ingen billeder må tages.
□ Ja, men billederne må ikke offentliggøres.
□ Ja, og billederne må gerne offentliggøres i en eller flere artikler. Du vil blive kontaktet og bedt om godkendelse for hvert billede, der eventuelt ønskes inkluderet i den færdige artikel.

Din deltagelse er fuldstændig frivillig, hvilket vil sige, at du til enhver tid har ret til at nægte at svare på specifikke spørgsmål. Du kan også helt afbryde samarbejdet uden at angive en grund og uden nogle konsekvenser for dig. Eventuelle data, der er blevet samlet i løbet af interviewet, vil i så fald blive destrueret.

Din anonymitet vil ligeledes være sikret gennem ændring eller sletning af personlige oplysninger såsom navne og stednavne. Du vil blive tildelt et tilfældigt navn, der vil blive brugt, når dine svar analyseres. Endvidere vil dit navn aldrig blive nævnt i forbindelse med en udgivelse af resultaterne.

JEG HAR HAFT MULIGHEDEN FOR AT LÆSE DENNE SAMTYKKEERKLÆRING, AT STILLE SPØRGSMÅL OMKRING STUDIET OG JEG ØNSKER AT DELTAGE.

_____
Deltagers navn

_____ _____
Deltagers underskrift **Dato**

_____
Interviewerens navn

_____ _____
Interviewerens underskrift **Dato**

Hvis du ønsker, at vi videresender vores kommende artikel, når denne (el. disse) er skrevet, skriv din e-mail her:

_____

English Version:

First and foremost, thank you for your participation.

Read this statement of consent thoroughly and do ask questions along the way, if there is something that makes you wonder or that you need a more thorough explanation about.

Through this statement, you consent to participating in an interview conducted by Casper Andersen and Claudia Gallas, master thesis students at Aalborg University under the supervision of assistant professor Nikita Kharlamov (nikita@hum.aau.dk). Your interview is part of a series of interviews for our Master's thesis in psychology.

The purpose of this interview is to investigate how you experience, understand and live in your home, your physical surroundings and your everyday life with the routines and circumstances that these entail.

The interview takes place in your residence and is expected to take one to two hours to complete. It is recorded on a dicta-phone and later transcribed into text. Alongside this we also take notes during the interview as a support for our later analysis. You give us permission that we may take pictures of parts of your residence:
□ No, no pictures may be taken
□ Yes, but the pictures may not be published
□ Yes and the pictures may be published in a professional journal (you will be contacted for permission if one of your pics are needed)

Your participation is completely voluntary, which means that you have the right to refuse to answer specific questions at any time. You may also terminate our agreement without any specified reason and without any consequences for you. Data, which has been collected during the interview, will then be destroyed.

Your anonymity is likewise assured through changing or deletion of personal information such as names and place names. You will be given a random name that will be used when your data is analysed. Likewise your name will never be mentioned in relation to a publication of the results.

I HAVE HAD THE OPPORTUNITY TO READ THIS STATEMENT OF CONSENT, TO ASK QUESTIONS ABOUT THE STUDY AND I WISH TO PARTICIPATE.

_____
Participant name

_____ _____
Participant signature **Date**

_____
Interviewer name

_____ _____
Interviewer signature **Date**

If you want us to forward our future article, when this (or these) is written, write your email here:

_____

11.8. Appendix H: Interview Guides

Pilot interview guide, Danish:

(opbygget som stikord til inspiration undervejs)

Intro:
Vi er ved at skrive speciale og derfor er vi her.

Vi laver en undersøgelse om hvordan psykiatribrugere forholder sig til deres hjem og hverdag og hvordan de bruger det.

Det virker ikke til at være undersøgt så meget, det synes vi er interessant og vigtig.

Her har du samtykkeerklæringen.

Personfakta: (tegne bolig-oprids)
Vi starter stille og roligt.

- Hvad er dit navn?
- Hvor gammel er du?
- Familiesituation?
- Historik i forbindelse med psykiatri, et kort oprids?
- Hvor længe har du boet her i din bolig?
- Hvilken slags bolig er det?
- Hvilken behandling har du fået/får du?
- Hvor langt tid er det siden det begyndte, hvornår stopper det?

Hjemmet (fokus på miljøet):

- Kan du fortælle os lidt om dit sted her?
- Vil du vise os lidt rundt?
- I det daglige, hvordan gør du med din dør, er den åben, lukker, låst?
- Hvorfor valgte du at bo her?
- Hvad betyder det at bo her for dig?
- Hvad laver du i lokalområdet?
- Bor du anderledes her end andre boliger du har haft?
- Hvad betyder hjem for dig?
- Hvad giver dig følelsen af hjem? Findes den i din bolig?
- Hvordan kommer det frem her for dig? /or not?
- Hvorfor tror du at hjem har fået den betydning for dig? Har det ændret sig undervejs i dit forløb?
- Hvorfor har du indrettet din bolig som du har?
- Hvordan ser en almindelig morgen/dag/aften/nat ud for dig?
    - Hvad laver du?
    - Hvad laver du i hjemmet?
    - Hvem er du sammen med?
    - Hvor opholder du dig mest?
    - Er der nogen grund til at du gør lige præcis sådan?
- Er der nogen dele af din bolig der er særlig vigtige for dig, fx ting eller rum?
- Hvad bruger du dem til?
- Ift. Din historik i psykiatrien:
    - hvordan kom de udfordringer til udtryk for dig i din hverdag og dit hjemmeliv før din behandling? (Hvordan? Kan du særligt huske en gang?)
    - Oplever du noget af det i dag? Hvordan? Kan du særligt beskrive en gang?

Hjemmet i behandlingens tegn:

- Hvad har din behandler sagt til dig at du skal gøre derhjemme?
- Hvordan blev du forberedt på at komme hjem (personen selv og systemet)?
- Hvad skete der da du kom hjem? Hvad gjorde du da du kom hjem?
- Hvordan var det at komme hjem til alle dine ting?
- Hvilke ting havde du med under din indlæggelse? Hvorfor? Hvor er de nu?
- Ser din dag anderledes ud nu efter din behandling/indlæggelse?
- Har dit hjem og din hverdag været en del af din behandling?
- Hvilken rolle spiller dit hjem i din behandling?
- Hvordan oplever du dit behandlingsforløb i din hverdag?

Sociale forhold:

- Forholdet til forældre/søskende/partner/børn/naboer/støttepersoner?
- (Forholdet til de andre beboere/personalet?)
- Hvad gør I sammen?
- Hvis du skulle holde selskab i morgen?

Slut:

- Er der noget du gerne vil tilføje til det vi har snakket om, som du ikke synes vi er kommet ind på?

Pilot interview guide, English:

(organized as key words for inspiration throughout)

Intro:
We are in the process of writing our thesis and therefore we are here

We are doing a study of how psychiatry users relate to their homes and everyday life and how they use it.

It doesn't appear to have been researched very thoroughly, which we think is interesting and important.

Here is the consent form...

Personal information (draw residence, make quick notes)
We start off very slowly

- What is your name?
- How old are you?
- Family situation?
- Psychiatry history, short version?
- How long have you lived here in your residence?
- What kind of residence is it?
- What treatment have you received/are you receiving?
- How long as it been since it began, when does it end?

Home (focus on the environment!)

- Can you tell us a little about your place here?
- Will you show us a little around?
- In your everyday life, what do you do with your door, is it open, closed, locked?
- Why did you choose to live here?
- What does it mean to live here for you?
- What do you do in your surrounding area?
- Do you live differently compared to other residences you have had?
- What does home mean to you?
- What gives you the feeling of home? Is it here in your residence?
- How does it emerge here for you? / or not?
- Why do you think home has gained this meaning to you? Has it changed during your trajectory?
- Why have you furnished your residence the way that you have?
- What does a regular morning/day/evening/night look like for you?
    - What do you do?
    - What do you do in your home?
    - Who are you together with?
    - Where are you mostly?
    - Is there any reason that you do exactly that?
- Is there any part of your residence that is particularly important to you, fx things or rooms?
- What do you use them for?

- With your history in the psychiatric system in mind
  - how have these challenges surfaced in your everyday life and your home life prior to your treatment? (how? Do you particularly remember one time?)
  - Do you experience any of that today? (how? Can you particularly describe one instance?

Home in light of treatment:

- What has your treatment provider told you that you have do at home?
- How were you prepared to come home (the person itself and the system)?
- What happened when you got home?
- What did you do when you got home?
- What was it like to come home to all your things?
- Which things did you bring along with you for your admission? Why? Where are they now?
- Does your day look different now after your treatment/admission?
- Has your home and your everyday life been part of your treatment?
- What role does your home play in your treatment?
- How do you experience your treatment in your everyday life?

Social relations:

- The relationship to parents/siblings/partner/children/neighbors/treatment providers
- (The relationship to other residents/staff)
- What do you do together?
- If you had to make a party tomorrow...?

Conclusion:

- Is there something you would like to add to what we have talked about, which you don't think we have touched upon?

Final interview guide, Danish:

(Ændringer på den originale guide er i kursiv)

FAQ:

- Hvad skete der?
- Hvornår skete det?
- Hvorfor?
- Hvem var der?
- Ved de noget om din behandling?

Introduktion:

- Rollefordeling – *vi supplerer hinanden undervejs, en af os er dog primær interviewer, den anden er primært observatør, men kan komme med opfølgende spørgsmål*
- Formålet med vores undersøgelse er at finde ud af mere om, hvad ”hjemmet” betyder for nogle af psykiatriens brugere. Gennem interviewet vil vi gerne høre mere om, hvordan netop du oplever, forstår og lever i dit hjem og din dagligdag. Derfor har vi fokus på dine rutiner, din oplevelse af dit hjem og dine erfaringer i hverdagen samt hvordan din behandling indgår i og påvirker alt dette. Vi er interesserede i disse ting, fordi der i stigende grad er fokus på ambulant behandling i psykiatrien i stedet for indlæggelser, men hvad betyder dette for den enkelte i forhold til deres hjem og hverdag?
- Samtykkeerklæring

Kernespørgsmål:

- Personlige oplysninger (navn, uddannelse, alder, diagnose)

- Kan du fortælle om hvad der i starten fik dig til at søge behandling og diagnosticering?
- Hvornår lagde du eller nogen omkring dig først mærke til problemer i din hverdag?
- Hvordan så dit liv ud, da blev syg? Hvordan oplevede du din sygdom derhjemme og uden for hjemmet?
    - Hvordan blev du behandlet?
        - Har du haft nogle ting med i behandlingen?
    - Hvordan bliver du behandlet nu?
        - Tager du nogle ting med i din behandling?
- Hvordan mærker du din behandling i din hverdag?
- *Hvad betyder hjemmet for dig?*
- Har dit behandlings/sygdomsforløb ændret dit syn på hvad dit hjem betyder for dig?

Indlæggelse:

- Hvad skete der da du kom hjem fra din indlæggelse?
- Hvordan var det at komme hjem?
- Hvordan har din behandler forberedt dig på at komme hjem og have din hverdag?
- Hvilke udfordringer har der været i at komme hjem og din behandling?
    - Medicin (konsekvenserne af denne ift. både hverdag og fysiske omgivelser?)
    - sociale relationer
    - rutiner/vaner, der skulle ændres/er kommer til

Ambulant behandling:

- Hvad gør du inden du skal af sted til ambulant behandling? Og efter det?
- Hvad har været sværest for dig i din behandling?
    - Medicin (konsekvenserne af denne ift. både hverdag og fysiske omgivelser?)
    - sociale relationer
    - rutiner/vaner, der skulle ændres/er kommer til
- *Har dit syn på dig selv ændret sig som led i dit forløb?*
- *Hvordan har du det med din nuværende behandling? At det blev det?*
- *Praktisk omkr. behandling:*
    - *Hvor er det?*
    - *Hvordan kommer du derhen?*
    - *Hvad betyder det for dig i din hverdag?*
    - *Hvordan oplever du det?*

Behandling i hverdagen:

- Hvad gør du inden at bostøtten kommer og besøger dig?
- Hvad betyder medicinen for din hverdag?
- Har nogle ting i din bolig været vigtig for dig i din behandling?
- Hvor opholder du dig mest? Når du har det godt/skidt?
- Hvad er din holdning til det psykiatriske system ud fra dine erfaringer?
- *Hvor meget er du oppe i hovedet?*

Andre spørgsmål:

- Hvad giver dig følelsen af hjem? Findes den i din bolig?
- Hvordan kommer det frem her for dig? /eller ej?
- Hvordan ser en almindelig morgen/dag/aften/nat ud for dig?
- Hvilken rolle spiller økonomien i din hverdag? (Hvordan får du det til at løbe rundt?)

Konklusion:

- Vi er kommet rundt om det meste vi ville spørge om
- Er der noget du gerne til sige eller uddybe/tilføje?

Debriefing!