Practices of Being Near: An Ethnographic Study of Family Members & Persons with Lived Experience of Mental Illness

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October, 2018

A thesis submitted to McGill University in partial fulfillment
of the requirements for the degree of Doctor of Philosophy

Abstract

Evidence underlining the vital role of social support in trajectories of personal recovery highlight the critical role of family members and mental health service providers. Family members are primary sources of support for persons living with severe mental illness, whether they are relatives or chosen from a broader circle of relationships. However, family members report being excluded from and unsupported by mental health services, increasing their burden of care and leading to a decline in their own physical and mental well-being. In response, recent recovery-oriented mental health policies aim to put the voices of family members at the centre of health services delivery and to create services that are culturally sensitive to the self-identified needs and values of diverse families. New approaches are needed that not only build upon the strengths and capacities of individuals living with mental illness, but that also support and build upon the capacities of family members', service users' and service providers' efforts to create supportive environments through actual practices and strategies. In this ethnographic study, I followed persons with lived experience of mental illness and their family members during nine months, conducting participant-observations and in-depth narrative interviews around their significant events and experiences. Drawing upon the phenomenological theories of Martin Heidegger and Hans-Georg Gadamer, and a narrative-phenomenological framework developed by Cheryl Mattingly, I present thick descriptions of three phenomena that have emerged from a hermeneutic analysis: excursions, furnishing, and standing by. Within the study participants' context of hospitalization and heightened uncertainty, I venture an interpretation of these actions, sustained across contexts and time, as practices of being near. I conclude the dissertation by discussing how considering together the perspectives of family members and patients can lead to a different way of seeing, which may then become the grounds for a different way of acting.

Keywords: family, ethnography, psychiatric hospitalization, practice, experience

Résumé

Les données soulignent le rôle vital du soutien social dans les trajectoires de rétablissement personnel mettent en évidence le rôle crucial des membres de la famille et des fournisseurs de services de santé mentale. Les membres de la famille, étant des proches ou encore faisant parti d'un cercle de relations élargi, sont les principales sources de soutien pour les personnes vivant avec une maladie mentale grave. Cependant, les membres de la famille rapportent être exclus et non soutenus par les services de santé mentale, ce qui alourdit leur fardeau de soins et conduit à une dégradation de leur bien-être physique et mental. En réponse, les politiques récentes en santé mentale axées sur le rétablissement visent à placer la voix des membres de la famille au centre de la prestation des services de santé et à créer des services culturellement sensibles aux besoins et valeurs rapportés par des familles diversifiées. De nouvelles approches sont nécessaires, qui non seulement s'appuient sur les forces et les capacités des personnes vivant avec une maladie mentale, mais qui supportent et renforcent également les capacités des membres de la famille, des utilisateurs et fournisseurs de services afin de créer des environnements favorables par le biais de réelles pratique et stratégies. Dans cette étude ethnographique, j'ai suivi pendant neuf mois des personnes ayant une expérience vécue de maladie mentale et des membres de leur famille, conduisant des observations de participants et des entretiens narratifs approfondis autour d'événements signifiants et de leurs expériences. En me basant sur les théories phénoménologiques de Martin Heidegger et Hans-Georg Gadamer et sur un cadre narratif-phénoménologique, développé par Cheryl Mattingly, je présente une description détaillée de trois phénomènes qui ont émergé d'une analyse herméneutique: les excursions, l'ameublement et être prêt. Dans le contexte d'hospitalisation et d'incertitude accrue des participants, je propose une interprétation de ces actions, soutenue à travers les contextes et le temps, comme une pratique de proximité. Je conclue cette dissertation en discutant comment considérer les points de vue des membres de la famille ainsi que des patients ensemble peut mener à une différente manière de voir, pouvant ensuite devenir le fondement d'une autre manière d'agir.

Mots-clés : famille, ethnographie, hospitalisation psychiatrique, pratique, expérience

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Acknowledgments

This research was supported by the Canadian Institutes of Health Research MD-PhD trainee stipend program.

I am profoundly grateful to Dr. Melissa Park, my PhD advisor and mentor, and to Ms. Janet Stewart and Dr. Laurence Kirmayer, members of my supervisory committee, for their constant support and guidance. To the families, patients, and staff members in this study, who invited me into their worlds and shared with me their experiences, I cannot give thanks enough. The support and belief of my teachers, colleagues, classmates, and friends have made this dissertation possible – thank you for all of your generous encouragement and for all that you have taught me. Thank you, my parents and grandparents, from you I learned my first stories of family. I dedicate this thesis in memory of Hu Cheng, my grandfather.

Preface

As the candidate I attest that this thesis is an original work of scholarship. It is written in the traditional monograph style. I conducted all stages of the thesis study including conceptualization, choice of theoretical frameworks, recruitment, data collection, analysis, interpretation, and writing. Vital conceptual and methodological guidance were given by my research supervisor, Dr. Melissa Park. With Dr. Park and my supervisory committee, I had regular meetings to discuss methodological choices and issues and concepts emerging from my interpretations of the data. To them and to teachers, colleagues, and classmates at McGill University and at conferences, I presented research in-progress and received feedback that allowed me to address issues and shape the major concerns of the study. I am the sole author of the chapters in this thesis. Chapters 1 and 2 articulate the study background and methodology that form the basis of this study. Chapter 3 provides the ethnographic context of the study. Chapters 4 to 7, comprising the study findings and discussion of their theoretical and clinical implications, are contributions to the advancement of knowledge. Chapter 8 provides a concluding overview of the study.

Chapter 1 Introduction

Being Alongside Health and Illness

During a lecture in my first year in medical school, one of our teachers displayed a graph from a research study that showed medical students would lose their empathy by the end of their medical training (Neumann et al., 2011). Most students entered medical school with high levels of empathy, but by the time they graduate, their levels of empathy would have significantly declined. The implication was that something about medical training itself was eroding students' empathy. To emphasize this point, the lecturer, a physician, remarked that studies done with students from other health disciplines have found the same downward trend.

I was, and am still, interested in the field of psychiatry, and at that time, people in the field were worried about the loss of seeing the patient as a person. For example, there was fear that the *Diagnostic and Statistical Manual of Mental Disorders* would reduce people to a checklist of symptoms while the rise of medications would necessitate understanding people only in terms of biochemistry and leave out the meaning of their illness. My classmates and I were concerned that we would lose our empathy and, even worse, that we would see stories as not worth gathering or as impediments to clinical work.

A few years prior to entering medical school, during my undergraduate studies, I conducted data collection for a neuroscience laboratory that was trying to map selfhood in the brain. As the research assistant, my task was to show participants in the study a series of images designed to evoke emotional responses. These images were taken from a standardized pool, the *International Affective Pictures System,* that had been created in the United States and validated cross-culturally. Following the experimental protocol, I asked the participants, recruited from a university in Taiwan, to lie down in a Magnetic Resonance Imaging (MRI) machine, after which I projected onto a small screen in the MRI machine around 40 pictures from the *International Affective Pictures System*. Beneath each image was a yes-or-no question posed to the participant – "Is this picture related to your self?" – to which the participant must give her most immediate impression, pressing a button in one hand for "no" or a button in the other hand for "yes". Although it was not part of the research protocol, I wanted to know the meaning of the variable of self-relatedness for each participant, so I asked my supervisor if I could ask the participants for their meanings, and he said I could do so in a post-experiment debriefing:

> "Were any of the pictures really special to you?" I asked one of the participants after a radiological technician and I helped her exit the MRI machine. In her answer, she referred to a close-up image of a bare arm, the upper arm tied with a rubber tourniquet and a needle with syringe being inserted into the lower arm. "The needle made me think of someone my group of friends and I are very worried about," she replied slowly. "He uses drugs. We want to help him, and in the past it.…" She closed her eyes, trailing off. "It wasn't good."

Her story stayed with me. It struck me that even though the study question had asked her about her own self, when she saw the picture she was not thinking about herself but about her friend who had an addiction and the group of friends who were trying to help him. Though the question was directed at her "self," it evoked a response that involved many other people.

I returned from this research experience to my neuroscience classes. In one class, we studied the visual neuronal pathway. A diagram was used to show us the rods and cones of the retina that were activated in the presence of light, that were connected to neurons in the primary visual cortex that encoded the shapes of objects, that were connected to neurons in the secondary visual cortex that encoded direction and speed and even faces, and that these neurons, in turn, would then connect to the thalamus at the sensory integration centre of the brain, and the visual information would continue to be transmitted to other parts of the brain to make possible visual perception. At each step along this visual pathway, integration of neuronal signals occurred and as the integration across different levels of organization was happening, something we were seeing was becoming meaningful to us. But I did not think that it was the physiological organization itself that gave meaning to what we see in the world.

In parallel with my studies in neuroscience, which often referred to the relevance of greater understanding of the nervous system for treating neurological and mental illness, I began to look for what people had written about their own experiences of mental illness. I found an essay in a newspaper by a man who did not want to take antidepressant medications (Ku, 2011). He was worried that the medications would change who he was as a person. He was afraid that if he took medications and felt better then the person he thought he was would not really have been real. Only at the end of the essay did he add that he is married, and that he and his wife are expecting a child. He then writes that he wants to be a good father and husband, and that he will take the medication in spite of his own qualms about doing so. I was struck by how his own concerns fell to the side in light of his desire to be a good father and husband.

When I read the newspaper essay and listened to the research participants in the neuroimaging experiment, I was struck by these stories. The stories were not just about the author nor participants themselves, but also about other people. Their stories were not about isolated selves, but about selves who were connected through their concern for one another. What I did not know was how meaning was created, nor the role of other people in creating that meaning. When I read the stories and listened to the research participants in Taiwan, I was struck by their stories. Their stories were not just about themselves, but also about other people. Their stories were not about isolated selves, but also about selves who were connected through their concern for one another. I wanted to learn about how meaning was created, and the role of other people in creating that meaning.

In his theory of hermeneutic phenomenology, Heidegger (Heidegger, 1962) writes in reaction to the transcendental phenomenology of his teacher, Edmund Husserl. He takes up the question of Being, starting not from transcendental structures, but from a Being that is inseparable from its World: objects, projects, and other Beings in its world. Thus Being is always a Being-with. The structure of being with other Beings in the world, of being-alongside other Beings, is to have concern and solicitude towards them (p. 158).

Regarding the question of meaning, Heidegger's phenomenology helped me to understand why I was struck by the presence of others in the stories I had read and heard. Being could not be separated from other Beings, and the meaning of Being's world for Being could not be separated from other Beings in its world. Although at the end of my undergraduate studies and in the first year of medical school, I wished to learn about meaning from the perspectives of the humanities and social sciences rather than the natural sciences, I was still interested in the field of mental health. I found myself developing a doctoral research study that could generate an understanding of the experiences of being-alongside for family members and persons with lived experience of mental illness.

Taking a Lens Upon Action to Understand the Experiences of Families

In the qualitative health research literature, in studies based upon open-ended interviews with family members who occupy a caregiving role to persons living with mental illness, family members report the significant demands upon them to contribute informal care: monitoring symptoms and medication (Marquez & Ramirez Garcia, 2011), providing assistance with transportation and other activities of daily living (Donnelly, 2001; Rooney, Wright, & O'Neil, 2006; Rossen, Stenager, & Buus, 2014), creating a safe and receptive environment for one's relative (Mijung Park, 2012), and helping relatives to have a sense of confidence (Lee, Yamada, Kim, & Dinh, 2015). Studies show a complex picture of family members' experiences (Aldersey & Whitley, 2015), reporting that their own health is negatively affected (Amir, 2016; Hernandez & Barrio, 2015; Schulz & Sherwood, 2008); that they experience fulfillment and satisfaction from caregiving while also reporting feeling burdened (Bauer, Koepke, Sterzinger, & Spiessl, 2012; Donnelly, 2001; Mijung Park, 2012; M. Park & Chesla, 2010; Rooney et al., 2006; Wyder & Bland, 2014); and that the family as a whole undergoes significant change (Gibbons, Ross, & Bevans, 2014). While playing an integral role in the lives of persons with lived experience of mental illness, family members also report being unsupported and excluded from mental health services, particularly during acute phases of treatment, such as emergency services and inpatient hospitalization (Ally, 2015; McNeil, 2013; Saunders, 2013). A major reason, family members cite, is that policies protecting the confidentiality of patients results in family members not knowing what is happening to their relative, leading family members to feel helpless (Leggatt, 2002; Quah, 2015). Living with the chronic and recursive nature of mental illness, and its at times overwhelming demands upon them, family members face uncertainty and question themselves: "Why did it happen?"; "How do I protect my loved ones?"; "What has it done to me?"; "What has it done to us?"; "How do I survive?" (Endrawes, O'Brien, & Wilkes, 2007).

Viewed in light of Heidegger's phenomenological structure of persons already being-alongside one another, the reports of family members from the qualitative health research literature show a picture of people who are present to one another even as they experience the various, often challenging circumstances, brought about by illness and hospitalization. Family members, while not knowing what is happening to their relative, are still oriented towards them, are still, in Heidegger's descriptions of being-alongside, concernful and solicitous towards them. In the worlds of family members, persons with lived experience of mental illness matter greatly even as they may not be physically present to one another due to hospitalization and as living with the conditions of illness – for family members live also with the effects of illness – can sometimes be overwhelming.

In Heidegger's hermeneutic phenomenology, Being's relationship to its world is characterized by the notion of comportment, Being's way of being-in-the-world. In more descriptive terms, Being is oriented towards the conditions of its world, and gathers itself in its world. Furthermore, Heidegger provides the insight that Being's comportment in its world discloses an understanding that Being already has. Because the World is largely given to Being, as Being finds itself in a World that has largely not been made by itself but by others and the past, one would expect Being to be at a loss for what to do. However, that Being is not at a loss, but always finds itself in a particular orientation to its World, means that Being already has an understanding of how to be in its world. Being's orientation to its world reveals an understanding it already has that is prior to any reflective or theorized understanding; this understanding, writes Heidegger, is a structure of Being's existence.

The experiences of family members, as reported in the qualitative health research literature, depict family members and persons with lived experience of mental illness being-alongside one another in a world shaped by conditions not of their own making – by conditions of the illness itself, the organization of healthcare services, and the effects of living with and answering to the demands that chronic illness places on persons and those around them. Following Heidegger's insight that comportment reveals an understanding of how to be in that world, family members possess an understanding of how to be in the very situations that they face.

Family members recognize that they have relevant knowledge and expertise to contribute and that they wish such knowledge could be called upon, included, and used in therapeutic treatment plans (Leggatt, 2002; Quah, 2015). In research study interviews, family members respond that they have knowledge gained from having lived with patients for many years, of what has and has not worked in the past, of the antecedents and presentations of symptoms. Drawing upon the hermeneutic phenomenological theory of Heidegger, I wish to suggest that family members also possess a deep knowledge and expertise, cultivated over time, that has become something like a stance that guides their actions in the everyday. This deep understanding – in Heidegger's phenomenology, disclosed by one's comportment in its world – is revealed in the actions that family members take, over time, in the face of certain enduring conditions.

Choice of Ethnographic Methodology and Thesis Aims

The qualitative health literature reports examples of actions of family members: such as involving their relative in the day-to-day tasks of running a shop, offering emotional support when their relative's mood is low, reminding their relative to take their medications according to schedule, and offering accounts of their relative's medical and social history to treatment teams when they are asked to provide this information. However, there is a lack of knowledge of the actions that family members take over time and of the deeper, implicit understanding from which these actions arise.

For this reason, I have employed an ethnographic methodology as a means to understand the actions of family members over time. I have followed family members prospectively as their lives unfold to be able to see, when there is a variety of possible courses of action, which possibilities become actuality and how the world of the potential becomes the world of the actual (Jackson, 2005). In particular, I have employed a narrative-phenomenological interpretive framework (Mattingly, 2010) for its lens upon action, its inclusion of multiple perspectives, and its centering interpretations around what is "at stake" for particular persons at particular times. Using this interpretive framework, elaborated upon in the next chapter and informed by theoretical resources from Heidegger and Gadamer, I aim to represent in this thesis an understanding of the practices through which family members and persons with lived experience of mental illness are alongside one another in concrete, particular situations from the lives of actual people. A broader aim of this thesis is to provide a person-centred understanding of how that which family members and persons with lived experience of mental illness care about and value organizes their world and guides their actions.

The Openness Required by Understanding

In "Truth and Method", Gadamer (Gadamer, 2004) offers an analysis of understanding that is achieved by entering into dialogical relationships with things in the world. Gadamer, in his conception of the dialogical relationship, does not claim that entities such as texts, objects, and ideas are alive and respond autonomously to us, or that to be dialogical requires speech. Rather, we are in relationship with something we are trying to understand, such as a work of art, because "it has something to say to us" (Gadamer & Bernasconi, 1986); that is, things in the world have something to reveal, signify, or mean to us and we are called to not turn away. An important concept of Gadamer's account of understanding is the "horizon", which encompasses all that persons can see and imagine at a certain moment, given their individual backgrounds and histories as well as their membership to particular cultures, traditions, and historical eras. In what Gadamer terms the event of understanding, one's horizon is enlarged by fusing with the horizon of that with which one seeks to understand. A transformation of the person also occurs, because in being open to that which is different, a part of oneself becomes more similar to what was once unfamiliar, and this contact leads one to become changed from what one had been before (Davey, 2012). Understanding requires openness to the unfamiliar and to also becoming changed. Gadamer's characterization of our relationship with understanding leads us to consider not only, "What can we do with understanding?" but also, "What does understanding do to us?" Understanding has a claim to truth, as well as a claim upon us to change.

I wish to suggest that the claims differ between understanding in the form of numbers and understanding in the form of stories, in the form of interpretive qualitative health research. Numbers invite comparisons and facilitate the creation of standards that individuals would aim to meet or surpass. Numerical data showing that a particular clinical intervention is superior, inferior, or equal to another in light of a chosen criterion (e.g. health-related outcome, safety, efficiency, convenience) has a particular claim on us. Such data compels us to make a decision about whether to continue in our current practice, or to do something different. These decisions may then be acted upon by persons working alone or together, in such local actions as placing hand-washing posters in one's clinic or finding a suitable physical therapist to whom one can refer clients, to wide-spread actions such as developing guidelines and policies, and asking individuals in diverse settings to commit to them. When we are faced with people's stories and perspectives, however, I wish to suggest that their claim on us is not one primarily of comparison. The claim of interpretive qualitative research on stakeholders, and the possibilities for change and action that they support, is not only of whether to continue in or change from current protocols taken as necessary, but also requires us to respond to: How does one recognize that the situation one faces can be informed by the experiences of others who have acted in similar circumstances? How does one become the kind of practitioner able to imagine the meaning of a patient as he or she wishes to be, to discuss the potential gains and losses of a medical intervention, to refrain from viewing symptoms through a single lens of meaning, who is open to that which he or she has not anticipated? This is a questions of what Aristotle has termed *phronesis*, that can be grounded in ethnographic accounts.

These concepts characterize a capacity for adapting to the particular needs and priorities of different people and contexts, of being responsive to what is different and unexpected in others and allowing this difference to also change oneself. I wish to suggest that detailed accounts of others, in the forms of stories, can offer understandings to support the ongoing cultivation by those around family members and persons with lived experience of mental illness to become more open to new understandings. That an understanding of how family members and persons with lived experience of mental illness are deeply alongside one another, and how their world is experienced by being already present to one another, can help healthcare practitioners to cultivate a stance of openness to the experiences of the patients and families with whom they work.

Chapter 2 Methodology

Theoretical Frameworks

I have chosen and used three interrelated theoretical frameworks. I draw upon Heidegger's existential structures from his analysis of Being, Gadamer's theory of hermeneutic experience, and Mattingly's narrative-phenomenological framework. I employed the theoretical frameworks for different purposes: Heidegger's phenomenological theory provided the outlines of a picture, sensitizing me to the existence of structures in a world I would not otherwise have seen; Gadamer's framework guided me in the process of filling in the outlines; and Mattingly's narrative-phenomenological framework provided the colours with which I filled the lines, for her framework enabled me to grasp the most significant experiences, follow them in the field, and identify them from the data collected.

Heidegger's phenomenology relates objects to Beings and Being to other Beings. As I have described in the previous chapter, Heidegger pointed out the existential structure that Being is always already alongside other Beings. To fill in this structure with colour and arrive at a picture of what family members are doing, I will elaborate below upon the theoretical frameworks of Gadamer and Mattingly: in my study, Gadamer offered a process for understanding how being-alongside is lived in a local context and Mattingly's framework pointed out the significant moments that reveal concrete, particular details of what matters to participants in their being-alongside.

Gadamer's theory of hermeneutic experience and a comportment of openness.

The influence of Hans-Georg Gadamer's (2004) theory of hermeneutic experience runs throughout this study, having shaped my comportment in the field, my remarking of significant moments, and the analysis, interpretation, and representation of the data. I chose to take up Gadamer's theory of hermeneutic experience as a foundational theoretical orientation because the interpretive process that leads to understanding is characterized as having a living relationship with something – a work of art, a text, another person – and being open and listening to what it has to say (p. 282). Being in a relationship with that which one is seeking to understand means that one is not in a position of examining it from a detached position, but that one brings all of one's interpretive resources, including one's past, to the task of understanding.

An essential interpretive resource is the foreknowledge that we have as historical beings, which Gadamer calls prejudice and prejudgment. Although prejudice has long been regarded negatively, Gadamer draws attention to the positive value of prejudice in understanding for if we recognize the prejudice, prejudgments, and foreknowledge that we carry, from which we project meanings, we can ground our interpretations more "in the things themselves" rather than in judgments that are arbitrary and "overhasty" (p. 290). The task of grounding our interpretations in the otherness of that which we are seeking to understand requires us, writes Gadamer, to hold ourselves open to different understandings even when no one is forcing us. The qualities of forming an understanding that is ever being deepened and revised, grounded in the phenomenon itself rather than in one's own expectations, anticipations, and projected meanings, were fitting for this study upon experience and supported me in making detailed observations that is central to ethnography.

Although Gadamer did not intend for his theory to be a "method" of understanding, elements of his theory of hermeneutic experience enabled me to be-alongside others during fieldwork and sensitized me to register moments of heightened emotions and bodily and emotional responses in myself (Davies & Spencer, 2010; Melissa Park, 2008). Many moments, particularly at the beginning of fieldwork, involved waiting and the sense of not very much happening overtly, but because something we are trying to understand has something to say to us, I did not turn away. In not turning away I learned that there was the presence of something deeper. Because human beings hold foreknowledge and project possible interpretations based on the knowledge we already have due to having history, we may be mistaken: this in the field often resulted in moments of surprise, thwarted expectations, and things turning out to be not as they initially appeared. I marked these moments and during the analytical stage found them to be turning points when an encounter in the field had led me to see the study participants and situations in a different light. Experiencing surprise especially indicated that something new is breaking through as these were moments when my prejudgments were altered by the situation at hand. Marking these moments when they occurred have later proved fruitful during analysis, for these moments of surprise, mistakenness, and revision of understanding point to prior understandings that I have carried into a fieldwork encounter. The revealing of these prior understandings implied the presence of structures, antecedents, and horizons of meaning that shape my own world and the worlds of the participants.

Mattingly's narrative-phenomenological methodology.

Developed by Cheryl Mattingly (Mattingly, 1998, 2010, 2014) through longitudinal ethnographic research projects, this framework draws from conceptual resources in phenomenology and narrative theory. Mattingly's framework flows from Heidegger's hermeneutic phenomenology, placing human beings within everyday, already-existing conditions of being embedded in significant projects, finding oneself in the company of others, and being oriented towards one's world through care. The narrative theory underlying the framework holds narrative as being composed of desire, significance, and suspense, which structure human action. I chose the narrative-phenomenological framework as it foregrounds the identification of individuals' agency amongst social structures, by making it possible to discern how persons take creative action in the face of conditions and circumstances over which they have little control. The framework contains the following orientations to data collection and interpretation:

Person-centred. Data collection and interpretation will foreground the particularities of a person's lifeworld rather than proceed from social categories to which a person may belong (Mattingly, 2010, p. 29-30). How do elements of a person's lifeworld come to take on significance for him or for her? What hopes, desires, values, and meanings do persons hold?

Event-centred. Echoing philosophical anthropologist Michael Jackson, how individuals react following events reveals who they are, the subjective and intersubjective meanings that the event holds for them, and their position as creative agents and as subjects of structural and circumstantial constraints (Jackson, 2005). Within the context of the study, following events and other significant experiences allows for access to the perspectives of multiple persons and to what is at stake for them, which guides their actions following events.

Discursive. Data collection and analysis will also focus upon discursive practices that persons employ to perform actions (Garro & Mattingly, 2000). How do participants describe themselves and their experiences? How do people draw upon broader cultural and societal discourses for one's own purposes?

As I enacted the frameworks throughout the study to understand what being-alongside means in the local worlds of family members, Gadamer's framework guided me to listen, approach, and be closer to the significant experiences and events that Mattingly's framework enabled me to locate. Gadamer's framework, the act of colouring closer to the lines, became a stance I held during fieldwork and interpretation that allowed me to stay with study participants and their significance experiences. In the beginning, the urge to turn away from situations in the field was very powerful because I did not fit into the world I had entered. However, as Gadamer says, gaining understanding through interpretation means being open to what things in the world have to say to us. This allowed me to enter into a position of being alongside the patients and family members over time. A narrative-phenomenological framework has made me attentive to moments of suspense, surprise, and small details and acts located in the everyday that take on force and significance in light of larger horizons and projects.

Sites of Study

My first entry into the field occurred one-and-a-half years before the start of my dissertation study in August 2015. I was a doctoral student apprenticing as an ethnographer in a study funded by the Canadian Institutes of Health Research and led by Dr. Park (Melissa Park et al., 2014), “Transforming Mental Health Services”, a participatory action research project upon the implementation of recovery-oriented policies in a Department of Psychiatry of a general hospital. This hospital was located in and served the population of a highly multi-cultural region of a city in Canada. The department offers a variety of services, organized into Emergency psychiatry, adult inpatient and outpatient services, and child psychiatry, serving a catchment area of more than 340,000 people. My apprenticeship involved attending the Morning Planning Meetings twice each week, wherein inpatient staff members reported upon patients’ statuses and discussed admission and discharge planning. It led me to know and to be known by several members of the staff. Later, when I began conducting this ethnographic study, I turned to these staff members for any referrals of family members to this study. By the time I re-entered the field in March 2017 to begin fieldwork, I was familiar to many of the staff members. They remarked that they have not seen me in a long time and asked me if I was part of the “Recovery Team”.

Gradually, the Inpatient Psychiatry Unit became the core site of my ethnographic data collection. Initially, patients, staff, and visiting family members invited me to sit beside them on the unit and to sit in during activities that were happening on the unit, such as occupational therapy activity groups, movie nights, music groups, and eating lunch in the day room. On one instance when I hurried from the outpatient services to the inpatient unit to not miss an occupational therapy session, wherein one of the study participants had invited me to sit with him as he painted, I saw that I had formed relationships with the patients, staff, and visiting family members that determined the pattern across time and space of my fieldwork encounters, whereas initially my encounters in the field more closely followed the schedule and routines of the Inpatient Psychiatry Unit itself.

Recruitment

I recruited family members through referrals by staff. It was important for staff to make decisions according to the needs of their clinical practice, as they expressed a concern that for some patients they would not recommend the family member to be recruited into the study because the patient could perceive their family member's involvement in a way that would damage the therapeutic relationship between them and the treatment team (e.g. one staff member explained that a certain patient would perceive his family member's involvement in a research study as an additional, unwanted action by the hospital: "We don't want it to be seen another intervention by the hospital…it might affect the alliance.").

"In our work we start with the patient and go towards the family member," said a psychiatrist working in outpatient services to me when I had approached him for family member referrals. "You are seeking to do it in reverse with the family member first." To preserve the patient's autonomy and confidentiality and to align with the values and practices of the staff members, I also sought to approach the patient first and to ask if it can be possible to speak with the family member, before approaching the family member. I stated that I would be seeking to understand the family member's perspective and not asking for sensitive information upon the patient.

In seeking referrals from staff members, I presented upon my study to three multidisciplinary teams working between the hospital and community. I approached through email and in-person meetings social workers, occupational therapists, nurses, and psychiatrists, who worked both in the inpatient and outpatient units. Several of the staff members replied that while they had spoken to family members about the study, no one was interested to participate. One of the social workers from inpatient services said that many of the patients she works with have few family members. Half of the clients upon her list "do not have family. They are estranged from one another. One person has not had contact with their family for 15 years, and do not know where they are." Another social worker said that she did not want to refer any family members who were "launching complaints against the hospital. Who are not on good terms with the patient." Upon telephone contact, several family members said that they did not have time. In the end the family members recruited into my study were referred to me by a psychologist and a social worker working in inpatient services. For the three families represented in this dissertation, the patients are men, the family members are women, and during the time of my fieldwork, experienced more than one period of inpatient psychiatric hospitalization.

Because of the desire for family members to participate, but due to their uncertainty about whether they could commit to being followed for a longer period of time, I developed two parts, so that the study could expand with them if they were available to be followed. The first part was a single narrative-based interview and the second part consisted of interviews and participant-observations over time. This was particularly fitting for family members who were not initially sure of the length of time they may have. They could consider the study as an activity to participate within according to their schedules, by varying the frequency of encounters for research. Once I had received full ethics approval, I returned to all the individuals whom I had intended to follow to ask if they would like to participate in the longitudinal aspect of the study and for participant-observation at sites other than Hillside Hospital. The flexibility in this study allowed me to arrive at an arrangement of being able to follow Brienne, who lived an hour-and-a-half's drive from the city, and Paige, who could not visit the hospital easily due to long hours at work and due to a separation in her marriage. For several patients upon the unit who wished to participate in the study, having two components meant that I could offer to have them participate in the first part, a single interview, so that they would not be excluded from their desire to participate when I was no longer in the recruitment phase.

I stopped to recruit any new participants in August, in the fifth month of the study. By that time I had been continuously following three other families, when at this time the fourth family in my study was recruited. Of the six families I had consented into the study, it is four that I have continued to follow. The other two families did not withdraw, but it is that I stopped to follow them after a period of prolonged contact. I had known the first family recruited into my study from May until September, and had asked to organize a follow-up interview, but the family member was very busy. For the sixth family, I had had initial contact with them in August and my last contact with them was in October, once more because the family member was busy. In this dissertation I do not present data from the fifth family as I have not finished following them. Data presented here are from the second, third, and fourth families I recruited.

Data Collection

I was in the field from August 2015, practising narrative interviews with patients, treatment staff, and to a lesser extent, family members while participating in data interpretation using Mattingly's (2010) narrative-phenomenological methodology with research team of the Canadian Institute of Health Research and RxD Health Research Foundation's Partnership in Health System Improvement grant (2013-2017) (Melissa Park et al., 2014). After conducting four months of intensive participant observation at the Department of Psychiatry at a large urban hospital to understand the context of the inpatient unit, under the CIHR "Transforming Mental Health Services" as an apprentice ethnographer, I received approval from the Research Ethics Board in July of 2017 for my ethnography. My dissertation is based on data collected from April to December 2017.

Participant observation.

In this study, employing Mattingly's narrative-phenomenological methodology, I followed patients, family members, and staff to understand their perspectives around significant events. I spoke with and conducted participant-observations alternating between patient, family member, and staff; this translated to alternations between the voices of different people, and juxtapositions of differing perspectives, in the following chapters. Participant observation, sometimes characterized as "hanging out" by researchers employing the method, entails the researcher witnessing, describing, and making sense of the routines, actions, and dialogue of a group of people while also taking part in their activities. I conducted participant observation in the Inpatient Psychiatric Unit for a period of nine months. I attended the Morning Planning Meetings twice each week. As time passed, I was invited into other spaces in the Inpatient Psychiatry Unit: from structured, clinical activities, such as the daily community meeting and the weekly music group, to emergent places, by going with a patient to the bank, to a Jewish holiday dinner, and to another area of the hospital to play the piano. I also conducted participant observations with patients in areas outside of the hospital, such as in smoking areas, at the fruit market, and at community centres, and with family members and patients in the community.

I did not enter into certain situations, such as more in-depth treatment team meetings and therapeutic discussion groups, to not cause discomfort to staff members and patients who expressed to me that these settings should be wholly confidential. However, I was invited by patients, family members, and staff in particular moments to attend family meetings, to participate in occupational activity groups, to accompany someone on an errand, and to stand in as a Mandarin-English interpreter when it was difficult to find someone else.

I wrote field notes immediately after the field encounter. I noted each field encounter in a log. In the days following the fieldwork encounter, I continued updating the field note to round it out with details that have come to mind only later. I took field notes in both a handwritten and digital, typed form. I noted sensory details of the place, dialogue, and gestures, what preceded and occurred after moments that I have registered as emotionally heightened and surprising, for myself and the participant. While there are many approaches to participant observation, I was broadly guided by a typology of Emerson, Fretz, and Shaw (1995), who conceptualized the participant-observer as a photographer, actor, and poet, paying attention to visual and spatial details of the physical setting; the actions that individuals perform, the activities they are engaged in, and their speech, gestures, body language, tone of voice, and facial expressions; and the rhythm of activities, emotional atmosphere, and meanings left unexpressed. I noted observations that I anticipated would most quickly fade from memory, such as segments of remembered dialogue and visual details of a scene. I noted the sequence of events and marked moments and details that I registered as bearing significance, an early interpretive act. For up until several days after an encounter in the field, I continued to write down recalled details to "thickly describe" (Geertz, 1973) the situations I had experienced as a participant-observer.

Narrative-based interviews.

I conducted in-person, open-ended and unstructured narrative interviews with the family members, patients, and staff members to elicit stories about significant moments in the recovery trajectory of families. Narrative interviewing invites participants to speak freely about significant experiences and events related to a phenomenon (Mattingly & Lawlor, 2000). Narrative interviewing does not use a predetermined structure or content of questioning, but instead invites participants to speak freely about significant moments and events related to their experience of a phenomenon.

At the start of my following the family members, I conducted an initial in-person narrative interview with each family member. I also conducted in-person follow-up interviews as their schedules allowed. With family members, after they were no longer coming to the hospital, my interactions with them continued by telephone at a frequency set by the participants and at an hour convenient to them. I continued to conduct participant observations and informal narrative interviews with the patients, who were receiving treatment on the Inpatient Psychiatry Unit, as they were comfortable with me doing so. This was a data collection process that emerged during the study. It resulted in that I would follow the different participants contemporaneously, as the family member would speak about an event on the telephone and the day after I would visit the Inpatient Psychiatry Unit and see the patient and staff members responding to the event. The telephone calls ranged from a frequency of biweekly to monthly and around a major event, such as a return to hospitalization, discharge, or move to a different clinical site, or a patient's birthday or visit to family. With Brienne I had the greatest number of in-person interviews and we continued to speak by telephone after her son was discharged from the hospital. With Clara I had the least number of phone calls and had significant in-person interactions with Alistair present. With Paige, I had more frequent phone calls and few instances of participant observation with her present.

I also asked the staff members if I could speak with them, especially following significant events. Although it took time for the interview to occur, they were not averse to doing so. They spoke with me, but their perspectives are most thin in my study and are the least developed; rather than their perspective, per se, it is the perspective of the system and of clinical practices, discourses from the Morning Planning Meetings, from interviews with them, that are represented in this study.

Multiple perspectives.

I have often wondered during my fieldwork, while preserving confidentiality for each participant, "Do they (the patient, family member, staff) know?" Yet what was given by taking a multiple perspectives lens was more than having information from one person that another may not have. The value to understanding has been to see persons in one setting, forming an image of them, and in a different situation, meeting them in a different context or in the stories others say about them, realizing that they are not saying or doing as I had expected based on previous encounters. I had the sensation, the impression, that I was meeting someone over and over – for example, I would first meet a patient as portrayed in discussions during the Morning Planning Meetings; then I would meet him or her in person; then in the stories of family members, staff members, and even other inpatients; and again during interaction in an activity upon the unit. This multiplicity has often led to surprise. Finding myself in a state of surprise has been important analytically, because that is when I am mistaken and the clarity around a prejudgment and how people see themselves arises.

Analysis and Interpretation

I conducted preliminary analysis and interpretation concurrently with fieldwork. During the last two weeks of August 2017, I took a two weeks' leave from the field to conduct more in-depth analysis and to locate the significant events.

I drew upon two interpretive frameworks, the theory of hermeneutic experience by Hans-Georg Gadamer and Cheryl Mattingly's narrative-phenomenological methodology, to locate the significant experiences as moments of surprise and unexpectedness and to see events as heightened moments that are implicated in multiple perspectives. Once I had done so, I applied Heidegger's descriptions of hermeneutic phenomenological structures to interpret the meaning of the significant moments identified. I included my own responses as an ethnographer in the analytical frame, as grounds for understanding a phenomenon as it unfolds before me.

As I wrote field notes, I became aware of and marked as significant observed details that appeared to stand out from others, that recurred in subsequent encounters, that were especially vivid, and that evoked emotion. At the end of the fifth month of fieldwork, I withdrew from the field for two weeks to conduct a more in-depth analysis of the data I had gathered up until then as a whole. I marked again the events, moments, and details that appeared to stand out more than the others. Around these significant moments, I identified and wrote descriptions of context and of preceding and subsequent details against which the significant moments that I had marked carried a more intense tone.

Every two weeks during fieldwork, I discussed with my PhD supervisor, Dr. Park, which moments were emerging as significant and for what reasons. With her reminders, I sought to first ground my thick descriptions in the actual words and actions of the research participants, instead of my own terms and concepts, to stay close to the language and experiences of participants (as Gadamer wrote, to ground understanding in interpretations of the things themselves). During these meetings with my supervisor I also marked my own emotional and bodily reactions to fieldwork experiences, particularly to moments of conflict. I conducted similar reflective discussions, at less frequent intervals, with members of my supervisory committee. The members of my supervisory committee have multiple disciplinary backgrounds and lived experiences. I have presented upon the study results, each of the three families, at three conferences (Society for Occupational Science, Society for Psychological Anthropology, and American Anthropological Association) between September 2016 and December 2017. I have also presented upon the data to the Culture and Mental Health Research Unit and the Rehabilitation Science Students' Symposium at McGill University, receiving feedback from peers and teachers.

During the writing phase, I turned my attention to writing first the details, moments, and events that I have repeatedly marked as significant. The first step of analysis was to locate significance – in events, details, and moments. I identified significant experiences as events that stand out from others by the recall of dialogue, description of sensory detail, shifts into present tense, heightened emotion, and use of metaphorical language (Mattingly, 2010). Something significant is happening when there is also a sense of suspense, drama, something we care about that is at stake for us, or something that we feel is worthy for us to live for. I put at the centre of my interpretations these significant moments, whether recalled in interviews or shared by myself and participants during periods of participant observation, to enter into participants' perspectives, understand what makes something significant for them, and see the overarching narratives to which particular acts, moments, and events may belong.

An important clue emerged during the interpretive process, which was that to understand what are the actions family members were taking with respect to patients, I needed to consider what are the actions that patients have taken with me. Each of the patients had invited me into their worlds. I have retained the concepts of excursions, furnishing, and standing by, depicted and discussed in the following chapters, as they have endured after I have taken multiple interpretive passes through the data, and as they are illustrated by multiple significant experiences in different contexts and at different times. After identifying the practice that emerged at the centre of each family's significant experiences, I returned to the data for each family in another analytical pass to identify and elaborate observed details that provide a grounding for the interpretations of excursions, furnishing, and standing by.

Representation of Interpretations

In the structure of the following chapters, one upon each family, I present thick descriptions of significant experiences. The significant moments have endured over the past two years of conducting the fieldwork and writing. I marked moments of surprise and heightened emotion as I continued spending time with the data. In the text of the chapters I have sought to preserve the order of events and details as I learned about them, so that the text may also represent the unfolding of experiences lived prospectively and the overlapping of different perspectives simultaneously followed. Through the accretion of details, I wanted to represent the felt sense of small acts and fleeting moments that reassert themselves over time and in different contexts. I have wanted to convey the sensations of being in a place, for it is a dimension of the reality of a place that undergirds the phenomenological world and holds explanatory power for understanding how people are affected by the places they are in, the situations in which they find themselves, and what they do in those situations and with what aims. I chose to write the descriptions in present tense to convey to the reader a sense of immediacy and of experiences unfolding in concrete, particular situations. In certain sections, I have used formatting more akin to literary stories in contrast to the type of academic writing more commonly found within a Faculty of Medicine or Rehabilitation. In this experience-near approach to representation, I have tried to stay close to moments of disorientation as I experienced them for they mark the horizons of unpredictability making themselves known**.**

In each chapter, upon each of the families, I have written of the first meeting with the family members and patients, as how I initially saw patients and family members changed by the end of doing fieldwork. The subheadings in each chapter reflect a structure of the world of the participants against which the practice recurs: 1) for Alistair and Clara, their practice of going on excursions took place in various contexts, and thus the subheadings mark the institutional context where Alistair was then residing; 2) for Xavier and Paige, their practice of standing by occurred across time, and thus the subheadings mark the passing of seasons and later, when more significant experiences were occurring with a greater density, the passing of months; 3) for Adam and Brienne, their practice of furnishing revealed itself amongst multiple perspectives, and thus the subheadings indicate significant objects. I placed the subheadings intending to capture Alistair's numerous and unpredictable displacements between institutional contexts and the many more excursions he takes *within* these institutional contexts; the increasing density of events for Xavier and Paige after his discharges and unexpected readmissions to the inpatient unit as everyone stands by; and multiple objects that pass back and forth between Brienne, Adam, his treatment team (and me), as they try to figure out what is the best course of action. I have used pseudonyms for the names of people, places, and organizations. I refer to the people in this study by the terms they use to convey their own positions: “patient”, “staff”, and “treatment team”. Amongst both the staff and patients, the doctors and psychologists are referred to by their titles and surnames while all other staff members are referred to by their first name; I have preserved this pattern of address in the dissertation.

Ethical Stance and Relationships in the Field

Lawlor (2003) emphasized the importance of upholding what she called a “relational ethics” in the field, an ethics based on responsiveness to research participants and to putting at the centre of ethical research conduct the relationship between researcher and those in the field. This relational ethics differs from an ethics solely determined by, and limited to, the following of clinical ethical guidelines and procedures. The ethical stance that I took in the field was after Lawlor's description of being relationally responsive. This led me to let the participants take the lead. For example, at times when they have indicated that they do not want to speak, I was particularly sensitive to not proceed. At times I exercised restraint so that I could better see or hear if people in the field were telling me that they did not wish for me to be there. There were times when Alistair, for example, asked me not to turn on the recorder. For Adam and Xavier, they did not want to be recorded in their speaking, but each of them said to me that they are happy to speak with me while they are in the hospital. I explained during the informed consent process that their healthcare would not be affected by their decision to participate in the study.

There were some matters that I had worried may come to pass but that ultimately did not. In the family studies literature, authors raised an issue of maintaining internal confidentiality between family members, of family members demanding from researchers to know information about other family members (Hall, 2014). This did not occur; the only times were few, when Paige asked me if I ever spoke to Xavier’s psychiatrist, to which she accepted my answer that I did not know of the details of Xavier’s treatment plan, which was also the case. The patients knew I would be speaking with the family member; Xavier informed me that his wife wishes me to call her (“Please call my wife,” he said to me); Adam asked me routinely whether I have been speaking with his mother, almost by way of greeting; Allister knew Clara and I make plans to visit him. None of the patients have asked me what do the family members and I talk about.

There was an understanding amongst the study participants that I did not have a therapeutic role. Brienne had said, “I do not mean to put pressure on you,” after describing some of Adam’s struggles. Yet my presence had significance to the family members, patients, and staff, one that was not of overt action, but of listening and of, as Xavier had put it, “being there.” As my own practices began to mirror that of the family members and patients – of going on excursions with Alistair to more distant sites, of bringing in objects to the ward to show Adam and playing the piano, of watching Xavier during the morning occupational therapy activities sessions, I found myself reflecting that I occupy a position, a being-alongside, that may otherwise be occupied by a family member or friend were they to be physically present if the demands of their own lives (e.g. employment) allowed. Upon my exiting of the field, several of the participants noted that they would like to know the findings of the study.

Many of the patients and staff members upon the Inpatient Psychiatry Unit knew I was doing research, and often took the time to ask me how my study was going, and whether I was planning to talk to someone that day ("Have you found someone to talk with today?"). Besides as researcher, my identity on the unit was perceived in a variety of ways:

> "Come in, come into the nursing station, you are a part of our team," said the head nurse.
>
> "They are psychology researchers," said a psychiatrist, introducing a fellow ethnographer and me at a family meeting.
>
> "I thought you were a psychiatrist," said a man who is a patient. "You're the flute lady. Now I place you. I was scared to talk to you because I thought you were a psychiatrist," referring to the times I had played the clarinet on the unit.
>
> "Are you a student?" asked a patient.
>
> "Are you a social worker?" asked a different patient.
>
> "She is not a patient," said one nurse to another, looking in my direction.
>
> "She is *my* researcher," said Alistair, introducing me to his friends and fellow patients.

From the perspectives of different people, I was someone they could talk to:

> "We will miss having another person whom patients can talk to," said a psychologist-in-training, when I informed her I will be taking two weeks' leave from the field to analyze and write upon the data I had collected.
>
> "My mother appreciates your phone calls," said Adam. "It was like having a friend," he says of our interactions, on the day of his discharge in December.
>
> "I feel very much alone," says Paige. "Please don't stop calling."

I was often noticeably out of place in the field.

> “You are always standing – I always see you standing – why don’t you sit down?” asked one of the orderlies.

Patients responded to this by inviting me to talk and to join activities. As they were filing into the occupational therapy room, they would ask for me to join them in the room as well. Seeing me hovering in the doorway as activities unfolded within, they invited me in, calling from their seats. A woman led me, her had gently placed on my left elbow, into the occupational therapy room while Diana, the occupational therapist, affirmed that it was not a problem for me to stay. Dr. Stills, a psychiatrist, invited me to sit in at family meetings, with the permission of the patient and family members. After being invited by Adam, one of the participants in this study, to play the piano, I was further invited to play music by other patients and even a few staff members. After seeing Adam bring his guitar to the day room, although he did not play it, I began bringing my clarinet case, and also stowing it in the day room in a spot similar to where he had placed his guitar case.

Because I frequently felt out of place, and worried that I would be asked to not return to the unit for any number of imagined reasons, I found myself seeking to find a suitable place on the unit in which to be. I unstacked and restacked chairs before and after the Morning Planning Meeting; I participated in the Community Meetings and activity sessions each morning in the occupational therapy room; I ate lunch in the day room with the patients. Most conspicuously I turned to music: after playing a piece for Adam upon the piano, I brought more sheet music the next time I visited the ward. I brought also my clarinet. It addressed my anxiety at not having a place, that I could bring out music into the space of the unit when it is asked for. Once, on one weekend, I played a piece for a patient as his mother visited. Yet as I came to occupy particular spaces in the later months of fieldwork, I learned that doing so did not guarantee belonging; the clarinet music I attempted to play in a closed unit was deemed too loud, and a staff member expressed concern that my playing the piano could result in a patient becoming reluctant to leave the unit as his discharge date approached.

Chapter 3 "Visiting Hours Are Ending"

In this chapter I present details of the context of the Inpatient Psychiatry Unit, which emerged as the main site of this ethnographic study. To form a backdrop for the following three in-depth case studies, the four sections I have chosen to write, below, explore overarching experiences of the inpatient unit as 1) a place distinct and distant from the everyday world in which 2) staff members face daily pressure to discharge patients so that beds can be filled by people waiting for admission; 3) patients, staff, and family members perform acts that reveal one another's humanity; and 4) patients, staff, and family members face the existential question of whether change is possible. These overarching experiences emerged from significant moments, drawn from across the entirety of my fieldwork that pointed to conditions affecting patients, staff, and family members together. I have used, respectively, the words of a patient, staff member, staff member, and patient as the four section titles. Their words speak to experiences affecting all who are implicated as actors in the Inpatient Psychiatry Unit.

Phenomenologically speaking, the first two sections pertain to the structures that shape the world in which human beings are thrown. In the context of the present study, these structures include: the spatiotemporal organization of the unit; the rules and policies ensuring patients' safety while limiting their autonomy; and the pressure to admit new patients and thus discharge current patients into uncertain situations when there is a limited number of beds. The last two sections describe creative acts that patients, staff, and family members perform to relate to one another as human beings in potentially dehumanizing contexts. It is important to start from an initial image of patients, family members, and staff already employing their agency to later be able to see the practices in which they repeatedly engage across time.

"The Outside World Is So Far Away"

> "Can you bring in some *bao zhi*?' Maria asks in Mandarin for some steamed buns. One of the inpatients, she always speaks with me in Mandarin, her mother tongue. We are sitting around a circular table in the day room, one of the common areas of the Inpatient Psychiatry Unit where people can come to watch TV, play board games, read, or simply sit to talk or to pass the time. "If you have them at home?" continues Maria. "Just one or two. I just would like to taste one, again." She turns

> her head to look beyond the window. “The outside world is so far away,” she says. “It’s a different world, here.”

Hillside General Hospital sits upon a hill at the intersection of two major streets, a kilometre from two subway stations on separate transit lines that traverse different parts of the city. The hospital overlooks one of the most multicultural neighbourhoods in the city. Upon one street are apartment buildings with brick facades. The perpendicular street is lined by restaurants, markets, a public library, and a community centre attached to a public elementary school. In the same plaza as widely-known department stores are also Asian and Middle-Eastern supermarkets, shawarma restaurants next to a pizza parlour beside a flower shop, dollar stores and luggage stores independently owned, a convenience store; branches of popular coffee shops, sandwich stores, and burger chains; a French-language bookstore by a copy printing shop beside a brunch restaurant and a pub. Opposite the hospital is a Tim Horton’s coffeeshop, a bank, a Mexican fast food restaurant, a mattress store, and a Community Health Services Centre. Above everything, the dome of St. Anne’s Cathedral rises from the top of the hill.

Inside the Inpatient Psychiatric Unit at Hillside General Hospital, on the sixth floor in one of the hospital’s oldest pavilions, there are three areas that figure largely in the experiences of the staff, family members, and patients (please see Appendix A for a diagram of the layout of the unit). To get to the unit after taking the elevator to the sixth floor, one needs to take two left turns. The double metal doors to the psychiatry unit read “ADULT PSYCHIATRY”. After May 2017, these doors became locked and a buzzer system was installed so that all patients and visitors must ring the buzzer and receive permission from the unit clerk to enter and exit the unit (the staff do not have to ring but instead swipe their access cards). Straight behind these front doors, a long corridor stretches, connecting the patients’ rooms of the Open Unit. At the end of this long corridor is another double set of locked doors, behind which is Closed Unit B. To the left of the front doors is a wider hallway leading to the kitchen, day room, occupational therapy room, and conference room. At the end of this hallway are the double locked doors of Closed Unit A.

Upon the Open Unit there are thirty beds and eight beds each in Closed Units B and C. Patients on the Open Unit are in a more stable medical condition, while patients in Closed Units A and B are at risk of harming themselves or others. The Open Unit contains the day room, occupational therapy room, and conference room. Patients on the Open Unit are free to use any of these areas and to go out of the unit for set periods of time with permission from their treatment team. In contrast, patients in both Closed Units are not usually permitted to go out of the locked area, though sometimes they are allowed to go on the Open Unit for the duration of a scheduled activity, such as music groups or occupational therapy sessions, while accompanied by a staff member. The hallways and common areas of the Closed Units are under greater surveillance, patients wear hospital gowns as they are not permitted to wear their own clothes, and meals are brought to those units and eaten there. Closed Unit A is a more secured and confined space than Closed Unit B, and patients who are determined to need more containment are placed there. Patients can be transferred between the three different units as their symptoms change.

Nursing station.

The nursing station on the Open Unit is very small, with an alcove to one side. There are cabinets holding stacks of folders of paper. The furniture, walls, and cabinets are all white. Next to, in front of, and behind shelves of stacked charts, staff members fill in forms, write reports, apportion appropriate dosages of medications into clear plastic bags to be later given to patients, and teach students. Beside the nursing station is a small pharmacy where there is a stool for patients to sit and receive their medications by injection. Somewhere in the nursing station is a depot of donated clothes, some brought from home by the staff, that are given to patients who have been admitted from Emergency psychiatry and do not have their own clothing. Sometimes when I see someone wearing clothes that fit them loosely, I wonder if they have received clothes from this depot. Not every patient can wear their own clothes. In the Open Unit Patient's Booklet, it is written that patients will be given a hospital gown and need to have written permission to wear their own clothes and to leave the unit: “This decision is based on your behaviour and safety,” reads a page from the book. As a compromise between hospital-issued garb and clothes that are comfortable and familiar, sweatpants with “Open Unit” embroidered in small letters over the left pocket area were created and given to patients to wear.

Outside the nursing station, the hallways of the inpatient unit are narrow. The small space makes it difficult for two people to pass by one another. A staff member is pushing a cart of binders and documents, and another staff member turns her body around to let the cart go past. Pushed against the walls, at regularly spaced intervals, are laundry hampers and metal carts upon which hospital gowns and towels are stacked. Some of the patients walk up and down the hallway, in front of the day room, around the corner by the unit entrance, down the hallway of patients' rooms, and back again. Other patients stand, waiting at the partitioning windows of the nursing station where the schedule for smoking breaks is posted next to a bulletin board made of cork. Upon the bulletin board is pinned a sheet of paper – titled "Who is My Nurse Today?" – showing which nurses and patients have been assigned to one another. In blue pen, the names of five to six nurses are underlined, and the names of five to six patients are handwritten beneath the nurses' names.

Day room.

Around the corner from the nursing station and the hallway of patients' rooms, there is the day room of the Inpatient Psychiatry Unit which is the largest open area in the unit. Though still relatively small, no larger than a school classroom, its layout combines the styles of living room and cafeteria. At one end, adjoining Closed Unit A, is a wall bearing a TV that faces a couple of chairs with faded, pink cushions arranged in the shape of a U. Along the wall next to the TV is a broken exercise bicycle. Along the long wall are windows offering a view of the hospital parking lot, the residential area stretching down the side of the hill, and neighbourhoods in the distance. Upon one of the window ledges sit piles of board games (chess, checkers, Monopoly, Jenga, Chinese checkers), jigsaw puzzles, and old magazines, the edges and corners of the board game puzzle boxes worn, the covers of the magazines torn from frequent reading and faded in the sun. In front of the ledge is a ping pong table, upon which four worn paddles and two white ping pong balls have been placed in an old puzzle box. Between the nearby two windows is a bookshelf with room for more books. Between the next two windows is a green chalkboard, on which is written in white chalk the schedule of activities for the day.

Each week, a different patient on the Open Unit volunteers to be the person who writes the daily schedule. Today, on Tuesday, there is a medication education meeting for patients at 9:30 AM, a Community Meeting at 10:15 AM, Occupational Therapy at 10:30 AM, and lunch at noon. At the bottom of the chalkboard someone had written the message, "Have a nice day", in block letters and drawn a small smiley face at the end. Supper begins at 5 PM but it is rarely written on the board. On most afternoons of the week, except for Friday, there is a group activity: Dr. Bouna's patient discussion group on Monday, Outreach discussion group on Tuesday, Expression discussion group followed by music group on Wednesday, and Wellness group on Thursday. The discussion groups occur in the occupational therapy room or the conference room, while during the music group and mealtimes, patients gather in the day room around the several circular tables, each surrounded by four to five chairs, that fill the rest of the space.

Continuing clockwise, along the third wall and facing opposite the wall displaying the TV, is a counter at chest-level that leads to a kitchen behind. At meal-times, an orderly wheels a cart of meals to the kitchen, each tray with a slip of paper bearing the patient's name and a list of items. At ten minutes before the start of mealtime, patients form a line leading up to the counter. The unit clerk stands behind the counter to give out the trays. Most of the time she would recognize the patient and hand him or her the matching tray, but for new patients she would pause for a moment to ask for their names. Next to the kitchen counter is a small side table where foods leftover from meals – cardboard cartons of milk, fruits, and sandwiches – are placed for anyone to take. Upon the table are also packets of Red Rose tea, a small woven basket containing packets of sweeteners and, for a time, a container of Maxwell brand instant decaffeinated coffee that quickly became empty. Beside this table is a desk with a computer. Along the fourth wall, opposite the wall of windows, is another desk with a computer and a phone for patients' use. Adjacent to these objects is an ice and cold-water dispenser that both patients and staff members use. Beside the water dispenser is an old upright piano. The dark wood of the piano is scratched in many places. An empty cardboard shipping box for medical supplies sits on its top.

Although the day room contains many objects that are old or broken, it is a place where life on the inpatient unit continually unfolds. The day room is never quite empty. Staff members walk through the length of it on their way to Closed Unit A and to their offices. Patients wave to staff as they rush past; sometimes the staff wave and smile back. Patients and staff members also meet to talk in this area, sitting across from one another at one of the round tables or on the sofas in front of the TV. Often, more than one meeting occurs at the same time. Nurses enter the area to take patients' blood pressures with automatic blood pressure machines. An orderly pushes an empty bed across the length of the day room and down the adjoining hallway. Patients play ping pong, attempt to pedal on the broken exercise bicycle, and sit in front of the small TV. Sometimes patients play upon the broken piano with several missing keys, tinkling a couple of notes as they walk past, but most of the time its lid remains closed. Maintenance staff come into the day room to wash the inside surfaces of windows and to install new panels for the worn and faded ceiling that is continuously being repaired. Men and women of all ages sit at the tables to talk, to look out the windows, to drink tea, to play Jenga, and to spend time alone. One time, in the day room, a man is sitting upon his chair to receive a haircut, a barber's cape covering his chest and torso. An orderly stands behind him, running an electric clipper slowly down the back and sides of his head. Upon each of his shoulders a pile of light, grey hair has fallen.

It is quiet during the afternoons. Usually there are only a few people sitting at the tables and in front of the TV, or no one at all. If they are not in the day room, patients are in the afternoon group activities, sleeping in their rooms, or out of the unit, which means they could be at court, looking for an apartment, interviewing to be housed at a community mental health organization, or on a pass which is to have free time. On some afternoons, especially during the visiting hours from 2 PM until 8:30 PM, the day room is filled with people and the outside world enters. Two brothers play chess. Several brothers and sisters sit around a table in silence, next to a patient who is looking down. A man carries a white plastic bag heavy with Styrofoam boxes of takeout to a table where another man and woman are sitting. An elderly woman gives a box of chocolates to a man who removes the lid, takes a chocolate, and passes the open box to those around him. A father leads his young son by the hand as they walk towards the room of the boy's mother. At other times, the computers and telephone are often in use. A young woman looks up a schedule for Spanish classes at the university she attends, wanting to take all the available courses from Levels 1 to 7 so that she can earn a language certificate. A man fills out a job application form. A woman shows me on her Facebook account photos from a vacation that she had taken with her daughter to the Caribbean, one of her favourite places in the world. She types in the address to her personal website, where she posts passages from the Bible that she finds inspiring. A woman sits down beside a man who is playing music videos on Youtube. He begins to sing along in a high, sweet voice.

Even though the outside world is far away, people have an urgency to continue with their everyday lives. On the nearby telephone, a man makes a call to inquire about his provincial tax return. Someone makes calls to look for an apartment to rent. On another morning, a psychiatry resident, Dr. Grace, and a man are sitting in front of a computer. Upon the screen is a spreadsheet and calculator:

> "…times eight hours a day times five days a week times four weeks a month," he says rapidly, his voice rising and his gaze downward, "is two thousand, is twenty-four hundred dollars. That I will never get back. Gone. Just gone. I am losing money by being in the hospital. My rent…"

> "Yes, I understand that," says Dr. Grace in a quiet voice, "but your life is more important. Your *life*," she says with greater emphasis, leaning forward in his seat and looking into his face. "You have talents. If we find what you're interested in…"
>
> "What I'm interested in!" The man rises from his chair and walks away.
>
> For a moment she remains sitting, facing the empty chair and computer, before rising and going to find him.

He would rather stay out of the hospital and continue to work, so that he can earn money to cover his rent. By becoming an inpatient, he would lose income and possibly his job and apartment, but the staff believe that he needs to stay in the hospital to receive treatment that could save his life.

Occupational therapy room.

Facing the day room, the occupational therapy room—like the nursing station, hallways, and common room—is another space where patients can go outside of their own rooms. Off the entryway is a small room, with a computer, printer, and black guitar case with metallic borders. The perimeter of the occupational therapy room is lined with cabinets, counters, and shelves. In one part of the room is a stove, a fridge, and a sink, comprising a small kitchen area that is used every second Friday morning during a Fun Group that involves making pancakes, fruit salads, pizzas, cookies, cinnamon rolls, and lemonade. In the middle of the room is a long, rectangular table and several round tables, with chairs pushed in underneath their sides. Upon the walls, above the doorframe and on some of the cabinet doors, are displayed patients' artworks. By the entrance of the doorway of the room is a full-length mirror and an erasable, wall-sized schedule, where the activities of the week are written. Opposite this is a bookshelf, shelves of paints of a variety of colours, and plastic cups of paintbrushes lined up side by side. In the corner facing the kitchen is another bookshelf displaying books and magazines. On some of the cabinets are materials for metalwork. Others contain piles of paper of different sizes, thicknesses, textures, and hues. There are decks of playing cards and trays of sorted beads and string. Upon the counters, leaning against the wall, are pieces of metallic art. On other counters are portfolios – large pieces of construction paper folded in half, containing artworks, word searches, and crosswords belonging to each patient. The light in the room is white and warm.

Every morning patients gather in the occupational therapy room for the Community Meeting, a brief meeting wherein patients share updates about how they have been, ask questions, and read and share their impressions of an inspiration quote. After this meeting, until lunch, is time for activities. Patients paint, play cards, thread beads into necklaces and bracelets; read, do crossword puzzles, make origami; work with clay, wood, and metal, as two occupational therapists go from person to person in the room, bringing requested materials and asking patients questions about their work. In the Fun Group, on one Friday morning, the activity is making cookies. A man wearing a towel around his neck spreads butter onto the cookie sheet, greasing it. A young woman, who day after day eats alone without speaking to anyone beside her and without anyone initiating conversation with her, stirs the batter with a long, wooden spoon. Beside her hand, by the bowl upon the table, is a red measuring cup filled to the brim with chocolate chips that she will later pour into the batter. Diana, the occupational therapist, has been singing along to a song on the radio.

> "I haven't heard this song in a long time," she says.
>
> "It's Justin Timberlake," says Raymond, one of the patients.

The cookies are placed into the oven to bake.

As the group waits, Diana starts a game of hangman on the whiteboard. Holding a black erasable marker, she makes horizontal ticks for letters that she counts silently to herself and draws two perpendicular lines at the left to represent the gallows. The aroma of cookies baking, of vanilla and butter, fills the room. There are murmured hopes that the cookies will be ready soon.

> "I want to guess the first word," says a man, whom the staff during a meeting described as having an intellectual disability and who had been in a forensic psychiatric institution for eight months prior. "Lemonade," he guesses correctly.
>
> "Lemonade on a hot summer day!" someone calls out from the back of the room, solving the rest of the puzzle.

The lemonade is finished quickly, poured into plastic cups that Diana reminds the patients to hold on to because there are no cups available on the unit for patients to use. The cups that come with meals must be returned to the cafeteria at the end of mealtime with the rest of the trays and containers. On another day, when one of the patients asks out loud if anyone has a cup as he stands in front of the cold-water dispensing machine, another patient gets up to wash his cup in the washroom sink before offering it to him.

“Can We Use His Bed?”

At 9:20 AM on a Monday morning, I stand outside the conference room, located opposite the day room and the occupational therapy room on the Open Unit. Upon the closed door is a weekly schedule of activities taking place in the room: Dr. Bouna’s patients’ discussion group and the medication education meeting, as well as exercise group on Wednesday mornings, yoga on Thursday afternoons, and various team meetings for staff and students filling out the rest of the schedule. Through the closed door I hear the muffled sounds of a table being moved and chairs being arranged. I am ten minutes early for the Morning Planning Meeting, but I open the unlocked door and enter anyway.

Inside, Nurse Geneve is placing chairs in a large circle almost to the perimeter of the room itself. On Mondays, when broad clinical plans are made for the rest of the week, more than thirty staff members and students from inpatient services would gather to discuss information about the number of admissions, the statuses of the patients, and whom on the unit can be discharged over the following few days. I set myself to helping Geneve arrange the seating. I locate a stack of chairs with green cushions and metal framing near the door, pull it out, and begin placing them to extend the circle she has already started.

> “How many do we need?” I ask, wondering if the whole stack of chairs would need to be arranged, for the circle of chairs is already quite full.
>
> “We’re going to need all of them,” she replies.

As we finish placing the chairs, staff members enter the room and fill the seats quietly. Any conversations are between two or three people. Sometimes, one can hear the sounds of the day room just on the other side of the longest wall, notes played on the piano, a ping pong ball bouncing, sometimes someone’s voice momentarily raised in laughter or in a shout. I take a seat and look around the room. Like the chairs of the day room, the ones in here are also worn. A couple are visibly broken, and one with an especially low seat and a torn cushion is often the last one to be taken. The walls also have several small areas that are scratched or peeling off. There is a small, faded reprint of a Renoir painting hanging in the corner, its pink and green hues visible from across the room. Upon the four bulletin boards placed around the room are pinned papers pertaining to training and educational presentations for staff; pie charts summarizing risks and incidents made by the Continuing Quality Improvement committee; and a large piece of paper bearing patients’ ideas on what they like and do not like about the inpatient unit, made during an occupational therapy discussion group.

It is 9:35 AM now. Twenty-nine people are in the conference room and still more are trickling in. They sit with purses and backpacks on their laps or placed on the floor by their feet, with coats unzipped and still upon their shoulders or taken off and folded over the back of the chair. Soon, all the chairs are filled. Any additional staff members who arrive will find that there are no free chairs left. They stand in an alcove, one by one. Someone moves to offer a chair; another waves her hand towards her own seat, and the staff member standing shakes her head and smiles. Someone makes do by sitting on a table pushed against the wall. When another person enters, she shifts further along the table to make room for one more. The last person to enter stands, holding her coat and handbag in her arms as she listens. As patients face a dearth of cups upon the unit, the staff face shortages also, from time and patient beds to having enough seats at meetings.

Today, the first update of the meeting is that there are many patients in Emergency psychiatry. A psychiatrist says that when he left the hospital yesterday evening there had been more than six patients in Emergency. When a nurse from Emergency psychiatry arrives to stand at the doorway, everyone's attention is turned to him. Dr. Bouna, the head of inpatient psychiatry services, asks him to read from his notes the names of patients in Emergency by order of priority, starting with the patients to be admitted. First is a man who had been waiting in Emergency for the past six days. The second is a man who is a new patient to the staff. Third is a man with whom the staff are familiar.

> "Oh God," someone says, upon hearing the news that he is back in Emergency after being discharged a short while ago.
>
> There are several sighs and murmurs.
>
> "He must have seen the new James Bond movie," says a staff member to my right.
>
> "It has to do with Paris," says the staff member to my left, quietly, referring to the recent terrorist attacks in that city.

For another individual, a staff member says:

> "He is back because it's the end of the month. His money has run out."
>
> "If he does something, he will end up in jail…" adds another.
>
> "He is belligerent," intones someone else.

> “We are afflicted,” says Dr. Bouna, who as the head of inpatient psychiatry is responsible for overseeing the use of beds. “We can admit three more people.” He asks a nurse to relay this information back to Emergency.

During another Morning Planning Meeting, the pressure to admit and discharge is not as immediate as on other days. The reports upon patients are more expansive. One staff member describes a woman as having poor motivation but a good support network. “Then she’ll do better on the Open Unit,” someone else intones, suggesting that she be transferred to the Open Unit where she can more freely socialize with other patients and participate in activities. “Closed Unit A isn’t where you get motivated.” Sometimes there are smiles from the staff when a fitting community placement has been found for a patient, for so few exist. Sometimes there are sighs, groans, and expressions of worry when it is announced that someone who was recently discharged is back in Emergency. The staff members go on to say about other patients:

> “He’s here because he constantly wants a job. He feels himself to be useless.”
>
> “We can’t discharge him. He’s too passive.”
>
> “He’s going to court this morning.”
>
> “She’s looking for an apartment.”
>
> “Lithium is helping him.’
>
> “Her parents won’t come to pick him up.”
>
> “She’s suggesting containment can help with her treatment.”

There is often greater demand for beds in the Closed Units than the Open Unit, for there is a fewer number of beds in the former and a significant number of patients awaiting admission are at risk of harming themselves or others.

> “We’re following the brother’s lead. We’ll do whatever he needs us to do.”
>
> “He went AWOL, was found in Lamontagne. Should we close his bed? It was washed.”
>
> “A man went out at 11 PM for his birthday over the weekend, on the town. He takes his taxi ticket, gives it to the taxi driver, they somehow have an amount left over to go have a burger meal, he returns at 3:15 AM. I hope his birthday will end soon.”
>
> “She reached an agreement with her sister to not have to babysit her children anymore. This is a small victory.”

> "His wife is exhausted. She says she can't take care of him anymore. She's burnt out."

During another Morning Planning Meeting, when the number of patients in Emergency waiting to be admitted to the Inpatient Unit is again high, Dr. Bouna asks a psychiatry resident:

> "Can the patient be discharged tomorrow? Can we send him home tonight? We can use his bed today." When the psychiatry resident does not answer, Dr. Bouna turns to a nurse. "Please let the team know we are at a surge and can admit four."

On this day there is a greater number of people than usual who are requiring admissions, waiting in the confined space of Emergency psychiatry for a bed to become free on the Inpatient Unit. Because there are almost always more patients requiring admissions than there are beds available, and often no more patients can be discharged to meet the demand for beds, sometimes for patients who have favourable statuses, or who are confined to the unit only because they are waiting to appear in court, the staff consider arranging for them to sleep at home. These patients, whose beds are "used" in the meantime to admit a patient requiring acute care, would still return to the unit for treatment during the day. For this reason, sometimes the number of patients on the Open Unit is greater than thirty, and the staff call this being "over census".

The pressure staff members are under to discharge and admit patients arises not only from the ever-present inflow of new patients to Emergency. It arises also from the staff's understanding of what the environment of Emergency psychiatry means for patients in the middle of a crisis. The rooms in Emergency psychiatry are newly renovated, but empty of any furniture except for beds bolted to the floor. It is often overcrowded. Patients to be admitted wear hospital clothing, green shirts and pants; they do not have access to their clothes and belongings, which are stored at the nursing station. The staff spoke of people staying in the hallways for days at a time as they wait to be admitted to the Inpatient Unit to begin treatment, because there are no available beds and rooms anywhere. The staff have called it a "terrible place" for people in crisis.

> "When you have sixteen people down there, it is a cage," says a nurse referring to the Emergency room during a reflective meeting for staff.
>
> "Closed Unit B is not much better, but the nurses there are perfect. Down there they are sitters, they don't care about our patients, they are sitters."
>
> Someone else intones, "It's inhumane down there."

The emotional tone changes throughout a single Morning Planning Meeting and between them. Against the pressure to discharge and admit, staff members' responses are often matter-of-fact. Sometimes Dr. Bouna's voice turns stern as he leads the group into the discharge planning, when during the discussion of patients' updates, the mood was more animated. Staff members, in desiring to "hold on" to patients who are not ready to be discharged against a pressure to let them go, do not always acquiesce to Dr. Bouna's questions.

On another Monday morning, the pattern of question-and-response is familiar:

> "How many in Emergency?" asks Dr. Bouna.
>
> "Twelve patients in Emergency. Five are waiting for admission," reads a nurse from his notes. There are groans from around the circle.
>
> "Let's go through the list," says Dr. Bouna. He reads the name of one patient after another, asking the staff gathered whether the patient is a suitable candidate for discharge. "What is the plan?" he asks, insisting that someone voice a solid reason for this person to remain on the unit. "Can they continue on the outside? Can they look for an apartment on the outside?"
>
> "He cannot be discharged," answers a social worker. "His apartment doesn't have a door. The landlord hasn't done anything about it for a couple of weeks now."
>
> "Can you imagine – two months!" says a nurse to a staff member next to him.
>
> "His landlord doesn't want him back," continues the social worker.

Dr. Bouna looks down at the paper in his hands. He reads aloud the name of the next patient on his list.

> "She just got here," says Dr. Carlin in response to Dr. Bouna's unspoken question of suitability for discharge. She shakes her head "no".

Dr. Bouna reads out the next name. Erica, an inpatient social worker, replies that the treatment team is waiting for the administrative steps of her community placement to be finalized.

> "Can't this be done on the outside?" asks Dr. Bouna.
>
> "Yes," replies Erica, "but it's easier to do all this when she is here. On the outside…"
>
> "I know," replies Dr. Bouna. "I am just thinking of the people waiting downstairs."

Dr. Bouna reads another name. It is one of his own patients. His voice softens.

> "We really held onto her this time because we want to give her the best chance possible at reintegration," he says, his voice quieter. "There are two patients this week whose reports are good," he concludes. "We can discharge them." He looks down at his page. "It looks like we have only three patients to discharge for this week," he says to the nurse who must report this information back to Emergency.
>
> "In conclusion," quips Diana, from her occupational therapy report, "everyone at the Expression group said they were doing fine, and so now we can discharge them all because they say they're well." Several staff members laugh.

Other times, however, the tone surrounding discharge is not light-hearted. A stark image emerges when a lack of free beds and of patients who are presently ready to be discharged on the inpatient unit is paired with knowledge that there are patients waiting in crisis in Emergency psychiatry. It is a difficult balance for staff between not giving in fully to the pressure to admit and discharge and not holding on to patients for longer than is necessary. Sometimes this tension cannot be resolved during the Morning Planning Meeting itself. During the discharge section of the Morning Planning Meeting, on another Monday, the tone turns sombre. Dr. Bouna is frowning as he reads from the papers in his hands. None of the patients he has just mentioned are affirmed for discharge. He reads out another patient's name.

> "Depressed," says Dr. Nadeau. There is no further discussion.

Dr. Bouna reads another name.

> "He's looking for an apartment. We can't discharge him until he finds an apartment," replies Dr. Jin, a psychiatry resident.
>
> "How long will it take?" asks Dr. Bouna.
>
> "You know, he has to get a lease, and –"
>
> "It doesn't mean tomorrow," says Dr. Nelson.
>
> Dr. Bouna says, "I want to let you know that we have had only three discharges this week."
>
> "Lucky Emergency was quiet this weekend," says Dr. Nelson.
>
> "But we are three over census," says Dr. Bouna, meaning that there are three patients of the unit who do not have beds assigned, who are sleeping at home. "Can other patients be discharged?" asks Dr. Bouna. "Can we use his bed?"

A medical student gives a quiet reply.

"Why the tentativeness?" asks Dr. Bouna, his frown still in place. "The 'maybe's…"

Sometimes, the Morning Planning Meeting is a special occasion, for example, the day the head administrators of the regional mental health services attend to explain the new re-organization of staff and mental health services in the hospital's catchment area. Going around the circle, the staff members introduce themselves by stating their position and the number of years they have been working at Hillside Hospital.

"Adult social worker. 15 years."

"Adult psychiatrist. 17 years."

"Geriatric psychiatrist. 16 years."

"Nurse. 16 years."

"Psychiatrist. 36 years."

"Psychiatrist. 42 years, 26 years of which were as a director."

"We serve a catchment area of 340,000 people," says Dr. Avery, the chief of the Department of Psychiatry.

After the administrators have presented the new changes, the staff members voice their questions and concerns.

"With all the paperwork we have to do, there is less and less time to talk with the patients," says Jean, a nurse who works in the Open Unit.

Florence, a social worker, raises an issue of a dearth of language- and culturally-appropriate units.

"It is a question of having money to create one," the administrator replies.

"We're lacking the infrastructure," says a staff member.

"The hospital has recognized that. A concern is that so much is demanded of us in an immediate manner."

At a later meeting, Dr. Bouna reflects back over the Morning Planning Meetings:

"I marvel at how we are able to do this day after day."

A social worker responds, "We were commended for doing much with very little resources. But it should not be this way. I worry it cannot be sustained…"

“We Have to Remember We Are Dealing with Human Beings”

During one of the Morning Planning Meetings, there is a disagreement amongst staff members about when patients in Closed Unit A should be allowed to wear watches. Dr. Nelson has noticed people in Closed Unit A wearing their own shoes, clothes, and other personal belongings usually kept stowed in the nursing station, including watches.

> “Is that a concern for safety, especially if you have to code someone or restrain someone?” Dr. Nelson asks, “I’m especially worried about the watches.”
>
> “Recently there has been a patient who lost his watch. He had an issue with it, and now all the patients in Closed Unit A want to wear watches, too,” intones a staff member.
>
> “Closed Unit A is a totally inhumane environment,” replies Dr. Bouna. “The staff are uncomfortable there. It wasn’t built for people to be there for weeks indefinitely. We have to humanize the environment to keep people for a long time. Smoking is not allowed, you can’t go anywhere, people are stuck there for six months for elopement risk,” he continues, his tone rapid and rising. He turns in his chair to look at Dr. Nelson. “We will keep what you said in perspective and ensure safety with good judgment.”
>
> “I am wondering though, what is the protocol?” asks Dr. Nelson. “And if the protocol can be made more clear?”
>
> “What do you mean by protocol?” asks Dr. Bouna.
>
> “I am wondering if there can be more clarity about whether an exception is being made, whether something applies to all patients or to a few,” replies Dr. Nelson.
>
> “Most of the time, the protocol has to be respected,” says Dr. Bouna. “We have to remember we are dealing with human beings. If there is a special request, particularly if the person has been there for a long time, I will let it go, to allow it to happen. John,” he continues, his tone softening, addressing Dr. Nelson by his first name for the first time at a Morning Planning Meeting, “it’s clear to me.”
>
> “It’s not clear to me,” answers Dr. Nelson.
>
> Dr. Bouna turns slightly away from Dr. Nelson towards the rest of the group seated in a circle. “It’s clear to the staff.”

> Dr. Nelson does not reply. The meeting moves to discuss the next updates.

After hearing Dr. Bouna speak of the need for staff to humanize the setting in Closed Unit A, I began to see additional moments in which staff members stepped out of their defined roles and related to patients as human beings. In some particular moments, I was struck by the physical closeness between staff members and patients.

> "I have something nice for you," I watch nurse Jean say to Ms. Gauthier, who is seated in a chair in the day room. She is very thin. Her gaze follows his face as he lowers himself into a crouching position by the right side of her chair, one knee on the floor. "I have something nice for you," he says once more, looking up to her face. "A private room."

During another moment of closeness, a tall, young man is walking barefoot in the day room. He is wearing sweatpants and a white T-shirt, both which fit his body loosely. A nurse working upon Closed Unit B, matching him in height and stride, walks beside him at his right. She is wearing a yellow hospital gown over her clothes, for added warmth, because sometimes on the unit it can get very cold.

> "*Je suis schizophène*," he says in a quiet voice: I am schizophrenic.
>
> "Lots of people have schizophrenia," she replies, and places for a moment her left arm around his shoulders.

Another time, nurse Patricia shows up an hour early for the music group, the patients from Closed Unit B who want to participate coming to a sudden stop behind her.

> "Can my people come to music group?" she asks out loud into the mostly empty day room. "Is this the right time? Not time yet? OK."

She and the patients behind her turn around to walk back to Closed Unit B. At 3 PM, when the music group is about to start, she and "her people" arrive once more in the day room. As I witnessed these moments between patients and staff, the starkness of the physical surroundings, of the patients' status as patients, and of the staff members' having power, receded. Instead, "something nice", in nurse Jean's words, was happening as a patient gets to wear a watch, a woman gets to have a room of her own, a young man hears that having schizophrenia does not reduce his humanity, and a nurse responds to working in a contained space by taking out "her people".

Witnessing the moments above led me to see that the patients also make the Inpatient Psychiatry Unit more human.

> "You are like my brother!" calls a woman to a psychiatry resident.
>
> "And psychiatrist!" he says, twisting his body towards her as he continues to walk down the hall. But he is smiling.

The woman has five sisters and no brothers. Her calling him her brother recognizes him as not only a staff member interchangeable with other staff members, but someone who has become meaningful to her.

A second moment occurred in Closed Unit A when snacks came in at 8 PM. In the common area, upon a cart lined with clean, white towels, is a small stack of toast and a pile of small containers of jam and peanut butter. I take a slice of toast for a patient, Alistair; it is still warm in my hand.

> "Here, take three," says Christophe and adds two more slices in my hands, both of us knowing that Alistair has a large appetite. "Don't worry about the other patients," he answers when I ask if other patients will have enough. "They had food already, they got food other people bought for them." He places a couple of packets of jam and peanut butter next to the pile of toast in my hands, and tucks in a paper napkin and a flat, wooden stick for spreading the condiments, as though arranging for me a takeout to deliver to his friend.

I witnessed a third moment upon the day of Maria's discharge, when after spending a weekend at home in preparation for her return to the community, she brings dumplings she has made. Moving slowly through the unit, offering them to each person in her vicinity, she tells every person, "You can take two if you want." A fourth moment was when, one afternoon, Mr. Williams, a patient, introduces me to his friend. "I am proud to know you," he tells me. Over the weekend, upon the unit, I play the clarinet for him and his mother. In all of these moments, it is patients who have also made the present situation more human.

The actions of family members also show themselves and others as human beings in Closed Unit A.

> A man wearing a yellow hospital gown is sitting beside two women, one older and one close to him in age. One woman sits across from the man and another woman sits beside him. In front of them are white, ceramic containers with

> serrated borders. With the container tops removed, there are marinated meats inside. The women and man speak in soft tones with one another.

At another instance, one morning in late May just before lunchtime, a week after the locking of the front entrance and when everyone is still getting used to the electronic buzzer system required to enter, someone is knocking.

> Three raps sound loudly against the metal door. Standing on tiptoe, a nurse peers through the narrow window of the door. She opens it to reveal a woman, in her middle-age, standing on the other side. It is not yet visiting hours. Wordlessly, the woman extends her right arm. In her hand she has an ice cream bar, covered with a brown and white chequered plastic wrapper. She is holding it by the wooden stick attached to the ice cream bar. “Can you please give it to Mr. Carlisle?” she asks, not stepping through the open doorway. The nurse takes the ice cream bar and holds it by the wooden stick as the woman had done, keeping the ice cream away from the heat of her hands. She quickly walks in the direction of Mr. Carlisle’s room to deliver it while it is still frozen.

It is remarkable to wonder where she had gotten the ice cream bar, a rare thing to enter the unit; it is unlikely it would have remained frozen had Mr. Carlisle’s visitor brought it from home. Witnessing her action made me wonder where in the vicinity of the hospital ice cream bars are sold. Later, Mr. Carlisle tells me that she is his daughter’s friend.

During the question and answer period of a Grand Rounds presentation, a psychiatrist stands up and addresses those around him.

> “Many of us are patients,” he says. “We should not have such a hard time to think of ourselves as people.”

To see oneself and others differently, not only as patient and professional but also as human, is difficult to do. Through many moments, the actions of patients, staff, and family members create upon the psychiatric unit scenes from the everyday: a family dinner even in the unit with the highest level of containment, a delivery of ice cream and a takeout of toast and jam, a brother gained and two people simply walking beside one another, one with her arm momentarily around the other’s. At multiple moments, through the actions of patients, staff, and family members, I experienced the unit not as a barren and empty place but one where life continues to unfold surrounded by others.

“Can a Person Change?”

I am sitting across one of the round tables from Maria. She is going to be discharged this week.

> “I am sorry to ask you this question,” I say in Mandarin. We have been speaking in Mandarin, her mother tongue, over the past month. “Do you think your illness can happen again?”
>
> “Yes, I think it can happen again, because of my emotions changing.”
>
> “The last time it happened you were 18, and now you are 36…”
>
> “I am 35. I suppose it is the kind of thing that can happen again – I do not know if it is an illness…”
>
> “Did the hospital recommend anything else that could help?” I ask.
>
> “That my husband could help me more with taking care of our son. That he wouldn’t transfer on to me the stressful emotions he has from work. I was talking to myself. My husband said, ‘Let’s go to the hospital.’ I said, ‘I don’t want to go to the hospital.’ There were times before when I would talk to myself. I wasn’t sleeping. I would sleep only two hours. I would be talking to myself. And doing calculations. What expenses are needed for my son, for our household, how much income my husband would need to make… Success for me is not coming back here again. I am not the way I was before, am I?” she asks me with a smile.

A month has passed since her admission, and she is no longer experiencing these symptoms. Following Maria’s discharge at the end of summer, I ask Erica, an inpatient social worker, for a moment that had given her hope during her work with Maria.

> “She was very alone,” says Erica of Maria raising her son and caring for her mother-in-law while her husband worked long hours. “She needed support. Sometimes, people just need to hear that someone believes they can do it.”

Five months later, at the start of the following spring, I greet Maria on the inpatient unit once more. Her words from the time of her previous discharge echo in my mind.

At one of the Morning Planning Meetings, a patient is reported as having had an improvement of symptoms. In one swift motion Jonah, the inpatient pharmacist, throws up both arms above his head.

“The medication worked!” he says, smiling, his laptop balanced upon his lap.

On another Thursday, during the Occupational Therapy report, Diana gives a summary of what has transpired during Expression group. The activity was to choose an object from an array of items spread out upon a table, and to say what one of them symbolizes.

> “And Mr. Carlisle rose from his chair, crossed the room, and chose the flower.”

People in the room gasp. Mr. Carlisle is an elderly patient who usually walks very slowly upon the unit, who rarely smiles.

> “He said, he chose the flower because he hoped his stay at the hospital can be a rejuvenation.” Several of the staff members are smiling.
>
> “She’s doing much better now,” whispers a social worker, smiling slightly, to a psychologist, when they cross paths in the hallway.

At another Morning Planning Meeting, a woman begins smiling after a course of four electroshock therapies.

> “Hers is the most dramatic improvement from electroshock therapy I have seen,” says Dr. Bouna.

The staff report upon patients smiling, spending more time outside of their rooms, and talking more with the treatment team as signs of progress. The staff do not only mark signs of change, but also express to patients that change is possible. During a recent Wellness discussion group, Diana, the occupational therapist, posed a question to the group.

> “Does having a mental illness mean always you are mentally ill?” “The answer is ‘No,’” she says. Several staff members smile.

Later, in the day room, a woman begins to yell.

> “I counted four evil people in this room. I’m a schizophrenic, OK? I’m a mental patient.” An orderly approaches her and walks with her to the doors of Closed Unit A.

At the Morning Planning Meeting, the staff had spoken of noticing that her paranoia was returning, of adjusting her medication.

> “Does it work, rehabilitation?” the orderly asks me, when he learns that I am a doctoral student in rehabilitation science. “People come back.” He looks around the day room at the patients sitting at the round tables. “She was discharged, but now she is back. And him, too.”

Medications need to be adjusted and patients do come back to the hospital when symptoms resurface again. Patients change in their mood, appearance, thoughts, and behaviour; staff members and patients themselves notice these kinds of changes. Sometimes, however, the change desired is not only of symptoms, but also of the kind of person one is and can be: His brow furrowed, Mr. Farhat tells me it is his first day as an inpatient.

> "I didn't know what depression was. I didn't think I would get depressed. But recently I divorced from my wife, and my business partner and close friend cheated me. My daughter is angry at me. My daughter and brother said they will visit me tonight. I would be really happy – I want to use this as an opportunity to bond with my daughter."

At 8 PM, his family members have not yet arrived.

> "They are not coming," he says. His eyes are red with tears.
>
> At the telephone he dials their number. His brother answers his call. After a few exchanges, he puts down the phone. "They are in the hospital," he says, smiling. "They are just lost – they don't know how to find this unit." His eyes are still shining.
>
> "Visiting hours are ending," the unit clerk announces over the intercom at 8:20 PM.

At 8:25 PM, the metal doors of the unit entrance swing open. A man and a teenaged girl walk in and immediately see us, standing in front of the doors. The next day, Mr. Farhat requests to participate in an interview with me.

> "Do you think a person can change?" he asks, speaking emphatically into the audio-recorder. "Do you think a person, at forty, can change?"

Chapter 4 Alistair and Clara

Ground Floor, Hillside General Hospital

At 3 PM there are not many people at the Café Atrium in the Main Pavilion at Hillside Hospital. The noon rush of hospital staff, patients, and visitors lining up to order soups, sandwiches, and daily specials has past, the circular tables and chairs in the eating area are now mostly unoccupied. The doorways of adjacent clinics, Dermatology and Internal Medicine, open onto empty waiting rooms. Two women wearing green aprons are cleaning up behind the counter and soon they will close the metal shutters of the Café, which reopens at 7 AM tomorrow. The sunlight of mid-June streams in through the floor-to-ceiling windows, illuminating the open space.

“How are you doing?” I hear a male voice say. I do not move. The voice may be addressing another person nearby. “How are you doing?” I hear the voice say once more. I turn my head left and right, scanning the area for anyone who may be looking my way. A second passes before I spot a man who is facing me. He is sitting at a table about five metres from me, his body half-turned in his chair as he looks in my direction. “How are you doing?” he asks a third time, his voice full and deep. As I approach to stand to his left, his appearance strikes me. His body is larger than his seat, but his stature is not wide. Clumps of long, curly white hair frame his face. A long, white beard, holding several strands of black, hangs from his chin. He has light-coloured eyes, a large nose with a round tip, and cheeks that bulge when he smiles.

“I’m doing OK,” I reply. “How are you?”

“Do you have some time?” he asks, his face upturned to look at me. He is still smiling. “Do you have to go?”

“No, I don’t have to go,” I reply. I sit down beside him.

Upon the round table in front of him, on top the brown Formica tabletop, a rectangular takeout box, an empty bag of Sun chips, and a white Styrofoam food container lie scattered. A thick yellow liquid, resembling corn chowder, had spilled across half of the table nearest to him. It has seeped under the empty containers. “Would you like to have a seat?” he asks. I nod, taking off my backpack and lowering myself into a chair to his left. The low-lying seat sags under my weight, bringing my body closer to the floor. The worn tabletop, and a haphazard arrangement of empty food containers and spilt soup, are now at my eye level.

"Let's move over to the cleaner side," he says. I notice a walker parked at his right. "Can I help you with that?" I ask, pointing to his walker. He does not reply right away. After several moments, he answers, "Yes." Rising from his chair, he leans forward and reaches with both hands to grasp the walker's frame. Tucked in the breast-pocket of his clean, plaid shirt is a pack of cigarettes. He points to a chair tucked under the far side of the table. "Can you – so I can –" I step around his back to move the chair half a metre closer, pivoting it to face him, so that he may sit down in it without having to take an extra step. With difficulty and a minute's effort, we shift our bodies to the seats at the other side of the table and sit down to a clean and empty surface.

"Do you have some time?" he asks once more. "Do you have to go?" "No," I say. I tell him that I am a PhD student. He says that he has been a jazz musician. It turns out that we have a friend in common, Amanda, who is a medical student.

"Do you have a minute?" he asks a third time. I nod. "May I sing a song for you?" He leans forward in his seat, sitting up straight and raising his chin to be parallel to the floor. His whole body has become still, his chest and jaw motionless. "I will sing a gospel song," he says as we sit facing each other, a high ceiling above and afternoon sunlight all around us. And then into the quiet of the hospital atrium he starts to sing a melody, his voice rich and full. His lips form an "O", their shape and the shape of his cheeks changing as the melody rises and falls. Small, shifting movements cross his face and neck as he carries the song. He is moving onto the lyrics now, singing each syllable clearly. After several verses and choruses, he comes to a stop. The quiet of the atrium returns.

After a moment, I say, "You are a wonderful singer."

"My father was a musician for thirty years," he replies. "I was one, too."

Over the next half hour, Alistair tells me about his love for music, his fear that he would lose his vocabulary because he does not usually have someone else to talk to, and his disagreement with his outpatient psychiatrist for placing him on a compulsory treatment order:

> "Psychiatry takes who you are as a person. It takes your life away. My daughter says to me, 'If they haven't turned you into a zombie yet, you'd think they would have stopped trying.'" When I say that I have to go, he asks, "Can I leave my phone number? I'm not a bad person – Amanda knows me."

I place a notebook and a ballpoint pen on the table in front of him. He takes the pen in his right hand and presses it tightly to the page, but no marks are made. The pen and his hand shake with effort. I offer him another pen. This time the ink flows easily. “I’m Alistair Samuels,” he says. We shake hands. “I’ll walk with you out of the hospital. I’m going to stay outside for a while to smoke.” He takes his walker and together we head out.

His name, Alistair Samuels, sounded familiar to me. Back at my home, I search for his name in my field notes, suspecting that I would find him already there. The staff members of the inpatient psychiatry unit have spoken of him at several Morning Planning Meetings:

> “He is not welcome at the Sunrise Café. He has burned all his bridges at the hospital.”
>
> “He is not a gift to any service in the hospital.”
>
> “He apparently cornered a girl in the elevator. He scared her,” said one staff member.
>
> “That doesn’t sound like Mr. Samuels. He wouldn’t do that,” said Dr. Bouna.
>
> “What a waste of a bed – there is nothing we can do for him here.”

I am struck by the contrast between the staff’s descriptions of Alistair and the man who had sung for me and taken me to sit at the clean side of the table. In an interview several months later, Alistair points out how differently the staff see him from those around him:

> “I’m a very creative person. I’m a musician, an artist. I have albums out, you know? And the doctor says I’m delusional. I befriended a lot of very big stars… I mean, I played with them. I rented halls. And the doctor says, ‘You’re delusional’, you know? […] What can I do to help myself as opposed to helping psychiatry and all this? What can I do? How is this thing gonna help me? I need help… Like my friend Ben and my mother help me. My daughter helps me. They give me support. They realize. They know who I am, that I’m not a psycho case like the doctor thinks I am.”

Open Unit, Inpatient Psychiatry, Hillside General Hospital

It is now March, dirty piles of snow left on the streets. I had been away from the field when I heard from a colleague that Alistair was back in the Open Unit of Inpatient Psychiatry at Hillside Hospital. I have come to visit and he has been waiting for me for two hours, sitting outside the double metal doors leading to the unit. He is not upset but one of the first things he tells me is that he is moving tomorrow. “Can we go to my room?” he asks. He says he wants to show me something.

Alistair is using his walker, his hands holding onto its black handles. The black wheels and black basket containing several of Alistair's personal belongings – a pack of cigarettes, a lighter, a wet towel – jut out from the walker's front. Alistair, leaning forward and over the seat, pushes from behind with every step. I follow him down the hall. "I call it my ambulator. I also call it my chariot," he says. "Have you seen 'Chariot of the Gods'? It's a TV show." A silver strand of tinsel is wrapped along the side of the blue frame, winding up the left column in a spiral. A small blue Star of David dangles from its end as Alistair walks.

"Did you make that?" I ask, pointing.

"Someone put that there. Around Christmas," he replies.

Alistair is wearing black pants of a thin, fleecy material, with an orange stain on the inside of the right pant leg. Later he tells me that he had spilt soup on himself. The waistband of his pants is stretched over his torso. Every now and then he would stop walking and adjust his waistband, pulling it over his abdomen to keep his pants from falling. The hallway is quiet. Dinner had finished, the meal trays stowed upon a metal cart and wheeled away from the unit. There are no evening activities scheduled, no sounds from the day room.

In the narrow hallway ahead of us, a man is walking slowly. A woman, dressed as a visitor or as a patient who has received privileges to wear her own clothes while on the unit, walks past us with swift steps. "Don't talk to him," Alistair speaks softly to her back, referring to the man ahead of us to whom she is catching up. It is unlikely she has heard, so quickly did she pass us. At the nursing station, Alistair stops to speak with the unit clerk through the open sliding window. "Are my things ready for tomorrow?" he asks her. Continuing to walk, we pass by a washroom and a shower, and several patients' rooms.

Alistair's room sits at the end of the long hallway where the Open Unit ends and another set of double metal doors, kept closed, forms the entrance to Closed Unit B. We turn rightwards into Alistair's room. Its dimensions long and narrow, Alistair's room has bare walls lit yellow by the fluorescent ceiling light. A tall window faces the door. A single hospital bed is pushed against the right wall, next to a small nightstand; Alistair is the only occupant of this room. A long, narrow table sits against the left wall of the room. In the righthand corner closest to the doorway, a tall, narrow locker, painted beige, reaches to the ceiling. In contrast to the quiet in the hallway outside, a small black radio is softly playing CBC Radio. "It's an evening jazz program," I say. We name the music program hosts we both know, discovering that we listen to several in common: we are both fans of Holger Petersen's "Saturday Night Blues". Alistair parks his walker, his chariot, beside his bed. He says that he will be moving to a group home in the eastern, French-speaking part of the city. "It's far from downtown," he continues. "How am I going to get around?" He asks me to visit him at the group home and I say yes, imagining the long subway ride there. Sitting upon the bed, Alistair motions to a spot under the long, narrow table pushed up against the wall. "Can you help me get clean clothes from that bag?" he asks. "I need them for tomorrow." I bend down and find his belongings gathered loosely in two large-sized blue, clear garbage bags. At the top of one bag is a pair of black lace-up shoes and several pieces of paper printed with Hebrew text. Alistair tells me to dig deeper. "That's a gift for my daughter," he says, as my hands move past a small paper box. I take out a pair of black pants and hand them to Alistair. "Are they clean?" he asks out loud before bringing the fabric to his nose. Seemingly satisfied, he lays them out on the bed.

When I next turn back to him, Alistair is holding a photo album upon his lap. "My sister made this for me," he explains. It is a large blue binder filled with pages and pages of photographs. On the very front, in cursive handwriting made with a gold pen, is his full name, "Alistair Samuels", upon thick, stock paper covers. They are mostly black-and-white photos. Here is Alistair in his twenties, wearing shorts and holding a guitar by the river near the family cottage. Here, he is standing in front of a cabin with five other members of a band; he is its leader. Here: a full-page photograph of the jazz musician Muddy Waters. "We used to smoke pot backstage," he says. In one image, he has an afro and is sporting sunglasses. In another, his slim figure is clad in a plaid button-up shirt, tucked into jeans and accompanied by a belt. He points to his father, smiling, and on another page, to his mother, also smiling. They both are wearing wide-rimmed glasses. There, he points to a portrait of his older sister, and there, his younger sister, who in her forties died of a drug overdose, and there, his younger brother, who had also died in adulthood. He rarely points to himself.

While we are looking at the photographs together, through the doorway I glimpse the doors of Closed Unit B swinging open into the hallway. A middle-aged woman, her black hair cut short, walks rapidly out holding a thin stack of magazines pressed to her left side. The doors shut automatically behind her. Seconds later, a loud smack sounds of a palm hitting the door. "Mommy mommy mommy don't go!" a woman shouts from behind the doors. "Are you OK?" Alistair asks me. When I look away from the empty hallway, he is posing with an "air" guitar, his face breaking into a wide smile. His belongings all in place, we walk down the hallway and exit the unit together. Beyond the metal doors bearing “ADULT PSYCHIATRY”, Alistair takes out a flip phone and dials his daughter’s number.

“Hello Allie!” answers the high voice of a young girl.

“Hello Jenna,” greets Alistair. “May I please speak with your mother Clara?”
Alistair turns to me. “That’s my grand-daughter. Isn’t she smart?” After some moments, Alistair speaks into the phone, “Do you know I am going to be moving tomorrow?” Once Alistair has hung up, we take the elevator to the lobby. He asks if I can go to the coffeeshop across the street to buy him a small coffee. He gives me loose change. When I return, he drinks the coffee quickly so that he can say goodbye and go upstairs to pray at the synagogue on the sixth floor. Seeing him point his walker in the direction of the elevators, I step outside into the night.

When I return to the unit two days later, at the Morning Planning Meeting, Alistair’s name catches my attention. “Mr. Samuels was discharged two days ago,” says a nurse, reading from a page held in her hand. A staff member gives a small cheer. Several staff members are smiling, because Alistair had been an inpatient on the unit for several months as he waited for a housing placement to accept him in the community. It had been challenging to find an appropriate placement for Alistair because he has difficulties with walking.

“He’s back in Emergency,” says another nurse. Several staff members groan.

“He hasn’t been out for more than 48 hours,” says Dr. Bouna.

“He fell,” intones another staff member.

“How did he fall?”

“He was on a bench, and then he was on the floor. They,” explains the nurse, referring to the staff members of the group home, “called the fire department.”

Dr. Bouna is frowning. “You can’t call the fire department just because a patient falls.”

“They couldn’t get him up again. And so he is back here. They are downstairs in Emergency and they are very angry. They’re ready to fight.”

“I will talk to them,” says Dr. Bouna.
The staff members of the group home do not want to take Alistair back as a resident. Alistair was sent back to Hillside Hospital because it is the place where he last resided and where there are staff trained, unlike at the group home, who can help Alistair with his mobility issues. Several

weeks later, when Amanda and I are visiting him at his group home, Alistair recounts how his falling led to his readmission to the Inpatient Psychiatry Unit. “I fell. She,” Alistair refers to a worker at the group home, “asked me if I could slide to the floor as she couldn’t pick me up. Then the ambulance came and they took me to Emergency. I asked for water but they wouldn’t give it to me. I called the police and said, ‘They are not giving me any water here and they are holding me captive.’”

Closed Unit A, Inpatient Psychiatry, Hillside General Hospital

During a subsequent Morning Planning Meeting, a few days after the announcement of Alistair’s return from the group home to the hospital, the staff are continuing to speak of the incident.

> “What happened?” says a staff member. “He sat awkwardly on a piano bench. He continued to fall.”
>
> “His behavioural problems were predictable,” says another staff member. “He asked Kristof to keep a bed for him on the way out.” Kristof is one of the orderlies.
>
> “I recommend Closed Unit A,” says Dr. Bouna. “Not the Open Unit. He doesn’t last.”
>
> “At Le Colibri group home he was asking all the residents to help him with everything,” says Florence. “‘Get water. Get this.’ He can’t walk. Grogginess, tiredness after his medication injection, contributed to the fall. I will ask Dr. Carlin regarding the medication. He calls to complain to his daughter, who shows up, and he starts walking again. He can’t do transfers on his own. For the night orderly, if he falls, they can’t pick him up.”
>
> A few days later: “He’s acting out, he’s letting himself go, urinating on the floor. Over the weekend he was verbally abusive with the nurses.”
>
> “He falls asleep in his chair,” says Florence. “He’s sitting all the time in Closed Unit A. It’s not good for his back.”
>
> “He has spinal stenosis,” says a staff member. “Can he walk?”

Someone mentions that Alistair has requested physiotherapy. The discussion turns to arranging physiotherapy for him. After the meeting, I ask Florence if I may visit Alistair. I do not know in which specific unit he is a patient, and I hope that if Florence agrees I may find out this information. “He will be happy to have a visitor,” says Florence, his social worker. I learn

Alistair is in Closed Unit A and go there to visit him in the afternoon.

In an alcove furnished with a row of chairs facing opposite a TV, Alistair is sitting in the chair closest to the nursing station. The alcove is only two metres by four metres wide. In front of him is the glass separating the nursing station from the rest of the unit; behind him is a small alcove of four chairs placed side by side, facing a flat screen TV attached to the ceiling; to his left extends one hallway and to his right, another, leading to the eight patients' rooms. Alistair is standing at the centre point of Unit A. A yellow hospital gown covers his body from his neck to his shins. His blue walker sits within reach to his right. Michael, an orderly working in the unit, sits cross-legged two seats behind him. His hair is cut short, and he is wearing light-coloured pants and a light-coloured, button-up shirt. His gaze is fixed upon the TV screen even though it is grainy. I sit beside Alistair, whose bare shins are visible below the hem of his gown. He is not wearing socks, and there is a large yellow stain on the part of the gown covering his chest. In succession, he tells me what he has been up to and times from his past. "I called Sally," he says of a friend and former patient upon the unit. "She isn't doing very well." Then: "I'm afraid of losing my legs. I'm afraid they will be amputated." We look down at his legs, the up again at the surroundings of Closed Unit A. "I've been jailed 150 times," he says. "The first time I was in a place like this, I was in my twenties."

He asks me to go into his room to help him find something. It is a room bigger than his former one on the Open Unit. The yellow and white walls are bare. The light switch does not work; later Alistair tells me it is broken. The single window, covered with a translucent material, is a source of light in the darkness. There is a clear plastic panel secured in front of the window. Behind this panel and the window behind, someone had slipped in a sticker of a red car, its colour now sun-faded.

When I return to Alistair's side, through the glass of the nursing station and beside its door, I see standing the figure of Dr. Stills, an inpatient psychiatrist in his sixties. He is wearing a brown blazer, dress pants, dark leather shoes, and purple-framed glasses. From the open hallway, he leans in the direction of one of the patients, Martha, as she approaches. For the last several minutes, she has been walking up and down the length of the unit's single hallway, singing a hymn in a soprano voice. "Do you want to talk?" he asks. She declines and continues walking, the hem of her long yellow hospital gown swaying at her ankles, the high, clear melody of her song filling the enclosed space. Dr. Stills, still leaning in the doorway, turns in Alistair's direction. "Do you want to talk?" he asks. "About medications. About how things are going, being here at the hospital." Seeing Alistair's response, he retreats into the nursing station. Beside me, Alistair is rising from his seat.

"Do you want me to stay here?" I ask.

"I would like for you to come with me," says Alistair.

We cross four metres to arrive at the nursing station. I walk in ahead of Alistair, who enters pushing his walker, followed by Michael. Christina, a nurse working in Closed Unit A, holds the door open for us to pass through. "Hurry, Mr. Samuels, you're keeping Dr. Stills waiting," she says in a soft tone, her expression neither tense nor frowning. Alistair comes to a stop beside the counter forming the perimeter of the nursing station. Dr. Stills stands facing him, two metres away. Nurse Christina stands a few metres behind Dr. Stills near the corner of the room. Michael, the orderly, remains by the door.

Dr. Stills asks Alistair once more if he would like to talk. Alistair speaks briefly and Dr. Still replies. Alistair goes on to mention that he has a lot of enemies at Hillside Hospital. Dr. Still responds, then Christina. They have known Alistair for many years.

"I would say Alistair has more friends than enemies," says Christina.

"Oh, I don't know about that," says Dr. Stills. He turns back to Alistair. "You can't get into big trouble. Falling, that's trouble. Coming here, that's trouble. I will decrease your medication if you don't get into trouble."

It is the end of their meeting. Wordlessly, Michael opens the door between the nursing station and the unit hallway. Alistair is starting to turn around, but Dr. Stills has not moved. He remains facing Alistair.

"Your clothes are unclean," he says in a tone changed from the rest of the meeting.

He takes in Alistair's appearance, from his dusty, black foam clog shoes to the darkly stained front of his too-big hospital gown. His gaze continues upward to Alistair's thick beard.

"Look at you. You are a pig-pen. You are a pig-pen."

"I can give him a trim," offers Michael, speaking for the first time.

Back on the patients' side of the closed unit, we return to the alcove of cushioned chairs, within sight of the nursing station but out of earshot. "I was very hurt by what Dr. Stills said," says Alistair. "I was glad you came in with me. Otherwise they would have been nastier." Not knowing what to say, I remain silent. In our brief interactions, in other situations, Dr. Stills has always made me feel at ease.

Over the following days, whenever I return to the hospital, I go to visit Alistair. He is often sitting in the alcove in the seat closed to the nursing station.

> "Did you see the new Anne of Green Gables movie?" he asks.
>
> "No," I reply, "only ads for it online."
>
> "I watched it on the television last Sunday evening," he says. "I liked it. It was good."

Next Alistair holds out for me to see, in the palm of his right hand, a keychain of a small, plastic black high heel. The high heel, glossy and decorated with white polka dots, is attached to a metal keyring. "It's for my daughter," he says. "Her birthday's coming up, and she asked me to get this for her." She visits him from time to time, and he will give it to her the next time she comes. Alistair closes his hand over the keychain and leans back in his chair, facing forward. "They want me to be autonomous," he says. "How can I be?"

Later that evening, Alistair gives me some change and asks if I can help him to buy a bottle of Coca-Cola. I return to Closed Unit A with a bottle of Pepsi from a nearby coffeeshop; it is the only soda that they carry. In the nursing station, before I cross once more into the unit hallway, one of the night-shift nurses asks me to bring the bottle back when I am done. It is an object that cannot remain on the patients' side. After I step into the patients' side, Alistair is once more sitting in the alcove, in the chair closest to the nursing station, when he sees me. I extend the bottle of Pepsi to him. "Can you please help me open it?" he asks. I hold the bottle between my hands. The plastic securing the cap breaks open upon a single twist. Alistair motions to a used, empty Styrofoam cup held in the groove made by his body and the cushion of the chair. He asks me to pour some of the drink into the cup for Christophe, a patient who is standing nearby. Christophe thanks us. Alistair drinks from the rest of the bottle. "My hands are gone," he explains. They have been damaged during the years he had spent homeless. "I can't make a fist." He tries, and looks down at his left hand, his fingers half-curled.

Le Colibri Group Home

Le Colibri group home is in the eastern, predominantly French-speaking part of the city. It is near the subway station and sits midway down a gently sloping road with wide lanes. Rain is falling as I press the buzzer on the porch. A man opens the door. "I'm here to visit Mr. Samuels," I say. He invites me to come in. I step into the entranceway. The man is holding open another door ahead. “Mr. Samuels is calling all the time,” he says from the top of the stairs, his hand making the universal sign for a telephone, thumb and pinky fingers brought to his ear. He gestures towards the room closest to the door, on the right, before leaving.

After the incident around his fall, Alistair had been discharged from Hillside Hospital back to Le Colibri group home. Here, his room has a thick wooden door frame, stained a dark brown, and a wide, wooden door with the same colour and finish. Inside, there is a large window with a view onto the street and a building opposite that used to be a convent, Alistair informs me. A gray, overcast sky is visible beyond. My eyes travel clockwise around the room. At the left side of the room is a sink. Lining the wall opposite the door, spanning the sink and the window, is Alistair’s bed. A two-drawered nightstand is placed between his window and the wall close to the doorway. To the right of the doorway is a commode, but the room does not smell of urine. There is a yellow laundry hamper. A laminated sheet of paper, printed with meal times, lies on the counter by the sink. Lunch begins at 11:30 AM. This room is at least twice as large as the one he had lived in on the Open Unit at Hillside Hospital. From Alistair’s small, black radio, Julie Nasrallah is hosting CBC’s morning classical music program.

Alistair is wearing a short-sleeved button-up, khaki coloured shirt. “One of the *intervenants* gave this shirt to me,” he says, referring to the title used by the staff members of the group home. “I received my long-acting injection a few days ago. I don’t like it here, because of the people here. “They gave me a new bottle,” he continues. He holds up a clear blue plastic water bottle. “I can open it from the top,” he says. It has a pull-out top, that does not require any twisting to open, and a handle around which he can slip his entire hand, with grooves for his fingers. He turns the bottle upside down. Its contents stay inside. “Can you fill it up for me, please?” I go towards the sink. “Let the water run for a bit,” he says. “To make it cold.” When I stand facing him to give him his filled water bottle, he says, “Thank you for visiting. I would be sleeping in my chair all afternoon if you didn’t come.”

A few weeks later, I visit Alistair again at Le Colibri group home. This time Amanda and I are visiting Alistair together before she moves away for work. Amanda is my friend and classmate and Alistair’s friend. She had met Alistair before me, when she was a medical student. Alistair was outside of the hospital, playing music, and they struck up a conversation. “I enjoy his company,” she told me, “and he remembers things that I tell him, like I would say I am going to the Maritimes and later he would say, 'I heard on the radio there is a hurricane headed there, please be careful.'" In his room, Alistair shows us his physiotherapy exercises. He raises his arms and fingers, wriggling them. Alistair has asked us to close the door to his room for greater quiet and privacy. "Have you seen my photo album?" he asks, just as someone knocks. We open the door.

> "Do you want to do your physio?" a staff member asks, standing in the doorway.
>
> "Can it be later?" asks Alistair.
>
> "We can look at your photographs after," intones Amanda.
>
> "Later…" considers the staff member, hesitating. There are other clients she must see.

After she leaves, we notice that it is already past noon. The staff in the kitchen downstairs will be keeping the meal trays warm but after a certain time all the meal trays are gathered up and cleared even if they are still uneaten. We make our way down the hallway to the elevators that will lower us to the basement containing the kitchen. "The wooden doors look nice," remarks Amanda. As we enter the elevator, Alistair turns to us and says of the other residents, "They are all intellectually handicapped here." Seeing us enter the kitchen, the staff ask, that as we are the last ones to come in, if we may please return our meal trays when we are finished. When we have sat down and Alistair is turning to the items on his tray, he and Amanda joke about their love for butter:

> "I feel like saturated fats have always had a bad rep," says Amanda. "Now that people are saying they're not so unhealthy, I feel vindicated."
>
> "I have a bad rep," quips Alistair. "My sister said something to my niece, and now she looks at me like I'm a saturated fat."

As we finish eating, Alistair says a prayer in Hebrew. He asks for blessings for himself, his deceased mother, for Amanda, and me, looking at each of us in turn as he speaks his prayer. "I am verbose. I pray for the replenishment of my articulation," he concludes.

As we head upstairs, Alistair tells us that he would like to go outside for a while. Amanda and I help him down the steps leading to the front entrance. We step outside onto the porch. It is raining and windy. Alistair takes out a cigarette and asks for help to light it. He holds the cigarette between his lips as Amanda flips the wheel of the lighter and brings the flickering flame closer, cupping his hands around it to shield it from the wind. I notice a dark yellow callous upon his index finger. "I got it from the lighter," Alistair answers when I point it out. "It's been there a long time. It doesn't hurt." He finishes smoking his cigarette quickly and takes out a thin, silver harmonica. Holding the small instrument between his hands, he raises it to his mouth, his fingers fanning outwards. The notes of a blues song sound out as Alistair pushes his breath into the harmonica and tongues a syncopated rhythm. He stops to sing a line, then plays a couple of notes more. Among the sounds of rain falling on the street, cars driving upon the wet road, and tires whipping water upwards, Alistair continues to play.

Upon the porch of Le Colibri House, Alistair surprised me with his song and his harmonica playing. Each time I visit him, he does something I do not expect. Amanda has told me that Alistair surprises her, too, by remembering where she was planning to go and asking her to be careful because the weather there is dangerous this time of year. Hearing Amanda's story made me curious to know more moments of surprise that Alistair has created for others around him. Months later, I meet nurse Christina by chance as she is on her lunch break. She is usually busy with her clinical duties, but today she has some time to talk with me. Recalling that she has known Alistair for several years as he has been in and out of Hillside Hospital, I ask her if there has ever been a time when Alistair has surprised her.

> "He surprises me all the time. He is capable of always doing something surprising. He was a musician. He still has it –" she touches a forefinger to her temple – "a part of him still responds to that."

Gazing forward, Christina pauses, her lunch container of rice, a chicken drumstick, and green, leafy vegetables momentarily forgotten in her lap. "He must have done good deeds. People have given him things. I saw gifts in his room, a sweater that wasn't his. 'You can have it,' he'd said. He maintains relationships in his life. Some people stay in his life – and so there must be give-and-take in his relationships. And sometimes it isn't always to help or to receive things. Sometimes it is just to have a conversation."

"What do you think his future will be like?" I ask.

> "If he is in the right place, he will blossom. He responds to care. He responds to human contact. If he is in a place where he receives care…" she trails off.

Open Unit, Inpatient Psychiatry, Hillside General Hospital

Alistair has been transferred from Closed Unit A to the Open Unit of Inpatient Psychiatry the next time I visit him. It is a very sunny day in June. Wearing a green T-shirt, he is sitting in a wheelchair at one of the round tables in the common area. “The group home said they couldn’t take me back,” is one of the first things he tells me. “I need to talk to them,” he says, referring to the Open Unit staff. “They wouldn’t let me out yesterday because I forgot to do something.” He goes on to ask, “Does my hair look OK?” His hair is getting longer, falling in curls around his face. In his photo album, his hair had always been long.

“Who helps you with your hair and beard?” I ask.

“Oh, lots of different people,” he says. “I cut my own hair.”

Close to noon, he asks, “Can I ask a big favour of you? Would you go downstairs with me – to help me with my equilibrium, with all those people?” Alistair tells me that they are Alfars and they suck away his energy. We prepare to exit the unit together. “I feel shaky today,” he says as he holds onto his walker and slowly steps forward. I wonder if he has recently had an injection of medications. He sometimes lets me know that he has just had an injection, or will be having one soon, to explain that he has difficulty speaking when we are having a conversation. This time, however, he does not say more as he looks forward, continuing to walk. We approach the washroom at the end of the day room and he tells me that he needs to use it. “Can you please hold the door open for me?” he asks. I raise my right arm against the door and place my right foot against its bottom as a stopper. The door is heavy. “That is good,” he says, and begins to walk in.

“Are you sure? Can I help?” I ask, though I do not know what else I can do.

“Yes, I will be fine in here.”

“Your walker –” I begin.

I am worried it would not fit into the very small space – less than 1.5 metres squared – of the washroom. I am worried the walker would be difficult for Alistair to manoeuvre and make him stuck. He tells me not to worry. “I can take it inside,” he says. He steps further into the washroom and closes the door. I wait outside. There is the sound of the toilet flushing, followed by the sound of water running from the tap. Alistair must be washing his hands, I think. After a while, his voice comes from within, muffled by the shut door. “Can you open the door?” he asks. I push open the door and Alistair steps out, holding onto both arms of the walker, his chariot, emerging as the door swings wider. He is smiling. Yet I find my eyes drawn to Alistair's feet. The small, thin, rectangular tiles of the washroom floor are shiny and wet. I wonder if the wetness is from water splashing when Alistair washed his hands, from the flushing of the toilet, or from when Alistair was urinating. Alistair is advancing towards a narrower part of the doorway, made narrow by another door swung into that place. As Alistair pushes his walker over the junction between the washroom and the hallway raised one centimetre from the floor, his walker suddenly cants to his left, the wheels wobble from side to side even as both his hands are grasping the frame of the walker, and his body is lowering to meet the ground. Alistair is falling to the floor. His legs slip out from beneath him and he lands on his bottom and back.

> "Are you OK?" asks a woman, another patient, nearby. She murmurs words of encouragement.
>
> "Someone fell! Someone fell!" yells a different woman, who is also a patient.
>
> "Are you hurt anywhere, Mr. Samuels?" said nurse Christina, who has come to stand in front of him, her voice one of concern.
>
> "No, I'm not," he answers.

Three men, working as orderlies, arrive to help. Taking each of Alistair's arms, they shift him so that he can sit up more comfortably against the doorway. Christina's and my own gaze follow how Alistair slides on the wet and slippery floor. The three men then help him up, one man holding each of his arms and a male nurse pushing him on his back. Christina is bending at her waist, speaking to Alistair who is still lying on the floor. "Use your feet, Mr. Samuels. Get up, Mr. Samuels. You can do it." It has taken slightly more than three minutes from Alistair's fall until he is up again.

A wedge to the door for the hallway had fallen out when Alistair slipped and fell. I move to put it back in its place. "Leave it there," Jason, one of the orderlies, says.

> "But it is blocking the washroom," I say.
>
> "Better to block it there than to block it here," he says, gesturing to the wider hallway space.
>
> "I want to go out later," says Alistair. The back of his green shirt is darkened by several wet patches.
>
> "What if he falls like that outside?" asks a male nurse who has joined a small circle of people around Alistair.

When they are about to go out, a man comes by and asks Alistair, “Can you walk?” He watches as Alistair walks a metre with his walker. The nurse then turns to Alistair, “Why did you fall?”

“The floor was wet,” Alistair replies.

“The floor was wet,” he murmurs, his tone quiet and soft.

“Don’t do that,” an orderly tells him sternly. “You have to more careful.”

Around this time, at the Morning Planning Meetings, the staff continue to give their reports upon Alistair. They are aware of his need to leave: to be discharged from the unit to a housing placement in the community and to exit the unit to go where he wishes to go:

> “He has a complaint with meds. Otherwise he sleeps in his chair.”
>
> “He hasn’t been discharged yet,” says Florence, his social worker, “not because of his behaviour – I want to make sure to say this. He is waiting for a spot to open up in the community.”
>
> “Mr. Samuels was out all weekend,” says a nurse.
>
> “It’s festival season,” replies Dr. Bouna, smiling widely, before moving on to discuss the next patient on the list.

On Father’s Day, a Sunday in mid-June, I go once more to the Open Unit of Inpatient Psychiatry to visit Alistair. I have not visited the unit previously during the weekend, and over the past while I have not been able to speak with Alistair during the times when we saw each other on the unit, as I was occupied with following other patients and family members. Alistair had also been angry at me because, when other patients interrupted our conversations, I said it was OK, and he told me I was making excuses for them. He apologized shortly after. Today, I am bringing a box of sugar-free chocolates that I had bought on sale as Alistair has diabetes. He is sitting upon his walker next to the Open Unit nursing station when I come by. Samantha, the nurse on duty, is standing next to Alistair.

> “It’s too hot,” she says. “I don’t want you going out. It’s an inferno out there.”
>
> “I have to go outside,” says Alistair. “I can’t stay inside the whole day.” He turns to me. “She can take me out,” he says to Samantha.

Samantha smiles at me. Her long, dark curly hair falls around her face. Today she is wearing red lipstick. She appears younger than Alistair, but not by many years. Her expression becomes stern when she again regards Alistair. Then she turns to me.

"You will go downstairs with him? Will you take responsibility for him?" She pauses. "You will take responsibility to go out with him, then come back with him?"

I look at Alistair.

"If it is OK with you," I say.

"It's OK with him," she says in a firm tone, turning to me. "You are very nice."

She addresses Alistair:

"I want you back in thirty minutes." Then, after a pause, "I want you back in an hour." Samantha leaves us for a moment, returning with a wheelchair for Alistair. He sits back and I bend down to pull out the foot-rests on the wheelchair.

"They keep worrying something is going to happen to me," he says.

"They are worried about your body," I say.

We turn into the elevator to go down to the lobby. Alistair calls Samantha a bitch.

"They're domineering up there, aren't they? They're messing with my head. They tell me that if I urinate on myself, I am not allowed to go out for the whole day."

Sometimes when Alistair urinates on himself, it is because he cannot move quickly enough to get to the washroom.

He does not have his water bottle with him. He asks me to push him closer to the drinking fountain in his wheelchair. "Put – go – just there, no, go left –". He stands up from his wheelchair. I ask him if he needs help removing his feet. He is holding onto the water fountain in a tight grip, his body leaning forward onto it, his feet behind him. He is not able to move his feet. As he lowers his head to drink from the fountain, he is gripping the spout with his left hand and with his right the platform of the fountain. I am pressing the horizontal bar for the water to run. After he finishes drinking, Alistair brings up his hands to wipe his mouth, for water had run down his chin, and he brushes the back of his left hand against his beard. Drops of water fall upon the floor and upon his chest, dampening his black T-shirt in dark spots.

He sits back onto the wheelchair. I stand at its back although its brakes are already on, gripping the handlebars just in case. I move to the front. "Do you need help putting your feet up?" I have learned to ask because it is not always that Alistair requires help. A number of times before, he has said, “No, I can do it myself.” This time, he accepts my offer of help. I crouch down at his left side, take his left foot, and attempt to bend it. “Be careful,” he says. His foot feels heavy in my hands. “Can you bend your knee?” I ask; Alistair answers it is not possible. I nudge his lower leg outwards so that his leg is flexing at his hip and push his entire leg down upon the footrest. We head outside to sit at the front of the hospital in the early summer light. Alistair lights a cigarette.

“I’m going to be discharged to Marquette Hospital,” he says.

“How do you feel about going there?” I ask.

“I don’t know. Maybe it will be better. Maybe it will be worse. It’s another hospital.” Once Alistair finishes his cigarette, we return to the hospital lobby.

“I don’t want to go back yet,” he says.

I look at my watch. “We still have thirty minutes.”

Alistair says he wants to go to the prayer room on the sixth floor. We sit as Alistair asks me to read from the prayer book. Afterwards he says he needs to use the washroom.

We take the elevator down to the second floor to use the washroom there, because the doors of the washrooms on the sixth floor are too heavy to move, he explains. Alistair takes his walker into the washroom with him. To respect his privacy, I wait with my back turned across the hall.

“Can you open the door for me?” he calls out after a time.

“Are you all dressed? Can I turn around?” I ask back.

As we take the elevators up to the Inpatient Psychiatric Unit, Alistair calls Clara on his cell phone, “We had a big fight with the nurses,” he says. I push Alistair in the wheelchair to the nursing station. Nurse Samantha looks up at us. As I walk away from them both, she says to Alistair, “You cannot go out again today. There is a tornado coming…”

Each time I go to meet Alistair, no matter in what institution he is housed, he takes me along with him to someplace new. Each visit has been a small adventure, with risk and danger. When I meet his adoptive daughter, Clara, I learn that they have been going on excursions since the time they met. “He was big, and he had his big hair. He wasn’t like anyone else I had ever seen,” says Clara of the first time she saw him. When we introduce ourselves, Clara mentions that her brother is diagnosed with schizophrenia. “I don’t care,” she says. “He’s still awesome.” She is sitting across from me at a table in a Tim Hortons coffeeshop near where she lives. Behind her, people are lining up to place their order at the counter. It is raining hard outside, a cold rain, and there are wet footprints all over the floor. At the beginning of June, I am meeting Clara for the first time after having already known Alistair for one year. At this time, Alistair had just been sent back to Hillside Hospital, for the second and last time, from Le Colibri group home.

Clara recounts how she had met Alistair seven years ago – "in 2011, 2012". Describing herself as a "stay-at-home mom", she has two daughters, ages three and eight. She is wearing a white jacket with a wide collar and wide shoulders. She has long, dark blonde hair that extends to the middle of her back. She is in her early thirties. On her jacket are yellow icons dotting the fabric. She is wearing jeans and a black shirt with pink letters, matching her long nails painted bright pink and slightly chipped around the edges. Her cheeks and the tip of her nose are round. She is about five feet tall. During our conversation she sometimes looks to the side when thinking, but she never looks down. She has placed her umbrella and black shoulder bag on the seat and table.

When she first met Alistair, he was homeless. She had bought him Tylenol when he asked. She describes how she decided to adopt him as her father:

> "When I said I had to go, he hugged me, and my father had died recently. Alistair whispered in my ear, 'I love you.' I just felt like it was my father speaking, like he was my father. I didn't have a good relationship with my father. I only really knew him the month before he died. So when he said that, I felt like my father was speaking. It's complicated – I don't know how to describe it. I felt it."

Because of meeting Alistair, she says, "I get to have a dad."

She speaks of how students at Stuart University – "they were preppy" – would stare at him, and she would yell back at them, "What are you staring at?" But after a time, doing that became too stressful. "Sometimes he would be really dirty," she says. "His shirt would be open. Or it would be no shirt. I took my older daughter to meet him once when he was really messy. I can understand it didn't leave a good impression." At the time of their meeting, he was living in a group home. He and Clara would go to get food together, get a coffee, smoke a cigarette, or simply sit and talk. She would go with him to a local governmental health and social services branch for him to pick up his benefits money. She would bring him something to drink and eat.

She visited him at the group home and did a project for one of her university classes with him, as she had to interview someone who is or had been wealthy.

"They think he's a big, incontinent mess," she says of the staff. "It's not right. It's not right. They punish him. They keep threatening him with Closed Unit A. They give him a point system if he does something that they do not like." Once, she recounts, she had asked Florence, Alistair's social worker, "What can I do?" The social worker had responded, "You see him as a human being. Keep doing that."

"How does everyone else see him?" I ask.

"I am not sure," Clara replies.

After a moment's consideration, she adds:

> "Well, I think they just see him as a big nuisance, a big troublemaker, who cannot follow any of their rules and doesn't fit into any of their little boxes. And even no matter how much they medicate him, he's still… he's never like a zombie. You know, he has his personality and he always… But that's what she told me. She's like, 'He's lucky he has one person who sees him as normal.' So it just shows me that they don't see him as normal. So it's very sad."

She no longer goes to visit Alistair on Closed Unit A. Visiting Alistair in jail was more tolerable.

> "Well when I'd see him in Closed Unit A, there was a woman there, and her family member was freaking out because, basically, they had let her have a seizure on the floor and no one had done anything. So the family was really mad. And that just showed that yeah, it's a terrible, terrible place. You know, they don't clean up."

It is difficult that he has not lived for long in one place:

> "Well, just that it's always gonna be hard. He just doesn't fit in. Society doesn't like people who don't fit in, you know? And he doesn't fit in anywhere. [I ask, 'Even though he's getting better?'] Yeah, even though he's getting better, he can still be very abrasive. He could be very mean for no reason. At Le Colibri group home, he was mean with the people. He didn't like them. He thought he was smarter than everyone, which is maybe true. 'Cause they weren't as vocal as him, um, he couldn't have a conversation […] but then he ended up getting kicked out of that group home and then he was homeless. Then he was at Hillside

> Hospital. Then he went to jail. Then probably Hillside. Then jail. Then always back to Hillside. It took him a long time to even go to Le Colibri . That's about it. But it was mostly at Hillside that I saw him. And downtown, when he was homeless. He's, like, a victim of the system."

At one point, she reflects, "We're going to keep doing what we've been doing. Keep talking on the phone. Keep meeting for food. Until he dies, I guess. Or I die. You never know in this life."

Unit 108, Beaupré Pavilion, Marquette Mental Health Institute

Marquette Hospital is close to the subway station, in the eastern, French-speaking part of the city, fifteen kilometres from Hillside Hospital and the city centre, farther east than Le Colibri group home. A residential area of townhouses, a park with swings and a children's climbing play structure, bicycle paths, a hydroelectric transformer, a supermarket, and a liquor store surround the hospital. Within Marquette Hospital grounds, Beaupré Pavilion is the farthest of three pavilions from the main entrance. Each pavilion is the joining of three wings. The buildings are made of stone, four storeys tall, with large, white windows. The windows on the first floor are almost two metres above the ground. Tall trees, with wide canopies, cast shadows upon the cut grass. Picnic tables, benches, and wooden chairs lie next to each pavilion.

Inside Beaupré Pavilion, three hallways extend diagonally from one another. The leftmost wing has a small metal plate above a set of double doors that reads "Unit 108". A doorbell is fixed to the right of the doorway. Alistair's room is opposite the nursing station. A radio in his room is playing CBC's music channel. There is a sink on the left, with a tap arching upwards and downwards in an upside-down U. In front of the sink is a mirror. Between the sink and the window is Alistair's bed. Opposite the sink is a tall window with blinds. Taped to one wall is a notice – the schedule for the day. By the door is a commode with paper towel inside, covering the urine which is seeping a bit through. The vertical, broad blinds are drawn at the back, but do not block completely the strong late morning sunlight behind. There is a fan whirring, but it does little to cool and to circulate the hot July air.

"I just finished calling Dr. Stills," says Alistair as I walk into his room. "He reduced my medication." Although Alistair has been transferred to Marquette Hospital, a large mental health hospital in the French-language health system with inpatient, outpatient, and long-term services, he is still being followed by treatment staff from Hillside Hospital. "I am getting stronger," he announces. He stands up, sits down, stands up, sits down, five times, to show the results of his daily physiotherapy. “I get physio five days a week. One of the physiotherapists gave me a ball to squeeze so that my hands can get stronger. I am getting stronger every day.” He continues to share his updates: “My room is by the nursing station. It has its advantages and disadvantages.” He holds up the blue bottle. “She fills it full of milk,” says Alistair of one of the *intervenants*. “She isn’t supposed to but she still does it when I ask.”

When we are walking in the hallway to go to the canteen for lunch, Alistair asks, “Do we have time for me to go to the washroom?” “Yes,” I reply. Alistair is sitting on his walker.

“Do you need a boost?” I ask, offering him my arm.

“No, I am OK,” he says. “I can get up by myself.”

Several minutes later, after Alistair has used the washroom, we move into the kitchen. Alistair unfolds the plastic wrap of his sandwich. On his tray is another sandwich, an orange, and a cup of coffee. “I get double portions here,” he says. “The food is good.”

After lunch, we move back into the hallway. Alistair uses the washroom on our way outside. He brings us to sit outside in a grassy, fenced area. In the distance, beneath a stand, a band is playing music. Several people are gathered around two picnic tables. After an hour spent outside, we decide to go back – he has to return for dinner, and I must go home. On our way back, we pass through the junction between the three wings of Beaupré Pavilion. We walk past a row of vending machines, an area of abstract stone sculptures surrounded by wooden seats, and a small number of men and women, all patients, who are standing around. A man wearing a red shirt, who has lost his left arm, takes a small step towards Alistair. He extends his right hand with his palm facing upwards.

“Go away!" Alistair yells. The man takes a step back.

We continue to walk back to his room. “Shit. What do I want?” Alistair wonders aloud after he enters the doorway. “I want to live where I want to live. I want my back to heal. I want to be able to walk. And to have money.” When I go to leave, at the nursing station I ask a staff member to unlock the door. At the double set of doors at the end of the long hallway, the doors are still locked. I press the doorbell, but there is no answer even after minutes have passed and several more presses of the bell. A staff member, also on her way out, approaches and opens the door with her ID card. I follow behind her, the doors swinging closed behind me.

As the summer continues, Alistair calls frequently from Marquette Hospital, leaving voice messages that narrate his day:

> "It is the morning. I am waiting for a shower.
>
> "It is the evening. I am sitting outside. The weather is nice. There are some Alfars walking about. They bother me.
>
> "Clara and I got mad at each other on the phone. She says I am mean to the other patients. She got mad at me that I wouldn't give them my lighter.
>
> "Today I had physiotherapy. And a friend called. Today has been good. I have to count my blessings.
>
> "There is carbon monoxide in Clara's apartment, and she had to take her kids out. I told her not to worry, but she's still very upset. Can you call her – check in on her?
>
> "I have to go, or I will piss on the floor.
>
> "It's Alistair Samuels. It's quiet and peaceful now. I hope it stays this way."

Sometimes, I return his calls. Alistair speaks more, his sentences are longer, his stories fuller, when he gets to talk to someone:

> "I am sitting in the park where you played your clarinet, to get away from the Alfars. Dr. Stills is no longer my doctor, so I have to call Dr. Abrams.
>
> "I called Clara, but she didn't pick up. I left her some weird messages. There were Alfars all around. I hope she doesn't listen to those… My educator talked with me today about getting a portable phone, that you can use just with your speaking voice. He will give me money to pay for my cellphone. About $125. I'm happy with that. I'm happy with my room. I'm sorry I'm such a cigarette addict.
>
> "People are standoffish, you know," he says of the other patients. "Can't talk to them.
>
> "I'll be seeing Dr. Bradbury," he says once, mentioning he will be visiting Outpatient Services at Hillside Hospital once a week. "He took me to court. I lost the case. They gave me injections. Every six months, I'm supposed to have a review board evaluation. To keep me in their auspices. I have a right to get my own independent psychiatric evaluation."

Almost always, he ends his phone calls with a prayer for the replenishment of his energy and good humour, for his deceased mother to be protected, and for the health of Clara and his friends.

In late August, Clara and I visit Alistair at Marquette Hospital. It is the first time I am visiting Alistair with Clara, as during Clara's past visits to Alistair on the Open Unit of Hillside Hospital and at Le Colibri group home, I was not keeping in touch with her. Clara has brought her daughter, Jenna. We sit outside in a grassy area that Alistair had suggested, watching Jenna play. In the hallway, Clara remarks that the walls are painted blue – that it was not like that before. On our way into and out of the unit, Alistair asks us to check for him if there is another patient behind him.

> "What does it matter if someone is behind you?" says Clara. "I don't care if someone is behind you."

When we arrive at the doors leading out of the unit, Clara presses the buzzer to be let out. Several seconds pass, and the door does not budge. We are far from the nursing station.

> "This is so stupid," says Clara. "They're so stupid."

She hits the metal door with the heel of her hand.

> "Open the door! Open the goddamned door! Let us out!" she yells.

Several more seconds pass and the door is unlocked. As she pushes upon the bar of the door, Clara says to Alistair:

> "I can't come back here. You know I can't come back here."

Four weeks later, I call Clara to ask if she is planning to make her monthly visit to see Alistair and if I may come along. I have been calling with Alistair during this time, but have not heard from him that he is expecting a visit from Clara. "I am thinking of visiting him at his physiotherapy session," she says. On the day of the planned visit, Alistair and I are waiting for Clara at the junction of Beaupré Pavilion and the parking lot, our backs to a black fence and, further behind, the stone wall of the hospital. He is sitting upon his walker and I am standing beside him. Opposite us, a woman is sitting on a light-yellow bench. Numerous cigarette butts lie scattered underneath. Nearby, several others stand, smoking, under a bright blue sky in brilliant sunshine. Alistair's walker is new, with a black frame thicker than the blue walker he had last. The tinsel and Star of David decorating his old walker had not been moved to his new one. In the basket are his familiar belongings: a blue water bottle, lighter, wet towel, and pack of cigarettes.

> "Fuck, it's hot," says Clara as she joins us.

She is wearing a pink tank top, bright as a pink highlighter; blue jeans tapering at her ankle; and flip flops.

"You didn't change your shirt," she says to Alistair.

"No. It has peanut butter on it."

He looks down at himself. He is wearing a large black T-shirt that hangs loosely upon his body, black sweatpants, black clog shoes, and a black knitted hat. The tops of his shoes and the bottoms of his pants have turned white with the dust of gravel.

Clara and I wait for Alistair to finish smoking his cigarette. It is nearing 11 AM, almost time for Alistair's physiotherapy session to start. Clara and I stand beside Alistair, watching him rise from the seat of his walker. "You should get up yourself," Clara says. Bracing his arms upon the walker and planting his leg firmly in the stance he has learned in physiotherapy – "One, two, three!" he coaches himself – Alistair rises. He turns his walker ninety degrees, then shifts his body relative to it, until he is facing forward with his walker in front of him, his hands grasping the handlebars. He pauses to pull up the waistband of his pants.

We return inside to the junction of the three wings of the pavilion. On our right we pass by the man sitting in a wheelchair who is wearing an orange T-shirt. He is standing by one of the vending machines. "I'm nervous," Alistair says. Where one moment he is beside Cassy, the next he has pulled ahead, walking rapidly, wheeling his walker. Alistair is pushing his walker ahead with rapid, small steps and his arms are on the walker, his elbows bent and braced. The walker itself is accelerating more quickly than he is and it is rolling away from him. It pulls his arms with it and he lurches forward with a stumbling step.

"You're going too fast!" Clara cries out.

Alistair stops his rapid steps and stands in one spot. He pulls the walker back to him.

"Don't look at him. Don't talk to him!" he says.

"Who?" asks Clara.

"Him!" Alistair replies with a twist of his head.

"That man, sitting all the way over there, in a wheelchair?" demands Clara.

"Alfars…" says Alistair in a quiet tone.

"He's not bothering us. He's not even looking our way. He's practically *catatonic*," Clara says, bringing her hand to wave in front of her face.

Her voice is raised. She points with her left arm in the direction of the man wearing orange, in the direction of the Alfar. "He didn't do anything to you. He's in a wheelchair all the way over there. He's not even looking at us."

We are approaching the doors to Unit 108. Clara peers through the vertical panel of glass in the door at the hall of patient rooms behind. “Fuck, there’s a lot of people here,” she says. “You’re going to start yelling.” She presses the doorbell at the side, to be let in. When we are halfway to his room, Alistair stops walking. He twists his body to look over his shoulder:

“Is anyone behind me?” he asks.

“Fuck, what’s the point of seeing if anyone is back there?” says Clara.

Clara brings her right forefinger and middle finger to point at her own eyes, “He has nothing wrong with him. He hasn’t done anything to you. His eyes aren’t *moving*.”

Back in Alistair’s room, we stand next to the open doorway and wait for the physiotherapist to appear. Her voice is no longer raised.

> “Is the Patients' Rights group going to come? I thought they were going to come today. Why won’t they allow you a bank account? You will still go even though they say it’s not allowed?”
>
> “My educator told my curator,” replies Alistair. “They tell everyone everything here.”

Clara turns to me.

> “I don’t understand why they speak to him in English. I get so mad when they do.”

She looks towards Alistair.

> “They expect him to be sitting on his walker and waiting outside, before the physiotherapy begins.”
>
> “Can we close the door?” Alistair asks. “The Alfars are walking in the hall.”
>
> “It’s too hot,” says Clara. “And it will smell.”

Yet she closes the door.

“There’s an Alfar standing just outside,” explains Alistair.

Shadows of people walking are passing from left to right and right to left in the narrow space between the floor and the bottom of the door. Despite the fan, it is hot in the room and the smell of the commode is strong.

“I can’t stand it,” says Clara.

We open the door once more.

Shortly after, a young woman with blonde hair and wearing silver stud earrings enters the room. She is shorter than Alistair, and nearer to Clara's height. "Marie-Eve," greets Alistair. "Would you like to have physiotherapy today?" she asks, bending her head to speak with him. We move into the hallway that is straight and long and empty. Large, panelled windows on both sides let in the sunlight and show the green grass, the tall trees, and parking lots of the hospital grounds. The floor stretches ahead, smooth, clean, and unchanging. Overhead, a set of three signs appear at regular distances, indicating the fire exit. Alistair walks ahead, leading our group. The physiotherapist, speaking quietly to Clara, follows with her behind him. Clara answers her questions in English. We exit the doors of the unit and turn left, past the doors of another wing and a set of vending machines, to reach a long hallway that connects one pavilion to another.

As we move down the hall, Marie-Eve, the physiotherapist, calls out words of encouragement to Alistair: "Keep going." At times she says the first part of her instructions in French, and then ends her sentences in English. Pushing his walker, Alistair is angling his upper body forwards, his elbows pointing back as he grips the handles with both hands. When his walker cants towards the right, the physiotherapist takes notice. "Can you bring it back to centre?" she asks. As Alistair's path continues to curve and he approaches the right wall, she goes to stand to Alistair's right, placing her body between his walker and the wall. Alistair pauses and gives his walker a tug with his left hand. The wheels shift from right to left. He begins walking once more, the physiotherapist matching his steps on his right. Clara moves to walk at Alistair's left. With Clara and the physiotherapist at either side, Alistair walks down the centre of the hallway. At the end of the hallway, Alistair makes a turn. He walks past arrangements of tables and chairs, Clara and the physiotherapist still on each side of him. He brings them to a stop in front of a vending machine, face-to-face with a large photograph of a pile of coffee beans upon its front.

> "Oh, he really likes this," says Clara. "Look, he's smiling. He always likes to get his coffee."

She and the physiotherapist take a step away from Alistair as he presses the button for his order. Clara is smiling also.

After Clara leaves, Alistair and I stay outside for a while. Alistair does not want to go back in yet. There is still an hour before supper. "Why don't you like the Alfars?" I ask. Alistair starts walking ahead of me to cross the parking lot. He is stopping from time to time to take his hands from his walker and raise them to his shoulders.

> "They bother me. They're always asking me for money. They come up and blow smoke in my face," he adds more quietly, "I am putting up my psychic barriers."

He brings his forefingers to the frame of the walker.

> "When they tap, I tap back."
>
> "What if they get angry at us?" I ask feeling afraid at Alistair's tone of voice. "What if they yell at us, or what if they want to hit us?"
>
> "I will protect you," he replies.

During this period when Alistair is in Marquette Hospital, I conduct another interview with Clara. We are meeting again at the Tim Horton's coffeeshop. This time we are near a window. She is again wearing her white jacket with the yellow icons and at her back is a view of the November outdoors through the window. She explains that she can no longer visit Alistair at Marquette Hospital:

> "It's really stressful for me going to visit Alistair in the hospital. I feel like I can't say anything. All I can do is listen. I can't say, 'Oh Alistair. Maybe, you know, they're trying to be your friend. You know, they want to be nice.' No, he gets mad at me. He says I'm taking their side. So I have to be like, 'Oh, motherfuckers, motherfuckers', you know? But you've seen the people there, they're not doing anything bad for him. They're just in the hallway, and that pisses him off so much. Then that gets me mad because he's getting mad for nothing. It's really hard for me to handle. And that's it. I just feel like I can't be honest with him and I can't say anything that doesn't agree with him. He gets mad at me, and it's just bullshit."

The phone calls with Alistair have also been getting more difficult:

> "And on the phone too, it's like he just talks, talks, talks. His train of thought is not…you know, he goes off topic a lot. Like I'm trying to find out about the patients' rights group, 'cause they're trying to help him, but then he just starts on something else, like about the people bothering him in the hallway. And if someone's in the hallway near his room, he just freaks the fuck out, you know?"

Consequently, she has been calling him less frequently:

> "He's talking about so many different things. It's all just negative; how he hates everyone there, and this happened, and this happened. So that really drains my energy, I find. And then I decide to not call him back after. So I'm trying to call him just once per day now, and even that is a lot. 'Cause when he talks, he talks like half an hour. I'm like, 'OK, Alistair, I gotta go. I gotta go.' He's like, 'Oh no. Wait, wait, wait.' But I understand he's alone. He's lonely. He feels like he doesn't fit in with the other patients, you know? He feels like he doesn't even have any kind of medical problem, you know? [….] It wasn't always so bad, now he hates everyone."

At Hillside Hospital, Clara explains, Alistair could go outside, and though there were certain people he disliked, such as the parking attendants, he did not hate everyone there.

> "He's supposed to make Marquette Hospital his home?" I ask.
>
> "Yeah, if they'll keep him. But other places won't keep him, you know? Because he doesn't fit in anywhere. But he is… like he's very… like some people just don't fit in society, you know? And he doesn't fit in; he's loud, he's big, he yells when he's not happy, he doesn't follow rules well. Like he doesn't have to. You know that doesn't make him a bad person. It's just how he is."

I still have the view that Alistair might eventually leave institutions altogether.

> "He talks about getting physio every day," I add.
>
> "Yeah, he likes that. He had physio today at 11," she responds.
>
> "He says that one day, maybe he'll drive again," I offer.
>
> "Uh-huh."
>
> "When he talks like that, I have a story in my head where he's driving, and then maybe he'll get his own place where he's not around other patients. Do you think that will happen?" I posit hopefully.
>
> "No! They don't even let him have control of his own money. He's on curatorship. So was his mom. And that too, Joan did that, his sister. So I don't know. He doesn't seem to accept that that's his life. So I don't even go there. I don't even talk about that. I just try to get him to be nice to the other patients, but he won't. He won't."

Even Marquette Hospital is not guaranteed to keep him. Clara says that she will be surprised if he stays at Marquette, because he has not been following the rules:

> "Because now they're giving him x's, and if he gets three x's in a week, he can't go outside for twenty-four hours. That's what's happening now. So I think it was last week that he had no x's though, and it was like, 'Oh, you had a good week'. They're implementing more rules. Well, what he told me, if they kick him out there, he's going to Closed Unit A at Hillside. That's where he's going. And if he really doesn't behave, then he'll go to a place that's like Closed Unit A, but permanently. That's how they threaten him all the time to get him to behave: Closed Unit A, Closed Unit A, you know? They threaten him with that."

I wonder if there could be something positive about Alistair's situation that we can talk about, and ask Clara if he had ever surprised her in a good way. Clara replies: "He could be really nice. He bought me this thing." She takes out the keychain of a black high heel. "I told him I wanted this for my birthday and then he bought it. I love it. From Hillside Hospital. He's bought me things. That kind of surprised me, I guess. That's about it."

P'tit Jo's Restaurant, 600 metres from Marquette Hospital

"We're planning to go to P'tit Jo's – it's close to the hospital, but whatever." Clara is referring to a popular burgers and hot dog chain where they are thinking of going. I ask if I can go with them and Clara accepts. "Yeah, he'd like that." Later when I am home, I look up using an online map the directions from Marquette Hospital to P'tit Jo's. There is only 600 metres between the two locations. Even this short distance would be too great for Alistair to walk outdoors. It is the occasion of Alistair's birthday.

At Alistair's room in Beaupré Pavilion, Marquette Hospital, I greet him as he is sitting in a chair between his bed and the doorway of his room. "This is a large shirt," he says, looking down at and gesturing to the green T-shirt he is wearing. "I am waiting for Rachel," he continues. "Rachel might be coming with us. But she didn't call. She is one of my friends." Alistair plays me a voicemail from Amanda. "Sending you lots of birthday love," she says, over the phone. "Let me call Laura," says Alistair. He dials her number, but she does not answer. "I'll give Rana a call," he continues. He dials Rana's number. Rana picks up.

> "How are you, my dear friend?" says Rana. "We will talk, and you will tell me everything."

After Rana hangs up, Alistair says, "I'm going to call Morris. He's the music therapist at Hillside Hospital. I'll see if he's there." Morris does not pick up. Alistair then stands up. He reaches beneath the hem of his shirt to pull up the waistband of his pants. Next he smooths his shirt over the waistband. We walk into the hallway of Marquette Hospital. A woman, who had been a psychiatric inpatient at Hillside Hospital, is about to pass by. She pours for Alistair into a Styrofoam cup a portion of the bottle of Diet Pepsi she is holding in her hand.

Outside, the sky is overcast with opaque, gray clouds. We stand waiting for the taxi that Alistair has called. A different taxi drives up and an elderly woman in front of us gets into it. A moment later, the taxi for Alistair arrives. I open the door to the passenger seat and he gets in. I place his walker into the trunk which the driver has unlatched from the inside. The driver, who appears near in age to Alistair, does not get out of the car or help us. "Just to P'tit Jo's," says Alistair to the driver when we are all seated in the car. As the car drives away from the hospital grounds, Alistair counts the trees lining both sides of the road.

> "One, two, three, five," Alistair says. "Skipping four because it's unlucky."
>
> "*Un*, *deux*, *trois*," the driver says softly. "*Il y a nombreux arbres, n'est-ce pas?*"
>
> "I'm counting to try control my anger," says Alistair. "I will pay you. I will leave a large tip."

The driver does not look at Alistair. He continues to speak, too quietly to be heard.

> "P'tit Jo's!" the driver says suddenly, forcefully, enunciating each syllable.
>
> "Would you stop your cursing?" says Alistair, his voice rising. "*Je te donnerai un gros tip*."

The car turns into the parking lot of the restaurant, which faces a gas station and a ramp leading onto the highway. The taxi ride took less than five minutes. Alistair gives a bill to the driver.

> "Can you please go closer to the door? Can you please go closer? I gave a large tip."

The taxi driver inches forward. As we shut the car door, the driver says, "*Bon appetit*."

Alistair pushes his walker to a table next to the entrance of the restaurant. The red sign of the restaurant, a huge burger, hotdog, and container of French fries, stands over us. The table is painted red with yellow seats. Alistair sits down. There is a cigarette butt holder and garbage container are nearby.

"Clara suggested this restaurant," says Alistair. "She likes this restaurant."

Almost half an hour later, Clara approaches us. She sits beside Alistair. "That winter jacket is too small for you," she says, looking at the thin, black jacket that Alistair is wearing.

"I'd like to have a smoke," says Alistair.

"Do you have to smoke now?" asks Clara. "I'll wait for you inside."

Moments later, Clara is sitting inside at a booth by the window. We are separated from her only by the window glass. She smiles and waves, then taps the glass. Alistair rises. When we are indoors, Clara gets up and comes to his side. "Don't fall backwards," she says. She leads us to a table with chairs that can be pushed in and out. Alistair sits down and places his walker in the aisle.

"You should use your money," she says.

Alistair gives her a green, twenty dollar bill, that has been released to him by the public curator.

I join Clara at the ordering counter. Clara looks up at the menu hanging from the ceiling. "How much is a combination of hot dogs?" she asks the woman at the cash register.

"Fifteen dollars," the cashier answers.

"I'll take two fries," says Clara.

The order come to just under twenty dollars. We carry the food on red trays back to the table. "Thank you for lunch," she says to Alistair, setting down two trays. "I have the fries." Alistair looks up at her. "Do you want any salt on your fries? Any ketchup?" she asks him as she gets into her seat. Taking one container of French fries, she turns it upside down and shakes its contents out onto the thin sheet of paper covering the plastic food tray. She does the same for the second container of fries, leaning to her left, over Alistair's food tray. Taking some salt packets between her thumb and forefinger, she tears off their tops and sprinkles the salt onto the fries.

We dig into our meals with our hands. At one point, Clara gets up from the table. "You are making a mess," she says to Alistair, before going to find more paper napkins. She returns and sits down.

"What's that sound?" Alistair asks.

"It's someone chopping food," says Clara.

The trays are cleared of food when we finish eating. There are a few pieces of French fries scattered upon the edge of the table. "I should get more food," says Alistair.

"You should save your money," says Clara.

Clara and I wipe the fallen French fries onto the trays. We get up to put away the trays and return to sit at the cleared table.

"My mind is shot," says Alistair.

Clara laughs.

"It's been long gone."

"I got my shot last Friday," says Alistair.

"Oh, you're doing pretty good," replies Clara.

"Sally called. And Mikey called," says Alistair of his older siblings. "But Rachel didn't call back. She couldn't join us."

"She has –" begins Clara –

"– issues," finishes Alistair.

"She's a patient, just like you are a patient," says Clara.

"But she did a nice thing for me," replies Alistair.

Clara tells us that she found a new place to move into. "Yesterday they told me I was accepted. It's just the next street over, but it's a step up." The shower at her current apartment leaks into the hallway.

"Do you remember my guitar? Did you see my guitar?" asks Alistair.

Clara takes out her phone, searches upon it, and shows the screen to Alistair, who continues to stare at the image.

"It's a photo I took of you and your guitar. You forgot?" she asks.

Clara sets her black handbag, its surface hard and shiny, upon the table. "I have a surprise for you," she says. She reaches inside and takes out a blueberry muffin wrapped in a clear plastic bag. The surface of the muffin has been baked golden, and small pieces of blueberry are embedded in it. She holds it out to Alistair, who takes it from her. "I have another gift for you," says Clara. She reaches again into her handbag and takes out a Choco Lux dessert, also wrapped in a clear plastic bag. It is a small, round cake the size of a palm, coated in dark chocolate, with a layer of marshmallow and vanilla wafer cookie underneath. She reaches once more into her bag, and takes out a clear, plastic sandwich bag containing four small birthday candles in different colours: pink, white, and green, with spiralling grooves running along their sides.

Clara unwraps the small cake and slides the four candles, in two rows of two, into its surface, until all four of them are at the same height, forming a square. Alistair reaches to take out one of the candles.

“Not four. Four is unlucky,” he says. He looks at me. I nod.

“Four is an unlucky number in Chinese,” I explain.

Clara puts the unused candle back in the plastic sandwich bag. There is a hole in the Choco Lux where that candle used to be. Clara takes out a lighter, holding it in her right hand. With a flick of her thumb, there is a flame. We sing for Alistair. “Happy birthday to you. Happy birthday to you.”

“You look like a monkey –” sings Alistair.

“– and you smell like one, too,” finishes Clara.

“I’m seventeen,” says Alistair.

We all laugh. Alistair makes some wishes. “I wish Rachel would call back. I wish to have a bank account. I wish I can get out of here.” After Alistair blows out the candles, Clara removes them, placing them back in the bag. “The taxi driver on the way here was rude,” continues Alistair. “He was yelling, he was screaming.”

Clara looks at me; Alistair notices.

“I just want to get a second opinion,” she says.

“He didn’t like that the trip was so short,” I say.

“If I was in the car, I would have told him off,” says Clara. “What about when you go back? I’m going to call the taxi company, to tell them, for when you go back. I mean, it’s their job. They have to understand that not everyone’s calling for a taxi from the airport to go downtown. It’s because you can’t walk.”

She looks at Alistair.

“Because you’re sick.”

“I’m not sick.”

“It’s because you can’t walk. But we’re going to milk it. I’m going to say, ‘My father is in the hospital. He wanted to go to La Belle Province. He can’t walk.’”

Clara is holding her phone in her hand.

“No, no, I’m not ready to go yet,” says Alistair.

"I'm just getting the number," Clara says. "I'm not going to get mad. I'm just calling them to let them know, so they can send someone who won't mind that it's a short trip."

Clara has dialled a number upon her cellphone. A moment later she is speaking rapidly in French. "*Pis…pis…pis…*" she says, using the colloquial word for "and then" as she describes the events of the taxi ride in quick succession. "It's my father. The driver was very disrespectful. The restaurant is just next to the hospital, it's a short ride, but he can't walk, and that's why he's asking for a taxi. He has a walker. He will leave a good tip." She listens some more. "Thank you!" she says. Smiling, she ends the call. "I have to go. I have to pick up my daughter and my friend's son from school." She stands up. Her eyes shining, her face held still, she bends down and hugs Alistair for a long time.

A while later, a white taxi from the same company takes us back to Marquette Hospital. As Alistair counts the trees lining the road, the driver, a tall, elderly man with a head full of white hair, remains silent. He helped Alistair to get into the passenger seat and stowed his walker in the trunk. Once Alistair is back in his room, Alistair asks if I can go to straighten the blinds. Some are broken, dangling at odd angles from the horizontal bar, but still they block the light. He closes the door and sits in his chair in front of the doorway.

"Thank you for being here," he says. The whirring of a fan, pointing down at us from above the window, muffles Alistair's soft voice.

"Where do you want to go? If not this place?" I ask.

"I don't know," he answers. "A place without lunatics."

He remembers that he promised to show me his electric guitar, bought for him with money from his inheritance by his older sister. Bending down, he pulls out an amplifier from beneath his bed. He twists the knob on the top of the amplifier. A small red light glows. From a compact case he takes out a red electric guitar. He connects some of its wires to the amplifier, and flips the switch on the body of the guitar. Sending the metal strings twanging, he starts to tune the instrument. Once he has finished, Alistair reaches for the knob on the amplifier. "We turn it off," he says. "Did you know I was so good at the guitar when I was younger, I was better than BB King?" Alistair is cradling the guitar, resting its bottom on his lap. His right hand clutches the slide, as his left forearm rests over the backing of the guitar. The fingers of his left hand are splayed apart, his fingertips slightly curled next to the strings, barely touching them.

"The CD player is over there by the sink," he says, gazing across the room.

"The CD is already inside. Do you see?"

I walk to the other side of the room. A small, portable CD player, with gray plastic casing, is on the counter, between the wall and the sink. Its top cover is propped open. Below it, a CD with black text, printed against a silver background, sits fixed to the disk drive. Next to the CD player rests a CD case. The album cover reads:

Allie Samuels

Solid Gold

Blues Review

Intro Groove
Hand Me Down My Walking Cane
Stormy Monday
Jam at ACUL Radio Station
Everyday I Have The Blues
Drifting Drifting
Dust My Broom
Sweet Little Angel

Susan McCarter, Drums
Charlie Rouleau, Piano
Tom Caravaggio, Bass
Steve Morrow, Harp
Allie Samuels, Vocals and Guitar

I close the cover and press play. The twang of a guitar, playing a four-four blues beat, fills the room. Alistair shifts his left hand ever so slightly, a few millimetres up, a few millimetres down, brushing the guitar strings. Then comes the sound of someone singing.

“That’s me,” says Alistair. “It was recorded on the radio in the 90s.”

His left hand stills, raised a centimetre away from the strings. In the absence of notes played, Alistair’s voice sounds, vibrating loud and deep. His living voice joining with the voice from the recording, Alistair sings.

Excursions

One afternoon in early June, when I learn from the Morning Planning Meeting that Alistair has been sent from Le Colibri group home back to Closed Unit A for the second (and last time), I go to visit him. When I enter the nursing station of Closed Unit A, I see him through the glass. I go to the door between the nursing station and the patients’ side, and a nurse unlocks it for me. When I step through the doorway, Alistair is already standing in front of me, holding onto the frame of his walker.

“Let’s go for a walk,” he says.

Instinctively, I look towards my right, down one leg of the corridor, behind which is the day room of the Open Unit.

> “Not that way,” he says, following my gaze down the empty hallway. “There’s a woman there who hits people. This way,” he says.

He turns his walker towards my left. I follow. We pass by patients’ rooms, some with doors open and no one inside, others with doors closed. After we walk a distance of ten metres from our start at the nursing station, the hallway opens onto a larger area, the yellow walls illuminated by several bright fluorescent lights above. Alistair turns left once more. He motions to an arrangement of three small tables bolted to the floor, each connected to two chairs. He parks his walker beside the table. I follow him to sit. I have never been in this area, with its cafeteria-style table and chairs, and would not have expected it to be here. Sitting across from me, Alistair begins to tell me stories from his day. I realize that even though we have only moved ten metres, he has taken me to someplace new.

During my fieldwork, each time I have visited Alistair, he has invited me to go on an excursion. With every meeting, we would go somewhere else. Even in a confined space such as Closed Unit A, where the only options for travel are going left or right, Alistair moves. He moves from his room in a group home to its porch, where he plays the harmonica; down a long hallway where he is strengthening his ability to walk during a physiotherapy session, to end at a vending machine dispensing coffee; and from his room in the Inpatient Psychiatry Unit to the water fountain in the lobby. At the moment of departure, before Alistair initiates the excursion, at first the qualities of the clinical context – the smell of urine, the narrow hallways, the confined rooms, other patients whose presence bothers him, the healthcare staff who have their own schedules to keep, the cigarette butts gathered at the front entrance where many patients smoke – seem so greatly present as to crowd out and overwhelm other possibilities. The moment before our departure, before the excursion begins, I still carry projected meanings of whom I take Alistair to be, from his dress and appearance, from his difficulty with mobility and the equipment surrounding him, from stories I have heard from staff and from others around Alistair. Then we are off. Even in the context with the greatest surveillance and the least amount of space, Closed Unit A, Alistair takes me to an area that stands out from the surroundings.

The short trips that he takes, bringing along Clara, bringing me along, inviting someone else he knows, often involve doing something enjoyable. They appear to make life in an enclosed, rule-bound, institutional setting more bearable. Yet the excursions Alistair has taken Clara and me upon are about something more than pleasure, for several of Alistair's excursions have incurred frustration and conflict. They are not always pleasant or indulgent, even as they involve buying food, enjoying music, or simply getting some fresh air. He leaves the clinical setting, albeit temporarily, as someone who has somewhere else to go, to spend time in; he returns to the institution as someone who has been someplace different. Clara has gone on these excursions with Alistair since the time of their meeting, and she continues to visit him no matter where he is housed in the mental health and social services system. She does not speak of her visits as being dependent on where he is. What is constant is that she has in him a father and sees him as a human being. For Clara, there are still songs for Alistair to sing and for her to hear. There are still stories for Alistair to tell her. There are still elements of the clinical contexts for them to both complain about and to oppose. Unspoken at each of their encounters is an understanding that they will attempt to meet again, even as they are unsure of the time and place.

Chapter 5 Xavier and Paige

May to June

In mid-May, I dial Mrs. Paige Blanchard's phone number for the first time.

"Hello?" answers a woman's voice. "Hello?"

I introduce myself:

"I am a student conducting research in the Department of Psychiatry at Hillside Hospital –"

"What?" Mrs. Blanchard interrupts, her voice rising. "What's happened?"

"I'm calling about a research study – I'm sorry to bother you – "

"Oh," she answers softly. "I had thought my husband…I had thought you were calling because something happened to my husband. Here I am and I thought my husband had died…"

I apologize once more, and she reassures me that it is OK. I explain the study to her.

"I would love to participate," she says, her voice filled with emotion. "Because I feel very much alone..."

She asks me to write down the email address of her husband, Xavier Blanchard.

"It's the email of his construction business, but it's mostly me who checks it now."

A few days later, I send an email to this address. I leave Mrs. Blanchard a voicemail a week after. Two weeks later, I call again and leave a second voicemail. During my initial contact with family members, I have learned that they are busy with their work and caring for their families. Several family members have said to me that they are interested in participating in the study, but now is not a good time. I do not call Mrs. Blanchard a third time. I assume that like many of the family members I have approached, she is also too busy to call back.

During the Morning Planning Meetings in May and June, the staff give reports about Mr. Blanchard. They describe him as being in his late fifties and having a diagnosis of bipolar affective disorder with a recent episode of severe depression. At consecutive meetings, the staff say of him: "He has been here since April 17. He AWOL'ed on us two times," reads Dr. Song, a psychiatrist-in-training, from a page of notes. She is referring to the times when Xavier left the hospital without notice. One morning, a nurse refers to him as "the gentleman who walked all the way to Lareau. He has blisters on his feet." Lareau is more than forty kilometres away from the hospital.

> "He was transferred from the Open Unit to Closed Unit B because of suicidal ideation. He looks very depressed."
>
> "He is self-isolative. He would not come out from his room. He is less agitated, denies suicidal thoughts."
>
> "He is still staying in his room, most times."

One morning, I catch a glimpse of Xavier in the day room as he slowly walks down the hall in the direction away from where I am standing. Viewed from the back, his hair is a mixture of gray and black and he is wearing a light-yellow hospital gown that is tied at his nape with a butterfly knot. At the front, his gown reaches past the level of his knees while at the back it is slightly parted, exposing the skin of his lower back and the fabric of his dark, loose-fitting pants. His gown and pants hang loosely upon his frame.

During an afternoon in mid-June, bright sunlight shines into the day room. Mr. Blanchard is sitting at one of the round tables in the middle of the room. A woman sits next to him. I greet her as Mrs. Blanchard.

> "I'm sorry for the phone call –" I begin.
>
> "Stop apologizing and come sit down," she says in a voice loud and clear.

Her blonde hair falls upon the shoulders of her gray blazer, its faint, chequered pattern shining in the light. She asks me to call her by her first name, Paige. Right after I sit down, Paige announces that they must go to a meeting. She stands almost as tall as her husband. She reaches out to touch my arm as she says goodbye and asks me to call her once more. I do not find the time, however, to call Paige that night, nor the day after.

Two days later, from the corner of my eye, I see someone walking rapidly in my direction. It is Xavier, taking large strides down the hallway, leaning forward at his waist as he walks toward me in the day room. "Paige, my wife, would like you to call her," he says. I call Paige later that day to arrange an interview the next time she visits the hospital. "Did you call Paige yet?" he asks me when I next return to the inpatient unit, and I nod. The next time we see each other in the day room, he waves his hand in greeting.

The staff's reports about Mr. Blanchard have become more positive. In mid-June, during a Morning Planning Meeting, a staff member summarizes of Mr. Blanchard: "He is recovering.

There's nothing reportable." A week later: "He is doing very well. He is reading a book and smiling." At a subsequent meeting, Diana, one of the occupational therapists, reports upon a recent patients' discussion group on having positive supports in one's life: "For Mr. Blanchard, it is his friends and work. He also has a son." Towards the end of June, Erica, a social worker in Mr. Blanchard's treatment team, gives an update as his discharge approaches: "Mr. Blanchard has picked two recovery classes: computer class and healthy lifestyle."

July to August

The sun is very bright in the family room on the sixth floor of Hillside Hospital, when I first have an interview with Paige. This morning, in mid-July, she has come to pick up her husband as he is being discharged from the hospital. She will drive him home after he finishes his occupational therapy session on the inpatient unit, two floors below. To our side, the large windows offer a view of the dome of St. Anne's Cathedral in the east. Potted plants are arranged beside single- and double-seated couches. An electronic, baby-grand piano is placed in one corner of the room. Paige is sitting on one of the double-seated sofas and I have drawn up a chair to face her. Our feet rest on a carpeted floor.

Paige is wearing dark pants and a collared, short-sleeved, button-up shirt of a light shade. She is in her early sixties, commuting between teaching music and English to students of all ages at two schools in the city. She went back to school at the age of fifty to earn her teacher's degree. Before becoming a teacher, she has held various jobs, including designing costumes for an opera company, catering, and running her own cleaning business. She and her husband live in a condominium in a neighbourhood just outside of the downtown core. They have been married for fourteen years.

> "Well, it's a second marriage for both of us. He was married for a long time and, uh… OK, he got sick as a younger adult. When I meet him, I think, he was fine. Like he was fine for about, ten years. Then he started to… He did tell me he had bipolar disease. I didn't know what that was, you know? I didn't realize what that was. I didn't know what it was to live that. I didn't understand. But it started to, uh…go off. He started to go off. It was around the time he was having trouble with his thyroid. He was beginning to be hyperactive. And he lost a lot of weight […] I was finishing my degree and I was out of the house a lot. My job is extremely taxing. Um, I was gone for ten to twelve hours a day. So, you know, he

> was taking care of himself. He was working intermittently. He never has worked really steadily, except at the beginning of our relationship. He was making quite a bit of money. He's a tradesman. Brilliant at it. Really, really incredible."

He had owned a construction company, built the kitchen for their home, and renovated their friends' homes, who admired the cabinets he had made for himself and Paige. He had learned the trade from his father, who supported a family of five children upon his successful business. Paige explains that recently, he has not been able to work. He has been in and out of the hospital for the past three-and-a-half years.

> "This last time has been the longest. They were trying to balance his medication properly because of the thyroid, and things that worked before didn't work now. I tried to stay out of it. You know, it's his business. But I now realize that I have to be on top of it because I don't trust him to make sure he's taking his medication. Because I know he's forgotten. Or not forgotten but…because he can't stand feeling like a zombie, he just doesn't…you know, he'll skip a dose or something. […] He's escaped from the hospital four times."

She laughs briefly, adding, "He's brilliant… He's an escape artist" and then apologetically, "I know it sounds disjointed" as she starts to recall the times her husband had left suddenly, when he was at the hospital and at home. One time, she had asked him to move his truck to the other side of the road to avoid a parking ticket, but he refused to leave the house.

> "But that morning, about 6:22 – I know the day, the time, because we have it on video, when he left the building – he left without his wallet, without any keys, without identification, without money. Everything. So he was gone. And I spent, I think, 24 to 36 hours wondering where he was. He ended up in Hillsview. He came back with several articles of clothing that I don't know where he got. Some people gave them to him at the church where he ended up. And then, um…how did I end up taking him to the emergency? He just wasn't right. So he ended up in the hospital. He came out again."

Paige trails off.

> "Then I had to…I don't remember. I don't remember how. I mean… I just don't remember."

I wait, and gradually she begins to recall the events.

> "I know he ended up back in, and then he escaped again. And he walked…he went out with no shoes on. Walked to Greenville, walked all the way down Anchor street, went into the Salvation Army, and they gave him a pair of running shoes, which were too small for him. He walked all the way to Adler street, down Adler street, over the bridge. Walked through Morton. Ended up in Lareau. Nobody's ever done that before. His feet were a wreck. Xavier, he's from Lareau, which is about twenty-five miles from here. That way. South. Directly south."

There was another time, Paige recounts, when Xavier escaped from their home. She believes he was psychotic then. He had crashed into a tree while driving and was taken to a hospital in Gosford, an hour from home by car. His leg was severely injured.

> "He had to have an operation. And, uh, it's a miracle that he's walking. He spent two months in a wheelchair. We had to take the bathroom door off. That is all while I'm teaching. When I think about it, I don't know how either of us got through it. Because I couldn't stay with him during the day. You know, I had to leave him alone. He was immobile, so I wasn't too worried that he'll do something stupid, you know, being in a wheelchair. And I said, "If you ever want to walk again, you'd better not try and stand on your leg, 'cause otherwise you're gonna be a cripple for the rest of your life, in a wheelchair." I think this shocked him a little you know?"

For the past two years, unopened boxes from moving still occupy their present home. Paige has not had the energy to open them, with having to put in many hours at work and Xavier's multiple hospitalizations. Yet Xavier is doing "much better now", and she has just gotten a new teaching position at a school much closer to home.

> "So for the first time in several years, I actually feel like unpacking those boxes, you know?" says Paige. "I'm hopeful. Cautiously hopeful, I would say."

Paige's gaze lifts. "Oh, there he is! Hi Xavier!" A tall man sits lowers himself to sit beside her on the double-seated couch. "How was OT?" she asks, turning to him as she asks about his occupational therapy activities session. Xavier replies. I am unable to catch his soft-spoken words. "But why?" asks Paige, her expression furrowed. "Was that all you could do?" Xavier again speaks, his face turned towards her, words too quiet for me to hear. Upon hearing his reply, Paige smiles. "Did you find any *mots cachés*?" she asks if he completed the word search puzzle.

They agree to continue the interview with me, together. Paige will speak to Xavier in English and he will reply in French at some times, and English at other times. I begin, "You had said, over the phone, that you felt very alone…". Paige replies first.

> "It was two years ago that Xavier was in the hospital. I was working in Blackwood. I dragged myself to work, I'd work all day, I'd come here on the way home – because it was easy to come here and visit him – and then I'd go home and fall into bed. And I'd schlep my way through the next day, you know, doing the same thing. Always alone. […] It's just knowing there's absolutely nothing I can do to change the situation and make it better. And there's nobody that can help me with it. You know, there's nobody to talk to. There's nobody to say, 'OK, well, I think we should try this.' I tried everything."
>
> "*C'est dure pour une couple*," says Xavier, his voice trailing off. It is hard for a couple.

At the end of the interview, Paige says that Xavier has changed his habits: he is eating less sugar, and has stopped drinking, which was interfering with his medications. "I think Xavier knows he has to change some of his habits, in order to keep it together. But change is very painful." She reaches over to his side and pats his abdomen. "He hasn't gained weight," she says, smiling. "We'll have to get you your strength back. Or else when you do manual labour again, you will hurt yourself." They get up to go, standing in the sunlight. Xavier turns to Paige, saying something to her. "We can drop by there on our way home," she replies.

Almost a month later, during the first week of August, I call Paige once more. "I am cautiously optimistic," she says upon answering the phone:

> "He did something today for the first time. He worked outdoors. He went to put on cladding for a friend. It's been a long time since he's done that. Now he's tired, and he's sleeping. Physical work tires you out. For the first time in our relationship I'm hopeful. I'm cautiously hopeful."

She has been thinking of unpacking the boxes lying about their home, and looking forward to teaching at a new, closer school: "I go back to work on August 26. Things will be a very different pace then. But work will be close to home and that will help a lot."

During this time, I run into Xavier one afternoon in Pavilion J, the building for outpatient psychiatric services. He is sitting in a cushioned, black chair outside of the office of his outpatient psychiatrist, Dr. Tamlinson. To his left is a small table holding a pile of magazines. To his left is the window, and as he turns rightward in his chair to speak to me, his head, neck, shoulders, and arms are outlined in the sun behind him. The creases upon his face follow the shape of his jaw, encircle his eyes. They lift and turn into curves when he smiles. "*Avez-vous un rendez-vous?*" he asks. I shake my head, indicating that I do not have an appointment. We smile at each other, and I continue down the hall.

Two weeks later, during an evening in late August, I call Paige once more. She has just finished heating her dinner but is staying on the phone to speak. Her voice rings loud and strong.

> "You know that my husband is in the hospital again? My husband is *very* angry with me right now. He shaved his head – he shaved his head and took out twelve hundred dollars from our joint banking account. He was going to leave. Two days ago, I called 9-1-1. I can't take it anymore. It's crazy. What he does affects *me* too, it affects the both of us […] I'm sure he stopped taking his meds for whatever reason. Maybe he was trying to take half the dose. I can't be there all the time. The only way I can make sure is if I watch him take it. If I'm in the bathroom with him. But what about when I am not there? I will be starting work in five days… I don't know if he can come home. It can't keep going on like this. They say hell is where there is no reason. The illogic of this."

Her voice quiets, "I don't know anything. Is he still in Emergency? I don't even know if he has a bed yet." Paige's tone then rises again but this time with anguish.

> "I don't deserve it. I'm 62 years old. I feel like I'm trapped in a prison. Even murders – even murderers get parole. I don't deserve a life sentence. He won't talk to me. He won't let me visit him. I don't even know if he's still in Emergency. He tells me he wants a separation. That he doesn't love me. He says he's not coming home. He says the boxes are everywhere, the house is messy. It's all my fault. I feel sad for him. 'Cause I'll survive. No matter what happens, I'll survive. But I'm afraid for him, to be honest."

In trying to see a future, I ask, "What do you think will happen to him?" Her tone has come down.

> "I think he'll end up on the street. That's what I think. I don't know if he can come home. Did I try hard enough? Could I have done more? I don't know if he

> can get a job. He doesn't know how to use a computer. Maybe it's the push that he needs…."

In the background is the sound of dishes sliding against one another. She has made corn and has to go to eat it while it is still warm.

> "Please don't stop calling."

The next week, I call Paige in the evening, after she has returned home from work.

> "He said I didn't visit him at the hospital last time. I was working fifteen, sixteen hours a day. And when you get home at five or six, you don't want to visit him at the hospital. The police came. He went with them in the end. I think he didn't know he had a choice. They said that if he didn't want to go with them, they couldn't make him. He says he's not coming home. He says the boxes aren't – that the house is messy. But I couldn't look at the boxes. He's a carpenter. He works in construction. He just wants to do the work. Oh, he did beautiful work. But not anymore. His brother says he's been making mistakes. He's not as good as before. He doesn't know anything else. He learned the business from his father. He renovated the shower, the kitchen…."

Her voice trails off, then begins again.

> "He says he will not come home. We're going to legally separate. So that means he does not love me anymore. Were the last fourteen years fake? I don't know what to do. I can't do this anymore. I can't go on like this anymore. I don't know who Xavier is anymore. Is he the illness? What is the illness and what is Xavier? Were the last fourteen years of our marriage fake?"

Paige then speaks of the significance of Xavier's son, from his first marriage.

> "He regrets not spending enough time with his son. He didn't put enough energy into his son. He was very sick when his son was young. He didn't teach his son or tell him 'no'. He indulged him. When his son screamed, he got him a motorcycle as a gift. And for one year, he got a job at a store, he was doing well, he could have become an assistant manager. Then when summer comes, Xavier says, 'Come learn the trade with me, come learn the business,' and his son took advantage of him, he took the money and bought drugs and he's never been well

> since. We don't even know where he is – he could be homeless. His son will be thirty next week."

Her voice is rising.

> "I mean, I don't even know when he's getting out, you know?" she continues. "I can't have him just arrive on my doorstep and just expect to come in. 'Cause he's not coming in. He's not coming in. I won't allow it. Send him back. He said he's not coming back, he's not coming back. I can't! You know, either he'll stay here and not leave, or else it will just go back to the way it was. No, I'm not doing that! He's been shy all his life. Maybe this will be the best thing for him. Maybe it will actually force him to get his life together by himself. Because there's nobody that can help him. Or he has to go and ask for help, direct help, which I don't think he ever will. You know, I don't know what to do. I don't know. It'll be the saddest thing if he ends up on the street, but what am I supposed to do about it? What am I supposed to do?"

A few months later, Paige tells me that around this time, Xavier had received news from the police that his son had been charged with assault. She wonders if it led Xavier to be readmitted during the summer.

> "You know, he came home and he was filled with ideas of things he could do […] So it was after that that things started to go down. That's my impression. It may be wrong, but that's my impression. And so he started to, you know, just not do anything. And being to the point where, you know, he just wouldn't go anywhere, do anything. And that's what I think drove him to this next stage. You know, where he took all our money out from the credit card, and said he's leaving, and said that he just can't stand it anymore. And that was the end there. And then I called 9-1-1. Because he had all that money in his pocket he had taken out from the credit card. He just wasn't making any sense. He had gone out for the night, and then he came back, and I wouldn't give him his keys because I didn't want him driving. He was manic. He was totally manic."

September

Xavier sits at a window in the corner of the day room, between the back wall and the kitchen counter, where during meal times patients line up to receive their trays as the unit clerk retrieves them from a cart. He sits, legs crossed, looking out the window onto a hospital parking lot and the tree-lined residential streets. His long, gray T-shirt covers part of his lap. Loose-fitting black pants, too short to cover his ankles, reach the tops of his bare feet, which are clad in green hospital-issued slippers. He has recently been moved to the Open Unit from Closed Unit B. I wave at him from across the day room and move towards where he is sitting. "*Je suis heureux de te voir*," he greets me. He is glad to see me. His short haircut, less than a centimetre long, follows the shape of his skull. Lines crinkle upon his forehead and around his mouth and light-coloured eyes when he smiles. He asks me to sit down. After asking how I am, he does not say very much. He tells me that the village where he grew up is beautiful, with trees and a pond.

Over the following days, Xavier continues to sit by the window in the day room in the mornings and afternoons, gazing outside. The window has a brown frame, showing a view of the hospital parking lot and of the houses and streets of the city occupying the downwards slope. Above this landscape, from the hospital's position upon the hill, one can see a far stretch of sky. Sometimes, Xavier stands up abruptly from his seat to walk or to fill his cup with hot water. Often, on the table beside him or held in his hand, is a cup with a Red Rose tea bag hanging over the rim. It is quiet in the day room during these times, when many of the patients are in the occupational therapy room during scheduled sessions. By mid-September, Xavier's hair has started to grow back. He begins to go to the Community Meetings. One morning, Diana poses to the group the question of the day: "What is your favourite animal?"

"A tiger, strong and beautiful," Xavier answers, his voice loud and clear.

"I like the way you said that," says Diana.

She sits up straight in her chair and looks back at Xavier.

"Strong and beautiful," she repeats, before continuing to the next person.

Another morning, in the Community Meeting, Xavier says to the group: "The weather is so good, *on doit profiter*." The next time I greet him, I tell him that I have taken his advice to enjoy the sunny weather we have been having despite the oncoming fall. The days continue to pass. One morning, in late September, Dr. Nadeau and Erica, a social worker on Xavier's treatment team, sit across from Xavier at one of the round tables in the spot where Xavier usually drinks tea and looks out the window. Xavier sits facing them with his back to the window.

"Where do you want to live?" asks Dr. Nadeau in French.

"*À l'est*," he answers.

The next day, Xavier, wearing a red T-shirt and dark yellow cargo shorts extending to the tops of his calves, is again sitting at the table by the window. He is speaking with a male, francophone social worker. Their heads are framed by the window behind them and the sunlight is streaming into the day room. The following week, Xavier is sitting at the desk by the patient's telephone. He is wearing a pair of glasses pushed back on top his head. A small green notebook sits close by his hand. He opens the notebook to a blank page and asks me to write down my phone number. "I was busy, yesterday, with my problems," he says.

One evening during late September, I call Paige.

> "I haven't heard anything from anybody," she says. "I can't manage the medications if I'm not in the know. He's so passive. I haven't cleaned up the place. I can't do it. It's my fault. He worked from 2002 to 2014. He would work a bit, then we would just start to get out of debt. He quit drinking."
>
> She pauses. "The only bright spot in my life is my job." She has written a play to be performed by her students. "I tell them stories that no one else would take the time to tell them," she says with a tone of pride.

At the end of September, in the Morning Planning Meeting, a nurse reads from her patients' notes that Xavier wants to sign himself out of the hospital against medical advice:

> "He will be back. Don't worry, he will be back," answers Dr. Nadeau, speaking into the empty space at the centre of the circle of staff members gathered for the meeting.
>
> "He is manipulating the system," says Erica softly, her eyes downcast.
>
> "We should stay the course," intones someone on Xavier's treatment team.
>
> "He has a follow-up appointment tomorrow with Dr. Tamlinson," says another, referring to Xavier's outpatient psychiatrist.

Outside the conference room, in the day room, Xavier is once more sitting by the window in the corner. The window shows a uniformly gray sky. He waves at me, and I walk once more towards him.

> "*Comment va tes etudes*?" he asks me about my studies.
>
> "*J'ai vu la signe pour Lareau*," I say, having seen the sign for Lareau when I had driven past.

> "*Ah, vous faites rappelles de mon hometown*," he replies, saying that I have remembered his hometown. "What would you do this afternoon?" he asks.
>
> "*Je ferai une entrevue avec un membre de staff – je joue au piano – parler avec une femme qui parle Mandarin. Et vous*? *Avez-vous des plans pour aujourd'hui*?" I reply, in my limited knowledge of French, that I will interview a staff member, play the piano, and talk with a woman who speaks Mandarin. I ask him what are his plans for the day.
>
> "*Chercher un job. En l'environnement*." He will look for a job.
>
> "*Quelle sorte de job*?" What kind of job?
>
> "*Nettoyage*." In cleaning.
>
> "*En dehors*?" Outdoors?
>
> "*Oui*." Yes.

October

On October 1st, I approach Xavier as he sits by the window in the day room. "I am sick," he says. "I am too sick to work." He turns slightly to his right, his gaze over my shoulder.

> "What do you want to do during the fall?" I ask.
>
> "Change," he replies, looking outside. "To not make the same errors. To take time for decisions. Will you play the instrument?" he asks, referring to my playing the piano and clarinet on the unit at times.

The next day, I learn Xavier has been discharged. That evening, it is already dark when I call Paige. She is again in the middle of preparing to have supper. She has also found out that Xavier will be discharged soon. "He was always gonna come home," says Paige. The course of things has changed.

> "Ever since he said to me he's not coming home, he's not coming home, he's not coming home, then, um, you know, I just don't trust him. I don't know what he could do, you know? He's still angry with me, and he says he doesn't love me. And so, then, you know, that's fine. You know, that's the way it goes. But frankly, we couldn't continue the way we were going. We just couldn't continue that way. It was so awful. You know, there was nothing to look forward to. It was dark and bleak as hell. It was awful. And you know, he's made up our minds for us, hasn't he? That's what he wants, and I'm fine with it. I'm really fine with it.

> Honestly. We'll see what happens. I don't know. I don't know. I can't leave him alone. I can't be there all the time."

Paige speaks of wanting to write the stories of her family into a children's book, to go back into music and theatre arts, and to take up sculpture again. She had done some of these things with Xavier.

> "Xavier has a beautiful voice, but no training," she says. "We used to do opera together."

Two days later, during the Morning Planning Meeting, nurse Patricia from Closed Unit B speaks.

> "Xavier is back in the ER. We knew this would happen."
>
> "He's stable. He shouldn't be admitted," says another staff member.

Later, as the patients take their lunches, Erica has brought her own lunch to her office on a floor above the Open Unit. She has found some time in her day to speak with me. Sitting at her desk and facing the window, she explains: "I believe that we do this job because we want to help. Given enough time, most people are fine after one episode, they do not come back. They have strange thoughts, but they are working, living their life. But when they come back, it's, 'Oh, there's a more chronic problem.'" She pauses for a moment. "It's different, in psychiatry, when it comes to privacy. On a different unit, no one is asking, 'How much money do you have?'" I take the opportunity to ask Erica about her work with family members, with Paige, and with uncertainty.

> "Mrs. Blanchard is coping well," says Erica. "She is going to work. She isn't in Emergency, yelling."

She considers for a moment.

> "Mr. Blanchard took the risk. He handled it."

One week-and-a-half later, and almost two weeks after Xavier's discharge, I call Paige once more. She replies that she has not heard anything more from the hospital, as Xavier does not want his treatment team to speak with her. Paige explains that Xavier had gone to her mother's garage to pick up his construction tools.

> "He's living in his van. He was supposed to sleep over in his sister's place. He hasn't showered in a week. They gave him a cellphone. Got it reconnected, got a new number. He smashed it. His sister thinks he thinks he's being monitored. He took out his inheritance. He will end up on the street. He's paranoid. Yesterday he

> did phone me but I had no way of knowing it was him. He's been in and out of the Hillside Hospital for three years now. It's not working. I think he needs a second opinion. He's refusing communication with his social worker. He's not forthcoming. If he goes back to Hillside, it'll be the same thing over again and again. I don't know if he's taking the medications, if he's even buying it...I can check from my insurance…."

She speaks of having asked the treatment team for Xavier to be transferred to another hospital that a priest from Xavier's hometown had recommended to her. Steps had been taken towards this until Xavier signed himself out.

> "Every time he goes back, it's worse and worse and worse. I'm going to push for a Quebecois, male, French-speaking psychiatrist. He needs someone from his cultural background that he can relate to, he can identify with. With others he doesn't know what to say to them. Even if they're nice […] Anyways, I don't know. I really don't know. It's really difficult, it's really sad, no one can do anything about it, and I'm not going to agonize over it anymore because it won't do anything good. And I don't think I should have to."

Her voice begins to trail off as she continues, "Maybe if he's in a new place, he can try again…. I know he's not in his right mind. Everyone is trying to help him and no one can get through to him. Is it early-onset dementia? Does he have what his mother had? I don't know anything…"

She tells me she had called Dr. Tamlinson, Xavier's outpatient psychiatrist, and left a message, but "he can't tell me because of privacy issues." With frustration in her voice, she wonders aloud of the staff, "Can you tell me some things – like if he's a danger to himself?" Then as if in response to the question she has just posed, Paige's tone grows stronger.

> "When he shows up, we will demand he see another psychiatrist. His sister will be on my side. If we present as a family… When I'm determined, you have no idea how determined I can be. I'm going to push for this. He has to go to an assisted living place. He can't wander the streets endlessly. My conscience tells me I have to do everything. I have to do it. I have to try. I have to accept whatever consequences happen. This limbo, it's like purgatory. It's a suspended place where you – where anything can happen one way or another."

The next day, on October 15th, at the Morning Planning Meeting, a nurse informs everyone that Xavier has been admitted to the Inpatient Unit once more. "He lost two finger-tips on his right hand," says the nurse. Several of the staff members gasp, and others' faces crease for an instant in mirrored pain.

"Did he do this to himself?" asks Dr. Bouna.

"He says it was an accident – he was using an axe to chop wood at night."

"Isn't he right-handed?" asked another staff member.

"He says he's ambidextrous," came the reply.

"But it's his dominant hand…" says another of Xavier's injured right hand.

Later, in the hallway, a nurse in Closed Unit B turns to me: "Do you believe it was an accident?" she asks. "A person doesn't hold an axe that way…" She brings her own hands together, fingers overlapping, posed to grasp a handle in between. "You would hold it with both hands if you wanted to chop something." Sandra, an orderly on the open unit, says, "He was always kind to me, always pleasant. I can't realize, how he could have cut off two of his fingers, how he could have cut his hand."

On the evening of October 16th, I call Paige. Her voice shakes as she speaks over the phone.

"It's sick. It's sick. It's sick. You heard what happened to Xavier?" she asks.

"He cut off two of his fingers," I reply.

> "His *fingertips*? I thought it was two whole fingers. They won't tell me anything, to protect his privacy. He *mutilated himself*. It's *horrible*. I can't think about it. I have to make a complaint to the ombudsman. They're not giving him care. He doesn't trust his treatment team at all."

Paige pauses, her voice calmer.

"Do you know what his psychiatrist thinks? Do you ever speak with them?"

"No, I don't know," I say.

> "He doesn't feel any pain," she continues, her voice quiet. "He called me. He sounded so normal on the phone. He's not the man I used to know. The man I know is gone."

"Will you go to see him?" I ask.

> "I can't. He doesn't want to see me. He tells me it's over. But I'm still responsible for him. I'm still…" she trails off. "He had such beautiful hands."

Later that week, during the Morning Planning Meeting, the staff continue to discuss Xavier.

> "He has a severely dependant personality disorder."
>
> "Even at his age?" asks Dr. Bouna.
>
> "His wife held him for many years. He says he was chopping wood and cut two fingertips."
>
> "He has sutures. He is taking antibiotics by mouth."
>
> "What did we discharge him to?" asks Dr. Bouna.
>
> "He signed himself out against medical advice."
>
> "He was sleeping in his car."
>
> "Drugs?" asks Dr. Bouna.
>
> "No."
>
> "What does he suffer from?" asks Dr. Bouna.
>
> "Psychosis with personality traits. Schizoaffective disorder."

On another day:

> "Mr. Blanchard, the gentleman who cut off two of his fingers, denies suicidality, doesn't talk very much to anyone. He promised not to go to the laundry hamper to escape like he did last time. His amputation stumps are becoming swollen – afebrile, no discharge, but maybe we should still take a look at it," reads a nurse from her notes, looking up at the end.
>
> "Should we get Plastics involved?" murmurs a nurse sitting next to me, referring to the possibility of sending Xavier to the Plastic Surgery Unit to reconstruct his hand.

When other staff members and I later ask Xavier about reconstructing his hand, he shakes his head no.

Xavier is now in Closed Unit B. I go to visit him. A nurse in the unit lets me through a locked door into the nursing station, and through another locked door into the patients' side of the closed unit. I find Xavier's room by its room number. His door is closed. I am reluctant to wake him. "You can knock," a patient standing in the hallway tells me. I knock upon Xavier's closed door. At first there is no answer from within. A moment later, the door opens. Xavier greets me with a smile. He walks out from his room and walks in long strides to the common area. He motions for me to sit down beside him, in the seats fixed to the floor. Sitting across from him, his back to the window, I gaze at his right hand, bound in a white gauze.

"Are you in pain?" I ask. He shakes his head.

"How do you eat, brush your teeth?" I ask.

"With my left," he replies in English.

The next time I visit him, I notice, upon a table beside his bed, a book flipped over with its covers splayed.

"My sister gave that to me," he says.

"How have you found the book?" I ask days later.

> "I can't concentrate to read like before," he replies. "I've read only forty, fifty pages," and then changes the topic, "Have you gone to the sixth floor? There a piano there." He is smiling.
>
> "Are you in pain?" I ask again.
>
> "*Je ne sens pas mal*," he says, his smile fading. He is not in pain.

Two weeks have passed since the incident to Xavier's hand. I call Paige at her home in the evening. Paige reflects, with frustration in her voice, upon the events of the past few weeks.

> "The least you can do is ask me. I'm not allowed to know anything. I need to know he's going to be in a safe place and taken care of. It's not your fault, but at the same time, you're not supposed to let them out. When I close my eyes, I see him chopping off his fingers. What am I supposed to do? He can hardly push a button – he doesn't know how to find an apartment. It's awful. Just awful. They're not allowed to tell me anything. Ask me some questions. Ask me what I know. They let him out. He spent time at emergency."

She interrupts herself, asking herself (or them).

"Why don't you call Paige?"

She responds to herself, resigned.

"We went for a day – half – then he disappeared again."

Almost without stopping, she then continues to tell me about the sequence of events from her perspective.

> "On Friday I came home for lunch. There was a knock on the door, two policemen, my heart's pounding, I open the door, they tell me, 'He's escaped again, they can't find him, your husband's missing.' The hospital calls, the police ask, 'Where did he go?' Every time he goes, it's someplace different. The hospital called back, 'He's been found, he hid in the laundry hamper.' It's funny, like a movie, and tragic, he climbed in."

Almost without pause, Paige then turns to question her own actions.

> "'Is there something I could have done?' I thought to myself. I never thought he would mutilate himself, I never really. I might have said it might be possible, but I never considered the possibility, I didn't think he would have the guts to do it to himself. It shows the extent of his psychosis. I don't know. I don't know what to say. He can't come home. He phoned me last week – 'I'm getting out on November 20th' – oh, I didn't know that. 'I'm going to get an apartment' – but nothing happened. I don't think he can live by himself. How can he live by himself? […] He gets psychotic, manic, I think he gets psychotic when he's depressed too. He never mutilated himself before. It's not responsible, just to believe him. He didn't even have a place to go. Just 'believe the guy.' Alright. Believe him. […] He's beautiful, so talented, I loved his hands, he just mutilated himself. Is there anything I could have done? I pushed to have him stay. I wrote to them. I should have – he can't find something by himself, no matter what he says, he's a man of the nineteenth century, he would have fit right in.

She reflects upon plans Xavier had made in the past that he never carried out:

> "I have lived with this man for twelve years. He has often said to me, he will go get a job, but he never does. You can believe it, but it's not going to happen. Nothing there – he doesn't have anything to look forward to. He says he's going to look for his son. Who's also on the street and takes a lot of drugs. And maybe he's bipolar too. He was in and out of the hospital. In his thirties to forty. And he was fine for fifteen years."

In spite of their separation and being unable to communicate with Xavier or his treatment team, Paige plans practical things to do in the time being. Her focus is upon the everyday.

> "I'll take back the book of cheques – things for another pharmacy, for the drugs – recommendation for a plastic surgeon for his hand. Just looking at that stuff makes me throw up. What did he buy Vaseline for? He bought a whole bunch of stuff, jackets and stuff. He bought twenty-five of them, clothing. He's got jackets, here – he wouldn't pick them up."

Returning once more to the present situation, Paige feels grief for everything that has happened.

> "I'll miss him my whole life, it's like he died, except it's worse. […] When someone dies you grieve, you gradually lessen, let it go, then you have the memory, right? This is not the same. This constant, ongoing grief. You can't let it go because the person isn't dead. You can't let it go because of the memories. The memories don't seem real anyway. For the past five, six, seven, eight years. No, I don't expect, it's just been so hard for so long that I don't know anybody, that's why mostly I've cut off contact with friends, I can't pretend I'm not going to. How wonderful things are, the trips they're going on. 'How's it going?' What can I say. I can't even pretend anymore. So I can't talk with them. Alone. Can't bear it. […] My principal knows my husband is in the hospital, but not the details. They don't want to hear that. Nobody wants that. I just don't think it's right to burden people with the terrible details of what happened. I feel like I'm treading water. Just keeping my head above water so I won't drown. I have incredible endurance.

A few weeks later, when I call Paige once more, she tells me she still has not heard any news of Xavier or from the treatment team. She shares, however, her understanding of how Xavier became injured. I have been visiting Xavier at the hospital and also have not learned news of him there. This is the first piece of new information that I have learned since Xavier's incident.

> "I know why he harmed himself. It was because he had visited a friend of ours. And this friend was everything that he wanted to be. He had a successful business. He had a family, a wife, and children. They were talking about his travels around the world. 'I wish I could be like you,' Xavier had said. And he punched him on the shoulder in camaraderie. And that's why he cut his two fingers off, because those were the fingers that touched him. Because he is jealous of his friend, and in the past he had a delusion that his friend was the devil and was chasing him and

> that was why he crashed his car into the tree – he did it deliberately, he avoided a sign-post in order to hit the tree. I know because I have driven past that spot. That's why he did it, I am sure of it."

When I ask Paige if she has shared this information with the staff, she says she has not.

November

During an afternoon in the first week of November, I visit Xavier once more in Closed Unit B. We sit in the common area of the closed unit, surrounded by white walls and linoleum flooring with a blue pebbled pattern. The tables, with seating for eight, are fixed to the floor. The surfaces of the tables are pink with a turquoise border. The seats are painted turquoise as well. A TV on the wall, behind a hard plastic surface, faces the seats and tables. Behind Xavier, two large windows face southwest, letting in sunlight and showing a view of the tops of low, brick houses and trees lining the street. There is a fridge behind where I am sitting. The nursing station completes the fourth side, facing opposite the wall displaying the TV. A wooden door, its top half detachable from the bottom, separates the common area from the nursing station. The bottom half is latched while the top half is open, swung outwards into the common area. From time to time, men and women go up to the half-open door to ask for medications, a pack of sugar, or an item from their belongings, as they stand before the ledge of the bottom half and sometimes lean upon it.

Xavier speaks to me half of the time in French, half in English. I try to reply in broken French, often reverting to English. Closer to the case, perhaps, is that he speaks in French and I hear him, attempt to take in his meanings, in English. His hand is still bandaged. During our conversation, he rests it on top of the table.

> "When I was a boy, I took a long trip with my father," says Xavier. "We headed west across Canada. He was building houses. One night it got so cold, we were in Calgary and staying in his car. My feet were cold and my father was very worried I would get frostbite. But I wasn't scared," he says, smiling. "Not at all. My foot was OK in the end."

He loved hockey, baseball, and other sports in his youth. He then remembers a story about he was around ten years old.

> "My father gave me a twenty-dollar bill. He said, 'You go line up there and sign up for the baseball team.' My father didn't know how to play baseball himself, but he gave me that bill and told me to sign up, so that I could."

His favourite movie is "Field of Dreams". I remember that he had mentioned that he once owned a dog.

> "Would you like to get a dog?" I ask.
>
> "No, too much work," he replies decisively.

He switches to talk about the present.

> "I would like to use the computer," he says at a later point. "I don't know how to use it at all. […] I am very careful now about what I put into my body. I don't want chemicals in my body." He closes his eyes, shaking his head. "I try not to take even Tylenol. To not put medications in my body." He pauses. "I have lost twenty pounds since coming to the hospital this year."
>
> "Do you feel pain in your hand?" I ask.
>
> "No," he replies. "Sometimes it is sensitive."

Our conversation turns to the colder weather. He tells me of his excitement to see the first snowfall of the year.

> "I am so happy, like a boy, when it snows. It is always, 'Wow!' Every year."

Through the windows of the unit, the sky has turned dark. Almost two hours have passed since we began talking. I tell Xavier that I have to go. We shake hands using our left hands. Before exiting through the locked doors of the nursing station, I turn around and wave at him through the glass. He waves back at me with his bandaged right hand.

The following day, when I return to the day room, a patient whom I have been following turns to me.

> "Something bad happened on the unit last night," he says softly and slowly.
>
> "What happened?" I ask.
>
> "Someone killed himself in Closed Unit B."
>
> At the news, I feel my entire body sink into my seat.
>
> "Someone named Xavier," he continues. "Do you know him?" Seeing my nod, he replies in a soft tone, "If you talk to the nurses, they would know…"

Questions and images appear rapidly in my mind: the sound of frustration and anguish in Paige's voice a few evenings ago, the sight of Xavier waving goodbye at me from behind the glass, the stories he had told me only yesterday afternoon. I walk slowly down the hallway toward the doors of Closed Unit B, unable to think.

Donny, a nurse, is walking down the hall towards me. He greets me with a wide smile. "I'm sorry for what happened," I say. Stopping in the middle of the hallway, he opens his arms wide and envelopes me in a hug.

"It's very sad," he says. "We are all sad."

"I'm sorry for what happened to Mr. Blanchard," I say.

"Mr. Blanchard?" says Donny. "Oh, it was Mr. Asselin – Xavier Asselin."

Releasing me from his hug, Donny smiles at me once more before continuing on his way down the hall. I stand, unmoving, for several moments. I am relieved that Xavier Blanchard is still alive. I feel a fresh wave of sadness at the death of Xavier Asselin, who had once led me to Xavier Blanchard's room and had sat beside me, his name unknown to me at the time, during an evening when I was visiting another patient in Closed Unit B. The next time I visit Xavier in the closed unit, he is sitting straight in his chair with his back to the window. He is smiling. I feel tears rising and do not let them fall.

In mid-November, Xavier asks me if I know about the music group every Wednesday afternoon. "Will you go to music group? Tomorrow?" The next day, he and I walk down the hallway towards the day room. Nurse Patricia had asked me to return with him to Closed Unit B at the end of the music group. "He has escaped before," she explains. When we arrive in the day room together, we join a few patients already gathered around one of the round tables. Some patients are already sitting. A man brings more chairs from nearby tables and arranges them to enlarge the circle; these seats become filled. Morris, the music therapist, places a black duffle bag upon the table. He unzips the bag and takes out a guitar from its black case. The patients and I take out the instruments from the duffle bag and spread them upon the table. The instruments are made of wood with a dark red or brown finish. There is a vibraslap, a cabasa, a red-lacquered maraca. A light yellow wooden guiro with a scratcher and a two-belled wooden agogo. There are two tambourines, one circular and the other crescent-shaped, and two white plastic egg shakers. Sometimes someone takes an instrument and puts it back. Often, someone takes a different instrument in each hand and shakes them throughout. During the Wednesday afternoon music group, those who are present sing and clap and shake their instruments with no concern for volume. And sometimes there is dancing. A nurse wearing a T-shirt and slim-fitting blue jeans walks past the music group participants on her way from one part of the unit to another. She stops for a moment to stand next to a woman wearing a blue patient's gown. They sway their hips in synchrony for two beats of the song before the nurse returns on her way.

Today and in subsequent music groups, Xavier motions for me to draw up a chair and sit beside him. Sometimes he would take a seat, often near the periphery of the circle of chairs. Sometimes he takes an instrument, plays it for a while, and places it back on the table in exchange for another one. This afternoon, Xavier takes the tambourine in his left hand. He shakes it and the small zils jangle. The song changes, and he has reached for an egg shaker. Next, he is shaking a cabasa. A young woman strikes the middle of a tambourine, her head titled back as she sings. An elderly man is striking a mallet against the wooden agogo. A man leans back in his chair, his hands empty and at his sides, listening. Strumming the guitar, Morris leads the group in singing. With dark brown hair, a short beard, and wearing glasses, dark pants, and dark coloured shoes, Morris holds his guitar upon his knee and stomps one foot to keep time as he sings. Members of the group request the songs and Morris looks up the chords and lyrics upon his iPad, ensuring that every member gets to request at least one song if desired. Over the hour, we sing and shake to: "Hallelujah" by Leonard Cohen, "Calling All Angels", "I Can't Help Falling In Love With You", "Black Magic Woman", "One" by U2, "Eye of the Tiger", and "*Je ne regrette rien*".

Xavier sings the chorus of "Hallelujah", drawing out the notes. His voice is deep and full. The following week, the group is singing "*Guantanamera*". Beside me, Xavier, one moment sitting still, suddenly sings out during the song's guitar bridge.

"Aye yi yi yi!"

The syllables pour forth, each one strong and distinct, arcing over the strumming of the guitar and the shaking of maracas and tambourines. When the chorus returns, the familiar guitar chords as the cue, Xavier tilts his chin slightly up and sings.

"Aye yi yi yi!"

His notes ring clearly and surprise all who are near. A nurse who is walking past stops suddenly. She laughs brightly, her long, dark hair framing the delight upon her face.

"*Guantanamera*."

We sing as a group, swaying with smiles upon our faces.

“*Guajira*, *guantanamera*.”

At the next music group, Xavier lends his voice to “Twist and Shout”.

“La la la la la…”

He sings in a sharply enunciated string over the percussive instruments shaking continuously.

“Come on baby,” he sings, “la la la la la.”

“Won’t you let it all out?” sing others in a call-and-answer.

Later that music group, Xavier sings along once more to “Summer Breeze”.

When the music group ends at four in the afternoon, I walk with Xavier back to Closed Unit B. The day room and hallways of the unit are quiet.

Around this time, Xavier has also begun to join the occupational therapy activity sessions every morning. Myra, one of the occupational therapists, stands by Xavier at the table, in the corner. She brings her thumb to her forefinger on her right hand, held in front of her face, and makes a twisting motion. Xavier raises his right hand to the top of his hospital gown, a white one with a pattern of blue shapes across it. His hand goes to the knot tied at the front of his neck that rests between his collarbones.

“Can you do your buttons?” she asks him in French

“With some difficulty,” he replies in French.

Diana, also an occupational therapist, brings to Xavier and Myra a sleeve to be worn over the wrist. She shows Xavier the hole in the middle and asks him a question in French. He shakes his head. Seeing his reaction, Diana puts the sleeve away. Xavier’s bandages have come off by now. Upon his right hand, his index and middle fingers have been severed distal to the middle knuckle. The skin covering his amputation stumps have been pulled to seal over the wound, bound together by criss-crossing stitches, small X’s made by a taut, black thread. The stumps are red and swollen. When I ask him if he feels any pain, he answers once more that there is none.

In the middle of November, one month after Xavier’s readmission to Hillside Hospital following his hand injury, over the telephone, Paige says she has not received more news. That week, she is going to attend a meeting with the ombudsperson of Hillside Hospital to voice her concerns about everything that has happened. Xavier; Erica, the social worker upon his treatment team; and the hospital ombudsperson responsible for receiving complaints will be present. Paige reads an email she has written to the treatment team.

> "'I've been very frustrated. I understand there is the need to protect Xavier's privacy. However, the lack of communication has caused me intense *anguish*…'"

Her voice rises.

> "'I'm sure we have Xavier's best interests at heart...'"

She sighs. The list of questions she had made, questions addressed to Dr. Nadeau, Xavier's inpatient psychiatrist, numbers more than a dozen:

> "'What treatment do you have in mind? Would it be better for him to be transferred to a different hospital? What's the extent of his injury to his right hand? Xavier has been moving money around – what can be done to prevent him from spending money? He is to be discharged on November 20. He is looking for an apartment. Do the staff seriously think that Xavier can live autonomously?'"

She goes on to ask whether it is the case that Xavier does not trust his treatment team at the hospital because he does not feel a connection with them. If this is true, she wonders, would Xavier benefit from a change in his psychiatrist?

Paige explains that she knew at the time when Xavier signed himself out against medical advice that he was not ready to leave the hospital. She can see the perspective of the treatment staff even though she wishes they should have acted differently.

> "He wasn't going to accept anything. He didn't have a place to go. He was in sandals. 'Well, we're under pressure to let him go.' They made a wrong judgment call. They're under pressure to open up beds. There's a lot of people needing care. He's cost the system several hundred thousand dollars. I wonder to myself what I would do if I didn't live in Canada. I would have to quit my job. I would be tied to him. He would be home. I mean, I don't agree somebody else should pay for me…he wouldn't be in hospital, he would be out, and I'll be dealing with him every single day. What a nightmare that would be. Real terrible.

As many of the stories Paige has told have been about events in the past or hers and Xavier's situation at present, I wondered about how Paige may see her future.

"What do you hope for?" I ask..

> "I hope he gets in a place where he's taken care of," she answers, sadness and anger in her voice. "I hope he develops an interest in something. He has nothing

> to hope for. He has nothing to look forward to. Just existing. He's not interested in reading. In anything, as far as I could tell. I don't know."

She recalls a time, several years ago, when Xavier was running his construction business.

> "He actually managed to work at that point. Now I think he's never gonna be able to work. So what's he gonna do with his fingers? I don't even know what's available to him. He had such beautiful hands."

At the same time, Xavier is transferred from Closed Unit B to the Open Unit, meaning that his clinical condition is deemed to be more stable. He no longer needs anyone to accompany him to the music group. Wearing a gray T-shirt, he is sitting once more by the window, his chair angled partway between the day room and partway to the world outside. He motions to the space next to him. No longer does he have to say to me, "Please sit." I understand now to take a chair nearby and bring it next to his.

> "Did you see the snow fall yesterday?" I ask.
>
> "Yes," he says, smiling. There was a light dusting of snow, fallen the previous evening and melted in today's sun.

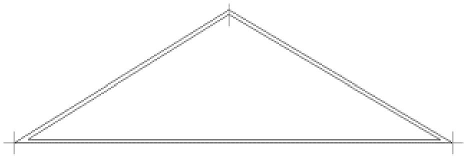
During the Morning Planning Meetings, Xavier's psychiatrist, Dr. Nadeau, says of him, "He is still superficial, he is still minimizing." On another day, a staff member reports, "He is not as self-isolative. He is more visible on the unit now." I conduct an interview with Dr. Song, a resident in psychiatry. I ask her about her work with Paige and Xavier.

> "He was always pleasant to us. She came to visit him in May and June. We were communicating by phone, arranging passes, getting collateral. We took reports from his wife about how he is, that he is smiling, that he is doing activities. […] We were uncertain about how to treat him, and worried about things getting worse. We worked as a team. A lot of medications have adverse effects…our hope was that he was responding… He AWOL'ed once. Then after that he was doing OK. We facilitated a process to transfer him to Dr. Tamlinson to write a report."
>
> "What is a time when he surprised you?" I ask.
>
> "Once I saw him kiss his wife goodbye. She had brought him a book. I had never seen them like that before…"
>
> "Do you have hope…?" I ask, trailing off.

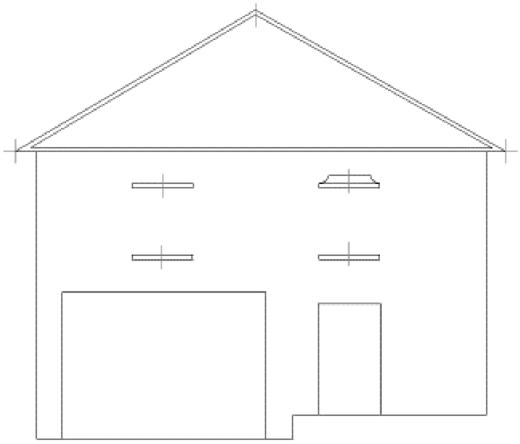
> "Of course there is hope," she says, "that he gets stabilized, goes back to work, that his managing would improve. That he would get better, work, get out, adjust to a new life in retirement. Not have to come here." Dr. Song's expression and voice become firmer. "He's resilient. He's still coming here, he's still accepting treatment. He hasn't given up on himself. He's still here. Because people…" she trails off, her words slower. "A lot of people commit suicide, or die, or get worse. People have taken their lives. Suicide isn't uncommon, but it's not rare. He's still working on his recovery. But maybe not," she says, softly. "Maybe – I don't know…"

Xavier has continued going to the morning occupational therapy activity sessions. I have started to sit by him as he works upon an activity.

Around the long table where we are sitting, people are engaging in different kinds of activities. Behind us a couple of people playing cards. A woman is making a bracelet, a tin of beads of varying colours on the table beneath her lifted hands. A woman wearing a blue hospital gown like a cardigan over a sweater and loose pants of a soft, brown material, is asking Diana how to burn a drawn design onto a piece of wood. Xavier is sitting upon a wooden chair. On the varnished, wood surface of the table in front of him is a piece of paper. He takes a long, wooden ruler and pushes it across the page. He marks a point and with a pencil draws a line between points. We sit in the occupational therapy room, next to the shelf holding stacks of paper in different sizes, textures, and hues of white. He holds the pencil in his right hand. With his left hand he presses a wooden ruler, painted yellow, flush to the white paper. He moves his right hand to draw a line from the middle-left to the top-middle of the page, a line traversing the top, upper-left quadrant of the page. This becomes the border of the roof of the house he is drawing, one edge of a triangle. He makes a vertical tick perpendicular to the line he has drawn. The pencil rests in his hand in the crook of his thumb and shortened index finger. His fourth and pinky finger reach over to support the pencil just above the nib. Beside a window already drawn, he draws another window with two vertical lines. Yet before drawing the horizontal lines, he

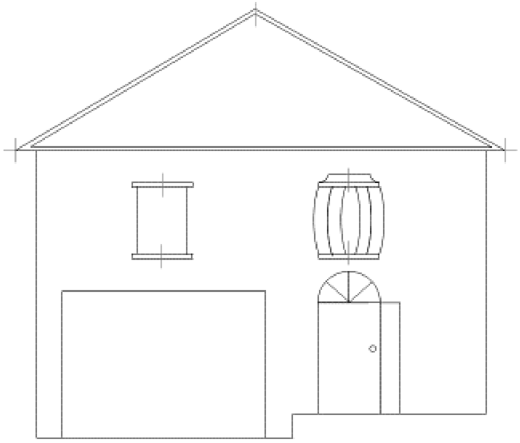


erases the vertical ones. He then makes ticks a few millimetres to the right. He redraws the two vertical lines. He then links their endpoints with two parallel horizontal lines. This becomes the second window on the left side of the house, at the same level with the window on the right. He erases the line he had drawn. He draws the same length of line, vertically, about a centimetre to the right of the shadow of the line he had drawn previously and subsequently erased. Using a ruler, placing it horizontally, he connects the tops of the vertical line he had just drawn and the top of a vertical line drawn earlier. With two more small ticks on either side of the window, with another horizontal line, Xavier gives the window a ledge. The erased lines are faintly visible. "I have built a house like this one," he says. "I will try to draw it from memory."



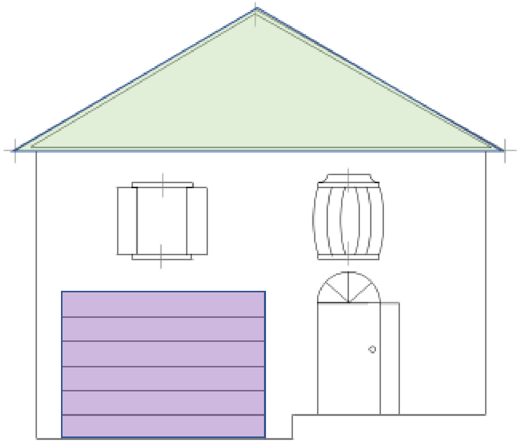
He has made a system of lines, a scaffolding constructed on paper, around which he will later draw the rest of the house. Down the middle of the house is the longest line, a vertical line, that ensures the symmetry of the entire house. In the middle of horizontal lines are ticks marking their midpoint. The way he draws the lines is by connecting two ticks, never from one tick alone. His lines do not begin from a point and reach into free space but reach toward a point already clearly marked and related to another line or point. Throughout, he marks where the line will start and end before drawing another line between to connect them.

Today, occupational therapist Myra is wearing large-rimmed glasses that match her dark brown hair. Walking past, she catches sight of Xavier's drawing upon the table and stops beside him. Speaking in French, she says that the drawings look very professional and asks Xavier where he had learned to make drawings in this way.



> "*C'est CAD*," Xavier replies, using the abbreviation for Computer-Assisted Drawing. "They do not have CAD paper here at the hospital," he says, turning to me. Glancing down at his drawing, Xavier says, "I will make a clean copy. I will trace it."

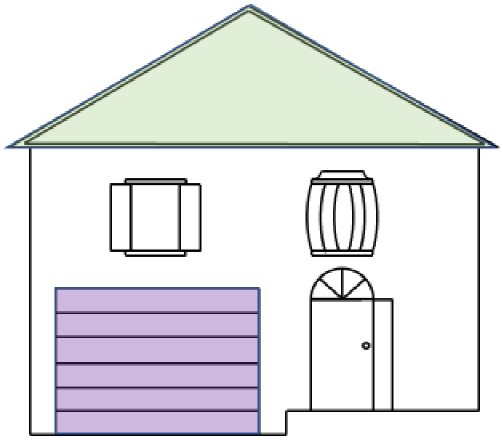
I notice that his hands show signs of healing. They are still swollen at the tips but the redness has disappeared. The skin surrounding the stitches is the same colour as the rest of his hand. With each occupational therapy session, a house materializes upon the page beneath Xavier's pencil, between Xavier's hands. When I return two days later, the roof has been coloured lightly green and the garage purple.



Flipping through a thin pile of paper in his portfolio, Xavier shows me several copies of his drawing. One of them is a *propre copie*, a clean, good copy, that Xavier made by tracing over the initial drawing. He had also darkened the lines. The drawing appears to pop from the page.

When the drawing is finished, the house has a door, a porch with three steps leading to the ground, a garage large enough to fit two cars that is coloured purple; a window with seven panels (it is not a bay window, Xavier taught me) on the first floor; and a green roof. He asks Myra if his drawing could be photocopied and shrunken in size.

"To fit four to a page," he says, "*pour un carte postale.*"



"Who will you send your postcard to?" I ask.

"To my son," he replies. Weeks later, he says, "I have good memories of my son."

Xavier is changing. At the Morning Planning Meetings, the staff say of him:

> "Mr. Blanchard, bipolar affective disorder schizoaffective, cooperative with care, socializing with others, brighter affect. He's improving, he's more visible on the unit."

In the day room, at one of the round wooden tables, by the window he had looked out of so often, Xavier sits facing his psychiatrist, Dr. Nadeau. She asks him about living in the east part of the city.

"Manon-Legault," he replies.

When their meeting is over, the unit coordinator walks by. Upon a table, towards the back of the common area, is a small potted plant, the pot wrapped in a metallic purple paper. She looks at the plant, tilting the pot at an angle to peer closely at the soil. She looks under the leaves, her brows furrowed as she examines the plant. "I think I will take it home," she says, having judged that the plant is not doing very well on the unit. She turns to me.

> "They say he doesn't talk, but is that true?" she asks, referring to Xavier. "He talks with me."

The stumps on his right index and middle finger, once red and swollen, are now the same colour as the rest of his hand. His stitches are removed. Xavier's hand is healing. He has finished drawing a house to be printed as a postcard which he aims to mail to his son. I am not able to tell Paige any of this, but still I keep calling her. She often tells me that she has no news to share with me and that she does not know what is happening with Xavier nor what the plans of the treatment team are. During this period, she asks herself how he may be.

> "I just want him to be safe. Nothing works. I don't think he does anything all day. Does he watch TV? I don't think so. Does he read? I don't think so. Does he go to occupational therapy? I dunno. I have no idea. I have no idea. Does he want to get better? I don't think so. Deep inside himself, I don't think so."

During the morning occupational therapy activity sessions, after finishing his drawing, Xavier has been given hand exercises to do. He curls and uncurls his fingers, flexing them to meet his palm, extending them to splay his fingers as far apart as possible on the table surface. Myra had given him purple plasticine to grip and mould. He breaks off a piece of plasticine from a large stick and rolls it between his palms to form a ball. He then transfers the ball to roll it between his right palm and the surface of the table. He opens and closes his hand. Myra holds in her hands a piece of paper with the exercises drawn – a piece of paper printed, she later told me, from a website she had found after searching for hand strengthening exercises. He places his hand on the table, lifting one finger at a time.

In the evenings, when I call Paige after she has gotten home from work, she speaks of the dilemma that she faces, of not being able to have Xavier back to live with her, but that she does not believe he can live independently.

> "I don't see how he can live on his own. How can he get a job? He doesn't even know how to use the computer. He doesn't want to learn. For his business it was me who wrote his resume and set up his webpage. He's just so passive. If only he would take an interest in something," she says. "But he doesn't read. He doesn't do *anything*. He just sits there. I would come home and he would be just

> there. He wouldn't talk. He's never made me a meal. He would look at me, expecting me to do it. The staff have to understand that he can't live on his own."

Xavier's current physician, psychiatry resident Dr. Salam, echoes Paige.

> "He doesn't follow through upon his plans. He is passive. He doesn't follow through. He said he would look for work, but…" she trails off.

I ask nurse Patricia, who works in Closed Unit B, what surprises her about her work. She mentions Xavier as an example.

> "That sometimes nothing changes," she says. "You see someone like Mr. Blanchard, how he comes back. But that doesn't mean we don't have hope. We just keep coming back and keep trying."

At the Morning Planning Meetings, it is announced that he Xavier been asking his treatment team for passes allowing him to go out.

> "When I can go out again," Xavier himself says to me, "I will take you to eat Subway."

He tells me he has not gone outside a single time since having arrived at the hospital. When we are in the occupational therapy room, Xavier says that one of the hand exercises has greater priority. This time, he is copying words, letter by letter, from a page from an old National Geographic magazine. Myra advises him that it would be easier if he were to write the letters bigger. Later, during the afternoon, I approach him as he sits by the window in the day room.

> "What's new with you?" he asks.
>
> "Oh, I am writing my study," I reply. "What's new with you?"
>
> "Nothing much. Have you played the piano on the sixth floor?"
>
> "Do you play?" I ask.
>
> "I have always wanted to learn to play," he says. His hands are in his lap.

December

In the occupational therapy room, as Xavier sits by the table, Dr. Nadeau is speaking with him, sitting by his side. She is leaning forward, her hands pressed together between her knees and her head turned to look at him. From her cellphone she reads aloud an email from Paige.

"'…I would be glad to have Xavier spend Christmas with my mother and my family,'" Dr. Nadeau reads.

Xavier replies to this in French. Dr. Nadeau leans back in her chair, her legs crossed, thumbs tapping upon the screen of her cellphone as she composes an email to Paige with an answer from Xavier.

At the Morning Planning Meeting, a staff member raises that Xavier has been confined to the unit for a long period of time.

"He has not been outside since his admission except for an appearance in court."

One morning, I sit beside Xavier by the window in the day room. Outside the wide sky stretches into the distance. All the leaves have fallen by now.

"What will you do for Christmas?" I ask.

"I will ask for a pass to go visit my friends. I'm not allowed to go out by myself."

"Is there a place in the world you would like to go to?" I ask.

"The Richelieu Region. To go to Florida, to see the whales."

"Have you seen the whales before?" I ask.

"In Jodoin. In Florida, they are different." He looks out the window. "I want to take a convertible, and drive with the top down."

There is powdery snow upon the ground, from a flurry the night before.

"Is there anything you are looking forward to, in the new year?" I ask.

"Oh, nah," he says, shrugging and shaking his head. "Not to make the same mistakes I did last time."

"*Merci de me parler*," I say, thanking him for speaking with me.

"*Merci d'être là*," he says, thanking me for being there.

During the evening of the winter solstice, I call Paige. She answers the phone. Her voice is thick with a bad cold. She tells me that a colleague at work is missing part of his arm and that one of the students in her class is missing a part of her hand.

"I am surrounded by people who are missing parts of themselves," she says.

She is planning to visit Xavier at the inpatient unit so that she can deliver to him her mother's gift. The thought of seeing his hand horrifies her.

> "I don't want to hear about it. I don't want to know. I don't even want to picture it. I can't. I can't. I can't. He'd have to wrap a towel around his injury because I would not be able to stand it. I would not. So I know that he can never come home. I know that I can never have him here, and I know that we can never be together again. That's it. Am I sad? Yes. But in a sense, it's made up. The path is clear. I know what it is, and that's all there is to it. I don't want, uh… I don't know how you can bear to look at things that are so horrific. Don't tell me it's not that bad. Don't tell me it's bad. Don't tell me. […] I told him, 'You're gonna have to wear a bandage if I come over.' […] I'm not going to have that image in my mind. I mean, I have an image in my mind, but it's not…you know, I don't know what it looks like. I don't want to se it. I don't want to see it in reality. And I don't think I should have to. It's too painful. And it's not because I'm a coward."

Paige says that the court did not grant the request by Xavier's psychiatrist to place Xavier in a supervised mental health facility for a minimum of three years.

> "The court said no, even considering that he'd hurt himself. Now, what is it? Because of *money*? I don't know. They should never have let him out against my warning them that he had no place to go. But they let him out. I find out the day after that he had been discharged. Nobody picked him up. He had no place to go. And off he went. Nothing. And then he hurt himself."

She speaks forcefully:

> "You know, I don't know whether he's playing a game with me, or whether it's his illness, or what. But it's like I'm living in a coo-coo house. You know, the floors keep moving, and the walls keep shifting, and I'm banging into them. I can't do this! And you know what? I'm not a young woman! I can't take it anymore. I can't. […] It's purgatory for me. It's like being in suspended animation. […] I've been living in hell for so long, but I'm gonna try and dig myself out. It's gonna take time, but I'm gonna do it."

Her tone softens as she reflects upon the past.

> "I didn't understand what it was like to be with someone who is bipolar, but also psychotic. He never exhibited anything before, you know? Then it just got worse, and worse, and worse, and worse, and worse, and worse. He's so down.

> He's so different from the way he was. At least he had some kind of hope, some sort of motivation. Now there's nothing there. It's just the days passing, you know?"

Yet immediately following her acknowledging that Xavier has changed from the person he once was, she wonders about the practical things she could still do to help him.

> "I mean… I don't even know if he's going to get any prostheses. To have some kind of function or something. I don't know. I should ask about that, actually."
>
> "What do you hope for, in the new year?" I ask.
>
> "Peace of mind," she says. "And for him to have peace of mind. For him to be safe. I want to have peace – away from this madness, this hell where there is no reason."

Standing By

During the evening in late August, in a phone call wherein Paige said Xavier had been re-admitted to the hospital again, she explained why he could not come home:

> "I don't trust him. I don't know what he's gonna do. Not because I'm afraid he's gonna, you know, jump off the balcony or something, but I don't know what he's gonna do. I just don't know. That's the big problem. I have no idea what he's gonna do. And I don't know where he's going or where he's thinking of going. He hasn't phoned me, he hasn't told me. And what if he disappears and I can't find him? I don't know the answer to those questions, you know? I really wonder, you know, where he's gonna go."

Xavier had withdrawn large amounts of money from his and Paige's credit card. He insisted, against Paige's wishes, to drive. Paige became worried.

> "And I called his brother," she said. "and his brother said: 'Call 9-1-1. You can't leave him by himself. Not in this state. You can't. You shouldn't leave him. You know, he's not suicidal, but you still can't leave him.'"

Paige did call 9-1-1, and Xavier was brought once more to the hospital.

In Paige's eyes, for someone who is an "escape artist", who has already traversed such great distances to Gosford and Lareau, to be left alone at home, where she cannot be with him as she goes to work, could mean another "escape" to a place no one else can foresee, perhaps resulting once more in injury or even loss of life. With Xavier's potential of travelling far when he is left at home, to send him to a secure place in the hospital is the opposite of leaving him to become lost. To go to the hospital is a way of keeping him close. At the hospital is where Paige and Xavier's brother can find Xavier. Although calling 9-1-1 is an act leading to a separation and to leaving Xavier's course to be directed by the treatment team at the hospital, she is not abandoning him. She is not leaving. She is staying.

In the past Paige has waited for Xavier to be found once more or to return home. She would then go to meet him. Through these several months, as Xavier goes in and out of the hospital and there is uncertainty about his own plans and the best course of treatment for him, she is still oriented towards his world though she may be on the periphery of it. The staff are also standing by when Xavier signed himself out against medical advice and they expected him to return. Paige tells often the same stories of events in hers and Xavier's past. She refers often to the same experiences and understandings that she is living, of feeling imprisoned and of realizing that Xavier cannot come home. She still projects forward his needs and anticipates finding more information for him or initiating other potential courses of action, for example to pursue treatment at a different clinical site with a psychiatrist from Xavier's own cultural background. The stories Paige tells again and again – small stories, such as her speaking of going to visit Xavier on the inpatient unit during the Christmas holidays because he will not likely be receiving visits from others – reveal a kind of ready waiting that is her standing by. She is in limbo. She does not know clearly what will happen nor what either of them will do. Although Xavier is in hospital and has separated from her, so that she has no news from him and is not welcome to visit him, he is still present in her world.

Chapter 6 Adam and Brienne

In early May, two members of Mr. Cole's treatment team refer me to speak with Mrs. Brienne Cole for this study. "I think she feels helpless," says Erica as we sit by the window in her office upstairs. "She's far – she's not living in the same city. I think she doesn't know what to do." During a Morning Planning Meeting, Dr. Goldman calls out to me from across the conference room. "Mrs. Cole. I think she would have something to say." She advises me to go to the nursing station of Closed Unit B, where Mrs. Cole's son is a patient. There, I can ask for her name and phone number from her son's chart.

Closed Unit B lies behind a double set of locked, metal doors at the end of the long, narrow hallway of patients' rooms in the Open Unit. After pressing a button to enter, I go to the glass partition of the nursing station. Standing there, in a blue and white chequered long-sleeved hospital gown wrapped around his thin body, is a tall man, standing more than a head above me. His dark blonde hair is of a medium length, not so long that it extends past the back of his neck, but long enough that it is combed back. His skin is very pale, he has blue eyes, and is not wearing glasses. He is wearing a pair of black sweatpants that end loosely at his ankles, and over bare feet foam slippers that are issued to all patients in the hospital. His slippers are pink, and each bears a smiling face over the toe, stencilled into the thin material of the slipper. He introduces himself as Adam. Soft-spoken, he asks in succession: "Are you a student?" "Is your family in this city?" "What would you like to be – to do, for work?" "Do you have any siblings?" "Are you waiting for anyone?"

Raising my head to answer him, as he stands more than a foot taller than me, I tell him that my family immigrated from China, that my parents migrated a few years before me and I reunited with them later, that I have a younger brother. He tells me that he immigrated from the United Kingdom with his family when he was a child. That he has an older sister living in the suburbs. Our conversation is interrupted as a man wearing a dark blue suit heads in our direction. "That's Dr. Bouna," Adam explains. "He's my doctor."

"Hello, Mr. Cole," says Dr. Bouna, clearly and loudly, as he walks swiftly past. "You are really a mystery to us." I realize then that I have been speaking with Mrs. Cole' son. That day, one of the orderlies in Closed Unit B tells me: "It makes me sad," he says, his hand held over his chest, "when I see him frustrated. When he says that he is hopeless. That he isn't like other young people his age." Shortly after, I meet his mother, Mrs. Brienne Cole in mid-May. "I was in great distress," she says. "I had a son in great distress and I didn't know what to do. I was very panicked, and my main panic was, um, the suicide side of it. And he was in such a terrible state. I didn't know what to do."

Sitting across from me, she is wearing glasses with a thin magenta frame, a light yellow, collared shirt with short sleeves, beige khakis, and sneakers, her clothes fitting her body loosely. She has blonde hair falling just past her shoulders. She has just come up the hill, having parked her car in a free spot that is a bit of a walk from the hospital. She is slightly out of breath. Upon the table she has placed an agenda with a soft pink cover bearing "2017", in which she writes her appointments. She works as a caregiver to the elderly. In her late fifties, she lives in the rural town of Lavallée with her husband and Adam's father, an hour and a half's drive away from the city, where both their son and daughter live in different areas. Her husband's health has been declining due to a neurodegenerative condition. She has been caring for him and Adam.

> "When my son started showing really weird signs it made me afraid because I heard all these things about, um, schizophrenia. And a lot of it's scary! And I've had to learn to be calm. And it helps him be calm. And then he'll open up a bit more. But you hear all these bad things about schizophrenia. Well I have," Brienne says, noting how she felt even though for a while she had worked as a pharmacist at a psychiatric hospital in her country of origin. "I'm the closest person he has," she continues. "A lot of his friends couldn't kind of cope with him anymore. But anyways, being mom, I stuck in there, stuck with him."

At this moment, Brienne explains, "He's locked in the ward and I don't want to take him out. 'Cause the last three times we took him out, it was crazy."

"What happened?" I ask.

> "He was very distressed. He was breaking down in tears in the mall. And then the last time he was talking about disappearing and, 'You're not going to see me anymore.' I don't like this," she says with a short laugh.

Brienne describes what happened just before Adam's present hospitalization: he was eating and sleeping very little for a period of two weeks. She received a call from his neighbour.

> "I don't know how she did it, but she managed to get hold of our number and say, 'I'm very concerned about him. He's visibly losing weight. He's saying

> strange stuff. He's afraid of the neighbours.' She wanted me to call 9-1-1 for him right then and there."

Brienne responded by going to Adam's apartment where he lives on his own. She brought some of his favourite foods and tried to convince him to eat. He told her about having had a very intense experience of being close to God. When he did not eat – "He just dodged the issue," recalls Brienne – she went home and began filling out a court order requesting a psychiatric evaluation. She spent the next day taking the form to be reviewed by a local mental health organization, depositing it at a courthouse, taking a copy to Hillside Hospital and another copy to the police to add Adam's name to a list, "so that when you call the police, 9-1-1, for that person, they know he has a psychiatric condition. And there's a group of people that will go and be with the police." But it was not the first time when she has seen Adam in a period of severe distress. "It wasn't until he was an adult and he broke down at work that we realized, 'Something's not right here.' We thought it was burnout, but it was the beginning of a psychiatric problem."

Adam had been working as a caregiver seven days a week. Thinking that after a few months of rest he would feel better, Adam's parents took him to live with them in Lavallée. "We should probably have taken him to see a doctor then," she says, in hindsight. "For a couple of years, things were very bad." It was no longer possible to have her son live together in the same house.

> "We loved him, we wanted to help him, but we couldn't have him under the same roof. It was just too stressful and scary. We did call the police on him once because he had a run in with his dad. His dad was saying, 'You've gotta go catch up,' and he just screamed. Huge crash. Went down the stairs. I thought, 'What the heck's going on?' I called 9-1-1."
>
> "He fell down the stairs?"
>
> "We didn't know what the big crash was, but he was in such a state that we called 9-1-1. What actually happened was he went down the stairs and he just threw his bike on the floor, which made a huge crash. And he went out the back door, slammed the back door. This was in the winter, he had almost no clothes on, and he was rolling around in icy snow at minus 20-odd. He very quickly kind of calmed down and came in and sat on the sofa downstairs, but he'd scratched

> himself a bit. And by then, Emergency Services had come, and they talked with him for quite a while. They wanted him to go to the hospital and they said, 'You shouldn't be feeling like this.' Because he was feeling suicidal. He had been talking about suicidal stuff on and off at that point."

However, because over twenty-four hours had lapsed since Adam had last talked about suicide, Emergency Services could not take him to the hospital against his will. Brienne avows that she could have lied – "In some ways I wish I had," she says – but she did not want to be marked down as a liar.

After that, Adam found and moved to a small apartment in the city. He worked at a series of jobs, one after another. Brienne realized later that during this time, Adam may have been already living with illness.

> "We learned that for many years he has been trying to pretend to be normal when he's not, but he's got to a point where he can't pretend anymore."

Brienne went with Adam to the local Community Health Services Centre, but they were faced with a waiting list of several months to see a psychiatrist. Adam missed the medical appointments that were set up for him. "His time-keeping was just awful," recalls Brienne. "He was just in and out of work, in and out, and just not being able to hold a job down enough to pay enough of the rent. Or pay for his food." She has been helping him financially, paying for his rent only, as she did not want him to become homeless. She found herself in a difficult position: "A son who just couldn't do those things, and I was trying to get him through the system, but he wouldn't sign the papers for me to take over his affairs. But it's also, I could see, good for him to do as much as he can of his own affairs."

At present, Adam is receiving medications and treatment under a court-mandated compulsory treatment order lasting one year. Brienne sees the tasks ahead as helping Adam to find a medication that works, to maintain taking that medication, and to have support. Brienne reflects: "He'd have an episode and then he'd kind of recover, but it was never quite the same. He'd have another episode and he'd kind of recover, but there were things under there that weren't right. Right from when he had the first episode, he was never the same person again. He was never the same person."

"What was he like before?" I ask. "And now?"

> "He was just an ordinary sort of guy. He was a bit shy. Um, he had…friends. He had quite a few friends. And he liked his friends. Still likes to have friends, but at the moment he doesn't know how to. Because he says he's lost a lot of his emotions. And from talking with the staff, it seems like it's the positive and the negative. He's lost a lot of the emotions. And he says without the emotions, it's hard to make connections with people."

She pauses.

> "What I maybe need to say to him is, 'They can help you learn how to make those connections. Even though your emotions are not quite what they should be, you can still learn how to make connections.' I said, 'Even if you don't have the feelings, you can still be a nice person. You know how to be kind to people and do good things.' Because he's always liked to help people…"

Brienne and Adam have gone through many difficult times in the past. Her actions in the past, of being present for Adam, access mental health services, and ensuring he does not become homeless persist in current circumstances.

Throughout May, before and after my first interview with Brienne, the staff speak of Adam's condition in concise updates during the Morning Planning Meetings. "Tom Bradbury [one of the outpatient psychiatrists] is worried he's a serious suicide risk," says Dr. Bouna gravely. "He has psychomotor retardation," says one of the nurses. "He's not compliant with medications – he thinks they are not helping him. He still has ideas of reference. He's still religiously preoccupied." At another meeting, Diana, one of the occupational therapists, gives her weekly report about one of the discussion groups, which was about finances: "Adam and Chelsea, the younger patients, talked about how it was difficult to have enough to live. In the middle of the month they would not have enough money for food." At another meeting, Diana gives an update upon the cooking session, "Even though it was not vegan, Adam strode over, chose the biggest cinnamon bun, and *ate* it."

May turns into June. Diana reports, "Mr. Cole says he has spent too much time sleeping, resting, here. He doesn't like his medications, but he complies."

During the first week of June, I go to Closed Unit B, past the double set of locked doors, to ask if Adam may be interested to participate in an interview with me. "Where would you like to go?" he asks. I look around Closed Unit B, at the patients' rooms, the hallway, the small common area consisting of four double-seating tables placed next to one another in front of the unit nursing station, similar to Closed Unit A. Everything is bolted down. “It is uncomfortable to sit for a long time here,” Brienne had said during her interview.

“How about the day room?” suggests Adam.

He asks Jordan, an orderly standing nearby, for permission to go.

“I’ll let your nurse know,” Jordan says.

We sit at one of the circular tables in the day room, beside a window and near one of the corners of the room. Adam does not want the digital recorder to be used.

“How did you come to be in the hospital?” I ask.

He leans back in his chair, an expression of surprise upon his face and in his body. He replies, slowly, and in a quiet tone.

> “What I’m going through is very personal. I can’t really talk about it…it’s very complicated.”

Adam goes on to speak of other things. He likes where he is living. He recounts meeting his neighbours for the first time: “I was bicycling around the streets. She and her boyfriend – they were walking their dog – and she was carrying strawberries. She shared them with me, and they invited me over,” Adam says, smiling. “It turned out that we lived next to each other. I knew that there was something special about them from the beginning.” After we have been speaking for thirty minutes, Adam says, “I’m getting emotional.” We decide to stop the interview. Sabrina, a psychologist-in-training, approaches us at the table. She would like to meet with Adam when we finish our interview. As we are both rising, Patricia, a nurse from Closed Unit B, is walking towards us with long strides. Today she is wearing a headscarf, a long white lab coat over a blue shirt, and dark blue pants.

“You can’t just take him out,” she says to me.

I apologize.

> “It’s OK,” she replies, her voice softer. “It’s just that if we can’t find him, we have to call the police. Next time, you can tell us when you are taking him out.”

I apologize again to Adam when Patricia has left. He responds that it is not my fault. He turns down the corridor between the occupational therapy room and conference room, where Sabrina’s office is at the end.

In mid-June, during an afternoon, Adam's parents are sitting in the day room at a table near the front, close to the ice machine, computer, and occupational therapy room. Adam's father is wearing a short scarf, dyed dark blue, tied around his neck forming two tails. He is wearing glasses and a black T-shirt. Brienne is also there; she has continued to visit Adam once or twice each week. "It has been eight years," Adam's father says. "What has been happening?" He speaks of how Adam came to the hospital.

> "It's when someone says they don't have hope, that I get really worried. It was when Adam said, 'I feel hopeless', that's when I picked up the phone and called the hospital. When a woman there asked me what was wrong, I said, 'If you were a person who've lost all hope, what's the next thing you would do?' So then she said, 'We will pick him up.'"

Adam's father pauses, then continues.

> "Brienne and I are different. She tries to understand, but I've accepted that I can't understand. I am grieving for someone, and you still have to do things. Someone is gone, but they are still here, and there is no closure."

When Adam approaches us, I rise to stand. "You can stay," Adam tells me. "You don't have to run away." Adam's parents greet him. "You look a lot better than the last time we saw you," says his father. "You looked like you were in a trance." Shortly after, Sabrina appears at Adam's side. She leads Adam and his parents to a room for a family meeting. Adam's father, pushing a walker with a dark blue frame, follows behind everyone else.

The Birthday Cake

"We don't really understand this voices thing. A lot of people with schizophrenia have voices. I don't know how that works," says Brienne. It is late June. She is once more visiting Adam in Closed Unit B. We have arranged another interview before the unit's visiting hours begin. "Um, initially he'd think it was God, but it's gotten more and more extreme. These days he gets commanding voices and he's afraid not to do what he's told. He's afraid there's bad consequences for not obeying. And I was saying to him, 'That doesn't sound like God to me, not the one I know.' But he's not listening. And all his friends who have faith are saying the same thing but, for the moment, he's not listening. We think the voices are getting in the way." The voices have told Adam to change to a vegan diet, to not eat, to go to certain places in the city, to give away his clothes to the homeless.

"Just before he went in this last time, he, um, was planning to take…I got to the apartment and there were piles of clothes, and I said, "What's going on?" but it turns out he was…he said he was sorting them. He wasn't saying he was giving them all away, but he just said he was sorting them. Clothes everywhere. But he said he was trying to take them to, um… there's a McDonald's, 24-hour McDonald's, on Adler Street. And he'd been meeting up with these homeless people. Because it's 24-hours, these guys know they can go there and it's safe. […] And he was gonna take the clothes to them. That's what his plan was. But he wasn't… he hadn't been eating. He's not right in his mind. He never managed to get there."

Adam has been giving away his belongings when he has little himself.

"He always wanted to give. But you have to have yourself before you can give. Or have a reasonable job before you can give any of your stuff."

"What other things would he give?" I ask.

"Uh, money. He has this thing about giving. It's kind of interesting. I think being as poor as he is, sometimes he's embarrassed at receiving things. But I learned he's happy if…say I give him something like chocolate – if I'll take a little back, it's like a little gift back. He likes that. It makes him a little happy. So instead of me refusing, sometimes I'll just take a little something and then he feels a little bit happy. He's given a little."

Brienne pauses, then continues.

"My birthday was a few months ago and he…I know he hadn't got any money and he bought me a little birthday cake. But then he had trouble getting it to me, so…I later found it in the fridge."

"In his place?" I ask.

"In his place. Yeah. He couldn't afford to buy a train ticket to come see me."

The auras and atmospheres scare Adam, explains Brienne.

"When he's very scared, he tends to freeze and not move much."

"What do you do?" I ask.

"Um, he sometimes…he'll just kind of sit and put his head down and whatever, and I'll think, 'Uh oh, he's not feeling good.' And I found it best just to

> let him be. Just to be near, but just to let him be. And he'll break out of it himself. Um, I've learned not to panic. I've learned if I'm calm it helps him be calm. These days I've been trying to just talk to him about ordinary things and trying not to talk too much about the mind stuff. Let him talk to the staff. Like my garden. Clothes he might wear. Um, ask what he had for dinner. Just everyday little things."

"What kind of clothes does he like? How do you pick that?" I ask.

Brienne laughs.

> "It's very hard. Coming up to the time when he went in last, I'd offer him, 'Come with me. I'll buy you some stuff.' But he just didn't seem to have the capacity to choose, which is kind of a pain. Himself, he had trouble. Yeah. I don't know. He, uh…it's going back to the voices. […] He's waiting for the voices to tell him if it's OK or not."

Brienne prepares to leave to go visit Adam on Closed Unit B.

> "He's calmer. He's more talkative. I'm not seeing the extreme emotions that I used to see and he's not kind of breaking down in tears at the slightest thing, which he was. And they just started him on the anti-depressants. I think maybe a week. But it's still a bit early days, really. Because it takes a while for the antidepressants to really kick in."

She says that the staff have asked her and her husband to keep Adam for additional weekends, that she needs to prepare a room for him in the small two-bedroom bungalow that she and her husband own in the country.

> "So today, I'm going to take him out for a bit. Maybe not even outside the hospital, but I'll go down to maybe the big cafeteria. Or maybe…I notice a little picnic table out there too. Maybe one of the little places outside, 'cause he likes a bit of fresh air. But not beyond hospital grounds today. And see how he is. See how he goes. And I get nervous a little bit because, in the past, he did try to jump out of the car and we were going at speed. […] So I want him to be OK before I drive him all the way back to Lavallée."

She shakes her head.

> "I don't know how I'm still with this guy. Sometimes it is, 'No no no I don't want any help.' Sometimes it is, 'I need help *right now.*'"

I walk with Brienne to the Inpatient Psychiatry Unit, where she will visit Adam. At the elevators, she stops and turns to me.

> "The signs of breakdown tend to repeat themselves. I notice when he stops eating, like last time, that happens before things get worse."

The Song of the Broken Piano

An upright piano, lidless and battered, sits against one wall of the day room. Its white wooden keys bear words written in fine black ink: "Not OK." "Not OK." "OK." Leaning across this labelled terrain, I press a "Not OK" key, listening for any sound. Where I expect a note to emerge there is only quiet; the sound I wait for does not arrive. There is only the expected tone ringing in my imagination. "The piano is broken," says a man, walking past. "So much in here is broken."

Adam has been returning to the unit, half of the days of each week, to attend the occupational therapy sessions in the morning and the patient discussion groups in the afternoon. He is sleeping at home, or at his mother's, while he is still an inpatient; the staff have assigned his bed to another patient to accommodate as many people who are awaiting admission as possible. I notice that he looks no longer as thin as before, his cheeks and arms are fuller. He is once more wearing his own clothes. One time he is wearing a blue T-shirt; another time, a shirt with an eagle upon it, wings outstretched, against a black background.

> "I like your shirt," says Jordan, the orderly. "With the eagle, it looks good on you."

Adam does not reply. He looks down at the floor, his expression hidden from view. During one of the morning community ward meetings, everyone is asked to speak about an animal they would like to be.

"A bird," Adam answers.

One day, Adam walks past in the day room, carrying a black guitar case. He sets it by one of the walls. Later, when I ask him about the guitar, he replies, "A friend from church was visiting. He was going to teach me how to play the guitar. But I find it difficult to learn." One morning he is sitting at the piano. He begins to play a song from memory in the key of D minor. The notes circle one another; his song has a haunting quality. It does not seem to matter that the piano has several missing keys. I do not anticipate the song's end until he stops playing. "Would you like to play a song?" he asks. Seeing my nod, he asks further, "What songs do you know? Maybe you can play the song you know without the notes? I would like to hear it before I go."

I bend my head and begin to play the only song that I know by heart. When the notes that I expect do not ring, my fingers falter on the next ones. My hand struggles to continue, carried forward by intention or muscle memory, to span the gap of the missing notes. My playing comes to a halt. To my ears the song sounds broken, almost unrecognizable, against the melody that I remember so clearly. "I'm sorry," I say. I feel anxious and disappointed in myself. "Maybe you can play it at a different place, so you won't have to use the missing notes," Adam offers. Closing my eyes, I shift my right hand to a higher octave. There are still some broken keys at this range, but the notes now take on a contour familiar to me. At the song's end, Adam says, "That sounded really nice. You played it even though notes are missing. I know that song. It's from the movie 'Amélie'. "

The sensation of unexpected gaps appearing, of the playing of the next note depending on the ones before, stays with me. To explain my own freezing, I recall the voice of Adam's mother, telling of how he had lost his emotions and how he feels that he cannot connect with others. I think of how I had lost my notes, how disconnected my own playing felt and sounded to me. Subsequently, other patients on the unit begin referring to me as "the player of the broken piano". "No one plays that piano," they say. Yet it is Adam who first played on the piano the song he had composed. Standing next to me when I froze, offering encouragement that prompted my hands to move again upon the keys, for a moment Adam was my piano teacher, and I his pupil.

A New Phone, Glasses, and Driver's License

I speak with Sabrina when the weekend approaches. Adam will be going to his parents' home in Lavallée on a weekend pass. I ask her about Adam's suicidal ideation. "He's on antidepressants. Antipsychotics. But he can't stay here forever," she says. "It's good for him to go outside, to spend time in the outside world. I told his parents that he cannot be left alone, he must be supervised. Because that's what happened last time – they took him outside and he had a breakdown. He was overstimulated." In mid-July, after Adam's discharge is discussed at the Morning Planning Meeting, I catch Sabrina in the halls. "I'm concerned that he's not taking his antidepressants," she tells me. "His mother is wishy-washy – I wish she could be more firm with him about taking them. Making sure that he has taken them would mean watching him as he swallows" – Sabrina opens her own mouth, pointing with her forefinger at her pink tongue – "and checking that the pill is gone." She continues, looking down: "He denies suicidal ideation, but when he visits home on a pass and it doesn't go well, he answers that he has been suicidal all his life. I think they put the responsibility on us, they don't want to take responsibility, if he does something to hurt himself," she says, referring to Adam's parents. "Sometimes I don't know if going home helps him or not. His family can be very stressful to him."

In late July, I call Brienne. "We made tabbouleh," she tells me, of what they had done during Adam's recent visit. "I went down to the store and I thought, why not make it from scratch myself for the same price?" Of Adam's medications, she says: "I stand in the washroom with him and watch him take them." As part of his treatment plan, Adam begins to spend more time staying with his parents. A few times each week, Brienne drives him from Lavallée to the city so that he may attend the occupational therapy sessions in the morning. On one of these times, in late July, while he is waiting outside the doorway of the activities room for occupational therapy to start, I ask him what he did over the weekend.

> "My mother and I went to a lavender farm, to a field of lavenders. To church. Then we did gardening."
>
> "What does a field of lavenders look like?" I ask.
>
> "There were so many of them. They are blue. Have you seen them?"

I nod. He takes out a small blue cloth sack from his pockets.

> "These are lavender seeds." He offers them for me to smell. "My mom also planted some lavender in her garden."

I catch sight of Brienne, one afternoon, as she is walking rapidly down the hallway to Adam's room. I ask what she is planning to do in her visit. "Oh, I thought to go with Adam to get him a new phone," she replies. "If there's time, we might go to his apartment to water his plants."

July turns to August. At the Morning Planning Meetings, the staff members continue to plan for Adam's discharge. "Steps House wants to come on Thursday from 1:30 to 2:30 to an assessment before he leaves," says Erica. "They will help him to live in his apartment."

"He's still envisioning his own death," says Sabrina.

"I feel like we're trapped. He is holding us hostage," says Dr. Bouna.

An official date is set for Adam's discharge.

I speak with Sabrina the day before Adam's discharge. I ask her about how she deals with uncertainty. "We try to minimize uncertainty for families," she says, speaking rapidly. "We have set him up with an outpatient psychiatrist. He is going to be visited by Steps House. He has a follow-up appointment with the First Episode Psychosis Program." She says they have all the bases covered.

"What about uncertainty – existentially?" I ask.

> "Oh," says Sabrina, smiling slightly, her tone softer. "I don't know what is happening with Adam's relationship with God. I don't really understand what is going on there."

Near the middle of August, Adam is discharged. He no longer returns to the unit for occupational therapy. My conversations with Brienne continue by telephone instead of in person. We speak in the evening, after 9 PM, when she returns from her day of work. She has given me her home phone number to call, to preserve the minutes she has on her cellphone for contacting her clients in her work as a caregiver. In late August, a sudden, severe storm causes trees to fall in Adam's part of the city. I call her in the evening.

"Is Adam's home OK?" I ask.

> "Yes, his street was untouched. But it's amazing how the next street over wasn't so lucky."

Brienne pauses.

> "Adam himself is not doing very well, however. I'm not sure what to do. Oh, I don't mean to put pressure on you, but he is very down. A group from Steps House visits him every morning, but he's not communicating with them, like usual. He's not telling them what's going on. Being alone is not good for him. He does worse on the weekends, when they don't do visits."

Brienne remarks that Adam values his independence, but she believes that living on his own is not good for him.

> "I don't think the best thing to do is to call 9-1-1 on him. Does he belong in a hospital? Of all the places where he's been, including the hospital, he said here is where he likes it best. To be close to nature. But there are no services here. I wonder if something else is better for him. Some kind of sheltered

> accommodations…. He really valued the independence. But he has changed from before. He has a diagnosis of schizophrenia. I've read that people with schizophrenia need to maintain relationships. He says he doesn't want to form new relationships; he just wants to keep the ones he has made from before. How do I help my son make new relationships? I wonder if there is anything that can help him do that."

Brienne speaks of sometimes feeling at a loss as to how to help her son, but this does not stop her from having ideas of what she can do. "I wish the family could be more included in the treatment team," she says. "It's like I'm getting calls of help from him and I don't know what to do. I have met many people who are mentally ill, but out here in the sticks there are no services. We live far away." She speaks of planning to dial back her work in the fall: "I'd like to have more time to help my husband, more time for my daughter, and to help Adam. I have some thoughts of what I'd like to do."

> "What are those?" I ask.
>
> "Oh, to help him get glasses. He is near-sighted – he cannot see very well without them. They are expensive, but he's always done better with glasses. And to re-apply for a driver's license. He had one, but he didn't renew it before it was going to expire. He was very sick at that time, you see."

Months later, Adam would tell me, "I actually can't see very much without glasses."

Brienne speaks of her concern about the impending cold, that she is not as able to visit him as often in the winter as the days get shorter and the roads from their rural home and the city are sometimes unsafe. She and her husband will also be taking time to travel. "I feel guilty when I go away. Adam doesn't do as well when he loses contact with us. I feel guilty when I think about my husband, or when I worry about other things, and I'm not worrying about him. But my husband wants to travel, and soon he won't be able to travel anymore. I'm glad that Adam is in the hospital. I'm glad that someone is keeping an eye out for him."

Before the end of the call, I say, "On the unit, I used to play the piano… And Adam…" I am struggling for words. Somehow it is important for me to let Brienne know about the piano.

> "What do you do on the piano?" she asks. "You would play and he would listen? You would teach him, or…?"

"I would play a couple of songs," I reply. "And then he would play. We would play the songs we know."

"Is the piano…has the piano been fixed?" she asks.

"Oh, it's still the old one," I say.

"Adam has always liked music. He says it helps him. I have been asking around, asking my friends, if they have an old piano they would like to donate…"

A Garden of Fruits

August turns to September. One day, down the hall, I see Adam walking. He has returned as an inpatient. He is again wearing a patient's gown. "I am back," he says, greeting me with a smile. "We will talk later," he says. I learn later that his psychiatrist had requested for him to be hospitalized, because he was concerned about how depressed Adam was. When I see Adam, I ask him about his summer. He tells me that his family made barbecue. "My mother made vegetarian dishes. Do you know hummus?" He pauses. "It's made with chickpeas."

We are sitting at a round table in the almost empty day room. Dr. Bouna's patients' group is taking place in the adjacent conference room, and there are no other activities scheduled for the afternoon. While Adam is one of Dr. Bouna's patients, he does not wish to attend the meetings. "The questions Dr. Bouna asks are very private," Adam explains. "And some of the things people say are strange." He offers to give me a small plastic box of corn from his salad lunch. "Or the Boost?" he adds, gesturing to the chocolate protein shake accompanying his vegan meal. He tells me about common, wild plants that are edible. "Some of them are sweet. It's really weird. Some of the leaves taste like lemon. And pineapple." He tells me that his mother keeps a garden.

"My mother does too," I say.

In my notebook, I draw a picture of a spiky cucumber that she has grown. Adam looks down at the notebook.

"That looks like a sour sop," says Adam.

"What's a sour sop?" I ask.

"Well, it's like a custard apple, but with spikes."

He draws both in my notebook, beneath the spiky cucumber. He adds grooves to the smooth surface of the custard apple. On the sour sop he places a stem and adorns its surface with several small spikes. We turn to talk about other Asian fruits.

"There is one I cannot remember the name of. It's orange."

"How big is it?" Adam asks.

I hold up my hand.

"Does it have a hard shell?"

"Yes," I say.

"Is it a mangosteen?"

"Yes!"

"It's one of the fruits I haven't yet tried," he replies. I think of another fruit.

"It's large," I pause, attempting to remember its name. "It smells. Stinkyfruit," I say, giving it a made-up name.

"Durian," replies Adam. I nod once more.

I ask him how his interest in plants began.

"Well, I've always felt a connection to plants. I realized instead of buying salads, I could pick them. There are many plants that you can pick wherever there is grass. They're everywhere."

He names them:

"Wood sorrel. They taste lemony, and they're easy to find.

"Greek basil.

"Stevia; they're sugary. They taste like custard apple.

"Pineapple weed.

"Dandelion.

"Plantain weed; they're medicinal.

"Some of them taste like mint chocolate," Adam finishes.

"Mint chocolate?" I ask.

"Mint chocolate. Like the – 'After Eight' fillings," he explains.

"When my parents moved to where they are now," he continues, "I became obsessed with which plants could grow in this climate. And my mother took an interest, too."

"What does she grow?" I ask.

He names the following, one at a time, without pause or hesitation:

Strawberries
Blackberries
Blueberries
Pink blueberries
Honeyberries
Boysenberries
Raspberries
Yellow raspberries
Kiwi
Saskatoonberries
Gooseberries
Black currants
Red currants
White currants
Nanking cherries
Passion fruit
Pears
Apples
Cherries

In succession, he elaborates the garden of his mother, a garden I have never seen, into the day room. I imagine myself to be sitting beside him as he points out the fruits in the garden surrounding us, appearing one by one as they are named. "I've always felt connected to plants," he has said; so connected, perhaps, his mother's garden is summoned. In asking him about his world, I learn of its fullness and even as his mother and himself speak of his loss of connection, still other parts of his world seem entirely present.

In late September, Adam mentions playing upon the piano. It is not to be found in its usual spot, pushed up against the wall adjoining the day room and the conference room. Adam walks away. After a while, a nursing student, who says he is working with Adam, approaches me in the hall.

> "We cannot let him go outside because," he says, his voice becoming quieter, "he is suicidal and now he has a plan. He mentioned that he would like to play on the piano. I think it would be good for him."

The conference room, where the piano with the broken keys has been moved, is unlocked for us. The piano had been moved to the conference room because someone was playing on it frequently, and it had become noisy for others on the ward. I play "A Thousand Years" by Christina Perri. It is a song I have played several times in Adam's presence, at his request. When I asked him why he likes the song, he says, "It's complicated. Because it's about eternity. And getting closer to heaven. It's about love. It's about long-lasting love." He asks, "Is this where the singing part begins?" Reading the lyrics, he begins to sing softly.

> "I wish I could sing again," he says, at the song's end. "Singing is different now. Before the breakdown, I could express myself more. It feels bad when I sing now. I feel like I shouldn't sing, like I'm sending out a bad message."

He plays another part of his melody on the piano.

> "I feel strange playing the piano now," he says.
>
> "How did you learn to play the piano?"
>
> "I lived in a house with many musicians, and there was a piano." He pauses. "Many of my friends died that year," he says.

Later, I would learn, one died from an accident, another from illness, another was murdered. Months later, I ask Adam, "How did you manage during that year?"

> "God was protecting me," he answers.

He shows me a succession of music videos of Christian music. The videos, independently, show backgrounds of nature. The first song features the seashore. The second, a forest. The third, the surface of water, lifting up into the sky. I remember Adam's saying that he wishes he were a bird.

It is early October, the day after Adam's birthday. I am visiting him in Closed Unit B, where he had been transferred from the Open Unit. I have not heard the staff speak directly about the reason for Adam's transfer. "My grandparents sent me cards," he says. "My mother will visit later this week." He is sitting at the tables in the communal area, the chairs bolted down, the common area of the unit between the nursing station and the TV. "They did not tell me I would be moved to Unit B. I was downstairs in the cafeteria with my family, to celebrate my sister's birthday, a few days ago. When I came back upstairs, they told me I had been moved to Unit B." He pauses for some seconds, then says, more slowly. "It was a bit mean."

We spend the rest of the time in silence. When I am getting up once more, to leave, he says, "I am very tired. It's not you. It is the medication."

"May I visit you again?" I ask.

He smiles.

"Yes, that would be nice."

During the month of October, on one rainy day when many leaves have fallen, I bring leaves in an orange envelope, fresh ones and dried ones, when I go to the unit. I give the envelope to Adam. He takes out the leaves in a bunch and places them on the windowsill. I notice, upon the nightstand: a bottle of water, almost empty; two bottles of chocolate protein shake; four cards, of different sizes and colours, one with Eeyore on the front, "Happy Birthday" on another, a single pink candle on a third; dried leaves; an apple saved from a meal; and a card made of blue watercolour ink on a white background, glued to a piece of construction paper, written:

"Thank you Adam
for your kindness on
a difficult night"

Erica, the social worker on Adam's treatment team, reflects upon Adam's status: "He's better. Not well enough to be in his own apartment. He really likes the Open Unit."

"How do you mean?" I ask.

> "He's comfortable here. He's not hiding in his room. He's fitting in. He's with other patients. For Steps House, we assumed it was going well. That it was a good fit. He is a lonely guy living alone. We were trying to fill in the gap."

During one occupational therapy session, Friday's Fun Group, the activity is to make pancakes and a fruit salad. After explaining the activity to the group, Diana gestures to a cardboard box. Adam peers in and says, with a wide smile on his face.

"This looks like fun."

Inside is a small pile of fruits, including bananas, grapes, and apples.

The Missing Heart

"Would you like to join us in OT?" asks a woman, a patient, who has become a friend of Adam's.

This is how, in mid-October, I have begun to sit in the morning occupational therapy activity sessions, when people play cards or chess, colour or do a crossword, or make art with materials that the occupational therapist helps them to select from the wide range of supplies available in the room. "May I sit by you?" I ask Adam. He shows me his artworks, a sheaf of papers in a folder made from a large piece of construction paper. There is a painting on wood of a girl standing by two elephants, an adult and child elephant. The background is painted in green. The elephants and the girl, their outlines drawn in pencil upon the wood, have been left uncoloured. In his folder there is also a painting of an eagle flying, its wings outstretched.

"I'm not sure I got the beak right," says Adam, looking down at the image.

There is a painting of a deer. A stencil artwork, with a geometric pattern of triangles and rectangles cut-out, painted over, and the pieces arranged and pasted onto a folding page. A painting of a parrot with colouful plumage. Turning the papers, crinkled with dried acrylic and watercolour paint, he selects a piece to continue working upon. It depicts a snowy plain under a sky painted dark blue with swirling brushstrokes.

"I haven't finished this," he says.

With a "tsk", Adam stands up, returning to the table with a pencil, a brush, a cup, and a tube of white paint. He is wearing dark yellow shorts that go to his knees, but it is one of the coldest days yet this year – only six degrees Celsius outside. In the lower right corner of the sheet, he begins to sketch, in pencil, the outline of a lion. Over the course of forty minutes, Adam finishes sketching and painting the lion. Taking a medium-sized brush and white paint, the first strokes Adam places define the front haunches of the lion, bent in mid-step. He follows the outline up to the lion's neck, and turns next to the lion's mane. Next to be filled in is the lion's back, and finally his hind legs and tail. With careful, measured strokes, his pace neither quickening nor halting, he fills in the body of the lion with white paint. He roughens the paint with his brush to make the fur on the lion's neck, flanks, and back appear windswept. With his brush he paints the outline of a small almond shape and leaves this unpainted. This is the lion's eye.

“Do you think it looks like a lion?” he asks.

“Yes, it looks like a snow lion,” I say, once he has finished. “Like it’s walking across a field of ice at night. It’s eyes, ears, and nose are the colour of the landscape.”

“Yeah!” he says, with a tone of surprise and curiosity, looking at his completed work. “I didn’t notice that.”

Some moments pass.

“It’s a shame you can’t draw. I think you can.”

“You mean draw here?” I ask.

“Yeah, they’ll probably let you.”

I open my notebook and turn to a page where I had recently sketched the objects in a patient’s room.

“It’s very messy,” I say. “I’m not sure it’s good.”

“You tried,” Adam says, looking at my drawing.

On another day, he catches sight of a National Geographic from the 1970s. On the cover is a photograph of a lion. We both pause, looking at the cover. “That looks a lot like the one you drew,” I say.

“Yeah,” he replies. “I didn’t know that it was here.”

Afterwards, standing in the hallway, outside of the occupational therapy session that has just ended and before the distribution of meal trays for lunch, Adam shares something about himself.

“I’m not who I was before. I’ve changed. I don’t like it.”

“You don’t like who you are now, or you don’t like changing?” I ask.

Adam nods.

“Who were you like, before?” I ask.

“I was more outgoing,” he says. “And nicer.”

He tells me about the church his parents go to and about his own church. “They are very lively,” he says, with a small smile. They are in the side of a mountain. He is part of a Church downtown. “We had lunch,” he says, of what happened over the weekend.

“They had so many vegetarian dishes. They pushed all the tables to one side.” A smile is growing on his face. “I was nervous about going back. They will have a Christmas party, too.” He pauses. “I’m not sure if I will go.”

I continue to sit by Adam during the occupational therapy activity sessions and beside him at lunch. Once I brought in a segment of a custard apple to share, and another time a piece of taro and sweet potato, Asian vegetables I have often eaten in my childhood.

> One evening in late October, he says: "I would like to show you something. Can I?" Sarah, an inpatient upon the Open Unit, and I follow him to the level below the lobby, in the now-empty waiting area of the Radiation-Oncology Centre. In the space there is a white baby grand piano. Sarah, Adam, and I approach the piano. As I play "A Thousand Years", Adam and Sarah sing, standing and walking in the space between the piano and the rows of chairs.

Afterwards, Adam suggests getting some fresh air. Sarah leaves to return to the unit. He raises himself to sit on a stony ledge to the left of the main entrance of the hospital. I sit beside him. Our backs are to the hospital as we sit facing the street and the residential area beyond. It is 7 PM, and the sky has already darkened fully.

> "Do you ever go to the markets near here?" he asks.
>
> "I pass them on my way, but I have not gone in."
>
> "They have all sorts of exotic fruits. Custard apple. Breadfruit," he brings his arms in a circle in front of his chest, to show its enormity. "There are tanks pull of crabs. Poor things." I picture crabs in a crowded tank, unable to get out.
>
> Adam continues: "I feel badly for all the people who are looking out for me. I'm a difficult case."

"Why are you a difficult case?" I ask.

> "Because I feel like there's no hope. And I don't want to try anything. I've tried so many things already. I feel like I am not connected to my heart. Like my heart has no love in it anymore. I feel like I have no heart."

"What do you hope for?" I ask, attempting to lighten the conversation.

> "It sounds really terrible, but I have no hope. I wish I were better. I wish I were different. I don't think anything can make it better. They won't let me out if I don't get better."

"What does it feel like to not be connected to your heart?" I ask.

> "Oh my goodness. It feels like torture. Nothing makes any sense. It's so overwhelming I can't even describe it. It makes me want not to be alive."

When we return to the unit, I ask Adam for more stories of his past. He tells me that he had worked as a summer camp counsellor, and then as the director of the camp.

> "It was hard – it was hard because I was struggling with my relationship to God and I didn't really want to be there."

He is silent for a time. At the far side of the room, the TV is playing a program. There is the sound of conversation.

> "I'm a different person now," he says, looking out the windows. "I care about different things now."

"What are those things?" I ask.

> "Oh. About keeping busy. Finding a job." He pauses. "Doing something good with my life."

The following day, Adam tells me that his discharge has been postponed for a few days. "I can understand," he says quietly. "I wasn't taking my medications." When I call Brienne once more in the evening, she mentions the medications too. "I think the medication is helping him," she says. "He's more logical. His mind is better. He is more calm." She recounts how the medication makes him very sleepy.

> "He came home the past weekend. I found out that he hadn't been taking his meds regularly. I made him take it on Saturday and then he was zonked out on Sunday. He would be tired until 1 or 3 PM. […] Before, he would take it at night and sleep through the worst of it. But the morning is the only time when people from Steps House can come to his place to make sure he takes his medication. He is getting used to the drowsiness. The zonking out shortens his day…"

Brienne explains that it has been a hard year for both her and Adam.

> "He was in the hospital for the last eight months. He has lost many of his friends. It has been eight months, a long time, to get back on his feet. It's hard to keep friendships when you aren't around."

Fall is advancing, and the weather is becoming colder. It is 9 AM, on a day in November, and we are in the day room after the end of breakfast.

"How are you?" Adam asks.

"I am OK," I say. "How are you?"

"Not good," he says. "When do you have to go?"

"At eleven," I say. "Will you go to OT?" I ask.

He nods and continues to sit in his chair. At 9:30 AM I say goodbye to Adam and enter the conference room to listen to the Morning Planning Meeting. After the meeting, I ask Diana, the occupational therapist, if I may enter the Activities Room as the session is already underway. I find Adam sitting by one of the round tables. He is wearing grey canvas shoes and a patient's gown, his hair combed back and face unshaved. His elbow is tucked across his chest, his eyes closed, shoulders slightly slumped against the back of the chair. There are no objects on the table in front of him. "What would you like to do?" asks Diana. Adam opens his eyes, and slowly lifts his head to look at her. She has bent down, almost crouching, to be nearer to his eye level. After listening to suggestions made by Diana, Adam gives his reply. Diana returns with a word search printed on a piece of paper. Adam picks up the pencil, then sets it down upon the table. After a time, he leans back in his chair, his shoulders rounding forward. Diana returns to his side, lowering down to one knee, and asks if it is the medication that is making him very tired.

> "Are you here because you want to fight through it? Because you don't want to fall asleep?"
>
> "I feel like I've come to the end of my life," says Adam slowly, his tone a whisper. "I don't think I can go another week like this." He is remaining still in his seat. Diana is frowning slightly.
>
> "If the medication is decreasing your quality of life, that is not what we want…" she replies. "I will talk with your treatment team. We just met and we are taking this very seriously. Dr. Bouna is open to…" Diana falters. "Do what you need to do," she says, gathering herself once more. "Do whatever it is you need to do."

Diana stands up after Adam replies. While she approaches the other patients and everyone in the room continues upon their chosen activity for the session, Adam continues to sit, leaning back in his chair, his arms held loosely at his sides, almost dangling, his eyes closed.

After several minutes pass, Adam turns to me. “Can I go take a nap?” We go back into the hallway. After the right-angle turn by the double doors through which we enter the unit, Adam sits down in a chair. Unconsciously mirroring Diana, I find myself lowered to one knee, so as to be able to hear Adam speak, his voice quieter than I have ever heard. He has never before sat so still; I notice there is a single sparkle on his face, and a flake of dandruff in his hair.

> “When do you have to go?” he asks.
>
> “At eleven – in ten minutes,” I reply.
>
> “I feel really bad,” he says.
>
> “What can help?” I ask.
>
> “Not taking the medication,” he says, in a slightly louder voice. “I’m going to take a shower.”

He rises, turns left, and walks to a trolley of linens parked at the right side of the narrow hallway of patients’ rooms. He takes a towel from the top of the pile. I turn right and exit through the double doors. Adam had walked with me to the front entrance, as far as he could go.

> “He needs to do something that’s, um, fun. But he says, ‘Well, I don’t know how to have fun.’ So I said, ‘Something that you like to do.’ So he’s gonna try to go to the gym,” says Brienne.

It is November. Over the phone, Brienne is speaking of Adam finding things to do to establish a routine for when he can return to live at his apartment once more.

> “He wants to find out whether he can somehow get a bus pass, ‘cause that would help. That would help getting to the hospital, and that would help when he wants to visit the gym.” She sighs. “That’s kind of where we’re at the moment. We have to take one step at a time and see how it goes. But it’s good to see him actually a bit better, because he was so low.”

She speaks of the chores that he does around his apartment building, which reduces his rent.

> “He needs to do something that gives him a little bit of self-worth,” she reflects. “I’m sure he could learn. He can learn things. His memory is OK. I know he has liked to do things with his hands. He is very good with his hands. Both him

and his sister. He fixed a lamp that I had at home. He used to work at the Stuart University science gardens – he did a bit of gardening."

She pauses, then continues: "It's not easy. I know it's not easy. People keep saying that he can have a good life. I'm not sure what they mean by that, but that's what they say. He needs to do something that's valuable, something worthwhile, and to feel good about it."

"Do you have any idea on what that would be?" I ask.

"Not really. I've kind of learned that I can throw out ideas but, in the end, it's him that's gotta kind of work through and work out to find something. But he needs a little bit of pushing sometimes. Or encouragement. But I can't do it for him. He has to find these things for himself. The people at Hillside Hospital have been very, very helpful."

Brienne speaks of a recent time when she saw Adam have a sense of self-worth

"One time he was over on the weekend, and he was quite into, um…we were kind of experimenting in trying to find vegetarian recipes and trying them out, and he seemed to quite enjoy that. Uh, we…well, Adam made – I've made some since – some hummus. Chickpeas with…originally we had to get all the ingredients. Uh, chickpeas, and lemon, and tahini, and uh, pepper, salt, olive oil. There's some cumin, I think cumin. And so he did one batch, and that kind of disappeared quite fast. Then he made another batch, but he changed the amount of certain ingredients more to his taste. And that was good too, because he was just taking charge and having a go at something, which was good. I know it seems like something simple, but it was good for him."

Brienne plans to make falafels with Adam from scratch. She tells me that they are made from uncooked chickpeas. "But we haven't yet kind of organized enough. Actually, it reminds me, I could probably put some in to soak, um, say, tomorrow." Returning to something she had said in our first conversation, Brienne reflects that Adam needs to find a new way of connecting with other people. When I ask her what those new ways might be, Brienne's first answer is that she does not know. Shortly after, she speaks of what she sees is possible.

"Um, in a way that doesn't involve emotions in the same way as it used to. Thankfully, he's a good guy. He knows what's right and wrong and he

> understands other people. He doesn't have the feelings himself at the moment. I hope that some of that returns, but it may not. I don't fully understand all this schizophrenic stuff. But, um, he can see when other people are pleased with something, or frustrated with something. He can see other people's emotions and feelings, even if he doesn't have them himself. He's upset that he's lost that."
>
> Brienne laughs tensely. "But there are ways of relating to people that don't involve so much emotion. It's a discovery journey. We're learning. We're learning. Little by little. Finding what helps, what doesn't help. I'm trying to help him and encourage him in the right directions."
>
> At the Morning Planning Meetings, the staff once more discuss Adam.
>
> "The report is that the pass went well," says a nurse.
>
> "Is he out of the suicidal?" asks Dr. Bouna.
>
> Erica purses her lips, her gaze downturned, and shakes her head.
>
> "Well, he's getting *better…*" says Dr. Grace.

A week later, Dr. Grace reports: "Adam's doing better. I don't want to set a date, but maybe within the week…" A few days later, a nurse asks, "Will Adam be discharged today?" In answer, staff members discuss the side-effects of Adam being on clozapine, which is used to treat schizophrenia in patients whose symptoms have not responded to other medications. Clozapine has side-effects that affect the heart and taking it requires regular monitoring by the treatment team. They are looking out for signs of myocarditis. A staff member reports that Adam's heart rate is too high. I speak with Jonah, his pharmacist, and Dr. Grace, the psychiatry resident working closely with Adam, about a moment of hope that they have experienced with them.

> "It is so that, with medication, he can live a full life. He can work. He can…" Jonah trails off.
>
> "He's more dynamic. He's smiling more," says Dr. Grace. "He's saying that he wants to go home to look after his plants. [Brienne has said that the plants at his apartment, when she goes to water them, are "pretty dry"]. He is different from the first time I met him, when he told me he has lost his salvation. When he says, 'I can't go on.' He says still that he has no hope. I said that it is our job to have hope for him.

"But our having so much hope scares him," she admits. "How far are we willing to go? Suggesting electroshock therapy was too far. I realized then that we did not have his trust."

The Apple Tree

"Are you waiting for your medication?" a nurse asks Adam as he stands in the day room. It is a late afternoon in November, a few days after my phone call with Brienne.

He shows her a small plastic bag in which there are three pill tablets, one yellow, one white. "I have my meds," he says to the nurse.

"How is your heart?" I ask, once the nurse has left.

He grimaces. "Not good enough."

During the half-hour before the start of dinner, it is already completely dark outside. Stéphane, Adam's psychologist, approaches Adam, who is singing quietly as he waits.

In the evening, Adam and I venture outside the hospital. We walk in the direction of the community centre where he has an appointment to take a tour. "It's cold," Adam says. He is shaking. He is wearing a new jacket that is thin and without a collar, with a red stripe running horizontally at the front.

"I'm worried about coming back," he says. "I don't want to come back. I'm worried I'm not stable enough.

"I like my place," he continues. "It's quiet. It can get lonely, but it has its plusses. I have all my things there, from over the years."

I notice that he holds an apple from his hospital dinner, which he has washed. "Do you like apples?" I ask.

"Do I like apples?" He considers for a moment. "They keep very well. My mother has many apple trees in her garden. She has so many apples she doesn't know what to do with them."

We are nearing the building that houses the outpatient psychiatry services.

"There is an apple tree," he says, pointing. "There, by the window. Do you see?"

"I didn't know there was an apple tree there," I say.

"It is outside of Dr. Kent's window," he replies. "I would pick the apples that have fallen, there. In September, when they were ripe."

I have gone into that building on a regular basis during all seasons for the past three years. I never noticed apples. In the mid-November chill, the tree's branches are bare.

On our way back from the tour, we pass by a market.

"Do you want to go in?" I ask.

He pauses, considering. The sky is now dark. The front window of Vinh's Market glows warm and bright.

"Maybe another time," he says.

Despite his answer, he does not move and I continue to stand beside him. We are both looking into the store. He has to return to the unit by 8 PM.

"Is it still open?" he asks.

Seeing the store's brightly lit interior, I take a guess that it is still open, and nod.

"Quickly," he says, approaching the store entrance.

The door swings open when I pull it. He enters and I follow after.

When I return to the unit the following day, the door to his room is closed. "Adam started a new medication today," nurse Donny tells me. "He is probably sleeping." I stand close to the place where Adam and I had first met, and where Dr. Bouna had walked past us and pronounced Adam a mystery. Turning from the closed door, I leave the unit with many questions. Will he get better? Will he remain in the world outside of the hospital? What will become of his heart?

Furnishing

During one afternoon in late September, when Adam named the plants in his mother's garden, I ask Adam what he did over the weekend at his parents' home. We are sitting at one of the round tables in the day room, after the lunchtime meal trays have been put away and the tables cleared.

"I went to my parents' home," he replies. "My mother and I cooked together."

"What did you make?" I ask.

"I took pictures on my phone." He pauses. "Would you like to see them?"

> Adam takes out a small, black phone from his pocket. After a moment, he turns the screen towards me. It shows a photograph of a vegetarian meal, presented upon a white china plate rimmed with a complex, blue woven pattern. Proceeding clockwise, he points out the ingredients, groupings of white, green, orange, and dark brown: "Those are grilled cauliflower. Those are green beans. That's

> spaghetti squash. And that's a veggie burger," he finishes, indicating the dark brown patty. The colours of the ingredients and the blue border of the china plate brighten one another.
>
> "I have never seen a spaghetti squash before," I say.
>
> "You can bake it, and then scrape it off with a fork," he replies. "You should try it."

There are more photos to see. He swipes the screen to show images of squashes his mother had planted and now harvested. There are five placed on a wooden rack in two rows, large enough that one would need to use both hands to hold them, some orange and some green, some oval and long, others square and bulky.

> "What is the green one?" I ask, pointing to the screen of his cellphone.
>
> "Hubbard squash."
>
> "And that green one?"
>
> "Hubbard squash too."
>
> "And that one?"
>
> "Cross between a Hubbard squash and a pumpkin. My mom crossed them by accident," he explains.

At the time of this conversation in late September, I was struck by the sight of Adam's phone, that brought to mind Brienne's saying, several weeks earlier in July, that she was planning to help Adam get his phone. I had believed that the importance of what Adam had told and shown me was that because he had a phone, and could take pictures with it and share them with others as he had just done with me, his world was increasing and he had more possibilities for action within it. It has been this moment that I saw Brienne's acts of bringing objects into Adam's immediate contexts as furnishing his world with possibilities.

Now I see there is much more in Adam's act of showing me the photo and in his and his mother's actions that have led to this moment. In offering to show me the image of the meal that he and his mother had made, taken before its eating and thoughtfully arranged on a blue china plate, Adam and Brienne shared with me their meal. The world at which the plate of vegetarian dishes is the centre is a world into which others can be invited, and this gives this local world between them a sense of worth. It is a world worthy for others to be invited into. Adam and Brienne have furnished my world with squashes and a meal served on a blue china plate. Though

I was not physically present at Brienne's home in the country, my experience of this moment is not the same as the story of the undelivered birthday cake. For a moment, Adam and Brienne have placed me facing the plate and the squashes alongside them.

Through the stories she has told, through her visits with Adam, she places him amongst a world of slippers, peanut butter, and dark chocolate; of bus passes, glasses, and driver's licenses; of gardening, cooking, and doing things with his hands; and of someone who has the possibility of having self-worth and of being a host. Her actions of bringing things into Adam's world, of furnishing his world, gives a cumulation of meaning to every day things. As things already in his world, they mean the world that is close at hand to him already has meaning. For someone who hears voices that are frightening and distressing, who believes he has lost his heart, and who may disappear or take his own life, Brienne's actions carry an existential weight. She is furnishing with Adam a world in which he can stay.

Chapter 7 Discussion

In this chapter, I will place the family members' actions of going on excursions, standing by, and furnishing in dialogue with Heidegger's hermeneutic phenomenology. In so doing, I venture an interpretation of the family members' actions as practices of being near. I next turn to Gadamer's concept of historical being to point out the significance and force of these practices, for they reveal family members and patients as responding to the demands of a present situation. The practices of being near, of going on excursions, standing by, and furnishing form the centre of a world to which the people engaging in those actions belong. I end the chapter by: 1) posing the question of how does the World, and Beings within it, appear differently to us when a practice is placed at the centre of a world rather than a Being and 2) a brief discussion of the theoretical and clinical implications of being-alongside, of being near.

Practices of Being Near

In "Being and Time", Heidegger reminds us throughout that comportment is Being's way of being-in-the-world. Being's comportment reveals that Being already has an implicit understanding of how to be in its world, and this understanding is prior to any theoretical understanding; it is grounded in the everyday. Throughout my own fieldwork, these concepts resonated with my approach, and helped me to wait, see, and listen for the fruits grown by Adam and Brienne, Alistair's dirty clothes, and Xavier's hand wrapped in gauze that is drawing a house. Being finds itself in a world largely not of its own making. Heidegger interprets the significance of Being's comportment in light of Being's finitude and ultimate horizon, death. Death is the horizon of concern that lends a weight and significance to Being's existential structures.

As the structure and routines of the inpatient psychiatry unit hold patients separate from the outside world while they undergo treatment (Barrett, 1996), a sense of being close was surprising. Barrett, a psychiatrist and anthropologist, in his ethnography found that patients diagnosed with schizophrenia were positioned by the routine practices of the inpatient psychiatry unit as being outside of lived time and responsibility to self and others. When I entered the world of the inpatient psychiatry unit at Hillside Hospital, I expected that I would readily see the patients in terms of emptiness, lacking initiative, and not fitting in to society. Finding myself in a position of nearness was also surprising because the projected meanings that I carried about patients actually placed them at a distance. Regarding Alistair, I had watched him and a nurse disagree about going outside, and learned from Clara that he can be abrasive to others; from this knowledge I feared that Alistair may not be someone I should approach and that I would be safer if I were not near to him. Regarding Xavier, I had heard him described as being passive by Paige and members of the treatment staff, and indeed I saw Xavier sitting often at the window seemingly not doing anything; from this knowledge I initially worried that I would be shut out or ignored by him. Regarding Adam, his mother and the treatment staff had called him a mystery, his family and treatment team fear that he will take his life, and Adam himself states that he does not think it is possible for him to feel better; from this knowledge I had worried that I would not be able to see Adam as a person and that I would feel only despair with him.

While all these experiences are part of the worlds of the patients, families, and treatment staff, being alongside with the patients over time showed me that Alistair is also a kind host who moved us to the clean side of the table and took me to a more comfortable seating area in Closed Unit A; Xavier sang, drew a house, and told me stories about his past and imagined future; Adam introduced new things into my world, squash, a role as the unit's piano player, and an understanding that he cannot find his heart. Through performing excursions, standing by, and furnishing with them, I became near to the patients. By being-alongside the patient, I understood my actions were also the actions of the family members in their stories of the past and at present. By entering the worlds of family members through being-alongside the patient, I came to see the horizons that family members are facing. The worries of the family members became real and urgent to me.

For the family members in this study, the horizon of concern is the possibility of loss. It is uncertain when loss will come, and if it will come, but to them loss is a very real possibility – a loss that includes not just death, but death by one's own hand (Adam and Xavier) or a death caused by a lack of recognition (Alistair). In furnishing, standing by, and going on excursions, the family members show how they are facing situations of potential, unpredictable loss: they are *taking actions* in the face of suicide and social death. Their actions keep that horizon farther than it would be otherwise. In my going on excursions with Alistair, standing by Xavier as he drew a house to make a postcard, and bringing piano songs to Adam, I came to be alongside the patients. After multiple encounters across time, in which I continued to go on excursions with Alistair to different parts of the hospital; continued to stand by with Xavier as he completed his drawing and moved onto hand strengthening exercises during occupational therapy; and continued to bring magazines, dried leaves, and fruits to share with Adam, I was not only alongside the patients but also came into proximity with them.

Proximity of being-alongside.

Heidegger offers two existential structures of being-alongside: leaping-in for another in their world and leaping-ahead (p. 158-9). Leaping-in means doing something for a Being what that Being would do for itself. Leaping-ahead, in contrast, is a way of being-with another Being that does not dominate the other. Both leaping-in and leaping-ahead involves a distance between Beings. Yet there is a proximity in going on excursions, standing by, and furnishing. The family members do not want to do for the other, nor do they want to leap ahead of the patient, which would leave the patients behind, which ultimately implies that the family members would, in turn, be left behind. They show that in these situations of imagined, nearly imminent loss, being near to the patient is profoundly important. Being near is a way of being-alongside in which the distance between Beings is closed.

As going on excursions, standing by, and furnishing brought me into a nearness with patients and family members, I began to see them differently. When I became engaged in the family's practices of being near, I began to see other possibilities in the patients' worlds. Once I have seen, as Clara does, Alistair as a human being and as her father, I did not want these experiences of Alistair as a person to be overshadowed by others' seeing him only as a pig-pen and a patient who falls. Having met Xavier and heard stories of his cabinet-making from Paige, I did not want him to disappear. Knowing Brienne's story of the birthday cake that Adam had bought for her but could not deliver, and her saying that Adam also likes to give, I felt an urgency that with each encounter there can be an enrichening of Adam's world.

These possibilities, grounded in the everyday, can lead to things potentially becoming otherwise as Mattingly (2014) has shown in her ethnographic studies with families of children diagnosed with chronic illness. I could see possibilities that I did not see before, because being near made it hard for me to hold onto my projected meanings of them and their worlds. Around Alistair, for example, it was difficult for me to see him solely as a pig-pen or an incontinent mess when I was right next to him going someplace new. Sitting beside Xavier made it possible to see him draw the house he had once constructed using his injured hand and to hear him break into song – two instances of something coming forth that ran counter to his psychiatric team's concern with him as being only passive. With Adam's invitation to enter the garden he and his mother have cultivated, there was a sense of possibility in his world, which contained berries, squashes, apples, music, and vegetarian meals upon a blue china plate. I no longer could see Adam as only a patient at risk of suicide but also as a person in search of his heart. Clara's planning to have a birthday celebration at a restaurant just 600 metres from the psychiatric hospital, Paige's knowing to wait for Xavier to appear again instead of pursuing him, and Brienne's bringing familiar objects to fill a world all came from possibilities created and sustained through their practices of being near to the patients.

Force of recurrence.

The family members of this study are always responding to the demands of a particular present. This recurrence of action is not mere repetition. To understand the recurrence of action as not being a mere repetition of the past, I turn to Gadamer. While Heidegger, in his theory of hermeneutic phenomenology, takes as his starting point Dasein and its world, Gadamer, in his theory of hermeneutic experience, takes as his starting point a human being who has history. Being historical is fundamental to human being and to the process of understanding, for much of being is already given just by human beings finding ourselves in a world we did not create from scratch. Our worlds are shaped by others and by the past. For Gadamer, human beings are always carrying a tradition in such a large part that we belong to a tradition. We belong always in some way to the past. Yet, although human beings belong to tradition and carry history into the present, we do not merely repeat it. Tradition, the past, is a living thing. It is not fixed:

> The task involved in bringing together the petrified remnants of yesterday and the life of today provides a vivid illustration of what tradition always means: not just the careful preservation of monuments, but the constant interaction between our aims in the present and the past to which we still belong (Gadamer, 1986, p. 49).

The past only becomes apparent in the present when there is an interaction between the past that we carry and the aims in the present. Although the aims we have in the present also depend on the situation in which we are thrown and on the demands that the situation places upon us, the aims that we intend to fulfill *in particular situations* call forth the past and direct it towards one's aims in the present.

For instance, responding to Alistair's inability to choose where he wants to live and his wanting to go out, Clara goes on excursions with him. Responding to how easily those around

Alistair can see him only as “a big, incontinent mess” and not as a human being, not least a father, Clara stands up for him as she had done on the streets when they had first met.

Through their practices, the family members are carrying the past to meet the demands of the present and of the concrete, particular situations in which they find themselves. At first glance, the recurrence of family members’ practices in different contexts and across time gives an appearance that they are unchanging. However, it is not that family members are stuck in their actions or in the past, but that they are calling forth the past in responding to situations that recur. They are facing potential loss again and again. It is not that, for example, Brienne furnishes according to something like a schedule by bringing glasses one month, then a next month helping Adam to get his driver’s license, and a following month a bus pass, but that the condition in which she and her son find themselves demands of them to make a world within which Adam can stay. Although family members find themselves in a similar situation again and again – Paige is once more receiving news of Xavier’s escape from the hospital, Clara is once more visiting Alistair in an institution that limits his movement, Brienne is once more seeing Adam stopping to eat – their experience is not a series of sameness, because they are called upon again and again to use what they have done and experienced in the past to reach their aims against the demands of a similar, yet different concrete situation in the present.

That the family members are called upon again and again to meet the particularities of a situation gives force and clarity to their aims across time and contexts. Paige tells me that she wants Xavier to be safe. Clara wants Alistair to be seen as human and to have in him a father. Brienne wants Adam to have something to do that will give him a sense of self-worth. The uncertainty they face resides not in their aims but in the unpredictable particularities of their situations, of Alistair’s being moved to different institutions, Xavier’s discharges and readmissions, and Adam feeling that he has lost his heart and his salvation. In contrast to the varying circumstances in which they find themselves, the family members’ aims are strong.

Resounding through different times and contexts, the aims of the family members have a constancy as they are asked by the situation at hand to furnish again, to go on another excursion, and to do more standing by not because they have run out of options, but because these practices keep alive the world between them. A recurring creativity is present as family members must figure out how to furnish, stand by, and go on excursions in changing circumstances to achieve their aim of keeping their family members present in their worlds. A world looks differently when action is placed at its centre.

Holding a World Between Them

If human beings belong through tradition to a world that is past, how can they also belong to a world in the present that is of their own making? The significance and force of family members' practices suggest that what holds family members and patients together, in a world of their own shaping, are the actions in which they engage with one another in different situations and across time. The anthropologist Michael Jackson, in his work with the Warlpiri people of New Zealand and the Kuranko people of Sierra Leone, wrote of the need for human beings to feel that they have some say in what happens to them and some effect upon their worlds (Jackson, 2005). When Heidegger places Being at the centre of its world, the presence of other Beings appears hazy. If a practice, such as going on excursions, standing by, and furnishing is at the centre of a world, other Beings seem clearer and closer to one's view. There is a whole world of others both present and imagined around a blue china plate filled with homegrown squash.

Action between Beings holds them in a world partly of their own making. The staff members, for example, are also standing by with respect to Xavier; are allowing Alistair to go out on excursions; are helping to furnish Adam's world with the clinical resources that they have: visits from a community mental health organization, medications, and passes for him to go back to his apartment and to visit his parents' home. As an ethnographer, I became implicated, implicitly and with remarkable ease, in these already existing practices, by going along with Alistair; by sharing music and foods with Adam; by standing by with Xavier as he sang, drew, and described scenes from his childhood. A shift from Being to action at the centre of a world transforms what becomes visible and important in that world. Multiple human beings stand out more clearly if action is at the centre of a world rather than a single Being. Other horizons come into view. The family members' and patients' practices of being near hold them in a world together, a Being-with-Being in the world. The family members show that it is through taking actions with others that one belongs to a world.

Practices of being near are everywhere. It is not only the family members who carry out this action; other Beings around them do so as well. Along with staff members, I have participated in their worlds for a time. Their worlds have come to matter to me. Through being near to the patients, I have come to see them differently. I see the possibilities in their world and my projected meanings of them have fallen away. As the family members fear the death, disappearance, or erasure of the patient, I fear the loss of these practices that hold a world between Xavier and Paige, Alistair and Clara, and Adam and Brienne against a horizon of potential suicide and social death. Actions of being near, having resounded through the past into the present, carry a sense of continuing to sound into the future. When Alistair returns from an excursion, the place to which he returns feels more like a home from which he can depart on another excursion at a future time. He does so even in a space as confined as that of Closed Unit A. Having heard Xavier sing and watched him draw a house upon the postcard, I cannot help but wonder what else he may yet build. Having seen the blue china plate that Adam has made, I am called to imagine what other meals he will cook and what other plants he will grow in his garden. Even as they face a horizon of loss and finitude, another horizon is coming into view. It is one of their worlds widening.

In this research study, the family members I met often found themselves in a state of not knowing and not understanding. Clara did not see as Alistair does why the Alfars should bother him so greatly. Brienne says she did not understand the voices that Adam hears. Paige did not know what Xavier intends to do. They face a horizon of social death or potential suicide that makes it urgent for them to act. As Gadamer's theory of historical being shows, not knowing does not preclude one from taking action when one can direct the past towards one's aims in a present situation. Under these conditions of uncertainty and potential loss, family members' actions pushed back against the horizon of loss and of being left behind, horizons that threatened their very worlds. Through their practices, they create and sustain a nearness to patients. By *acting alongside* patients, the family members stayed open to other horizons in the patients' worlds to see possibilities. These other horizons, gained through everyday action, in turn became the grounds for their taking further actions directed at their aims of keeping the patient in the world. The centrality of taking action with others, as demonstrated by the family members in this study, has important implications not only for the theoretical conceptualization of a world, which I have introduced above, but also for clinical practice, which I will discuss below.

Acting Alongside One Another in Clinical Contexts

The daily work of practitioners (or policy-makers, healthcare service users, or family members) brings them into contact with uncertainty and otherness. Invoking Gadamer, the health philosopher and educator Les Todres (2008) emphasizes the importance for practitioners to cultivate a relational kind of understanding with otherness, by being with that which lies beyond ourselves and our present understanding. He argues that healthcare practice cannot become wholly procedural and technocratic, which is appropriate for systems comprising of only physical objects, but must also make room for relational and judgment-based practices, for healthcare practice is also intersubjective and deals with "unique persons, contexts, and practices that are always transcending rules and categories" (p. 1568). Echoing Aristotle's distinction between episteme, techne, and phronesis, three forms of knowledge commonly referred to, respectively, as abstract or theoretical knowledge, the knowledge of application or craft, and practical wisdom, Todres highlights the importance of not neglecting to develop the third category in an era of health care where biomedical and technical-procedural knowledge hold power.

At the end of his chapter upon a theory of hermeneutic experience, Gadamer (2004) writes: "To reach an understanding in a dialogue is not merely a matter of putting oneself forward and successfully asserting one's own point of view, but being transformed into a communion in which we do not remain what we were" (p. 387). To understand something means that it has a hold upon us and changes us. For this reason, Gadamer writes that we must remain open to what something has to say to us if understanding is to be possible. Adding to Todres' assertions, then, along with a motivation to enter into relationship with otherness, we also need to have a way of being – a comportment – that allows us to remain open and to be changed.

In this research study, it was not merely through comportment that they remained open to being changed, it was by *acting alongside* patients, that the family members stayed open to other horizons in the patients' worlds. Through taking action with family members and patients, I became alongside them. It has been an engagement in practices that matter to family members and patients, rather than only cultivating something more like an attitude or mindset of openness, that I started to see different possibilities and horizons. My experiences with patients and family members show that it is by becoming alongside through taking action with others that we can be open to understanding and to being changed. In this *acting alongside* family members and patients, what has emerged as important is not the complexity or exceptionality of the act; indeed, the actions of going on excursions, standing by, and furnishing are ordinary. What makes the actions matter is that they are significant to patients and family members and connect in some way to their already-existing aims.

Although they may not have realized the force of their own engagement, the staff members in this study also took part in the family members' and patients' going on excursions, standing by, and furnishing. They understood and ultimately permitted Alistair to go out, and made it possible for him to receive physiotherapy to strengthen his walking ability. Like Brienne, Xavier's treatment team also was standing by when he had signed himself against medical advice, expecting him to return at which point they could continue pursuing treatment. Adam's psychiatrist noted his desire to water his plants and to go to the gym as signs of positive change, and his nurse unlocked the conference room for us so that we may play the piano which has been moved there. It was by engaging in ordinary actions that matter to patients and family members, and allowing themselves to do so, that these practitioners cultivated a responsiveness to the worlds and horizons of Alistair, Xavier and Adam.

Throughout my fieldwork, the family members were telling me that the things they do over time and in different contexts are important, so important that practices are the centre of a world. There is a whole world around furnishing and the blue china plate, and a whole world around excursions and the act of standing by. These practices show themselves as being very important because they are oft-used. They are called upon again and again. The ease with which I found myself a participant in these practices is remarkable. With the practices of going on excursions, standing by, and furnishing at the centre of their worlds, I saw that staff members and other patients have been going on excursions, standing by, and furnishing alongside Alistair, Xavier, Adam and their family members. As someone who entered their worlds for a time and came to be alongside them, I cared a lot if the worlds between Xavier and Paige, Alistair and Clara, and Adam and Brienne disappeared. As an ethnographer, I became worried when Paige and Brienne said that they are very tired or when Clara said that visiting Alistair at the hospital was so stressful that she is not sure she can do so any longer. The family members were pointing to a finitude of their practices and how – if going on excursions, standing by, and furnishing were to end – Alistair, Xavier, and Adam might die.

As the family members and treatment staff worried about the loss of the patients, I worried about the loss of their practices. Without them and the worlds and people that they hold, the horizons of unpredictable, uncertain loss become nearer. Without family members' practices of being near, we would lose a view of the possibilities in patients' worlds and become closed off from other horizons in their worlds. We would lose a way of seeing them differently apart from the projected meanings from their past and from what others say about them. To be alongside others, and even more essentially to *act* alongside others, is to maintain a stance of openness towards them. By engaging in practices of being near, we gain a way of participating with others in actions that point to horizons other than loss. We gain a way of being part of something greater that runs across contexts and time. For mental health practice, in which there is uncertainty about what will happen and what may or may not change, being near is a way of cultivating possibilities.

With this understanding, projecting myself into the future as a future clinician, I ask: What can I as a clinician do to help the furnishing continue? Am I being called upon to be a co-furnisher? Could the task of furnishing be made easier for a family member so that they could carry it out for a longer time? For Paige who is determined in her standing by, yet uncertain that she would have the energy to continue, would she wish for someone to stand by with her or in place of her, so that she may have some respite? I would be worried if certain policies may inadvertently destroy these practices, which hold family members and patients in a world where loss is not the sole horizon. In clinical mental health practice, we are worried about the finitude of human beings but, coming under the horizons of the family members, I am worried also about the finitude of action. Certain practices hold family members and patients in a world of other possibilities and horizons. They are important to preserve.

Chapter 8 Conclusion

When I have listened to the stories of family members, I imagined myself traveling amongst sounds distantly heard. The family members' stories were distantly heard not in the sense that they were faint, but that they had been carried across great physical distances and over time, the meaning of each successive event filtering through the others. Each time I have telephoned or visited with a family member, I see the effort of their being present amongst circumstances and language that work to keep them at a remove from patients undergoing psychiatric hospitalization. These have been said of patients by staff, family members, and patients themselves:

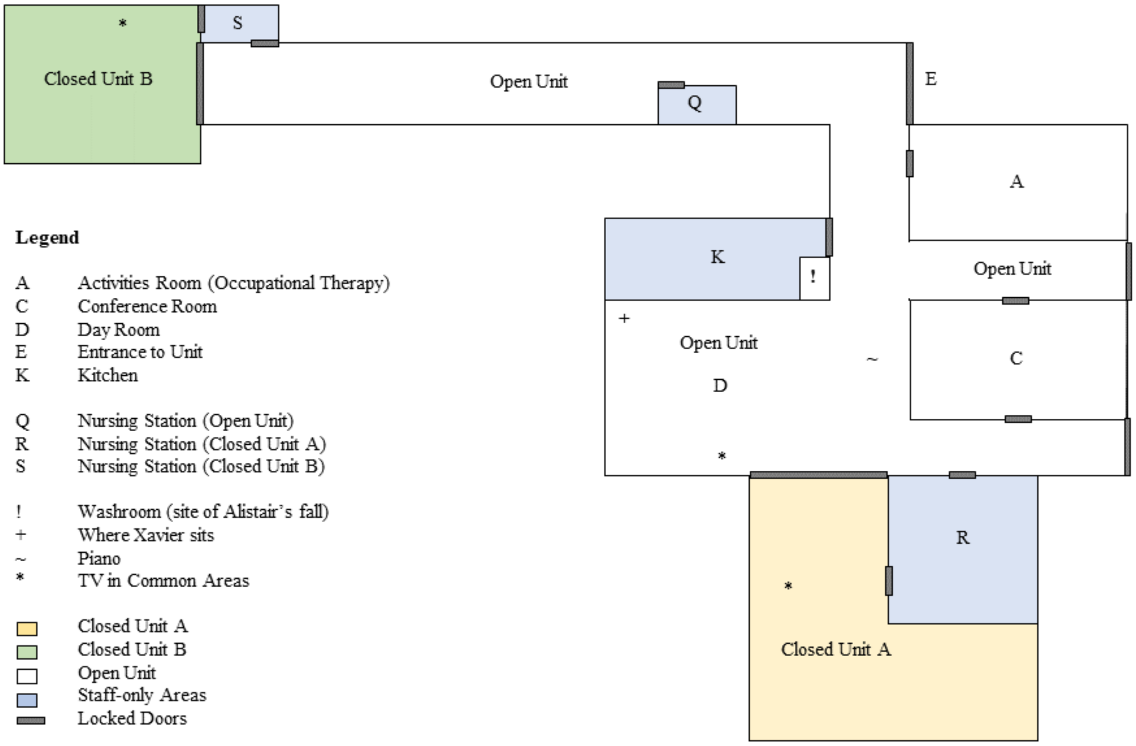
> "He is helpless."
> "He's so passive."
> "He is dependent."
> "Nothing reportable."
> "Each time he gets worse."
> "It is not possible for me to change."
> "He doesn't do anything. He just sits there."
> "He's still here. He's still accepting treatment. He hasn't given up on himself."

One evening when I had called Paige, after putting down the phone, I was struck by the realization that family members are quite alone in their experience and that their particular aloneness may not be widely recognized. Patients are surrounded by a healthcare team and the treatment staff can turn to one another. The family members in this study, however, rarely mentioned other persons in their interviews nor did any others appear during my participant observations on the unit. They did not seem to have anyone beside them in their experiences.

Qualitative health research on family members' perspectives show that they wanted to be more included by healthcare teams in supporting the patient and to have their knowledge contribute to the treatment plan. This was echoed by the family members in this study who also said that they wanted the treatment team to ask them what they know and to be more included in the treatment plan. This was echoed by Clare, Paige, Brienne and, indirectly, by their brother-in-laws, husbands and even neighbors. Yet, the methodology and phenomenological framework also revealed that to family members the meaning of being included or sharing information extended beyond the act itself to figuring out what could be a good course of action as guided by a lived past creatively reconfigured to meet the demands of the present.

To family members in this study the present clinical situation is one more time, amongst a backdrop of previous times. I want to recognize that what family members have to contribute is not only their knowledge of the patient's past and what may or may not work, but also the practices they have been called upon to create and do again and again. These practices consist of ordinary actions of creating and going on excursions, standing by, and furnishing. These were only a few practices to keep their family members present among potential others yet to be discovered. When family members and staff engaged in these practices of being near, they came alongside each other instead of leading ahead or taking the place of another. When there is being *and* acting alongside one another, people do not feel alone nor left behind. By engaging in these ordinary actions with family members and patients, and by allowing themselves to do so, healthcare practitioners can experience a sense of possibility. They can enact treatment plans that are closely connected to what matters deeply to the people and families whom they aim to help. They can also ultimately help themselves to stay present amidst the tensions and uncertainties of their work.

Appendix A Layout of Inpatient Psychiatry Unit



Appendix B Staff Members of the Department of Psychiatry, Hillside General Hospital

Christina (nurse, Closed Unit A)
Danika (social worker, inpatient and outpatient services)
Diana (occupational therapist, inpatient services)
Donny (nurse, inpatient services)
Dr. Avery (psychiatrist-in-chief)
Dr. Bouna (chief psychiatrist of inpatient services)
Dr. Tom Bradbury (psychiatrist, outpatient services)
Dr. Carlin (psychiatrist working with geriatric inpatients)
Dr. Barbara Goldman (psychologist, inpatient services)
Dr. Grace (psychiatry resident)
Dr. Kent (psychiatrist, outpatient services)
Dr. Nadeau (psychiatrist, inpatient services)
Dr. Nelson (psychiatrist, inpatient and outpatient services)
Dr. Salam (psychiatry resident)
Dr. Stills (psychiatrist, inpatient services)
Dr. Tamlinson (psychiatrist, outpatient services)
Erica (social worker, inpatient services)
Florence (social worker working with geriatric patients)
Jason (orderly, inpatient services)
Jean (nurse, inpatient services)
Jonah (pharmacist, inpatient services)
Jordan (orderly, inpatient services)
Michael (orderly, Closed Unit A)
Morris (music therapist)
Myra (occupational therapist, inpatient services)
Patricia (nurse, Closed Unit B)
Sabrina (psychologist-in-training)
Samantha (nurse, Open Unit)
Sandra (orderly, Open Unit)
Stéphane (psychologist-in-training)

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