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Mental Health Diversity and Integrative Recovery: A Lived-Experience Case Study of Voluntary, Trauma-Informed, And Culturally Responsive Care

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Abstract

This study examines mental health diversity through an in-depth qualitative lived-experience case study that explores the intersections of trauma, neurodivergence, chronic physical illness, gender, ethnicity, and societal perception within recovery processes. Grounded in trauma-informed and recovery-oriented paradigms, the research employs a narrative inquiry methodology informed by Elisabeth Kübler-Ross's Grief Model and a customised SMART-SWOT reflective framework developed in Restored (Kapuscinska, 2024). Data sources include longitudinal reflective narrative, contextual clinical observation, arts-based material from the award-winning documentary Bipolar: What They Don't Tell You, and culturally responsive psychosocial support practices.

All mental health interventions and hospital admissions described in this study were voluntary and undertaken through informed, person-centred decision-making. Findings indicate that sustained psychological stability and reduced crisis frequency were most effectively supported through an integrative mental health approach combining selective Western pharmacological care, prescribed medicinal cannabis, meaningful daily occupation, creative practice, and cultural–spiritual support within a trusted multidisciplinary network.

The study contributes to interdisciplinary mental health scholarship by challenging reductive diagnostic models and emphasizing the centrality of patient autonomy, environmental compatibility, cultural responsiveness, and integrative care in long-term recovery. By foregrounding lived experience as an epistemological resource, the research advances trauma-informed, voluntary, and person-centred approaches to mental health practice, policy, and knowledge production.

Keywords: *Mental health diversity; lived-experience research; trauma-informed care; voluntary treatment; integrative recovery; recovery-oriented practice; patient autonomy; cultural responsiveness; narrative inquiry; prescribed medicinal cannabis.*

1. Introduction

Mental health diversity encompasses a broad range of psychological, neurological, physical, social, and cultural experiences that shape how individuals perceive themselves, interact with others, and manage daily life. While contemporary mental health discourse increasingly acknowledges trauma-informed and person-centred approaches, dominant biomedical models often remain limited in their ability to account for the cumulative and intersecting effects of neurodivergence, chronic illness, ethnicity, gender, lived trauma, and environmental compatibility.

This limitation is particularly evident in the experiences of women from ethnically diverse backgrounds whose narratives frequently fall outside standardised diagnostic frameworks. Lived experience research has highlighted how misinterpretation, over-pathologisation, and insufficient cultural responsiveness can exacerbate distress rather than support recovery.

This study examines mental health within the context of an interracial family of four (three males and one female, aged 45, 35, 14, and 10) of British, Polish, Caribbean, and African heritage. The research focuses predominantly on the mother, diagnosed with bipolar disorder, functional neurological disorder (FND), autism, ADHD, dyslexia, fibromyalgia, temporomandibular joint dysfunction, tarsal coalition, and post-traumatic stress disorder (PTSD). Two children were also diagnosed with autism, one later in childhood, highlighting intergenerational and developmental dimensions of neurodivergence.

The subject's initial psychiatric diagnosis followed her second pregnancy and natural delivery. Subsequent pharmacological intervention for suspected post-natal depression preceded an episode of medication-associated psychosis, leading to voluntary hospital admission. This experience became a catalyst for critical reflection on diagnosis, medication effects, autonomy, and the role of environment in mental health.

Over time, the subject actively pursued voluntary, integrative, and culturally responsive strategies to prevent crisis escalation and further hospitalisation. These experiences informed the development of the Restored framework, which integrates reflective practice, environmental awareness, and personalised self-management.

The objectives of this study are to:

1. Explore how mental health diversity emerges through intersecting diagnoses, trauma, and identity.
2. Examine the impact of societal perception and stigma on self-identity and recovery.
3. Evaluate voluntary, integrative mental health approaches in sustaining long-term stability.
4. Contribute to trauma-informed, recovery-oriented mental health practice and policy.

Literature Review

Mental health care has shifted over recent decades from a predominantly clinical and pathology-oriented model toward a more holistic, integrative approach that recognizes the importance of diversity, lived experience, cultural context, and trauma-informed care in recovery processes. This shift responds to extensive criticism of traditional models that inadequately address the complexity of individual experience, particularly among historically marginalized populations (Browne et al., 2016; Herman, 1997). Integrative recovery models emphasize collaboration, respect for clients' cultural identities, and empowerment through voluntary participation in care decisions (Topor, Borg, Di Girolamo, & Davidson, 2011). The current literature situates voluntary, trauma-informed, and culturally responsive care as pivotal components in effective mental health practice and highlights how lived experience enriches understanding of recovery dynamics.

Mental Health Diversity and Recovery Frameworks

The concept of *mental health diversity* encompasses recognition of varied pathways to recovery shaped by cultural, social, economic, and personal identities (Sue et al., 2012). Historically, mental health services were developed within Western frameworks that prioritized biomedical explanations and standardized treatment protocols (Kleinman, 1988). However, scholars argue that such approaches often marginalize individuals from non-Western, Indigenous, and minoritized backgrounds whose worldviews and coping mechanisms diverge from dominant paradigms (Gone, 2013). Research by Williams and Mohammed (2009) underscores the role of systemic inequality and cultural disconnection in exacerbating mental health disparities, suggesting that culturally grounded interventions can enhance engagement and outcomes.

Recovery models informed by lived experience such as the *Personal Recovery* paradigm shift from symptom reduction to meaningful life participation, self-determination, and resilience (Anthony, 1993; Leamy et al., 2011). These models challenge clinician-led definitions of success by privileging the narratives of individuals with lived experience of mental health challenges. The recovery philosophy aligns with voluntary care by advocating for autonomy and consumer choice in designing treatment plans (Ridgway, 2001). Evidence indicates that when service users are empowered as active partners in care, they report higher satisfaction, improved self-esteem, and better long-term outcomes (Slade et al., 2014).

Trauma-Informed Care and Its Relevance

Trauma is highly prevalent among individuals with mental health conditions, and traditional treatment environments may inadvertently retraumatize service users when trauma histories are not acknowledged (Sweeney, Clement, Filson, & Kennedy, 2016). Trauma-informed care (TIC) responds to this challenge by integrating knowledge of trauma into every facet of service delivery (Fallot & Harris, 2009). Key principles of TIC include safety, trustworthiness, choice, collaboration, and empowerment (SAMHSA, 2014). These are congruent with voluntary care models that respect clients' pace and readiness to engage in therapeutic processes.

Studies demonstrate that trauma-informed approaches improve engagement and reduce retraumatization in diverse settings for example, in inpatient psychiatric units,

community mental health programs, and substance use recovery services (Isobel & Edwards, 2015). By acknowledging the pervasive impact of trauma, TIC advocates for organizational transformation, not merely clinician training, to prevent re-exposure to stressors and to support holistic healing (Menschner & Maul, 2016). Thus, trauma-informed practice is increasingly recognized as foundational to ethical and effective mental health care.

Culturally Responsive Care: Beyond Cultural Competence

Culturally responsive care extends beyond basic cultural competence to involve deep engagement with clients' cultural values, communication styles, and worldview systems (Sue, 2006). Cultural competence, the ability to understand and appropriately respond to cultural differences has been critiqued for its tendency to treat culture as static and monolithic (Kirmayer, 2012). In contrast, cultural responsiveness emphasizes dynamic, contextually grounded interactions that honor the cultural identities of clients and integrate traditional healing practices where appropriate (Gone & Kirmayer, 2020).

Literature highlights the effectiveness of culturally adapted interventions in improving access and outcomes among racially and ethnically diverse groups (Bernal, Jiménez-Chafey, & Domenech Rodríguez, 2009). For instance, community mental health programs that incorporate storytelling, spiritual practices, and family involvement demonstrate enhanced engagement relative to conventional treatments (Gone, 2009). Culturally responsive care recognizes that culture shapes expressions of distress and recovery meaningfully; thus, recovery cannot be fully realized without attention to cultural context (Tseng, 2004).

Lived Experience in Integrative Recovery

Lived-experience perspectives offer vital insights into the recovery process, underscoring the significance of agency, narrative identity, and peer support (Mead & MacNeil, 2006). Peer-led services and involvement of consumers in program design have become hallmarks of recovery-oriented systems (Davidson, Chinman, Sells, & Rowe, 2006). Narratives of individuals who have navigated mental health challenges reveal common themes: the need for trusting therapeutic relationships, flexible service models, and recognition of cultural and personal strengths (Repper & Carter, 2011).

A case study approach within lived experience research further demonstrates the interaction between personal meaning systems and formal care structures, showing how integrative care when voluntary and culturally attuned enhances self-efficacy and identity reconstruction (Topor et al., 2011). Such evidence positions lived experience not merely as an outcome measure but as an epistemological foundation for designing interventions and informing policy.

Synthesis and Gaps

The literature converges on the understanding that effective mental health care must integrate diversity, trauma awareness, and cultural responsiveness within voluntary frameworks that honor lived experience. However, notable gaps persist. Many systems remain anchored in clinician-driven models that emphasize pathology over personhood. There is also limited integration of Indigenous and non-Western healing traditions in mainstream services, often due to institutional barriers and epistemic biases (Kirmayer et al., 2011). Moreover, evaluation research on integrative recovery models is still emerging, with a need for methodologically rigorous studies that assess long-term outcomes across diverse populations.

Contemporary mental health scholarship underscores a paradigm shift toward holistic, person-centered care that is voluntary, trauma-informed, and culturally responsive. These elements are essential for honoring mental health diversity and supporting authentic pathways to recovery as articulated by individuals with lived experience. An integrative approach does not reject clinical expertise but contextualizes it within frameworks that promote dignity, agency, and cultural resonance. Continued research, policy innovation, and service redesign are needed to fully realize recovery-oriented systems that are equitable, inclusive, and transformative.

2. Methodology

This research adopts a qualitative reflective case-study methodology grounded in lived experience research and narrative inquiry. The approach prioritises depth, reflexivity, and contextual understanding rather than generalisability.

Data were generated through longitudinal self-reflection, lived narrative documentation, contextual analysis of clinical and community experiences, and reflective integration of creative and arts-based material. Analytical frameworks include Kübler-Ross's Grief Model and a customised SMART-SWOT framework (Restored, Kapuscinska, 2024), supporting structured reflection on emotional adaptation, strengths, vulnerabilities, opportunities, risks, and environmental compatibility. The analytical process was further informed by a customised SMART-SWOT framework developed in Restored (Kapuscinska, 2024), which integrates reflective practice, lived experience research, and recovery-oriented self-management.

An award-winning short documentary, Bipolar: What They Don't Tell You, is included as an arts-based and

educational artefact to support public understanding and stigma analysis. It is not treated as empirical clinical evidence but as a reflective and narrative contribution.

3. Ethical Framework

This study adheres to UK ethical standards for qualitative and lived-experience research, including respect for autonomy, dignity, confidentiality, and informed consent.

All treatments, community engagements, cultural practices, and hospital admissions described were voluntary, initiated by the participant through informed decision-making as part of a proactive self-management and safety strategy. No compulsory or coercive interventions were used.

Informed consent was obtained and revisited throughout the research process. Identifying information relating to family members and children has been anonymised. No clinical records were accessed; all data derive from first-person narrative and reflective documentation.

Positionality and Reflexivity Statement

This research is situated within a lived-experience and scholar-practitioner paradigm, in which the author occupies the dual position of researcher and primary subject. This positionality is acknowledged transparently in line with best practice in qualitative, narrative, and trauma-informed research, where reflexivity is recognised as a methodological strength rather than a limitation.

As an author, researcher, and individual with lived experience of complex mental health diversity, neurodivergence, chronic physical illness, and trauma, Madame Kapuscinska brings experiential knowledge that informs both the framing and interpretation of the data. This insider perspective enabled nuanced understanding of embodied experience, identity negotiation, and recovery processes that may be inaccessible through detached observational methods alone.

Reflexive practice was employed throughout the research process to mitigate potential bias. This included structured reflection using the SMART-SWOT framework developed in Restored (Kapuscinska, 2024), critical engagement with existing literature, and deliberate separation between descriptive narrative and analytical interpretation. The study does not claim objectivity in the positivist sense; rather, it aligns with interpretivist and constructivist traditions that value situated knowledge and contextual truth.

The author's positionality also informed a strong ethical commitment to voluntary participation, patient autonomy, and non-coercive care, shaped by prior experiences within mental health systems. This informed the study's emphasis on trauma-informed care, recovery-oriented practice, and culturally responsive support frameworks. Acknowledging power dynamics between clinician, researcher, and participant was central to maintaining ethical integrity.

Importantly, while the author is also the creator of the Restored framework, this self-citation is presented transparently as a methodological contribution grounded in lived experience rather than as an attempt to universalise findings. The framework is offered as a reflective tool that may inform future inquiry, not as a prescriptive model.

By foregrounding reflexivity, this research seeks to contribute responsibly to mental health scholarship, demonstrating how experiential knowledge can coexist with academic rigour, ethical accountability, and interdisciplinary relevance.

4. Findings / Results

Theme 1: Voluntary Admission as Insight-Led Self-Care

Voluntary hospital admission functioned as a preventative and insight-led strategy rather than a loss of autonomy. Over time, improved self-regulation reduced reliance on inpatient care.

Theme 2: Integrative Mental Health and Medicinal Cannabis

Prescribed medicinal cannabis (flower and oil formulations), used voluntarily and under medical supervision, supported symptom regulation related to chronic pain, neurological distress, sleep, and trauma-related dysregulation. Clinical observations aligned with lived experience reports of improved tolerability compared to previous medications.

Theme 3: Cultural and Spiritual Support

Regular engagement with shamanic practitioners formed part of a culturally responsive psychosocial support system, contributing to emotional grounding, meaning-making, and resilience without replacing clinical care.

Theme 4: Meaningful Occupation and Creative Restoration

Re-engagement with singing, movement, tai chi, and creative authorship correlated with improved self-identity, emotional regulation, and agency, reinforcing the role of occupation in recovery-oriented practice.

Theme 5: Arts-Based Knowledge Translation

The documentary Bipolar: What They Don't Tell You supported stigma reduction, public education, and validation of lived experience beyond clinical settings.

This study contributes to contemporary discourse on mental health diversity by demonstrating how recovery and long-term stability can be sustained through voluntary, trauma-informed, and integrative mental health practices grounded in lived experience research. Rather than attributing improvement to a single intervention, the findings highlight the importance of patient autonomy, cultural responsiveness, and meaningful occupation within recovery-oriented practice.

5.1 Mental Health Diversity and the Limits of Diagnostic Reductionism

The findings reinforce existing critiques of diagnostic reductionism within mental health care. The participant's experiences illustrate how co-occurring mental health conditions, neurodivergence, chronic physical illness, and trauma interact dynamically rather than existing as discrete clinical entities. This aligns with research emphasising that rigid diagnostic categorisation may obscure lived realities and contribute to misinterpretation or inappropriate intervention (Pilgrim, 2015; Rose, 2018).

Lived experience research has increasingly argued for models that acknowledge mental health as relational, contextual, and environmentally mediated (Beresford, 2016). In this study, stability improved not through intensified diagnostic management but through approaches that recognised identity, creativity, cultural background, and environment as integral to wellbeing.

5.2 Voluntary Treatment, Autonomy, and Recovery-Oriented Practice

A central contribution of this research lies in its explicit focus on voluntary treatment, including voluntary hospital admission. All admissions were initiated by the participant as part of an insight-led safety strategy, reframing admission as a form of self-care rather than coercion or clinical failure. This finding strongly aligns with recovery-oriented practice, which positions autonomy, choice, and collaboration as foundational to sustainable mental health care (Slade, 2009).

Trauma-informed frameworks emphasise that perceived loss of control can exacerbate distress, particularly for individuals with histories of trauma or neurodivergence (Harris and Fallot, 2001). In contrast, voluntary engagement enhances trust, reduces re-traumatisation, and supports long-term engagement with services. The present findings suggest that autonomy itself functions as a stabilising mechanism, supporting emotional regulation and reducing crisis escalation.

5.3 Integrative Mental Health and Prescribed Medicinal Cannabis

Within the integrative mental health framework described, prescribed medicinal cannabis functioned as a supportive, supervised intervention rather than a stand-alone solution. Both lived experience accounts and clinical observations indicated improved tolerability and functional regulation compared to previous pharmacological treatments, particularly in relation to chronic pain, sleep disturbance, and trauma-related dysregulation.

Emerging literature suggests that medicinal cannabis may have a role in symptom modulation for selected individuals when prescribed within regulated frameworks and accompanied by clinical oversight (National Institute for Health and Care Excellence, 2019; Schlag et al., 2021). However, consistent with ethical qualitative research practice, this study does not claim causality or generalisability. Instead, it demonstrates how integrative mental health approaches may reduce harm and improve engagement when conventional treatments are poorly tolerated.

The emphasis on informed consent and voluntary use is critical. Ethical concerns surrounding cannabis-based interventions are mitigated when decision-making remains patient-led and embedded within multidisciplinary support structures.

5.4 Cultural Responsiveness and Shamanic Support

The inclusion of regular shamanic support highlights the importance of cultural responsiveness in mental health care. These practices were not positioned as clinical treatments but as culturally and spiritually meaningful psychosocial supports contributing to emotional regulation, resilience, and identity coherence.

Medical anthropology and cultural psychiatry literature recognises that non-Western healing practices can play a legitimate role in wellbeing, particularly where they enhance meaning-making and social connection (Kirmayer, 2012). Dismissing such practices may undermine engagement and exacerbate feelings of alienation. In this study, respectful integration of cultural-spiritual support strengthened trust and continuity of care without compromising clinical safety.

5.5 Meaningful Occupation, Creativity, and Identity Restoration

A significant discussion point concerns the role of meaningful occupation in recovery-oriented practice. Periods of deterioration coincided with withdrawal from creative expression, social engagement, and purposeful activity, while recovery was supported by re-engagement with singing, movement, tai chi, and creative authorship.

This finding aligns strongly with occupational therapy and recovery literature, which emphasises that wellbeing is sustained through participation in meaningful daily life rather than symptom suppression alone (Wilcock, 2006). Creativity functioned as both emotional regulation and identity restoration, countering the erosion of self commonly reported in individuals experiencing long-term mental health challenges.

The development of the Restored framework from lived experience further demonstrates how experiential knowledge can generate transferable insights for recovery-oriented mental health practice.

5.6 Arts-Based Evidence and Knowledge Translation

The award-winning documentary Bipolar: What They Don't Tell You functioned as an arts-based narrative artefact supporting stigma reduction and public understanding. While not treated as empirical clinical evidence, its inclusion reflects growing recognition of arts-based research as a valid method of communicating complex mental health experiences beyond academic and clinical settings (Leavy, 2015). Such approaches are particularly valuable where conventional outcome measures fail to capture identity, social perception, and lived complexity.

5.7 Implications for Practice, Policy, and Research

The discussion suggests several implications:

- Mental health services should expand voluntary, autonomy-supportive pathways.
- Integrative mental health approaches should be evaluated ethically rather than dismissed a priori.
- Cultural and spiritual supports can be safely incorporated within multidisciplinary frameworks.
- Recovery-oriented practice must prioritise environment, occupation, and identity alongside diagnosis.

Future research could build on this work through participatory, multi-case, or interdisciplinary designs, incorporating clinician perspectives and policy analysis.

The Potted Plant Method as a Neuro-Emotional Regulation Model

A Lived-Experience Contribution to Integrative Mental Health Scholarship

Mental health discourse has historically blurred the distinction between emotional turbulence and psychiatric pathology, often resulting in over-pathologization of normal human responses to trauma, stress, and unmet developmental needs. While Duchess Dr. Letitia Kapuscinska's doctoral research rigorously establishes the importance of trauma-informed, voluntary, and integrative mental health care, my contribution provides the experiential and pedagogical translation layer that allows individuals to understand, self-regulate, and meaningfully participate in their own recovery.

The Potted Plant Method is a trauma-informed, neuro-emotional mapping framework that translates complex nervous-systems and attachment dynamics into an accessible, visual, and developmentally coherent model. It explains why human beings cycle through depression, inspiration, frustration, and resilience, not as pathology but as adaptive nervous-system states responding to environmental and relational conditions.

Emotional Turbulence vs. Mental Illness

All human beings experience:

- emotional fluctuation
- intrusive or repetitive thought patterns
- stress-induced dysregulation
- periods of depletion and renewal

These experiences constitute emotional turbulence and mental discourse, not mental illness. As Duchess Dr. Letitia's research demonstrates, true psychiatric conditions such as bipolar disorder, psychosis, or neurological dysregulation require medical support and sometimes pharmacological stabilization. However, what many people present with in community and clinical settings is unprocessed trauma, attachment injury, and nervous-system overload, not disease.

The Potted Plant Method clarifies this distinction by showing how:

- emotional expression (leaves)
- behavioral patterns (growth)
- internal beliefs (soil)
- nervous-system wiring (roots)
- and environment (pot)
- interact to produce what clinicians often label "symptoms."

A Neuro-Developmental and Trauma-Informed Framework

The infographic you have reviewed maps the four primary nervous-system states into seasonal cycles:

- Winter – Depression (freeze)
- Summer – Frustration (fight)
- Spring – Inspiration (regulated expansion)
- Autumn – Resilience (integrated stability)

These states align with contemporary trauma neuroscience, polyvagal theory, and attachment research. They also correspond with Duchess Dr. Letitia's lived-experience data showing how stability increases when individuals are supported to regulate their nervous systems rather than merely suppress symptoms.

My model allows women to **see**:

- where their emotional reactions originate
- how trauma is stored in the body
- how beliefs distort perception
- and how support and regulation restore capacity

This visualization transforms abstract clinical concepts into practical self-awareness, which is essential for voluntary, recovery-oriented care.

Where My Work Integrates with Duchess Dr. Letitia's Doctoral Research

Duchess Dr. Letitia's doctoral framework demonstrates that sustainable mental health emerges through:

- voluntary engagement
- integrative care
- cultural responsiveness
- patient autonomy
- and meaningful daily structure

The Potted Plant Method provides a mechanism by which individuals can engage those supports effectively. It bridges:

- medical stabilization
- emotional processing
- cognitive regulation
- trauma recovery
- and identity restoration

without reducing the person to a diagnosis.

In clinical language:
My framework operates as a psycho-educational, somatic, and attachment-informed regulation system that enables individuals to maintain stability between medical and therapeutic interventions.

Why This Matters for Higher Learning and Mental Health Practice

Large segments of the population have never been taught:

- emotional literacy
- nervous-system regulation
- trauma processing
- or internal safety

Instead, they have learned survival strategies that later present as anxiety, depression, emotional volatility, or dissociation. The Potted Plant Method makes these invisible processes visible and teachable, allowing individuals to participate in the kind of autonomy-centered, integrative care that Duchess Dr. Letitia's research validates.

We are not witnessing a global epidemic of broken minds.

We are witnessing a global absence of emotional and nervous-system education.

By combining Duchess Dr. Letitia's clinical and interdisciplinary scholarship with my lived-experience-driven neuro-emotional mapping, we offer a complete mental health ecosystem one that honors both medical necessity and human developmental truth.

APPENDIX A

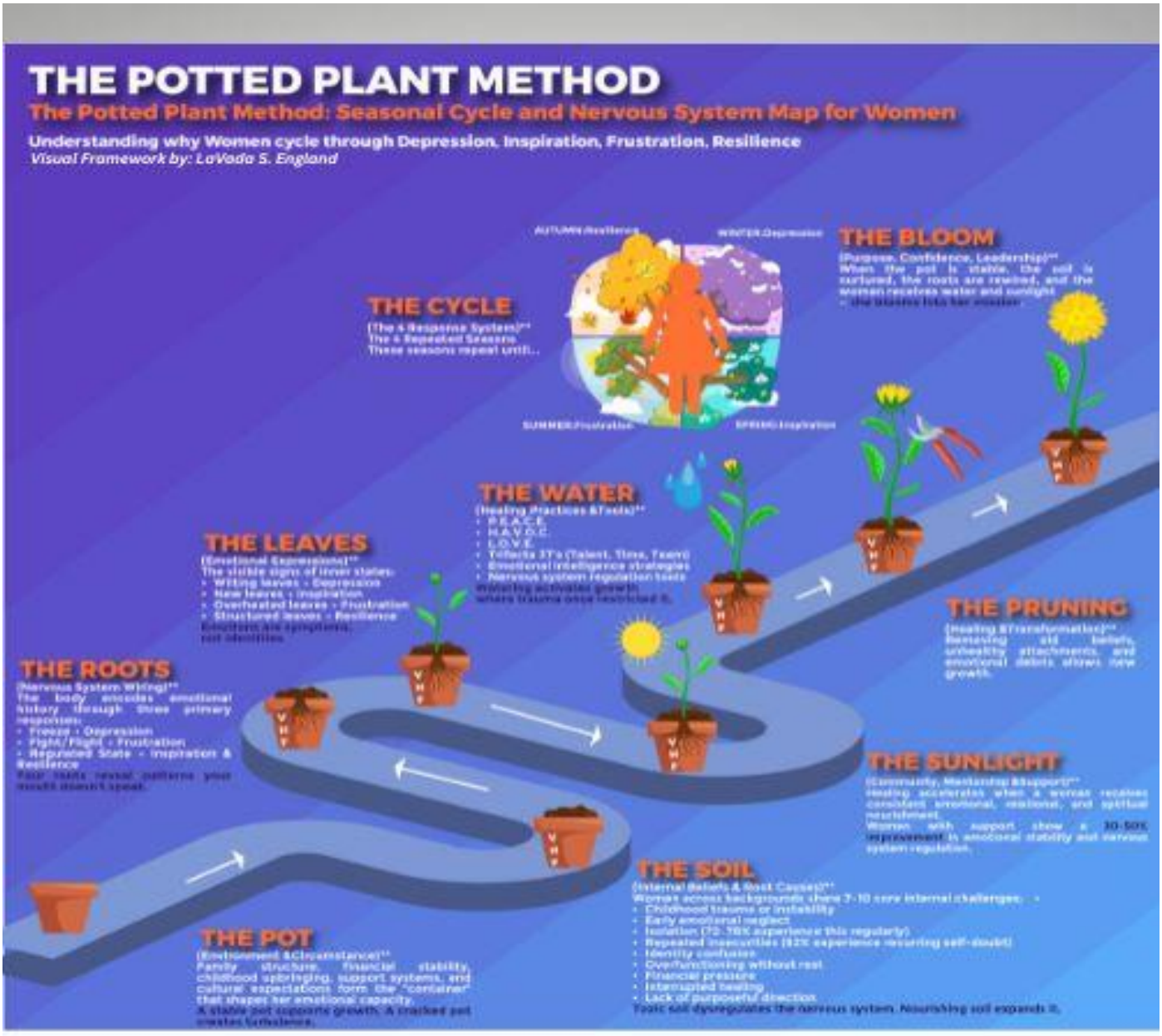
The Potted Plant Method as a Neuro-Emotional Regulation and Recovery Framework
Author: LaVada S. England

A1. Purpose of Inclusion

This appendix presents the Potted Plant Method as a lived-experience-derived psycho-educational and neuro-emotional regulation framework designed to complement the trauma-informed, voluntary, and integrative mental health model articulated by Dr. Duchess Letitia Kapuscinska.

Where Duchess Dr. Letitia's doctoral research establishes the clinical, ethical, and interdisciplinary foundations of recovery-oriented mental health care, this appendix provides a practical and embodied translation of those principles into a form that individuals can understand, internalize, and apply in daily life.

The model addresses a critical gap in contemporary mental health systems: the lack of accessible frameworks for understanding emotional turbulence, nervous-system dysregulation, and trauma-conditioned behavioral patterns.



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