Towards a Theory of Perspective Enhancement for Mental Health

Towards a Theory of Perspective Enhancement for Mental Health

By

Carolyn Joy Perry

BA Qld., BSocWk Qld., MSocWk Qld.

School of Human Services, Faculty of Health

Griffith University

Submitted in fulfilment of

the requirements of the degree of

Doctor of Philosophy

January 2008

ABSTRACT

This study develops a comprehensive framework for understanding mental health and well-being outside of the traditional medical paradigm influencing mental health service delivery. A literature review was undertaken using the concept of 'therapeutic landscapes' (Gesler, 1992) to explore tangible and existential factors that have contributed to enhanced mental health and well-being.

A Grounded Theory methodology was used to explore the factors contributing to mental health and well-being as perceived by recipients in the field of mental health (including mental health consumers and carers) as well as stakeholders in the fields of hospitality and natural therapies. Sixty interviews were undertaken across the three theoretical samples: mental health, hospitality and natural therapies. A range of secondary data was gathered, including informal observation notes, photographs, mind maps, focus group summaries, and participant feedback forms.

While the main concern was how mental health consumers and carers became disillusioned as a result of relationships, environments and intervention strategies, the development of a practice framework encapsulated the conditions and contingent factors upon which individuals within the substantive and comparative samples had their perspectives enhanced. Findings revealed that perspective enhancement occurred through relationships that *welcomed* and *connected* individuals, through the principles of *holistic engagement*, the practice behaviours of *authentic tailored engagement* and through relationships that facilitated *time worthiness* and feelings of *safety* and *intrinsic worth*. Conditions that facilitated perspective enhancement included intervention strategies that were

individualised and *replenishing,* and environments that generated a *sense of escape,* a level of *connection and captivation*, *welcome,* and *activity/space compatibility*.

These findings were integrated to commence the development of an interpretive framework for practice called *The Theory of Perspective Enhancement*. This theory may be used by social workers, other mental health workers or staff in any industry interested in enhancing the mental health and well-being of its stakeholders. From a mental health social work perspective, challenges are identified in implementing this theory in practice, given that this thesis extends current thinking around mental health and recovery outside of the medical paradigm. It generates a discourse that couches mental health and wellbeing firmly as core concerns for all human beings, with the capacity for the theory to be transferred into a range of contexts and discipline areas.

ORIGINALITY OF THESIS

I hereby certify that this work has not previously been submitted for a degree or diploma in any university. To the best of my knowledge and belief, the thesis contains no material previously published or written by another person except where due reference is made in the thesis itself.

Carolyn Perry

January 2008

ACKNOWLEDGEMENTS

I wish to dedicate this thesis to the organisation that gave me the inspiration to write it – Association of Relatives and Friends of the Mentally Ill (ARAFMI Qld). Sincere thanks go to all who shared their experiences around the topic of mental health and well-being, especially ARAFMI consumers and carers who shared with me deep-felt moments of sadness and joy and whose lived experiences will stay with me forever. A special thank you to Marj Bloor and the Management Committee who showed me immense support during this five-year journey.

To my now departed friend and colleague, Gerry Hines, who passed away in 2004, thank you for your words of wisdom and for your compassionate nature that I felt was so grounding in the early days of this thesis, and upon which I often reflect.

Words will never be able to express my thanks to Associate Professor Dr Jayne Clapton who heard my initial visions for this thesis and who has believed in me throughout the journey. I would also like to express my gratitude to Dr Julie Clark who has motivated me to keep on task, and to Professor Nicholas Buys who maintained a supportive interest throughout my study. Much appreciation also to Professor Leslie Chenoweth and Dr Donna McAuliffe whose editorial advice assisted me refine this piece of work in its final stages.

To my parents and to my husband Roy, thank you for your patience, and your love and encouragement as I progressed through each stage of the thesis. Your support has been amazing. Thank you.

CONTENTS

LIST OF FIGURES

LIST OF TABLES

CHAPTER 1: PRESENTING A CHALLENGE FOR THE MENTAL HEALTH FIELD

1. INTRODUCING MENTAL HEALTH AND RECOVERY

In the context of mental health, Ralph (2000) makes the following poignant comments after a comprehensive review of the recovery literature:

> Recovery can be defined as a process of learning to approach each day's challenges, overcome our disabilities, learn skills, live independently and contribute to society. This process is supported by those who believe in us and give us hope.
>
> However, many consumers report that recovery is not an adequate word to describe the journey through and to overcome their mental illness, or the accompanying social consequences; nor does it describe the results or outcome of that journey. While many agree that, no one term is adequate, words such as healing, transformation and overcoming have been suggested. (Ralph, 2000, p. 27)

While there may be a range of terms that can be used to describe the process of regaining one's sense of mental health and well-being, the paradigm of recovery seems to have become the predominant discourse within the mental health policy context in Australia over the last ten to fifteen years. The term recovery was first used in the United States in the 1930s by recovering alcoholics who undertook a psycho-social spiritual 12-step peer support program (Pearson, 2004). Since that time, the concept of recovery has evolved through the consumer movements of the 1960s and 1970s, and the rise in societal consciousness of the need for civil rights to redress the power imbalance for marginalised and excluded individuals (Allott & Loganathan, 2002). Alongside the development of anti-discrimination legislation in Western society addressing the position of women and people of different races, service user movements were emerging, recognising the need for people with mental illness to have control over their own lives and eradicate stigma.

In the 1970s and 1980s, a consumer movement evolved in the United States through consumer-run organisations and peer support groups; people who had experienced mental health problems and treatment began writing about their experiences (Allott & Loganathan, 2002). Since the late 1980s, there has been an increasing richness in the literature of the lived experience of mental illness, evidenced by the work of such people as Patricia Deegan (1990; 1997a; 1997b; 2005a; 2005b), Mary Ellen Copland (1999), Arana Pearson (2004), Anna Schiff (2004) and many others. Alongside this movement, Anthony (1993) reports that the failures of the policy of de-institutionalisation made it clear that people need not only symptomatic relief, but also support for their vocational, educational and social needs and wants. Anthony argues that a recovery-orientated system deals with more than just service outcomes in terms of symptoms management, but considers more subjective outcomes, such as self-esteem, empowerment and self-determination (Anthony, 1993). It can be argued, however, that services often claim they have insufficient time to pay attention to these factors.

It would seem that, as mental health professionals have begun to appreciate the richness of consumer experiences, they have taken on board the concept of recovery. However, the difficulty, as Pearson (2004) argues, is that this concept has been understood in many different ways by professionals in mental health, including reduction in symptoms, social recovery through psycho-social connectedness and participation, cultural recovery through knowledge of one's cultural roots, and personal recovery. Pearson argues that person-managed recovery is not enough; recovery must be driven by the mental health sector and beyond. Anthony (1993) argues that mental health systems must design their structures so that recovery 'triggers' are present (p. 21). More recently Fleming, Foster and Taylor (2008) discuss working with wellness and recovery and emphasise the importance of health care

practitioners working in partnership with others to recognise the subjective experience of wellness. Bland (2008), however, articulates the challenges of engaging consumers as real partners: the lack of adequate resources, the need for organisational cultural change, the lack of respectful relationships between mental health service workers and consumers, and the need to give professionals the skills to engage more fully with consumer perspectives, stating that 'consumer perspectives are lost amid the competing demands of other powerful interest groups' (p. 251).

Thus, it is not enough for professionals within mental health services to be intrigued and captivated by the lived experiences of consumers if they merely treat the recovery experiences of individuals as part of the service standard of consumer participation within mental health services. While mental health and well-being depends on these individual experiences being recognized, what requires most critical attention are the ways that the services and supports provided for individuals facilitate their mental health and well-being.

Widely used definitions of mental health and recovery certainly point out that mental health, well-being and recovery should focus on individuals leading a meaningful life; however, these definitions tend to concentrate on describing the state of being of the individual, rather than on addressing society's responsibilities for enabling it to be manifest. According to the World Health Organisation:

> Mental health is not just the absence of mental disorder. It is defined as a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community. (World Health Organisation, 2007)

The definition of recovery that has been endorsed in Queensland (Queensland Health, 2005) also tends to emphasise the individual rather than contextual factors.

> Recovery is the journey toward a new and valued sense of identity, role and purpose outside the parameters of mental illness: and living well despite any limitations resulting from the illness, its treatment, and personal and environmental conditions (Queensland Health, 2005 p. 9).

1.1 The Research Question and its Significance

While these definitions are useful in thinking about mental health and well-being and set the scene for an enhanced quality of life for individuals, there are issues that must still be addressed because they have significant implications for practice in the mental health field. Is our vision for mental heath and well-being for people so embedded in a more powerful context and discourse that our capacity to facilitate it becomes clouded? What is happening at the heart of our system that makes change seem so complex? Given the difficulties described above, as a mental health practitioner, I wished to explore the following question: *How can mental health service delivery be shifted beyond the medical paradigm?*

The views of Shery Mead and Cheryl MacNeil (2004) (as cited in Walker, 2006) seem to highlight the problem of moving forward with recovery within the current mental health service delivery paradigm.

> Recovery in mental health has most often been defined as a process by which people labelled with mental illness regain a sense of hope and move towards a life of their own choosing (President's Freedom Commission Report, 2003). While this definition on the surface seems obvious, what remains hidden is the extent to which people have gotten stuck in a medical interpretation of their experiences. With this stuckness comes a world view in which one is constantly trying to deal with their perception of what's wrong with them instead of what's wrong with the situation. In other words, even if I have hope of moving into a better life, I have been taught to pay attention to my 'symptoms'. This interpretation of my experiences leaves me constantly on guard for what might happen to me should I start to get 'sick'. Even with recovery skills (learning to monitor my own symptoms), I find myself creating a life that is ultimately guided by something inherently wrong with me. With this understanding, I may continue to see myself as more fragile than most, and different than 'normal' people. I then continue to live in a community as an outsider, no matter what goals I achieve (p. 7).

The recovery literature emphasises the lived experiences of mental health consumers (Anthony, Cohen, Farkas & Gagne, 2002; Deegan, 2003; Glover, 2005). From a social work perspective, honouring these experiences would seem an influential way of minimising the powerful impact of medical vocabularies, and recognising the uniqueness of each individual. However, as Walker (2006) points out, recovery programs can still be bound by medical and psychological discourses which 'linguistically cast clients in roles in which they are in fundamental ways different from the rest of humanity' (Walker, 2006, p. 9). For example, it is argued that the definition of who is mentally ill and who is not still rests with clinicians, and the power to choose interventions to help consumers with their 'pathology' often rests with professionals.

Walker (2006) suggests that despite the more empowering structure of consumer roles in recovery models, power is still maintained by the clinician, whose language is often taken as a 'truth' rather than as a tool for client-focused, solution-focused exploration. He states:

> Though recovery-orientated programs are more client-centred, the double-bind communications of days of old are still alive and well. The content of our conversations with clients can be about their goals, their quality of life, accountability, community integration, high expectations, self-determination, independence, self-reliance etc; but the context of our communication is 'you have a pathology that makes you different from the rest of society and 'we have the expertise to help you overcome this pathology in order to live meaningfully like normal people do'. (Walker, 2006, p. 7)

Walker is arguing, that by seeing medical and psychological vocabularies as 'truths', we fail to see their destructive consequences, because we become locked in a 'hermeneutically sealed conceptual system' (Walker, 2006, p. 12) that blocks the real voices of the people we are seeking to help.

Because systems also pay attention to these 'truths', since they rely on the credentials of professionals to develop them, it can be argued that the systems rely on the same medical and psychological vocabularies in deciding who to help. This is articulated well in the qualitative study by McGrath and Jarrett (2004), who describe an individual's experience of seeking help.

> The expectation was that a serious diagnosis of type one rapid cycling mood disorder would provide access to help. This expectation was thwarted for the participant by the fact the private psychiatrists contacted were not taking new patients and in the public system she did not qualify for the criteria for the local mental health service as she was not a suicide risk (McGrath & Jarrett, 2004, p. 10).

Fortunately, when a compassionate psychiatrist gave help, the most important feature for the consumer was a 'sense of trust creating a safe space' (McGrath & Jarrett, 2004, p. 9). The significant human-to-human connection that took place also enabled the client to have sufficient control of her therapeutic regime to enter into a therapeutic relationship that allowed a level of risk taking and provided the capacity to move forward creatively. The values underpinning this study are also my own social work values: respect for the individual, empathy, self-determination and social justice (Australian Association of Social Workers, 2002). Unfortunately, however, social workers often work in a context within mental health where these values are not reflected by the dominant discourse. Even the discourse of psychiatric rehabilitation, while it is recognised as a tool to facilitate recovery (Anthony et al., 2002; Deegan, 1997b) has been critiqued as highly manualised, structured and rigidly scripted, breaking down tasks in a rhetorical fashion; Lilleleht (2005) argues that participants may be locked into a structured program of positivist thinking that may inhibit the underlying intentions of real autonomy, integration and independence, stating, in a critique of a psychiatric rehabilitation program:

> One is left wondering whether, given the scripted presentation of these instructions, participants might feel the need to follow and repeat them in a verbatim manner. At the very least, this degree of structure leaves little room for independent, spontaneous,

> creative thought or behaviour. And the question arises as to whether such thought or action, being unregulated and asystemic, might be considered a source of error or difficulty. (Lilleleht, 2005, p. 8)

Given these challenges, as a social work practitioner, I wished to explore if a contribution could be made to facilitating mental health and well-being by moving beyond the traditional realms of mental health service delivery. The following account outlines my personal inspiration for addressing this question.

1.2 My Inspiration for the Thesis

As a new graduate of social work in clinical mental health service delivery in the early 1990s, I started working in the public mental health system with a desire to contribute to mental health service delivery in a proactive and creative way. Unfortunately, however, the dominant discourse of 'illness' and 'pathology' did seem to create barriers in terms of working towards enhancing the mental health and well-being of consumers. While some colleagues expressed a lack of sense of hope, others appeared to hold a more entrenched view that nothing much would or could change for people. Client files also seem to contain a discourse that negatively labelled people and tended to stereotype individuals from one report to the next. This seemed to further reinforce and perpetuate the historical myths and baggage around consumer deficits that had evolved over time, rather than contemplating enriched possibilities in the lives of individuals.

Fortunately, I experienced a renewed sense of idealism as the opportunity emerged to work with Project 300 in the late 1990s. Project 300 was introduced as an innovative project funded by the Queensland Government that enabled people to move out of institutional care and live in the community of their choice.

> The program provided housing, clinical and support services for people leaving long-stay psychiatric institutions and gave birth to a vibrant non-government mental health sector in Queensland. (Queensland Alliance, 2001, p.1)

Evaluation of the project (Meehan, O'Rourke & Drake, 2001) revealed that clients' quality of life had improved, and that after 18 months, only 3 of the 213 people discharged had returned to long-term care (p. 26). Consumers perceived disability support staff as more attuned to their needs (Meehan, n.d.). Project 300 also assisted by allowing opportunities for consumers to participate in their services and supports more formally, through the development of the Consumer Participation Project auspiced through a state-wide non-government organisation (Community Resource Unit, 2004). The results after 7 years were that only 13 consumers out of 181 studied were admitted to long-term care. The evaluation team stated:

> This fact that only 13 clients were readmitted to long-term care on its own highlights the success of the program since almost all of these clients were resident in long-term care for the two years prior to the introduction of the Project 300 program. (Meehan, Stedman & Robertson 2007, p. 4)

For me, Project 300 demonstrated that flexibility, creativity, innovation and the amplification of consumer voices were essential in facilitating mental health and well-being. What I observed was the difference that non-clinical support workers tended to make in the lives of individuals. Fresh relationships were established. Consumers seemed to be greeted and accepted by support workers in a non-judgemental way. I had glimpses of how the excitement of a new beginning gave hope to individuals. They appeared less constricted by the powerful medical discourse within the institutional setting, which had seemed for many years to have entrapped their bodies, pervaded their minds and dampened their spirits.

Having gained a passion for what the non-clinical support sector could offer, in 2001 I was granted the opportunity to work with another innovative organization: Association of Friends and Relatives of the Mentally Ill (ARAFMI Qld), and was able to make a contribution to setting up what is now known as the 'guest house model of psychiatric

disability support.' This provided support (and still does) to 92 families in the Brisbane North Region (ARAFMI, 2007).

A significant component of the success of the 'guest house' model was the nurturing and welcoming relationships created with families. Support workers engaged with people, journeyed with people in times of distress, and shared in the celebration of their achievements. Paying attention to the comfort levels of people was a significant part of everyday practice – this included negotiating routines, levels of interaction and support, dietary requirements, physical surroundings and atmosphere. While this model of service delivery embraced restoring the individual worth of individuals and their families, I was still confronted with some attitudes and practices in the broader mental health system that devalued and rejected people, ignored their humanity, and denied their intrinsic right to respect. Often these practices occurred in the context of individuals being denied access to services or having their level of distress minimised, which increased their feelings of fragility. Too often, I encountered individuals whose physical and emotional safety appeared jeopardised.

Thus, the purpose of this thesis, which I commenced in 2003, was to look beyond the mental health system in order to make a contribution to it. I wished to explore new discourses around mental health and well-being that incorporated perspectives outside those of traditional mental health service delivery. Such a framework would not be restricted to the context of mental health service delivery but would more broadly provide an understanding of how to facilitate positive mental health and well-being, so as to enhance humanity in general.

In order to do this, a departure from the traditional paradigm of mental health service delivery was necessary. I purposefully undertook work that was not specific to mental health for four years, so as to remain open to new ways of thinking about mental health and well-being. This was necessary in order to retain inspiration and stay open to new discourses.

This thesis aims to introduce a framework for practice, based on Grounded Theory, which bridges the gap between the recovery rhetoric espoused and the reality of work in the mental health sector. Ultimately, the goal is for this framework to inspire and be applied by other practitioners. As I prepare to re-enter mental health 'service delivery land', I do this with a renewed enthusiasm and a strengthened desire to facilitate the mental health and well-being of others.

This introductory chapter will provide justification for the research in the Australian context, highlight the vital contribution of social work in mental health, and give an overview of the chapters to follow. A brief account will be given of the policy context of mental health in Australia, how social work is uniquely positioned to make a strong, deliberate and well informed contribution to mental health, and how, through the chapters to follow, the research identifies some clear implications for how social work practitioners can apply theory in practice.

1.3 The Policy Context of Mental Health in Australia

Significant developments have occurred in mental health policy since the release of the report *Human rights and mental illness: report of the national inquiry into the human rights of people with mental illness* (Human Rights and Equal Opportunity Commission, 1993), which fiercely criticized Australia's lack of adherence to the UN Rights of the Mentally Ill, declared in 1991. The Australian Government had developed a *Mental Health Statement of*

Rights and Responsibilities (Australian Health Ministers, 1991) and these principles have been articulated through subsequent policy documents.

Since the *National Mental Health Policy (*Australian Health Ministers, 1992) three *National Mental Health Plans* have evolved (Australian Health Ministers, 1992; 1998; & 2003), as well as *National Standards for Mental Health Services* (Australian Health Ministers Advisory Council, 1996) and *National Practice Standards for the Mental Health Workforce* (Australian Health Ministers Advisory Council, 2002).

Major goals in relation to mental health service delivery in recent years have included suicide prevention, greater community awareness and management of depression, greater sensitivity to the mental health of Australia's Indigenous population, service integration and mainstreaming, greater interface between general practitioner and mental health services, de-institutionalisation, the growth of the non-government sector and greater participation of consumers and carers in service delivery (Australian Health Ministers, 1992; 1998 & 2003).

At a state level, Queensland Health has produced a document to promote recovery-orientated service delivery entitled *Sharing Responsibility for Recovery* (Queensland Health, 2005); and Disability Services Queensland has introduced the *Strategic Plan for Psychiatric Disability Services and Support 2000-2005* (Disability Services Queensland, 2000) and a related implementation plan, all of which encourage collaborative, innovative and responsive approaches to people with a psychiatric disability.

Despite an espoused commitment by the Commonwealth Government to mental health in recent years, the *Not for Service Report* (Mental Health Council of Australia, 2005) raised

significant concerns about the increasing numbers of people relying on community care and about its effectiveness. Lack of access to appropriate care and lack of respect to consumers given by service providers were key concerns highlighted by the report.

The views in many of the submissions quoted in the Mental Health Council of Australia Report reveal long standing concerns, as these two anonymous submissions from Queensland demonstrate:

> Brian Burdekin's 1993 report is just as valid as it was eleven years ago, and in some instances the situation is worse, e.g. psychiatric clients losing case management support; and the decrease in housing stocks. (Anonymous Queensland, Submission #67, Mental Health Council of Australia Report, 2005, p. 488)

> I am constantly amazed at how many people in the community have expressed difficulties with the service over the years and it continues unabated, theirs and my constant frustration that nothing changes and that the treatment of consumers and carers remains poor. We have brought many issues up and were tired of our own voices and frustrations; we each have our own stories it just goes on …. (Anonymous Queensland, Submission #113, as cited in Mental Health Council of Australia Report, 2005, p. 488)

Concerns around the standard of service delivery in mental health in Australia have been long-standing, and services have a history of poor coordination and varying quality (Townsend, Pirkis, Pham, Harris & Whiteford, 2006). The common themes identified by Townsend et al. (2006) through an analysis of the submissions of the National Mental Health Council of Australia included a system poorly orientated towards consumers and carers, poor stewardship, funding scarcity, workforce issues, a lack of a comprehensive and accessible continuum of care, under-serviced groups, poor intersectorial linkages and a lack of commitment to the improvement of quality through research, evaluation and innovation.

Challenges for the mental health workforce have also arisen in implementing the policy framework of recovery. A study by Deane, Crowe, Kind, Kavanagh and Oades (2006)

highlighted the challenges in implementing mental health policy at a service delivery level. Despite high level policy and managerial support for delivering a collaborative recovery-based training program for staff, the study revealed:

> Effective implementation is likely to require more active practitioner process management, which may require a degree of culture change given strong traditions of practitioner autonomy. (Deane et al., 2006, p. 309)

This study revealed that organisational and procedural changes were considered necessary before innovations in mental health could be effectively disseminated and implemented.

Adding to the complexity of mental health care issues, according to the Australian Institute of Suicide Research and Prevention (2007), suicide is now the leading cause of death among people in Australia under the age of 30 years. While approximately 2400 Australians die by suicide each year, the number of people estimated to attempt suicide is assumed to be potentially ten to twenty times greater (Australian Institute of Suicide Research and Prevention, 2007). As community concern persists in relation to depression and suicide, a sense of urgency can be detected through the following types of statements. Jeff Kennett, Chairman of Beyond Blue, a national not for profit organisation states:

> Currently, there is limited access to preventative and acute care; little continuity of care and almost no availability of rehabilitation services. People are committing drastic acts in order to get into care and rates of suicide are often too high following discharge. (Kennett, 2006, p. 135)

Mental health advocates would seem to have been arguing for many years for increased funding and service delivery. Perhaps their voices have been heard at last — in May 2006 the Australian Government announced an additional 1.9 billion dollars over a five-year period, to improve services for people with a mental illness, their families and carers (Council of Australian Governments (COAG), 2006) demonstrating a political commitment to the

National Action Plan for Mental Health 2006-2011. Priority areas include promotion, prevention and early intervention, improving and integrating the care system, enhancing community mental health services and workforce development and an increase in psychiatric disability recovery-orientated and respite programs (Frkovic, 2007). There has been a commitment to enhancing services for Indigenous communities, people with drug and alcohol problems as well as access to practitioners, web-based and telephone counselling services (Department of Health and Ageing Budget, 2006-2007).

In turn, the Queensland Government has dedicated $895 million dollars to the National Action Plan in mental health across the government departments of Health, Disability Services Queensland, Queensland Housing and the Department of Justice and Attorney General (Frkovic, 2007*).* As part of this, over $98 million is being committed to the priority of community participation in 2007-08 (involving allocations to Disability Services Queensland, and Queensland Housing) which will directly enhance non-government psychiatric disability support sector in Queensland. Such a commitment to mental health at both levels of government offers an enormous window of opportunity to initiate meaningful attitudinal and cultural change.

1.4 Why a Contribution from Social Work to the Mental Health Field?

Given that such opportunities in mental health are about to be 'rolled out', there are five reasons why social workers, as practitioners integral to mental health, have a responsibility to make a contribution to the field of mental health and well-being and, more specifically, to mental health service delivery. These reasons will be discussed in turn and include:

1. social work has a sound value base for facilitating mental health and well-being;

2. it is a profession that can potentially make progressive linkages between research and practice;
3. it has an inclusive and diverse knowledge base that operates at many levels;
4. it enables the transfer of knowledge from one context to another; and
5. it embraces a purpose of socially just change.

These factors will now be discussed in turn.

1.4.1 A sound value base

Social work has an important role to play in mental health. Carpenter (2002) argues that the values and beliefs of the consumer-survivor recovery movement are closely aligned with the profession of social work. As a discipline, social work embraces strengths-based approaches. Strengths based approaches encourage hope, a sense of discovery and facilitate individual resilience, competence and future possibilities for change through internal and external sources of support (McCashen, 2005; Rapp, 1998 & Saleebey, 2006). These values are inherent in the recovery paradigm, and align with the social work values of self-determination, empowerment and individual worth (Australian Association of Social Workers, 2002). A significant amount of work has also been done in Australia to develop competency standards for mental health social workers that serve as important benchmarks for the mental health workforce (Australian Association of Social Workers, 2004).

While social work carries with it the values and competencies to work well with mental health issues and encourages flexibility and the potential of human beings, it can still be argued that much of mental health and psychiatric disability support is still service driven. That is, it is aligned to criteria established by government that direct how services develop, rather than services being driven by the values that facilitate mental health and well-being.

Because social workers value viewing human beings as a whole in their social context (Bland, 2001), and aim to foster individual well-being, social work values are fundamentally important in terms of discerning the perspective through which social reform occurs.

1.4.2 The importance of social work - the relationship between practice and research

McCrae, Murray, Huxley and Evans (2005), in a UK study, raised concerns about the research contribution of social workers to the mental health field. This study revealed that many practitioners were too embroiled in practice to take up research, and that social work had fallen behind nursing in terms of academic progress. Not only was research not seen as part of the conventional career path, but there were difficulties in measuring the concepts used in social work. In summary, there was not a strong research-practice tradition. Unfortunately, the information gathered in that study was mainly seen as being for managerial purposes rather than as a contribution to social issues. In a US study, Proctor (2004) also identified a gap between social work research and practice, arguing that social work has not contributed to research on a level commensurate with its service provision capacity. I am keen to bring research and practice closer together and welcome the theory of social work expertise articulated by Fook, Ryan and Hawkins (1997), and which was further explored by Merighi, Ryan, Renouf and Healy (2005). These researchers showed that social workers in community-based mental health settings could articulate clearly various aspects of their practical and theoretical wisdom, underpinned by the professional values and ethics of their respective organisational contexts.

The importance of praxis, involving developing theory through practice is emphasised by Everitt (2002):

> Praxis involves a commitment to understanding in order to take action, a recognition that understanding comes through engagement and debate with others, and a preparedness, through deliberation, to judgements about the 'good'. (p. 114)

If social work is concerned to challenge the discriminatory aspects of the lives of those affected by the mental health system, then the encouragement of enquiry and critical reflection would seem an essential component of the repertoire of skills needed to inform the practice of leadership, management and staff in the future. A social constructionist approach is useful in bringing the theory/practice link to life. Kearney (2004) states:

> From a social constructionist perspective 'reality' or 'truth' is not represented by language but is constructed in language. And consequently, rather than trying to separate them radically, one would see theory, research and practice in social work as intertwined, and as historically situated and emerging forms of acting/living rather than timeless/fixed entities. (p. 165)

Kearney discusses how action and meaning come together in social work practice. For example, when social workers refer to going out on a 'section' under the legislative authority of a Mental Health Act, the meanings already adopted suggest the potential outcomes, so that, due to the nature of that classification, a particular form of intervention is already under way. A social constructionist approach allows an understanding of how practice emerges, and through this process, contributes to better practice. Kearney (2004) explains how this approach joins with the experience of others and assists in overcoming ambiguities, so that social workers can become informed enough to know which direction to take, for those involved and for the context of the work. It is my intention to use this type of approach to construct an emergent theory to enhance mental health social work practice.

1.4.3 An inclusive knowledge base: from the micro to the macro

A third reason why a contribution by social work to research is important is that it uses an inclusive knowledge base that allows the profession to work at many levels. The use of an

inclusive approach to knowledge is noted by Gould (2006). It incorporates knowledge drawn from qualitative methods, epidemiological studies, practitioner and user knowledge combined in a non-hierarchical way.

Frey and Dupper (2005) also argue for a broadening of the framework of clinical social work practice, maintaining that social workers must be free to move along a continuum of knowledge and skills between working with individuals and attending to social justice issues, choosing between micro and macro levels as the situation demands. Dominelli (2002) describes this as an emancipatory approach to social work - one that incorporates social change at both the individual and social levels, explaining that this approach is not only preoccupied with implementing social justice, but also it is:

> […] intimately bound up with notions of improving quality of life or well-being for individuals, groups and communities. This concern lends it a holistic mantle which encompasses all aspects of social life – culture, institutions, legal framework, political system, socio-economic infrastructure and interpersonal relationships which both create and which are created by social reality. (Dominelli, 2002, p. 3)

Similarly, Bland (2001) argues that the strength of the profession includes its diversity and its capacity to work at many levels, where the domain of social work in mental health deals with the social context and social consequences of mental illness.

> As a result of this diverse professional background, social workers generally demonstrate a capacity to look beyond the illness and treatment issues to consider the broader human, social and political issues in mental health. (Bland, 2001, p. 148)

This demands that social workers become adept in influencing policy and programming decisions towards early intervention, prevention and ecological approaches which consider the relationship between individuals and their environment. This thesis aims to make a significant contribution in these areas.

1.4.4 Transferability of knowledge between contexts

Fook (2004) argues that 'contextuality' is a major feature of social work and that the transferability of knowledge can enhance expertise. Fook recognises that social work is adept in its ability to work within the whole context of a situation, but that its foremost capacity is recognising the impact of competing factors.

This thesis aims to do this by understanding mental health and well-being from various perspectives, incorporating expertise from different disciplines to synthesise knowledge in a new way. Given that social work as a profession has a respect for diversity and an appreciation of the overall context in which individuals lead their lives, this thesis is able to explore new territory beyond the traditional clinical mental health context to provide insights about what contributes to the mental health and well-being of human beings, regardless of whether they perceive themselves, or are perceived by others, as having a definitive diagnosis or not. I hope that the insights gained from outside the mental health system will provide knowledge that can be transferred back into it. Exploring alternative knowledge bases might also encourage critical reflective practice within the profession. This leads to the fifth reason why research contributions are important in social work – the desire for social change and socially just outcomes.

1.4.5 Making a contribution towards social change and social justice

Fook (2004) emphasises the need for the social work profession to make a broad social contribution, while remaining true to its mission of service and to its value base. Social work has often offered or supported alternative viewpoints that contribute towards the goal of a just society (Lacasse & Gomory, 2003). An international study by Weiss (2005) of social work graduates involving ten countries found that social work students shared a commitment to

social justice issues and individual well-being, and that Australians attached more importance to social justice than to any other goal examined in the study. All of them shared a common understanding; however, that facilitating social justice required that structural inequalities be addressed by redistributing resources to promote individual well-being. Newhill and Korr (2004) identified systemic barriers, such as poor community resources and agency demands, as major obstacles in social work practice that increase the vulnerability of individuals.

Consequently, if social work is about facilitating social change and contributing to social justice, then a great deal more responsibility rests with this profession than it has taken on board so far. Social work has an important role in explaining how mental health and well-being evolves generally and how this knowledge can be applied to facilitate major organisational and cultural shifts. For real change to occur, not only must service delivery reflect the important social work values, but also strategies and practices based on research must be adopted, which can influence the decisions necessary to facilitate such change.

1.5 Overview of Chapters

This chapter has begun to set out the context for this thesis, introducing my understanding of significant challenges in relation to the discourse of mental health in Australia. It has revealed my inspiration for the thesis, highlighted key issues in the policy context and provided a justification for why social work should contribute to the mental health field.

Chapter Two surveys the research done on the factors that contribute to mental health and well-being, using the concept of therapeutic landscapes (Gesler, 1992). The literature review discusses research on the tangible factors in the natural environment, residential communities and service delivery environments that contribute to mental health and well-

being, as well as the meanings they generate. Commonalities between the service delivery areas of holistic health and well-being and the hospitality/tourism industries are also examined, in terms of their role in facilitating mental health and well-being.

Chapter Three justifies and explains the Grounded Theory methodology used; issues around the use of Grounded Theory are highlighted, the process of theoretical sampling is discussed and the primary and secondary data identified. The interview design and processes are explained, including the procedures used in preparation for the data analysis. Chapter Four outlines the data analysis process: open coding of the data, selective coding, determining the core category, theoretical coding, memoing, and identifying the basic relationships between the psychosocial and structural processes. This chapter also discusses the sorting of memos, the write-up and the steps taken to ensure the integrity of the data.

Chapter Five presents an overview of the findings and describes primarily the disillusionment that consumers and carers experience in the substantive field of mental health and identifies the processes through which occurred.

Chapter Six provides an analysis of the data across the three theoretical samples of mental health, hospitality and natural therapies with the aim of discovering more about how participants experienced a sense of mental health and well-being. Through this chapter, The Theory of Perspective Enhancement (TToPE) for mental health is articulated.

Chapter Seven explores how The Theory of Perspective Enhancement builds upon the existing literature to offer the fundamental components of a practice framework for mental health and well-being.

Chapter Eight presents conclusions, implications and recommendations for mental health practitioners. This chapter sets out the ways that The Theory of Perspective Enhancement can contribute to a practice framework for service delivery in mental health and the challenges associated with this. Strengths and limitations of the study are outlined and finally, suggestions for future research are explored.

SUMMARY

The purpose of this thesis is to bring our thinking outside of the traditional mental health paradigm. Mental health service delivery has been tarnished through its history by punitive practices and the perpetuation of stigma. I entered the field with the belief that much could be learned outside this medical paradigm about how to facilitate mental health and well-being. Social work as a discipline has a sound value base centred on individual worth, and has expertise in partnerships, networking, developing transparent and accountable systems, and community education and awareness. This thesis aims to build on this value base and the expertise inherent within social work, and to develop a practice framework that promotes mental health and well-being.

CHAPTER 2: REVIEWING THE LITERATURE ON MENTAL HEALTH AND WELL-BEING – STEPPING OUTSIDE THE MEDICAL PARADIGM

2. INTRODUCTION

As argued in the previous chapter, the key strengths of the social work profession appear to be the appreciation of diverse knowledge bases and practices to synthesise knowledge and practice in an inclusive yet proactive way in order to contribute to social change. The following review embraces these attributes and is designed to allow the reader to 'step outside' of the traditional clinical mental health field in order to gain a more comprehensive appreciation of other frames of reference.

In order to achieve this, the review will explore the recovery literature and move beyond it to examine the value of the concept of 'therapeutic landscapes' (Gesler, 1992). This concept will be applied to mental health and well-being within the area of mental health service delivery and beyond it, into the disciplines of natural therapies and hospitality. Through the merger of the fields of holistic health and hospitality has emerged the growth industry of 'wellness tourism' (Devereux & Carnegie, 2006; Steiner & Reisinger 2006). The concepts of mental health and well-being will be discussed appreciating how these disciplines can enhance our understanding of what contributes to mental health and well-being. The focus, rather than being on mental illness, will be on what contributes to wellness and mental health generally in the sense of feeling revitalised, renewed and replenished.

The World Health Organisation in 2006 introduced a new glossary of terms which defines wellness more broadly than the individualised definition of mental health.

> Wellness is the optimal state of health of individuals and groups. There are two focal concerns: the realization of the fullest potential of an individual physically, psychologically, socially, spiritually and economically, and the fulfilment of one's role expectations in the family, community, place of workshop, workplace and other settings. (Smith, Tang & Nutbeam, 2006 p. 5)

This definition, like in the literature in hospitality and natural therapies that will be explored later, appreciates how individuals are gaining mental health benefits from a range of experiences which depart from the traditional mental health system. Like the natural therapies sector, this definition recognises the range of holistic factors in the lives of individuals, and similar to wellness tourism, it enables a more interpretive view of mental health in terms of what is fulfilling or satisfying for the individual. However, before moving forward into other disciplines, the recovery literature in the mental health sector must first be critiqued.

2.1 Scoping Recovery and Beyond

Within the current mental health context in Australia, it is the recovery literature that dominates. This literature identifies a range of factors that contribute to mental health and well-being from a holistic perspective. Key factors include acknowledging the inner strength of individuals, the importance of compassionate human responses, safe spaces for the expression of emotion, peer support, individual growth and discovery, and the importance of generating a sense of hope and meaning (Anthony, 1993; Copeland, 1999; Deegan, 1997a; Glover, 2005; Lehman, 2000; McGrath & Jarrett, 2004; Repper, 2000; Roe & Chopra, 2003). The recovery paradigm values lived experiences and highlights the unique potential of each individual. This notion is captured by Deegan (1996), (as cited by Ralph, 2000) who states that 'the concept of recovery is rooted in the simple yet profound realisation that people who have been diagnosed with mental illness are human beings' (p. 6).

It can be argued however, that mental health service provision is still largely dependent upon the integrity of each service and the attitudes of its staff. Glover (2005) argues that professionals need to place increasing value on individuals' experience of distress and the experiences of overcoming it. Glover recognises that for many service providers, there is still a dilemma in embracing a recovery orientation because it requires them to adjust from an 'objective' and 'external' treatment provider (2005, p. 2), to one who synthesises and values the lived experiences of others in every aspect of practice.

Repper (2000) also highlights the diversity of the convictions of mental health professionals, in that while some emphasise the importance of person-centred relationships with people in distress, others focus on specific interventions and treatment regimes for patients. Repper (2000) states:

> For example, it is easy to define giving a pill and relatively easy to measure its effect, but it is far more difficult to define the development of a trusting relationship and to measure the extent to which it engenders hope and self-belief. (p. 577)

Rickwood (2004), recognises that while some service providers in Australia have developed comprehensive service frameworks around recovery, others may not relate to it because they perceive it merely as being 'symptom free' (p. 2), rather than seeing it as maximising well-being, empowering, and creating opportunities or meaning in people's lives.

Given that recovery would seem to be fundamentally about valuing and respecting the personal accounts of individuals, it is of concern that the Mental Health Council of Australia Report (2005), *Not for Service,* finds the attitudes of some mental health service providers to reflect a lack of respect and dignity towards service users and their families. Beyond the mental health literature we discover a broader understanding of mental health and well-being

in new concepts and service delivery practices that allow human service professionals to address mental health and well-being from a fresh perspective.

A range of literature can be found that discusses mental health and well-being outside of the traditional clinical mental paradigm. Given more recent trends towards 'holistic health' (Bright, 2002), 'optimal healing environments' (Findlay & Verhoef, 2004; Frost 2004; Miller & Crabtree, 2005), 'healing spaces' (Schweitzer, Giplin, & Frampton, 2004), 'wellness tourism' (Devereux et al., 2006; Masserli & Oyama, 2004; Mueller & Kaufman, 2000) and 'holistic tourism' (Smith & Kelly, 2006), I sought to scan the areas of hospitality and holistic health care so as to capture an understanding of how a contribution to mental health and well-being has evolved outside the mental health care system. These areas were chosen primarily because of the benefits I had observed myself, as well as hearing of them from colleagues and consumers who undertook activities in those fields to enhance their own mental health and well-being.

Through exploring this literature, I aimed to highlight key themes across disciplines that would assist in formulating a general practice framework for facilitating mental health and well-being. I anticipated that such a framework would be useful not only to mental health practitioners, but also to any service delivery area interested in the mental health and well-being of its stakeholders.

2.2 Conceptual Framework Guiding Review

In order to guide this review the concept of the 'therapeutic landscape' (Gesler, 1992) was adopted to assist the analysis of the literature. This concept refers to landscapes of healing or treatment (Gesler, 1992), and can be explored through the dimensions of

therapeutic environments, therapeutic relationships, and the values and meanings underpinning them (Gesler & Kearns, 2002). The use of term 'therapeutic landscape' is useful in linking the notion of place and mental health recovery in that both concepts recognise the importance of the environmental context, therapeutic relationships and the significance of meaning for individuals. Key factors identified in the relationship between recovery and place, in a study by Chesters, Fletcher and Jones (2005) from Monash University in Victoria, were stability, affordability, a sense of control over space and a low level of stress in the environment, particularly in relation to conflict with others. It could be anticipated that these authors would support the notion of therapeutic landscapes by recognising that a variety of ingredients are essential to recovery including an appropriate and homely living environment and meaningful supportive social relationships.

Both Gesler and Kearns are health care geographers who have written extensively on the connection between health and place. The concept of landscape enables a more interpretive approach to health care (Kearns & Moon, 2002). Gesler (1992) describes the concept of landscapes in the following way:

> […] landscapes, as well as being influenced by physical and built environments, are a produce of the human mind and of material circumstances, […] landscapes reflect both human intentions and actions and the constraints and structures imposed by society. (p. 743)

The concepts of landscape and therapeutic landscape have been widely used over the past 15 years in various fields of study including environmental psychology, health care geography, the psychology of tourism, and architecture and planning. I believe that this concept is also aligned with the values and purpose of social work, in terms of facilitating the physical, emotional and spiritual well-being of individuals within their social and cultural environments.

Saleebey (2004) is perhaps the most prominent social worker who has made the connection between individual health and well-being and the 'power of place' (p.7) and raises the concern that social workers have tended to ignore the impact of the environment and its symbolic significance on the lives of everyday people. Saleebey encourages social workers to pay attention to human suffering and human potential in its environmental context and advocates for 'person in environment' assessment models. In particular, Saleebey stresses the importance of the way the 'intimate environment' (p.16) interacts with human beings:

> […] whether a surgical theatre, an intensive care unit, a child protective services worker's cubicle, a waiting room in a mental health clinic, a playground and garden in a public housing community, a family reunion at a church social hall, an airplane at 35,000 feet, a kitchen table around which family has gathered – these are the relationships and transactions that shape us in the moment, that give us courage or pause, hope or despair, shame or pride, and that instruct us about life. Perhaps this is so much a part of our lives that we cannot see it. (Saleebey, 2004, p. 16)

Kearns and Moon (2002) encourage innovation and creativity and urge that interdisciplinary research is beneficial to extend the margins of academic thinking in relation to the geography of health and place. The intention of this study is to extend our thinking about mental health and place to explore their implications for human service practitioners in the area of mental health and well-being.

2.3 Structure of the Review

The themes that emerged through this analysis will be discussed in three parts. The first part of the literature review describes the tangible or physical factors within the landscape that contribute to mental health and well-being. These include features within the landscapes of the natural environment, residential communities and the tangible aspects of 'servicescapes' (Bitner, 1992, p.57). The term 'servicescapes' is used to include a facility or organisation offering services and will include 'healthscapes' (Bitner, 1992; Hutton &

Richardson, 1995) such as traditional and alternate health care services, as well as services offered within hospitality and tourism.

The second part of the review examines the existential aspect of landscapes: how individuals develop meaning through their encounters with place, through built and symbolic metaphors, cultural norms, the identity associated with place, and language.

The third part of the literature review draws together the common themes occurring in the commodification of tourism and health landscapes in response to demands from individuals generally for a sense of restoration and renewal. The commodification of place through marketing responds to the desires of the people and plays a key role in how landscapes are interpreted and portrayed as desirable.

2.3.1 Natural environment – tangible factors

Before the emergence of the term ‘therapeutic landscapes’ (Gesler, 1992), studies had already begun to illustrate the importance of nature and the environment in relation to mental health and well-being.

William Tuke, a Quaker and philanthropist, is credited with introducing the concept of moral or humane treatment in 1796, when he raised funds to open the York Retreat – an environment that emphasised a respectful and homelike atmosphere for people with a mental illness (Borthwick et al., 2001). The York Retreat, designed by Quaker John Bevan, was purposely located in airy surroundings amongst greenery and gardens, because of the calming and healing influence attributed to nature (Edginton, 1997). Similarly, by noticing the effects of colour, light, and nature on the physical recovery of patients, Florence Nightingale is

associated with the beginnings of environmental psychology as early as the mid 1800s (Geary, 2003; Nelson, 2006; Stevens Barnum, 1998). It has been noted, however, that as institutions grew in size during the mid 19th Century to become 'soulless human warehouses' (Borthwick et al., 2001, p. 427), less attention was paid to the impact of the environment upon human beings.

Studies that demonstrate the restorative effects of the natural environment have grown in complexity over the last 25 years. Ulrich (1983) claimed that perceiving natural qualities in a scene supported psychosocial stress recovery and restricted negative thinking. In 1984, he reported that patients being treated for gall bladder conditions, whose windows overlooked deciduous trees rather than a brick wall, recovered more quickly and had shorter post-operative stays.

Kaplan (1987) captured an important connection between human choice and landscape by examining how people preferred natural scenes (featuring trees, foliage and water) over urban scenes. Palka (2000) studied the psychological responses of over 160 people who viewed Delani National Park, Alaska to record that this experience had been markedly refreshing and restorative for many people. While this was a largely qualitative study, a larger more sophisticated statistically measured study by Ogunseitan (2005) of 379 people, identified a strong correlation between preferences for flowers and water in the environment and a sense of restoration.

Kaplan and Kaplan (1989) developed attention restoration theory, in which the four components of environmental restorativeness were: a feeling of being away, entering into and spending time in another environment, a level of fascination, and a level of compatibility

between the individual and the environment. Laumann, Garling, and Stormark (2002) validated Kaplan and Kaplan's results in a larger study that highlighted to a greater degree that being away was not only important in terms of physical absence, but also as a psychological sense of escape.

Hartig, Evans, Jamner, Davies, and Garbling (2003) extended this work by discovering favourable effects, both emotional and physiological, of participants exposed to views and nature walks, as opposed to those who had no views and walked in an urban setting. In a larger study of 541 participants in Japan, Morita, Sukuda, Nagano, Hamajima, Yamamoto, Iwal et al. (2006) revealed that a forest walk decreased hostility and depression, regardless of the type of forest, whether or not individuals undertook much exercise, or spent a minimal or an extended amount of time there.

In relation to natural environments minimising stress, van den Berg, Koole, and van der Wulp (2003), in a study of 106 individuals, revealed exposure to natural environments after a frightening visual experience improved mood and concentration more than exposure to an urban built environment. Similarly, Roszac (1996) shows how stressed individuals prefer to relax by visualising soothing scenes such as seascapes, forests, wilderness or starry skies, rather than images of a shopping mall or a freeway. Tyson (2002) elaborates on the qualities of healing gardens, particularly when people are experiencing stress, recovering from illness or trauma, or coming to terms with a difficult situation. A range of literature supports the restorative and therapeutic effects of gardens contributing to healing through a sense of well-being (Marcus & Barnes, 1999; Geary, 2003; Gerlach-Spriggs, Kaufman & Warner, 1984; Hitti, 1991).

From these studies, it would seem that exposure to natural environments could be a significant therapeutic intervention for improved mental and well-being, or for feeling calmer after experiencing a stressful situation. However, there appears to be no significant or recent research in Australia on the ways that nature may be incorporated into the treatment of people with mental health issues. This study aims through the development of a practice framework using Grounded Theory research, to contribute to such an understanding.

2.3.2 Residential/community landscapes and mental health – tangible factors

A range of studies has been done indicating the tangible factors impacting on mental health and well-being in the residential/community context. Blackman and Harvey (2001) explored the mental health benefits resulting from a housing renewal strategy in the UK. This comprised work on the building walls, footpaths, security, lighting, heating, street repairs, street calming and landscaping. Discretionary renovation grants were also made available for refurbishment of individual dwellings. Results indicated that psychological distress and smoking decreased, and that children's health and residents' perceptions of safety increased.

Srinivasan et al. (2003) also discuss the link between substandard housing with poor urban design and housing disrepair as contributing factors to anxiety, depression, attention deficit disorder and substance abuse. Similarly, Jackson (2003) points out that depression is just one public health issue that could be better responded to by incorporating greenery, landscaping, natural light, open spaces, mixed land use, and pedestrian walkways to enhance exercise and involvement in civic life. It is argued that the collaboration of health practitioners and urban designers is essential for improved ecological design. An ecological approach was also taken by Hartig, Johansson and Kylin (2003), who recognise the impact on coping and stress levels of non-restorative factors, such as noise, location, proximity to and

frequency of stressful situations in the immediate living environment, discomfort, poor ease of movement, pollution and crowding.

A comprehensive literature review by Evans et al. (2003) found that residents on higher floors had poorer mental health. The results of this extensive review suggested that housing quality is positively correlated to psychological well-being. For instance, issues impacting negatively on residents included poor housing structure, cockroach and rodent infestation, dampness, mould, inadequate size and poor building layout, noise, chaos and crime.

While this research did not use standardised measures across the scope of its review, and the majority of participants in the studies were self-selected rather than a representative sample, similar themes emerged overall. Evans (2003) suggests that while people in sub-standard accommodation living on higher floors have poorer mental health, it is also possible to conjecture that people with mental health issues may have an increased likelihood of living in such conditions, making these factors more difficult to correlate.

While the above authors would strongly advocate for greater multi-disciplinary research to influence government policy and community health initiatives, there appears to be a low level of research and policy responsiveness to factors impacting on mental health in the Australian context.

2.3.3 Servicescapes and mental health – tangible factors

Other studies have examined how built environments specific to health care impact upon people. Canter and Canter (1979) discuss how built environments should be facilitators of the therapeutic process, and how therapeutic environments need to be carefully designed to reflect the goals and activities for which they are designed.

The importance of access to windows and views benefiting health status has been identified (Kearns, Ross Barnett & Newman, 2003; Kearns & Joseph, 2003; Lawson, 2002; Remen, 1991; Ulrich, 1984; Verderber & Reuman, 1987). Various studies have also examined the need for an architectural layout that flows and allows for smooth transitions between the indoors and the outdoors and a balance between areas for privacy and individual expression and those for community and social interaction. The personalisation of space and how this space connects with the outside world is discussed by Gutowski, Ginath and Guttman (1992), Gross, Sassoon, Zarhy and Zohar (1998), Lawson (2002), Remen (1991), Timko (1996). Similarly, Lennard and Gralnick (1986) describe the importance of 'personal patient territories' (p. 188).

Furnishings, it is suggested, should be homely, well-coordinated, clean, well maintained and comfortable, but not overly plush (Giplin, Schweitzer & Frampton, 2004; Gutowski et al., 1992; Hutton & Richardson, 1995). Studies by Gutowski et al. (1992), Lawson, (2002) and Remen, (1991) reveal unwanted stimuli such as noise, confusing layouts, crowds, light reflections, vibrant carpet designs or artwork are detrimental to health. Vidarkliniken, a healing hospital in Scandinavia, promotes the use of colour in the process of healing, shared spaces for staff, patient and visitor socialisation, and the construction of corridors to mimic inviting pedestrian streets (Coates & Siepl-Coates, 1992). The innovative

Planetree Hospital in California provides kitchenettes for families, flexible visiting hours for patients, open nurses' stations and cosy inviting décor, including floral sheets and bedspreads, pastel curtains and hand-painted room numbers (Martin, Hunt, Hughes-Stone & Conrad 1990; Weber, 1992).

Other studies revealing important aspects of the environment for people with mental health issues have been undertaken by Gross et al., 1998; Lawson, 2002; Hutton & Richardson, 1995; Schweitzer et al., 2004; Timko, 1996; Ulrich, 1992a. These authors emphasise a level of freedom and control over space including lighting and temperature, visitor and telephone access, adequate ventilation and a sense of safety. Likewise, Huelat (1998) discusses the importance of simple factors, such as adequate signage and parking facilities for visitors.

Lawson (2002) revealed that patients in a newer environment with a level of privacy and control over their environment viewed their treatment more positively, with fewer reports of self-injury, physical and verbal abuse. La Torre (2006) emphasises the importance of colour to promote relaxation and balance, the use of daylight and windows to reduce fatigue and depression and the use of *feng shui* to positively channel energy and create balance.

Andrews (2002) argues that it is not possible to separate the experience of health care from the place in which it is experienced. Furthermore, Levin (2007), President of the Centre for Health Design in the United States, recognises the need for evidence-based design in health care facilities that create healing environments, and promote family engagement, quality, safety and efficiency.

While significant research has been done in the area of mental health and environments, significant issues are identified in the Mental Health Council of Australia report *Not for Service* (2005). Space issues in Australian mental health landscapes included a lack of privacy and outdoor physical space, inadequate physical care environments, a lack of control over personal space, and a poor standard of accommodation options for mental health consumers.

These factors are vital in understanding the relationship between consumers and place, particularly for social workers who work with individuals in the context of their environment. Social work is undertaken in a vast array of settings, but as a discipline it also plays a major role in working with emotional and social well-being, all which have a significant connection to place.

This segment of the literature review has emphasised the significance of the natural and built environments as contributing factors to overall mental health and well-being. The next section examines how meanings are created through landscapes, and how both tangible and more interpretive factors impact on how place is perceived in terms of its impact on mental health and well-being.

2.4 Meaning through Landscape

Mitchell (2000) argues that landscapes are made of history, culture, ideology and social relations. The meanings extracted through the representation of landscape then play a powerful part in constructing the identity of those within it. This review shows that meanings are conveyed through individual encounters with the landscape, built metaphors and structures, cultural norms, perceived cultural identities associated with place, as well as by the use of language.

2.4.1 Meaning through individual/landscape encounters

While the tangible factors of landscape are important, it is the meanings evoked by individuals through the landscape that are crucial. Research studies in healthcare and tourism report how people have formed a connection with the landscape through special experiences they have encountered within it. Davidson & Milligan (2004) and Milligan (2005), use the term 'emotiospatial hermeneutic' to describe the emotions that begin to make sense in the context of place. Davidson and Milligan (2004) state, 'place must be felt to make sense' (p. 524).

Conradson (2005) argues that human beings not only interact with the landscape, but also internalise their experiences so that these encounters can have long-lasting effects. Conradson (2005) suggests that while the bulk of the psychotherapy literature has focused on psychosocial forms of engagement, an ecological perspective generates an understanding of how individuals engage with their environment, at both a physiological and an interpretive level.

Conradson's (2005) study of guests with a disability engaging with the landscape at an English respite centre, demonstrates that exposure to landscape through activities such as exploring, bird watching and gardening generated a sense of internal calmness and well-being. Individuals experienced renewed self-confidence and the capacity to undertake new challenges. While this qualitative study was small (22 participants) and measurement of internal well-being is difficult, it does contribute to an understanding of how different 'self-landscape encounters' (p. 345) will hold different significance for different individuals. This is especially important in the field of mental health, as what will be therapeutic for one person may be traumatic for another; Gesler (2005) refers to this as being 'context dependent'

(p. 296). Thus, landscapes will be perceived by people differently, depending on the associations and meanings they ascribe to it, as well as the variation in the economic, social and cultural conditions that make up the landscape. For example, an individual who has spent most of his/her life in a busy hospital ward, may view a small one-bedroom unit as their own special healing space, while another may view it as an isolating and lonely existence. Hartig and Lawrence (2003) argue that housing evokes social and emotional meanings for people, such as a place of refuge, continuity, connectedness and security. While, for one person, housing in the community may generate these meanings, for another, the social and emotional meanings may have evolved through an extended time spent in hospital.

This sense of significant meaning and attachment to the landscape was highlighted in an Australian study by Cox and Holmes (2000), where a sudden bushfire devastated a local community, destroying more than seven hundred homes and killing three people. Amazingly, while people had been through trauma and loss, many continued living in the area because of their relationship with the environment, and their association with what the built and natural environment meant to them. As the landscape grew back, the narratives of residents revealed a sense of healing.

Another study examining the meaning generated by encounters with the natural environment was conducted by Fieldhouse (2003), who reported enhanced mood and the development of meaning for people with mental health issues who were part of a gardening allotment group. Tending to their plants not only enabled them to benefit cognitively and emotionally from the environment, but also revealed how meanings were generated, through metaphors of stability, growth, resilience, hopefulness and nourishment, in the autobiographical accounts of participants. While this study was also small (nine participants),

and the long-term benefits of the experience are not known, it does suggest that interaction with the natural environment gave participants a more integrated sense of self, at least in the short term.

In a tourism context, Brooks, Wallace and Williams (2006) describe how wilderness experiences in the Rocky Mountains National Park offered tourists special experiences while they were exploring, for instance, interaction with animals that created significant meanings for them. Similarly, Farber and Hall (2007) studied the responses of 445 people visiting a scenic route in Alaska whereby 89.4% of guided visitors and 95.6% of independent tourists reported a 'very special experience' (p. 256) with the landscape. Of these, 54% of people mentioned scenic elements, particularly the mountains, while 50% also identified wildlife and proximity to animals as significant. Emotions and affective states were reported by over 50% of respondents and included feelings of pleasure, happiness, enjoyment, awe, amazement, excitement, thrill or exhilaration. This study suggests a strong correlation between meaningful or special experiences in the landscape and positive emotional reactions.

Likewise, Voase (2002) highlights the importance of meaning in tourist encounters, as shown by the way people like to immerse themselves in an experience. An example is the way that Madame Tussauds Wax Museum in England was remodelled after research had shown that satisfaction for visitors emanated from the memories, feelings and emotions conveyed by the wax figures rather from their artistry. More opportunities were then provided for tourists to walk around the figures, touch them, and have their photo taken with them, to give greater meaning to the experience.

2.4.2 Meaning through built visual metaphors

Bitner (1992, p.57) argues that organisations such as hospitals are 'servicescapes' that provide a visual metaphor influenced by physical design, image and layout. Kearns, Ross Barnett and Newman (2003) discuss how the Ascot Private Hospital in New Zealand disseminates a bold message of difference, designed with distinctive monumental architecture linking the material and ideological aspects of the healthscape. The authors argue that its location and the stone wall that surrounds it create an image of English upper-class respectability. Similarly, the Starship Children's Hospital in Auckland is noted as an elaborate architectural spectacle that links the built environment with the ideology of contemporary health care and private funding (Kearns & Ross Barnett, 1997).

In contrast, the architectural design of The York Retreat was designed to be comfortable and to resemble a family home, mirroring the Quaker principles of community, family, and collective support. The environmental design at the York Retreat emphasises the physical and social aspects of life and reflects a respect for human rights, personal respect, and everyday relationships (Borthwick et al., 2001). Ion and Beer (2003) suggest that the importance of therapeutic relationships and treatment environments in an era of moral treatment serve as useful reminders for modern day clinicians of many of the concerns raised by service users and families about the quality of inpatient care. This seems highly important given the appearance of many hospitals today, which appear to be built with visual metaphors that give prominence to technological advancement rather than human interaction.

While the two hospitals in Auckland (Ascot Private Hospital and the Starship Children's Hospital) discussed above may represent visual metaphors of prestige and

distinctiveness and the York Retreat one of simplicity, it can be argued that other visual metaphors portray power relationships.

Andes and Shattell (2006) discuss the lack of control over space that patients' experience in psychiatric units, including physical barriers, locked doors and Plexiglas walls in nursing stations. Physical structures equate to visual metaphors of power, giving nursing staff the power to engage or not with patients. Similarly, Bondi and Fewell (2003) recognise that the waiting rooms and consulting rooms of practitioners are the 'exteriorisation' (p. 542) of the world into which they invite their clients; they suggest that positioning of counsellor and client in a non-hierarchical way and creating an atmosphere of safety and a confidential environment enables the person to feel accepted and safe.

Lin (2004) discusses the concept of a servicescape and how image leads to an emotional response, even before any interaction with staff. It is argued that that the physical interaction with the facility outweighs interactions with service employees, and that servicescape design will guide the beliefs, attitudes and expectations of customers. While the aesthetics of a servicescape are important, this thesis also addresses whether or not the importance of human interaction in the servicescape is undervalued. Many mental health consumers may tolerate poor environmental conditions, but may feel that positive interactions with others are more memorable, or more important for their recovery, than the environment. Thus, exploring the significance of human interaction in the landscape is also important for this research.

2.4.3 The development of meaning through cultural norms and identity

Gesler (1992) states that:

> …what we say about landscapes is mediated by how we have been acculturated to see the world, what our society believes is important, and by our individual experiences. (p. 743)

This stresses the importance of the interaction between human beings and the environment, the dominance of social forces, and individual philosophies of meaning. These are especially important when considering how current therapeutic landscapes in mental health facilities are shaped by dominant social forces, and how they rarely offer messages of hope. This in turn influences the interpretations of landscape, and the human actions that occur within them. Sadly, the report by Mental Health Council of Australia (2005) offers many examples of how stigma is culturally perpetuated in the mental health landscape through community attitudes, media representation, and the actions and attitudes of service providers.

Smyth (2005) agues that the symbolism and cultural values associated with therapeutic landscapes (spaces, places and social networks) can also serve to regulate and normalise behaviour. It is argued that the cultural ideologies associated with the landscape influence the power relationships and the inclusionary or exclusionary practices that operate within them. An example of how cultural values impact on place, is seen in Cornish's (1997) account of the landscape of a former asylum; the land on which the former asylum had been located had been sold but was not yet reused. Redefinition of the landscape to take on a different identity was difficult; the meanings attached to the asylum were still attached to the landscape, seen as a place where people had been left on the margins or worse.

In contrast, sites sacred to particular cultures, or places having positive association with prayer retreats, have taken on identities of ‘networks of interpersonal concern’ (Gesler, 1992, p. 738). For example, Gesler (1996) points out how tourists have interpreted Lourdes in France as a healing place, based on its historical connotations of pilgrimage and divine intervention. Similarly, Gesler (1998) describes how Bath in England has maintained a reputation as a healing place, based on its Celtic history and the mythology associated with the power of healing springs, which continues to survive with symbolic importance, whether or not it is scientifically proven.

A more recent example of how meaning is mediated though the culturally constructed landscape is offered by Day (2007). In this study, the interpretation of air quality by the population was affected by whether the place was associated with material disadvantage or with affluence and by the ways that people felt about this. Those in affluent areas with poor air quality saw their environment as buffered by the high social and physical quality of their neighbourhood and did not recognise the pollution to be as significant as did people living in poorer neighbourhoods.

Similarly, Wakefield and McMullen (2005), in a study of a stigmatised industrial area of Ontario, described how people would still identify health-affirming elements in their everyday lives, such as their local social ties. Hartig and Lawrence (2003), who explore the residential context of health, also argue that health is affected by the meanings attributed to housing, levels of social support, sense of identity and security, and socioeconomic status and access to resources. These studies suggest the importance of the individual’s interpretation of the ways the therapeutic landscape is encountered so that, while one person may view their

neighbourhood as culturally poor and unhealthy, another may deem it healthy due to the bond shared with neighbours.

Parr and Philo (2003) also explored how community belief systems influenced attitudes towards mental health service users. Over 100 users of psychiatric care were interviewed in the highlands of Scotland, together with 62 formal and informal carers. Issues raised in relation to seeking help included the high level of social proximity and visibility in the community. It was found that the community valued a high level of stoicism, self-reliance and non-disclosure in relation to mental health issues. Thus, there was concern about what other members of the community would say or do if more caring relationships or activities were undertaken with people with a mental health issue. This highlights the need to examine relationships within the therapeutic landscape as a vital part of finding out how meaning is developed through cultural norms.

Therapeutic landscapes are influenced not only by the identity of service users, but also by that of service providers. Brinkley Bowler (1991) discusses how the transformation of a psychiatric ward in Nevada into a healing healthcare environment was achieved by changing how nurses saw themselves; rather than perpetuating their identity as 'victims' in the system, they were encouraged to see themselves as empowered individuals who could facilitate an environment of authenticity and community, overcome conflict and take on a fresh perspective. A parallel transformation was also observed in the consumers, in terms of their personal growth and sense of empowerment.

Similarly, within the tourist servicescape, McCabe and Stokoe (2004) describe how tourists construct identities through the place they are staying; for example, how they belong

to it, how place facilitates relaxation activities, or how they connect to it through family or time (for instance, Sunday being a day of relaxation), or how place creates meaning because it is removed from the sights and sounds of the everyday world.

It seems then, that an understanding of the cultural constructions of landscape may be important for human service practitioners. Not only do they have a role in working with clients and communities whose mental health and wellbeing may be affected by the landscape around them, but they also have a responsibility to make a constructive contribution to the cultural interpretation of landscapes, so as to ensure that clients are treated with dignity and respect, rather than suffering exclusionary practices.

2.4.4 Meaning through language

As well as understanding the interpretation of landscape, Gesler (1999) also identifies language as a key factor in the creation of medical places, arguing that language represents not only knowledge but also power. He argues it can be used to separate and exclude people, and gives examples of how language is used in medical settings to persuade and interrupt patients, generate meaning, and diagnose or label people. Deegan (2005b) argues that mental health professionals need to be particularly conscious of language and refers to disrespectful language as a form of micro-aggression that is commonly used. She points out, ‘over time this begins to wear people down and their hope. It creates a culture of hopelessness and despair’ (p. 5).

At a service delivery level, Joseph and Moon (2002) describe how the Homeward Sanatorium of Guelph Ltd, in Ontario (a mental health facility), altered its image by re-naming itself the Homewood Health Centre to reflect a more holistic approach to mental

health. Similarly, Kearns et al. (2003) describe the name ‘Ascot’ associated with the Ascot hospital as elite class-based and affluent, while the use of the word ‘integrated’ in the promotional literature suggests wholeness and completeness.

Language and the way it is conveyed affects people in a diverse range of ways. The metaphor of a journey, often used in counselling practice, can give client a sense of spatial liberation to explore new territory in the context of a grounded yet contained safe setting (Bondi & Fewell, 2003). Counsellors, these authors suggest, view themselves more as navigators or guides, not intruding on the client’s journey, but steering into areas of personal growth.

With the advent of more complementary and alternative approaches to health care and the creation of optimal healing environments in the 1990s, it is useful to note the change in language from ‘therapeutic’ to ‘healing’. They have different connotations; while therapy has been seen as a part of treatment, the notion of healing relationships generates a range of different types of attributes and qualities. Terms emerging in the trend towards optimal healing environments include ‘mindfulness’ (Miller & Crabtree, 2005; Schmidt, 2004), ‘healing intentions’, ‘compassion’ and ‘love’ (Gargiulo, 1999; Schmidt, 2004; Stickley & Freshwater, 2002), ‘inner transformation’ (Findlay & Verhoef, 2004), the ‘healing presence’, ‘connectedness’, ‘spiritual grace’ (Jonas & Chez, 2004), ‘spirituality’ (Mc Donough-Means, Kreitzer & Bell, 2004), and ‘humility’ (Miller & Crabtree, 2005). While this language tends to be opening up possibilities and generating uplifting connotations, much of the language in mental health care still tends to categorise and restrict. While words linked with personal growth have been instilled into the language of recovery, discovery and hope, they still tend

to be used within the dominant discourse of mental illness, rather than of mental health and well-being (Walker, 2006).

2.5 Therapeutic Landscapes - the Interaction between Health and Hospitality

The literature on therapeutic landscapes discussed above demonstrates a close relationship between hospitality and health care for two significant reasons. The first is that health care and hospitality have both become increasingly commodified or packaged to align with customer behaviour.

Second, customer behaviour that has emerged in response to this commodification has developed similar desires in the pursuit of mental health and well-being. The literature review reveals six key shared characteristics identified as desirable by clients/recipients of both healthcare and hospitality/tourism. These are: hospitable treatment, a desire for sanctuary, holistic health-promoting experiences and empowering experiences including the search for new alternatives, a search for authenticity and a desire for transformation. The notion of commodification itself, and the shared client/recipient characteristics brought out by the commodification of health care and hospitality will be discussed in turn.

2.5.1 Commodification

The private sector hospital market has been growing in Australia (Brown & Ross Barnett, 2004) due to increasing corporate ownership of private health care. The development of hybrid health care spaces in Australia has meant greater co-location of private and public hospital systems.

The marketing of these hospitals is similar to that of first-class hotels, advertising their proximity to the airport and transport systems, cafés, private rooms, and air conditioning. Kearns et al. (2003) discuss how medical centres have emerged in close proximity to fast trading food and retail outlets, contributing to the normalisation of commodified health care. While the goal of health care is the provision of treatment, a further dimension also involves making it comparable with other community spaces, such as airports or holiday destinations (Gesler, Bell, Curtis, Hubbard & Francis, 2004).

Kearns and Ross Barnett (1997) explore the political ideology of health care promotion through the use of bold architecture, advertising and signage, like the corporate world. Capitalism has made health care a commodity, so the symbolic content in its advertising makes it attractive. The legitimisation factor of health care through being offered by health professionals, who are socially respected, appears to override the variability of standards brought about by competitive practices (Kearns et al., 1997).

Kearns, Ross Barnett and Newman (2003) describe the Ascot hospital in Auckland as a 'contrived therapeutic landscape' (p. 2309) — it has purposely been designed with the idea that recovery is a holiday. Kearns et al. (2003) describes some of the factors involved in reading the landscape, including the buildings, their distinctive architecture and ideological representation, and the structures that encourage people to divert their attention from health issues to entertainment. This health care facility has been directly influenced by the hospitality industry and therefore appreciates that health is heightened through comfort and helping people 'feel special' within their environment. The landscape is composed of ideological representations that resonate with the private commodification of health care and

appeals to the upwardly mobile health care consumer who desires comfort and a pleasant ambience during the process of recuperating toward optimal health (Kearns et al., 2003).

Romano (2003) identifies the intersection of hospitality and health through the case of the Memorial Hermann Southwest Hospital in Houston, which opened a luxury spa in response to client demand for complementary therapies and pampering treatments. Masserli and Oyama (2003) claim that spas are becoming more like alternative medical services and medical services are offering more holistic alternatives in spa-like environments.

Glader (2002) in an article in *The Wall Street Journal* announced the opening of Duncan Lodge, a $2000 a day psychiatric hospital advertising Jacuzzi jet-tubs in private bathrooms, a gourmet chef, daily fresh flowers, high speed internet connection, TV and DVD in each room, antique furnishings and a concierge. This facility aims to attract well-off consumers, and the profits from them compensate for the losses experienced by the standard psychiatric facility next door where patients share a phone, eat in a cramped cafeteria and share a room with rollaway beds.

Trauer and Ryan (2005) argue that tourism is being commodified to give people personalised and special experiences. This is not unlike the commodified health facility mentioned above. With the commodification of health and tourism, what is purchased is much more than just a place – it also offers special interactions and encounters that will give 'time away' a special significance and meaning.

The trend that has arisen with the commodification of healthcare and tourism is that there is no longer just one function being performed. Health care is also about ambience and

comfort and tourism is also about enhancing well-being. The ideology of these commodified servicescapes is that they include well-off clients, and exclude those without economic means. Given that currently there are significant increases in funding aimed at benefiting mental health consumers, it is timely and appropriate that an understanding of therapeutic landscapes be introduced into the design of mainstream human services and health care delivery.

2.6 Shared Trends in Health and Hospitality

With the advent of increasing commodification in health care and tourism, the literature which revealed some common trends in what people are seeking for their mental health and well-being is described as follows.

2.6.1 The notion of hospitality

Hepple, Kipps and Thomson (1990) describe how the idea of hospitality has relevance for hospitals, not only because the more people feel at ease, the quicker they will recover, but also as it is a means of evaluating patient satisfaction. Reviewing definitions of the concept of hospitality, it can be argued that its key factors are that it is interactive; conferring both tangible and intangible effects upon guests who are away from their usual homes, and that the host provides the guests with psychological and physiological comfort (Hepple et al., 1990). Patients were asked to rank the factors of hospitality in the hospital setting from most to least important. In a study of three hospitals, on average, the rank order of factors was: friendly medical staff, smooth admissions procedure, information regarding routine, varied choices of menu, adequate parking for visitors, comfortable furniture, privacy, attractive surroundings and/or décor, clear signposting and adequate recreational facilities.

The study demonstrated that the concept of hospitality can be applied to the hospital setting and that the non-medical aspects of service within hospital environments are very important for making people feel at home. It also suggested that hospital management could use questionnaires that focus on hospitality as a useful measure of patient satisfaction.

Hospitality in health and tourism shows similarities in the ways in which people wish to be treated. In a study of the expectations of Russian and German tourists (Atilgan, Akinci & Aksoy, 2003), the characteristics seen as most important were assurance, empathy, reliability, responsiveness and tangibility (such as following through on promises and commitments). These characteristics supported the findings of White and Rudall (2000), Victoria University of Technology that the most reliable measures of internal service quality for customers were the empathy and assurance shown by the hosts.

Similarly, in a study of guest perceptions of hotel quality by Hartline, Ross Wooldridge and Jones (2003), the most desirable functional cue was front desk performance. This view of immediate hospitality recipient contact was also mentioned by Christou (2000), who explained that staff communication skills were a significant influence on guests' levels of satisfaction. Findings made by Barsky and Nash (2002), at the University of San Francisco, revealed that guests were more likely to return to a hotel if they felt an emotional connection to it through the way they were treated. Thus, it is also possible to conjecture that individuals might return to health care facilities if they felt they were treated well there.

Voase (2003) uses the term 'hospitality instinct' (p. 1) to describe the passion people have for delivering others their dreams, which seems to play an important role in the development of meaningful relationships. Aspects of the hospitality instinct are described by

Voase (2003, pp. 14-20), and the table below summarises how the 'hospitality instinct' applies in practice in the field of hospitality.

Table 2.1
Summary of the concept of the 'hospitality instinct' (Voase, 2003).

Concept of Hospitality Instinct	Hospitality Applied
The manner in which a service is delivered	Deportment, dress, language, code of conduct
Consumer has high expectations	The holiday will be a positive experience
Staff self-motivated in line with vision for service	Employees, through their everyday engagement are a part of something special
Style and creativity	A range of activities to meet with consumer aspirations
Welcome and comfort	Warmth, acceptance on entry

This concept would seem to have significant potential in informing mental health service delivery. I was interested whether features of the 'hospitality instinct' that contribute to mental health and well-being would emerge from the data collection in this study.

2.6.2 The desire for sanctuary

Joseph and Moon (2002) and Moon, Kearns and Joseph (2006) discuss how the commodification of private psychiatric hospitals promotes sanctuary. As Government policy has rejected asylum care and promoted community alternatives, the private sector has still been able to tap into the public demand for asylum; these authors suggest that what was once thought of as removal from society now appears to be more about discreet seclusion and sanctuary. The marketing appeal is one of calming, high quality service and seclusion, whilst still remaining connected with urban life. Moon et al. (2006) argue that the private psychiatric hospital offers a hotel type experience, architectural appeal, status, access to alternative

treatments and tranquil serene surroundings, thus promoting both the material and symbolic connection to the environment as a source of healing.

In a similar way, Jordan (2006) discusses how the wilderness of the Hawaiian Islands, with its medicinal plants, is being promoted as a paradise to reinvigorate the body and soul. As a part of wellness tourism, its lush gardens, medicinal plants, seaside walks, and playing with dolphins in cleansing water and fresh salt air, are promoted as conducive to treating depression. While this is being marketed to tourists, the notions of peace, tranquillity, purification and cleansing are not unlike the concept of sanctuary offered by the private health care system.

2.6.3 Holistic health promoting experiences

The third commonality between health care and tourism is the desire for holistic health promoting experiences. Williams (1998) brings the notions of holistic approaches and therapeutic landscapes together by stating that such landscapes are not only healing places, but are for maintaining health and well-being, recognizing the benefits of preventative measures.

As previously discussed, one activity serving both health care and tourism is contact with nature. The importance of nature in health care is noted by Maller, Townsend, Pryor, Brown and St Leger (2006) while Finnicum and Zeiger (1996) claim that the environmental dimension of tourism (ecotourism) is important in campaigns for national wellness.

Education is another component of holistic health promotion. Hancock (1999) describes how health promotion in hospitals combines a bio-medical approach with educational, socio-

political, and environmental approaches to encourage healthier lifestyles. Similarly, the health-promoting features of wellness tourism include educational seminars on health and well-being (Hallab, 2006).

Another dimension of holistic health promotion is the relationship between spas and healthcare. Frost (2004) emphasises the growth in holistic health care as the interaction between spa environments and health care facilities, since spas are viewed as an aid to staying healthy and relieving stress arguing:

> Health care organisations integrating spa services into its offerings hold greater potential for success than health services in a spa setting. The factors that determine this are the credibility of the sponsoring organisation and the financial reality. It is much easier to incorporate moderately priced body workers into the health care financial structure than it is to employ a medical doctor, registered dietician or doctor of philosophy into the spa setting. (Frost, 2004, S-91)

While day spas and destination spas use natural therapies, so do some health care establishments. Vidarkliniken in Sweden has been described as a house of healing that speaks to the needs and capacities of the whole human being (Coates & Siepl-Coates, 1992). Founded on the spiritual science of anthroposophy, it uses allopathic and homeopathic medications, rhythmic massage, air, light and warmth therapies, proper nutrition, mineral baths and artistic therapies.

Luskin (2004) discusses how practices such as prayer, meditation, mantra, affirmations, yoga, and tai chi, as well as positive psychology, are helpful to bridge the mind-body connection through lessening depression and anxiety, and assisting physical conditions such as blood pressure and immune system responses. However, considered research is still required to determine which practices or combinations of them are most helpful for specific complaints.

While there is generally a growing acceptance of the use of natural therapies, examples in the nursing literature recognise that there are challenges in implementing holistic practices in the context of traditional health care models. A key conflict identified is setting the managerial priority of cost effectiveness and client outcomes over and above a paradigm that values individuals in their life context. There is discussion (Griffiths, 1999; Hem & Heggen, 2003; Henderson, 2002; Raingruber, 2003; Salmon, 1984; Stickley & Freshwater, 2002) about how some nurses have become dispirited, viewing their profession as depersonalised, since they are engaged in more technological relationships than human ones. Bennett (2001) raises concerns about the ways that reductionism reduces interests in the lifeworld of the person, while O'Brien (2001) is more positive in terms of the increasing prevalence of more interpersonal relationships in health care, in contrast to a previous custodian/observer type model. Griffiths (1999) recognises that the nursing profession is attempting to encourage holism and respect for intuition, harmonious energy, balance and spirituality within the caring/healing model.

In wellness tourism, holistic therapies are being used by 'healthy living vacationers' (Hallab, 2006, p. 71). These tourists attend health care type facilities such as spas, fitness clubs and educational seminars on health and well-being, and seek pure environments, herbal remedies and healthy food. Puczko and Bacharav (2005) identify how the idea of wellness tourism encapsulates various types of health spas, such as day spas and destination spas.

Smith and Kelly (2006) discuss how health and tourism meet through destination spas, such as Skyros in Greece, that attract people who have experienced a personal life crisis or a level of burnout prior to their stay. Smith and Kelly argue that people are sick of the sense of alienation in busy urban lifestyles and that their psychological well-being has become more

important. Some authors (Finnicum & Zeiger, 1996; Mueller & Kaufman, 2000) associate the growth of the wellness market with innovative package deals that promote a sense of wellness, featuring the harmony of the body, mind and spirit. These health-promoting factors make holistic health and wellness tourism highly compatible.

2.6.4 Empowerment and the search for alternatives

A further commonality between health and tourism is the notion of empowerment through choice, and the search for alternatives. As individuals take on more responsibility for their own well-being, they are empowered to search for alternative strategies to meet their needs.

The concept of people taking ownership of their own treatment is identified by Gesler and Kearns (2002) as important for health consumers, particularly at the elite end of the market. Kaiser (1992) describes how the more recent philosophy of health care is more holistic, yet is difficult to translate into practice because of the traditional dynamics of health care settings that do not allow consumers to 'own' their own health care. One study that illustrates this lack of ownership was undertaken in Germany by Kilian, Lendenbach, Lobig, Uhle, Petscheleit and Angermeyer (2003), in which the majority of patients with long-term schizophrenia had been reduced to a medication regime. They did not feel actively involved in the decision-making about their treatment, and they had little hope of recovery. Only a small minority of these patients felt a sense of support or respect from their psychiatrists.

Lafferty (2004) relates how a new vision for health care in a healing environment would need to include empowered patients, satisfying emotional interactions between patients and excellent staff communication and a focus on lifestyle, and would give patients a

choice of integrating complementary providers into their routine care. While this is ideal, a study by Crigger (1999) revealed that only 40% of physicians would initiate conversations with patients about complementary or alternative therapies.

Health-promoting hospitals need to view patients as active partners and participants in the healing process, facilitated by supportive relationships and structures (Bohart, 2000; Hancock, 1999; Hovarth, 2000). Hovarth (2000) emphasises that client need to actively endorse the core activities that make up their therapy. Descriptions are given (for example Martin et al., 1990; Weber, 1992) about the way that the Planetree model of health care, founded in the United States, encourages patient choice, education and self-care. Individuals are encouraged to read up on their illness, consult with doctors about their choice of treatments and develop a treatment regime conducive to their sleeping and eating patterns. Patients are able to contribute to their own progress notes, read their chart at any time and have access to alternative therapies as desired. Each patient has a primary person to coordinate their stay, with consultations organised around times to suit patients rather than staff.

Graham (1999) argues that, because many doctors do not seem to engage actively with patients, patients seek alternative choices.

> The failure of many doctors to respond to patients as human beings accounts for much of the drift towards so-called ‘alternative’ medicine, which recognises the person’s role in maintaining health and overcoming disease, and encourages active participation in treatments that are generally non-invasive and avoid iatrogenicity. (p. 13)

Hobert (1999) describes how people are looking for alternative wisdom through ancient cultures to gain a different perspective on health and spirituality. It is argued that traditional mechanistic and materialistic views of health are being rejected in favour of a greater degree

of interest in the ecology of the world and in the impact of toxins on human beings. Ancient ideals of harmony with nature become more inviting as people search for meaning within illness, seek to understand what their body is trying to tell them, and link with opportunities for growth and development.

Doel and Sergott (2003) argue that the packaging of alternative therapies is based upon customer behaviour to the degree to which people are seeking an alternative. In a study of the British mass media, they identified three discourses about how complementary and alternative medicine (CAM) was presented to its audience. These included promoting CAM as part of the practical medical toolkit to relieve symptoms, as a part of healthy living, useful to cope with and counteract the effects of urban living, and thirdly, to lure people to a more empowered and alternative or natural lifestyle that encouraged greater self-expression and a different philosophical view of being in and living in the world. From this study, it would seem that individuals take up CAM on a sliding scale, depending on their values and ideological viewpoints and the degree to which they are seeking alternative experiences.

Kessler, Soukup, Davis and Foster (2001) reported that the use of complementary therapies is highest for those with self-reported depression and anxiety than with any other commonly occurring chronic condition other than back or neck problems. The study revealed:

> Close to nine out of 10 patients with self-defined anxiety attacks who are seen by a psychiatrist also use some type of complementary and alternative therapy to treat anxiety, while more than six out of every 10 patients with self-defined severe depression who are seen by a psychiatrist also use some type of complementary and alternative therapy to treat depression. (p. 294)

In an Australian study on the Gold Coast, 171 people were surveyed about their use of complementary and alternative therapy (O'Callaghan & Jordan, 2003); 36% of those

interviewed used CAM. Reasons for seeking this treatment included concerns over the side effects of prescription drugs and a desire for safer alternatives, a desire to actively participate in their own care, failure to gain relief from other treatments, and a more empowering relationship between practitioner and client. In a New South Wales study by Connor (2004), nearly one quarter of the participants (27 out of 111) interviewed indicated that they had sought treatment outside of traditional medical care due to dissatisfaction with the care, the need to seek an alternative form of relief, or as a safer alternative. While these studies were small, they suggest that people are more actively seeking alternatives to address their health and well-being.

Singh (1999) brings together the ideas of empowerment and the search for alternatives by suggesting that the beliefs and values underlying Shamanism are gaining momentum in current western mental health practice with the development of person-centred planning and strengths-based perspectives.

> ... recent emphasis by therapists on finding out how the individual views his mental illness, what it means to him, and what he thinks can be done to heal him suggests that the individual's world view or context is seen as a critical aspect of mental health treatment. After all, the individual cannot have harmony in his life if the mental health treatment being prescribed is not consistent with his world view. Like the Shamans, who view healing as coming from within the individual and treatment from external sources, modern mental health professionals are acutely aware that long-term mental health gains can only be sustained by building on the individual's spiritual strengths rather than by externally imposed treatments that focus on a disease or disorder. (p. 134)

Customer purchasing power is also enabling people to seek different experiences and alternatives in wellness tourism. Cleaver, Green and Muller (2000), list the six main trends of 'baby boomer tourists' as motives for self-betterment, seeking new thrills, making discoveries, achieving higher status through keeping up with others, or going to places friends have not been, reminiscence and escapism. Voase (2003) highlights how hospitality

recipients are seeking healthier living, a better quality of life, and a greater interest in ecotourism and new cultures, while Masserli and Oyama (2003) and Connell (2006) discuss the concept of wellness holidays, particularly for women, as part of trying something new to discover a sense of rejuvenation.

2.6.5 The search for authenticity

Rogers (1951) defines authenticity as a key component of the therapeutic relationship within client centred practice. In his book *The Social Work Interview*, Kadushin (1972) describes authenticity in relation to therapeutic relationships:

> Authenticity on the part of the interviewer requires that he or she be real and human in the interview. It implies responsiveness and spontaneity, the willingness and readiness to share with the interviewee one's own feelings and reactions about what is going on in the interview. (p. 53)

Using this framework, authenticity is recognising the importance of respectful genuine human relationships and accepting each human being in the context of their life. A range of studies in health care highlights the importance of authenticity in relationships.

Gargiulo (1999) encourages the importance of creating an authentic safe space for people through caring relationships where people can be heard and respected for their reality as they narrate their own life scripts. Authenticity is discussed by Williams (2002) in holistic health care in terms of taking into account the lifeworld of the person and the dynamics of the client's life in their environment (Williams, 1998, 2002). Gesler discusses 'networks of interpersonal concern' p.738) in terms of meaningful non-visual fields of care that are a part of the therapeutic landscape.

Similarly, Myers (2000) in a study of client experiences in therapy reports:

> Participants experienced being heard when therapists created a safe space for self-exploration, were actively and genuinely engaged in the therapeutic dialogue (paraphrasing, clarifying, questioning and remembering details), and did not flinch when painful material was brought to the therapeutic process. (p. 148)

Frankel, Sung and Hsu (2005) also found that patients perceiving enhanced health characterised their relationships with doctors as having a sense of mutual respect and positivity. In a study by Barry, Stevenson, Britten, Barber, and Bradley (2001), a survey of doctors' consultations revealed that more successful outcomes were reported when general practitioners engaged in the lifeworld of their patients, enabling them to feel listened to, validated, and respected.

Nelson, Lord and Ochocka (2001) in a study of 50 people with a psychiatric illness found that supportive, responsive, genuine, positive and client-directed relationships encouraged a sense of well-being and empowerment. McCabe and Priebe (2003) recognised that positive relationships between clinicians and patients are desirable in terms of creating more humane and acceptable services for users. The importance of an authentic therapeutic relationship is also identified by numerous other researchers over several years (Henderson, 2002; Howego, Yellowlees, Owen, Meldrum & Dark, 2003; Smith & Kelley, 2006; Cutcliffe & Barker, 2002; O'Brien, 2001; Shanley, 2001; Zuroff & Blatt, 2006).

While the hospitality literature does suggest a trend towards a greater interest in authentic relationships with others, the concept of authenticity in tourism adds two further dimensions, authenticity of experience and authenticity of place.

Firstly, Kim and Jamal (2007) point to the importance of experience based authenticity in a commodity-driven and contrived industry. In a study undertaken at a Texas renaissance festival, 37 interviews were conducted with regular festival attendees. Festival participants were keen to have 'experience-based authenticity' or 'existential authenticity' (Wang, 1999), rather than authenticity of the sights or historical representations presented, or object-related authenticity, (Wang, 1999). Thus, authenticity was about people bonding with each other, and gaining a sense of their own identity. Authenticity was also about people feeling free to be themselves without the pressures of everyday life, social norms and regulation. Kim and Jamal (2007) argue that existential authenticity is made up of egalitarian acceptance of interpersonal relationship bonding within the community, and intrapersonal authenticity in which people are involved in their own sense of identity and self-development.

Similarly, Yeoman, Brass, and McMahon-Beattie (2007) emphasise that demand for authentic experiences is moving beyond fulfilment through goods and services, to experiences that are consistent with a level of self-actualisation. Authenticity in tourism is about giving people more individually meaningful experiences and moving away from mass packaged holidays and over-commercialised experiences. It is argued that rather than just seeing the world, people want experiences that can give them a better quality of life. Hall (2007) views authenticity in terms of connectedness to individuals in their perceived world and their everyday lived experiences, rather than to things or places. Steiner and Reinsinger (2006) view authentic experiences in terms of tourists being self-directed, finding their own way around and exploring the views autonomously.

Authentic places are those sought out in untouched and unexposed areas while avoiding areas and activities with lots of other tourists (Yeoman et al., 2007). These authors claim that

people are seeking a sense of place through historical heritage environments, ‘real food’ as opposed to ‘fast food’ and real places, such as villages, where they can meet ‘real villagers’ to have a deeper experience (p.1135). Similarly, Voase, (2002; 2003) argues that tourists are seeking real historical places of significance, rather than interpretations of them at heritage centres. While it is anticipated that mental health consumers will identify with authentic relationships, it is also interesting to consider whether they perceive their mental health has benefited through authentic experiences and places.

2.6.6 The desire for transformation

Health care is related to inner transformation – living a healthier lifestyle, gaining insight, meditation, or a search for higher self. All of these aspects are about transforming inner well-being. Vidarkliniken, a health facility in Sweden, at one extreme aims to translate people to a higher level of consciousness and health, to the extent that illness will be viewed as an opportunity for spiritual development and an insight into the purpose of life (Coates et al., 1992).

Moon et al. (2006) discuss how Ashburn Clinic, a private psychiatric facility in New Zealand, is marketed with an emphasis on serenity that links it with new age spirituality and cycles of nature pertaining to reminders of inner personal growth. Similarly, the Homewood Health Centre is described as a place where a ‘healing journey’ (p. 143) can begin taking the person to a range of destinations that offer guidance with emotional and mental health problems.

Tourism trends also reveal an increased interest in renewal and rejuvenation. Devereux and Carnegie (2006) discuss the concept of pilgrimage in tourism as a type of

transformation, in terms of a physical and life journey. Pilgrimages are journeys that search for meaning and renewal through reflection and new encounters and challenges. Devereux and Carnegie describe pilgrimage as incorporating spirituality, a journey, a sense of community, tourism and wellness. The authors suggest: 'wellness tourism — in relation to pilgrimage — needs to allow individuals to become reacquainted with themselves and their community at all levels, with their own physical, spiritual and emotional needs' (p. 54). Smith and Kelley (2006) describe self-development and life enhancement as important factors, and suggest that more than 30% of people who attend Skyros, a health retreat in Greece return because the experience is so life-changing.

Wilson and Harris (2006) described the travel experiences that were seen to be meaningful for women, by way of three themes that are not dissimilar to the transformations that have been described for a pilgrimage. These were a search for self and identity, self-empowerment, and connectedness with others and/or global citizenship. The search for self was to do with a journey on a psychological as well as physical level that enabled a degree of introspection and reflection, and facilitated personal awareness and growth.

Empowerment came from independent travel, while a sense of meaning developed through connections made and a feeling of greater responsibility for the planet. This research suggested that the emotions connected to travel were extremely important and that meaning derived from this experience would continue to develop after the journey had ended.

Steiner and Reisinger (2006) describe how transformation is brought about by healthy eating and habits, while Smith and Kelly (2006) discuss how the holistic tourist has a desire to search for 'true self' (p. 15). Cleaver, Green and Muller (2000) discuss transformation as

spiritual renewal, expressing creativity, or improving oneself as a human being, while Lea (2006) describes the market for new age tourism as one that helps people to seek out and appreciate new meaning and purpose in their lives.

2.7. Research across Disciplines

The concept of the therapeutic landscape offers the capacity for cross-disciplinary research and can be used in the discipline of social work to gain a better appreciation of the impact on individuals of interaction with their geographic, social and cultural landscape. To revisit the significance of the literature review in terms of the research question: *How can mental health service delivery be shifted beyond the medical paradigm?*

The concept of therapeutic landscapes assists in two ways. First, it opens up the discourse around mental health and well-by being removing it from traditional mental health service delivery, to a much broader domain of influencing factors.

Second, it not only recognises the factors that assist in contributing to and maintaining mental health and well-being, it also highlights the continuum of wellness by capturing how mental health evolves for people in the context of their need for rejuvenation, restoration and renewal.

SUMMARY

This chapter opened by identifying the prominence of the recovery paradigm in the mental health literature and some of the concerns raised about its implementation in mental health service delivery. While the values underpinning recovery are consistent with mental health social work, the scope of the literature using the concept of therapeutic landscapes, spread beyond the niche of mental health social work, to the tangible and existential factors

that contribute to mental health and well-being. The concept of therapeutic landscapes highlighted the environmental, social, structural and cultural factors that contribute to mental health and well-being. The commonalities of healthcare and tourism landscapes were then melded together, in recognition of the power of commodification and the trend for individuals to seek hospitality, sanctuary, health promoting experiences and empowerment, and to search for alternatives, authenticity and transformation. The following two chapters will explain the Grounded Theory methodology that was used to interview 60 participants in the areas of mental health, natural therapies and tourism/hospitality to further explore the notion of what contributes to mental health and well-being.

CHAPTER 3: USING GROUNDED THEORY

3. INTRODUCTION

The previous two chapters have set the scene for understanding mental health and well-being from a broad perspective. This chapter describes the methodology of Grounded Theory used to further this understanding and provides a rationale for its use, in an insightful exploration across three disciplines to discover what contributes to mental health and well-being. Issues and pitfalls of the methodology are considered, the process of theoretical sampling and the use of primary and secondary data sources are also discussed.

Since data was collected across three disciplines over a two and a half year period, the gathering and treatment of data is separated out into three stages to reflect each discipline area. Milestones at each stage are then discussed in terms of the recruitment of participants, developing the structure of interviews, the interview process, and member checking with participants. An explanation is given about the preparation of data for analysis, followed by a diagram summarising the process of data collection and the time frames associated with this process. This chapter focuses on the use of Grounded Theory methodology prior to data analysis, while Chapter Four will explain the process of data analysis using Grounded Theory.

3.1 The Grounded Theory Approach

The approach to Grounded Theory used here is primarily that of Glaser and Strauss (1967) to whom its development is attributed, based on the idea that the research process is guided by emerging theory, with research and theory becoming part of the one continuum.

> Generating a theory from data means that most hypotheses and concepts not only come from the data during the course of the research, but are systematically worked out during the course of the research. Generating a theory involves a process of research. (Glaser & Strauss, 1967, p.6)

Thus, as Glaser (1978) explains, the generation of theory through data becomes part of the process of undertaking social research. Unlike with other qualitative methods, the researcher must be constantly immersed in the data, in order to determine in which direction the research moves, and how data is to be collected, coded, analysed and integrated to develop the theory (Moghaddam, 2006).

While Glaser and Strauss went in different directions in their approach to Grounded Theory in the early 1990s (Heath & Cowley, 2004) the methodology and analysis used in this research reflects Glaser's style in terms of uncovering what is happening for participants, while Strauss's method assisted in clarifying specific research procedures, such as line-by-line coding of data, axial and selective coding and memo-writing.

One key area of departure between Strauss and Glaser was that while Strauss (Strauss & Corbin, 1990) emphasised the importance of scientific validation through testing the reproducibility of the theory, Glaser (1992) emphasised theoretical emergence and discovery (Allan, 2003; Moghaddam, 2006). Glaser (1992) focused on the capacity to modify theory, arguing that what is analysed is a process rather than a unit of analysis; hence Glaser became concerned that Strauss's approach would encourage forced description instead of theory grounded in reality.

While I thought Glaser's approach to be more compatible with a social work process-orientated background, other Grounded Theory research assisted me to become familiar with

Grounded Theory as applied in health care contexts. A number of studies were gathered from the field of nursing; for example, McCann and Clark (2003), who undertook studies in the Australian mental health context into the role of nurses in enabling consumers and carers to access community mental health services; Gass (2006), on the experiences of nurses in Scotland working in the area of electroconvulsive therapy; and Cutcliffe, Stevenson, Jackson and Smith (2006) on the experiences of nurses working with suicidal patients in the United Kingdom. Other informative studies include Skodol Wilson (1995), on healing communities; Hutchinson (1995), on the experiences of people with bi-polar affective disorder; and Beal, Veldhorst, McGrath Guruge Grewal, DiNunzio et al. (2005), on how individuals with schizophrenia who have been hospitalised form relationships in the community.

Specific Australian mental health studies reviewed included Gibb (2003), on mental health nursing in rural and remote areas; and Wynaden (2007), on the experiences of caring for a person with a mental illness. Elements from the above studies that I found useful were the sorting of data into codes and properties, the analysis of key stages and transitions within participant experiences, and recognising key factors that either detrimentally or positively influenced these experiences. Other Grounded Theory researchers, Faberhaugh (1995), Allan (2003), Bowen (2006), and Shah and Corley (2006), were helpful in clarifying issues around conceptualisation and analysis.

3.2 Rationale for Using Grounded Theory

One of the attractions of Grounded Theory for me was its transparency and openness to understanding social psychological processes, allowing the empirical world and theory to come together. As Glaser explains, the mandate of the researcher is to ‘remain open to what is actually happening’ (1978, p. 3).

As a social worker with an interest in mental health and well-being, the use of Grounded Theory offered me the opportunity to make explicit the implicit beliefs of respondents around the question, *"What contributes to mental health and well-being?"* After many years of experience working within the context of traditional mental health and disability systems, I was eager to view mental health and well-being from a fresh perspective; I had a genuine desire to set aside the pre-existing biases and hypotheses about mental health to which I had been unavoidably exposed in my career, and launch into unknown territory.

Grounded Theory emphasises the importance of comparative analysis (Glaser, 1978) allowing for the comparison of data from different disciplines and enabling the researcher to reinterpret the data to establish its meaning, leading to the emergence of new conceptual frameworks for practice. This was of particular value for me, as it allowed different perspectives to emerge in relation to the concept of mental health and well-being. Grounded Theory enabled the broad exploration of the following questions (which are derived from the research question) *What contributes to mental health and well-being generally? What are the processes and events happening in other fields that can apply to mental health service delivery?*

Undertaking the Grounded Theory process of theoretical sampling (Glaser, 1992; Glaser, 1978; Glaser & Strauss, 1967), I started the research in the area of mental health, moving later into the hospitality and natural therapies sector. While I had some inclination at the beginning of the research that areas may be useful, specific decisions about each sample emerged as the research progressed. One advantage of entering these new fields is that they do not carry the historical connotations of mental health and well-being in the context of

illness that are often experienced by stakeholders working within the paradigm of the general mental health service delivery system.

While data was being collected, I was constantly immersed in its conceptual analysis. There was an exciting prospect of developing theory that potentially could be applied to enhance the mental health and well-being of the consumers of a mental health service.

The Grounded Theory processes of purposive and theoretical sampling (Glaser, 1978) and conceptual data analysis through open, axial and selective coding (to be explained in the next chapter), enabled me to search within various groups for 'social processes' (Glaser, 1978, p. 96) that contributed to mental health and well-being, and for their explanations. These groups were either providing or receiving services, which (implicitly or explicitly) had the function of contributing positively to mental health and well-being.

Glaser captures the practicality and purposefulness of undertaking Grounded Theory research through the following statement:

> This theoretical grasp of problems and processes within data is –in our perspective –a very useful way to understand what is going on in a substantive area and how to explain and interpret it. It is a succinct, interesting, and easy way to remember the data and a transcending way to view it. The data of the substantive area becomes theoretically tractable. It guides future research in the same area, and its formulations guide work in other areas. It is very catching and meaningful to many colleagues and students. (1978, p. 3)

Glaser argues that a key goal of Grounded Theory is to account for the 'patterns of behaviour' of participants (1998, p. 117). If the core problem is poor mental health and well-being, then the question can be posed: *"What are the patterns of behaviour undertaken by service providers and individuals that assist individuals improve their mental health and well-being?"* An understanding of this may also contribute to an answer to: "*What inhibits*

mental health and well-being in the mental health system and how may these factors be addressed?"

I considered that such questions might also have implications for service providers in the hospitality and natural therapies fields, for exploring 'what is going on?' and what this might mean in their respective industries. In doing this, practical applications of the theory outside of the substantive field of mental health were contemplated as desirable.

Grounded Theory also enables the use of various types of data from different sources, such as observations, informal conversations, brochures, noted impressions, photographs and literature. This data triangulation (Denzin, 1978) adds a further richness to the research process. In addition, Grounded Theory offers a systematic and organised methodology to code and analyse qualitative data.

3.3 Issues and Pitfalls in Grounded Theory Research

While the constructionist approach that this methodology allows was enticing in terms of exposure to the field and to a broad range of data, I needed to be mindful of potential pitfalls before commencing the journey.

3.3.1 Difficulties in the evolving conceptual analysis

A number of difficulties in undertaking Grounded Theory are documented by Glaser (1978, 1992, 1998, 2002a, 2002b). These include being prepared to wrestle with theory as it emerges, rather than making assumptions based on preconceptions; constantly and industriously comparing the data, to lessen bias in the substantive field; not being constrained by time or place when undertaking theoretical conceptualisation; remaining open to the

continual emergence of new categories and properties; and not being influenced by buzz words or the respected works of others while undertaking conceptual analysis. Glaser (1978) also warns against being seduced by the colourfulness of description, rather than undertaking a disciplined and vigorous conceptual analysis of it.

Given these pitfalls that Glaser (1992) suggests can force the data, the attraction for me as a social worker was to acquire the perspective of the respondents, in the hope of understanding as closely as possible what was happening for them. Glaser states:

> My goal in writing Grounded Theory was and is to empower researchers with an open, generative, emergent methodology. It gives them an honest approach to the data that lets the natural social organisation of substantive life emerge. (1998, p. 94)

3.3.2 The use of literature review in Grounded Theory

Glaser (1998) also warns against pursuing a formal literature review until you are ready to integrate relevant literature into the formulation of your theory. This leaves the researcher free to discover new concepts rather than undertake the research with preconceived ideas. Glaser suggests that through this process, the researcher can take on a wider view of the substantive area to give it a fuller perspective.

While some reading was undertaken in the early phase of the study, to define the general area of interest, the majority of the literature review for this study was undertaken after the data had been coded and analysed, so that a more discerning approach could be taken to integrate it, rather than making assumptions about how it related to the topic area. The literature was treated as part of the data and provided another lens though which comparisons could be made. The literature and the collected data both played key roles in enabling me to ask further questions about the emerging theory.

3.3.3 The methodological issue of taping

While Glaser warns against taping interviews, instead favouring comprehensive field notes, there were a number of reasons why taping was essential for me. First, opportunities for field interviews arose over a number of years and were often to be fitted in between paid work appointments. I did not always have the luxury of time immediately after the interviews were done to reflect and elaborate on field notes. Often, tapes were listened to over a couple of weeks in order to make comprehensive notes.

Second, a small tape recorder was less obtrusive than writing copious field notes. From my experience, as an experienced mental health practitioner, I anticipated that participants (particularly mental health consumers and carers) would appreciate a regular conversation that generated interest and provided them with eye contact, rather than being faced with the formality associated with documenting their situation, in the way that many mental health professionals may have done before. This also enabled me to focus more on my interviewees' body language and their experiences, paying attention to what information would be useful to ask for next, rather than simply documenting what had just been heard.

Finally, if some consumers and carers were to reveal hurtful experiences in terms of their encounters with the mental health system, I wished to be able to engage empathetically with them, rather than having to focus upon writing intensive field notes, which may have elicited unnecessary feelings of discomfort or even paranoia.

While transcribing and listening to tapes was going to be time consuming, I believed it would add richness and authenticity to the data collected. Glaser (1998) argues that, through taping, observations are lost. However, to accommodate this relevant concern, I planned to

take notes on my general feelings and impressions after the interview to preserve the integrity of the interview experiences with participants.

3.4 Commencing the Research Process and Ethics Approval

Given the above exploration of Grounded Theory methodology and consideration as to how I intended to address the methodological challenges associated with Grounded Theory, the process I took of theoretical sampling and data collection will now be explained. This will include the use of primary and secondary data, how interview participants were recruited, ethical considerations, how interviews were structured, the interview process and member checking with participants.

Ethics approval was sought for this study through Griffith University and approved prior to commencement of participant interviews. This involved submitting a detailed application for consideration by the Griffith University Human Research Ethics Committee which was required to comply with Australia's National Statement on Ethical Conduct Involving Humans.

Particular consideration was given to information management procedures and safeguards (for example support processes) that were arranged for mental health consumers and carers. Given this particular data sample had the potential to be vulnerable, react adversely to stress or have impaired decision making capacity, safeguards put in place will be discussed at the recruitment stage of stage one of data collection.

3.4.1 Theoretical sampling

An important component of Grounded Theory is theoretical sampling (Glaser, 1978), which involves taking data out of the context or discipline area in which it began. Through sampling, the developing theory is tested in comparison with other data, leaving the significance of time and place behind. This means the research plan evolves; it is directed by the data already collected, in terms of knowing where to search next rather than having a preconceived framework. As Glaser states:

> The analyst who uses theoretical sampling cannot know in advance precisely what to sample for and where it will lead him. Only as he discovers codes and tries to saturate them by looking for comparison groups, does both what codes and their properties and where to collect data on them emerge. It is never clear-cut for what and to where discovery will lead. It is ongoing. (1978, p .37)

It was only after coding the data obtained through interviews with mental health consumers and carers (to be explained in the next chapter) that I was able to make decisions about where to go next for further data. Glaser describes this as the 'deductive' part of Grounded Theory research (1978, p. 38). For example, when interviewing consumers and carers about mental health and well-being, key themes that emerged initially included freedom, rejuvenation, natural environments, relationships, and being made to feel special. Deductively, I wished to seek out those groups in which these sorts of processes might be going on, but where there would be less of an emphasis on mental illness and more of a focus on mental health and well-being.

Given that many individuals with mental health issues believed their mental health to be better when they are away on holidays, the next theoretical sample chosen was hospitality providers and recipients. This exploration sought to discover: *What is going on that contributes to mental health and well-being in hospitality settings?*

Through the initial coding process (which is further explained in the next chapter), themes emerged around the topics of giving up responsibility, relaxation and again, a sense of rejuvenation. A further decision was then made to interview natural therapy recipients and providers to make comparisons with the emerging data, and to gain a holistic perspective of mental health and well-being, thus furthering the comparison of data received by consumers and carers who had been primarily exposed to clinical settings.

3.5 The Primary Data

Both primary and secondary data samples were collected in the substantive field of mental health, and the comparative fields of hospitality and natural therapy. The primary data will be discussed first.

Using theoretical sampling, research participants for this study were affiliated with three fields of service delivery, with two different groups being interviewed within each field. I viewed the disciplinary fields chosen as potentially valuable, given the contributions they make to general mental health and well-being. Their relevance was further highlighted and confirmed through a more intensive literature review, which was able to contribute to the meaningfulness of the data.

It was unclear, at the beginning of the primary data collection, how many interviews would need to be undertaken. Initially, at the time of ethical approval, it was thought that up to 25 individuals in each of the substantive areas of mental health (consumers and carers) might need to be interviewed. However, as the data was collected and coded, it became evident that a sample of ten in each area would lead to a point of saturation, after which further data collection was unlikely to reveal any additional significant information.

With the intention to create a diverse yet manageable theoretical sample, the following groups were interviewed:

Mental Health (10 mental health consumers and 10 carers).

Hospitality Industry (10 hospitality service providers and 10 hospitality service recipients).

Natural Therapy Industry (10 natural therapists and 10 natural therapy recipients).

The processing of the data samples through comparative research is known as space triangulation (Denzin, 1978). Research into the other fields (hospitality and natural therapies) was conducted to compare the themes associated with mental health and well-being. This research was designed to elicit further data on the experiences of people who had felt rejuvenated or renewed and how service providers had contributed to these experiences.
A decision was made early on in the research process to not interview mental health workers. The rationale for not interviewing practitioners comprised three factors.

First, the intention of this study was to develop a new understanding of the factors contributing to mental health and well-being that was removed from the traditional language and perspectives of mental health clinicians. The use of the sample selected aims to broaden the understanding of mental health and wellbeing by introducing its significance into new settings, to facilitate a shift towards a new paradigm for mental health service delivery.

Second, in line with the grounded theory approach, the theoretical sampling process intended to give as much opportunity as possible for the discovery of new meaning and understandings attached to mental health. Individuals were chosen to capture the voices of those who experience the current mental health system as consumers and carers rather than

clinicians. Natural therapy providers and hospitality providers and recipients were chosen as they were both providing and receiving a service that contributes to general mental health and wellbeing, while outside the current mental health service delivery system. It was anticipated that through this sample, a more diverse understanding of mental health and well-being would be gained.

Third, while initially, some consideration was given to whether mental health workers should be interviewed, the time constraints and volume of data gathered would have made analysis unmanageable. It was determined that future research could present findings from the samples to mental health clinicians to seek their feedback and input. Should a model of mental health service delivery emerge, practitioners could then be consulted in relation to implementing this model into practice.

Given this rationale for the selection of the sample, sixty research participants were interviewed over a two and a half year period. As I came from a mental health background, and understanding the mental health and well-being issues of consumers and carers was fundamental to the study, I chose to start interviewing with a familiar participant group before moving to the unfamiliar. The initial interviews in the substantive area of mental health influenced the topics and issues that would be discussed with research participants in other fields, as well as how those topics would be approached. This followed Grounded Theory methodology, enabling the researcher to make sense of one set of data in order to discover how to approach the next stage of the research process.

As the questions formulated for mental health consumers and carers were relevant for eliciting information on mental health and well-being, a similar meta-question framework

was used for the other areas; however questions were tailored and targeted towards the specific discipline area and role of the individual being interviewed (for example, recipient or service provider in the areas of hospitality and natural therapies).

3.6 Stage One- Mental Health

3.6.1 Recruitment process for stage one of the data collection

While considerations of an ethical nature were important for all interview participants, in relation to confidentiality, informed consent and access to relevant information about the study, mental health consumers and carers required special consideration. All mental health participants in the study were recruited through ARAFMI Queensland (Association of Relatives and Friends of the Mentally Ill), which took a key role in ensuring participants were safeguarded. The Association reviewed all information sent out to participants and approved the statements on confidentiality and informed consent (Appendices A & B).

The Coordinator of a Family Support Program located in Brisbane, (funded through ARAFMI Qld), acted as the primary gatekeeper by identifying research participants who may be interested in the study. This gate keeping role enabled the Coordinator to reflect on the mental health status of participants at the time of the study (relying on observation and interaction with consumers, file notes and staff feedback). Mental health consumers were identified as potentially suitable if they were currently experiencing no acute symptoms, if they were capable of understanding the purpose of the study and could give consent freely, and if there were no other stressful circumstances in their lives that might interfere with their ability to participate. Consumers were also selected if they were generally known to like speaking up and offering their viewpoint on mental health issues.

Similarly, carers were considered potentially suitable if their own life circumstances were relatively stable in terms of their caring role, and also if they were known to have an interest in expressing their views on mental health and well-being. All participants were required to be over 18 years, but there were no further defining characteristics in relation to living circumstances, age, or whether carers or consumers might be related to each other.

The Coordinator of the program sent out a letter on my behalf, inviting participants to be interviewed. As part of this process, she also screened consumers and carers that she judged could not be approached for the study, given their level of vulnerability or their mental health status at the time.

All participants were informed of the purpose of the study and received an information sheet about it. Informed consent was obtained and confidentiality issues discussed. Mental health consumers and carers were offered support for the interview and could request someone to sit in on it (two people made use of this option). Both the Coordinator and Executive Officer perused the interview guide for its user-friendliness as part of the gate keeping role to ensure its appropriateness for participants.

It is noted that given the fact that ARAFMI consumers all had carers, the study did not access people who lived without the support of carers, or who did not access respite services. Thus, it could be argued the sample reflected those consumers who had received some consistent support in their lives as opposed to those who do not. Another factor influencing the sample was that consumers approached for this study were more likely to be well known to the service and to staff (to ensure a thorough risk assessment regarding their participation),

than those accessing it for the first time whose circumstances may have been less well known to ARAFMI Qld.

3.6.2 Developing the structure for the initial interviews

The structure for the initial interviews was developed by framing meta-questions developed from my initial questions about what contributes to mental health and well-being. A preliminary literature review also aided the development of these questions.

Initial questions were designed to bring people into touch with their memories of experiencing mental health and well-being; they were designed to take people outside of the context of mental health service delivery. For example, questions encouraged them to think about holidays, or places where they had been, when they had experienced a sense of rejuvenation or well-being. Questions then gradually led people to think about these experiences in relation to how they could be applied to people experiencing a mental health issue or to their carers.

Consequently, the major themes centred on questions relating to environments and relationships that influenced mental health and well-being. Key exploration areas included:

1) environments that facilitated mental health and well-being;

2) environments conducive to effective communication;

3) environments reflecting a value of recovery;

4) environments that reflected a holistic view of the person;

5) environments that constituted a feeling of warmth and welcome;

6) features of helpful or therapeutic relationships;

7) examples of engaging or effective communication;

8) features of relationships that are welcoming and take account of the whole person;

9) ideas on what most needs to change about mental health service delivery; and

10) significant learning from consumers and carers.

The same topic areas were discussed with carers as with consumers, although they were contextualised to bring out the life experience of carers and their perspective on contributing factors to mental health and well-being. The interview guide allowed a level of flexibility, which was important in allowing people to share their stories.

Before the interviews were conducted, the interview guide was trialled with two mental health consumers. In light of this trial, some questions were separated out for clarification and their language simplified. As discussed, The Coordinator and Executive Officer also perused the interview guides for consumers and for carers to be used in the study (Appendices C & D), to ensure that they were clear and user-friendly for participants.

3.6.3 The interviews

After the letters were sent inviting people to participate, I received a positive and timely response toward organising the interviews. Most interviews were conducted at the Family Support Program or at the homes of mental health consumers and carers. One interview with a carer took place over the phone, as she felt her daughter was too unwell to leave the house, and, she felt disinclined to receive any visitors at home. All information and consent forms in this instance were sent and returned by mail.

Mental health consumers and carers were informed that some of the questions might elicit uncomfortable memories for them, and should this be the case they could request

debriefing or support from staff at ARAFMI Queensland or from me. All participants were told that they could withdraw from the interview process at any time without giving a reason. Mental health consumers and carers were assured that, should they choose to withdraw, their rights to mental health service delivery would not be jeopardised in any way. No participants who began being interviewed withdrew from the process; in fact, feedback from several consumers and carers indicated that they enjoyed the experience and appreciated having their views heard about mental health and well-being and service delivery.

Most interviews took from one to two hours. Interviews did not take place in any particular order, except that those consumers and carers expressing the most interest in the interviews and being most available were interviewed first. Interview responses were coded chronologically by date. The demographics of the mental health consumer and carer groups at the time of the interview were as follows (Table 3.1 below and Table 3.2 on the next page).

Table 3.1
Mental Health Consumer Demographics

Interviewee	Age (in years)	M/F	Mental Health Issue
Consumer 1	40	M	Axis I diagnosis
Consumer 2	30	M	Axis I diagnosis
Consumer 3	56	M	Axis I diagnosis
Consumer 4	41	F	Axis I diagnosis
Consumer 5	47	F	Axis I diagnosis
Consumer 6	36	F	Axis II diagnosis
Consumer 7	73	F	Axis I diagnosis
Consumer 8	51	M	Axis I diagnosis
Consumer 9	47	M	Axis I diagnosis
Consumer 10	52	F	Axis I diagnosis

There were 10 consumers interviewed (5 women and 5 men), ranging in age from 30 to 73 years at the time of interview. Six out of the 10 individuals had been given a diagnosis of schizophrenia; one had been given a diagnosis of bipolar affective disorder, one with major

depression, one with personality disorder, and one with post traumatic stress disorder and major depression.

Table 3.2
Mental Health Carer Demographics

Interviewee	Age (in years)	M/F	Mental Health Issue of Person Cared For
Carer 1	55	F	Axis I diagnosis
Carer 2	82	M	Axis I diagnosis
Carer 3	48	M	Axis I diagnosis
Carer 4	61	F	Axis I diagnosis
Carer 5	56	F	Axis I diagnosis
Carer 6	70	F	Axis I diagnosis
Carer 7	60	F	Axis I diagnosis
Carer 8	55	F	Axis II diagnosis
Carer 9	61	M	Axis I diagnosis
Carer 10	57	F	Axis I diagnosis

Only one consumer and carer interviewed were part of the same family unit, being husband and wife. Seven of the carers interviewed were mothers of the person they cared for and two were fathers. Carers ranged in age from 48 years to 82 years at the time of interview. Interviews with consumers and carers took place between May and December 2004.

3.6.4 Member checking at stage one

After interviews with mental health consumers and carers, participants were phoned, and thanked for their time and asked if there was anything they would like to add. Additional notes were taken and added as secondary data (explained later in this chapter). After the 20 interviews were conducted in the substantive field of mental health, all recipients were sent a summary of the themes that emerged from the interviews (Appendix E). Recipients were also sent a feedback form (Appendix F), which they could fill in to highlight particular themes or

issues that were important to them. The report summary and returned feedback forms were also considered as secondary data.

3.7 Stage Two – Hospitality

3.7.1 The recruitment process: stage two of data collection

At the time of the study, I was fortunate enough to be working in employment that enabled some travel through various parts of Queensland, which proved useful for interviewing hospitality providers. A balance was sought, through interviewing a range of hospitality accommodation providers including owners and managers.

In light of the Grounded Theory principle of collecting a diverse range of data in any one theoretical sample, a variety of hospitality providers were interviewed. The location of providers was selected to ensure a range of metropolitan and country environments with a mixture of beach and nature settings, including two spiritual retreats that were conducive to a focus on holistic health and well-being. All providers were contacted by telephone in advance with a request for an interview and were given written information as well as a verbal explanation about the research project. All signed a form consenting to take part in the research process. On the basis of a fundamental tenet of Grounded theory that 'all is data' (Glaser, 1998, p. 8), I also stayed in six of the ten locations at the time interviews took place to immerse myself in the experience and gather further secondary data.

Hospitality providers selected for the project included a beach motel in Townsville, a country motel in Mt Isa, a country bed-and-breakfast in Ipswich, a coastal bed-and-breakfast in Byron Bay, a rainforest retreat in Springbrook, a country retreat in Grandchester, an inner city hotel (part of an international chain) in Brisbane, a Gold Coast Hotel (also part of an

international chain), and two spiritual retreats (one at the Sunshine Coast and one Christian retreat in a Bayside suburb of Brisbane).

Some general demographics of these areas are provided, with a map of the locations in Appendix G.

Table 3.3
Hospitality Providers Interviewed

No.	Type of Hospitality Provider	M/F	Age	Location	Demographics
Hosp prov 1	Owner of Beach Motel	F	NK	Townsville	Population approximately 160,000. Large urban coastal area, surrounded by mountains and off-shore islands. Significant for government infrastructure, mining, commerce and retail. [1]
Hosp prov 2	Owner of Bed and Breakfast	F	NK	Ipswich	Population approx. 150,000, 30km from Brisbane CBD – known for historical buildings and mining history. [2]
Hosp prov 3	Manager of Country Motel	F	37	Mt Isa	Population approx 22,000. Popular for tourists visiting outback Australia. Primary industry of mining –lead, copper, zinc, iron ore. [3]
Hosp prov 4	Owner of coastal Bed and Breakfast	F	64	Byron Bay	Population approx. 9000. 175 kilometres south of Brisbane. Known for relaxed lifestyle, beaches and unspoilt hinterland. [4]
Hosp prov 5	Owner of Rainforest Retreat	M	38	Springbrook	World heritage tourist area. Known for rainforest and rare flora and fauna. [5]
Hosp prov 6	Manager of Inner City Hotel Chain	F	34	Brisbane	Population nearly 1.8 million. Culturally diverse city known for business, education, health and recreation. Features inner city parklands and river walks. [6]
Hosp prov 7	Spiritual Retreat	F	NK	Sunshine Coast	Population approx. 270,000 – rapidly growing professional population. Features surf beaches, river estuaries and green hinterland. [7]

No.	Type of Hospitality Provider	M/F	Age	Location	Demographics
Hosp prov 8	Manager at Country Retreat	F	33	West Moreton Region	Population approx 500. Historical village with historical railway and sawmill. 76 km west of Brisbane. [8]
Hosp prov 9	Manager at International Hotel Chain	M	35	Gold Coast	Population approx 500,000. An international tourist destination and business centre featuring beaches, attractive scenery and modern conveniences. [9]
Hosp prov10	Christian Spiritual Retreat	F	53	Brisbane Bayside Suburb	Outer Brisbane suburb. Popular destination for family outings. Overlooking Moreton Bay, features sailing club. [10]

Eight out of ten interviewees were female. Four interviewees were the owners of hospitality businesses; four were managers, while the two staff who were interviewed at the spiritual retreats were a Buddhist nun and a lay spiritual counsellor. Because three of the hospitality providers did not agree to give their age at the time of interview, it could be only be established that five of the providers were in their 30s, one was in their 50s and one was in their 60s. The provider in her 60s owned her business with her husband, appeared to be highly regarded in their community, and had built up the business over many years. The managers interviewed who gave their ages were typically younger (in their 30s) and appeared highly committed to building up the business. Only one person in their 30s was an owner and manager.

[1] Retrieved October 30, 2007, from www.townsville.qld.gov.au/atlas/population

[2] Retrieved, October 30, 2007 from www.lgp.qld.gov.au/docs/corporate/planning/demographic/profiles/demographics_and_housing/ipswich

[3] Retrieved, October 30, 2007 from www.buffs.com.au/about mt_isa.htm

[4] Retrieved, October 30, 2007 from www.byron_bay.com/byronbay/general.html

[5] Retrieved, October 30, 2007 from www.epa.qld.gov.au

[6] Retrieved, October 30, 2007, from www.ourbrisbane.com/living/brisbanelife/facts/statistics.html

[7] Retrieved, October 30, 2007 from www.tourismsunshinecoast.com.au

[8] Retrieved, October 30, 2007 from www.grandchestersawmill.com.au/AboutGrandchester.html

[9] Retrieved, October 30, 2007 from www.goldcoast.qld.gov/t_standard2.aspx?pid

[10] Retrieved, October 30, 2007 from www.wynnummanly/com.au/modules

To gather data on the experience of a holiday, ten hospitality recipients were recruited for interview. All recipients had experienced a holiday within six months of the interview being conducted and a sample was deliberately sought in terms of participants in a range of age groups with varied vacation experiences. A combination of opportunistic and snowball or chain sampling (Patton, 1990) was undertaken in order to access participants. Contacts were made with people known through family, work colleagues and through cold surveying at university at the beginning of a new semester. This enabled decisions to be made during fieldwork as the sample emerged. Chain referrals also enabled a snowball effect as individuals referred me to other people who had recently travelled away on vacation. Six out of ten individuals interviewed discussed a recent overseas vacation, while four people spoke of significant experiences they had within Australia. Individuals were sought purposely across a range of ages and types of vacations. Some vacations lasted a weekend while others spanned several months. Some individuals sought a holiday to experience new places and a level of adventure, while others desired a quiet relaxing break away.

3.7.2 Interview structure

The interview structure for hospitality providers retained similar meta-questions to that of the first survey, although the language was recontextualised to the hospitality industry. Mental health and well-being was discussed more in terms of guests feeling rejuvenated and refreshed through exposure to the setting and the hospitality of workers. Hospitality providers were asked how they viewed themselves accommodating the needs of guests so as to assist in improving their mental health and well-being. They were also asked about the ideal qualities of hospitality workers, and the attitude and approach necessary to maintain oneself in the hospitality industry. The hospitality provider questionnaire is attached as Appendix H.

While the meta-questions for hospitality recipients remained similar (Appendix I), the interviews allowed a significantly greater level of richness in the ways that the travel experiences they related influenced their mental health and well-being, both in terms of the environments they visited and the people to whom they were exposed. Questions were posed at the end of the interview that asked hospitality recipients what they had most learned about their own need for rejuvenation in relation to their mental health and well-being, and how best they could support it.

3.7.3 The interview process at stage two

It was interesting to note that hospitality providers were generally enthusiastic in discussing the topic and could relate well to it, not only because of their own 'natural' people skills but because they recognized how specific environments and a hospitable approach were beneficial to the mental health and wellbeing of their guests. An information sheet was discussed and a consent form signed prior to the interviews. Hospitality providers' interviews were coded in chronological order; most interviews ranged in length from an hour to an hour and a half. Interviews with hospitality providers occurred between January and May 2005.

Hospitality recipients were also eager to recount their holiday experiences and appeared to enjoy reliving the memory of their vacation. Interviews with hospitality recipients also took place between January and May 2005. An information sheet was discussed and a consent form signed prior to each interview. The demographics of hospitality providers and recipients are listed on the next page.

Table 3.4
Hospitality Recipients Interviewed

No.	Destination	Type of Holiday	M/F	Age
Hosp rec1	Island off Queensland Coast	Two-week summer vacation	F	47
Hosp rec 2	Round the world trip	One-month vacation over Christmas	F	48
Hosp rec 3	Ecoresort, Queensland	Christmas break	F	35
Hosp rec 4	UK	Working holiday	F	28
Hosp rec 5	USA and Canada	Christmas vacation	F	18
Hosp rec 6	Asia	Several months	F	37
Hosp rec 7	New Zealand	3 weeks (Spring)	M&F	65 and 60
Hosp rec 8	Malaysia	Extended holiday	F	25
Hosp rec 9	Around Australia	Retirement trip	M&F	78 and 76
Hosp rec 10	Gold Coast	Weekend away	F	51

Interviewees ranged in age from eighteen years to a retired couple in their seventies. Eight of the interviews conducted were with women who had been on holiday, and two interviews were undertaken with married retired couples who explicitly wished to be interviewed together to recount their travel experiences. It is noted that this may have limited the study, as the perspective gained in these two interviews was a joint one, rather than individual perspectives. There was no linkage between the hospitality providers interviewed and hospitality recipients; in other words, all the holiday makers had stayed at different locations to those at which providers were interviewed.

3.7.4 Member checking at stage two

At the completion of the second round of interviews a further report was written (Appendix J) and posted to all 40 interviewees letting them know of the prominent themes that emerged. A feedback form was attached enabling participants to give feedback and comment on the findings that were emerging.

3.8 Stage Three - Natural Therapies

3.8.1 The recruitment process: stage three

To further explore the theme of what contributes to enhanced mental health and well-being, a range of natural therapists were interviewed. These individuals were contacted through drop in and phone contact in the local areas of Ipswich, Brisbane, and Nimbin, a small town in Northern New South Wales. Nimbin was chosen since it is an alternative community that has traditionally attracted people with an interest in alternative health care, and has been open to receiving people with mental health and substance abuse issues. It has attracted people who choose to deviate from having a mainstream lifestyle in order to live in an alternative community structure or to be part of an organic food cooperative to enhance their lifestyle.

I decided to holiday in Nimbin for one week in September 2005 and one week in February 2006 to recruit participants. This was done by establishing a relationship with the two co-owners of a natural therapy centre in Nimbin and explaining the research project. The co-owners then gave me referrals to natural therapists and natural therapy recipients who were willing to be interviewed. In order to gather a range of data therapy providers with different kinds of therapy experience and expertise was deliberately sought. A similar process in terms of approaching managers of therapy centres was used in Ipswich and in Brisbane and

again participants were sought through opportunity sampling (Patton, 1990). Chain referrals from one therapist to another assisted in gaining a range of different types of therapy providers.

3.8.2 Interview structure

The same meta-questions were used for natural therapy providers and recipients, to enable comparison with previous interviews (Appendices K & L), however questions were tailored and targeted towards the specific discipline area and role of the individual being interviewed (for example, natural therapist, natural therapy recipient).

3.8.3 The interview process

Natural therapy providers expressed enthusiasm about the study and stated they enjoyed sharing their own perspective on the importance of a holistic approach to mental health and well-being. They were well versed in working with people who had experienced major mental illnesses, addictions and various forms of anxiety and stress. All natural therapy providers were provided with information sheets on the study and consent forms were signed. Natural therapy providers' interviews were coded in chronological order, and most interviews ranged in length from an hour to an hour and a half. Interviews occurred between August and December 2005.

Rich information was received from natural therapy recipients on their own need to maintain their mental health and well-being and the strategies they use to facilitate this. Most natural therapy recipients participated in a range of natural therapy sessions and were open to exploring alternatives and recounting their experiences.

Several recipients had experienced episodes of acute stress in their own lives and described how natural therapy interventions had been able to assist with anxiety, addictions, and in one case a drug-induced psychosis. The research project was explained to participants and consent forms were signed. Interviews ranged in length from an hour to an hour and a half. Interviews occurred between October 2005 and February 2006. The demographics of natural therapy providers and recipients are listed in Table 3.5 and Table 3.6.

Table 3.5
Location and Types of Natural Therapy Providers

No	Type of Therapy	Location	Age (in years)	M/F
Nat ther prov 1	Massage/Weight Loss Counselling	Ipswich	41	M
Nat ther prov 2	Herbal Therapy	Nimbin	51	F
Nat ther prov 3	Naturopathy	Nimbin	53	F
Nat ther prov 4	Acupuncture	Nimbin	51	F
Nat ther prov 5	Chiropractic	Ipswich	38	M
Nat ther prov 6	Massage/Kinesiology	Ipswich	48	M
Nat ther prov 7	Counselling	Ipswich	42	F
Nat ther prov 8	Naturopath/Bowen Therapy	Ipswich	42	F
Nat ther prov 9	Kinesiology/ Reiki	Brisbane	48	F
Nat ther prov 10	Psychic Healing	Brisbane	52	F

Three practitioners were male, and seven were female. Four of the natural therapists interviewed owned and worked in their own healing centre, and the rest were independent practitioners. Four practitioners worked in a healing centre, and two worked from home. All practitioners were quite experienced in their field and ranged in age from 38 to 52 years at the time of the interview.

Table 3.6
Natural Therapy Recipients

No.	Type of Natural Therapy	Location	M/F	Age
Nat ther rec 1	Meditation	Brisbane	F	47
Nat ther rec 2	Spiritual Counselling	Brisbane	F	32
Nat ther rec 3	Experiential Counselling	Brisbane	F	51
Nat ther rec 4	Massage	Brisbane	F	25
Nat ther rec 5	Kinesiology	Brisbane	M	38
Nat ther rec 6	Reiki/Massage/Remedies	Nimbin	F	29
Nat ther rec 7	Massage/Acupuncture/Herbal Remedies	Nimbin	F	29
Nat ther rec 8	Affirmations/Massage/Herbal Remedies	Nimbin	F	28
Nat ther rec 9	Massage/ Flotation Tank/Acupuncture	Brisbane	F	55
Nat ther rec 10	Crystal healing/Cranial Therapy/Kinesiology	Ipswich	F	36

Nine out of the ten natural therapy recipients interviewed were female: their ages at the time of interview ranged between 28 and 41. The three natural therapy recipients from Nimbin had received treatment from the natural therapists in Nimbin. There were no other links between recipients and providers of natural therapies.

3.8.4 Further member checking

At the completion of all of these interviews a further report was sent to all 60 research participants (Appendix M) inviting feedback. To relate all of these fields back to the area of mental health and well-being two forums were held with the assistance of ARAFMI Queensland, one for consumers and another for carers. A report from these forums was sent

to ARAFMI Queensland also welcoming comments on the content of research findings. (Appendix N). The data from these forums added to the secondary data.

3.9 The Secondary Data

Secondary data, in line with the purpose of theoretical sampling, allows the researcher to collect different types of data. It was also able to provide different vantage points from which to understand the emerging data, and maximise the properties found within it. It also reflects Glaser's view that 'all is data' (1998, p. 8).

Secondary data sources included observations and impressions taken after each of the interviews, as well as additional notes and diagrams that I made as themes emerged. A follow up phone call was made within two weeks of the interview, to thank all mental health consumers and carers for their time, and to ask if there was anything since the interview that they would like to add. Notes from these conversations were also added to the secondary data.

After the interviews in each field, a summary report was sent out with feedback forms encouraging participants to respond to the themes emerging from the study. Given that interviews with mental health consumers and carers were part of the first stage of the study, they received three reports and feedback forms over the course of the study. Hospitality providers and recipients, interviewed as part of the second stage of the study, received two reports and feedback forms. Natural therapists and natural therapy recipients, interviewed as part of the third stage of the study, received one report and a feedback form. From the total of 120 invitations to respond forms via the forms distributed, I received 39 feedback forms, three letters and three phone calls, amounting to a 37.5% response rate, all of which contributed to the secondary data.

Other sources of secondary data included the notes taken from two forums described above (one for mental health carers and one for consumers); notes from the guest books of hospitality providers; informal observations in reception areas of mental health services; natural therapy centres, and hospitality providers; natural therapy and hospitality advertising brochures and photographs. The literature also became additional data as the themes emerging from the interviews added meaning to it. Examples of secondary data are provided in Appendix O.

3.10 Preparation for Data Analysis

As soon as practicable after the interviews, the data was transcribed verbatim for analysis. Given that there were 60 interviews, a transcriber was sought after each ten (10) interviews, by which time the researcher had listened to each interview and made notes. Only one interview could not be transcribed, since it was done over the phone and adequate technology was not available to record it; however detailed notes reflecting the discussion were made. Each interview was given a code that was reflective of who was being interviewed and the chronological order of the interview. For example hosp prov 4 would indicate the fourth hospitality provider interviewed. Codes used are listed in Table 3.7 on the next page.

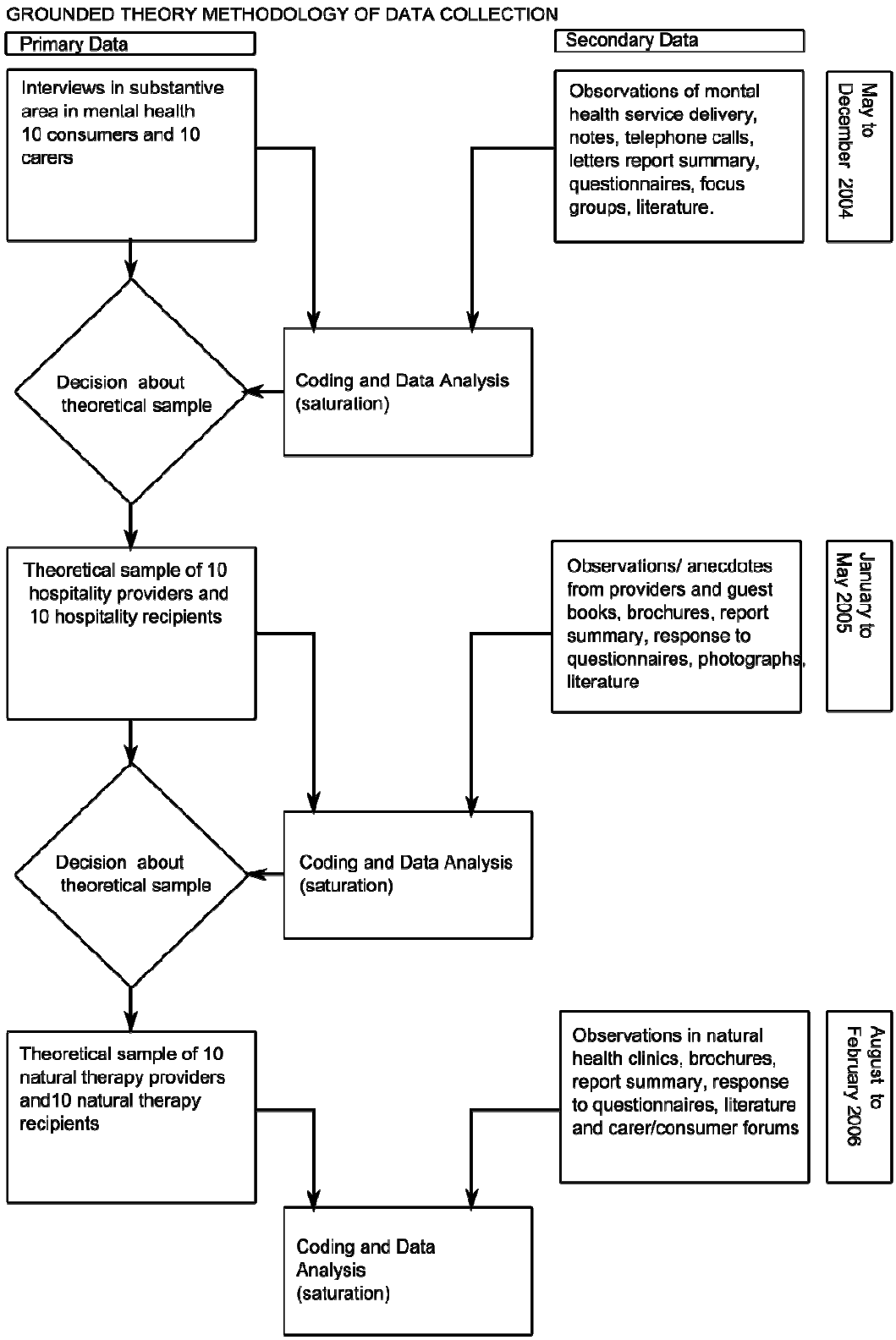
Table 3.7
Codes for Interviewees

Interviewee	Code
Mental Health Consumer	Consumer
Mental Health Carer	Carer
Hospitality Provider	Hosp prov
Hospitality Recipient	Hosp rec
Natural Therapy Provider	Nat ther prov
Natural Therapy Recipient	Nat ther rec

All transcripts were coded accordingly to protect privacy, and all identifying information of participants was stored securely and separately from the data. All secondary data was coded to reflect the appropriate theoretical sample and filed for reference. Data collection occurred over a two and half year period and continued until final write up.

Figure 3.1 on the next page summarises the processes and timelines for collecting all primary and secondary data. It also captures the dates at which data was coded and analysed (coding and analysis is discussed further in the next chapter), and identifies the key decision making points that influenced each stage of data collection.

Figure 3.1 Time Frames and Process of Research



SUMMARY

This chapter has discussed the Grounded Theory approach, and provided a rationale for the methodology. I identified key issues and pitfalls when preparing for the research. The process of theoretical sampling and the collecting of primary and secondary data was discussed, taking into account ethical considerations, the need for data triangulation and member checking. The next chapter will discuss how this data was analysed using Grounded Theory methodology.

CHAPTER 4: ANALYSING THE DATA USING GROUNDED THEORY

4. INTRODUCTION

The previous chapter summarised the methodology and data collection process prior to in depth conceptual analysis, while this chapter presents an overview of the analysis done in the process and following data collection. This is based on Glaser's three levels of conceptual analysis, the data, the conceptualisation of this into categories and properties and the integration of these into theory (1998).

A definition of open coding is followed by a description of the coding process for the substantive and comparative data. The process of selective coding to 'delimit the theory' to the core variable (Glaser, 1978, p. 61) is then explained. The use of axial or theoretical codes and their combinations, to give further insight and depth to the evolving concepts are then explored, highlighting the importance of memo writing. Basic social processes are defined, paying particular attention to the relevance of the relationship between the basic social and basic psychological processes in this study. Finally, I discuss the sorting of memos, the write-up, and issues of data trustworthiness in terms of data credibility, transferability and audit trail.

4.1 The Process of Open Coding

Glaser describes the essential relationship between data and theory as the conceptual code. Coding allows the researcher the process of 'fracturing the data' (Glaser, 1978, p. 55) then grouping it again, through the relationships that emerge between categories and their properties.

Strauss and Corbin (1998) explain open coding as a process of microanalysis undertaken through a line-by-line analysis of the data. Glaser (1998) discusses how the researcher compares incidents by a detailed reading of the data and by asking relevant questions such as: *What category does this incident indicate? What property of what category does this incident indicate?* Lastly, *what are the participants' main concerns?* (Glaser, 1998, p. 140). Grounded Theory relies on patterns emerging, incident by incident, until no more properties of the category are revealed and the category is saturated. Through this process, the researcher is able to 'move beyond description' to a 'conceptual mode of analysis' (Strauss & Corbin, 1998, p. 66).

4.1.1 Open coding the data

Open coding commenced in the substantive area of mental health, by coding the interview transcripts of consumers and carers. Open coding was also used to code the feedback forms (secondary data) of consumers and carers as well as other secondary data including researcher notes, records of phone conversations, letters, member checking summaries sent to consumers and carers and the notes taken from consumer and carer forums. Questions that were used to start coding included: *What is the experience of participants? What processes are happening for them? How do these processes relate to each other?* The same questions were asked when coding the comparative samples to ensure consistent comparisons of incidents and participant experiences.

Glaser argues that it is this continued questioning that makes the researcher 'theoretically sensitive' (1978, p. 57) Doing line-by-line coding, Glaser says:

> [...] forces the analyst to verify and saturate categories, minimizes missing an important category, produces a rich dense theory and gives a feeling that nothing has been left out. (1978, p. 58)

In keeping with the Grounded Theory approach, it was important to code and re-code the mental health data over a period of time, to ensure the relevance of the initial conceptual framework. Open coding was not begun until all 20 interviews in the substantive field of mental health were completed. This enabled me to become familiar with all the data (both primary and secondary) and to avoid conceptualising too quickly after only a few interviews.

Codes were continually refined during the open coding process; I went over the data several times to ensure that the codes generated fitted with the data (at the same time memoing ideas and relationships between concepts). Interviews were transcribed onto two-thirds of the page width so that open coding could run down one third of the page. Coding was done in pencil so that concepts could be refined and replaced readily. As Allan (2003) has reported, I often found that more than one code emerged from the same text. An example of open coding is provided in Appendix P.

After the mental health interviews were coded, I proceeded to code all the data in the comparative field of hospitality (after all 20 interviews were complete), followed by all the data for natural therapy (again, after all 20 interviews were complete). The secondary data coded in these fields included researcher observation notes, notes from guest books, brochures from service providers, photographs, member checking reports and feedback forms. A time frame of between one and two months was allowed, to become immersed in the open coding in each area before proceeding to the next set of interviews. Glaser summarises the process of saturation within open coding in the following way:

> Open coding carries with it verification, correction and saturation phenomenon. As the analyst gets deep into the data, he discovers that all data can be subsumed as an indicator of some category in the analysis. Later in the study nothing occurs as a surprise, after constantly comparing, analysing and generating, sufficient codes to handle differential emergent. In short a total saturation occurs: all data fit. (Glaser, 1978, p. 60)

During the open coding process and comparing the data, key concepts and categories common to the substantive area and the comparative samples emerged relatively quickly. For example, early on in the open coding, the concept of freedom emerged as an important category in mental health. Freedom here relates to freedom in the environment that is being physically away, psychologically free, and free from responsibility. Later in the data analysis however, the concept of freedom was also recognised in the fields of hospitality and natural therapies and was able to saturate other categories and properties by being elevated to the category of *a sense of escape,* which was also significant to mental health. The *sense of escape* was particularly relevant to the way people could allow their minds to drift or be distracted in a positive way by music, movies or another setting.

In a similar way, open coding began with presenting themes of being or feeling a part of something that was significant and was elevated to a *sense of connection and captivation.* This could then relate to connection and captivation with the environment, activities or relationships in which individuals became involved. Saturating the codes was a lengthy process that occurred throughout the coding, and was strongly facilitated by the use of memos and diagrams and assisted in incorporating the secondary data thoroughly in the analysis process. See an example in Appendix Q.

4.2 Selective Coding

Glaser discusses the process of selective coding as delimiting the theory to one core variable.

> The other variables are not lost, but to focus on the analysis of one core variable merely demotes other core variables to a role subservient to the variable under focus. (Glaser, 1978, p. 61)

The Grounded Theory approach states that when the core variable is identified, it becomes easier for the researcher to look for conditions and consequences that relate to it, by comparing incidents and looking for similarities and differences. Codes become further refined during this process.

> The researcher starts analysing the core variable and its relations to other categories which resolves the main concern of the participants. (Glaser, 1998, p. 85)

Glaser (1978) explains the characteristics of core categories: they are central and related to many other categories and their properties; they recur frequently in the data; take time to saturate; and relate meaningfully and easily with other data.

4.3 The Core Category

While the above description by Glaser indicates that a core category may be relatively easy to identify, in this study there was much procrastination with naming the core category and it was not done until all the data had been coded. Various terminologies were used over the duration of the study to understand the experiences of participants, such as *the process of rejuvenation*, achieving *holistic health and well-being*, and an *inner sense of healing.* The core category of *perspective enhancement* was only revealed after I had been immersed in the coded data for some time. In fact, it was only after I had read the mental health data many times and recognised that a process of disillusionment had occurred with many mental health participants, that the process of achieving an enhanced perspective was identified as the core category. Thus, disillusionment was at the opposite pole to perspective enhancement; however it was not until all the processes occurring in relation to disillusionment and perspective enhancement were recognised, that they were identified as part of the same continuum.

Rather than being able to identify the core category easily, I wrestled with the core conditions that the core category relied upon to exist, before the core category itself was identified.

Strauss and Corbin (1998) define conditions as:

> Sets of events or happenings that create the situation, issues and problems pertaining to a phenomenon, and to a certain extent, explain why and how persons or groups respond in certain ways. Conditions may arise out of time, place culture, rules, regulations, beliefs, power or gender factors as well as the social worlds, organisations and institutions in which we find ourselves along with our personal motivations and biographies. (Strauss & Corbin, 1998, p. 130)

I was able to identify the conditions that facilitated the core category before naming the core category itself; they were environment, and intervention modalities. The eventual naming of the core category of perspective enhancement (on a continuum with disillusionment) significantly assisted in understanding how the presence or absence of those conditions impacted upon the experience of participants. Perspective enhancement was seen to be on a continuum that also took in perspective destabilisation (when perspective was being challenged), and disillusionment (when perspective was being lost). Once the core category and its continuum were identified, refining sub-categories and their properties became much easier.

4.4 Theoretical Coding

The process of theoretical coding or axial coding gives scope and adds a new perspective to the emerging theory. Glaser (1978) identifies 18 coding families. Four in particular were used in a helpful way in this analysis. These were The Six C's, the process model, the strategy family, and the coding family of cutting points. These will be discussed in turn.

The first coding family that was used was that of The Six C's (see Figure 4.1). This coding family consists of causes, contexts, contingencies, consequences, covariances and conditions. This model enabled me to ask questions such as:

How does the condition of the environment or intervention strategies alter with the context in which people find themselves? How do these conditions impact on their perspective? What are the causes of feeling trapped? What are the consequences? Are there underpinning contingencies as to whether perspective enhancement occurs or whether individuals become disillusioned?

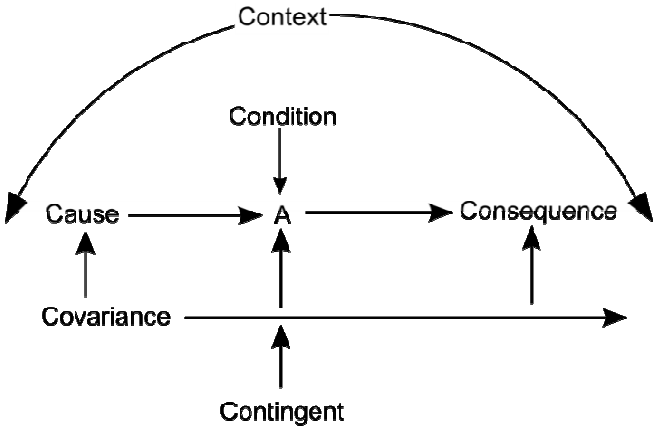


Figure 4.1 The Six C's, (Glaser, 1978, p.74)

Second, the process model was also helpful in encouraging me to consider phases or stages in the theory. I used the term 'cognitive chapters' here, to reflect the stages of thinking that individuals progressed through, on their journey towards perspective enhancement or disillusionment. This enabled me to ask questions such as: *What has happened to facilitate the way this person thinks of their life now, as opposed to before they had this experience? What has contributed to this different way of viewing the world?* The term cognitive chapters was particularly helpful in understanding how, after experiencing conditions that enhanced

their well-being, individuals (whether hospitality recipients, consumers, carers or natural therapy recipients), were able to reflect on their experiences and integrate them to a new way of thinking or a deeper insight or understanding about themselves.

Third, the strategy family enabled me to identify what mechanisms or tactics people used to manage, handle or cope with specific situations. For example: *What did that person do to survive that experience? What facilitated them coping? What strategies did that person use to get by?*

Finally, the coding family of cutting points was useful in terms of revealing turning points or breaking points for participants. These were broadly referred to as critical junctures. Questions were asked such as: *What made the difference at that point? What was the turning point that led to disillusionment or perspective enhancement? What occurred for the person at that moment that contributed to the change?* It was interesting to note that critical junctures seemed to manifest as core emotions, identified as a sense of hurt and or disappointment, or a sense of healing and/or attachment. These codes were combined to theoretically analyse data in the following way (see Figure 4.2) below.

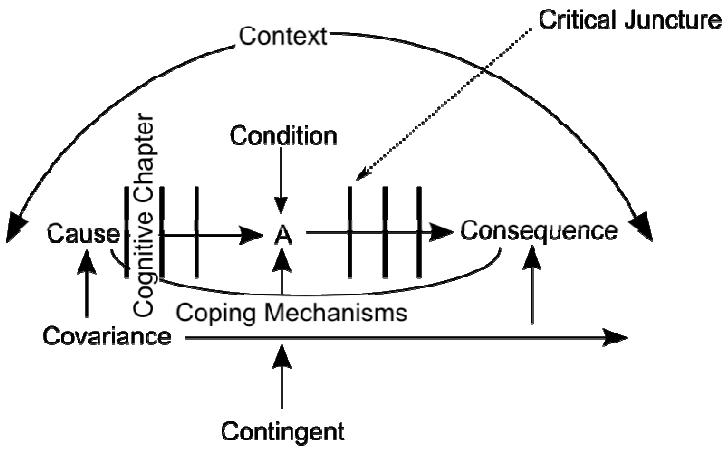


Figure 4.2 Variation of The Six C's used in Conceptual Analysis

Theoretical codes were crucial in bringing the substantive data to life. Throughout the data analysis phase there was constant interaction between the substantive and theoretical codes and this assisted me in accounting for the broad range of categories and properties.

> Theoretical codes implicitly conceptualise how the substantive codes will relate to each other as interrelated, multivariate hypotheses in accounting for resolving the main concern. They are emergent and weave the fractured story turned into concepts back to an organised whole story. They provide the models for theory generation and emerge during coding, memoing and especially in sorting. (Glaser, 1998, p. 163)

The theoretical coding families included in the second diagram enabled me to bring forward further insights about the data by asking the following kinds of questions relating the coding families and the data such as:

Is there a relationship between underpinning contingencies of perspective enhancement and the phases that people move through to gain an enhanced perspective? How do the conditions impact on coping strategies? What is the impact of moving through the critical junctures if the conditions change but the contingencies remain the same? What are the consequences of this?

The process of theoretical coding was useful in the way it forced me to think theoretically about categories and their properties, maximising the coverage of the data in order to apply it to the substantive area of mental health. Glaser and Strauss (1967) state:

> Maximizing brings out the widest possible ranges, continua, degrees, types, uniformities, variations, causes, conditions, consequences, probabilities of relationships, strategies, process, structural mechanisms, and so forth, all necessary for the elaboration of the theory. (p. 57)

By drawing out the theoretical codes and the boundaries of categories, their relationships to the core category of perspective enhancement began to emerge.

For example, while tourism providers and natural therapists may seem substantively dissimilar, the properties associated with the environmental conditions and intervention strategies were very similar, for example, a welcoming environment, a hospitable interaction or an individually tailored approach. These conditions (when they were present in mental health) also facilitated perspective enhancement. When they were not, the categories and properties associated with disillusionment would emerge, such as feeling disconnected, or feeling like a lesser being.

4.5 Memoing

Glaser (1978) states that the core stage of generating theory occurs through memoing. He says '[m]emos are the theorizing write up of ideas about codes and their relationships as they strike the analyst while coding' (p. 83). Glaser describes memoing as keeping track of what is emerging and its relationships to other concepts. Memoing is vital as different conceptual levels emerge and memos assist in managing the complexity of conceptual levels. Memos were written as ideas emerged, in a format that was comfortable to me and in a way that would ease sorting. Memos also assisted in connecting the concepts identified in the primary and secondary data. For example, while in the primary data the concepts of hospitality and welcome were emerging, the secondary data was also reflecting this through researcher impressions, observations and photographic records. Glaser (1978) states that memos should be titled by category or property and other categories or properties should be highlighted or underlined so linkages are clear and they can also be sorted readily. If the categories are related, a hypothesis about this relationship can emerge. Highlighting linkages was an important part of the memo process. An example of a memo is given in Appendix Q.

Memos were written on colour-coded paper and labelled with the concept and substantive area being coded. A separate scrapbook was also maintained to draw diagrams relating codes and their properties through the process. Mind maps (Appendix R) were used as one way of quickly raising the data to a conceptual level and distinguishing properties from their overarching categories; and provided another way of linking the primary and secondary data. Relationships could then be more easily seen, to develop connections and decide codes of high relevance. This allowed for a great deal of description in the data to be subsumed pictorially.

While memos started during the data coding and comparison process, they continued throughout the analysis until final write up. They constantly forced rethinking and reworking of the data, pointed out gaps and posed questions to ask in the coding of theoretically sampled data. In particular, the memos assisted me to track the themes that emerged, continually seek an extended understanding of the core category and remain open to documenting new questions that arose pertaining to the data.

The nature of memos changed from comments on themes at the beginning of the process to questions and hypotheses about conceptual relationships as time progressed. In accordance with Glaser's view of Grounded Theory (1978), memos were kept separate from the data. Memoing interrupted the coding process as is necessary to keep the researcher alert to capture new meanings and ideas, and locate variables, patterns and links within the data as these arose. The memos were also valuable in being able to track a historical record of data conceptualisation as the research evolved.

4.6 Basic Social Process

Glaser (1978) describes the core features of a basic social process. These are that it explains a problem free of time and place, is generalisable, remains separate from the participant and the researcher, is durable and is able to be modified. A basic social process can also be applied to new conditions subject to appropriate theoretical sampling to verify its theoretical completeness across place and time.

Basic social processes require stages and occur over time. Grounded Theory relies on the researcher to perceive stages through large numbers of individual histories and see as social what individuals may see as personal. These stages then tie together various sets of conditions and properties. Faberhaugh (1995) describes the explanatory power of basic process analysis in the way it is able to integrate multiple parts of the study (the who, what, when, how and why questions of the research problem) into a logical and understandable whole.

Glaser (1978) argues there are two types of process – basic social psychological processes (BSPP) and basic social structural processes (BSSP). Recognising the connection between the two is important. While a basic social psychological process of perspective enhancement was chosen as the core category, it was strongly influenced by basic social structural processes. For example, a critical juncture pertaining to the way people felt whether or not their perspective was enhanced in the mental health system was often connected to the social structural process of *being received*. While in a hospital, this may be *admission*; while at a holiday retreat, it may be *check in.*

Unfortunately, for many people in the mental health system, who were viewed as patients, the way they were *received* often led to a sense of disillusionment rather than to

perspective enhancement. However, tourists often gained a sense of perspective enhancement while going through the same process of *being received.* While this example illustrates that not everyone goes through the process in the same way, the basic social structural process of *being received* can uncover the conditions or variables that give rise to contextual differences.

In this study, it became evident that the social structural processes and social psychological process were closely related. The social structural process could either support or impede the social psychological process of perspective enhancement; in this study, the various basic social structural processes facilitated the basic social psychological process of perspective enhancement or disillusionment. Further examples will be given in Chapters 5 and 6 when data is presented.

4.7 Sorting

Sorting of memos commenced after considerable memo writing. Glaser (1978) discourages outlines, trusting that memos will integrate in their own way after continual re-sorting and comparing. Through this process, some earlier memos were disregarded and replaced by more theoretical memos written later on in the research process. Similarly, further memos were written that asked more questions of the data, pertaining to how it connected or related to the core variables and theoretical codes. Sorting as Glaser (1978) suggests, also created the formulation of more memos, particularly considering the nature of the social psychological and social structural processes.

Glaser (1978) states that sorting stops at theoretical completeness:

> Theoretical completeness implies theoretical coverage as far as the study can take the analyst. Thus, it means that he explains with the fewest possible concepts, and with the greatest possible scope, as much variation as possible in the behaviour and problem under study. (p. 125)

Thus memoing and sorting continued until as many theoretical questions as possible about the data could be answered while still maintaining a relationship with the core category of perspective enhancement. Sorting allowed the researcher to be discerning about ideas, rather than being too prolific, and also controlled the density of the data. The order of the memos assisted in drawing forth the writing in line with the theoretical coding families chosen.

4.8 Write Up

Glaser (1978) discusses the need to funnel down so that the theory does not wander. This entails identifying the core dimensions of the problem and the properties that lead in from the nature of the problem to the problem itself. The write up of findings emerged through memo sorting and a Grounded Theory process that was able to condense over 1000 pages of transcripts and other data into two chapters on findings – one on *Becoming Disillusioned* and the other titled *Towards a Theory of Perspective Enhancement for Mental Health.* The writing phase consisted of writing about the categories that emerged, using descriptions of specific incidents as illustrations. Glaser also argues that writing up recommendations and conclusions may be useful for practitioners; they will be included in this study, serving the fundamental purpose of the research.

4.9 The Integrity of the Data

Various checks and balances were undertaken to ensure the integrity of the data. The criteria used to assess this were data credibility, data transferability and an audit trail.

4.9.1 Data credibility

Glaser and Strauss (1967) stress the importance of ensuring data credibility through the actual detailed and rigorous strategies used for collecting, coding, analysing and presenting the data. Shah and Corley (2006) also recommend detailed formal and systematic methods of data collection and analysis as a way of opening up the methodology for peer review to ensure it meets rigorous standards. I made every effort to follow meticulously the Grounded Theory analysis procedure discussed by Glaser.

Glaser and Strauss (1967) emphasise that credibility is also gained through immersion in the social world of research participants.

> He has [been] theoretically immersed in this world enough to know it, and at the same time has retained enough detachment to think theoretically about what he has seen and lived through. (p. 226)

Lincoln and Guba (1985) refer to this as *prolonged engagement* in the field to ensure sufficient time to understand the world of research world of the participants and to develop trust. I gathered data by lengthy interviews and maintained engagement with participants by sending research reports and inviting participants to focus groups over a two and a half year period.

Glaser and Strauss (1967) state that credibility is conveyed to the reader if the comparative method of the research is conveyed in a clear, integrated and clear fashion, if data is gathered in various ways and if the reader also gains a sense that he or she too was in the field. Many months were spent analysing, reviewing and integrating the data to establish clear and constructive themes. It is anticipated that the reader will gain a sense of the world of the participants through the data revealed in the following chapters.

A further aspect of credibility discussed by Lincoln and Guba (1985) is triangulation. Miles and Huberman (1994) discuss triangulation as a way of double-checking findings using multiple sources and types of evidence to verify findings. According to Fielding and Fielding (1986), if diverse sources of data support the conclusion, confidence in the data is increased. They argue that triangulation allows the researcher to view the data more critically, to test it, to identify weaknesses and decide whether and how to test it further.

Denzin (1978) discusses various types of triangulation. These include time (hearing consistent information over a period of time), space (establishing data consistency across locations), and person (collecting information from groups, and individuals in different ways). Gaining information through different methods such as questionnaire, interview, observation is referred to by Denzin (1978) as method triangulation. All of these forms of triangulation were used during the course of the study. Feedback was requested and received at different intervals of time, theoretical sampling and interviews allowed the research to take place in different spaces, and research proceeded with individuals and in groups to discuss the findings. Additional method triangulation included the use of feedback forms, collecting advertising material, and maintaining a journal of personal observations in order to reflect on impressions in the field. This became a part of the secondary data. Denzin (1978) also refers to investigator triangulation, as the way in which investigators in a team can come together to corroborate data. While this was not possible in this research (due to lack of resources), intercoder-reliability was used, in which coding was also undertaken by a colleague unfamiliar with the data.

Ten per cent (or 6 of the interviews) were checked for inter-coder reliability. These consisted of two interviews from each substantive group chosen at random. The remaining 50 interviews and all other data was coded by me alone.

The purpose of checking inter-coder reliability was to:

1) check the similarities and differences in the codes generated by another researcher;

2) discuss the similarities or differences in the meaning of these conceptual codes;

3) compare the frequency with which they appeared in the data and finally; and

4) compare thoughts on processes, patterns and linkages of data incidents.

Differences in coding included data that was coded by one coder and not by another, as well as differences in coding concepts. Table 4.1 illustrates the similarities and differences in coding and the percentage of initial agreement in code formulation. The interviews and substantive areas and the order in which inter-reliability coding took place were chosen at random.

Table 4.1
Inter-coder Reliability

Sequence of Interviews Coded	Substantive Area	Number of Same Initial Concepts Coded	Number of Additional or Different Concepts Coded	Percentage of Agreement During Initial Coding Process
1	Mental Health Consumer	47	5	90%
2	Natural Therapist	59	12	82%
3	Natural Therapy Recipient	36	7	84%
4	Hospitality Provider	46	4	92%
5	Tourist	40	3	93%
6	Mental Health Carer	39	5	89%

The average inter-coder reliability across the interviews was 88.33%. Discussion occurred until coders reached 100% agreement on the presence and relevance of codes. A further test of credibility was undertaken through member checking. Lincoln and Guba (1985) describe this as the process through which data, analytic categories, interpretations and conclusions are tested with members of the stakeholder groups from which the data was originally collected. Member checking took place after each round of interviews and with both sets of focus groups.

The feedback sheet on the research was sent with a report at the completion of each phase of interviews. The development of these reports also provided an opportunity for me to summarise the data, which Lincoln and Guba (1985) describe as an important step in analysing the data.

The questions were the same for each group of participants interviewed. Feedback form comments as part of the secondary data included:

From consumers:

> A very small amount of genuine caring and kindness can make a very big difference if it received in multiple levels from multiple sources.
>
> I recently spent a weekend at a resort on the Sunshine Coast with my son and his girlfriend and had reason to phone reception regarding my state of mind, and I found them very helpful and sympathetic. I agreed with section 3 (of your report) in this respect.

From carers:

> An appreciation of human diversity, yet common humanity.
>
> I felt that the themes and ideas expressed were pretty well ‘spot on’.

From hospitality providers:

I agreed with all of your findings and can relate to the resulting effects of all types of therapy. This is very much shown in our departing guests.

I'm strong on environmental impact and its effect on stress personally.

From hospitality recipient:

Self directed holiday/vacations are important.

We strongly agreed with the summary.

From natural therapists:

The update has given me an insight into client expectations and how to address their needs.

I feel positive thought processes have a significant effect on ongoing well-being Thank you for sharing this information as it highlights areas we need to be focused on.

From natural therapy recipients:

Yes, viewing the therapist as a guide in my own healing is a very important thing for me.

All remedies need to be trialled and experimented with to find a suitable one or combination

In some of the feedback forms sent back, participants incorporated additional information as to how their life experience since the interview could relate to the data; for example, the benefits of having a holiday or time away.

4.9.2 Transferability

A further criterion of data trustworthiness described by Lincoln and Guba (1985) and Shah and Corley (2006) is transferability. Evidence of transferability is provided through extensive description of the concepts and categories in Grounded Theory and the structures and processes that relate to it. Such detail allows the data to be transferred to others who may wish to apply it. It is also possible that the data may be transferred from substantive to formal theory. This was a core issue in my mind and was one justification for interviewing in depth with the comparative groups. The level of similarities and differences of these groups were fundamental to drawing forward a broad spectrum of categories and properties, while noticing how the conditions within the social structural processes impacting on these categories changed the nature of the basic social psychological process of perspective enhancement.

As I became immersed in the data, questions arose as to whether similar categories and codes could relate to people who encountered other types of services, such as income services or the housing services. There was the possibility that similar conditions and contingencies could also result in individuals either feeling disillusioned or that their perspective was enhanced. Thus, I considered the transferability of the theory to other contexts an interesting prospect and one which may have the potential to stimulate future research.

4.9.3 An audit trail

An additional way in which the data can be viewed as trustworthy is through the researcher's audit trail. This included satisfactory purposive and theoretical sampling, maintaining the confidentiality of participants and ensuring a clear audit trail of data collection and analysis processes. The audit trail of data of primary and secondary data was

systematically collated and stored and consisted of notes on observations, verbatim transcripts, contacts, brochures, digital photographs, report summaries, returned feedback forms and letters, mind mapping, memos and progress notes detailing theoretical decisions.

4.9.4 Grounded Theory evaluation

Strauss and Corbin (1998) and Creswell (2002) pose a range of questions to researchers for assessing Grounded Theory research; in this case, the checklist developed by Creswell (2002) was used due to its user-friendly yet comprehensive explanation of questions pertaining to quality. These are outlined in Table 4.2.

Table 4.2
Questions for Assessing Grounded Theory Research (Creswell, 2002)

Is there an obvious connection between the categories and the raw data? Is the theory useful as a conceptual explanation for the process being studied? Does the theory provide a relevant explanation of actual problems and a basic process? Can the theory be modified as conditions change or further data are gathered? Is a theoretical model developed or generated that conceptualises a process, action or interaction? Is there a central phenomenon (or core category) specified at the heart of the model? Does the model emerge through phases of coding (e.g., initial codes to more theoretically orientated codes or open coding to axial coding to selective coding?) Does the researcher attempt to interrelate categories? Does the researcher gather extensive data as to develop a detailed conceptual theory as well as become saturated in the data? Does this study show how the researcher validated the evolving theory by comparing it to the data, examining how the theory supports or refutes existing theories in the literature, or checking theory with participants? (pp. 468-459)

These questions were important for me to keep in mind at all times. Some of them will be addressed in future chapters. In addition, Strauss and Corbin (1998, p. 272) ask, ‘Does the theory stand the test of time and become part of the discussions and ideas exchanged among relevant social and professional groups?’ This remains to be seen.

SUMMARY

This chapter has given an explanation of the process of analysis of the substantive and comparative data, giving an explanation of open coding and selective coding to reach the core category, the identification and use of theoretical codes, and how I related these codes to the substantive and comparative data. This chapter has also given an example of the relationship between the basic social psychosocial process of perspective enhancement and the basic social structural processes that either facilitated or impeded it.

The use of memos and the sorting of them were explained as a vital link in tracking, and conceptualising the linkages between sets of data and organising the write up of the next two chapters.

Finally, the criteria used to assessing integrity or trustworthiness were discussed, including credibility (through rigorous analysis strategies, immersion in the field, space, time, person and method triangulation), transferability, the use of an audit trail, and evaluative questions about the theory and the research process that guided its formulation.

CHAPTER 5: PRESENTING THE DATA: “BECOMING DISILLUSIONED”

5. INTRODUCTION

The overall analysis of data across the substantive and theoretical samples revealed the core category in this Grounded Theory as *perspective enhancement*, perspective referring to one’s mental outlook or view of themselves and the world around them. However, in recognising this core category the data also revealed how at the other end of the continuum, this perspective can be destabilised to the point that mental health consumers and carers become disillusioned. This chapter will explore how perspective destabilisation occurred to the point of disillusionment. It was revealed that that this could occur at any point on the continuum, and that there were core conditions that contributed to this process. Once individuals experienced the critical junctures of hurt or alienation, cognitive chapters would begin to develop in the way that they perceived their life story, which contributed to a ‘spiral down effect’ that was indicative of perspective destabilisation or *disillusionment*. At this point, a new cognitive chapter would develop confirming this disillusionment until and unless a condition that facilitated perspective enhancement could be identified.

The theoretical sampling in this study undertaken with the hospitality and natural therapies industry helped to highlight how perspective enhancement was identified as a key factor contributing to mental health and well-being, and how disillusionment by hospitality recipients and natural therapy recipients was only a minor occurrence for them. In contrast, in the mental health field, the data shows how prevalent disillusionment is for mental health consumers and carers who tend to capture only limited glimpses of an enhanced perspective through the services they receive.

This chapter will focus primarily on how mental health consumers and carers in the substantive area of mental health became disillusioned, but will also give examples from the comparative data. The findings will highlight the combination of causes and conditions that contributed to disillusionment in various contexts, the coping mechanisms developed to deal with these, and the consequences of disillusionment. The nature of relationships will be identified as a contingent factor determining whether disillusionment occurred or not. This chapter will also give an overview of the relationship between the basic social structural processes and basic social psychological processes identified within the study.

The following chapter, Chapter Six, will provide an analysis of the processes that contributed to perspective enhancement across all theoretical samples. A comparison of findings with the literature will then be made, and implications from the data and the literature will be drawn upon to make recommendations for service delivery in the area of mental health service delivery.

5.1 Core Conditions and a Contingent Factor

There were two conditions and one contingent factor that contributed to perspective enhancement and disillusionment across the study, for each theoretical sample. The conditions were the nature of the environment and the nature of intervention strategies. By intervention strategies, I am referring to those key therapeutic or treatment methods or activities through which individuals gained an enhanced perspective or were disillusioned. While both of these conditions were important, throughout all samples of the study, the core contingent factor that determined whether or not mental health consumers would experience perspective enhancement was exposure to perspective enhancing relationships.

This study suggests that perspective enhancing relationships had priority over perspective enhancing environments, as is noted in this quote:

> I don't know if it has a lot to do with the environment. It is sort of like who you are opening up to more than where you are. (Consumer 1 May 2004, p. 3)

A similar view was expressed by carers:

> Well personally for me it doesn't matter what it (the building) looks like for me it is what's in it. If there is a sense of trust and the people I am with, the building itself really doesn't matter. (Carer 1, June 2004 p. 5)

> I don't think it matters. No, I think it is more the people having people in the same situation as you that understand just what you are going through. (Carer 10, December, 2004 p .2)

Given the importance that was attributed to the quality of relationship, this was treated as a contingent factor affecting whether the perspective of individuals was enhanced or not. While individuals could tolerate conditions associated with a perspective-destabilising environment and intervention strategies, the most difficult to tolerate were relationships that destabilised the perspective of individuals, because they felt hurt or alienated at some level. Thus, it is argued that while there can be multiple causes and conditions that have some impact, becoming disillusioned is contingent on a perspective destabilising relationship.

In line with the Grounded Theory process, I wished to gain an understanding of 'what is going on' for mental health consumers and carers in relation to their mental health and well-being. Once I had identified perspective destabilisation to the point of disillusionment as a concern, it became important to understand the processes through which this occurred, particularly for consumers and carers within the mental health system.

5.2 Becoming Disillusioned Through Perspective Destabilising Relationships

The interviews indicated that the nature of relationships were crucial in the psychosocial process of becoming disillusioned. Relationships were especially important in two ways. First, they appeared to be a crucial contingent factor as to whether or not people would become disillusioned. For example, while people could tolerate the conditions of perspective destabilising environments and intervention strategies, it was much more difficult to tolerate perspective destabilising relationships. Second, critical points about the nature of relationships could also be identified as critical junctures or turning points determining the depth of disillusionment experienced. These critical junctures could be identified when a level of hurt or alienation jolted the perceptions of individuals to the point that they moved into a new cognitive chapter in terms of their way of thinking about how they viewed themselves and the world around them.

The properties of the sub-category ‘perspective destabilising relationships’ were feeling unwelcome, feeling disconnected, being engaged with through a narrow lens, being treated as a lesser being, and feeling unsafe. The consequences of this included that consumers would internally discredit themselves, feeling surprised by any external validation. They would cope with the mental health system by making excuses, or focusing on one specific thought, belief or activity to get them through the experience. The process of ‘becoming disillusioned’ will now be explained with reference to the data.

5.2.1 Feeling unwelcome

While both consumers and carers expressed their view of unwelcoming relationships experienced through interaction with staff at their local mental health clinic, the most

powerful statements across the theoretical samples were these statements expressed by carers who were seeking help on behalf of their loved ones.

> Yes in the hospital situation you will often go to visit someone or go to see someone and you can stand at a desk and wait and wait and wait and people are everywhere and don't even lift their head to acknowledge you and say 'I won't be a moment. Can you wait a moment please'. That really sets you back […] And whether you have to wait ten or fifteen minutes it doesn't matter if you have been acknowledged because half the time you don't know if people know whether you are there or not. (Carer 10, December 2004, p. 4)

> The whole environment – it never once gave me a sense of warmth and friendliness and safety. All those things that one needs when you are trying to deal with things and that even went as far as the people behind the counter. Never a warm smile or a friendly hello – it was more of a 'what do you want' type of thing. (Carer 1, June 2004, p. 6)

Similarly, tourists indicated that they were influenced by the demeanour of those greeting them, and that this had a major impact on deciding on whether to stay or dine at particular locations. One tourist travelling in Asia states:

> Definitely, when you are trying to choose a hotel the demeanour of people really helped us choose the place. (Hosp rec 6, 2004, p. 11)

These examples reveal a critical juncture for people in the way they were *received*, particularly in the context of the mental health system. The social structural processes of *being received* described here were fundamental in generating a sense of disillusionment, since a sense of hurt or alienation could be recognised, particularly in relation to feeling invisible, rather than worthy of attention.

5.2.2 Feeling disconnected

A further property of perspective de-stabilising relationships that created a sense of disillusionment was feeling disconnected. A young man who was discouraged from seeing a psychologist provides an example of this:

> I think psychologists should be more easily accessed than they are at the moment because I went to the [community mental health service in Brisbane] and seen a psychologist for about a year and she was really helpful. Then I went back and she went on leave and when I went back and told the psychologist my problems she said 'You have insight, I have got a waiting list here, sorry we can't see you any more'. (Consumer 2, May 2004, p. 15)

The feeling of disconnection experienced by mental health consumers also included just being heard and observed by professionals rather than being engaged by them or with them. While this could also be identified as a part of the social structural process of *being managed*, it is also part of the social structural process of *being assessed.* Thus, the way in which needs were perceived when being assessed, both as not important enough and as only a one-way assessment, generated a feeling of disconnection. This lack of engagement was often seen as being reinforced by the assessment and management processes that was described by consumers and carers as inconsistent, ad hoc or arbitrary. Thus, these processes tended to minimise meaningful engagement, and in so doing, heightened the likelihood of feeling disconnected.

A level of disappointment was expressed by the next carer, because what she thought was a meaningful connection did not come to fruition. She felt hurt by the fact that the promises and commitments made would not be followed through:

> They (the staff) don't last and then they have to start again. This person has failed to do something with him then the next person comes in and starts from scratch. (Carer 4, November 2004, p. 8)

Another carer also expressed her disappointment at the lack of continuity:

> But one of the big complaints is in continuity. There is just none, no follow up and they are there one minute and gone the next. (Carer 6, November 2004, p. 11)

Carers expressed how they had been 'fobbed off' and received false promises by mental health professionals and politicians, with one carer stating that it was like being 'put back on

the merry-go-round'(Carer 4, November 2004, p. 11). This 'fobbing off' also occurred when people were trying to admit family members into hospital; a part of the frustration of *being received.*

A further level of hurt and frustration was expressed by one carer who had to demand a service from the case manager before any was forthcoming. Not only was there an enormous amount of effort going into *being received,* but even more effort into convincing the other that there was a need for *assessment* and *management.*

This carer notes the distinction between a connected versus disconnected approach from psychiatrists.

> The two doctors recently that we had. One of them listened and he actually took notice of me and held him in there for an extra two days, the other one he told him that he was going to ring him and organise a letter for him and what not, and never bothered to follow it up. Also he called me an over-anxious mother because [name of son] actually asked him 'Could my mother come in with me?' and I don't think he was too happy about that. Lots of barriers with the actual doctors that are on duty at the time. (Carer 5, November 2004, p. 9)

For this participant, the second doctor not only wanted to assess and manage the person with the mental health issue, but also assess and manage the mother, as if she were a mental health consumer. In contrast, natural therapy recipients would assess potential therapists for a sense of connection; one experience of feeling disconnected from a therapist would terminate future attendance. In fact, several natural therapy recipients said that if they did not feel a connection over the phone with the provider, they would not attend an appointment.

A critical juncture on the path to disillusionment for carers and consumers would seem to be when someone, in the mental health context, had a genuine desire to connect in order to seek help, only to have this desire for connection ignored or rebuffed by the other. Unlike in

the hospitality or tourism sectors, consumers experienced little choice if they were unhappy. An example here could be someone generating the effort to make an important phone call, only to be 'hung up on' at the other end. Again, a critical juncture is revealed through the emotions of hurt and alienation generating a sense of disillusionment.

5.2.3 Engagement through a narrow lens

A further property contributing to becoming disillusioned in relationships was when individuals felt as though their relationship with the other person was being viewed through a narrow lens. One consumer explained how difficult it was to have needs met holistically because everyone in the mental health system had their own orientation and perspective.

> Because everyone has got their angle and the system that we are in they all put their angle forward. (Consumer 8, June 2004, p. 7)

This consumer discussed how relationships between mental health professionals and consumers are viewed as specialised and narrow, rather than as an ordinary connection between human beings:

> Professionals can become very cynical […] when they start treating the clients or every consumer as a job and you know you are in big trouble because then consumers start feeling like they are a just work to someone. […] the more ordinary the relationship is the better and that is why a lot of professionals like psychiatrists have lost it; they haven't got that ordinary relationship. (Consumer 8, June 2004, p. 7)

Narrow engagement was also reflected by the way people described how they were screened out of treatment:

> I am not happy with the services now because they have decided to make it for the chronically mentally ill and anyone who has just got personality disorders or depression and anxiety and who hasn't got chronic schizophrenia or manic depression is told to get their own private psychiatrist. (Consumer 2, May 2004, p. 4)

One carer shared this view about his son's experience within the mental health system as being narrow through 'being purely deficits-based'. He Stated:

> In fact I can't think, from any of the advice that he has been given, he has altered his basic thinking. I mean outside an illness, his life approach, his approach to life, there is nothing that has been an insight to him in that whole, in that life insight improvement. All the information has been given to support the notion of illness. There has been only the odd comment, one private doctor said to him 'look just try and get on with your life' that was the closest I got to hearing anything which might be outside a deficits-based mindset. (Carer 9, December 2004, p. 10)

There are a number of social structural processes that can be identified in the way individuals perceived they were viewed through a narrow lens. These include *being assessed, appropriately managed* and *maintaining professional boundaries.* Each assessment undertaken by mental health professionals is couched in the framework of their particular profession, with each engagement mindful of the professional boundaries reinforced by that profession. A sense of disillusionment occurs when the professional framework of assessment moves away from seeing the person as a whole, and the level of professional boundaries maintained inhibits the interaction from seeming real and genuine. One consumer said that this was like a 'pretend relationship' and that this could do a lot of 'harm to people' (Consumer 8, June 2004, p. 13). Thus, the critical junctures of hurt and alienation were again revealed.

5.2.4 Being treated as a lesser being

Another property of perspective destabilising relationships that contributes to disillusionment is the feeling of being treated as a lesser being by mental health professionals. This consumer discusses the importance of being seen as an equal:

> So someone who sees them (consumers) as an equal not someone who thinks they are a professional and better than the mentally ill person, that treats them like an equal, yes. (Consumer 9, June 2004, p. 8)

For another consumer, this was reflected in the power imbalance in the engagement process with the doctor:

> Not like when you go to the doctor and you say 'How are you Doctor', and the doctor knows everything about your life and you know nothing about him. (Consumer 2, May 2004, p. 15)

One woman told of her experience of power imbalance in hospital when she was called into a room to be interviewed by seventeen doctors. Her permission was not sought and she felt powerless. Another participant revealed that the language used towards her by professionals made her feel disrespected and without a choice. One young man reported feeling powerless when he was suddenly managed through a consultation held via video-conference. His sense of alienation was generated by the fact that the psychiatrist did not travel to the next town to see him.

A carer described how her son who had mutilated his arm and presented in emergency was treated with less regard than other patients without a mental illness. She described how they both waited in emergency from 10pm one evening until 7am the next morning, before health professionals would stitch her son's arm. She believed that if her son had not had a diagnosis of mental illness, he would not have been denied treatment for so long.

Other similar examples of the power imbalance experienced by carers were most commonly expressed through the fact that health professionals did not listen to them. Carers identified that if mental health professionals took in more of the history, knowledge and perspective of the carers, it would save a lot of work for the health professionals and pain for the person undergoing treatment. Carers often reported feeling sick of telling their stories over and over repeatedly and yet, when they did so, were not respected or included as part of the treatment process.

One carer explained to professionals what drugs had worked well for her son and that they should change his current medication regime. She stated:

> I just feel that when they (mental health consumers) get to a certain age, they (the mental health professionals), don't take into consideration [that] the parent might actually know the son better than what they do, especially if you have had years of problems. (Carer 5, November 2004, p. 8)

One mother described how she felt disbelieved when trying to advocate for ECT for her daughter, knowing, based on her history, that it would achieve the best results. Instead, staff chose not to read the file, and to use her preferred treatment as a last resort, which delayed her recovery. She stated:

> It is sad to see yourself as one of those fishwife-nagging mothers that is in there nagging at the service. That is the last thing we really want to go through. I think too that some service providers aren't aware of the impact that mental illness places on the relationships of the person. I understand that keeping that person as their primary concern but from the carers perspective they almost don't ever call on you themselves, so you need some acknowledgement of that from service providers. (Carer 7, November 2004, p. 5)

This same carer also referred to the tokenistic nature of many carer participation events in which people were not taken seriously.

> I think I would like to see more carer and consumer participation that isn't on a tokenistic level. I would like to see, and I know in some areas it is generally happening but not in all areas. I think people who have lived the experience have a really sound basic knowledge base and I think that needs to be heard more rather than academic people telling us what should be happening in people's best interest. (Carer 7, November 2004, p. 7)

Part of what appeared to be happening for consumers and carers in terms of being treated like a lesser being, was a sense that they were being discredited.

Individuals experiencing a mental health issue said that they were used to being told that what they were saying was not true anyway. Professionals were seen to be disallowing

the perspective of the consumers rather than listening. Thus, for some consumers seeing themselves as different became the norm

One man described this:

> For too long, it has been that you have just got the illness and then you have been written off […] (Consumer 2, May 2004, p. 3)

One carer explains how the labelling process discredits consumers:

> Those problems are around explanation of the illness. Those problems are around all those things around illness including you lack insight, that you are in denial and that you have been labelled with an illness which in the general community is seen as crazy, mad and all that. You know there is stigma attached to all this, you know that the community doesn't deal with these things well and so you have all these additional problems at a time when you are very confused and disorientated. They (the mental health professionals), are not very clear about anything in your life and so you are told to go home with these additional problems none of which can be easily resolved, none of which are going to be worked through with a professional. So the idea is you go home with your sickness or chronic sickness and don't expect that you are going to get over it. (Carer 9, December 2004, p. 5)

Another carer also confirmed:

> […] illnesses have been stigmatised and have been for so long, I mean that has come through in even some so-called nursing staff or so-called service providers. (Carer 1 June, 2004, p. 4)

Carers indicated that they felt discredited, because they were not viewed as important or relevant in the communication process around assessment, or included in the discharge planning cycle. This carer describes her view of how carers have been discredited by being viewed as part of the problem:

> Often the service provider sees the carer as being part of the issue. In the past, they have even been known to blame the carers especially if the person who is unwell has been venting their anger, as they often do, at the family. Then there is another barrier because there is also a lack of trust there. So I see that as another barrier as well. (Carer 7, November 2004, p. 6)

Perhaps the most alarming case of discrediting for a family carer revealed through the data was when she sought help for her son through a private therapist. The carer recalled how the private therapist not only stated that her son should be institutionalised, but also told the mother he believed she was suicidal and should divorce her husband. Thus, any expectations of affirmation of her needs were torn apart with destructive comments discrediting the whole family.

Feeling like a lesser being and being discredited as part of this process, can be seen to interact with the way people are *assessed* and consequently *stigmatised* through social structural processes of *treatment* and *management*. It can be argued that the social structural processes of professionals *gaining qualifications, achieving status* and *maintaining professional boundaries* within the mental health system influences the prescribed way in which individuals are *assessed and managed.* While these social processes treat credentials in high regard, they can also impact in a negative way in the way consumers and carers are denied the worth of their life experience and wisdom, generating a sense of powerlessness and inferiority. It can be argued that the very process of discrediting consumers and carers, as part of the *assessment* potentially serves professionals as a social structural device to elevate their status and widen the boundaries and power imbalance between consumer and professional.

Thus, it can be speculated, for people who have experienced a sense of powerlessness by the way that they have been treated like a lesser being, or have been discredited, that their experiences would expose them to the critical junctures of hurt and alienation on the path to disillusionment.

5.2.5 Feeling unsafe

The value of a sense of safety in relationships cannot be underestimated for mental health consumers.

One carer described how his son learned not to engage fully with his psychiatrist because it would not be safe; on one occasion when he conveyed to his doctor what he was truly feeling, the result was documented file notes that generated treatment that he considered harmful and a betrayal of trust. Subsequently, he chose not to engage honestly with his psychiatrist and remain guarded in his self -disclosure rather than risk feeling unsafe and receiving harsh treatment consequences. Unfortunately, when this was realised by the psychiatrist, he was then labelled as 'feigning' the doctor-patient relationship.

A level of trust is vital in relationships, for mental health consumers to feel safe. However, when unsafe experiences are revealed the consumers' trust can be easily broken within the social structural context of *performing mental health assessments*. For these individuals, the critical juncture of no longer feeling safe in the relationship could then bring on a feeling of hurt and alienation — a further step towards becoming disillusioned.

In summary, relationships that create a sense of disillusionment for consumers are those that give them the sense that they are unwelcome, disconnected, viewed through a narrow lens, treated as a lesser being and unsafe. The social structural processes of being *received, assessed, managed* and *treated* in accordance with the mental health system by people with *status and strong professional boundaries* interact with the psychosocial process of becoming disillusioned. Table 5.1 summarises how the contingent factor of relationships interact with the social structural processes in the mental health context.

Table 5.1
The Contingent Factor of Relationship in Disillusionment, Social Structural Processes and the Mental Health Context

Contingent on Relationship (with Self or Other) for Path to Disillusionment	Social Structural Processes	Characteristics in Context of Mental Health Contributing to Disillusionment
Feeling Unwelcome	Being Received	Lack of acknowledgement
Feeling Disconnected	Being Received Assessed and Managed	Being 'fobbed off' One way communication No continuity
Being Viewed Through a Narrow Lens	Assessment and Management (by professionals in a framework of professional expertise with professional boundaries)	Superficial relationship Consumers are seen as 'work' to be compartmentalised Require a specialist approach
Being Treated Like a Lesser Being	Assessment and Management (by professionals in a framework of professional expertise with professional boundaries)	Consumers are not equal – professionals decide worthiness Power demonstrated through privileged knowledge and punitive interventions Carer and consumer participation tokenistic Being 'written off' and discredited Consumer perspective 'disallowed' Labelling, blaming
Feeling Unsafe	Assessment and Management (by professionals in a framework of professional expertise with professional boundaries)	Vulnerabilities heightened No trust of health professional Feeling betrayed

5.3 Becoming Disillusioned Through Perspective Destabilising Environments

The study revealed that there were core conditions and processes within the substantive area of mental health that contributed to the destabilising of individual perspectives. The initial sub-category revealed was perspective destabilising environments, which create a feeling of being trapped, as well as feelings of being disconnected, unwelcome and unsafe.

The condition of the environment for mental health consumers also draws attention to a range of social structural processes that contributed to the psychosocial process of becoming disillusioned.

5.3.1 Sense of entrapment

Perspective destabilisation through entrapment was experienced by consumers and carers as feeling trapped in terms of their physical environment and a lack of control over their circumstances, involving restrictions at both an economic and social level. A sense of physical entrapment is exemplified by the following account described by this young man in the mental health system.

> Like outside in the smokers area they have got at the [hospital in Brisbane], they have got metal mesh up and you look through and it is sort of like you are in prison. That is unfriendly - it is not like you walk out in your back yard sort of thing; you walk out and it has metal mesh up and they lock the doors at night when you put out your cigarette … . You feel a bit trapped. (Consumer 1, May 2004, pp. 4 & 5)

Feeling trapped through a lack of control over the environment was expressed by mental health consumers in terms of not being able to watch TV at certain times or eat when hungry. It included adapting to the routines or restrictions preferred or imposed by others, including sharing spaces with others and giving up the right to privacy. The social structural process of *being managed* within the hospital system is highlighted here and the way in which the mental health system administers prescribed and restrictive practices that, in turn, create a sense of entrapment and disillusionment

This carer gave an example of how this occurs through the restrictive practice of recording a narrow level of information in patient assessments:

> One small part of the form is currently devoted to strengths and in my son's case the only strength written there was that he was compliant with medication and everything else was a deficit. (Carer 9, December 2004, p. 6)

A sense of entrapment was experienced not only in hospital. One consumer spoke about a sense of feeling restricted in her private rental accommodation, as she was not allowed to hang pictures on the walls. She also felt restricted in her life in the community by the medication she was expected to take, which affected her eyesight. Another woman living in the community felt as though she had no control over when or if her medication would be reviewed. These examples also demonstrate a level of *being managed*, whether this occurs through the community mental health system, or the wider level of management imposed on those who rent their homes instead of owning them.

Another consumer talks about the sense of entrapment associated with public housing and the way this creates a sense of disillusionment.

> […] public housing is substandard because they are really close to each other and they are right next to each other and there is a lot of noise. Because everyone is on low incomes, everyone is unhappy because they have nothing to do and no future. I know a few friends in public housing that don't like it and they want to go into private housing but it is too expensive and they don't have the money on the pension so they are stuck there. (Consumer 2, May 2004, p. 7)

One carer described her son's public housing as a 'housing commission six pack' that is made of concrete and extremely basic, has 'no leafy surroundings' and is so upsetting that she 'cannot wait to get out of it' when she visits (Carer 4, November 2004, pp. 3-4). This level of entrapment can also be understood as part of the social structural process of *allocation.* In this instance, the allocation process within the welfare system defines how society views mental health consumers and thus the standard of housing they deserve. This *allocation* process in turn, influences how individuals define their own lifestyle and sense of worth.

For one young man, his sense of entrapment included the reduction in the economic standard of his living environment compared to the family home. This could also be identified as the social structural process of *social drift,* as mental health consumers are no longer able to maintain the standards established by their family of origin.

Another carer expressed a sense of entrapment for her son, in terms of an impoverished lifestyle and the vicious cycle faced by carers through continually having to pick up responsibility when things go wrong. Parents became financially trapped through supporting their loved ones and doing without their own recreational spending. Parents who saw themselves as having earned the right to retirement were also trapped in the social structural process of *social drift* downwards while they retained a caring role. A further sense of feeling trapped is described by this carer who already had one son living at home:

> A lot of them come out (of hospital) they have nowhere to go, and no money and no family support. A lot of the time, I live in a two-bedroom house and my son has been in and out of hospital a lot. When I eventually get him out, he demands sometimes to come to me and I end up having him in my bedroom, which is not a good thing anymore because he is nearly 30 … I felt that when he was here and sleeping on the floor in my bedroom that I was not able to go anywhere in case I came back and you know he had the stove on. (Carer 5, November 2004, pp. 2-3)

Carers also pointed out consumers are limited as to where they can go, and have no money to do anything to pursue their interests or to travel to maintain friendships.

Thus, part of the sense of entrapment experienced also includes the sense of loneliness and isolation experienced by both carers and consumers in terms of not being able to exercise the freedoms that they believe are enjoyed by much of the population. One carer said that her son has nothing to look forward to, no reason to get out of bed in the morning, and no money to do anything, anyway. He regularly spirals into depression. She stated he was a good sportsman and used to like to play football at a local club, however the insurance costs the

players had to contribute to the club made it prohibitive for her son to play while only receiving a pension. She also described how her son also feels trapped by the losses he has experienced and is aware that his own life does not meet the usual social expectations of society – a further sense of entrapment made more apparent through the process of *social drift:*

> You know…people on Friday nights... it is knock off time; he knows what normal every day things are like that go on. The cycle of life that you go to school and do this, you get a job and you get married, you become parents, you have a home. He knows all that stuff […]. (Carer 4, November 2004, p. 16)

Similarly, this quote reveals how mental health consumers may feel trapped by being aware they are not having the same life opportunities, experiences and milestones as other people. Across the other comparative data samples, there were few instances of people feeling trapped. One incident described by a tourist was the time when she was on holiday on a crowded beach and felt trapped by the noise of parents and children yelling at each other. This type of experience influenced her and her family to take holidays in far less crowded surroundings in the future. Fortunately, she had the economic resources and choices at her disposal to do this.

Throughout the carer and consumer transcripts, there were overwhelming examples of feeling trapped caused by the characteristics of the physical environment, the restrictive practices that occurred there, and the deprivation of physical resources and social experiences in the environmental context within which these people lived.

5.3.2 Unwelcoming environments

Unwelcoming environments were another factor that contributed to disillusionment.

This carer gives her impression of feeling unwelcome:

> At the [hospital in Brisbane] it was pretty awful […] where you would have to wait there, and then again… they could try and put a few things around in the outside area to make it a little better. You go in and you just, it was very much an institutional sort of place that was something that yes was definitely not crash hot. It was just a cold … there are no welcoming things in the corridor you know. (Carer 2, August 2004, p. 5)

A number of consumers said that locked nursing stations were unwelcoming. This is also captured by the comments of this carer:

> I have been around hospitals both here and in Adelaide; they have such a 'them' and 'us' feel to the place. The nursing staff are always behind thick counters or glassed in areas. (Carer 1, June 2004, p. 6)

This carer's sense of disillusionment is identified through the lack of friendliness or welcome in a hospital setting:

> […] on the balcony it was grotty out there, there was papers everywhere and a pigsty basically. You know and I can see that there may have been safety problems and that so that was pretty awful there. (Carer 2, August 2004, p. 5)

Another carer felt unwelcomed by the fact there was no water, no toilet and no capacity to sit comfortably in the hospital area. This carer describes his son's first experience in the mental health system that was most unwelcoming:

> Yes certainly the first hospitalisation my son was at the [hospital in Brisbane] and it was, the whole scene there was very, very depressing. The care was quite good but the whole setting was really from the dark ages. Unfortunately that was my son's first experience in a mental health setting it was absolutely devastating for everybody. For us the whole scene was depressing. (Carer 9, December 2004, p. 6)

This is further explained by the following comments:

> [ ] my son's introduction there was to be held down and injected in his backside and so on and all of that; while it was not friendly it was not like our story was that much different to other people who went through the system.
> (Carer 9, December 2004, p. 9)

Other carers discussed the drabness of the waiting areas of community clinics. One carer explained that the clinic her son went to never provided the sense of warmth of friendliness that was needed at the time. She described how the environment was 'closed off' from the people who were there for help. In contrast to the mental health field, there were few accounts across the other theoretical samples of people feeling unwelcome. In one instance, tourists felt unwelcome by the small amount of space in an English hotel room (where there was barely enough room to place suitcases), and in another instance where a busload of tourists had to wait several hours for their rooms to be ready. Also, from my diary notes, one particular location where I stayed was classified as less welcoming in the environment due to the 'clinical white colour of the room and the smell of hospital type disinfectant' (Researcher notes, February 2004).

It is possible to view the sense of unwelcome experienced in the context of the mental health environment as part of the social structural process of *managing consumers.* Processes such as *segregation* and *differential standards* for consumers and staff seemed to be part of the way in which people are *managed* within the system, which contributes to the feeling of not being welcome.

5.3.3 Feeling unsafe

Another factor creating disillusionment in the environmental context was lack of safety. While for consumers, the purpose of their stay was to recover, some commented that a lack of safety made hospital an incompatible space for the activity of recovery. One woman disclosed this feeling of being unsafe through her experience of having items stolen in hospital:

> […] the old [Brisbane hospital ward] they have like common rooms for all your belongings, they don't have to have wardrobes in your bedroom. You know like you take stuff into to hospital and it its gets stolen from the room ... but I had stuff go missing from my bag and that … (Consumer 5, June 2004, p. 4)

One carer commented how hospitals have become far removed from the quiet sanctuaries that were once intended. Instead, she indicated that people feel unsafe by the fact that they have become 'public thoroughfares', which can lead to consumer exploitation and victimisation. Again, the social structural processes of *being managed* and being *allocated spaces* that restrict privacy and autonomy are identified here as interfering with a sense of safety.

The data revealed the importance of recognising that the safety or comfort zone for one person is different for another. This became evident through data collected during the consumer focus group. Feeling safe did not only relate to the environment but to the interaction between the nature of the symptoms experienced and the environment. For example, for individuals who are highly sensitive to external stimuli, birdcalls could seem overwhelming or threatening. Similarly, while many people associate being around water with tranquillity, the prospect of being around water for others could create stress or anxiety if it were associated with memories of trauma. While it is apparent that what constitutes a safe environment for consumers is an individual matter, the social structural processes involved in creating *standardised design* and *standardised assessment* protocols in the provision of mental health services, often do not allow for this.

In summary, environments that create a sense of perspective destabilisation and disillusionment for consumers are those that create a sense of feeling trapped, feeling unwelcome and unsafe. The social structural processes of being *managed, allocated,*

standardised, segregated with imposed differential standards are embedded in the psychosocial process of disillusionment. Both consumers and carers also experience the phenomena of downward *social drift* through feeling both economically and socially trapped in the context of their environmental circumstances.

5.4 Becoming Disillusioned Through Intervention Strategies

The second condition which influenced whether people would become disillusioned or not, was the nature of the intervention or treatment strategies to which they were exposed. This seems to occur in two ways; consumers feel disillusioned through the standardisation of treatment strategies within the context of the mental health system, and/or they feel physically or emotionally depleted by their treatment.

5.4.1 Feeling standardised

The most common view from mental health consumers was that interventions centred on medication under the direction of the psychiatrist rather than discussion of other interventions that might benefit their mental health. One example of standardisation occurred when one woman in a private psychiatric hospital experiencing anxiety and depression was denied a massage. The woman believed this would be the most helpful way for her to calm herself, yet the hospital was not willing to compromise and allow her day leave to receive her desired treatment which she thought would be most beneficial at the time.

A further aspect of standardisation is reported by this consumer:

> Well you are socially disadvantaged for a start. You know because you are from a stigmatised, marginalised group of people who rely quite heavily on mental health professionals. It is frustrating to be treated like something out of a text book, especially when you don't see it. (Consumer 5, June 2004, p. 12)

One carer referred to a standard way in which consumers are perceived on a continuum of mental health care from ‘acute’ to ‘chronic’. Standard phrases spoken by psychiatrists, according to this carer, were ‘there is no cure’ and that people ‘will have to be on medication for the rest of their life’ (Carer 9, December 2004, p.4). This carer stated that, even when symptoms abate, the standardised approach is one of continual monitoring of symptoms, because there is still seen to be ‘an underlying problem’ that is permanent.

One natural therapy recipient who had also experienced the mental health system states:

> They are just so happy to just write a script and that really worries me. They very rarely look at other ways, the life context or your world and stuff. (Nat ther rec 9, February 2005, p. 4)

This young woman revealed how she refused to accept the standardised treatment approach of the mental health sector and how she had worked with natural therapy methods, such as positive affirmations and massage, to relieve her anxiety.

There were some examples of people feeling standardised in the natural therapy and hospitality sector, but they were far less common. For one recipient of a massage, she felt that the therapist was treating everyone the same, with a level of disinterest, and for a tourist, some examples of standardisation given were at busy counters, where workers were trying to meet everyone’s needs as promptly as possible.

5.4.2 Feeling depleted

One of the most disturbing factors relating to mental health interventions was that people could feel disillusioned through feeling depleted by the treatment given by mental health professionals. One man described the session with his psychiatrist as being ‘worked

on' (Consumer 8, June 2004, p.14) to the extent that he felt his defence mechanisms were dismantled to erupt strong emotions that he preferred to be left alone. He felt that his psychiatrist over 27 years opened up his sensitivities to the point of being destructive. He says:

> I had a lot of defences, which I really liked […] and because I was a good bloke he used that to take it away from me. Now I have lost all my defences, people like me. …He dismantled all that stuff I really liked about myself. As one woman said to her psychiatrist, 'Oh yes, you can pull me apart, but can you put me back together again?' (Consumer 8, June 2004, p. 14)

Other examples of feeling depleted included the way in which people were treated disrespectfully by staff, especially when they were in distress but their needs were not considered important. Experiences in the hospitality and tourism areas revealed far fewer instances of people feeling depleted through interventions, although one young woman related the following bad experience of going to a massage therapist that she would never attend again:

> […] she pretty much abused me; she was flipping me over, hurting me on one side, stretching me on the other side […]. (Nat ther rec 6, February 2006, p. 3)

The social structural processes associated with individuals feeling standardised and depleted in the mental health context may be related to the *educational processes* through which mental health professionals' progress, the standard *assessment processes* used by mental health professionals, as well as the standardised way in which people are *managed* based on their assessment. In summary, disillusionment through intervention strategies was more likely to occur when individual uniqueness was denied and well-being was disregarded. Understandably, the critical junctures of hurt or alienation would then remerge.

5.5. Consequences of Becoming Disillusioned

It was interesting to note that the consequences of becoming disillusioned included internalised discrediting of self and surprise at any external validation.

5.5.1 A consequence - internalised discrediting of self

This consumer believed that it was his fault for not being able to connect with mental health professionals or learn about himself, thus contributing to his own discrediting perspective of himself:

> I am not the same as someone else, like other people are clear headed and they know, and I'm sort of going through stuff […]. I am not sure like my situation it is not really their fault it is my fault because I have trouble concentrating and stuff and because I am in my own world all the time […]. Learning about myself is really hard because I have got this problem and I feel like it is not me and stuff so it is hard to know myself. I don't (learn) because I can't think […]. (Consumer 1, May 2004, pp. 6-14)

During the research process, I complimented this young man for his communication style and his articulate responses. He chose to discredit himself and told me that it was the voice in his head that was really telling him what to say. The examples given by this young man highlight the importance of relationship with self. This raises several questions: *Can someone ever escape a sense of disillusionment if they are in a cycle of continually discrediting self? Perhaps it is the nature of relationship with self and beliefs about self that really determine whether people journey on a path towards disillusionment or perspective enhancement.*

5.5.2 A consequence - surprise at external validation

A further consequence of becoming disillusioned was that when consumers were viewed by an external source as valued, they were quite surprised and flattered. It was as if

mental health consumers did not expect to engage with anyone who would make them feel good about themselves or be told anything that was validating.

One young man appreciated that a support worker thought he would make a good flatmate; this was quite validating**:**

> It felt good – like he thought something of me. It was good of him to say that. (Consumer 1, May 2004, p. 12)

And from another consumer:

> Oh it feels really good; it feels like there is hope for you. While, a lot of them don't give you hope, believe in you and when you feel they believe in you […] is good because most of the system is saying 'You are not okay'. (Consumer 2, May 2004, p. 13)

For these individuals, their perspective of themselves has been jolted by a perspective-enhancing remark. When this was occurring, it can be argued that their perspective was being enhanced through a sense of being anchored and uplifted. Potentially, these individuals could either develop a new cognitive chapter in their life on the path towards perspective enhancement, or experience hurt and alienation again, leading them back on a journey of disillusionment.

5.6 Coping

Throughout the data there were examples of the ways in which individuals would cope with becoming disillusioned, including excuse-making or focusing on one key thought or activity to get them through a difficult experience. It could be argued that focusing was also a form of grounding, in that it enhanced perspective, rather than destabilising it.

5.6.1 Coping by excuse-making

It was interesting that some mental health consumers found excuses to explain why they did not deserve affirming relationships, and felt surprised when it happened. Consumers also made excuses about why they did not receive enough time because of the difficulties of the case manager's job.

One consumer states the difficulties case managers' experience:

> They have got the problem that they might hear eight or nine consumers every day and they have got to hear all of their garbage. So that is stressful on them and then they are trying to give them advice which wouldn't be easy and they have their own stresses in life to deal with. (Consumer 2, May 2004, p. 10)

In this instance the consumer made internalised value judgements about other consumers that were discrediting. Consumers also made excuses for themselves, that they were not worthy of much time and were problematic. They also tended to excuse professionals for taking years to get their medication regimes right – as if it were the consumer's own fault for having such an uncontrollable illness over such a long period of time.

Another consumer excused the fact that mental health facilities do not have houseplants because it probably would not be possible for someone to water them. Thus, through this comment, she was able to excuse any improvement (through natural greenery) in the mental health environment from really happening.

One woman stated she would no longer talk to her case manager about some things – and that she would leave those things for discussion with her psychiatrist, since her case manager was just not smart enough to 'get it', and that was frustrating (Consumer 5, June

2004, p. 9). Again, she accepted the inadequacy of her case manager, what ever the reasons for it, by making excuses for her.

5.6.2 Coping by focusing

It was noted that both consumers and carers would cope with feelings of being unwelcome or unsafe in their environment by focusing purely on the purpose of being in the environment, actively trying to block out the negativity associated with it, or focusing on an important thought, belief or activity.

One young man coped with feeling trapped in the following way:

> I just listen to music; when I was in hospital I just listened to music and that sort of helps me, just listening to music. It is good to make friends - that helps too. (Consumer 1, May 2004, p. 5)

Other consumers also related to the importance of having trustworthy friends when they were placed in uncomfortable environments such as hospital.

This young man focused on his desire not to disappoint his parents because they had given him so much assistance over the years. His parents helped give some meaning in life. For this consumer in an uncomfortable environment, her focus became on why she was there, in terms of seeking welfare assistance:

> I just thought well I had come for a reason and I will just state why I am here and I was aware not to come back (Consumer 6, June 2004, p. 4)

This woman used her own survival message to cope:

> I always have a survival message to myself and that is ‘I have been through worse and survived’; you know I found that really helped me in my life. (Consumer 5, June 2004, p. 5)

For carers it was fairly much a case of tolerating frustrating settings 'because they had to' and getting used to them while ignoring the judgements of others:

> It just had to be done so I did it. (Carer 4, November 2004, p. 3)

> I try to focus on what you are there for. You have to do that focus and just forget about it. You become used to it when you are in this game. (Carer 6, November 2004, p. 6)

Other coping mechanisms included focusing on positive affirmations, meditation or spiritual beliefs. These will be addressed more, however, in the chapter on perspective enhancement.

Figure 5.1 represents the overall theory of how people become disillusioned.

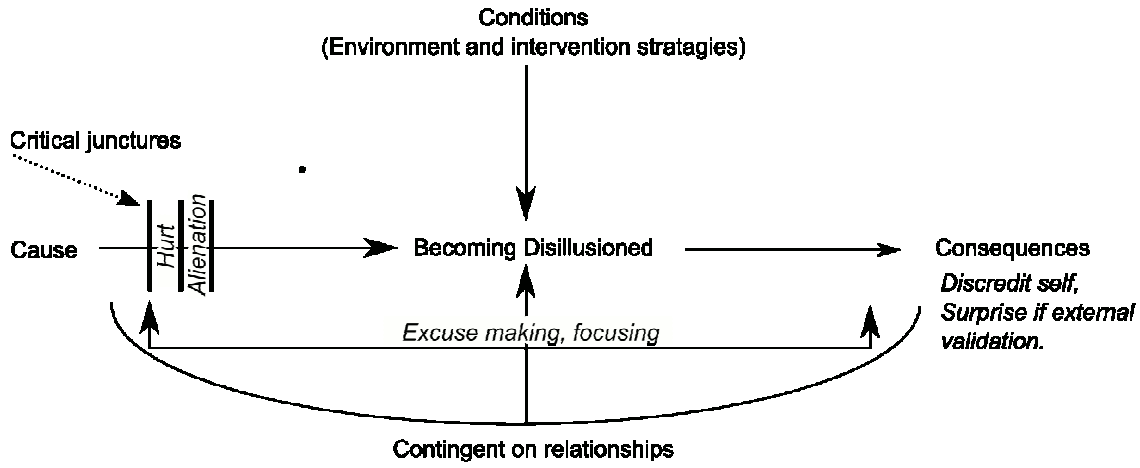


Figure 5.1 Becoming Disillusioned – Illustration of the Causes, Context, Conditions, Contingent Factor, Consequences and Coping Mechanisms.

Table 5.2 on the following page summarises the conditions impacting on disillusionment and the social structural processes of which it is a part in the mental health context.

Table 5.2
Conditions of Disillusionment, Social Structural Processes and the Mental Health Context

Conditions (Environmental and Intervention Strategies) Contributing to Disillusionment	Social Structural Processes	Characteristics in Context of Mental Health Contributing to Disillusionment
Sense of entrapment	Being Managed Process of Allocation Consequential Social Drift	No control No resources Sub standard conditions Physical restriction, isolation
Unwelcoming Environment	Being Managed Standardised Design Standardised Assessment	Segregation -'us and them' Unfriendly Lack of amenities Harsh, cold, drab
Unsafe Environment	Being Managed Allocation of Space Standard Design and Treatment	No privacy Sense of violation
Feeling Standardised	Consistent Education of Professionals Assessment Being Managed	Focus on medication Stand alone treatments Treated as textbook No treatment choices
Feeling Depleted	Being Managed	Feeling worn down or worn out by intervention

Given the data outlined, it can argued that for anyone to become disillusioned they must have experienced an environmental condition, intervention strategy or relationship, with self or other that has generated critical junctures of hurt or alienation. It is also argued that these feelings were more intense than any coping mechanism to do with focusing or excuse-making that could have prevented or interrupted this critical juncture from occurring.

SUMMARY

This chapter has provided an analysis of the data describing how individuals become disillusioned through the conditions of their environment and intervention strategies, as well as the contingent factor of relationships. It revealed that people were more likely to experience a sense of disillusionment through destabilising relationships than because of conditions in the context of their environment or intervention strategies. Evidence was provided as to how the critical points of hurt and alienation emerged on the path to disillusionment. The consequences of disillusionment are revealed as internal discrediting of self as well as surprise at any external validation, while the coping mechanisms identified are focusing and excuse-making.

It was evident that the processes that contributed to disillusionment occurred much more frequently with mental health consumers and carers than within the other theoretical samples. While a common purpose of all service recipients across the samples was to seek out mental health and well-being, the experiences of mental health carers and consumers, were markedly more negative than the comparative samples. The next chapter will examine the psychosocial process of perspective enhancement, and how this manifested itself across the substantive and comparative data.

CHAPTER 6: PRESENTING THE DATA: TOWARDS A THEORY OF PERSPECTIVE ENHANCEMENT

6. INTRODUCTION

The previous chapter identified the ways in which individuals became disillusioned, and highlighted how readily this occurred in the context of mental health service delivery. The following analysis discusses the findings from across the theoretical samples of mental health, hospitality and natural therapies that combine to articulate The Theory of Perspective Enhancement (TToPE) in mental health. There are two core factors that can contribute: perspective-enhancing environments and perspective-enhancing strategies. Whether or not perspective enhancement would occur was found to be contingent on perspective-enhancing relationships (with self or other). An example of a contingent factor in terms of self-relationship was an internalised belief that a person deserved perspective enhancing conditions in his/her life.

The critical junctures in experiencing perspective enhancement were feelings of healing and attachment, contrasting with the critical junctures of hurt and alienation in the process of becoming disillusioned. In this view, the journey of perspective enhancement is continuous, and as a consequence people feel anchored and uplifted. Conversely, the path of disillusionment manifests after they have met too many critical juncture points of hurt and alienation.

While the previous chapter examined how consumers and carers have had their perspective destabilised within the mental health system, it is encouraging to note that there are also some very powerful examples of perspective being enhanced in the mental health

context. Analysis across the theoretical samples helped to bring out the relevance of these examples.

6.1 Perspective Enhancing Relationships

Perspective enhancing relationships included those relationships where people felt connected with others and made welcome. It also included those where individuals felt they were engaged with others holistically, and where there was demonstration of empathy and authenticity, time worthiness, and a sense of safety with a feeling of comfort. A consequence of perspective enhancing relationships (with self or others) was also that the way people were treated instilled the belief that they were deserving of perspective enhancement, thus affirming a more positive view of self.

6.1.1 Relationships that welcome and connect

In the hospitality sector, in contrast to what many consumers and carers had experienced in the mental health sector, relationships were very much about connecting with people from all walks of life and constantly 'reading' them to put any issue right as soon as possible.

> So we met a diverse range of people and we had to learn how to get on with people at all levels whether they were educated or weren't, whether they were blue collar, or up there with the richest you know. Like it was we basically how to learn how to be thrown into any situation and read what people were all about and be on their level. (Hosp prov 3, February 2005, p. 10)

This mental health consumer emphasises the importance of first impressions:

> I get more of my vibes from people rather than from the environment of physical surroundings. But if I walk into a place and the first person I meet is friendly or seems a nice person that has more of impact to me than the actual surroundings. (Consumer 8, June 2004, p. 5)

While for many people in the mental health example, where there was a lack of acknowledgement in terms of receiving people, the hospitality and natural therapy sectors emphasised connection through greetings, smiling, remembering names and letting someone know that their needs would be attended to shortly.

> The greeting is important and open doors are important, the exchange of names, handshakes and smiles. We show them into the guesthouse and offer them something to drink whether that is water or tea or coffee. (Hosp prov 4, February 2005, p. 8)

One natural therapist described the importance of this initial contact, in the way the receptionist interacts with people:

> […] they are pleasant on the phone and their efficiency at answering the phone is very important and I think you know the old fashioned 'Your first impression goes a long way.' I really believe that in terms of business. That voice when you ring on the end of the phone is important. For my business, people are very hesitant - people are very hesitant to seek counselling so often they are very nervous so if someone was quite abrupt to them they would never ring back. (Natural ther prov 7, September 2005, p. 5)

As one natural therapy recipient said:

> […] what is always important is that they look at you and welcome you. They ask you to make yourself comfortable and look after your needs. (Nat ther rec 3, January 2006, p. 9)

For one regular natural therapy recipient, the initial connection was vital.

> Yes like just if it is somewhere I would continue going to I would like the receptionist to go 'Hi you must be [name of woman]', to show an interest in my name and who I am. Maybe like a brief greeting and a welcome. (Nat ther rec 8, February 2006, p. 5)

This is how one natural therapist makes an effort to connect with her clients:

> And you can always get down, well most of the time, you can just find a common ground that you can relate to them … just that initial moment where you get an agreement, a connected agreement and then it can just gently step up from there. (Nat ther prov 3, February 2006, p. 9)

The perspective of a tourist in the hospitality industry expresses what the essence of the connection is like for them:

> Nothing seems like too much trouble for people, which is kind of refreshing really. (Hosp rec 2, January 2005, p. 5)

It is this initial connection and welcome that can be viewed as a critical juncture of attachment on the way to perspective enhancement and a part of the social structural process of *receiving people.*

6.1.2 Holistic engagement

Holistic engagement occurred when individuals felt others fully engaged in and appreciated their world view, preferences and life experiences. It included people extending their activities and behaviours to intentionally recognise this lifeworld. For example, one consumer stated how she appreciated the level of engagement through intellectual conversation with her psychiatrist because her psychiatrist took an interest in her area of study, without thinking that she was unable to study due to having a mental illness.

In terms of holistic engagement through activities, one young man stated that he felt he really connected through a game of pool with a support worker while having respite. He believed good communication was more than words — it was taking the initiative behaviourally to join with the other person in their world. The following are perspective-enhancing examples of holistic engagement given by mental health consumers.

One consumer who was staying in respite:

> They always try to have fish here when I am here, because I like fish.... It makes me feel wanted. (Consumer 7, June 2004, p. 10)

This consumer spoke of her case manager:

> One time she brought a knitting book … I love knitting. (Consumer 5, June 2004, p. 10)

For this man, his ex-wife cared and engaged with him in many ways:

> She helped me get over picking my nails; she got me brushing my teeth.
> She rubbed my back when I had bronchitis. She used to elevate the bed and she used to sit on my backside and rub my back to bring the junk out of my lungs.
> (Consumer 3, May 2004, p .8)

This man reports three ways his psychiatrist holistically engaged with him:

> He [my psychiatrist] is very practical. He looked at my arm, noted a number of possible cancers on my arm, and said, "Hey, I think you will need to have this seen to." (Consumer 9, June 2004, p. 8)

> When I first started reporting vision problems, although he is not a qualified optometrist, he was able to get an eyeglass from someone at the hospital and looked at the back of my eyes to see if they were swollen. (Consumer 9, June 2004, p. 8)

> My health fund was getting to the stage in this particular year where negotiations between the health fund and the hospital were not that great according to reports from the hospital administration and pressure was being applied to me. But the psychiatrist went into bat for me and was able to secure some additional bed days … so that helped me no end. (Consumer 9, June 2004, p. 12)

Similarly, this woman describes the approach of her doctor in this way:

> Consumer: When I first met my doctor we sort of talked as woman to woman and mother to mother. Right from the start I really appreciated that approach. (Consumer 5, June 2004, p. 13)
>
> Interviewer: So right from the start you identified with the roles you play in life?
>
> Consumer: Yes

This carer appreciated how her family doctor took special steps to engage her in the midst of a family member going through a mental health crisis:

> He actually rang me at home that night to see how I was going. He had never met me before. So he went the extra mile and I will never forget that. An almost perfect stranger could care to that extent. It is special so he has been the family doctor ever

> since and he has been a great support. He helps all of us keep ourselves on the move. He gives us an even perspective on our health. (Carer 7, November 2004, p. 4)

One carer stated when her son became paranoid; friends took him in, fed him, took him to hospital and waited in hospital for hours before he was admitted. It was at this stage that the carer really appreciated her friends for their willingness to fully engage in her world.

While mental health consumers and carers tended to feel privileged when they experienced instances of holistic engagement, it was common for hospitality providers to go to the special effort to meet the needs of their customers by understanding all aspects of their life.

The manager of a city hotel also explained how staff would do everything they could to accommodate the need of their customers, whether providing discrete anonymity, responding to health care issues, sending a prompt fax for a businessman or delivering flowers.

In one country town, one motelier took a special effort to look after the doctors staying there, knowing that they were very busy when in town.

> Like the doctors, for instance we know they are busy at work and they are continually rushing out. So what we do is we do their washing and we do their ironing put it back in their room so when they have knocked off at the end of the evening they know they can just relax and we know in his usual job away from here he is on call all the time. So on the weekends we give them complete privacy we don't go anywhere near them, we ask them if they want their rooms serviced and if not we just leave them alone. But just little things like before they arrive ringing the general medical centre and asking if they want a drink or would they like a bottle of wine in the room for when they arrive. (Hosp prov 3, February 2005, p. 1)

This hotelier also cooked meals for those who were recovering from hospital treatment, watched children in the pool for parents needing a rest, and gave people a lift to the hospital because they were unwell.

Another country hospitality provider recounted the following extraordinary story that takes holistic engagement to an exceptional level.

> Well I have done lots of things for lots of people but I think if there is any one thing I remember when I was about 17 and this has stayed in my mind and I have thought about it a lot. There was an old gentleman and he lived in the town of [name of town] which was where my dad's hotel was and he used to get very drunk or he would be very sober. He would go from one extreme to the other and when he was sober, he was just the loveliest old gentleman. When he was having his bad days we used to have an old room down the back of the stables of the hotel and we used to take him down there and look after him for three or four days. We would bathe him; we would feed him soup; and one of the cooks that cooked for us, she was a country girl; she used to even shave him with a cutthroat razor. So we would clean him up and when my father announced we were going to sell the hotel he said to me - he always called me little one - and he said 'if you leave here, little one, I am going to shoot myself'. I said '[name of man] you won't do that, someone else will come and look after you' and he said 'No one will ever look after me the way you have and [name of woman].' When we did leave, he did put a double barrel shotgun and he blew himself away, he put it to his head, we paid for his funeral. We were very sad. I've always remembered that. (Hosp prov 1, January 2005, p. 5)

In this example, holistic engagement was described in terms of individuals extending themselves to meet the full range of human needs. The role of a publican extended to providing accommodation, intervening in crises, providing basic personal care needs and friendship, and finally giving human respect, by financing a funeral.

In the natural therapies field, holistic engagement took into account the links between physical pain, emotional stress, thought processes and spirituality with the aim of bringing aspects of the person into balance. As one natural therapist stated:

> Because I work looking at the whole person it is very important for the clients to know that I am interested in what is happening in their life not just physical symptoms but also what is going on behind the scenes. (Nat ther prov 9, November 2005, p. 4)

This holistic approach included altering treatments when understanding more about the life world of the person. For example, a natural therapist discussed how a young girl with stomach pains may have initially been treated for a stomach upset. However, through more

broadly exploring her life context, it was revealed she was also worried about upcoming high school exams. This natural therapist explained the difference in this way:

> […] when you go to a traditional medical setting you have absolutely no control over what is going on. They very rarely ask your opinion about it, they very rarely ask what you feel, and they are directive and prescriptive. When you go to a natural therapy environment the contrast is that they will gauge your opinion. They will look at the whole, they are looking for the cause rather then the symptom and in that respect it actually gives you some amount of control over what is happening. (Nat ther rec 1, December 2005, p. 4)

While all of the above examples involve a social structural process of *assessing* and *managing* people, it was evident that this style of holistic engagement allowed for more in-depth and contextual understanding of people's lives that encouraged a sense of healing and attachment to the relationships around them. The sense of healing and attachment offered to people were then critical junctures towards an enhanced perspective.

6.1.3 Authentic tailored engagement

I developed the notion of authentic tailored engagement to collectively describe the client-centred concepts of empathy, authenticity and unconditional positive regard described by Rogers (1951). These characteristics of the therapist were viewed as central by Rogers in forming the therapeutic relationship. Authentic tailored engagement recognises this and also highlights the importance of active listening and genuine caring. This style of communication was highly valued by mental health consumers.

> He was just concerned about me and I like that … caring. (Consumer 1, May 2004, p. 8)

> Someone who can listen, someone who cares, someone who reassures. Someone who is very gifted in communication in being able to empathise with the patient and can encourage that patient to open up. (Consumer 9, June 2004, p. 11)

One carer states the value of this engagement:

> Well for me the biggest thing is the warmth that comes from the people within – that is what I would like to see. People who have some empathy, who show some compassion as needed, if it is needed at the time. Who are, who have an attitude of 'I am here because I want to help because I want to make this journey easier, because it is hard enough.' (Carer 1, June 2004, p. 8)

One consumer expresses the value of authenticity in relationship in the following way:

> I do like the support workers here because they are not highly trained and to me they are just ordinary people. Because they seem to me to be just ordinary people, they treat me as just an ordinary person. When I come in here people like [name of support worker] and [name of support worker] treat me like an ordinary person, and that is something to value that is important. (Consumer 8, June 2004, p. 7)

The manager of an inner city hotel chain also expresses the importance of authenticity:

> I think that genuineness that comes with guests and their needs without just offering lip service. So you can say thank you very much for coming here, but it's in your delivery and how genuinely you really feel it. And I do feel that some places that don't necessarily offer that, and it's quite routine and they don't have things in place to recognise their guests, and I may reiterate that with the associates that you know, you can say thank you but unless you mean it, and it's in your eyes, and in your smile then it's, you may as well not say it. Because guests are not stupid and they're very perceptive, and if they feel you're just offering something that means nothing to you then it annoys them. (Hosp prov 6, March 2005, p. 14)

It was interesting to note that in the hospitality and natural therapies industries these qualities tended to be expected as part of the experience. The quality that most disturbed the perspective of tourists and hospitality recipients was abruptness, either over the phone or in person. As paying customers with choice, they would not come back. It can be clearly seen that a consumer who is part of the social structural process of investing in resources for their own health and well-being will be engaged differently from mental health consumers who are using public resources because they have no other option. It is speculated that the higher the level of investment, the more holistic and perhaps authentically tailored the engagement that will be received. It is also possible to argue, that the social stigma of a mental illness may create a view that people with a mental illness are seen as less 'worthy' or deserving' of

authentic tailored engagement than those who are not recognised as having a mental health issue.

6.1.4 Timeworthiness

While there were not many examples of consumers feeling timeworthy in the mental health sample, this young woman valued her worker because she would sit down, spend time with her and show her things on the computer.

She adds:

> She seemed to be caring in a way; she wouldn't rush out smoking or anything. (Consumer 4, May 2004, p. 7)

Particularly affirming for recipients of the natural therapies industry was that consultations were never rushed. One recipient expresses this in the following way:

> For some reason, there isn't a massive emphasis on time and so I think that when people relate to you, they are looking into your eyes and they have not got twenty things stacked up behind them that they have to get done. Whereas when I have been to hospitals and like especially hospital and doctor's surgeries as well, there is this certain busyness or franticness to their lives. So the quality you are getting is so much more brief and it is a lot more impersonal I guess. Maybe they are getting so many more people through they don't have the money, the time, or the people to kind of sit there and spend time with you. (Nat ther rec 8, February 2006, p. 4)

This natural therapist insisted on giving people adequate time to let their story evolve, but also time to re-check and re-negotiate the outcomes.

> Well I think you need to definitely need to give people time to speak. You know how sometimes we pre-empt a lot that is a really bad habit because often it cuts people right off […]. But you know what I mean; you have to give time for them to speak. I think that is really important, let the story come out from people's own point of view instead of, sometimes, I think we just judge too quick […]. I think I also ask 'Does that sound okay? Are you happy with what we have talked about?' (Nat ther prov 8, November 2005, p. 10)

Timeworthiness was a valued component of the way people were assessed and managed. It was considered important to clearly understand the individual's needs and ensure that these were addressed and tailored satisfactorily. One could speculate that the prospect of being more timeworthy would allow for the critical juncture of attachment to emerge on the path of perspective enhancement.

6.1.5 Sense of safety

Several consumers described how their time in respite enabled them to feel safe; while one young man particularly appreciated the soundproofing in his psychiatrist's office as an aspect of safety.

Two Natural therapists commented on creating safe places by saying:

> […] they can divulge everything, or they just want some certain things [to be said] that they might not be able to say to anybody else, but know it is not going anywhere outside those four walls, so they feel safe to be able to do it here. (Nat ther prov 1, August 2005, p. 9)

> Just to give the person that sense of comfort so they know they can say whatever they need to say without feeling guilty or without feeling any fear or anything like that. (Nat ther prov 9, November 2005, p. 6)

Just to give the person that sense of comfort so they know they can say whatever they need to say without feeling guilty or without feeling any fear or anything like that. (Nat ther prov 9, November 2005, p. 6). Safety was a key factor in the way people wanted to be managed by service providers and was a high priority for consumers and carers within the mental health context. It is anticipated that many of the aspects of the environment and relationships in which individuals feel safe have already enabled people to experience a critical juncture point of attachment in order to realise that sense of safety.

The following table summarises the contingent factor of relationships and the interaction with social structural processes that contribute to perspective enhanced service delivery.

Table 6.1
The Contingent Factor of Relationships, Social Structural Processes and the Characteristics Contributing to Perspective Enhancement.

Relationship Properties on the Path to Perspective Enhancement	Social Structural Processes	Characteristics in Context of Service Contributing to Perspective Enhancement
Welcome and Connection	Being Received Assessment of Need	Responsiveness Welcoming gestures Nothing too much trouble Comfort, amenities available
Holistic Engagement	Being Assessed and Managed	Enters the life world of the person and responds according to their needs.
Authentic Tailored Engagement	Assessment and Management	Empathy Authenticity Unconditional positive regard Active listening Caring approach
Time worthy	Assessment and Management	Adequate time taken to address needs Time to negotiate strategies and outcomes
Feeling Safe	Assessment and Management	No fear No sense of vulnerability

6.2 Perspective-Enhancing Environments

Contributing factors that led to perspective-enhancing environments were a sense of escape, including voluntary surrender of responsibility, a sense of connection and captivation, a sense of welcome, and activity/space compatibility.

6.2.1 A sense of escape

For mental health consumers, carers, hospitality and natural therapy recipients, there was an enormous recognition of the need for a sense of escape. This involved being away from the routine physical environment and usual responsibilities as well as escaping from stress. For mental health consumers this also included escape from symptoms, such as persistent voices or anxious feelings.

A sense of escape for some involved a distracting activity, such as gardening, fishing or sailing. For one consumer it meant going to a beautician. For this next young man, escape was about going to the movies:

> …I like going to the movies ... that is good to get away from my problems. Because I hear voices all the time and stuff so it is good to find something to occupy myself so I am not distracted all the time. (Consumer 1, May 2004, p. 1)

For a stressed teacher who was also a natural therapy recipient, a sense of escape was created through getting away from the world in a flotation tank. For one carer, it meant reading the words of a meaningful text and for another, entering into the world of meditation.

One man who experienced the distressing symptoms of schizophrenia described a sense of escape in terms of physically removing himself from his usual environment, and spending time in a respite facility.

> […] it is more getting away from the situation, removing yourself from the situation. Allowing me time and space to think things through. (Consumer 7, June 2004, p. 2)

In a similar context, this carer commented on the need for her son to physically get away in order to escape reminders of the past or a negative situation:

> He has this need sometimes to run away from where he lives. Away from the hospital and he just wants to get away somewhere and I guess going to a place like that, he is away from everything that he has come out of or been reminded of a bad situation. (Carer 5, November 2004, p. 2)

This natural therapist wanted to create an environment in Nimbin that was distant from the reminders of a heavy drug culture to which many people in the area had become accustomed. She reports how her customers recognised the sense of escape when entering her shop.

> So often people walk into the shop and just go ahhhh, this is such a sanctuary in here, you know, so yeah, we feel that it is really, really important, the atmosphere that people walk into, yeah. (Nat ther prov 2, September 2005, p. 1)

An important part of the process for escape for some people was *voluntary surrender of responsibility*. This enabled people to escape everyday responsibilities and routines and get away from usual pressures. It is important to note here, that for some mental health consumers, their responsibilities were removed forcibly in the mental health system. Voluntary surrender of responsibility provided a sense of escape by allowing mental health consumers to have someone else pick up their responsibilities by choice, to alleviate their own stress.

While consumers were quick to indicate that mental illness does not leave them when they leave their environment, being away from external stresses, having someone to cook meals, and generally 'giving over' the responsibility of running a household was helpful. For consumers, it was indicated that the most dangerous time for them was returning home from hospital when responsibility comes flooding back and they are coming to terms with whether they are able to manage it. One man who experienced a mental illness for many years discussed the benefits of surrendering responsibility when unwell:

> So when I come here (respite) or go to hospital, it is like someone else is in charge, someone else is supervising. That takes some weight and responsibility off yourself and sometimes you need that. It is not that we are irresponsible people … it is just the stress of the illness is so more consuming, so total that sometimes we haven't got time to look after ourselves. (Consumer 8, June 2004, p. 5)

For carers too, it was indicated that the most valuable part of carer retreats was being away from their day-to-day responsibilities. One carer stated in relation to carer retreats:

> I think that wherever it is, if you can allow the carers to be free of anything … in other words, even if they took the time to have everything provided for them, complete freedom of even any duties that they may have. Peace and no responsibility. (Carer 6, November 2004, p. 5)

For a retired couple interviewed as tourists after going to New Zealand, voluntary responsibility surrendering meant having all accommodation and transport organised by someone else, as well as no longer having family responsibilities to consider.

> On this holiday I felt very different … haven't got the confines of the children or worrying about what we are going to do with them … we could virtually do whatever we liked. (Hosp rec 7, February 2005, p. 6)

Another tourist expands on this idea of voluntary responsibility surrendering.

> It is more than just being 'away from home' and not having the responsibilities of having a home. Staying in hotels and cottages, or whatever, all you have to worry about is what you are going to put on in the morning and what you have to enjoy seeing, and what you might eat. You don't have to worry about household security; you don't have to worry about housework, looking after pets or paying bills, any of those everyday things. You are completely separated from them … that is mental freedom. (Hosp rec 2, January 2005, p. 2)

In all of the situations described above, the feelings underpinning the descriptions were of a sense of attachment to the environment or context of the escape, which tended to bring with it a sense of healing or wholeness.

While a sense of escape may entail some level of *managemen*t at a social structural level, for example, management by tourist operators or respite services, where this was done,

it was unobtrusive, 'behind the scenes' and was conducive to the notion of voluntary surrender of responsibility for the person wanting to experience the sense of escape.

6.2.2 Connection and captivation

The second property of a perspective-enhancing environment is one of connection and captivation. People felt connected to and captivated by their environments through the senses, through feelings that emerged for them, or through a deep sense of attachment to the environment.

A connection through the senses was the most easily revealed form of connection for mental health consumers. The following accounts are examples of this through sight, smell and sound:

> A natural setting is better because it makes people feel a bit calmer if they are looking at something like a beach or a rainforest rather than just being shut between four walls. (Consumer 2, May 2004, p .2.)

> The scents of the flowers and the freshness of the garden. (Consumer 6, June 2004, p. 2).

> At Bribie we had a view over the passage …. At night, the lights shine in the water and it was really beautiful …. There were a lot of Lorikeets flying and making beautiful birdsong. (Consumer 7, June 2004, p. 2)

There were many of these types of examples throughout the data. This level of connection and captivation, while allowing people to be away, enabled people to see new sights and experience new settings with a sense of calm. In this next example, the mental health consumer describes the connection and captivation that occurred through the senses when going to a friend's place for dinner:

> Like when he makes me dinner he has the best, freshest food and we always have the nicest wine because he has a really good wine cellar and the music is always nice. I don't know … and I always like talking to him because it is sort of like a meeting of minds you know. (Consumer 5, June 2004, p. 7)

This person also articulated the connection she has two birds that she has been watching with interest for years:

> Well there are a pair of doves in that tree and I have been watching them for years, they have been nesting and rearing young and seeing them off and courting every now and then and coming down when you mow the grass they come down and pick the insects and that up. They are there all the time they are really…. But you know I have been observing them for years. And that always made me feel good. (Consumer 5, June 2004, p. 2)

This carer brings together the essence of a feeling of escape and a strong connection to the environment:

> It very carefree, as if the salt and the wind blow out all the cobwebs. And that lovely feeling you that you get when you get out of the sea; you can just float there and just let everything float away from you. (Carer 7, November 2004, p. 1)

Likewise, a strong sense of connection and captivation was of key relevance to tourists when they felt they were entering a different world; whether it was different vegetation, uninhabited territory, or experiencing a special connection to the natural environment of fauna and flora. This tourist experiences a strong sense of sensory connection and captivation experiencing marine life:

> I think when you put your face under the water with your mask on everything disappears and it is like looking into a jewellery box you just have this amazing other world that most people don't even know is there. There are characters there these different kinds of fish and all sorts of relationships going on in front of you it is beautiful. The sea breezes and the soft sand and eating fish every day really fresh food, being places that are remotely only they can get locally this amazing fresh food those are the things that make that kind of holiday really rewarding. (Hosp rec 6, March 2005, p. 2)

It can be argued that what is evidenced through these examples is a level of control and choice in the environment, whereby individuals do not consider themselves as being

managed through a social structural process in a way that inhibits their freedom, autonomy or curiosity. It is also indicates a level of attachment to the environment through the senses, attachment being a critical juncture on the path to perspective enhancement.

6.2.3 Welcoming environments

The interviews revealed the different feelings people experienced when entering into new environments. It highlighted how entranceways, reception areas, comfortable furniture and access to private and clean amenities made a significant impact on people. One example of this was reported by a mental health carer, attending a community clinic with family:

> It [the clinic] is in a suburban street and you might walk in there. Not just the paint and everything but even just they are quite welcoming and the fact that everything, the staff and their reception staff and that, they know who you are. Yes they know who you are and that is just constant. 'How are you? Sit there'. (Carer 2, August 2004, p. 7)

And another by a person entering respite:

> It has a homely feel to it – it is not like a residential place where you have strictly this or strictly that or signs up all over the place. I mean you walk in and there is a lounge room comfortable chairs, a television, a dining room, a kitchen, off the left a games room. (Consumer 9, June 2004, p. 3)

One tourist explained a sense of welcome when he booked in to accommodation and felt that the staff at reception had been waiting all day to meet him.

Another tourist explained:

> Well you feel welcomed and that you are meant to be here, they help you feel like you belong. (Hosp rec 3, February 2005, p. 6)

One example of a hospitable environment was discussed by a country motel manager:

> We always get the feedback of 'Do you know those rooms it is just like my grandma's kitchen'. So we get a lot of that but I think because they are not overly flash and people you know they haven't got that: 'I can't sit this there'. They can literally just

> unwind and put their suitcase on the port rack and they can relax without thinking they are going to damage anything. (Hosp prov 3, February 2005, p. 6)

A coordinator of a spiritual retreat gave another example of a welcoming environment where all aspects of the environment were important:

> Well they would take in the beauty and the nature of the environment… and wherever I think just that friendliness of staff. The way décor is in place. Like there's a really beautiful way in which things are done here and I think indicates too, that it's very artistic, even with charcoals. The way the meals are served. People often describe it when they come, there's a real warmth about being here. People are greeted very warmly. There's a wonderful sensitivity I think too for the individual. The fact that they're here to be renewed. So we try to do that in different ways, the rooms are kept clean. Very user friendly, very warm. The group – meals are done with a real sensitivity to greet the people, it's with every sincerity. With meals and nutrition, nourishment. Yeah. (Hosp prov 10, May 2005, p. 4)

In summary, the common themes that emerged about physical aspects of the environment that generated a sense of welcome were aspects of the environment that facilitated an atmosphere of warmth, homeliness and belonging. This was appreciated through cleanliness, comfortable furnishings, informal and thoughtful presentation as well as attention to detail. The way in which the environment was laid out also enabled people to associate it with other places to which they had experienced fond memories.

In these examples the social structural process of how one is *received* and greeted to enhance comfort is vital. A social structural process of being *assessed, managed* and *allocated space* is still taking place, yet the focus is on individual need above all else. The environment is being purposefully yet discreetly managed to create a relationship with it in a way that encourages the critical junctures of healing and attachment within the context of the setting.

6.2.4 Activity/space compatibility

A further property of perspective enhancing environments is that they are activity/space compatible. This allowed people choice and privacy in their environment when it was required. For some mental health consumers this meant having the capacity to entertain friends. For others, it included having open spaces to reduce stimuli and alleviate symptoms. Consumers mentioned on a number of occasions that the club-house model of a Brisbane service provided them with a level of flexibility and structure, the capacity for spaces to accommodate activities, or for people just to 'be'.

One consumer described how when she visited a friend in [private hospital in Brisbane] she could appreciate a private room, pleasant decor, nice carpet and a phone. This was conducive to the person's recovery needs, including privacy. For one man, his parent's home gave him activity/space compatibility.

> It is good to lie down and watch TV – you can't do that in hospital…. To be able to go to the fridge and get some food and stuff like that. You have control over what you want and you are not relying on other people. (Consumer 1, May 2004, p. 6)

Tourists certainly appreciated activity/space compatibility and discussed this in terms of large comfortable rooms with plenty of room for luggage, different restaurants, choice of activities, well-lit walking areas, and the capacity to come and go as they please with easy access. One example of an activity/space compatible layout was shared by this tourist:

> The reason I liked it so much was because all the rooms are basically so big so there is heaps of space there. Each room had a veranda like a covered deck that came out of the room, out of the bedroom there were a few seats and a small table that looked over the water. (Hosp rec 3, February 2005, p. 1)

A hospitality manager discussed activity/space compatibility in terms of room configurations and their flexibility, while natural therapists focused on discussing how their work was vital in producing a relaxing environment at all stages of the treatment process.

This included all rooms, from waiting room to treatment room, to the post treatment spaces that would assist in giving people further private space for integrating their experiences before they drove home. While the social structural process of *space allocation* was occurring in these examples, the approach was highly individualised and tailored.

In the following quote, this tourist encapsulates the sensation of escape, responsibility surrendering, a level of captivation and connection with the environment, and the importance of activity/space compatibility. As the tourist returns from holiday, a sense of feeling trapped, disconnection, sense of being unwelcome and lack of safety creep back in:

> There was no TV or computer or telephone or radio, or anything like that on the island –that was something that I really appreciated. Besides that there was no people around to meet, asking you questions and wanting something from me and I could have time for myself. You know if I wanted to go to the beach and lay down on the beach I could do it, if I wanted to swim for ten hours I could do it. It was very peaceful, it was so peaceful; and so beautiful and it differs … from civilisation. Then we were coming back I was crying … we were going through Brisbane and I was sitting with the backpack on my face you know, I could smell all the poisons in the air. (Hosp rec 1, January 2005, p. 1)

6.3 Intervention Strategies

The second factor that contributed to perspective enhancement was the nature of the intervention strategies (including activities) to which they were exposed. Individuals described their experiences as more perspective-enhancing if these strategies or activities were individualised or replenishing.

6.3.1 Individualised approach

Many consumers and carers were able to acknowledge what was helpful or unhelpful to them; they indicated that they also needed to have their own strategies acknowledged, whether by meditation, self-talk, keeping active, and feeling listened to at support groups,

affirmations or calling on their own spiritual beliefs in times of distress. One older carer described how he would refer to bible scriptures every day for guidance, and another the importance of visiting the hospital chaplain or chapel to gain a sense of meaning from the situation. This carer discusses her use of visual imagery when stressed to access her spirituality.

> I think the best place for me is not so much that place outside of myself, it is the place inside of myself. […] It doesn't matter where I am at in a physical sense. It is where I am at internally and spiritually that I think I have found the key. […]I can use visual imagery to get there by going through a rose garden or to an island setting, beach setting […]. I am left in this place of feeling quite calm, less agitated, recharged. (Carer 1, June 2004, p. 1)

Carers also stated that there needed to be a range of flexible and individualised service delivery approaches for people at different points in time. For example, when people are too sick to be at home, yet are not sick enough to be in hospital, intermediate individualised support strategies conducive to the person were valued as useful. One carer identified that a carer drop in centre would be helpful when her situation at home became overwhelming.

> It could be like a home that you could go in but like in the community […] where people (carers) could pop in and have a coffee and have a chat to whoever is there at the time (Carer 5, November 2004, p. 3).

A level of individualisation was also identified, through discussion in the consumer focus groups, as important in intervention strategies. For example, while people valued relaxation strategies some people viewed relaxation and meditation as dangerous as it opened up too many stimuli. Thus, safety was also a key factor in tailoring intervention strategies. Non-clinical supports were viewed positively by consumers, due to the level of flexibility they provided in terms of giving the practical or emotional support that people needed at a specific point in time. In a similar way, this natural therapist explained her approach to individualisation in terms of giving people the strategies and ideas they need in everyday life, so they are in control and can call on these tools as necessary:

> We discuss everything but I try to give people strategies and ideas to go away and use things they can use. Not just the issue that they are coming about but for something that may come up in six months time. So really enabling people to take control and deal with issues as practically as they can. But I also draw on all kinds of things so when I did my training we learnt about lots of different types of counselling strategies and techniques and a lot of people go just with one; I draw on lots of different things. (Nat ther prov 5, September 2005, p. 1)

6.3.2 Feeling replenished

A further key factor in intervention strategies was that the person needed to find these strategies replenishing in order for them to be helpful. For carers and consumers, feelings of replenishment came when they experienced situations, places or people that enabled them to feel anchored and uplifted. Both carers and consumers identified with the importance of being able to express themselves freely and experiencing situations where they felt their burdens had been lifted, for example, carer retreats, staying in respite. For this man, feelings of being healed and at peace were important.

> [..] I can go there for a week and feel healed and rejuvenated. Feel like part of my emotions, part of my mind has been healed. […]Often if I have time out I can think through things and often reach some understanding of peace with the problem I have. (Consumer 8, June, 2004, p. 1)

For another man, being near the water was replenishing and peaceful.

> The island, it just does something for me that I really, my inner self and I really enjoy being there.[…] it is a combination of things, the sight the smell, the atmosphere. One (referring to a feeling) of peace comes across very benevolent every time I have been there. (Consumer 9, June 2004, pp. 1-2)

Unfortunately however, while the importance of feeling replenished was identified for carers and consumers, the descriptions were not as frequent, as vivid or as rich as the examples provided across the comparative samples.

The next example shows how a natural therapist viewed the need for treatment strategies to be individualised and replenishing by leaving people with a better feeling about themselves and giving them an inclination to try something new.

> Even something as simple as reflexology […] it can be very effective at calming people helping to increase their overall bodily health and that is quite a simple therapy. It is non-invasive and it doesn't cost a lot. And it is about quality of life… it doesn't mean that if someone has a mental illness that reflexology is suddenly going to make them better. It might give them a better quality of life it might give them a better feeling about themselves and in turn could actually act as a catalyst for something else. (Nat ther prov 9, November 2005, p. 16)

For a regular massage recipient, feeling replenished included a feeling of relief and clarity of thought:

> The clear thinking that is sort of the most important thing because I am always thinking at a hundred miles an hour, that sort of calms me down… and that is sort of really important for me especially with my job. I find that really important to sort of rejuvenate … and you feel fresh, you feel like you are new; just like you have been given a new body for another month. (Nat ther rec 4, February 2005, p. 9)

One natural therapist explains that her clients undergo a transformation as they become replenished:

> They are less tense and the first thing I notice is that they stand upright. They don't stoop or have tension in their face … they look clearer around the face, much clearer. You know sometimes you see people and you think they are constantly walking in a black cloud. You know particularly around here in [name of place]. It is so murky that you want to wash yourself just going past. Yes, as the client leaves, it is good. Particularly the expression in the eyes, as well as the clarity in the eyes. (Natural ther prov 4, September 2004, p. 2)

This natural therapy recipient describes her sense of replenishment after a massage.

> Particularly when you might go in scattered when you go in and you come out focused. You might be unaware of your body and what it is going through but when you come out you do have that awareness. (Nat ther rec 4, February 2006, p. 5)

Feelings of inner lightness and relaxation are also described by this tourist, as she took some time out to replenish herself:

> After a few walks I start feeling much better and start feeling like my shoulders are feeling much lighter and my head is feeling much lighter. You know I can walk even farther and people around me aren't really annoying me anymore. I can adjust to a bit more people and I can feel when these things are changing inside me the whole things over the year and feeling much lighter. It is like my spirit is lighter. (Hosp rec 1, January 2005, p. 3)

Similarly, for this hospitality recipient, the strategy of taking time out away from work enabled her to feel replenished:

> You feel alive again, you feel like you have a lot of energy and a lot of passion to do the work you want to do and you remember the reasons why you started doing what you wanted to do in the first place like with work. You feel happier ... you can feel like a physical change in your body and in your mind as well and you look forward to new challenges instead of being scared of what obstacles might be ahead. You look forward to doing a lot of new things that you didn't have the energy or motivation to do before. (Hosp rec 3, February 2005, p. 10)

The desirability for people to receive individualised and replenishing intervention strategies also has implications at a social structural level in the way staff are *educated* and how individuals are *assessed and managed*. These strategies in particular, also enabled people to arrive at a critical juncture of perspective enhancement through gaining a sense of healing.

Table 6.2 on the following page summarises the conditions of perspective enhancement and how these interact with social structural processes to contribute to perspective enhanced service delivery.

Table 6.2
The Conditions of Environment and Intervention Strategies and the Social Structural Processes in the Service Delivery Context

Conditions (Environmental and Intervention Strategies) Contributing to Perspective Enhancement	Social Structural Processes	Characteristics in Context of Service Delivery Contributing to Perspective Enhancement
Sense of Escape	Managed 'behind the scenes'	Provides sense of awayness and alleviation from unwanted responsibilities and worries.
Connection and Captivation	Managed 'behind the scenes'	Allows freedom and autonomy Enables exploration Arouses curiosity
Welcoming Environment	Being Received	Comfort Provides sense of belonging Good amenities
Activity/Space Compatibility (including safety)	Being Managed Space Allocation	Allows choice Tailored/individualised Flexibility Usable spaces
Individualised	Negotiated Assessment and Management	Tailored Active participation
Replenishing	Management (that allows active participation and the capacity for people to integrate their experiences)	Exposure to different experiences Opportunities for Personal growth Opportunities for meaning to develop

6.4 The Consequences - Deserving and Self-Affirming

While it was noted in the previous chapter that the consequences of becoming disillusioned were that people discredited themselves and were surprised at any external validation, it is interesting to note that the consequences of perspective enhancement tended to be that people had a perception of themselves as more deserving with a more self-affirming view of themselves.

6.4.1 Deserving

A feeling that they were deserving of interventions that were individualised and replenishing was particularly found in the responses given by natural therapy recipients. They tended to hold a view that they were deserving of rejuvenating treatment. Whether this belief was internalised within self, through others, or through spiritual beliefs, the belief in itself appeared to create an anchor for perspective enhancement. This natural therapy recipient describes it as:

> Topping up your cup, filling your goblet. It is about giving yourself the love and the time and the energy that you deserve. When I get that feeling that it is all so hard it is to make sure that you don't get below, to make sure that you don't get below that you need so much work too rejuvenate yourself. That is where massage to me is really good for my neck and it is very much about time too that is something we don't give ourselves. As your body gets older you don't have to wait until you have a need or that you can't move to go and get a treatment. (Nat ther rec 7, February 2005, p. 9)

Unfortunately, it seemed those mental health consumers who had learned to internally discredit themselves and their abilities, seemed to appear further away from achieving an underlying belief system conducive to perspective enhancement.

6.4.2 Self-affirming

Part of the notion of feeling self-affirmed was that people could gain a deeper sense of themselves. For these consumers, this occurred through some external validation:

> From giving me feedback like 'keep going, keep going, you can do this'… Encouragement and support. (Consumer 6, June 2004, p. 11)

> […]and when you are told you are okay you have this feeling of euphoria. Not really euphoria but "hey everything is okay" and that is what I like about this place is that the staff work on the member's strengths not on their weaknesses. So if they see that you are good at giving presentations they encourage you and if they see that you are good at another thing they encourage you and so you just feel empowered. That is the word for it - empowered. (Consumer 2, May 2004, p. 13)

This quote reveals how workers affirmed this man by recognising his strengths and capabilities. This external validation gave him a sense of confidence enabling him to have a more hopeful and positive sense of himself.

An example of how one male mental health consumer negotiated critical junctures is given through these comments:

> If I say I will survive this system I hope and pray I will survive in spite of it not because of it. I have learned that I can achieve personal goals and a lot of the time people wrote me off and said 'he will never develop as a person.' I don't see my achievements in financial or social terms; I see them in terms of personal achievements as far as myself and my development. (Consumer 8, June 2004, p. 20)

This quote reveals a belief in self that was affirming, thus helping to facilitate an enhanced perspective. It can only be speculated that if this man had taken on the belief that he would not develop as a human being, he might have found himself on a journey towards disillusionment Validation helped consumers feel clearer, and gave them the capacity to reflect on themselves and their lives to gain a deeper sense of their own being. For the other groups interviewed, this occurred in other ways. For example, for one tourist, the experience of learning about the history of another country was inwardly thought provoking, enabling her to become more grounded by appreciating the past.

For this person, the experience of another culture was affirming in that through the experience and appreciation of diversity, she felt more settled and satisfied with her approach to others.

> After being in Asia, I was more relaxed and willing to listen to people about any issues they might have generally – generally more easy going in every aspect – yeah. (Hosp rec 8, May 2005, p. 2)

For others, being self-affirmed was about taking the time out to make important life changes and decisions:

> […] time to step back from what I've been doing at home, and just see it from a different – an outside perspective kind of thing. Get away from my home environment and looking at it outside… It was a good time for me to reflect. And just to make some decisions about my life. … I was able to weigh things up and I was able to have the time to weigh things up… and see where I want to go and you know, stop things in my life that really weren't healthy […]Think about new directions […]. (Hosp Rec 8, April 2004, pp. 6-8)

For others it gave a deeper appreciation of the world around them and enabled them to be more in tune with their own values, as revealed by these two tourist accounts:

> A feeling of belonging more in the world and knowing more about the world and how it fits together and that the world is not such a big ugly frightening place. That everyone everywhere in the world is really just the same. Yes, I ended up feeling more positive about the world. (Hosp rec 2, January 2005, p. 13)

> So in the end there are things that I like but the feeling of wellness and relaxation came not from being in places that I like but by doing things that expanded my ideas and my soul. So I come back feeling like I could probably do anything. Yes I think it is a nice thing to do and I have always thought it has been worth the time and the money. So this time when I look back on it, it really changed my way of thinking like going to places that were really poor and different so it made me think differently while I was there so I came back with a different perspective on possessions and values for everyday. (Hosp rec 6, March 2005, p .6)

These examples demonstrate how through perspective-enhancing experiences, new cognitive chapters emerged in the way individuals were thinking. While some mental health consumers had timely respite within which to self-affirm, this opportunity for deep inner self-reflection was not a prominent aspect described by those who had spent time in the general mental health service. Generally, in this environment, they did not experience the critical junctures of a sense of healing or attachment to the same extent as the recipients of natural therapy or hospitality.

The data revealed overall, perspective enhancement generated a feeling of being anchored yet uplifted, with a sense of balance, calmness, centeredness and clarity. In whatever environment feeling anchored yet uplifted is felt (mental health service delivery, hospitality or natural therapies), it reveals a positive outcome in the way individuals have been able to *participate* in the social structural processes of which they have been a part as well as to *integrate their experiences.* Figure 6.1 represents The Theory of Perspective Enhancement.

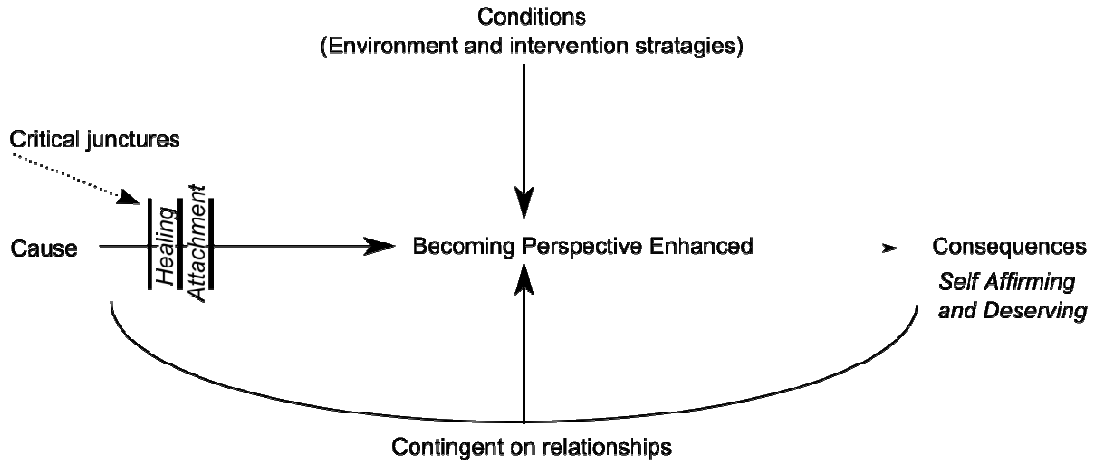


Figure 6.1 Becoming Perspective Enhanced – Illustration of the Causes, Context, Conditions, Contingent Factors and Consequences

To compare the processes which to contribute to perspective enhancement and disillusionment, Table 6.3 on the following page gives an overview of how the social major structural process contrast in their characteristics in either facilitating disillusionment or perspective enhancement. The social processes identified and compared are those of being received, being assessed and being managed. The critical juncture points (of hurt and alienation or attachment and a sense of healing) are key in determining whether the social structural process manifests disillusionment or perspective enhancement.

Table 6.3
The Social Structural Processes – How They Contribute to Disillusionment or Perspective Enhancement

Social Structural Process	Features Creating Disillusionment and the Critical Juncture Points of Hurt and Alienation	Features Creating Perspective Enhancement and the Critical Juncture Points of a Sense of Healing and Attachment
Being Received	Not acknowledged 'fobbed off'	Responsive Welcoming gesture and environments Serve to please
Being Assessed	One way communication from service provider Pathology reinforced Vulnerability heightened Labelled Feeling unsafe Written off Blamed	Enters the life world of the other Respectful communication Allows time to identify needs Safe Values other as worthy
Being Managed	Restricted Standardised approach No choice No privacy No control No participation in decision making	Time to negotiate strategies Allows choice, flexibility, consumer directed Exposure to fulfilling experiences Individually tailored approach Participatory approach Time to integrate experiences.

SUMMARY

In summary, this chapter has argued that for people to enhance their perspective they must have experienced an environmental condition, intervention strategy or relationship with self or other that has generated critical juncture points of a sense of healing or attachment. People may be prevented from becoming disillusioned through focusing or excuse making, but until they are more actively seeking out perspective enhancing critical junctures, they face barriers to experiencing perspective enhancement. On a continuum from disillusionment to perspective enhancement, Table 6.3 highlighted the characteristics of the different social structural processes necessary to facilitate either dimension.

This theory would suggest that people could go back and forth on this continuum at various points in their life, and that cognitive chapters would be written and re-written accordingly in the context of their experiences. The following chapter will draw together key findings in the data and integrate this with existing literature.

CHAPTER 7: INTERPRETING THE LITERATURE AND THE DATA TO DEVELOP BETTER MENTAL HEALTH PRACTICE

7. INTRODUCTION

Based on the data of the preceding two chapters, this chapter will explore how The Theory of Perspective Enhancement (TToPE) can integrate and build upon the existing literature to cultivate the beginnings of a practice framework designed to enhance mental health and well-being for human beings generally. This framework is developed in response to the original research question: *How can a contribution to mental health service delivery be shifted beyond the medical paradigm?*

This chapter opens by linking the importance of the contingent factor of perspective enhancing relationships in TToPE to other studies. Throughout this chapter, I identify crucial aspects from across the literature to help to interpret the data on perspective enhancing relationships. These include establishing the values base, the practice behaviours required, the characteristics of perspective enhancing relationships, and the four important practice principles underpinning them.

Second, this chapter describes how the conditions of the environment and intervention strategies can be linked with existing literature to build a practice framework that facilitates perspective enhancement. Third, this chapter explores how the critical junctures of attachment and healing relate to existing literature and how the literature supports the coping mechanisms (focussing and excuse making) identified through TToPE.

7.1 Perspective Enhancement – Contingent on Relationships

At the heart of The Theory of Perspective Enhancement (TToPE) is the idea that an enhanced perspective is contingent upon relationships. The theory points out individuals can tolerate unsatisfactory environments and poor treatment, but that whether or not they become disillusioned or perspective enhanced is contingent on relationship factors. Data from participants suggested that while environments facilitated comfort, it was the nature of relationships that made a substantial difference.

A useful example of the importance of relationships over and above context is given in the study by Wakefield and McMullen (2005) cited earlier. The study, which involved interviews with over 50 people, highlighted how people in a marginalised and disadvantaged neighbourhood still maintained an enhanced perspective regarding their lifestyle — as long as the relationships they had with self and others in their community were positive. Residents were more likely to become disillusioned if they viewed their relationships as negative, for example, if they had poor relations with neighbours. What this study highlights is the importance of the meaning of relationships for people, in terms of whether or not they have an enhanced perspective.

TToPE also supports the view of Miller and Crabtree (2005) that relationships are at the heart of any healing encounter. Miller and Crabtree found that relationships become transformational when practitioners become more self-aware, let go of routines and assumptions about people, and attended to process. Practitioners must be open to new possibilities and courses of action, collaborate with others, and facilitate trust and healing spaces (Miller & Crabtree, 2005). TToPE embraces this view and suggests that relationships play a critical role in how individuals perceive themselves, the treatment they receive, and how they interpret the environment around them. Again, it is not just the nature of the

relationship, but the meaning underpinning it; as the framework of therapeutic landscapes suggests, that is of key significance in perspective enhancement.

TToPE is able to move forward the research of Howego et al. (2003) who suggest that there are beneficial outcomes for patients engaged in a therapeutic alliance with case managers. Howego et al. (2003) suggest that further research is required on the impact of the alliance, such as the skills and/or competencies of practitioners, personality factors and interventions that promote this alliance. A key purpose of the research underpinning TToPE is that it attempts to address this issue by capturing some of the skills, competencies and personality factors that contribute to this alliance for consumers. TToPE can then be articulated in a succinct framework that is appropriate not only for mental health practitioners, but for anyone concerned with enhancing mental health and well-being.

The data revealed that there are two core underpinning values necessary for engaging in perspective enhancing relationships with people. The first of these, which is also fundamental to the AASW social work code of ethics, is intrinsic worth, and the second is time worthiness. Thus, TToPE must provide a framework that assists to restore intrinsic worth and promotes time worthiness so that these values are transformed into 'living' practice rather than mere human services rhetoric. These two values will be discussed in turn.

7.1.1 The restoration of intrinsic worth

The belief that every individual is a worthy and deserving human being is essential for perspective enhancing relationships. The value of the intrinsic worth of the individual is captured strongly in strengths based practice (McCashen, 2005; Rapp, 1998 & Saleebey, 2006). The significance of intrinsic worth within TToPE becomes evident through realising

that the consequences of perspective enhancing relationships are that people view themselves in an affirming and deserving manner. This belief in self is internalised within self, through others or through spiritual beliefs. Unfortunately, the data showed how all too often, dehumanising treatment processes and stigmatising practices damaged intrinsic worth. At other times, individuals denied their own intrinsic worth through internalised discrediting.

TToPE is supportive of the view of Deegan (1990) who warns against professionals adopting professional roles to the extent that they lose sight of common humanity. She says:

> Our responsibility is to never lose sight of the fundamental sanctity, dignity and sovereignty of another human being no matter what their diagnosis may be, no matter how 'regressed' or 'poor' their prognosis may be, and no matter what their disability may be. (Deegan, 1990, p. 302)

The importance of the intrinsic worth of the individual is also identified by Raholm, Lindholm and Ericksson (2002) in a literature review of spirituality. A similar point is made with the theme described as 'confirmation of dignity'.

> The most central element in 'dignity' is the patient's intrinsic value in their own capacity as human beings. In their inner world people have thoughts, experiences, values, norms, and this world is of central importance to their sense of and preservation of dignity. (Raholm, Lindholm & Ericksson, 2002, p. 7)

The issue of intrinsic worth is also highlighted in the Swedish study of Johansson and Lundman (2002), who found that involuntary psychiatric patients felt that their human value and physical integrity had been violated, in that they were not heard and felt like an 'object of care' (p. 643). Similarly, Ferguson, Petrie and Stalker (2007) in a study of service users in Glasgow state that, perhaps above all, 'feeling valued and wanted as a person rather than simply a service user' (p. 30) was most important to consumers.

TToPE recognises evidence of this confirmation of dignity or intrinsic worth through having a presence while people journey through suffering. One young man indicated that

while in rehabilitation he vividly remembered one person whose presence was appreciated by just ‘being there’ when he needed someone. He indicated that if he had not experienced the presence of that person, and the sense of worth that was transmitted to him through that person, he believed he would be dead.

Raholm et al. (2002) put the view forward that abandoning people gives rise to hopelessness and despair. In the same way, TToPE identifies how a sense of disconnection leads people to experience critical junctures of hurt and alienation and, ultimately, disillusionment.

The recognition of a common humanity that is over and above organisational roles and responsibilities is vital for the recognition of intrinsic worth. As Shanley (2001) states, this will depend on individuals at all levels being willing to identify with the common humanity of other people, regardless of whether they fulfil a professional role and/or experience a mental illness.

Similarly, Jacobson and Greenley (2001) state:

> A true collaborative relationship is one in which both consumer and provider come to see each other as human beings. For providers, this means learning to see beyond the diagnostic – or racial, ethnic and socioeconomic categories they have been trained to use and rethinking ‘boundary issues’ so they can allow themselves to relate to consumers on a human level. (Jacobson & Greenley, 2001, p. 286)

Miller and Crabtree (2005) also argue that people have their own narrative identity that is much greater than the ‘face of a patient’ and that the ‘professional cloak’ (p. 43) can routinise work, blocking empathy. They argue that the professional role only sees a glimpse of a person who is a part of broader humanity; a unique individual with a life story, or a

person struggling with inner pain. TToPE challenges professionals to recognise the worth of each individual as a unique part of humanity and join and support them at this level.

Fundamental to TToPE is the recognition that the very process of being diagnosed with a mental illness can confront one's own sense of intrinsic worth, and that all staff working in the mental health system must take a proactive and dedicated approach to recognising the 'person' whose well-being and sense of identity requires preservation and restoration. This view is supported by Marsh (2000), who states that the responses of others, after someone receives a diagnosis of mental illness, can result in loss or confusion, with a pervasive effect on their personal identity. Cutcliffe and Barker (2002) advocate human-to-human engaging connections that convey tolerance, hearing and understanding, particularly with suicidal clients. It is argued that when staff recognise their own humanity and vulnerability, it can be an asset; particularly in terms of recognising the conflicts that can be involved in maintaining professional boundaries, yet responding meaningfully to the crisis experienced by another. This next quote captures the importance of taking stock of every interaction in terms of placing the core of humanity first. Cutcliffe and Barker (2002) state:

> How people are treated ultimately has an influence on how they feel about themselves. A wide range of messages are communicated by the nurse's attitude, demeanour and approach. If the suicidal person senses that a nurse is disinterested, uncaring, condemning or judgmental, then the effect on the person's feeling of self-worth is likely to be negative. Additionally, there is the likelihood that a subliminal message of hopelessness will also be communicated. (Cutcliffe and Barker, 2002, p. 618)

Through the data collected, TToPE recognises the harm that can be created by the discrediting messages people may have received, and maintains that the beginning point of a practice framework for mental health must be the role that relationships take in affirming individual intrinsic worth. Subsequent to the fundamental value restoration of intrinsic worth comes time worthiness.

7.1.2 The value of being time worthy

The data revealed that individuals with mental health issues valued workers who spent time with them. Horwood (1998) quotes a general practitioner who talks about the importance of time worthiness in the therapeutic relationship:

> Crucial to the setting is making enough time. My experience tells me that people vary enormously in how easily they form relationships. For some, it is a major achievement while for others, it builds easily. I have found spending whatever time is needed to ensure a good working relationship is an invaluable investment. (Horwood, 1998, p. 162)

Time worthiness in the medical profession is also discussed as important by Frankel, Sung and Hsu (2005) who through 30 video tapes of patient-doctor interactions, with 15 different doctors, found doctors received higher levels of satisfaction from patients when they took longer with their patients, found more to comment on, were more vigorous and made fewer assumptions. Frankel et al. (2005) state:

> While this may be bad news in terms of productivity and throughput, this and other studies have shown that a time difference of 2-3 minutes per visit differentiates physicians who have a history of medical malpractice from those that have never been sued, those who engage in collaborative decision making from those who don't, and physicians who elicit the full range of patient concerns at the beginning of the visit. (Frankel, et al., 2005, p. 38)

In a study by Riebschleger (2005), in which 73 community mental health professionals were interviewed at two agencies in Michigan about their contact with families, lack of time was the most highly reported barrier. Riebschleger (2005) states:

> To be fair, it is difficult to know what is low or high family contact hours per week because there are no practice standards or benchmarks for the recommended amount of family contact time. Practice standards for family contact time need to be developed and measured within mental health agency management information systems. If this were done, the actual time spent in contact with families could be measured and analysed for consumer and family member outcomes. (Riebschleger, 2005, p. 14)

Similarly, in an interview from the comparative data, the manager of an inner city hotel chain pointed out the value to customers of a small boutique style hotel that could afford to spend time with people, as opposed to larger hotels that could not.

Kaplan & Kaplan (1989) focused on the restoration of individuals through natural environments, and suggests that time is an important environmental factor. TToPE suggests however, that showing a sense of time worthiness is more important than necessarily allowing a significant amount of time. For example, a carer may not be able to spend much time in a natural environment, but feeling that they are time worthy enough to spare 20 minutes a day to meditate, may contribute to an enhanced perspective. Similarly, a person with a mental health issue may not need a lot of time for support, but it will be restorative in itself simply to know that they are worthy of it when it is needed.

While it can be argued that time worthiness contributes to perspective enhancement, at the other end of the continuum there is disillusionment, as affirmed by Cleary and Edwards (1999) who discuss how psychiatric patients are often ignored, or felt they would have liked more time with staff. In this study, the use of time was controlled by staff, and hence patients were made to feel they were unworthy of the time of the professionals.

TToPE recognises that individual intrinsic worth and time worthiness are core values essential to practice. These values need to be reflected in the behaviours of staff, to enable people to gain an enhanced perspective.

7.2 Practice Behaviours

The second building block in creating a practice framework for perspective enhancement incorporates the practice behaviours that are important for staff to adopt; one that is essential is providing a sense of welcome and safety.

7.2.1 Feeling at ease – through a sense of welcome and safety

The data, across both the substantive and comparative fields, clearly showed that individuals saw initial meetings with service providers as important. For mental health consumers, feeling worthy and validated through the supportive actions and welcoming approach of staff in their environment was very important. Being acknowledged, addressed by name and having immediate comfort issues attended to, were all desirable for mental health consumers and provided a sense of safety. First impressions were vital across all data samples.

One young man who attended a clubhouse for mental health consumers particularly enjoyed the way that the staff would greet him when he arrived, and how the environment offered comfort and a sense of belonging and camaraderie. For another older man, gaining a friendly welcome at respite made him feel accepted.

The research data is supported by Hepple, Kipps and Thompson (1990) in a medical context, who revealed that friendly medical staff and smooth admissions procedures were extremely important to people, so emphasising the holistic factors, over and above medical matters, in enabling people to feel at home. The data revealed that in natural therapy settings, recipients would come to consultations expecting a set of interactions that gave priority to a

sense of ease and comfort. This was confirmed by natural therapists, who tried to provide such interactions at the first point of contact.

Natural therapy recipients appreciated therapists with whom they felt a warm and immediate rapport and who were inviting in their demeanour, and who paid attention to the state people were in when they arrived, for example providing tissues, a drink, or a comfortable place to sit. This promoted a sense of safety. This data supports the description of Kearns, Ross Barnett and Newman (2003), of a contrived therapeutic landscape, in the way people were made to feel special within their environment.

This sense of feeling special was also prominent in the data gathered from tourists, when they perceived that nothing was too much trouble. This data supports the findings of Hartline, Ross Wooldridge and Jones (2003) who argue that guest perceptions of customer-employee contact at the front desk is a key indicator of quality service. Similarly, Orsingher and Marzocchi (2003) stated that the indicator most reported by hotel guests, on what constituted a satisfactory service recipient experience, was when people were made to feel at ease. While feeling safe was an environmental comfort factor, it also relied on a sense of personal well-being and on staff kindness.

The hospitality industry is recognized for encouraging a sense of welcome and connection. The concept of ‘hospitality instinct’ discussed by Voase (2003) highlights the importance of the manner in which a service is delivered, and the understanding that the hospitality recipient has high expectations, so there is a desire for staff to be motivated, inspired and creative in their approach, with the capacity to offer a sense of welcome and

comfort. In this framework, the employees are inseparable from the service; Voase gives an example that a waiter serving coffee is just as much a part of the service as the coffee itself.

Unfortunately for mental health consumers and carers, the data showed that they often felt far from 'special' or 'safe' and, rather than being welcomed, they would feel they were being 'dealt with' in a disconcerting way. Translating this into the mental health environment, TToPE appreciates how a triage nurse in emergency may be just as much a part of the experience of treatment as the intervention strategy itself. In a practice framework for mental health, TToPE recognises the importance of the 'hospitality instinct' and how the dimensions of this concept are of value within the mental health field. Table 7.1 extends Table 2.1, presented in Chapter 2, to incorporate the health context.

Table 7.1
Summary of the Concept of the 'Hospitality Instinct' Described with an Additional Health Component (Adapted from Voase, 2003)

Concept of Hospitality Instinct	Hospitality Applied	The Health Context
The manner in which a service is delivered	Deportment, dress, language, code of conduct	Professional well presented demeanour, polite and respectful to consumers.
Consumer has high expectations	A holiday will be a positive experience	Being a part of the health care setting will be a positive experience.
Staff self-motivated in line with vision for service	Employees through part of their everyday engagement are a part of something special	Staff know that through every interaction of which they are a part they are creating an image conducive to quality health care.
Style and creativity	A range of activities to meet with consumer aspirations	Staff will take the initiative to think of innovative ways to facilitate the health and well-being of consumers.
Welcome and comfort	Warmth, acceptance on entry	Warmth, acknowledgement, acceptance on admission

TToPE identifies providing a sense of safety and welcome as an important set of practice behaviours that can be applied to the mental health field in the same way that the 'hospitality instinct' is applied in tourism. It is a set of practice behaviours that enable people to be received, acknowledged, feel at ease, welcomed and appropriately responded to in accordance with their immediate needs. TToPE argues that it is only after these behaviours have been established that a trusting relationship can commence.

7.3 Characteristics of Relationships

The third building block in TToPE recognises authentic tailored engagement as the key characteristic human service workers need for cultivating an enhanced perspective with consumers.

7.3.1 Authentic tailored engagement

The research data across all industries clearly values the core concepts of client-centred practice (Rogers, 1951), in particular authenticity and empathy.

TToPE validates the data of Glass and Arnkoff (2000) who discuss the perceptions of mental health consumers in terms of the positive attributes of therapists. Positive attributes were reported for therapists who reached out with warmth, kindness and patience, and demonstrated empathy, care, compassion and genuineness. Acceptance and openness to the validity of the client's feelings and frames of reference enabled them to develop meaning from their own experiences and to have a sense of identity beyond the traditional deficits-based view of the patient's role.

Wilkin (2006) describes how a deep empathetic connection between therapist and client using a shared language can help a person in distress discover the true self.

> From a psychotherapeutic perspective, the music of a shared language actually carries the whole process of a person's healing and becoming. The rhythm, the pitch and the timing of the therapist's responses provide golden moments full of potential self-knowing. (Wilkin, 2006, p. 17)

Empathetic qualities were also reported to be of primary importance by Zuroff and Blatt (2006), who obtained data from 191 patients experiencing major clinical depression. They found that the quality (according to the qualities described by Rodgers – empathy, positive regard and genuineness) of the early therapeutic relationship played a substantial and significant role in determining therapeutic outcome. It is argued that the ingredients of the relationship contribute more directly to a positive outcome than any specific techniques, and that the patient's early subjective perception of the therapist emerges as a key contributor to the therapeutic process.

This supports the earlier studies of Barber, Connolly, Crits-Christoph, Gladis & Siqueland (2000), Klein, Schartx, Santiago, Vivian, Vosciano & Castonaguay (2003) and Hovarth (2000), who showed that a therapeutic alliance in the critical early stages of therapy had an effect on patient outcomes, in that those patients who improved tended to have a stronger bond with their therapist. Bernier (1998) emphasises the importance of establishing trust and genuine concern, particularly in emergency situations. Myers (2000) revealed, through a study of 100 sessions at a university counselling centre, that all participants who felt heard said that they had been understood empathetically and had received constructive feedback.

This is also supported by the work of Conradson (2003), in a non-clinical setting, who argues that the client-centred core conditions of congruence, unconditional positive regard and empathetic warmth towards users were vital for volunteers to cultivate at a community drop-in centre in the UK.

The aspects of relationships contributing to disillusionment were described by mental health consumers, who said that when they were not treated with the principles of client-centred practice and they felt like lesser beings. The study by Jackson and Stevenson (2000), of interactions in a psychiatric ward, highlights the power imbalance between patients and staff that is the antithesis of client-centred practice. They suggest that this power imbalance is maintained through professional control, jargon, structure and distance. For example, while patients were expected to interrupt what they were doing to attend to a nurse's request, nurses could decide how and when to engage with patients.

In response to this study, the data gathered to formulate TToPE challenged the traditional professional boundaries of mental health practitioners and highlights the need for ordinary, honest and authentic communication. Participants valued staff who treated them like equals and who did not use their professional status as a mechanism to create social distance. Participants wanted to relate to someone who could speak on their level who appeared responsive, real; and genuine. TToPE argues that interactions that are the antithesis of client-centred practice lead to the critical junctures of hurt and alienation generating disillusionment. In contrast, the attributes of client-centred practice that lead towards perspective enhancement emerge through the critical junctures of attachment and a sense of healing. Once a therapeutic relationship is established, holistic engagement provides the principles that underpin it.

7.4 The Principles of Holistic Engagement

The fourth building block needed for perspective enhancing relationships embodies the principles of holistic engagement, which consist of four essentials. The first involves client-directedness and individual empowerment, recognising the importance of client choice and participation in their health and well-being. Second, TToPE engages the person as a whole. Mind, body, emotions and spirituality interact to make up a person, who is much more than a medical diagnosis or prognosis. Third, TToPE expresses the importance of the lifeworld of the person: the activities, relationships and environments that are of personal significance. Finally, holistic engagement is about the collaboration and interconnectedness of people in organisations and communities. These four principles are discussed below in the light of recent and relevant research findings.

7.4.1 Client directedness and individual empowerment

Holistic engagement places the client at the centre of the interaction in their world. Gesler and Kearns (2002) assert that an important aspect of holistic health care is the ownership of the ways that health is defined, and thus who is ultimately in control of the landscape. The principles articulated by Gesler and Kearns, of consumer choice, negotiation, and consumer directedness support the view that the consumer needs to have a level of control over the landscape of health care to enable perspective enhancement. Bohart (2000) and Horvath (2000) both recognise the importance of client involvement in the therapeutic relationship, while Marsh (2000) emphasises that consumers must become active agents in their own recovery and take an active role in managing their illness. TToPE recognises that, for many consumers, active involvement in their own care is a relatively new possibility and a potentially frightening concept. TToPE does not advocate that individuals be thrust into

managing their own health care, but that through constructive relationships, they will begin to develop the confidence and trust to take more of a leadership role.

7.4.2 The person as a whole

Second, holistic engagement recognises the person as a whole in the overall context of their life. Milligan (2006) states that the health and well-being needs of carers cannot be seen in isolation from care recipients, and emphasises the importance, in health care settings, of attending to the physical, social, emotional and spiritual needs of care recipients. Watson and McDaniel (2000) argue against categorising symptoms, rather suggesting that every psychological assessment should incorporate an understanding of physical well-being and how this has impacted on interpersonal processes in the family; thus, they recognise interaction between biopsychological processes. While TToPE supports the value of such assessment, it also realises the importance of undertaking it as part of a natural dialogue that establishes where people are at, rather than a structured and rigid clinical assessment tool which would serve to routinise and unauthenticate the relationship.

7.4.3 Connecting to the life world

Third, holistic engagement connects people to their life world. It recognises the various parts of the individual that make it up and connects the person into the activities, events or relationships that are significant for them.

The data found evidence of holistic engagement by doctors who extended themselves to take an interest in the other health issues of their patients, advocated for clients with health funds, or contacted family members out of hours. Holistic engagement was demonstrated by

support workers who joined with people in activities that were meaningful for them, or who prepared food that consumers like, or provided them with books they liked to read. Similarly, a mental health consumer reported how her social worker had made her feel cared for through assisting her move furniture in her flat.

TToPE recognises the value of therapists entering the life world of the individual. Frese (2000) encourages therapists to leave their offices and experience the world that clients inhabit. Glass and Arnkoff (2000, p.1468) also emphasise the importance of the therapist's willingness to enter into the client's community and experience 'real-life environments.' This includes being with the client in times of crises and developing relationships with their supportive networks. McCrea et al. (2003) discuss how performing tasks for patients, listening to their stories, sitting with suffering, noticing discomfort, and engaging with patients within their comfort zone were helpful. Repper (2000) points out the importance of offering practical help to develop and sustain relationships, while Myers (2000) acknowledges the importance of the therapist allowing the client to explore his/her philosophy or life experience.

In the Australian context, Renouf and Bland (2005) discuss two key principles that emerged through the Deakin Human Services Project on mental health workforce education and training reform. These principles included valuing the lived experience of consumers and carers, and recognising and valuing the healing potential in the relationships between carers and service providers. These principles demonstrate holistic engagement through valuing the life world of the other as well as the connections and learning that develops from relationships with others.

It is interesting to note that in a study of professional expertise of expert mental health social workers by Merighi et al. (2005), there are many examples of holistic engagement with consumers. While this is referred to in different ways such as 'recognising multiple viewpoints', 'knowing […] about clients and the environment in which they live', 'respecting cultural beliefs and practices', (pp.-716 -717) as well as engaging in alternative settings with consumers, using their language and thinking practically, flexibly, contextuality and creatively . The study revealed many examples of holistic engagement given by experienced social work practitioners. From this study, it would seem that social workers with sound skills already have a solid practice framework that incorporates holistic engagement.

7.4.4 Collaboration

The fourth important principle of holistic engagement is collaboration. A good example of this emerged through the data: one natural therapist took it upon herself to link people with domestic violence services, emergency services and rehabilitation services when it was felt this would be helpful. The same clinic also worked collaboratively with the hospital when the individuals' preferences were for natural remedies.

Watson and McDaniel (2000) advocate a collaborative stance with family, community and other professionals, rather than with just one expert opinion. The Planetree model of health care successfully puts this principle into practice through family and client. involvement in care (Jenna, 1996). Patients and their friends and families are partners in care, with a choice of treatments and routines made available. Individuals make entries in their own medical charts and are included as part of a team in managing their own care. Milligan (2006) also discusses the importance of two-way communication and collaborative decision-making in care settings:

> Feeling included in the care of the care-recipient extends to: (i) how decisions are made with regard to their care and potential changes in care; and (ii) the extent to which informal carers have access to medical records relating to the care-recipient. (Milligan, 2006, p. 328)

Summarising holistic engagement, Lafferty (2004) discusses many of the aspects of holistic engagement through the context of optimal healing environments. He argues that the conceptual model of optimal healing environments reveals a need for empowered patients, satisfying emotional interactions between staff and clients, excellent communication, patient choice and an emphasis on lifestyle issues. To achieve this approach, the underpinning values of health service organisations need to reflect attitudes that discourage toxic and invasive medical procedures and move towards more patient-centred leadership, community involvement, recognition of the mind-body connection (the relationship between physical and mental health), and a more integrated approach to the delivery of medical services.

The notion of holistic engagement affirms the challenges of current nursing practice described by Griffiths (1999), Henderson (2002), Hem and Heggen (2003) and Raingruber (2003). These authors argue that, although nurses value the fact that developing relationships with patients requires a holistic view of the person and a genuine human connection, scientific and managerial influences within health care demand measured outcomes and a degree of professional distance from the patient. Raingruber (2003) argues that such reductionist views promote an individualistic view of the world that ignores the fact that people live in webs of relationships, in terms of families, communities and cultures that shape behaviours. Henderson (2002) also identifies a theory-practice gap in nursing in relation to holistic care, arguing that the setting of a practice is orientated to task completion and ‘doing to’ patients rather than engaging with them. While these authors discuss the challenges of a holistic approach from a nursing framework, it is anticipated that many social workers and

other human service practitioners could experience similar challenges in the health care context. Thus, it can be argued that without role models and a framework for holistic practice, learned ideals are at increased risk of becoming sacrificed for day-to-day routine demands.

7.4.5 Integrating the relationship component of perspective enhancement

Table 7.2 illustrates the building blocks of perspective-enhancing relationships in terms of underpinning values, practice behaviours, relationship characteristics and principles for practice. A brief description of these building blocks is also offered, with reference to important literature and studies that affirm them.

Table 7.2
Building Blocks For Perspective Enhancing Relationships

Elements of Practice Framework	Categories within Perspective Enhancing Relationships	Integration with Existing Literature	Authors
Underpinning Values Of Perspective Enhancing Relationships	1) The restoration of intrinsic worth	Common humanity	Deegan (1990); Jacobson & Greenley (2001); Shanley (2001); Miller & Crabtree (2005); Kavanagh (2002); Marsh (2000); Cutcliffe & Barker (2002); McCashen (2005); Rapp (1998) & Saleebey (2006)
		Confirmation of dignity	Raholm, Lindholm & Ericksson (2002)
	2) Time worthiness	The importance of spending time with people	Frankel, Sung & Hsu (2005); Horwood (1998); Kaplan (1987); Kaplan & Kaplan (1989)
		Being available	Cleary & Edwards (1999)

Elements of Practice Framework	Categories within Perspective Enhancing Relationships	Integration with Existing Literature	Authors
Practice Behaviours	Feeling at ease - providing a sense of safety and welcome	Friendly staff, smooth admission procedures Feeling special	Hepple. Kipps & Thompson (1990); Kearns, Ross Barnett & Newman (2003)
		Importance of front line counter staff Sense of ease	Hartline, Ross Wooldridge & Jones (2003); Orsingher & Marzocchi (2003)
		'Hospitality instinct'	Voase (2003)
Qualitative Therapeutic Relationship Characteristics	Authentic Tailored Engagement	Genuine, authentic, empathy, compassion, positive regard, mutual respect, positive, genuine, supportive	Rogers (1951); Glass & Arnkoff (2000); Zuroff & Blatt (2006); Wilkin (2006)
		Heard and genuinely engaged Trust	Barber et al. (2000); Klein et al. (2003), Hovarth (2000); Bernier (1998), Myers (2000)
		Emphasis on relationships over and above techniques	Conradson (2003); Jackson & Stevenson (2000)
Underpinning Practice Principles	Holistic Engagement	1) Client empowerment	Gesler & Kearns (2002); Bohart (2000); Hovarth (2000); Marsh (2000)
		2) Person as whole	Watson & Mc Daniel (2000); Milligan (2006)

Elements of Practice Framework	Categories within Perspective Enhancing Relationships	Integration with Existing Literature	Authors
		3) Life world of client	Frese (2000); Glass & Arnkoff (2000); Mc Crea et al. (2003); Repper (2000); Myers (2000); Renouf & Bland (2005); Merighi et al.(2005)
		4) Collaboration	Watson & Mc Daniel (2000); Jenna (2006); Lafferty (2004); Milligan (2006); Henderson (2002), Hem & Heggen (2003); Raingruber (2003); Griffiths (2003)

TToPE argues that that the central linking factor in perspective enhancing relationships is the importance of the authenticity of ordinary human connections. The following diagrams on the next page capture how this feature of TToPE contrasts with previous models that retain a level of superficial distance and contribute to disillusionment. The first diagram shows the features of relationships that contribute to perspective enhancement, while the other shows the elements that result in a contrasting effect.

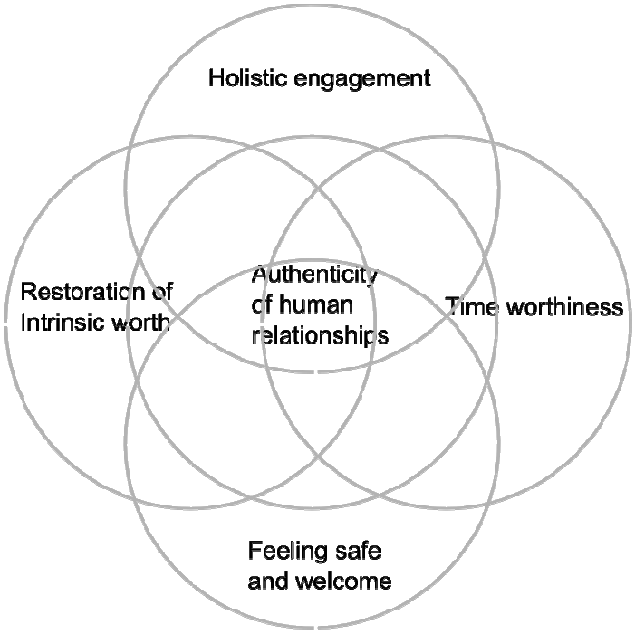


Figure 7.1 Towards Perspective Enhancing Relationships

Figure 7.2 Towards Relationships Generating Disillusionment

7.5 Perspective Enhancing Environments

TToPE identifies the core categories of perspective enhancing environments that are fundamental for day-to-day practice. These categories are integrated with relevant literature with the intent to develop a framework for mental health practice.

7.5.1 Feeling at ease – a sense of safety and welcome

For the mental health consumers who stayed in respite, many identified with the immediate comforts of walking into the environment. It was evident that consumers and carers appreciated tastefully-designed hospital facilities where furniture, décor and the use of colour made a significant difference. Milligan (2006) also describes the importance of informal carers experiencing care settings where staff made them feel comfortable and welcome in residential care. The findings across the data supported the views of other researchers (Hutton & Richardson, 1995; Lawson, 2002; Remen, 1991; Schweitzer et al., 2004) who suggest clean, well maintained, comfortable, homely well-coordinated décor can be seen to contribute to the sense of welcome. While for some individuals some of the aspects of welcome identified by Gesler et al. (2004), such as modern conveniences and an environment of ambience and comfort were important; for others, it was an environment that conjured up safe, nostalgic memories.

In the hospitality sector, one hotel purposely used muted tones and described the feeling they intended create as ‘cocoon-like’ and ‘embracing’ (Hosp prov 6, March 2005, p.2) This was done purposely to generate a sense of ease and safety and is not unlike the concept of discreet seclusion and sanctuary identified in the initial literature review. One country motel provider and a country bed-and-breakfast deliberately developed the décor so as to establish fond memories for example, the kind of décor that may remind people of their

grandparents' homes. This practice of evoking fond memories through the landscape supports the view of Conradson (2005), that encounters with the landscape have long lasting effects, as well as the work of Hartig and Lawrence (2003), which emphasises how places generate emotional meanings for people.

Within the mental health context, TToPE recognised that what was welcoming and inviting for one individual may not be for another. Generally, environments such as Lawson (2002) suggest, that allowed space and privacy were appreciated. While tourists appreciated luxury, functionality was more important to mental health consumers. Essentially, it was the usability of the space and ordinary home-like comforts that were most appreciated.

7.5.2 The importance of a sense of escape

The data strongly revealed that a sense of escape was central to perspective enhancement, as entrapment was to disillusionment. The sense of entrapment is also identified by Goffman (1991) as a characteristic of total institutions, through the sense of having no control and a loss of personal space. The data supports Goffman's concept of 'removal activity' (p. 67). He describes how patients physically or mentally escape in order to adjust to their institutional environment. This includes participating in sports, theatre, religious activities, and 'portable ways of getting away' (p. 272), such as reading paperbacks and doing jigsaw puzzles. These instances compare to the sense of escape that both carers and consumers entered into to remove themselves from the impact of illness. Helpful escape activities included watching movies, listening to music, reading a book, gardening, meditation or physically 'getting away'.

While TToPE affirms the work of Kaplan & Kaplan (1989) on attention restoration theory in terms of the importance of being away in nature, it also argues that a sense of escape may not need to be in a natural environment, so long as the person was able to gain a sense of attachment or healing from it. While TToPE does not deny that nature contributes to individual restoration through the escape it provides, it argues that nature is only one form of escape that can lead to perspective enhancement and that perspective enhancement is much more reliant on 'removal activities.'

The data about factors that lead to a sense of entrapment reveals similarities to the work undertaken by Nelson et al. (2001) who described factors facilitating empowerment or disempowerment. These were levels of control, community integration, and access to valuable resources. The data strongly showed how control (or lack of it), access to community (or lack of access to it) and resources (or lack of them) facilitated a sense of escape or a sense of feeling trapped for consumers and carers. Similarly Milligan (2005), in a study of carers for older people, identified not only the issues of feeling trapped at home with no control over the situation, but that there also seemed to be an emotional internal entrapment that can develop, with carers emotionally overcome by guilt and grief.

Entrapment, as seen through the data gathered from mental health consumers and carers also reflected the stresses of everyday routine demands, as well as the inability to escape the symptoms and feelings generated by the impact of illness. For some, a key component to finding a sense of escape was the strategy of voluntarily surrendering, so as to remove oneself from day-to-day responsibilities. This is similar to the way that Conradson (2005) identifies the importance of enabling 'individuals distance from home demands, both in terms of

domestic tasks and the social expectations that structured the homespace' (p. 346), in a study of the experiences of guests in respite in Southern England.

The significance of entrapment can also be related to more recent studies of the psychiatric ward. Glasby and Lester (2005), highlight, in a narrative review of inpatient services, how individuals can be traumatised by an admission process that denies them freedom and privacy. Andes and Shattell (2006) describe the limitations of the psychiatric ward in terms of space and mobility for psychiatric patients, and how the space that they occupy is continually invaded by staff and other patients. These authors discuss how the design of the nursing station entraps patients through locked doors and windows and requires them to wait while having no control over, or access to personal space. In this study, the data supported these features and they were strongly commented on by both mental health consumers and carers.

The notion of feeling trapped and alienated is also identified in a recent Australian study by McLoughlin and Warin (2008) highlighting the detrimental effect on mental health of Australian immigration detention centres. The authors state: 'The physical structures are similarly alienating in their prison like architecture, where the iron gates speak of danger and confinement' (p. 262). TToPE would argue that through the duration of entrapment, asylum seekers continually experience the critical junctures of hurt and alienation leading to disillusionment.

TToPE can also be used to explain, in the residential context of health, the way environmental conditions impact on patients' sense of entrapment. The review of literature undertaken by Evans et al. (2003) and the study undertaken by Hartig and Lawrence (2003),

suggest that factors that contributed to poor health were evidenced by the lack of control people had over their living environment and their tenure.

Conversely, the study by Blackman and Harvey (2001), on housing renewal, supports the notion of how environmental improvements contribute to perspective enhancement. The landscaping and refurbishment undertaken may have allowed people a greater sense of escape in comparison with their previously confined environments.

A number of studies reveal that a sense of escape can be achieved through design, via aspects of image, layout, design, lighting, entrances, cleanliness, pleasant sensory stimuli, personalised spaces, and community connection (Bitner, 1992; Gutowski et al., 1992; Johansson & Lundman, 1992; Lawson, 2002, Hutton & Richardson, 1995; Timko, 1996). Verderber and Reuman (1987) discuss how views and windows can lead to a sense of escape, further elaborated upon by Brown and Ross Barnett (2004) and Ellen (2003) on creating a sense of escape with sanctuary-type environments and luxurious surroundings.

TToPE would suggest, however, that a sense of escape does not depend only upon luxurious surroundings, but is about allowing people to be where they need to be at the time that they need it. The fundamental factors contributing to escape are the nature of the environment, or an activity that can relieve the level of stress experienced by the individual at the time.

The tourism industry thrives on giving people a sense of escape. As Trauer and Ryan (2005) suggest, however, it is much more than just purchasing a place, it is also having the dynamics and encounters that create the specialness and meaning for the person with regard

to the sense of escape. Similarly within TToPE, the sense of escape was much more than just 'being away' physically or engaging in an activity, but, in accordance with the concept of therapeutic landscapes, it also depended on the meaning that activity or environment provided for the person.

TToPE also supports the view that perspective is enhanced through the anticipation of a sense of escape, in that it gives meaning and hope to those anticipating it. A study by Gilbert and Abdullah (2002) supports this view through a study of the well-being of people who were anticipating a holiday. Those who were waiting to go on a holiday experienced more pleasant feelings and were happier with their life on the whole than those who were not.

Thus, based on TToPE, it is anticipated that those people who cannot even contemplate a sense of escape in the future are more likely to experience the critical junctures of hurt and alienation leading to disillusionment. Unless a sense of escape can be provided, a sense of enhanced perspective is unlikely to occur.

7.5.3 The relevance of connection and captivation

A sense of connection and captivation with the environment was found across the data, to be vital for perspective enhancement. The majority of people interviewed commented on the importance of nature and its beneficial effects through connection and captivation.

Connection and captivation provided individuals with a level of interest or fascination that was supportive of Kaplan and Kaplan's (1989) attention restoration theory that people need to have a level of fascination with their environment through the stimulation it provides.

Thus TToPE further extends the work of Fieldhouse (2003), Kaplan (1987), Kaplan and Kaplan (1989), Kaplan (1995), Ogunseitan (2005), Thoms (2003), Tyson (2002), Ulrich (1983) and (1984). These authors emphasise the importance of the natural environment for individuals in order to feel restored by exposure to foliage, gardens, water and other elements of nature. TToPE argues that it is the connection and captivation with these natural elements, and the meanings that they convey, which is important. Similarly, Schwitzer, Giplin and Frampton (2004) suggest that images of nature that depict life cycles and renewal are beneficial in health care environments, partly due to the meanings they convey.

TToPE develops the view of Beal, Veldhorst, McGrath, Gurunge, Grewal, DiNunzio et al. (2005) who argue that place facilitates connectedness and that one can have a connection with the environment by appreciating it. Within the built environment, TToPE represents connection and captivation through scents, noise (including the presence or absence of music), aesthetics, air quality, colour and lighting. Perspective enhancement was occurring in these settings while a sense of healing and attachment was developed. Fundamentally, individuals were able to interpret their environment as perspective enhancing through their level of connection to and captivation by it.

The data on perspective enhancement supports and substantiates the importance of the literature on therapeutic landscapes (Conradson, 2005; Gesler, 1992; Kearns, 1997; Kearns & Moon, 2002; Parr & Philo, 2002; 2003; Smyth, 2005; Wakefield & Mc Mullen, 2005; Williams, 2002) by affirming the impact of natural and built environments and how meaning was created through it, in TToPE's view through the level of attachment or sense of healing it generated. While the earlier literature review highlighted the significance of authenticity of experience and place for tourists, there would seem to be a relationship between this concept

and the significance of connection and captivation in the natural environment identified by TToPE, in that people tend to feel connected to or captivated by a level of authenticity of place or experience that enhanced their perspective.

Conversely, TToPE argues that a lack of captivation and connection in the environment leads to disillusionment. This is supported by McCormack, Funderburk, Lee and Hale-Fought (2005) who report that individuals with serious mental illness living in the community regularly experienced boredom and spent 75% of their time undertaking activities that were below their skill level. Similarly, Fone and Dunstan (2006) found that there was a correlation between poor mental health and living in an economically deprived area with high unemployment. This would affirm TToPE by recognising how a lack of connection and captivation in relation to an experience or activity would contribute to disillusionment. The issue of boredom also relates to the category of activity/space compatibility.

7.5.4 The importance of activity/space compatibility

The data strongly indicated that people needed to be in spaces that were conducive to their own healing, and that these would be different for each individual. In complete contrast to the notion of activity/space compatibility, Goffman (1991) argues how individuals in total institutions use artefacts as ‘make-do’s’, (p.187) to compensate for their environment. Given the data and research explored, it can be argued that mental health consumers, both in the community and in clinical settings, tolerate or invent ‘make-do’s ‘(for example, using a tin as an ashtray, or toilet paper as facial tissues) to survive in environments that are incompatible with their mental health and well-being.

TToPE recognises how Canter and Canter's (1979) study is relevant to the notion of activity/space compatibility, as therapeutic environments need to reflect the goals for which they are designed. Kaplan and Kaplan's (1989) attention restoration theory also describes how the environment must be compatible with the individual for them to feel restored.

Conradson (2003) discusses how a community drop-in centre was activity/space compatible, playing an important role as a meeting place, as a place to find someone to talk to, or to get information services or advice. Thus, the functions or activities provided suited the space provided for them. Saleebey (2006) also highlights how the power of place can impact significantly on the behaviour of individuals. Social work, Saleebey argues, must pay attention to the 'ambience of environments where people live out the rhythms and tempos of their daily lives' (p. 242). Saleebey gives the example that if an environment appears cared for; people are more likely to be respectful in the way they behave within it.

Within the hospitality literature, individuals' perceptions of accommodation standards are directly related to activity/space compatibility. For example, a New Zealand study by Lockyer (2003) found that the most important aspect of hotel cleanliness was to do with bathrooms and kitchens. It could be argued that guests' expectations of these areas were high due to their functions; unless they were clean, guests were discomforted about using them to perform their intended functions.

TToPE recognises that activity/space compatibility is just as important for staff as for clients. An interview with the manager of large hotel chain emphasised the importance of the working space in order for people to feel a part of a team. This is also evidenced in the hospitality literature. Yagil (2006) discusses how employees in service industries felt more a

part of the facility when the space they worked in was compatible with the activities they performed.

Poor activity/space compatibility revealed in a study by Rapport, Doel and Elwyn (2007), found that general practitioners positioned their furniture and work spaces predominantly to reflect an air of seniority or social status. The strong prominence of the computer in the consulting room made it easy to maintain just as much, if not more, interaction with the computer than with the patient. This was a feature of larger, more managed, commodified and impersonal health care work spaces. The researchers' state:

> If our environments shape our identity we must conclude that, at least to some extent, the GP's in this study are displaying low morale, low self-esteem, where practice is characterized as 'doing one's best' in poorly functioning spaces within a setting of tightening resources. (Rapport et al., 2007, p. 523)

TToPE recognises that the location of buildings and public transport systems also affect activity/space compatibility. Similarly, Yanos (2007) identifies how urban sprawl creates barriers for people with mental health issues to integrate into the community, due to structural issues such as lack of services and public transport. Perspective enhancement argues that the design and intention of community living, in terms of providing a level of activity/space compatibility needs to be continually questioned and proactively maintained.

Studies that discuss the importance of facilities for people in experiencing a level of comfort and community integration are explored by Beal et al. (2005); Jacobson (2004) and Knowles (2000), who suggest a need for more research into the relationship between social connectedness and the location of housing so as to facilitate health and well-being. Such research is fundamental to the notion of activity/space compatibility required in perspective-enhancing environments.

TToPE recognises that space impacts on the perspectives of both clients and staff; whereas some spaces uplift and anchor, others contribute to a sense of disillusionment. Table 7.3 highlights the characteristics of perspective enhancing environments, and the practices important in facilitating them as indicated by the research.

Table 7.3
Characteristics of Perspective Enhancing Environments and Supporting Research

Characteristic of Perspective Enhancing Environments	Practices	Authors
Sense of Safety or Welcome	Homely, comfortable, safe, inviting	Remen (1991); Gesler, Bell, Curtis, Hubbard & Francis (2000); Conradson (2003); Hartig & Lawrence (2003); Lawson (2002); Hutton & Richardson (1995); Schweitzer et al. (2004); Milligan (2006)
Sense of Escape	'removal activity'	Goffman (1991)
	Being away, nature	Kaplan & Kaplan (1989) ; Conradson (2005)
	Empowerment facilitated	Nelson et al. (2001), Milligan (2006)
	Facility design	Andes & Shattell (2006); Glasby & Lester, (2005)
	Residential context	Evans, Wells & Moch (2003), Hartig & Lawrence (2003)
	Housing renewal	Blackman & Harvey (2001)
	Escape by design	Bitner (1992); Gutowski et al. (1992); Johansson & Lundman, (1992), Hutton & Richardson (1995); Timko (1996); Gross et al. (1998); Lawson (2002); Verderber & Reuman (1987); Ellen (2003); Brown & Ross Barnett. (2004); McLoughlin & Warin (2008)
	The experience of escape	Trauer & Ryan (2005)

Characteristic of Perspective Enhancing Environments	Practices	Authors
	Anticipation of escape	Gilbert & Abdullah (2002)
Connection and Captivation	Fascination with environment	Ulrich (1983); Ulrich (1984); Kaplan (1987); Kaplan & Kaplan (1989); Kaplan (1995); Ogunseitan (2005); Fieldhouse (2003); Tyson (2003); Thoms (2003); Schweitzer, Giplin & Frampton (2004); Beal et al. (2005)
	Place facilitates connectedness Therapeutic landscape facilitates mental health and well-being	Gesler (1992); Kearns & Moon (2002); Kearns (1997); Smyth (2005); Williams (2002); Milligan (2005, 2006); Conradson (2005), Parr & Philo (2003); Wakefield & Mc Mullen (2005)
Activity/Space compatibility	Design to reflect goals of environment	Canter & Canter (1979)
	Compatible	Kaplan (1987)
	Meeting space	Conradson (2003); Saleebey (2006)
	Cleanliness facilitates function	Lockyer (2003)
	Employee tasks	Yagil (2006); Rapport, Doel & Elwyn (2007)
	Integration	Yanos (2007) Beal et al. (2005); Knowles (2000); Jacobson (2004)

The first diagram on the following page captures the core features of perspective enhancing spaces and the characteristics that are fundamental to them. The second diagram provides a contrast in terms of the core features of spaces that contribute to disillusionment.

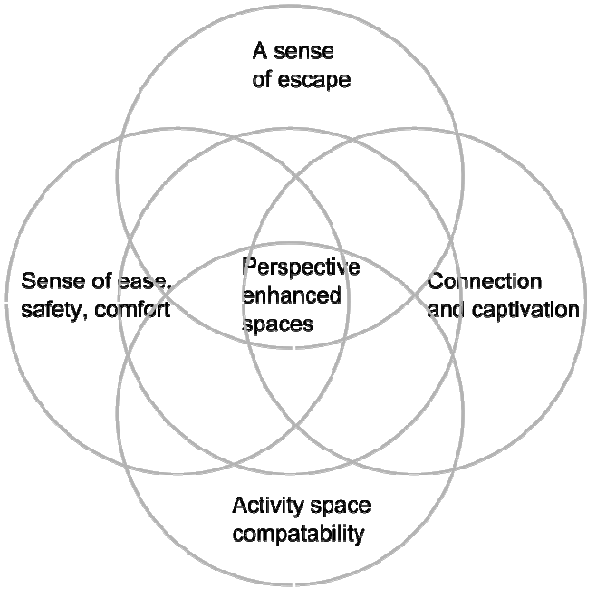


Figure 7.3 Towards Spaces Generating Perspective Enhancement

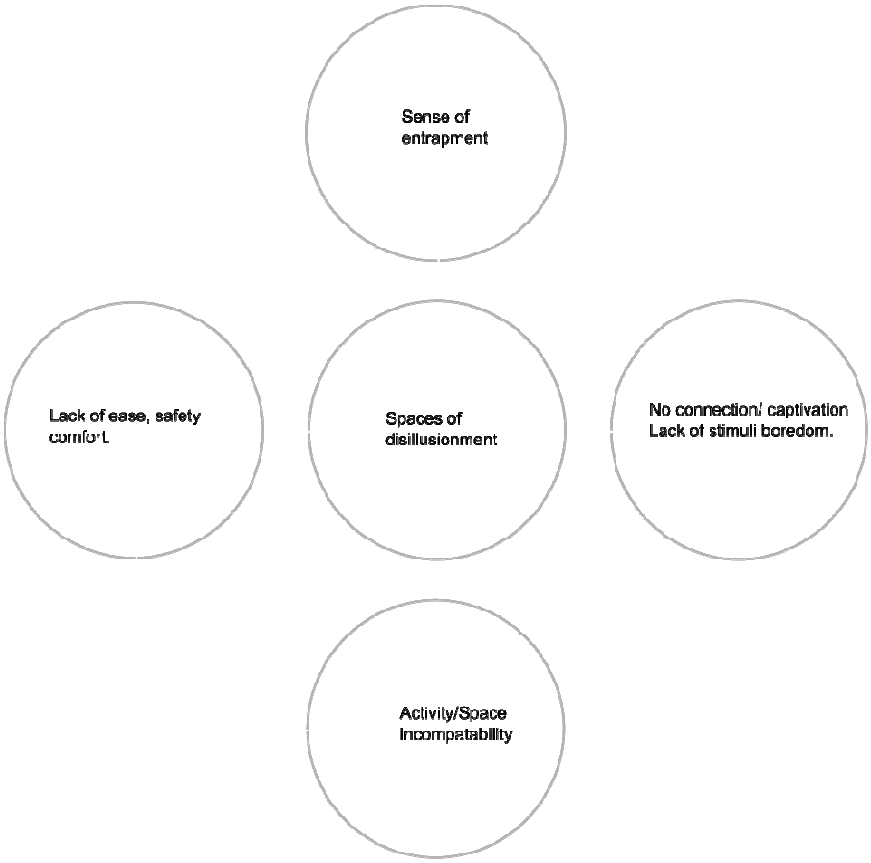


Figure 7.4 Towards Spaces of Disillusionment

7.6 The Nature of Interventions

The data revealed that the most important aspects of intervention strategies were that they should be individualised and replenishing as opposed to standardised and depleting. These aspects will be discussed in turn.

7.6.1 Individualised approaches

TToPE recognises that the person needs to be at the core of intervention strategies, rather than standardised intervention strategies being imposed on the person. The data suggested that when practical problem-solving approaches and coping strategies were tailored to the individual, individuals perceived these as more valuable than any particular standardised approach. The issue of standardisation of treatment experienced by mental health consumers is well articulated by Bennett (2001):

> Emphasis on the uniqueness of the individual patient, which is foundation of the humanistic tradition, has given way to standardisation which involved a focus on commonalities. Often it appears that the disorder, rather than the patient who suffers from it, is regarded as the target of treatment and the measure of its success. (p .6)

Bennett (2001) argues that any clinical intervention should only occur after empathetically knowing the person first. It is the attitude of genuine curiosity about the person and a desire to assist that is the catalyst to healing, rather than the interventions themselves. Similarly, Glass and Arnkoff (2000) also recognise the importance for the therapist to match treatment interventions to the needs of clients.

7.6.2 Replenishment

The data revealed that replenishment was like a 'top up' for people – that allowed them to think more clearly, feel less tense, or just generally feel better. Having a broad view of mental health and well-being, TToPE not only values tailored intervention strategies in a timely way, but also recognises the importance of preventative health care as part of the need for replenishment. Williams (1998) and Hancock (1999) also support the importance of preventative health models to maintain health and well-being, thus highlighting the idea that good health is more than the absence of illness. The Theory of Perspective Enhancement is encouraging of a holistic approach and affirms the views of Williams (1998), in terms of holistic health care landscapes that include a range of activities, lifestyle strategies or healing practices, and beliefs outside of Western medicine, that can assist or revitalise the person as a whole.

While TToPE contributes to maintaining and preserving mental health and well-being through replenishing strategies, the reported features of many health-care environments of which consumers were a part often tended to destabilise their capacity to maintain a sense of mental health and well-being because of depleting strategies.

Goffman (1991) gives examples of how this kind of depletion occurs for individuals in psychiatric hospitals as they lose their social roles, give up their life history, give up personal possessions for storage, or undergo admission procedures such as being weighed and wearing a hospital gown. TToPE re-affirms the work of Goffman (1991) in that such procedures are both standardised and depleting and are still occurring today. Unfortunately, the research revealed that maintaining an enhanced perspective would often be interrupted by depleting

rather than replenishing experiences, bringing forward critical junctures of hurt or alienation that would slide people towards becoming disillusioned.

7.7 The Critical Junctures of Meaning Development

Fundamental to perspective enhancement are the critical junctures generating a sense of healing and attachment through which meaning developed. Passing through these critical junctures enabled individuals to feel anchored and uplifted. The development of meaning occurred through self-reflection, spending time in the environment, interactions with others, or involvement in activities or therapeutic intervention strategies. This was not unlike the concept of inner transformation revealed through the earlier review of health and hospitality literatures, although the critical junctures through which individuals journeyed are made clearer through TToPE, both in terms of a positive or negative transformation. Much of the literature on healing (for example Blasjki, 1998; Bright, 2002 Gawler, 1998; Graham, 1999; Singh, 1999; Williams, 1998) discusses how a sense of healing is about regaining a sense of being a whole human being.

Wilkin (2006) articulates the importance of a sense of healing in mental health as a person becoming closer to his/her true self.

> Healing is a complex process that happens slowly beneath the protective layer of our emotional dressings….The most meaningful pieces of dialogue (for that is what we mental health practitioners are about) are those that open up the patient's store of self-knowing enough for them to discover something about their self that will make a difference. Something that causes them to light up in wonder…and, most importantly, make sense of their distress. (p. 17)

One man who had suffered with schizophrenia for many years articulated an example of negotiating the positive critical junctures of healing and attachment. He needed time out after feeling emotionally exhausted, and indicated two favourite places (respite and a private hospital) where he felt a sense of healing and a sense of peace. A level of attachment was

indicated through these places being fondly remembered when he needed space away from stress.

Kirmayer (1993) states that meaning is discovered constructed and transmitted through interpretation. TToPE argues that interpretation (via one's own perceptions of healing or attachment or conversely of hurt or alienation), may evolve through activities, environments, or relationship development. For some individuals interviewed, there was a clear attachment to particular places, activities or people that were meaningful in their lives. TToPE captures how meaning is developed through therapeutic landscapes. Various authors (for example Barry et al., 2001; Bondi & Fewell, 2003; Cornish, 1997; Gesler, 1999; Mitchell, 2000) have noted the significance of meanings held within landscapes, whether this is elicited by historical connotations or whether it is concretised through buildings, metaphors, language or décor. Similarly, Kearns et al. (2003) reveals the importance of discrete sanctuary and symbolic places for healing.

The research data supports Conradson's (2005) view of an interpretive framework. Conradson discusses how the self-landscape encounter can generate new dimensions of self-hood; thus, creation of meaning will be different for each individual. Conradson indicates how different 'self-landscape' (p. 345) encounters will have different significance for different people. Similarly, Gesler (2005) refers to the importance of therapeutic landscapes being 'context dependent' (p. 297).

This is further revealed through the study by Milligan and Bingley (2007), in that what is therapeutic to one person is not necessarily therapeutic to another. While woodlands were viewed as therapeutic by some children they were viewed as scary by others. Key findings

which contributed to the development of TToPE and which are suggested in the study by Milligan and Bingley was that individuals were less likely to have a positive meaningful experiences of their environment if they felt trapped, unsafe or had been exposed to previous negative associations with the environment. The importance of a sense of emotional attachment to place is also discussed by Milligan and Bingley (2007), in the way that children felt nurtured and supported by entering favourite woodland settings when stressed. In the same way that perspective enhancement enabled people to feel anchored and uplifted; the trees provided a sense of stability with a level of sacred significance.

It is interesting to note that in the tourism literature, authenticity of experience or place seems to occur when there is a level of bonding or connectedness to it (Kim & Jamal, 2007; Yeoman, 2007). Attachment as discussed by Bowlby (1973) is relevant here and discussed by Fullilove (1996):

> Attachment to place, like attachment to person, can be conceptualised as a series of emotions and behaviours that modulate distance from, and hence maintain contact with, the object of attachment, which is a source of protection and satisfaction. (Fullilove, 1996, p. 1519)

Other factors that maintain this attachment, it is argued, are positive memories, photographs or souvenirs. Similarly, Trauer and Ryan (2004) argue that successful tourist experiences are based on the experience of place in terms of the meanings developed through past experiences, and interactions with others that are able to conjure favourable memories. Through gaining an understanding of this literature, it becomes evident that when items that generate feelings of attachment are displaced or lost (a common experience for people in institutionalised settings), a sense of hurt and alienation may result which could lead to disillusionment.

Fullilove (1996) describes the process of alienation in the way it is symbolically constructed by society:

> The soundness of individual place identity rests on having a place and on knowing that one's place is held in esteem by others. When identity is betrayed in either of these ways, alienation may result. (Fullilove, 1996, p. 1520)

This view supports the data on the way individuals felt their sense of place identity was destabilised through relationships, environments and standardised and depleting intervention strategies. When there was a sense of destabilisation, coping mechanisms became important.

7.8 Coping

The data revealed that the two prime ways in which people coped with disillusionment was focusing and excuse-making. These coping mechanisms will be discussed in turn and compared with other relevant studies.

7.8.1 Coping by focusing

The data revealed similarities in how individuals focused in order to cope, and the sources of hope for people with a mental health issue, as discussed by Bland and Darlington (2002). While the sources of hope in this study included family, friends, practical support from professionals, religious beliefs, a positive attitude and evidence of recovery, the Theory of Perspective Enhancement (TToPE) affirms that people focus on a particular belief or entity to help them survive their experiences, for example, belief in the future, belief in family, music, inner survival messages or their purpose in seeking help.

Focusing can also be compared to what Goffman (1991) refers to as the coping mechanism of 'situational withdrawal':

> The inmate withdraws apparent attention from everything except events immediately around his body and sees these in a perspective not employed by others present. (p. 61)

This level of focusin*g* assisted people in sustaining themselves in challenging situations, in the same way that sources of hope from both internal and external sources become an important focus for carers in perspective destabilising situations.

TToPE acknowledges how individuals were able to cope in challenging environmental circumstances. Swanson (1996) argues that people survive in their environmental field and encounter either growth-enhancing or crazy-producing stimuli. The ultimate paradox is that while mental health consumers are considered 'crazy' their coping strategies are growth-producing. Through a disciplined degree of focus, they are able to place their growth producing strategies ahead of the many 'crazy-producing stimuli' (p. 61) they may encounter in their environment.

TToPE argues the that critical junctures on the path to 'crazy-producing stimuli' are exposure to environments, relationships and intervention strategies that generate hurt or alienation, while growth-producing stimuli facilitated a sense of healing or attachment. The challenge for many consumers and carers would appear to be to ensure that the growth-producing stimuli they have at their disposal on which to focus, outweigh those that might lead them to the critical junctures of hurt and alienation and to subsequent disillusionment.

7.8.2 Coping by excuse making

The data on coping with disillusionment revealed that at times when there was a sense of hopelessness; excuse making was a common and useful strategy, particularly when the

situation appeared outside the individual's locus of control. Individuals coped by making excuses for the busy workload of nurses and their responsibilities and inadequate nurse-staff patient ratios. This was also noted by Cleary and Edwards (1999). Similarly, Williams, Coyle and Healy (1998), in a study on patient satisfaction found a trend towards making excuses for poor service delivery, as patients tended to accept mitigating circumstances more readily, for example, failure to respect confidentiality, long waiting times, inability for mental health professionals to cure the problem. This study revealed:

> Individuals will not evaluate a service negatively, even if it has produced a negative experience (and failed in its duty), if there are sufficient mitigating circumstances for the service failure. (Williams, Coyle & Healy, 1998, pp. 1355-1356)

Milligan (2006) also found that informal carers had limited expectations of staff and empathised with paid staff:

> Most acknowledged the difficult task that paid carers undertake and made allowances for occasional mistakes and mishaps. (Milligan, 2006, p. 328)

Similar experiences of excuse-making were often expressed by mental health carers who would often refer to the high staff turnover and high case loads in excusing the lack of service they received.

7.9 A Consequence of Perspective Enhancement - Deserving and Self-Affirming

For individuals who had learned to navigate the critical junctures towards perspective enhancement and to cope with periods of disillusionment, the consequence was that they became more affirming within themselves and believed they were deserving individuals.

In particular, the data from tourists confirmed the concept of 'pilgrimage' (p. 47), as discussed by Devereaux and Carnegie (2006), who explore the concept in terms of individuals feeling more re-acquainted with self and more affirming of their own identity and true self. Similarly, Smith and Kelly (2006) and Wilson and Harris (2007) also acknowledge

the value of the tourism pilgrimage experience, a way in which people go on a journey to heighten and affirm their sense of self.

7.10 Constructing a Framework for Practice

The following diagram, Figure 7.5 illustrates how the core features of a framework for practice incorporates TToPE and how they relate to each other. At the core are the values of intrinsic worth and time-worthiness, surrounded by the principles identified in holistic engagements and the characteristics essential to the therapeutic relationship. These engage with therapeutic environments and intervention strategies through the practice behaviours of creating a sense of welcome and safety for clients. The values, principles and relationship characteristics meld back and forth and interrelate with the practice behaviours and conditions of which they are a part as indicated by the permeable boundaries.

Figure 7.5 Core features of a Perspective-Enhancing Framework for practice

SUMMARY

What is highlighted through the literature and the data is that perspective enhancement is about encountering an overall meaningful experience and that there are key factors in relationships, environments and intervention strategies that contribute to it. Critical junctures at both ends of the spectrum influence the development of meaning, while individuals find their own ways of coping in challenging circumstances, through excuse-making and focussing. Experiencing the critical junctures of healing and attachment were important for enhancing perspective, allowing people to feel more self-affirmed, anchored and uplifted. The core features of the practice framework identified assist in facilitating individuals to have an enhanced perspective.

CHAPTER 8: CONCLUSIONS, IMPLICATIONS AND RECOMMENDATIONS

8. INTRODUCTION

The previous chapter highlighted how TToPE relates to the existing literature, both within and outside the mental health field, contributing to a practice framework that facilitates mental health and well-being. This chapter will draw conclusions about the significance of TToPE, and how it challenges and extends current thinking about mental health and well-being. Comparisons will be made between the features of TToPE and recovery, showing how TToPE can fill a practice gap in the recovery framework.

Recommendations will be made about the ways that TToPE can inform current practice in service delivery for mental health and well-being, specifically for social work. Implications for practice will be highlighted, particularly in relation to how TToPE could be translated into dynamics and practices of organisations in the human services context. Major challenges in implementing TToPE at an operational and practice level will also be identified as operational and practice issues were a key factor in motivating this research. Finally, the limitations of this study and recommendations for future research will be outlined.

8.1 The Significance of TToPE

TToPE challenges the existing paradigm that mental health lies on a continuum from wellness to illness. Mental health and well-being have often been viewed on such a continuum, in which different symptoms and categories of illness have been clustered together and differentiated based on the severity of symptoms a person is experiencing. For example, a person with mild levels of anxiety from time to time, but no other mental health issues, might be viewed as being generally at the well end of the mental health continuum. A

person, however, with acute psychotic symptoms and a lengthy history of mental illness may be at the lower end of the mental health and well-being continuum.

An alternative continuum of disillusionment to perspective enhancement avoids altogether the clinical clustering of symptoms based on their severity. Mental health and well-being on this continuum has much more to do with how a person feels in the context of their environment, their relationships with others and within themselves. It may be that a person with mild levels of anxiety is severely disillusioned through feeling trapped, unwelcomed, and unsafe and is engaged in relationships that devalue, disconnect, stereotype and discredit. Although, on the generally accepted mental health continuum, their mental health would be viewed as generally good, they may feel extremely disillusioned after many experiences of feeling hurt and alienated through their experiences.

In contrast, a person who might be considered to have poor mental health, due to the severity of their clinical symptoms may feel their perspective is enhanced through experiencing a sense of escape, feeling connected to and captivated by their environment, feeling accepted and welcomed, and be in a space that is compatible for him/her. It is possible that this person, although experiencing severe symptoms, may feel anchored and uplifted within their individual context through the meanings generated for him/her that enable a sense of healing and/or attachment to develop.

The Theory of Perspective Enhancement attaches little importance to the ways that mental illness is usually categorised, but deals with what the person is experiencing in the context of the environment, relationships and the interventions of which they are a part. One could argue that for a period of time, those having a manic high experience an enhanced

perspective, however there is a clear difference. Through a manic high one is not anchored and is likely to eventually experience the critical junctures of hurt and alienation on becoming aware that these experiences are too good to be true.

It is important to note that perspective enhancement as a theory applies to mental health generally, and accordingly the capacity to adopt perspective enhancing practices does not just rest with mental health professionals but with all people who have a commitment to the mental health and well-being of people they serve. Thus, it could apply to service providers who offer services to those who experience domestic violence, homelessness, general disability services or drug and alcohol services. In fact, it is applicable to any system that values the mental health and wellbeing of its stakeholders.

8.2 TToPE and Recovery Compared

Crucial to both the recovery and perspective enhancement paradigms is the development of meaning. Glover (2005) argues that recovery is rooted in the subjective experiences of individuals which must be incorporated into the paradigm of professional knowledge, rather than being an 'add on' factor. The Theory of Perspective Enhancement respects this view and, like the paradigm of recovery, perspective enhancement needs to infiltrate established professional knowledge bases and practices.

Like recovery, perspective enhancement demands holistic and authentic tailored engagement with individuals so as to tailor intervention strategies that are meaningful to them. Deegan (2005a) emphasises the importance of personal medicine, in terms of self-care strategies, roles and activities that give people meaning and purpose in life. The emphasis is on helping people to discover what is important and workable for them rather than taking a more paternalistic diagnostic approach.

Another similarity between perspective enhancement and recovery is the notion of connectedness versus disconnectedness. Glover (2005) identifies disconnection through specialist programs that identify people through illness. Perspective enhancement is able to articulate how this disconnection occurs and how the consequence is disillusionment.

There are two key reasons, however, why perspective enhancement transcends recovery. First, the research on perspective enhancement has come from fields other than mental health. The intent is not to separate out service delivery for mental health consumers, but to add a dimension to what contributes to mental health and well-being generally, over and above specialist mental health service delivery. While the notion of recovery tends to be used in the health industry, the application of TToPE is potentially broader than this.

Second, while perspective enhancement still appreciates the fact that consumers can take more active responsibility for themselves, develop an active sense of self and move towards discovery, it also offers a framework for practice that alleviates the level of personal responsibility placed on the individual. It hands over more responsibility to service providers in their day-to-day practice, by highlighting significant factors that can facilitate perspective enhancement. Perspective-enhancing environments, relationships and intervention strategies integrated into service delivery it is argued should make recovery easier for consumers. Rather than consumers having to survive the challenges of the current approach to psychiatric service delivery, it is hoped that a perspective-enhancing framework for service delivery can give people greater capacity to journey successfully through the mental health system.

Perspective enhancement does not wish to detract from the flexibility and uniqueness required in recovery spaces. It does, however, demand that services and systems take the responsibility of providing environments and staff that are highly respectful and committed to the provision of services that embody a holistic, consumer-focused and health promoting approach to mental health and well-being. Unfortunately, recovery as defined in the *National Mental Health Plan 2003-2008*, still tends to emphasise recovery as excessively individual:

> […] a deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills, and or roles. It is a way of living a satisfying, hopeful and contributing life. Recovery involves the development of new meaning and purpose in one's life as one grows beyond the catastrophic effects of a psychiatric disability. (Anthony as cited in Australian Health Ministers, 2003, p. 11)

While the intent in Australia is that recovery should maximise the well-being of individuals and empower people with mental illness, this may remain a challenge if it fails to call on perspective-enhancing relationships, intervention strategies and relationships. While Glover (2005) recognises that services need to take on a framework of recovery, The Theory of Perspective Enhancement gives additional tools and resources for services to apply, based on what contributes generally to mental health and well-being.

8.3 What Does Perspective Enhancement Mean for Mental Health Service Delivery and Social Work?

In order for perspective enhancement to be integrated into mental health service delivery or any other context, both the psychosocial process of perspective enhancement and the social structural features that facilitate it need to be appreciated and implemented. The advantage of TToPE being introduced into social work practice is that, as pointed out earlier, social work is a profession that reaches across many contexts. TToPE can be applied across all of these.

The theory is significant to both clinical and non-clinical mental health support services, as well as to other agencies that wish to facilitate the heath and well-being of their clients; for example, domestic violence services, aged care, disability, housing and so on. TToPE resonates with the core values of social work, and identifies principles, practice behaviours and relationship characteristics that influence how human service professionals engage with, receive, assess, and work with people. TToPE can offer practical suggestions as to how agencies and staff need to present themselves, and how they can cultivate the work practices and organisational culture necessary to facilitate perspective enhancement. Earlier it was identified that social work has a key role in attending to the needs of individuals in their social context. TToPE, as a theory, recognises the importance of the interaction between the individual and their social context, and can provide a framework for social workers to implement in their respective agency contexts.

At a broader community-development level, TToPE has the potential to add a new dimension to urban renewal and community development studies, by allowing an exploration of factors that contribute to perspective enhancement. While the characteristics of population and places are always unique, substantial research has been done to document how the material conditions in neighbourhoods impact on health. The data suggests that factors impeding health included a sense of feeling trapped (including lack of control and lack of privacy), lack of comfort and lack of safety. These factors are also discussed by Warr, Tacticos, Kelaher, and Klein (2007), who suggest that a more assertive approach should be taken with urban renewal projects to focus on creating a sense of freedom, safety, comfort and pride in urban neighbourhoods.

The concept of the therapeutic landscape in urban renewal has the capacity to promote social connections, and help to design a more aesthetically pleasing environment that in turn promotes the intrinsic worth of individuals. All of this work complements the values and practice base of social work and can make a useful contribution to community-development contexts.

8.4 The Beginnings of a Framework for Practice in Human Service Organisations

It is recognised however, that in order for perspective enhancement to be fully operationalised, a framework for practice is required that can be applied to human service organisations. A framework for practice is important for a number of reasons. Healy (2005) states that theoretical frameworks guide practitioners in deciding who or what should be the focus of the assessment or intervention, and that a well articulated framework recognises the accountability to service users, employers and funding bodies. It also enables critical reflection to improve service quality as well as develop the professions established knowledge base (Healy, 2005).

In order to articulate where TToPE would position itself in terms of a framework for practice, it has been useful to contemplate the four dimensions of practice articulated by Burrell and Morgan (1979). This allowed me to clearly identify how the constructionist approach of Grounded Theory could be articulated into an interpretive framework for practice.

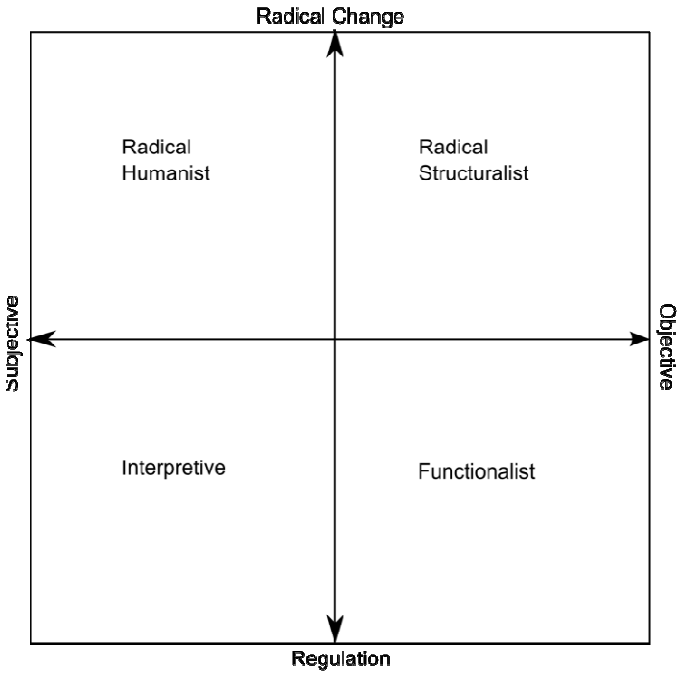


Figure 8.1 The Four Dimensions of Practice (Adapted from Burrell and Morgan, 1979 as cited in Netting and O'Connor, 2003, p.81)

Netting and O'Connor (2003) state that these 'mutually exclusive paradigms define four alternate views of the social work based on meta-theoretical assumptions regarding the nature of science and society' (p. 81).

TToPE fits within a subjective interpretive paradigm, in that the reality of individuals is linked to their experience and to what is meaningful for them. It relies on individuals constructing and creating their own realities. Netting and O'Connor (2003) discuss this perspective as being ideographic, meaning that 'concern should not be focused on universal principles or an 'absolutist view' (p.78). TToPE gives emphasis to how individuals construct the world around them, as opposed to a positivist approach in which 'social reality sits outside the individual' (Netting & O'Connor, 2003, p. 79).

An awareness of where TToPE fits into this paradigm assists in remaining true to the perspective and enables a greater understanding of the basis of philosophical conflicts that may be encountered. TToPE also requires a level of order, in terms of working with consensus and social cohesion to make sense of the emergent reality. Netting and O'Connor (2003) summarise the interpretive view of organizations:

> Interpretivists look for multiple truths to arise from within people. Therefore, an interpretive organisation would be an alternative to traditional ways of thinking because traditional thinking seeks order through locating the best way to do the work of the organisation. The interpretive paradigm seeks order but knows that order is socially constructed by those involved and will change over time. (Netting & O'Connor, 2003, p. 188)

This approach has certainly been integral to the way that TToPE has been constructed. It has been formulated through the perspectives of either those receiving services to enhance their mental health and well-being or those making a positive contribution to the mental health and well-being of others. In order for TToPE to have value to clients and be interpreted by social workers and human service practitioners, it needs to be translated into the context of human service organisations. Based on a realistic understanding of human services organisations, Table 8.1 sets out the characteristics of a perspective-enhanced organisation based on The Theory of Perspective Enhancement. The implementation of TToPE into practice has implications for the underpinning values of service delivery, leadership and management styles, organisational culture, training and recruitment practices. Most importantly however, to retain its interpretive dimension, TToPE demands client involvement.

Table 8.1
Integrating TToPE into Human Services Organisations

Perspective Enhancement	Relationships	Environments	Flexible Intervention Strategies	Assessing Critical Junctures	The consequences uplifted and anchored
The Values	Values the intrinsic worth of human beings, and the credibility of human experience People are timeworthy	Everyone deserves a level of comfort and safety in their environment	Respect for individual preferences in relation to how they are assisted Individuals will bring their own lived experience about how they can feel replenished	Everyone has the right to feel a part of (or attached to) the service delivery process that contributes to their wholeness/healing	Services have a responsibility to ground individuals yet harness and cultivate the potential of the individuals they serve, the staff they employ and the communities of which they are a part.
Leadership	Servant leader style of leadership. Shows humility grace, serves others, asks questions, is real, demonstrates integrity	Intentionally facilitates welcoming, safe and comfortable environments conducive to the needs of stakeholders Respect for diverse environments and their meanings. Engages in learning networks Collaboration for expertise	Learning new ways of doing things Considers new possibilities. Driven by mission	A sense of wholeness in teams that they are a part of the leadership Attachment within team to leadership	The leadership style is grounded yet excited by innovation and new possibilities. There is no 'ownership' of the work – it has a life of its own, yet there is a vision that can be articulated.
Management Style	Democratic and authentic –makes meaningful connections with others. Encourages diversity yet seeks peace within larger	Open to suggestions – Respect for diversity	Opportunities for sharing, deep questioning, supportive dialogue Agreements as to how communication takes	A sense that communication is transparent and given in its entirety A view that management	The management is stable yet progressive.

Perspective Enhancement	Relationships	Environments	Flexible Intervention Strategies	Assessing Critical Junctures	The consequences uplifted and anchored
	group. Recognition is given		place	assists in pulling the team together	
Organisational Culture	Values team work, reflective practice. Healthy relationships are fundamental at levels Participatory approach with peer support and recognition Values life experience Recognition that all staff have vulnerabilities –a recognition of the conflict inherent in 'being professional' and 'being human'	Comfort and safety A work environment design that welcomes and connects people, activity/space compatibility to perform the functions of the job The opportunity for a sense of escape if required	Open respectful, honest communication	A strong grounding energy with the capacity to question and become re-vitalised	Influenced through on the ground issues and to take performance to a new level.
Training and Recruitment	Incremental people skills that welcome and connect Authentic tailored engagement and holistic engagement Learn ways to enter the clients world –listening, emotional exploration, supporting client's autonomy –not a discrete	Experiential understanding of aesthetics –welcome, connection, safety, comfort meaning of spaces and sense of escape Staff are recruited and trained in activity/space compatible spaces Ongoing mentoring	A variety of learning teaching styles employed to target key objectives and needs of participants Involvement in partnerships between professional organisations and consumer groups to encourage creative and experiential staff training	Sense of completeness and connection of knowledge and skills learned and an ability to resonate to the values underpinning the learning Reflective learning	Staff have core knowledge and are inspired to take their learning further.

Perspective Enhancement	Relationships	Environments	Flexible Intervention Strategies	Assessing Critical Junctures	The consequences uplifted and anchored
	set of documented techniques, but attuned to each persons behaviour and personality A level of self-awareness and capacity to reflect in order to develop maturity and capacity to work with inner conflict.		Participatory techniques for assisting clients come in touch with their own world – biographies		
Client involvement	Valued and respected through every communication –an integral part of service evaluation	A sense of environmental affinity (design, comfort. safety)	Empowered to ask for assistance, initiate new ideas.	Sense of healing Sense of attachment.	Feeling uplifted and anchored. A sense of balance, calmness, centeredness, hopefulness.

8.5 Challenges for Service Delivery

A number of challenges arise in implementing this framework in practice. At the forefront, perhaps, are the changes required in day-to-day operational practice. Tables 8.2 and 8.3 on the next page offer practical suggestions for the implementation of perspective enhancing relationships, environments and intervention strategies that are embedded in the social structural processes of service delivery.

A number of key challenges will then be discussed in turn. These include the challenges of building a reflective and interactive leadership style, generating an organisational cultural shift, achieving a balance between authenticity and commodification, implementing appropriate staff support mechanisms, anticipating the readiness for change, and creating perspective-enhancing evaluation tools.

Table 8.2
Operational Features of Perspective Enhancing Relationships for Service Delivery in Mental Health

Relationship	Social Structural Process	Suggestions for Enhanced Service Delivery
Restoration of Intrinsic Worth	Being Received Assessed Managed	The approach of staff must be to value each individual giving each person priority in the context of their unique circumstances
Timeworthiness	Being Received Assessed Managed	Negotiated appointment times Availability and responsiveness of staff Length of times negotiated dependent upon negotiated intervention strategies
Safety and Welcome	Being Received Immediate Assessment of Need	Incremental people skills – responsiveness, acknowledgement People are put at ease –encouraged to relax Needs assessment, immediate comfort assured Expectation raised –nothing is too much trouble Consumers have entered a service which is a part of something 'special' Consumers have permission to ask for what they need
Authentic Tailored Engagement	Being Received Assessed Managed	Relationships with staff are characterised by empathy, warmth, positive regard, authenticity, genuine care Sincere interaction
Holistic Engagement	Assessment Management	Service users have great in control the process and must feel empowered to explore what they feel will work for them Recognition of the interaction between mind and body as well as the social environmental, cultural and spiritual issues of consumers A holistic assessment process Staff engage with consumers in ordinary activities and are able enter into the life world of consumers Collaborative partnerships with other services and organisations

Table 8.3
Operational Features of Perspective Enhancing Environments and Interventions for Service Delivery in Mental Health

Conditions	Social Structural Process	Suggestions for Enhanced Service Delivery
Sense of Welcome and Safety	Received and Managed (behind the scenes)	Décor is designed for comfort Signposting and information is clear Good amenities and conveniences Safety An atmosphere of welcome rather than uncertainly
Sense of Escape	Managed (behind the scenes)	Consumers benefit through a sense of awayness through environment or activities to minimise stress and encourage clarity of thought. The environment enables freedom, one to feel immersed in a different yet appreciated space or activity Mechanisms for escape in the environment for example, nature settings, art rooms, opportunities for musical escape
Connection and Captivation	Managed (behind the scenes)	Consumers feel a level of curiosity, fascination and captivation setting opportunities for connection and captivation
Activity/space Compatibility	Received, Assessed and Managed (space allocation)	Spaces are usable, flexible and tailored to the activities undertaken. Layout encourages relationships and mingling rather than ‘us and them’ No differentials in the standards of spaces or artefacts used by staff and consumers Activities that allow people to focus on what will assist them Space that is private providing safeguards for against intrusion
The Development of Meaning through the Experience	Managed (behind the scenes)	Exposure to different experiences opportunities for personal growth Through interactions, insight and meaning is developed Allows for a self-landscape encounter which will be unique and context dependent for each individual Sense of healing and attachment to the landscape develops through individual interpretation of it
Individualised and Replenishing Strategies	Managed	Consumers are enabled to have choice in terms of what they believe will be most beneficial for them

8.5.1 The need for an interactive and reflective management and leadership style

A significant challenge for the implementation of TToPE is that it challenges traditional top-down rigid organisational approaches to service delivery due to the importance it gives to subjective and emerging meanings and collaborative approaches. While typical management style approaches in mental health may require that the environment be controlled in a routine and ordered manner, TToPE encourages environmental comfort, consumer choice, and a sense of freedom and flexibility. TToPE suggests that needs should be attended to unobtrusively, that there is a subtle capacity to anticipate consumer requirements and attend to these in a hospitable manner, which reflects a desire to serve rather than control.

Thus, it requires an interactive and reflective management and leadership style.

Shepherd (1998) states:

> In the future, staff must be prepared to deliver services much more on the user's terms and much less according to a professional view of what might be most beneficial. This is not because users' views have a right to be taken seriously; it may be the only way to work with individuals whose willingness to engage in traditional services is limited. (p. 174)

> […] staff need to be flexible and creative: they need to be prepared to deliver their interventions at home, in the street, in shops, the park, the pub and the café. (p. 174)

Perspective enhancement desires to assist people in the context of their everyday life, offering flexibly tailored on-site support. Where healing environments are developed, there needs to be a commitment to reflective learning and exploring perspective enhancement at both a personal and professional level. While recovery recognises the importance of working with consumers and their lived experiences, TToPE emphasises the importance of a reflective and interactive management and leadership style in order for this to occur in a meaningful way. While Anthony et al. (2002) discusses eight principles of leadership that are generally

compatible with TToPE, there is still much work to do to implement such principles into practice. Perhaps one of the most poignant comments that Anthony et al. (2002) makes on the principle of leadership and vision that is compatible with TToPE is that a leader live a life compatible with the vision.

Jonas and Chez (2004) extend the relevance of this comment by stating:

> Healing spaces in health care setting require the understanding, experience and support of the leadership and organisational decision makers for successful implementation of an OHE (optimal healing environment). Health care managers and leaders ideally should have the experiences contained in OHE domains, and practice self-care, personal wellness, and prevention approaches in their own lives. (Jonas & Chez, 2004, p. 5)

Thus, for TToPE to be implemented in the workplace, its values must also be taken on board in everyday life to be meaningfully put into practice. Thus, it requires leaders who can model the roles of what the framework means in an authentic manner.

8.5.2 A shift in organisational culture

Perspective enhancement would require a significant cultural shift in health care environments. The Theory of Perspective Enhancement applied to staff would suggest that they feel *welcomed* in their work environment and that the functions they have to perform are *compatible with the spaces* available to do them. The organisational culture would need to cultivate beliefs and practices that encourage the potential of both staff and consumers. This would require eradicating outdated and stigmatising beliefs about mental illness and clearly challenge those traditional organisational practices that have contributed to the disillusionment for both staff and consumers.

Team-work and collaboration are required above competitiveness. Because perspective enhancement is about facilitating a complete experience for individuals, this cannot be achieved within a fragmented staff culture. All staff would be recognised for performing a part of a vital and important function.

Jones and Chez (2004) summarise this by stating:

> […] optimal healing environments highlight the importance of establishing patterns of team work, shared values, learning form each other, accepting the expertise of others, communicating openly and effectively, helping integrate services at an individual and systems level, confronting issues of hierarchy, specialisation and privilege and entering into non-competitive supportive relationships with colleagues. (p. 2)

Jacobson and Greenley (2001) in their discussion of conceptualising recovery orientated services, state that a culture of healing in human services begins with an environment characterised by 'tolerance, listening, empathy, compassion, respect, safety, trust, diversity and cultural competence' (Jacobson & Greenley, 2001 p. 486). This is also fundamental for TToPE.

Such an organisational culture would recognise the completeness and uniqueness of all individuals (staff and consumers) as well as of the relationships between individuals and their social world.

8.5.3 The balance between authenticity and commodification

With the growth of larger managed health-care environments, it is important that spaces designed for human interaction do not become standardised and reflect solely a commercial operation. Perspective enhancement requires that the environment reflect the tastes and talents of those of which it is a part, allowing some freedom and innovation to flow. Imposing

a standard template of perspective-enhancing healthcare design is not possible, although the fundamentals of activity/space compatibility, safety and comfort apply.

Geary (2003) gives an example of the flow-on effects created by healthy enthusiasm in the Planetree Model of health care, which occurred when staff were encouraged to play an important role in bringing the work environment to life through their own creativity, teamwork and initiative. Ultimately however, TToPE would insist that consumers and carers must play an integral role in the design of health care environments. If this were the case, the many frustrations that consumers and carers experience in 'putting up with' or 'making do' in health care settings could be eliminated.

8.5.4 Staff support – emotional labour versus authenticity

A major challenge in this practice framework is how to maintain staff morale and support staff, when they may encounter conflicting attitudes externally and within themselves at different times. TToPE requires staff to work in a respectful and welcoming way, even if they are experiencing a turbulent time at a private emotional level. In the hospitality industry, when staff must conceal or manage actual feelings to benefit service delivery, this has been described as emotional labour (Hochschild, 1983, p. 35), as service providers engage in either 'deep' or 'surface' (Hoschsild, 1983, pp. 37-38) acting to cope with customer needs and to meet industry demands.

Van Dijk and Kirk Brown (2006) have since argued that the conflict displayed by what is expressed and what is experienced can be better articulated through cognitive dissonance theory. This theory argues that psychological discomfort can occur when there is a conflict between the thoughts, feelings, values, attitudes and behaviours of staff. It emphasises that

the level of dissonance is likely to be greatest when the behaviours undertaken violate one's sense of true self or self-concept.

This is a useful concept when applied to TToPE, as TToPE identifies the importance of individuals being affirmed, and how a significant level of value incongruence or activity/space incompatibility can lead individuals towards becoming disillusioned. For example, TToPE would suggest that staff could be more likely to become disillusioned if they believed in maximising the comfort of consumers, yet worked in cramped or uncomfortable conditions themselves. The values underpinning staff support within TToPE need to encapsulate the intrinsic worth of the individual and the fact that staff are time-worthy. It requires staff to be 'real' with themselves and place tailored authentic engagement at the core of supervisory practice with their colleagues and supervisors. For staff to be adequately supported, it requires that they be authentic with each other to express the challenges they face.

Larson and Yao (2005) suggest an understanding of emotional labour is useful because there has been insufficient training and education in compassion. Training in the emotional aspects of health care and providing a better understanding of empathy and psychological and behavioural activities in this process would be beneficial for health care practitioners. Emotional, cognitive and behavioural dissonance would need to be discussed openly to ensure that any form of 'surface' or 'deep' acting does not threaten an individual's sense of self.

Given the fact that the research revealed that many mental health consumers value the importance of simple ordinary human relationships, it is also important to question to what

extent and circumstances individuals may need to resort to ‘surface’ or ‘deep’ acting. While there may indeed be a level of emotional labour in health care, de Raeve (2002) suggests that professionals have a responsibility to show a genuine interest in people over and above other service industries. It is argued that a deeper understanding of the other and a level of compassion would seem more appropriate than the ‘acting’ associated with service workers serving commodities to others. People need to come to understand themselves and others through their own emotional maturity and collaborative staff support practices. Perspective enhancement ultimately encourages self-awareness and authenticity, not acting.

A more recent challenge to the concept of emotional labour emerges from the hospitality industry. Riley (2007) makes use of the concept of ‘role interpretation’ (p. 412) stating that a service worker may re-interpret their role during an encounter with another person when it begins to break down. Riley describes how service workers can manipulate their role to undertake a minimalist, yet still legitimate role if the encounter proceeds badly. Riley (2007) explores the danger of this phenomenon by stating:

> Given that the experiences of encounters become antecedents of future encounters, the obvious danger is that of the parties take their more limited interpretations of roles into a new encounter they are likely to continue in that mode. In such a manner, a general air of indifference and low expectations is bred. (p. 413)

The ethics of human service work require the human service worker to perform their role in accordance with the best interest, rather than their own. If a human service worker minimises interaction with a consumer to minimise their own stress level, a key issue for the consumer may not be recognised, and the interaction maybe not in the individual’s best interest, thus defying both the ethics and purpose of the profession.

While there are some relevant practice behaviours that can be taken on board from the hospitality industry, the challenge remains to integrate these authentically and genuinely into day-to-day human services practice, rather than taking on board the concept of emotional labour and all of its connotations in the form in which they exist in the hospitality industry.

8.5.5 Readiness

Findlay and Verhoef (2004) discuss the challenges of developing an optimal healing environment. These include the readiness of decision makers and practitioners, and the work processes, structures and outcomes relevant to optimal healing environments. Findlay and Verhoef revealed through their study that the complexity of the underpinning values of the health care professional are fundamental to the success of such an environment.

Middleton, Stanton and Renouf (2004), also identified this issue in the way it was articulated by consumer consultants in the mental health context of developing recovery based service delivery. They state:

> For example, one of the consumer consultants with experience in working in two different services felt he had made good progress in one service where as, in the other:
>
> Every single time we try and do something different they make a blanket statement that 'staff aren't ready for that' and we couldn't progress anything. We've tried all sorts of different strategies and mechanisms and we can't get past it. (p. 515)

TToPE assists in identifying key areas of readiness that the research suggests needs to be tackled by decision makers, such as the readiness to invest in healing environments, collaborative teams, client-centred and directed approaches and more flexible service delivery. All of these areas require significant commitment and investment by decision makers.

8.5.6 Evaluation tools

Service evaluation tools need to target the fundamentals of perspective enhancement from a client- centred approach. They also must be assertive in identifying whether 'excuse making' was happening within the environment, by either staff or clients.

Table 8.4 highlights the style of perspective enhancing evaluation questions that may be appropriate.

Table 8.4
Evaluation Questions Relevant to Perspective Enhancement

Questions for Consumers
What in the environment in this setting was significant for you?
Did any particular part of the setting stand out for you? If so, what was it and why?
Did time spent in this setting enable you to think about what is happening or has happened in your life in a different way?
Where there any new understandings that emerged?
Do you feel as if you have personally grown from the experience of being away?
Will you approach life when you leave here any differently? If so, how?
What contributed the most to any realisations you may have experienced?
Are there any recommendations as to how people might be able to gain more from this experience?

Questions for Staff
What in this work environment is significant for you?
Does any particular part of the setting stand out for you? If so, what and why?
Does time spent in this setting enable you to think about your work in a different way?
Have new understandings emerged?
Have you personally and professionally grown from the experience of working in this setting? If so, how?

Such questions attempt to elicit the more subtle experiences of staff and consumers and develop a culture of self-reflection. This would be compatible with an action research style approach to service evaluation.

8.6 Limitations and Strengths of the Research

The key limitation of this research is that it has attempted to draw from many disciplines to gain a better understanding of mental health and well-being and what this means for social workers in practice. There was an enormous amount of literature that needed to be reviewed and integrated to formulate the understanding required to engage in this Grounded Theory research across different disciplines. Essentially, the research compared data from industries that traditionally have not been compared in the context of mental health and well-being.

Thus, I understood that it was ambitious to draw upon a broad array of literature to understand key concepts in multiple disciplines. It is recognised that that there is a much greater scope to explore these disciplines in more depth and that there is the possibility that I have really only scratched the surface of how TToPE and these disciplines interact. At the same time, the fact that this research crosses across many disciplines could be considered a strength in terms of integrating key themes and concepts that are relevant to traditional mental health service delivery, yet have the capacity to extend beyond it. It also extends the practice of social work by introducing therapeutic landscapes to the profession developing a framework for how this concept may be applied. In turn, it is hoped that TToPE may be useful to the hospitality and natural therapy sector that contributed so strongly to it.

Another possible limitation of this research is that I chose not to interview mental health practitioners, but to remain more open in the discourse on mental health and well-being. It is possible, that had time allowed, some convergent interviewing could have been done with mental health practitioners to better elicit the challenges that might be associated with implementing TToPE. This I recognise, however, would be another potential area of study in itself. Conversely, a strength in keeping with the original research question is that I

made a strong initial commitment to explore mental health outside of the traditional mental health service discourse and held true to this for the course of the study.

One of the complexities of using Grounded Theory was that the research process took on a life of its own. It is noted that in the initial information given to participants, a key purpose of the research in terms of contributing to mental health and well-being flagged the possibility of developing new mental health service delivery models. As the research progressed and findings emerged however, the contribution of the research became much more about developing the fundamentals of a practice framework that captured a view of mental health and well-being beyond traditional mental health service delivery. Thus, while a limitation of the methodology was that it was difficult to project the nature of the outcome of the research, a key strength was engagement in the field allowed concepts to emerge and evolve allowing myself to fully appreciate the sense of discovery that is associated with Grounded Theory research.

A further limitation of the research in terms of the participant sample is that individuals self-selected to participate generally because they were interested in the research. While this may have biased the data, a strength of research can be identified in that no participants withdrew from the research and the ethical safeguards put in place for mental health carers and consumers appeared to be adequate.

Finally, this study noted how a focus on spirituality was a coping mechanism. This deserves greater attention and could be explored in more depth as a vital contributor to perspective enhancement. Much secondary data was collected around the significance of spirituality. To do this data justice, perhaps it requires its own separate write up.

8.7 Implications for Future Research

Anthony, Rogers and Farkas (2003) argue that, while research in evidence-based practice must be informed by a vision of recovery, much implemented evidence based practice was implemented prior to the conception of the recovery vision. This can also be argued of TToPE. Anthony et al. (2003) argue that research is required that highlights consumer perspectives, more in-depth qualitative approaches, relational factors, characteristics of models rather than replicating models in their entirety, research that is relevant to cultural/contextual conditions and that embarks on studying operational values that their effects. TToPE certainly provides a framework under which many of the facets of this type of research could be undertaken.

Renouf and Bland (2004) pinpoint the challenges of the social work profession in embracing evidence-based practice. However, if evidence-based practice is broadened in accordance with the above approach outlined, there is immense potential for social workers to undertake qualitative research that connects consumer and carer needs to a broader service delivery and policy level. Given that perspective enhancement is contingent on relationships, and relationships are fundamental to social work practice, the scope for research in this area would seem of central value to the social work profession.

There is potential for social workers to undertake more research in the area of emotional geography in terms of understanding the connections between emotions and space for individuals in their social and built environment. This would enable a greater understanding of how human beings construct their identities, and in so doing, enable service providers in various fields to practice in a way that is perspective-enhancing for clients. Fleuret and Atkinson (2007) argue for further research into the idea of ‘spaces of wellbeing’

(p.115) and for this to form a part of a conceptual tool for policy makers. This is certainly an area which social work could further research and operationalise.

This research has required linkages across disciplines, yet collaboration and networking are fundamental to the social work profession. Such research needs to continue. Landscapes of health care need to be a part of our language, with the expectation that optimal healing environments can be created through reflective leadership and the constructive facilitation of consumers, carers, researchers, policy makers and human service workers.

To date, research in community mental health has been done primarily with those individuals with severe mental illness, such as schizophrenia and depression Wiley-Exley (2006). Perspective enhancement views mental health from a more holistic perspective in the community. As such, the theory suggests that more research should be done to affirm the impact on people of perspective-enhancing relationships, environments and intervention strategies. Given that mental health and well-being are part of everyday life, a crucial part of de-stigmatising mental health is to undertake research to improve health generally, rather than just through traditional clinical interventions in the context of community health treatment models.

While the focus of the notion of recovery has focused on mental health specific services in its implementation, TToPE may have the capacity to be extended beyond the mental health sector, thus giving many service types a framework through which to understand and practice mental health and well-being in all aspects of their life. This in itself is an important way in which the stigma associated with mental health may be dismantled.

Given that perspective enhancement recognises the importance of meaning in the lives of people, the leadership and organisational practices that are part of spiritual intelligence (Zohar & Marshall 2000), are also compatible with TToPE. A further opportunity presents itself to undertake research on the connection between spiritual intelligence and TToPE, and what this means for the way services are delivered.

A further challenge would be to consider how perspective enhancement applies across different cultures, differences between rural and urban areas and different contexts.

For example, it would appear that people who live in unsatisfactory environments rely more on relationships with others. How does this apply to the mental health and well-being of the regular city office worker? Do they also have an enhanced perspective if they have supportive relationships around them? Do people who live in perspective enhancing environments rely less on relationships with others for their own mental health and well-being? Is the mental health of people better when they seek out intervention strategies in their lives that have been individually tailored to them rather than a part of the status quo? Are the people that seek out these interventions already at a stage in which they are already attuned to the importance of their own health and well-being and intrinsic self worth as opposed to people who do not?

These are the nature of just some of the questions that TToPE presents in furthering its application to the lives and the mental health and well-being of ordinary people.

In terms of the key contribution to mental health service delivery, TToPE captures key concepts and practices that have traditionally been a part of the hospitality and natural

therapies settings. These have been incorporated into a framework for practice that shifts the traditional mental health focus to further facilitate recovery, while fostering personal growth and a holistic approach to mental health and well-being. It recognises the benefits of interventions and environments that have not traditionally been a part of mental health practice and poses recommendations for the way management and staff operate to respectfully enhance service delivery. While these recommendations may be challenging because the concepts within TToPE are interpretive and difficult to objectively measure, it invites mental health practitioners to creatively and innovatively embrace the concept of therapeutic landscapes in working with mental health consumers.

SUMMARY

In summary, TToPE, The Theory of Perspective Enhancement, affirms much of the recent literature on healing health-care environments, the values underpinning recovery and the importance of human relationships.

The potential for TToPE to be applied to community development practice and service development in the way people are received, assessed and managed may be significant. Fundamental to any such change, however, involves addressing the beliefs, values and motivations of human service leaders and staff in the way they engage with people and appreciate the importance of the environment as well as individualised, replenishing intervention strategies. While these conditions have a role to play in how people are valued, it the notion of relationship and how meaning is generated through it that most contributes to mental health and well-being. Given that social work has a core interest in relationship and mental health and well-being, social work must then play a vital role in integrating this theoretical understanding into practice.

The inspiration for this thesis emanated from a social work practitioner who wished to make a contribution to the field. The question was asked: *How can mental health service delivery be shifted beyond the medical paradigm?* Through utilising a Grounded Theory methodology, TToPE was generated as a response to this question.

TToPE has not been constructed within the domain of traditional mental health care. The theory has been articulated through the common language of various groups all of whom have a desire to promote and enhance mental health and well-being. It can be argued then, that TToPE draws insights from beyond the views of the traditional mental health sector and speaks of the lived experience and wisdom of human beings in general. Thus, TToPE may have the potential to extend the current recovery paradigm discourse outside of the health care sector and position mental health and well-being as a core component of our everyday lives. It is one medium through which, if a shared understanding were to be generated in a range of contexts, the social injustices associated with the stigma of mental illness could be tackled. Instigating social change is pivotal to social work. TToPE offers the profession one medium for the future, through which this could occur.

REFERENCES

Allan, G. (2003). A critique of using Grounded Theory as a research method. *Electronic Journal of Business Research Methods, 2* (1), 1-10. Retrieved September 11, 2007, from http://www.ejbrm.com.

Allott, P. & Loganathan, L. (2002). *Discovering hope for recovery from a British Perspective – A review of a sample of recovery literature, implications for practice and systems change.* West Midlands Partnerships for Mental Health, Birmingham. Retrieved October 23, 2007, from www.wmpmh.org.au

Andes, M., & Shattell, M. M. (2006). An exploration of the meanings of space and place in acute psychiatric care. *Issues in Mental Health Nursing, 27* (6), 699-707.

Andrews, G. (2002). Towards a more place sensitive nursing research: an invitation to medical and health geography. *Nursing Inquiry 9* (4), 221- 238.

Anthony, W. (1993). Recovery from mental illness: The guiding vision of the mental health service system in the 1990's. *Psychosocial Rehabilitation Journal. 16* (4), 11-23.

Anthony, W., Cohen, M., Farkas, M., & Gagne, C. (2002). *Psychiatric Rehabilitation* (2nd ed.), Boston: Centre for Psychiatric Rehabilitation.

Anthony, W., Rogers, S.E., & Farkas, M. (2003). Research on evidence-based practices: future directions in an era of recovery. *Community Mental Health Journal, 39* (2), 101-114

ARAFMI Queensland Inc. (2007, November). Highlights from 2006-2007. *Arafmi news 106*, p.7.

Atilgan, E., Akinci, S., & Aksoy, S. (2003). Mapping service quality in the tourism industry. *Managing Service Quality, 13* (5), 412-422.

Australian Association of Social Workers. (2002). *AASW Code of Ethics 1999*, (2nd ed.), Kingston, ACT: Australian Association of Social Workers.

Australian Association of Social Workers. (2004). *The Development of Competency Standards for Mental Health Social Workers, Final Report.* Kingston, ACT: Australian Association of Social Workers.

Australian Health Ministers. (1991). *Mental Health Statement of Rights and Responsibilities.* Canberra: Australian Government Publishing Service.

Australian Health Ministers. (1992). *National Mental Health Plan.* Canberra: Australian Government Publishing Service.

Australian Health Ministers. (1998). *National Mental Health Plan.* Canberra: Australian Government Publishing Service.

Australian Health Ministers. (2003). *National Mental Health Plan.* Canberra: Australian Government Publishing Service.

Australian Health Ministers Advisory Council. (1996). *National Standards for Mental Health Services.* Canberra: Australian Government Publishing Service.

Australian Health Ministers Advisory Council. (2002). *National Practice Standards for the Mental Health Workforce.* Canberra: Australian Government Publishing Service.

Australian Institute for Suicide Research and Prevention. (2007). Retrieved September 24, 2007, from www.griffith.edu.au/school/psy/aisrap/content_overview.html

Barber, J.P, Connolly, M., Crits-Christoph, P., Gladis, L., & Siqueland, L. (2000). Alliance predicts patients' outcome beyond in-treatment change in symptoms. *Journal of Consulting and Clinical Psychology, 68* (6), 1027 -1032.

Barry, C.A., Stevenson, F.A., Britten, N., Barber, N., & Bradley, C.P. (2001). Giving voice to the lifeworld. More humane, more effective medical care? A qualitative study of doctor-patient communication in general practice. *Social Science and Medicine, 53* (4), 487-505.

Barsky, J. & Nash, L. (2002). Evoking emotion: affective keys to hotel loyalty: the emotions a guest feels during a hotel stay are critical components of satisfaction and loyalty. *Cornell Hotel and Restaurant Administration Quarterly, 43* (1), 39-46.

Beal, G., Veldhorst, G., McGrath, J., Guruge, S., Grewal, P., DiNunzio, R., & Trimnell, J. (2005). Constituting Community: Creating a place for oneself. *Psychiatry 68* (3), 199-211.

Bennett, M. (2001). *Empathetic healer – an endangered species?* San Diego, California: Academic Press.

Bernier, E. (1998). How to establish a therapeutic relationship. *Emergency 30* (2), 15.

Bitner, M. J. (1992). Servicescapes: The impact of physical surroundings on customers and employees. *The Journal of Marketing, 56* (2), 57 -*72.*

Blackman, T. & Harvey, J. (2001). Housing renewal and mental health: A case study. *Journal of Mental Health, 10* (5), 571-583.

Bland, R. (2001). Social assessment. In G. Meadows & B. Singh (Eds.), *Mental health in Australia* (pp. 255-265). Melbourne, Victoria: Oxford University Press.

Bland, R. (2008). Encouraging principles of consumer participation and partnership: the way forward in mental health practice in Australia. In S Taylor, M Foster, & J Fleming (Eds.), *Health Care Practice in Australia: Policy, context and innovations* (pp. 239-254). South Melbourne, Victoria: Oxford.

Bland, R. & Darlington, Y. (2002). *Perspectives in Psychiatric Care, 38* (2), 61-68.

Blashki, L. (1998). In I. Gawler (Eds.), *Healing spirit mind and body.* Yarra Junction, Victoria: Channel Press Pty Ltd.

Bohart, A. (2000). The client is the most important common factor: Client's self-healing capacities and psychotherapy. *Journal of Psychotherapy Integration, 10* (2), 127-149.

Bondi, L. & Fewell, J. (2003). 'Unlocking the cage door': The spatiality of counselling. *Social and Cultural Geography, 4* (4), 527-547.

Borthwick, A., Holman, C., Kennard, D., McFetridge, M., Messruther, K., & Wilkes, J. (2001). The relevance of moral treatment to contemporary mental health care. *Journal of Mental Health, 10* (4), 427-439.

Bowen, G. (2006). Grounded Theory and sensitizing concepts. *International Journal of Qualitative Methods, 5* (3), Article 2. Retrieved 7 August, 2007 from http://www.ualberta.a/~ijqm/backissues/5_3/pdf/bowen.pdf

Bright, M.A. (2002a). Health, healing and holistic nursing. In M.A. Bright *Holistic healing and health.* (*pp*. 31-46), Philadelphia, PA: Davis Company.

Bright, M.A. (2002b). Paradigm shifts. In M.A. Bright *Holistic healing and health. (*pp. 3-30), Philadelphia, PA: Davis Company

Brinkley Bowler, J. (1991). Transformation into a healing healthcare environment: recovering the possibilities of psychiatric/mental health nursing. *Perspectives in Psychiatric Care, 27* (2), 21-25.

Brooks, J.J., Wallace, G.N., & Williams, D.R. (2006). Place as relationship partner: an alternative metaphor for understanding the quality of visitor experience in a backcountry setting. *Leisure Sciences, 28* (4), 331 -349.

Brown, L. & Ross Barnett. J. (2004). Is the corporate transformation of hospitals encouraging a new hybrid health care space? A case study of the impact of co-location of public and private hospitals in Australia. *Social Science and Medicine, 58* (2), 427-444.

Burrell, G. & Morgan, G. (1979). *Sociological paradigms and organisational analysis; Elements of the sociology of corporate life.* London: Heinemann.

Canter, S. & Canter, D. (1979). Building for therapy. In Canter, S., and Canter D. (Eds.), *Designing for therapeutic environments,* New York: Wiley.

Carpenter, J. (2002). Mental health recovery paradigm: implications for social work. *Health & Social Work, 27* (2), 86-94.

Chesters, J., Fletcher, M., & Jones, R. (2005). Mental illness, recovery and place. *Australian e-Journal for the Advancement of Mental Health. 4* (2), 1-9.

Chez, R.A. & Jonas, W.B. (2005). Developing healing relationships: Forward from the organisers. *Journal of Alternative and Complementary Medicine.* 11(Suppl.), 1-2.

Christou, E. (2005). Revisiting competencies for hospitality management: Contemporary views of the stakeholders. *Journal of Hospitality and Tourism Education, 14,* (1) 25-32.

Cleary, M. & Edwards, C. (1999). 'Something always comes up': Nurse-patient interaction in an acute psychiatric setting. *Journal of Psychiatric and Mental Health Nursing, 6* (6), 469-477.

Cleaver, M., Green, B.C., & Muller, T.E. (2000). Using consumer behaviour research to understand the baby boomer tourist. *Journal of Hospitality and Tourism Research, 24* (2), 274-248.

Council of Australian Governments (COAG), Mental Health (2006). Joint Release May 2006. Retrieved on 24 September, 2007 http://www.health.gov.au/internet/budget/publishing.nsf/content/budget2006-hmedia.htm

Council of Australian Governments (COAG). *National Mental Health Action Plan 2006-2011.* retrieved on 23 October, 2007 http://www.gov.au/internet/wcms/publishing.nsf/content/coag-mental-back.

Coates, G. & Seipl-Coates, S. (1992). The Healing Environment :Vidlarkliniken. *Health Care Forum Journal, 35* (5), 27-30.

Community Resource Unit (2004). *Recommendations for the consumer participation project,* Brisbane, Queensland: Community Resource Unit.

Connell, J. (2006). Medical tourism: The newest of niches. *Tourism Recreation Research, 31* (1), 99-102.

Connor, L.H. (2004). Relief, risk and renewal: mixed therapy regimens in an Australian suburb. *Social Science and Medicine, 59* (8), 1695-1705.

Conradson, D. (2003). Spaces of care in the city: The place of a community drop in centre. *Social and Cultural Geography, 4* (4), 507-525.

Conradson, D. (2005). Landscape, care and the relational self: Therapeutic encounters in rural England. *Health & Place, 11* (4), 337-348.

Copeland, M. (1999). *Winning against relapse: A workbook of action plans for recurring health and emotional problems.* Oakland, California: New Harbinger Publications.

Coppock, V. & Hopton, J. (2000). *Critical perspectives in mental health.* London: Routledge.

Cornish, C. (1997). Behind the crumbling walls; the re-working of a former asylum's geography. *Health and Place, 3* (2), 101-110.

Cox, H.M. & Holmes, C.A. (2000). Loss, healing and place. *Human Studies, 23* (1), 63-78.

Creswell, J.W. (2002). *Educational research: planning, conducting and evaluating quantitative and qualitative research.* New Jersey: Merrill Prentice Hall.

Crigger, B. (1999). Alternative and complementary medicine: Training doctors to treat the "invisible mainstream". *The Hastings Centre Report, 25* (9), 47-48.

Crigger, B. (2000). Alternative and complementary medicine: What's a doctor to do? *The Hastings Centre Report, 30* (1), 47-48.

Cusack, K., Freuch, C., Hiers, T., Suffoletta-Maierle, S., & Bennett, S. (2003). Trauma within the psychiatric setting: A preliminary empirical report. *Administration and Policy in Mental Health, 30* (5), 453-460.

Cutcliffe, J. & Barker, P. (2002). Considering the care of the suicidal client and the case for engagement and inspiring hope or observations. *Journal of Mental Health Nursing, 9* (6), 611-621.

Cutcliffe, J., Stevenson, C., Jackson, S., & Smith, P. (2006). A modified Grounded Theory study of how psychiatric nurses work with suicidal people. *International Journal of Nursing Studies, 43* (7), 791-802.

Davidson, J. & Milligan, C. (2004). Embodying emotion sensing space: Introducing emotional geographies. *Social and Cultural Geography, 5* (4), 523-532.

Day, R. (2007). Place and the experience of air quality. *Health and Place. 13* (1), 249-260.

Deane, F., Crowe, T.P., King, R., Kavanagh, D. J., & Oades, L.G. (2006). Challenges in implementing evidence-based practice into mental health services. *Australian Health Review,* Aug 2006, *30* (3), 305 -309.

Deegan, G. (2003). Discovering Recovery. *Psychiatric Rehabilitation Journal, 26* (4), 368-376.

Deegan, P. (1990). Spirit breaking: when the helping professions hurt. *The Humanistic Psychologist, 18* (3), 301-313.

Deegan, P. (1997a). Recovery as a journey from the heart. In L. Spaniol, C. Gagne, & M. Koehler (Eds.), *Psychological and social aspects of psychiatric disability* (pp. 74-83), Boston: Boston University Centre for Psychiatric Rehabilitation.

Deegan, P. (1997b). Recovery: The lived experience of rehabilitation. In L. Spaniol, C. Gagne, & M. Koehler (Eds.), *Psychological and social aspects of psychiatric disability* (pp. 92-98), Boston: Boston University Centre for Psychiatric Rehabilitation.

Deegan, P. (2005a). The importance of personal medicine: A qualitative study of resilience in people with psychiatric disabilities. *Scandinavian Journal of Public Health. 33* (Suppl.), 29-35.

Deegan, P. (2005b). *Workforce issues with recovery-based care transformation* Retrieved November 20, 2007, from http://www.namisc.org/Recovery/2005BasedCareTransformation.htm.

Denzin, N. (1978). *The research act: A theoretical introduction to sociological methods* (2nd ed.).New York: Mc Graw Hill.

Department of Health and Ageing Budget. Retrieved November 30, 2007, from http://www.health.org/internet/budget/publishing.nsf/Content/budget2006-glance.htm

de Raeve, L. (2002). The modification of emotional responses: A problem for trust in nurse-patient relationships. *Nursing Ethics. 9* (5), 465-471.

Devereux, C. & Carnegie, E. (2006). Pilgrimage: the journey beyond self. *Tourism Recreation Research, 31* (1), 47-56.

Disability Services Queensland. (2000). *Strategic Plan for Psychiatric Disability Services and Support.* Brisbane: Queensland Government.

De Rios, M.D. (2002). What we can learn from shamanic healing: Brief psychotherapy with Latino immigrant clients. *American Journal of Public Health, 92* (10), 1576-1579.

Doel, M. & Sergott, J. (2003). Self, health, and gender: Complementary and alternate medicine in the British mass media. *Gender, Place and Culture, 10* (2), 131-144.

Dominelli, L. (2002). Anti-oppressive practice in context. In R. Adams, L. Dominelli, & M. Payne (Eds.) S*ocial work: Themes, issues and critical debates* (pp. 3-19). New York, NY: Palgrave.

Edginton, B. (1997). Moral architecture: The influence of the York Retreat on asylum design. *Health and Place, 3* (2), 91-99.

Ellen, E. F. (2003). Psychiatry's hottest niche markets. *Psychiatric Times, 20* (4), 1-4.

Evans, G. (2003). The built environment and mental health. *Journal of Urban Health: Bulletin of the New York Academy of Medicine, 80* (4), 536-555.

Evans, G., Wells, N., & Moch, A. (2003). Housing and mental health: A review of the evidence and a methodological and conceptual critique. *Journal of social Issues, 59* (3), 475-500.

Everitt, A. (2002). Research and development in social work. In Adams, L Dominelli, & M Payne (Ed.) S*ocial work: Themes, issues and critical debates* (pp. 109-120). New York, NY: Palgrave.

Faberhaugh, S. Y. (1995). Analysing data for basic social processes. In B.G. Glaser (Eds.), *Grounded Theory 1984-1994.* (pp. 173-187). California: Sociology Press.

Farber, M.E. & Hall, T.E. (2007). Emotion and Environment: Visitor's Extraordinary experiences along the Dalton highway in Alaska. *Journal of Leisure Research, 39* (2), 248-270.

Fallon, P. & Schofield, P. (2004). First-timer repeat visitor satisfaction: The case of Orlando Florida. *Tourism Analysis, 8* (2), 205-210.

Fellows, J. & R. (1990). *Buildings for hospitality: Principles of care and design for accommodation managers.* London: Pitman Publishing.

Ferguson, I., Petrie, M., & Stalker, K. (2007).With them all the way. *Mental Health Today,* February, 28-31.

Fieldhouse, J. (2003). The impact of allotment group on mental health client's health, well-being and social networking. *British Journal of Occupational Therapy 66 (*97), 286-296.

Fielding, N.G. & Fielding, J.L. (1986). *Linking data: The articulation of qualitative and quantitative research methods in social research.* Beverley Hills, California: Sage Publications.

Findlay, B. & Verhoef, M. (2004). Operationalizing the concept of the optimal healing environment in clinical settings: the importance of "readiness". *The Journal of Alternative and Complementary Medicine, 10* (Suppl.), 121-126.

Finnicum, P. & Zeiger, J.B. (1996). Tourism and wellness: a natural alliance in a natural state. *P & R,* September, 85-90.

Firth, S. (1999). Counselling model: creating a healing environment in hospitals. *Patient Education and Counselling, 36* (1), 81-89.

Fleuret, S. & Atkinson, A. (2007). Wellbeing, health and geography: a critical review and research agenda. *New Zealand Geographer, 63* (2), 106-118.

Fone, D. & Dunstan, F. (2006). A multilevel analysis of economic inactivity and social deprivation. *Health and Place, 12* (3), 332-344.

Fook, J. (1996). *The Reflective Researcher*. St Leonard's, NSW: Allen and Unwin.

Fook, J., Ryan, M., & Hawkins, L. (1997). Towards a theory of social work expertise. *British journal of Social Work, 27* (3), 399-417.

Fook, J., Ryan, M. & Hawkins, L. (2000). *Professional expertise: Practice. theory. and education for working in uncertainty* (pp. 198-236). London: Whiting & Birch

Fook, J. (2004). What professionals need from research: beyond evidence based practice. In D. Smith (Ed.), *Social work and evidence-based practice* (pp. 29-46). London: Jessica Kingsley.

Frankel, R.M., Sung, S.H., & Hsu, J.T. (2005). Patients, Doctors and videotape: a prescription for creating optimal healing environments? *The Journal of Alternative and Complementary Medicine, 11* (Suppl.), 31-39.

Frese, F.J. III. (2000). Psychology practitioners and schizophrenia: A view from both sides. JCLP/I*n Session: Psychotherapy in Practice, 56* (11), 1413-1428.

Frkovic, I. (2007, October 19). *Queensland Mental Health Service delivery system and social work.* Conference presentation for the Australian Social Workers Association conference, Yeppoon, Queensland.

Frey, A. & Dupper, D. (2005). A broader conceptual approach to clinical practice for the 21st century. *Children & Schools, 27* (1), 33-44.

Frost, G.J. (2004). The spa as a model of an optimum healing environment. *The Journal of Alternative and Complementary Medicine, 10* (Suppl.), 85-92.

Fullilove, M.T. (1996). Psychiatric implications of displacement: contributions from the psychology of place. *American Journal of Psychiatry 153* (12), 1516-1523.

Gargiulo, G. (1999). Language, love and healing: a psychotherapist's perspective. *Journal of Religion and Health, 38* (4), 341 – 345.

Gass, J. (2006). Electroconvulsive therapy and the work of mental health nurses: A Grounded Theory study. *International Journal of Nursing Studies,* Article in Press, doi:10.1016/jj.ijnurstu.2006.08.011.

Gawler, I. (1998). *Healing spirit mind and body* . Yarra, Victoria: The Gawler Foundation.

Geary, H. (2003). Facilitating an organisational culture of healing in an urban medical centre. *Nursing Administration Quarterly, 27* (3), 231-239.

Gerlach-Spriggs, N., Kaufman, R. & Warner, S. (1984). *Restorative gardens: the healing landscape.* London: Yale University Press.

Gesler, W. (1991). *The cultural geography of health care*. Pittsburgh, PA: Pittsburgh University Press.

Gesler, W. (1992). Therapeutic landscapes in light of new cultural geography. *Social Science and Medicine, 34* (7), 735-746.

Gesler, W. (1996). Lourdes: healing in a place of pilgrimage. *Health and Place, 2* (2), 95-105.

Gesler, W. (1998). Bath's reputation as healing place. In R.A. Kearns & W.M. Gesler *Putting Health into Place (pp. 17-35*). New York: Syracuse University Press.

Gesler, W. (1999). Words in wards: language, health and place. *Health and Place, 5* (1), 13-25.

Gesler, W. (2005). Therapeutic landscapes: an evolving theme. *Health and Place, 11 (*4), 295-297.

Gesler, W., Bell, M., Curtis. S., Hubbard, P., & Francis. S. (2004). Therapy by design – evaluating the UK hospital building program. *Health and Place, 10* (2), 117-128.

Gesler, W. & Gordon, R. (1998). Alternative therapies-why now? In R. J. Gordon., B. Neinstedt, B. & W. Gesler (Eds.), *Alternative therapies – expanding options in health care* (pp. 3-12). NY: Springer.

Gesler, W. & Kearns, R. (1998). *Putting health into place: Landscape, identity and well-being.* Syracuse, NY: Syracuse University Press.

Gesler, W. & Kearns, R. (2002). *Culture/place/health.* New York: Routledge.

Gibb, H. (2003). Rural community mental health nursing: a Grounded Theory account of sole practice. *International Journal of Mental Health Nursing, 12* (4), 243-250.

Gilbert, D. & Abdullah, J. (2002). A study of the impact of the expectation of a holiday on an individual's sense of well-being. *Journal of Vacation Marketing, 8* (4) 352-361.

Gimbel, B. (2004). Jerry Levin's high profile retreat. *Fortune, 150 (*8), 54.

Glader, P. (2002, November 4). Haute Mental treatment – Psychiatric hospitals open deluxe facilities for the rich, gourmet chefs and concierges. *Wall Street Journal, p. B1.*

Glasby, J. & Lester, H. (2005). On the inside: A narrative review of mental health inpatient services, *British Journal of Social Work, 35* (6), 863 -879.

Glaser, B. (1978). *Theoretical sensitivity: Advances in the methodology of grounded theory.* Mill Valley, California: Sociology Press.

Glaser, B. (1992). *Emergence vs. forcing: Basics of Grounded Theory analysis.* Mill Valley, California: Sociology Press.

Glaser, B. (1993). *Examples of grounded theory.* Mill Valley, California: Sociology Press.

Glaser, B. (1994). *More grounded theory methodology: A Reader.* Mill Valley, California: Sociology Press.

Glaser, B. (1998). *Doing grounded theory: Issues and discussions*. Mill Valley, California: Sociology Press.

Glaser, B. (2002a). Conceptualisation: on theory and theorizing using Grounded Theory, *International Journal of Qualitative Methods, 1* (2). Article 3. Retrieved 14 August, 2007 from http://www.ualberta.ca/~ijqm/

Glaser, B. (2002b). Constructivist Grounded Theory? *Forum: Qualitative Research, 3* (3) retrieved 13 November 2007 from www.qualitative –research.net/fqs-texte/3-02/3-02glaser.pdf.

Glaser, B. & Strauss, A. (1967). *The discovery of grounded theory.* New York*:* Aldine De Gruyter.

Glass, C. & Arnkoff, D. (2000). Consumers' perspectives on helpful and hindering factors in mental health treatment. *JCLP/In Session: Psychotherapy in Practice, 56 (*11*),* 1467-1480.

Glover, H. (2005). Recovery based service delivery: are we ready to transform the words in to a paradigm shift? *Australian e-Journal for the Advancement of Mental Health. 4* (3) retrieved 11 September 2007 from ausienet.com/journal/vol41553/glover.editorial.pdf.

Goffman, E. (1991). *Asylums: essays on the social situation of mental patients and other inmates.* London, England: Penguin Books. (Original work published in 1961)

Gould, N. (2004). Qualitative research and social work: the methodological repertoire in a practice orientated discipline. In R Lovelock, K Lyons & J Powell (Eds.), *Reflecting on social work – discipline and profession* (pp. 130-144). Hants, UK: Ashgate.

Gould, N. (2006). An inclusive approach to knowledge for mental health social work practice and policy. *British Journal of Social Work, 36* (1), 109 -125.

Goulding, C. (2000). The Commodification of the past, postmodern pastiche, and the search for authentic experiences at contemporary heritage attractions. *European Journal of Marketing, 34* (7), 835-853.

Gordon, R., Neinstedt, B., & Gesler, W. (1998). *Alternative Therapies – Expanding Options in Health Care.* New York*:* Springer Publishing.

Gordon, R. Alternative therapies: quo vadis? (1998). In R.J. Gordon, B. Neinstedt, & W. Gesler. (Eds.) *Alternative therapies – expanding options in health care* (pp. 219-233). New York, N.Y: Springer Publishing.

Graham, H. (1999). *Complementary therapies in context – the psychology of healing.* United Kingdom: Jessica Kinsley.

Griffiths, V. (1999). Eastern and western paradigms: The holistic nature of traditional Chinese medicine. *The Australian Journal of Holistic Nursing, 6* (2), 35-38.

Gross, R., Sasson, Y., Zarhy, M., & Zohar, J. (1998). Healing environment in psychiatric hospital design. *General Hospital Psychiatry, 20* (2), 108 -114.

Gutowski, S., Ginath, Y., & Guttman, F. (1992). Improving architecture through minimal architectural change. *Hospital and Community Psychiatry, 43* (9), 920-923.

Hall, M. (2007). Response to Yoeman et al. The fakery of 'The authentic tourist'. *Tourism Management. 28* (4), 1139-1140.

Hallab, Z. (2006). Catering to the healthy-living vacationer. *Journal of Vacation Marketing, 12* (1), 71-91.

Hancock, T. (1999). Creating health and health promoting hospitals: A worthy challenge for the twenty-first century. *International Journal of Health Care Quality Assurance Incorporating Leadership in Health Services, 12* (2), viii-xix.

Hartig, T., Evans, G.W., Jamner, L.D, Davies, D.S., & Garling, T. (2003). Tracking restoration in natural and urban field settings. *Journal of Environmental Psychology, 23* (2), 109-123.

Hartig, T., Johansson, G., & Kylin, C. (2003). Residence in the social ecology of stress and restoration. *Journal of Social Issues, 59* (3) 611-637.

Hartig, T. & Lawrence, R. J. (2003). Introduction: The residential context of health. *Journal of Social Issues, 59* (3), 455-474.

Hartline, M., Ross Wooldridge, B., & Jones, K. C. (2003). Guest perceptions of hotel quality: determining which employee groups count most. *Cornell Hotel and Restaurant Administration Quarterly, 44* (1) 43-52.

Healy, K. (2005). *Social work theories in context: Creating frameworks for practice.* New York*:* Palgrave Macmillan.

Heath, H. & Cowley, S. (2004). Developing a Grounded Theory approach: a comparison of Glaser and Strauss. *International Journal of Nursing Studies, 41* (2), 141-150.

Helman, C. (2000). *Culture, health and illness.* Oxford*:* Butterworth Heinemann.

Hem, M. & Heggen, K. (2003). Being professional and being human: one nurse's relationship with a psychiatric patient. *Journal of Advanced Nursing, 43* (1), 101-108

Henderson, S. (2002). Factors impacting on nurses' transference of theoretical knowledge of holistic care into clinical practice. *Nurse Education in Practice, 2* (4) 244-250.

Hepple, J., Kipps, M., & Thomson, J. (1990). The concept of hospitality and an evaluation of its applicability to the experience of hospital patients. *International Journal of Hospitality Management, 9* (4), 305-318.

Hitti, M. (1991). Healing Gardens: horticultural therapy can make you healthier and happier. Retrieved March 13, 2003, from http://www.homestore.com/homegarden/garnening.features/gardens/healing.asp

Hobert, I. (1999). *Guide to Holistic Healing in the New Millennium.* Florida: Leo Publishing.

Hochschild, A. (1983). *The Managed Heart: the Commercialisation of Human Feelings.* Berkeley: University of California Press.

Hovarth, A. (2000). The therapeutic relationship: from transference to alliance. *JCLP/In Session: Psychotherapy in Practice, 58* (2), 163-173.

Horwood, J. (1998). My journey into holistic practice. In I. Gawler (Ed.), *Healing spirit, mind and body* (pp. 153-170). Yarra, Australia: Chanel Press Pty Ltd.

Howego, I., Yellowlees, P., Owen, C., Meldrum, L., & Dark, F. (2003). The therapeutic alliance: the key to effective patient outcome? A descriptive review of the evidence in community mental health case management. *Australian and New Zealand Journal of Psychiatry, 37* (2), 169-183.

Horvath, A.O. (2000). The therapeutic relationship: from transference to alliance. *JCLP/ In Session: Psychotherapy in Practice, 56* (2), 163-173.

Huelat, B. (1998). 10 Myths of Healing Environments. Retrieved 3 March, 2003, from htto://www.healingdesign.com/10_myths_of.htm

Human Rights and Equal Opportunity Commission (1993). *Human Rights and Mental Illness: report of the national inquiry into the human rights of people with mental illness.* Canberra, Australian Government Publishing Service.

Hutchinson, S. (1995). People with bipolar disorders quest for equanimity: doing Grounded Theory. In B. Glaser (Ed.) *Grounded Theory 1984-1994* (pp. 317 -335) California: Sociology Press.

Hutton, J. & Richardson, L. (1995). Healthscapes: the role of the facility and physical environment on consumer attitudes, satisfaction, quality assessments and behaviour. *Health Care Manager Review, 20 (*2), 48-61.

Ion, R.M. & Beer, D. M. (2003). Valuing the past: the importance of an understanding of the history of psychiatry for healthcare professionals, service users and carers. *International Journal of Mental Health Nursing, 12* (4), 237-246.

Jackson, L. (2003). The relationship of urban design to human health and condition. *Landscape and Urban Planning, 64* (4), 191-200.

Jackson, S. & Stevenson, C. (2000). What do people need psychiatric and mental health nurses for? *Journal of Advanced Nursing, 31* (2), 378-388.

Jacobson, N. (2004). *In recovery: The making of mental health policy*. Nashville, Tennessee: Vanderbilt University Press.

Jacobson, N. & Greenley, D. (2001). What is recovery? A conceptual model and explication. *Psychiatric Services, 52* (4), 482-485.

Jenna, J. (1986). Toward a patient-driven hospital. *Healthcare Forum. 29* (4), 52-60.

Johansson, I. & Lundman. (2002). Patients' experiences of involuntary psychiatric care: good opportunities and great losses. *Journal of Psychiatric Mental Health Nursing, 9* (5), 639-647.

Jonas, B. & Chez, R. (2004). Towards optimal healing environments in health care, *Journal of Alternative and Complementary Medicine, 10* (Suppl.), 1-6.

Jonas, W.B. & Crawford, C.C. (2004). The healing presence: Can it be reliably measured? *Journal of Alternative and Complementary Medicine, 10* (5), 751-756.

Jones, K. & Moon, G. (1987). *Health, disease and society: A critical medical geography.* London: Routledge & Kegan Paul Inc.

Jordan, M. (2006). Hawaiian healing: Recover from life's stresses by escaping to the big island. *American Fitness, 24* (3), 52-54.

Johnstone, S. (2000). Guided imagery: A strategy for improving relationships and human interaction, *The Australian Journal of Holistic Nursing, 7* (1), 36-40.

Joseph, A.E. & Moon, G. (2002). From retreat to health centre: Legislation, commercial opportunity for the repositioning of a Victorian private asylum. *Social Science and Medicine, 55* (1), 2193-2200.

Kadushin, A. (1972). *The Social Work Interview,* New York: Columbia University Press.

Kaiser, L.R. (1992). The hospital as a healing place. *Healthcare Forum Journal, 35* (5), 9-40.

Kaplan, S. (1987). Aesthetics affect and cognition: environmental preference from an evolutionary perspective. *Environment and Behaviour, 19* (1), -32.

Kaplan, S. (1995). The restorative benefits of nature. *Journal of Environmental Psychology, 15* (3), 169-182.

Kaplan, S. & Kaplan, R. (1989). *The experience of nature: A psychological perspective,* New York: Cambridge University Press.

Kaufman, S. (2003). Hidden places, uncommon persons. *Social Science and Medicine, 56* (11), 2249-2261.

Kavanagh, K. (2002). Good fences don't necessarily make for good therapists. *Annals of the American Psychotherapy Association, 5* (1), 34-37.

Kearney, J. (2004). 'Knowing how to go on': Towards situated practice and emergent theory in social work. In R. Lovelock., K. Lyons., & J. Powell (Eds.) *Reflecting on social work – discipline and profession* (163-180*).*Hants, England: Ashgate.

Kearns, R.A. (1997). Narrative and metaphor in health geographies. *Progressing Human Geography, 21* (2), 269-277.

Kearns, R.A. & Ross Barnett, J. (1997). Consumerist ideology and the symbolic landscapes of private medicine. *Health & Place, 3* (3), 171-180.

Kearns, R.A., Ross Barnett, J., & Newman, D. (2003). Placing private health care: Reading Ascot hospital in the landscape of contemporary Auckland. *Social Science and Medicine, 56* (11) 2303-2315.

Kearns, R. & Gesler, W. (1998). *Putting health into place: Landscape, identity and well-being.* Syracuse, New York: Syracuse University Press.

Kearns, R.A. & Joseph, A. E. (2000). Contracting opportunities: Interpreting post-asylum geographies of mental health care in Auckland. New Zealand. *Health and Place, 6* (3), 159-170.

Kearns, R. & Moon, G. (2002). From medical to health geography: Novelty, place and theory after a decade of change. *Progress in Human Geography, 26* (5), 605-625.

Keiser, J.D. (2000). Non-profit management in the hospitality and tourism industries. *Journal of Hospitality and Tourism Education, 12* (3), 16-20.

Kennett, J. (2006). It's time for action: Do something to help, *Australian Health Review. 2* (30), p.135 -136.

Kessler, R.C., Soukup, J., Davis, R.B., & Foster, D.F. (2001). The use of complementary and alternative therapies to treat anxiety and depression in the United States, *American Journal of Psychiatry, 158* (2), 289-294.

Kilian, R., Lendenbach, I., Lobig, U., Uhle, M., Petscheleit, A., & Angermeyer, M.(2003). Indicators of empowerment and disempowerment in the subjective evaluation of the psychiatric process by persons with severe and persistent mental illness: a qualitative and quantitative analysis. *Social Science and Medicine, 57* (6), 1127-1142.

Kim, H. & Jamal, T. (2007). Touristic quest for existential authenticity. *Annals of Tourism Research, 34* (1), 181-201.

Kirmayer, L.J. (1993). Healing and the intervention of metaphor: The effectiveness of symbols revisited. *Culture, Medicine and Psychiatry, 17* (2), 161-195.

Klein, D.N., Schwartz, J.E., Santiago, N.J., Vivian, D., Vosciano, C., & Castonguay, L. et al. (2003). Therapeutic alliance in depression: Controlling for prior change and patient circumstances. *Journal of Consulting and Clinical Psychology, 71* (6), 997-1006.

Knowles, C. (2000). Burger king, dunkin donuts and community mental health care. *Health & Place,* 6 *(1),* 213-224.

Lacasse, J. & Gomory, T. (2003). Is graduate social work education promoting a critical approach to mental health practice? *Social Work Education, 39* (30), 383-408.

Lafferty, W.E. (2004). Healing, medical care and health service organisations, *The Journal of Alternative and Complementary Medicine. 10* (Suppl.), 141-146.

Larson, E. & Yao, X. (2005). Clinical empathy as emotional labour in the patient-physician relationship. *JAMA, 293* (9), 1100-1106.

Laumann, K., Garling, T., & Stormark, K. (2002). Rating scale measures of restorative environments. *Journal of Environmental Psychology, 21*(1), 31-44.

La Torre, M. (2006). Creating a healing environment. *Perspectives in Psychiatric Care. 42* (4), 262 -264.

Lawrence, J. (2002). A century of psychiatry in Queensland. *Australian Psychiatry, 10* (2), 155-161.

Lawson, B. (2002). Healing architecture. *The Architectural Review, 211* (1261), 72-75.

Layne, K. & Hurdle, D. (2003). An empowerment-based approach to mental health services. *Health & Social Work, 28* (3), 206-213.

Lea, J. (2006). Experiencing festival bodies: Connecting massage and wellness. *Tourism Recreation Research, 31* (1), 57-66.

Lehman, A. (2000). Putting recovery into practice: A commentary on "what recovery means to us". *Community Mental Health Journal, 36 (*3), 329-331.

Lennard, H. & Gralnick, A. (1986). *The psychiatric hospital: Context, values and therapeutic process.* New York: Human Sciences Press, Inc.

Levin, D. (2007). CHD president highlights pebble project successes and plans for 2007.Retrieved March 25, 2007 from http://www.rwjf.org/portfolios/features/featuredetail.jsp?

Lilleleht, E. (2005). Paradox in practice? The rhetoric of psychiatric rehabilitation. *International Journal of Psychosocial Rehabilitation, 10* (1), 89-103.

Lin, I.Y. (2004). Evaluating a servicescape: the effect of cognition and emotion. *Hospitality Management, 23* (2), 63-178.

Lincoln, Y. & Guba, E. (1985). *Naturalistic inquiry.* Beverely Hills, California: Sage Publications.

Lockyer, T. (2003). Hotel cleanliness – how do guests view it? Let us get specific. A New Zealand study. *Hospitality Management, 22* (3*),* 297-305.

Lovelock, R., Lyons, K., & Powell, J. (2004). Reflecting on social work – discipline and profession. Hants, UK: Ashgate.

Luskin, F. (2004).Transforming practices for integrating mind – body – spirit. *The Journal of Alternative and Complementary Medicine, 10* (Suppl. 2), 15-23.

McCabe, R. & Priebe, S. (2003). Are therapeutic relationships in psychiatry explained by patients' symptoms? Factors influencing patient ratings. *European Psychiatry, 18* (5), 220-225.

McCabe, S. & Stokoe, E.H. (2004). Place and Identity in Tourists' Accounts. *Annals of Tourism Research, 31* (3), 601-622.

McCann, T.V. & Clark, E. (2003). A Grounded Theory of the role that nurses play in increasing clients' willingness to access community mental health services. *International Journal of Mental Health Nursing, 12* (4), 279 289.

McCormack, B., Funderburk, J., Lee, Y. & Hale-Fought, M. (2005). Activity characteristics and emotional experience predicting boredom and anxiety in the daily life of community mental health clients. *Journal of Leisure Research, 37* (2), 236 -253.

McCrea, M., Atkinson, M., Bloom, T., Merkh, K., Najera, I., & Smith, C. (2003). The healing energy of relationships: A journey to excellence. *Nursing Administration Quarterly, 27* (3), 240-248.

McCrae, N., Murray, J., Huxley, P., & Evans, S. (2005). The research potential of mental-health social workers: A qualitative study of the views of senior mental-health service managers. *British Journal of Social Work, 35* (1), 55-71.

McDonough-Means, S.I., Kreitzer, M.J., & Bell, I. R. (2004). Fostering a healing presence and investigating its mediators. *The Journal of Alternative and Complementary Medicine, 10* (1), S-25- S41.

McGrath, P. & Jarrett, V. (2004). A Slab over my head: Recovery insights from a consumer's perspective. *International Journal of Psychosocial Rehabilitation, 9* (1), 61-78.

McLoughlin, P. & Warin, M. (2008). Corrosive Places, inhuman spaces: Mental health in Australian immigration detention. *Health and Place, 14* (2), 254-264.

Maller, C., Townsend, M., Pryor, A., Brown, P., & St Leger, L. (2005). Healthy nature healthy people: 'contact with nature' as an upstream health promotion intervention for populations, *Health Promotion International, 27* (1), 45- 54.

Marcus, C.C. & Barnes, M. (1999*). Healing Gardens: Therapeutic benefits and design recommendations.* New York: Wiley.

Marsh, D. (2000). Personal accounts of consumers/survivors: Insights and implications. *JCLP/In Session: Psychotherapy in Practice, 56* (11), 1447-1457.

Masserli, H. & Oyama, Y. (2004). *Travel and Tourism Analyst,* August, 1-54.

Martin, D. Hunt, J., Hughes-Stone, M., & Conrad. (1990). The Planetree hospital project: an example of the patient as partner. *Health Services Administration, 35* (4), 591-601.

Mead, S. & Copeland, M. (2000). What recovery means to us. *Community Mental Health Journal, 36* (3), 315.

Meadows, G. & Singh, B. (2001). *Mental Health in Australia.* Melbourne, Victoria: Oxford University Press.

Mental Health Council of Australia, Brain and Mind Research Institute in association with the Human Rights and Equal opportunities Commission. (2005). *Not for service: Experiences of injustice and despair in mental health care in Australia.* Canberra, ACT: Mental Health Council of Australia.

Meehan, T., Stedman, T., & Robertson, S. (2007*). Resettlement from psychiatric hospital to community under Project 300': Outcomes for consumers at seven years post-discharge.* Wacol Qld: The Park Centre for Mental Health.

Meehan, T. (n.d). The outcomes of providing disability support to people with severe and persistent mental illness. *Occasional Paper Number 2 Consumer Participation Project,* Brisbane, Queensland: Consumer Participation Project.

Meehan, T. O'Rourke, P. & Drake, S. (2001). *Final Report Project 300 Evaluation December 2000.* Brisbane: Queensland Health

Merighi, J., Ryan, M., Renouf, N., & Healy, B. (2005). Reassessing a theory of professional expertise: A cross-national investigation of expert mental health social workers. *British Journal of Social Work, 35*, 709-725.

Middleton, P., Stanton, P., & Renouf. N. (2004). Consumer consultants in mental health services: Addressing the challenges. *Journal of Mental Health, 13* (5), 507-518.

Miles, M. B. & Huberman, A.M. (1994). *Qualitative data analysis.* Thousand Oaks, California: Sage Publications.

Miller, W. L. & Crabtree, B. F. (2005). Healing landscapes: Patients, relationships and creating optimal healing places. *The Journal of Alternative and Complementary Medicine, 11* (Suppl.), 41-49.

Milligan, C. (2000). 'Breaking out of the asylum': Developments in the geography of mental ill-health – the influence of the informal sector. *Health and Place, 6* (3), 189-200.

Milligan, C. (2005). From home to 'home' situating emotions within the caregiving experience. *Environment and Planning, 37,* 2105-2120.

Milligan, C. (2006). Caring for older people in the 21st century: 'Notes from a small island', *Health and Place, 12* (3), 320 -331.

Milligan, C. & Bingley, A. (2007). Restorative places or scary places? *Health and Place, 13* (4), 799-811.

Milligan, C. Gatrell, A., & Bingley, A. (2004). 'Cultivating health': therapeutic landscapes and older people in northern England. *Social Science & Medicine, 58* (9), 1781 -1793.

Mitchell, D. (2000). *Cultural geography: A critical introduction.* Oxford: Blackwell.

Moghaddam, A. (2006). Coding issues in Grounded Theory. *Issues in Educational Research, 16* (1), 52-66.

Moon, G. (2000). Risk and protection: The discourse of confinement in contemporary mental health policy. *Health and Place, 6* (3), 239-250.

Moon, G. Kearns, R., & Joseph, A. (2006). Selling the private asylum: Therapeutic landscapes and the (re)valorization of confinement in the era of community care. *Transactions of the Institute of British Geographers, 31* (2), 131-149.

Morita, E., Fukuda, S., Nagano, J., Hamajima, N., Yamamoto, H., Iwal, T., Nasashima, H. Ohira. H., & Shirakawa, T. (2007). Psychological effects of forest environments on healthy adults: Shinrin-yoko (forest air bathing, walking) as a possible method of stress reduction. *Public Health, 121* (1), 54-63.

Mueller, H. & Kaufman, E.L. (2000). Wellness tourism: Market analysis of a special health tourism segment and implications for the hotel industry. *Journal of Vacation Marketing, 7* (1), 5-17.

Myers, S. (2000). Empathetic listening: Reports on the experience of being heard. *The Journal of Humanistic Psychology, 40* (2), 148-173.

Nahrstedt, W. (2004). Wellness: A new perspective for leisure centres, health tourism, and spas in Europe on the global health market. In K. Weiermair & C. Mathies Ed.) *The Tourism and Leisure Industry: Shaping the Future* (pp. 181-198). New York: Haworth Hospitality Press.

Nelson, G. Lord, J., & Ochocka, J. (2001). Empowerment and mental health in Community: Narratives of psychiatric consumers/survivors. *Journal of Community and Applied Social Psychology, 11* (2), 125-142.

Nelson, R. (2006). Designing to heal. *American Journal of Nursing, 106* (11), 25-27.

Netting, F.E. & O'Connor, M.K. (2003). *Organization practice: A social worker's guide to understanding human services*, Boston*:* Allyn and Bacon.

Newhill, C. & Korr, W. (2004). Practice with people with severe mental illness: Rewards, challenges, burdens. *Health & Social Work, 29* (4), 297-305.

O'Brien, A.J. (2001). The therapeutic relationship: Historical development and contemporary significance. *Journal of Psychiatric and Mental Health Nursing, 8* (2), 129-141.

O'Callaghan, F.V. & Jordan, N. (2003). Postmodern values, attitudes and the use of complementary medicine. *Complementary Therapies in Medicine, 11* (1), 28-32.

Oguneseitan, O. (2005). Topophilia and the quality of life. *Environmental Health Perspectives, 113* (2), 143 – 148.

Orsingher, C. & Marzocchi, G. L. (2003). Hierarchical representation of satisfactory customer service experience. *International Journal of Service Industry Management, 14* (2), 200-2216.

O'Hagan. M. (2004). Recovery in New Zealand: lessons for Australia. *Australian e-Journal for the Advancement of Mental Health, 3* (1), 1-3.

Olesen, S., Eikard, B., Gad, P., & Hog, E. (1997). *Studies in alternative therapy – lifestyle and medical paradigms*, Denmark: Odense University Press.

Orsinher, C. & Marzocchi, G. (2003). Hierarchical representation of satisfactory consumer service experience. *International Journal of Service Industry Management, 14* (2), 200-216.

Pain, R. (2006). Social geography: seven deadly myths in policy research, *Progress in Human Geography, 30* (2), 250-259.

Palka, E. (2000). *Valued landscapes of the far north: A geographical journey through Delani National Park*. New York: Rowman and Littlefield.

Parr, H. & Philo, C. (2003). Rural mental health and social geographies of caring. *Social & Cultural Geography, 4* (4), 471-488.

Patton, M.Q. *Qualitative Evaluation and Research Methods.* Newbury Park, California: Sage Publications Inc.

Pearson, A. (2004). *Recovery: Challenging the paradigm,* paper presented at VICSERV Conference, Melbourne

Proctor, E. (2004). Research to inform mental health practice: Social work's contributions. *Social Work Research, 28* (4), 195-197.

Queensland Alliance. (2001). *Submission to the Senate Inquiry,* Brisbane: Queensland Alliance.

Queensland Health. (2003). *Draft Background Paper on Recovery: Alternatives to Acute Admission.* Brisbane: Queensland Government.

Queensland Health. (2005*). Sharing responsibility for recovery: Creating and sustaining recovery orientated systems of care for mental health.* Brisbane: Queensland Government.

Raffoul, P. R. (1996). Social work and the future: some final thoughts. In P. R. Raffoul & C.A. Mc Neece (Ed.), *Future Issues for Social Work Practice* (pp. 293-299). Boston: Allyn and Bacon.

Raholm, M., Lindholm, L., & Eriksson, K. (2002). Grasping the essence of the spiritual dimension reflected through the horizon of suffering: An interpretative research synthesis. *The Australian Journal of Holistic Nursing, 9* (1), 4-12.

Raingruber, B. (2003). Nurture: The fundamental significance of relationship as a paradigm in mental health nursing. *Perspectives in Psychiatric Care, 39* (3), 104-135.

Ralph, R. (2000). *Review of recovery literature*: Maine, USA: National Technical Assistance Centre for State Mental Health Planning and National Association for State Mental Health Program Directors.

Rapp, C. (1998). *The strengths model: case management with people suffering from severe and persistent mental illness.* New York: Oxford University Press.

Rapport F. & Doel, M.A. & Elwyn, G. (2007). Snapshots and snippets: General practitioners' reflections on professional space. *Health and Place, 13* (2), 532- 544.

Remen, S. (1991). Signs, symbols and the psychiatric environment. *The Psychiatric Hospital, 22* (3), 113-118.

Renouf, N. & Bland, R. (2005). Navigating stormy waters: Challenges and opportunities for social work in mental health. *Australian Social Work, 58* (4), 419-430.

Repper, J. (2000). Adjusting the focus of mental health nursing: Incorporating service user's experience of recovery. *Journal of Mental Health, 9* (6), 575-587.

Rickwood, D. (2004). Recovery in Australia: Slowly but surely, *Australian e-Journal for the Advancement of Mental Health, 3* (1), 1-3.

Riebschleger, J. (2005). Mental health professionals' contact with family members of people with psychiatric disabilities. *Families in Society, 86* (1), 9-16.

Riley, M. (2007). Role interpretation during service encounters: a critical review of modern approaches to service quality management. *Hospitality Management, 26* (2), 409 -420.

Roe, D. & Chopra, M. (2003). Beyond coping with mental illness: Toward personal growth. *American Journal of Orthopsychiatry, 73* (3), 334-344.

Rogers, C. (1951). *Client centred therapy.* Boston: Houghton Miffin.

Romano, M. (2003). Spacious quarters. *Modern Healthcare 33* (6), 30-31.

Ruga, W. (1992). Break through thinking in health care design. *Health Forum Journal 35* (5), 17-19.

Roszac, T. (1996). The nature of sanity. *Psychology Today, 29* (1) 22-24.

Saleebey, D. (2004). 'The power of place': Another look at the environment. *Families in Society, 85* (1), 7-16.

Saleebey, D. (2005). *The strengths perspective in social work practice.* (4th ed.). Boston: Pearson Education Inc.

Salmon, W. (1984). Redefining health and reorganising medicine. In W. Salmon, (Ed.), *Alternative medicines –popular and policy perspectives* (pp.252-281). New York: Tavistock.

Salmon, W. (1984). *Alternative medicines –popular and policy perspectives.* New York: Tavistock.

Schiff, A. (2004). Recovery and mental illness: Analysis and personal reflections. *Psychiatric Rehabilitation Journal,* 27 (3), 212-218.

Schmidt, S. (2004). Mindfulness and healing intention: concepts, practice and research evaluation. *The Journal of Alternative and Complementary Medicine, 10* (Suppl.), 7-14.

Schweitzer, M., Giplin, L., & Frampton, S. (2004). Healing spaces: elements of environmental design that make an impact on health. *Journal of Alternative and Complementary Medicine, 10* (S1), (S-71 – S-83).

Seymour, D. (2000). Emotional labour: A comparison between fast food and traditional service work. *Hospitality Management 19* (2), 159-171. *Management, 19*, 159-171.

Shah, S. & Corley, K. (2006). Building better theory by bridging the quantitative-qualitative divide. *Journal of Management Studies, 43* (8), 1821-1835.

Shanley, E. (2001). Common experiences of mental health nurses and consumers: ingredients of a symbiotic relationship? *Australian and New Zealand Journal of Mental Health Nursing, 10* (4), 243-251.

Shepherd, G. (1998). Models of community care. *Journal of Mental Health, 7* (2), 165-177.

Singh, A.N. (1999). Shamans, healing and mental health. *Journal of Child and Family Studies, 8* (2), 131-134.

Singh, B. & Meadows, G. (2001). Integrating concepts about understanding mental disorders and mental health practice. In B. Singh & G. Meadows (Eds.), *Mental health in Australia* (pp 422-427). Melbourne, Victoria: Oxford University Press.

Singh, J. (1990). A multifacet typology of patient satisfaction with a hospital stay. *Marketing Health Services, 10* (4), 8-21.

Skodol Wilson, H. (1995). Limiting intrusion: Social control of outsiders in a healing community. In B.G. Glaser (Ed). *Grounded Theory 1984-1994* (pp. 355-375). California: Sociology Press.

Smith, B, Tang, K., & Nutbeam, D. (2006) WHO health promotion glossary: new terms. *Health Promotion International Advance Access*, September, 1-6.

Smith, C. (2000). Many years on….when afar and asunder? *Health & Place, 6* (3), 251-255.

Smith, M. & Kelly, C. (2006). Holistic tourism: Journeys of the self? *Tourism Recreation Research, 31* (1), 15-24.

Smyth, F. (2005). Medical geography: Therapeutic places, spaces and networks. *Progress in Human Geography, 29* (4), 488-495.

Srinivasan, S., O'Fallon, L R., & Dearry, A. (2003). Creating healthy communities, healthy homes, healthy people: Initiating a research agenda on the built environment and public health. *American Journal of Public Health, 93* (9), 1446 -1453.

Steiner, C.J. & Reisinger, Y. (2006). Ringing the fourfold: A philosophical framework for thinking about wellness tourism. *Tourism Recreation Research, 31* (1), 5-14.

Stevens Barnum, B. (1998). Rediscovering nightingale: Back to the future. In R. Gordon, B. Neinstedt, & W. Gesler. (Eds.), *Alternative therapies – expanding options in health care* (pp. 177-188). New York, N.Y: Springer Publishing.

Stickley, T. & Freshwater, D. (2002). The art of loving and the therapeutic relationship, *Nursing Inquiry, 9* (4), 230- 256.

Strauss, A. & Corbin, J. (1990). *Basics of qualitative research: Grounded theory procedures and techniques*. Newbury Park, California: Sage Publications.

Strauss, A. & Corbin, J. (1998). *Basics of qualitative research: Techniques and procedures for developing grounded theory.* Thousand Oaks, California: Sage Publications.

Swanson, J. (1996). The call for gestalt's contribution to ecopsychology: Figuring in the environmental field. *The Gestalt Journal, XVIII* (1), 47 -85

Swanson, K. & Woinar, D. (2004). Optimal healing environments in nursing. *Journal of Alternative and Complementary Medicine, 10* (Suppl.), 43-48.

Taylor, S., Foster, M., & Fleming, S. (2008). *Health care practice in Australia: Policy, context and innovations.* South Melbourne, Victoria: Oxford University Press

Thoms, L. (2003). Back to our roots for serenity? *Psychologist, July, 16* (7), 356-357.

Tian-Cole, S. & Crompton, J.L. (2003). A conceptualisation of the relationships between service quality and visitor satisfaction, and their links to destination selection. *Leisure Studies 22* (1), 65-80.

Timko, C. (1996). Physical characteristics of residential psychiatric and substance abuse programs: Organisational determinants and patient outcomes. *American Journal of Community Psychology, 24(*1), 173 -182.

Townsend, C., Pirkis, J., Pham, A., Harris, M., & Whiteford, H. (2006). Stakeholder concerns about Australia's mental health care system. *Australian Health Review, 30* (2), 158-164.

Trauer, B. & Ryan, C. (2005). Destination image, romance and place experience –an application of intimacy theory in tourism. *Tourism Management, 26* (4), 481-491.

Tyson, M. (2002). Treatment gardens: Naturally mapped environments and independence. *Alzheimer's Care Quarterly, 3* (1), 55-60.

Ulrich, R.S. (1983). Aesthetic and affective response to natural environment. In I. Altman, & J.F. Wohlwill (Eds.), *Behaviour and the natural environment (*pp. 85-125*).* New York: Plenum.

Ulrich, R.S. (1984). View through a window may influence recovery from surgery. *Science, 224* April 27, 420-421.

Ulrich, R.S. (1992a). How design impacts wellness. *Healthcare Forum Journal, 35* (5), 20 –23.

Ulrich, R.S. (1992b). What supportive design can mean. *Healthcare Forum Journal, 35* (5), 24.

Ulrich, R.S. (1999). Effects of Gardens on Health Outcomes: Theory and Research. In C.C. Marcus & M. Barnes (Eds.*), Healing gardens*. New York*:* Wiley

van den Berg, A., Koole, S.L., & van der Wulp, N.Y. (2003). Environmental preferences and restoration: (How) are they related? *Journal of Environmental Psychology, 23* (2), 135-146.

Van Dijk, P. & Kirk Brown, A. (2006). Emotional labour and negative job outcomes. *Journal of Management and Organisation, 12* (2), 101-115.

Verderber, S. & Reuman, D. (1987). Windows, views and health status in hospital therapeutic environments. *Journal of Architectural and Planning Research, 4* (2), 120-133.

Voase, R. (2002). Rediscovering the imagination: Investigating active and passive visitor experience in the 21st century. *International Journal of Tourism Research, 4* (5), 391-399.

Voase, R. (2003). *Tourism: The human perspective,* London: Hodder and Stoughton.

Wakefield, S. & McMullan, C. (2005). Healing places in decline; (Re)imagining everyday landscapes in Hamilton Ontario. *Health & Place, 11* (4), 299-312.

Wang, N. (1999). Rethinking authenticity in tourism experience. *Annals of Tourism Research, 26* (2), 349-370.

Warr, D.J., Tacticos, T., Kelaher, M., & Klein, H. (2007). 'Money, stress, jobs'*:* Residents' perception of health-impairing factors in 'poor' neighbourhoods. *Health and Place, 13* (3), 743- 756.

Watson, W.H. & McDaniel, S. H. (2000). Relational therapy in medical settings: Working with somatizing patients and their families. *JCLP/In Session: Psychotherapy in Practice, 56* (8), 1065-1082.

Weber, D. (1992). Planetree transplanted. *Healthcare Forum Journal, 35* (5), 30-37.

Walker, M. (2006). The social construction of mental illness and its implications for the recovery model. *International Journal of Psychosocial Rehabilitation, 10* (1), 71-87.

Watson, W. & McDaniel, S. (2000). Relational therapy in medical settings: Working with somatizing patients and their families. *JCLP/In session: Psychotherapy in Practice, 56* (8), 1065-1082.

Weber, D.O. (1992). Planetree transplanted. *Healthcare Forum Journal, 35* (5), 30-37.

Weiss, I. (2005). Is there a common core to social work? A cross-national comparative study of BSW graduate students. *Social Work, 50* (2), 101-110.

White, A. & Rudall, L. (2000). Interserviqual: An investigation of the dimensions of measurement of internal service quality in the hospitality industry. *Australian Journal of Hospitality Management, 6* (2), 1-6.

Wiley-Exley, E. (2007). Evaluations of community mental health care in low- and middle-income countries: A 10 – year review of the literature. *Social Science and Medicine, 64 (*6), 1231 -1241.

Wilkin, P. (2006). In search of the true self: a clinical journey through a vale of soul-making. *Journal of Psychiatric and Mental Health Nursing, 13* (1), 12 -18

Williams, A. (1998). Therapeutic landscapes and holistic medicine. *Social Science and Medicine, 46* (9), 1193-1203.

Williams, A. (1999). *Therapeutic Landscapes: The dynamic between place and wellness*. New York: University of America Press.

Williams, A. (2002). Changing geographies of health care: Employing the concept of therapeutic landscapes as a framework for examining home. *Social Science and Medicine, 55*(1), 141-154.

Williams, B., Coyle, J., & Healy, D. (1998). The meaning of patient satisfaction: An explanation of high reported levels. *Social Science and Medicine, 47* (9), 1351-1359.

Wilson, E. & Harris, C. (2006). Meaningful travel: Women, independent travel and the search for self and meaning. *Tourism, 54* (2), 161- 172.

Wolch, J. & Philo, C. (2000). From distributions of deviance to definitions of difference: Past and future mental health geographies. *Health and Place, 6* (3), 137-157.

World Health Organisation. *Fact Sheet No. 220,* (2007). Retrieved October 31, 2007, from http://www.whi/int/mediacentre/factsheets/fs220/en/index.html

Wynaden, D. (2007). The experience of caring for a person with a mental illness: A grounded theory study. *International Journal of Mental Health Nursing, 16* (6), 381-389.

Yagil. D. (2006). The relationship of service provider power motivation, empowerment and burnout to customer satisfaction. *International Journal of Service Industry Management, 17* (3), 258-270.

Yanos, P.T. (2007). Beyond "Landscapes of Despair": The need for new research on the urban environment, sprawl, and the community integration of persons with severe mental illness. *Health and Place, 13* (3), 672-676.

Yeoman, I., Brass, D., & McMahon-Beattie, U. (2007). Current issue in tourism: the authentic tourist, *Tourism Management, 28* (4), 1128-1138.

Zohar, D. & Marshall, I. (2000). *Spiritual intelligence: Connecting with our spiritual intelligence.* New York: Bloomsbury.

Zuroff, D. & Blatt, S. (2006). The therapeutic relationship in the brief treatment of depression: Contributions to clinical improvement and enhanced adaptive capacities. *Journal of Consulting and Clinical Psychology, 74* (1), 130-140.

APPENDICES

Appendix A: Information Sheet for Participants

On University Letterhead

Supervisor and Chief investigator Dr Jayne Clapton RN BA PhD School of Human Services Griffith University Logan Campus Ph 3382 1223 Email: J.clapton@griffith.edu.au	Assistant Researcher Carolyn Perry 5 Ross Street EBBW VALE Ph. 3389 4006 or 0416 18 4141 Email: cperry@ucaqld.com.au

The purpose of this research towards a PhD thesis is to gather information from consumers with a psychiatric disability in order to encourage the development of new and innovative models of service delivery in the area of mental health and disability support. This involves interviewing consumers about their own personal experiences to discover their views on what contributes to therapeutic environments and relationships in the area of mental health and well-being.

Involvement of participants requires that they engage with the researcher in an interview about their experiences (both within and outside of the mental health and disability support system) that have lead to feelings of renewal and rejuvenation. This interview would take approximately two hours and could be done either in one or more than one session.

Participants would need to be aware that this research could elicit some painful memories or uncomfortable emotions for them about experiences they have had within the mental health system, but that the focus of the research is to understand how current service delivery practices can be improved upon. The researcher is an experienced counsellor and debriefer and will ensure that participants have access to adequate supports should any issues arise.

All data will remain confidential between the researcher and supervisor, and will be coded in a non-identifying way. Data will be stored securely and participants will be allowed access to transcripts of the information which they contributed. Participants may contact the Chief Investigator about any matter of concern regarding the research on the above contact numbers. Feedback to participants about the progress and outcomes of the research will be available at six monthly intervals.

Participation in this research is voluntary and participants may withdraw at any time. Participants may refuse to participate at any time without explanation and be assured they will experience no negative ramifications. (e.g., No threat to existing mental health services or supports)

The university requires that all participants be informed that if they have any complaints concerning the manner in which research is conducted it may be given to the researcher, or, if an independent person is preferred, either:

The University Research Ethics Officer Office for Research, Bray Centre Griffith University Kessels Road Nathan Qld 4111 Phone (07) 3875 6618	OR	The Pro-Vice Chancellor (Administration) Bray Centre Griffith University Kessels Road Nathan Qld 4111 Phone (07) 3875 7343.

The researcher, on behalf of the School of Human Services, Logan campus would like to thank you for your assistance with this research project.

Appendix B: Informed Consent

On University Letterhead

Supervisor and Chief Investigator	Assistant Researcher
Dr Jayne Clapton RN BA PhD	Carolyn Perry
School of Human Services	5 Ross Street
Griffith University	EBBW VALE 4034
Logan Campus	Ph. 3389 4006 or 0416 18 4141
Ph 3382 1223	Email: cperry@ucaqld.com.au
Email: J.clapton@griffith.edu.au	

The purpose of this research towards a PhD thesis is to gather information from mental health carers in order to encourage the development of new and innovative models of service delivery in the area of mental health and disability support. This involves interviewing carers about their own personal experiences to discover their views on what contributes to therapeutic environments and relationships in the area of mental health and well-being.

Involvement of participants would require that they engage with the researcher in an interview about their experiences (both within and outside of the mental health and disability support system) that have lead to feelings of renewal and rejuvenation. This interview would take approximately two hours and could be done either in one or more than one session.

Participants would need to be aware that this research could elicit some painful memories or uncomfortable emotions for them about experiences they have had within the mental health and disability support system, but that the focus of the research is to understand how current service delivery practices can be improved upon. The researcher is experienced in the areas of counselling and debriefing and will ensure that participants have access to adequate supports should any issues arise.

All data will remain confidential between the researcher and supervisor, and will be coded in a non-identifying way. Data will be stored securely and participants will be allowed access to transcripts of the information which they contributed. Participants may contact the Chief Investigator about any matter of concern regarding the research on the above contact numbers. Feedback to participants about the progress and outcomes of the research will be available at six monthly intervals.

Participation in this research is voluntary and participants may withdraw at any time. Participants may refuse to participate at any time without explanation and be assured they will experience no negative ramifications. (e.g., No threat to existing mental health services or disability supports)

The university requires that all participants be informed that if they have any complaints concerning the manner in which research is conducted it may be given to the researcher, or, if an independent person is preferred, either:

The University Research Ethics Officer Office for Research, Bray Centre Griffith University Kessels Road Nathan Qld 4111 Phone (07) 3875 6618	OR	The Pro-Vice Chancellor (Administration) Bray Centre Griffith University Kessels Road Nathan Qld 4111 Phone (07) 3875 7343.

The researcher, on behalf of the School of Human Services, Logan campus would like to thank you for your assistance with this research project.

Appendix C: Questions for Mental Health Consumers

Meta-Questions – highlighted, followed by related interview questions

What features of the environment (both natural and built) facilitate mental health and well-being?

Interview Questions

Some people have special places they like to go (e.g., nature settings, holiday destinations) because it helps them feel refreshed, rejuvenated and healthy.

1. Take your time to recall a special place/s where you have been (or that you have created) that has helped you feel rejuvenated and refreshed (feel good about yourself)? If you cannot recall a special place, try to imagine what one might be like.

2. Describe this special place/s. (consider sights, feelings, tastes, smells, sounds).

3. What was it about this place/s that helped you feel refreshed (good about your self)?

4. Are there parts of this special place you would like to see within mental health/psychiatric disability support settings? If so, what parts?

5. What do you think is the ideal place/setting for people with mental illness to recover?

How can mental health environments be best designed to facilitate effective communication?

Interview Question

6. If you can, describe a place/setting where you felt could freely open up/talk about yourself?

7. What was it about this place that made you feel at ease/comfortable?

8. If you could design the ideal place where people with a mental health problem could communicate safely and openly with each other, what would this place look like?

How can environments be designed reflecting the underpinning value of recovery?

Interview question

9. Some places can feel quite cold and unfriendly. Sometimes this is because of the design, the colours, the furniture, décor or messages conveyed through pictures on the walls or written messages/signage. Describe a place you have been that conveyed unfriendly, negative messages.

10. What impact did this place have upon you?

11. What did you do to cope/survive in this situation? (How were you resilient?)

12. Some places feel warm and friendly. Sometimes this is because of the design, the colours, furniture, décor or messages conveyed through pictures or signs that were hopeful and caring. Describe a place you have been that you thought was warm and friendly.

13. What impact did this place have upon you?

14. What do you think could be taken from this place to help people in mental health/psychiatric disability support settings?

How can environments be designed to reflect a holistic connection between mind and body and between individual and community?

Interview question

15. many traditional treatment settings, the treatment setting is divided up (separated) to only concentrate on one specific aspect of a person's needs. e.g., different hospital wards look after different parts of the body. Can you think of a place/ situation where all of your needs were taken into consideration (mind, body, family, community)?

16. you consider your own home to be a special place that looks after many of your needs? If so, what is special about your home?

17. you could change anything about your home to be more comfortable, what would it be?

What constitutes a warm, welcoming environment for mental health consumers?

Interview question

18. When you walk into a new place, what do you look for in to consider if you feel welcome and comfortable in that place?

What are the ideal features of a therapeutic relationship in mental health?

Interview question

19. Describe a positive/special relationship with someone that really helped you. Share a story about this person and what the person was like.

20. What did the person do that helped you?

21. Imagine your ideal mental health worker. What would that person be like? Describe the relationship you might have with this person.

To what extent have mental health workers engaged in the lifeworld of the client? What barriers exist and what could be described as effective communication or language?

Interview question

22. How often have you felt that mental health workers have listened to you to the extent that your story were truly heard and understood? Consider this as a percentage (e.g., 'I felt heard 50% of the time')

23. What barriers/difficulties do you think mental health consumers come across in relating to mental health workers?

24. What barriers/difficulties do you think mental health workers have in relating to consumers?

25. If you have had an experience where you felt you really connected with the other person, what was good about the communication that occurred?

How do mental health workers who believe in a strengths based recovery perspective engage with consumers?

26. Have you ever felt that a mental health worker really believed in you?

27. If so, how did you know that they believed in you?
If not, what would you look for in the future to know that a mental health worker really believed in you?

28 If you have had a mental health worker believe in you, what did this feel like?

If not, what do you think it could feel like if someone did believe in you?

How important is a holistic approach towards consumer need?

Interview question

29. Do you think mental health workers should work with you around all aspects of your life, or only your mental health? Why?

30. If you can, give an example of how a worker has treated you as a whole person, being aware of all of your needs?

31. What was this experience like?
How have workers demonstrated the 'hospitality instinct'?

32. Describe how a worker or (what a worker has done) to make you feel comfortable and welcomed?

What needs to change in mental health service delivery?

Interview question

33. you could make your journey through the mental health system different, what would you most like to change?

What have consumers learned about themselves and what do they most want to share with others?

Interview question

34. Based on your experiences, what have you learned most about yourself?

35. What advice would you give to others?

Appendix D: Questions for Mental Health Carers

Meta – Questions – highlighted, followed by related interview questions

What features of the environment (both natural and built) facilitate mental health and well-being?

Interview Questions

Some people have special places they like to go (e.g., nature settings, holiday destinations) because it helps them feel refreshed, rejuvenated and healthy.

1. Take your time to recall a special place/s where you have been (or that you have created) that has helped you feel rejuvenated and refreshed (feel good about yourself)? If you cannot recall a special place, try to imagine what one might be like.

2. Describe this special place/s. (What did you see, hear, smell, taste, and feel?).

3. What was it about this place/s that helped you feel refreshed (good about your self)?

4. Are there parts of this special place you would like to see within mental health/psychiatric disability support settings? If so, what parts?

5. What do you think is the ideal place/setting for people with mental illness to recover?

How can mental health environments be best designed to facilitate effective communication?

Interview Question

6. If you can, describe a place/setting where you felt could freely open up/talk about yourself?

7. What was it about this place that made you feel at ease/comfortable?

8. If you could design the ideal place where carers of people with a mental health problem could communicate safely and openly with each other, what would this place look like?

How can environments be designed reflecting the underpinning value of recovery?

Interview question

9. Some places can feel quite cold and unfriendly. Sometimes this is because of the design, the colours, the furniture, décor or messages conveyed through pictures on the walls or written messages/signage. Describe a place you have been that conveyed unfriendly, negative messages

10. What impact did this place have upon you?

11. What did you do to cope/survive in this situation? (How were you resilient?)

12. Some places can feel warm and friendly. Sometimes this is because of the design, the colours, furniture, décor or messages conveyed through pictures or signs that are hopeful and caring. Describe an environment that you have been in that you thought was warm and friendly.

13. What impact did this place have upon you?

14. What do you think could be taken from this place to help people in mental health/psychiatric disability support settings and their carers?

How can environments be designed to reflect a holistic connection between mind and body and between individual and community?

Interview Question

15. In many traditional treatment settings, the treatment setting is divided up (separated) to only concentrate on one specific aspect of a person's needs. e.g., different hospital wards look after different parts of the body. Can you think of a place/ situation where all of your needs were taken into consideration (mind, body, family, community)?

16. Do you consider your own home to be a special place that looks after many of your needs? If so, what is special about your home?

17. If you could change anything about your home to be more comfortable, what would it be?

What constitutes a warm, welcoming environment for carers?

Interview Question

18. When you walk into a new place, what do you look for in to consider if you feel welcome and comfortable in that place?

What are the ideal features of a therapeutic relationship for carers in mental health?

Interview question

19. Describe a positive/special relationship with someone that really helped you. Share a story about this person and what the person was like

20. What did the person do that helped you?

21. Imagine the ideal mental health worker. What would that person be like? Describe the relationship you might have with this person.

To what extent have mental health workers engaged in the lifeworld of carers? What barriers exist and what could be described as effective communication or language?

Interview questions

22. How often have you felt that mental health workers have listened to you to the extent that your story were truly heard and understood? Consider this as a percentage (e.g., 'I felt heard 50% of the time')

23. What barriers do you think mental health carers come across in relating to mental health workers?

24. What barriers do you think mental health workers have in relating to carers?

25. If you have had an experience where you felt you really connected with the other person, what was good about the communication that occurred?

How do mental health workers who believe in a strengths based recovery perspective engage with consumers and carers?

Interview questions

26. Have you ever felt that a mental health worker really believed in you and the person for whom you care?

27. If so, how did you know that they believed in you and the person for whom you care? If not, what would you look for in the future to know that a mental health worker really believed in you and the person for whom you care?

28. If you have had a mental health worker believe in you and the person for whom you care, what did this feel like? If not, what do you think it could feel like if this did happen?

How important is a holistic approach towards carer need?

Interview questions

29. Do you think mental health workers should work with you around all aspects of your life, or only the mental health needs of the person for whom you care? Why?

30. If you can, give an example of how a worker has treated you as a whole person, being aware of all of your needs?

31. What was this experience like?

How have workers demonstrated the ‘hospitality instinct’?

Interview Question

32. Describe how a worker or (what a worker has done) to make you feel comfortable and welcomed?

What needs to change in mental health service delivery?

Interview Question

33. If you could make your journey through the mental health system different, what would you most like to change?

What have carers learned about themselves and what do they most want to share with others?

Interview Question

34. Based on your experiences, what have you learned most about yourself?

35. What advice would you give to others?

Thesis Update – Promoting Healing in Mental Health through Nurturing Environments and the Facilitation of Inner Well-being.

By Carolyn Perry

1. Introduction

This research commenced in January 2003 with an extensive literature review that incorporated the historical context of moral treatment, environmental and relational psychology, the psychology of tourism and therapeutic landscapes (found primarily in the sociological, architecture and planning literature). Some key themes that emerged from this were:

- The importance of the interaction between environments and individual well-being.
- The relevance of therapeutic relationships, and
- The underpinning meanings and messages that emerge from both specific environments and human interactions.

This literature review helped to identify important questions to ask mental health consumers and carers about their experiences of what has contributed to therapeutic environments and relationships. Ethics approval for these interviews was given in November 2003, and interviews were conducted with consumers and carers between May and December 2004.

2. The Interviews – themes

It became evident throughout the interview process that a sense of rejuvenation and renewal emerged in the lives of individuals not only through therapeutic relationships and environments, but also through a sense of inner spirituality where they could feel internally at peace.

2.1 Therapeutic Environments

Aspects of therapeutic environments included:

- A special appreciation of natural environments and their stimuli, rather than urban landscapes (e.g., the beach, parklands, gardens, bush settings with lots of trees and the presence of water, watching things grow or observing the bird life).
- A sense of freedom and escape, including being away from responsibilities and routines with permission just to ‘be’ and think things through.
- The warmth and freedom of feeling at home, especially when this entailed being with an accepting and loving family.
- Having privacy as well as the freedom to interact with others when needed.
- A comfortable setting that offered recreational or social activities.
- Places that were bright and airy yet calming.

- Places that brought nature inside e.g., plants, photographs of nature, goldfish.
- Architecture that flowed, rather than lots of buildings.
- Open air spaces with freedom to move.
- Places that had a positive energy and felt friendly on entering.
- Environments that were not too formal, but rather homely and informal (often this might include home-made décor or personal family photos).
- Places where one could feel safe and secure.
- Places where the food was good and there was choice in deciding what time to eat or what to eat.
- An environment that offered peace and quiet with an opportunity to slow down.
- Places that instilled positive memories when leaving.

2.2 Therapeutic Relationships

Key aspects contributing to therapeutic relationships that emerged included:

- People who were able to listen empathetically without giving advice.
- Relationships that were given time to develop, and that allowed adequate time with the person when it was needed. Being available and accessible was important.
- Relationships that took into account the whole person, their family and community rather than just their mental health.
- Relationships that gave practical assistance, particularly when professionals went ‘the extra mile’.
- Relationships that demonstrated a level of reciprocity and self-disclosure with a capacity to talk from a similar role e.g., mother, sister.
- Relationships that demonstrated a sense of belief in a person and their family to get through difficult times.
- A relationship where trust and compassion were viewed as ‘real’ rather than ‘contrived’.
- Situations where the professionals did not see themselves as ‘experts’, but were forever learning from their own life experiences and the lived experiences of others.
- Interactions that were honest and caring and devoid of judgement.
- Circumstances in which promises were followed through and people would ring to check how things were going, and were responsive to requests. This could also include proactive advocating on behalf of an individual or their family.
- Relationships that allowed for a sense of humour, where it was OK to look back on both the good times and the bad times.
- Situations where no assumptions or comparisons were made about the similarity or difference of one situation to another.

2.3 Spirituality

In terms of the notion of spirituality, it emerged for people in different ways. Aspects of this included:

- Being a part of a church or spiritual community, when being in that church or community provided a sense of serenity, sanctuary and belonging.
- Having a sense of a higher power that provided guidance, and a sense of purpose and meaning.
- Gaining a deeper sense of self-understanding, awareness and growth through meditation or through following a particular philosophy or belief system.
- Gaining a satisfying or appreciative perspective about how the world operates and responding to it accordingly.
- Achieving a greater sense of inner calm or inner peace.
- Being able to 'live in the moment' rather than generate anxiety about the future or the past.
- Through awareness, gaining a greater sense of life as a personal journey of self-discovery leading to greater personal freedom.
- Through personal reflection and evaluation, gaining a better a sense of what is important in life.
- Through acknowledging that, through crises, transformations can occur that lead to good.

3. Summary

The themes discussed here, are only a brief summary of what has emerged to date, but would tend to suggest that people may need to experience a sense of rejuvenation or renewal before they can fully participate in a journey towards recovery or re-discovery of themselves.

An overarching concept that has emerged from the research to date is that of freedom. This applies at all levels, since it would seem that individuals:

- Enjoy being in an environment that allows for a sense of freedom rather than one that constrains them.
- Desire to be a part of a relationship that allows the freedom for a person just to be themselves without unwelcome or punitive consequences.
- Engage in their own form of spirituality, see it as one which frees up (rather than constricts) their perspective about themselves and the world around them, leading to new possibilities.

Appendix F: Feedback Sheet

Feedback Sheet on research summary on mental health and rejuvenation

Is there anything that you strongly agreed with or could relate to in the summary?

Were there themes you thought might have come through, but did not appear?

Was there anything that you read that you strongly disagreed with or felt you could not relate to?

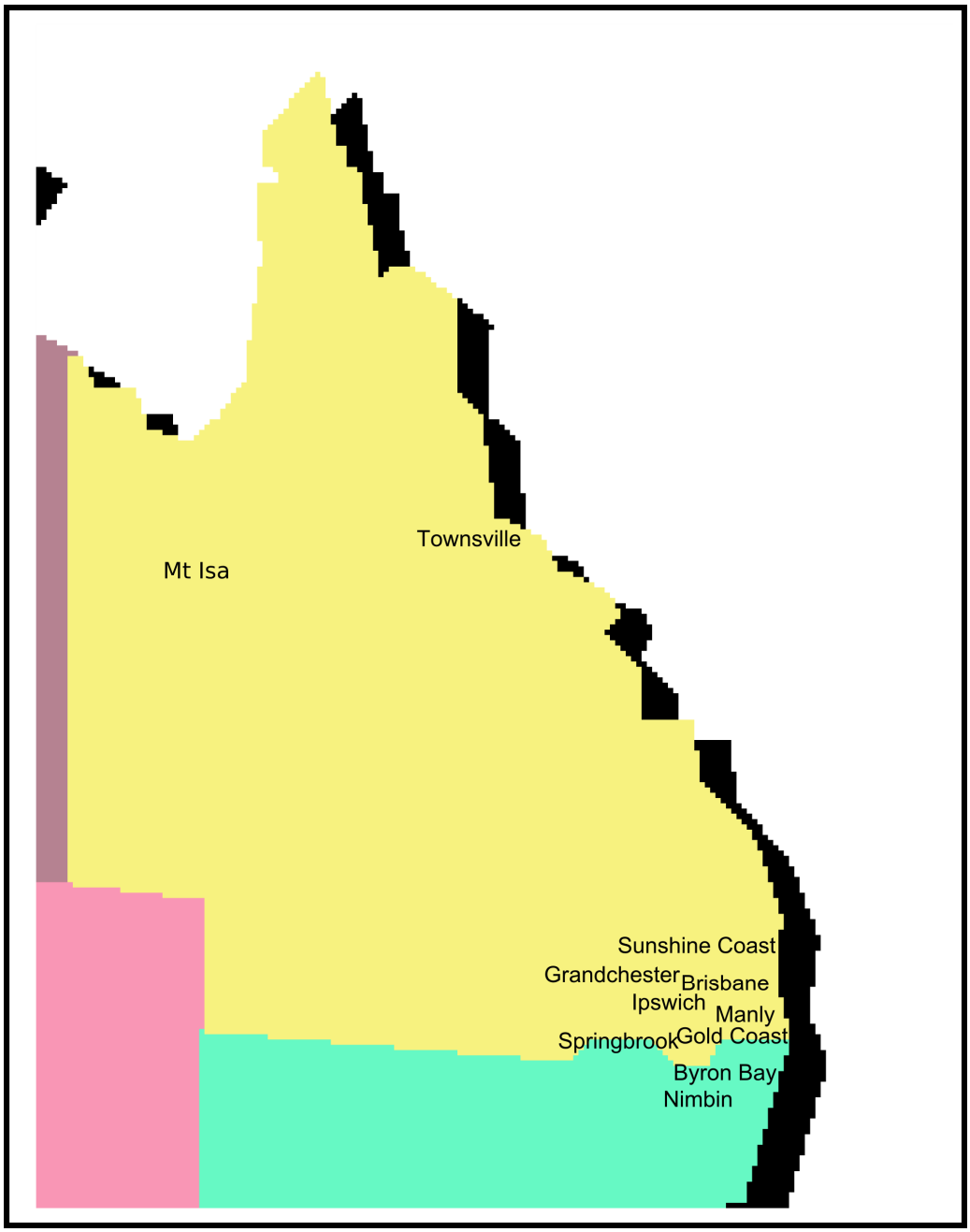
Are there any other comments you would like to make in relation to the concepts of mental health and rejuvenation?

Given what you have read, is there any other experience of rejuvenation which you would like to share? If so, please comment.

Any other comments?

Thank you for your assistance

Appendix G: Map



Appendix G: Locations of interviews

Appendix H: Questions for Hospitality/Tourism Providers

Meta – Questions – highlighted, followed by related interview questions

What features of the environment (both natural and built) in this environment facilitate mental health and well-being?

Interview Questions

1. Feeling rejuvenated and refreshed is often an important part of mental health and well-being for those holidaying. How do see that this setting/place facilitates mental health and well-being?

2. Describe the features of this place/s. (consider sights, feelings, tastes, smells, sounds) that may contribute to overall mental health and well-being?

3. What feedback do you recall (either formal or informal) from people feeling refreshed or rejuvenated? What do you think feeling rejuvenated or refreshed meant for them?

4. In what special ways have you accommodated individual needs? (Consider in particular people who may have been in highly stressed circumstances.)

5. How do you see that you assisted these people in their respective situations?

How can environments be best designed to facilitate effective communication?

Interview Questions

6. What ways do you see this setting assists people freely open up and communicate about themselves or with others?

7. What is it about this setting that assists people made feel at ease/comfortable?

8. Have you received any feedback from guests (either formal or informal) around what made people feel at ease or comfortable communicating?

9 If you could design the ideal place where people who have been highly stressed could freely communicate safely and openly with others, what would this place look like?

How can environments be designed reflecting the underpinning value of recovery?

Interview Questions

10. What do you pay attention to in the environment to design a warm and friendly environment? (Think about colours, décor, design, atmosphere, furnishings)

11. What messages do you try and convey?

12. What impact do you think this has on people? (consider formal or informal feedback)

13. Are there ways in which aspects of this design have impacted upon individual's mental health and well-being? In what way?

How can environments be designed to reflect a holistic connection between mind and body and between individual and community?

Interview Questions

Many people spend time trying to attend to various parts of their needs. E.g., attending the doctor/dentist, attending to family, exercising, shopping.

14. What does treating people in a holistic way mean to you?
Can you give an example in which this place helped facilitate that?

How do you create a warm, welcoming environment?

Interview Questions

15. What do you do to create an immediate impression of a warm welcome in this environment?

What are the ideal features of a good relationship in the hospitality industry?

Interview Questions

16. Describe something that you have done to make someone's break away really special? What did you do that made the difference? What feedback did you receive?

17. . Imagine the ideal hospitality worker in this setting. What would that person be like? Describe the relationship they may have with guests.

To what extent do hospitality workers engaged in the lifeworld of the client?

Interview Questions

18. Describe the importance of understanding the world of your clients and their everyday lives? If understanding their 'lifeworld' is important, how do you engage with people to do this? What do you do to create rapport with people?

19. If you can, recall a situation in which you felt you established an excellent relationship with a client or received positive feedback indicating this?

How do you keep believing in what you do?

Interview Questions

20. What attitude or approach do you think is important to maintain yourself in this industry? How do you do that?

21. Are there ways your attitude/approach as been reflected in feedback?

How important is a holistic approach towards client need?

Interview Questions

22. Can you recall a situation in which you addressed a client's need in a very holistic way? What occurred and what feedback did you receive?

How have workers demonstrated the 'hospitality instinct'?

Interview Questions

23. How do you go about making someone feel comfortable and welcomed, particularly if they appear to be under stress?

What have workers learned about themselves and what do they most want to share with others?

Interview Questions

24. Based on your experiences, what have you learned most about people skills in this industry? And how (has this been through intuition, training, experience)

25. What advice would you give to others in the industry in relation to optimising the mental health and well-being of guests, so that they go away with memories of a rejuvenating experience?

Appendix I: Questions for Hospitality/Tourism Recipients

Meta – Questions – highlighted, followed by related interview questions

What features of the environment (both natural and built) in this environment facilitate mental health and well-being?

Interview Questions

1. Recall a holiday on which you felt rejuvenated and refreshed in terms of your mental health and well-being. How do see that this setting/place benefited/facilitated your mental health and well-being?

2. Describe the features of this place/s. (consider sights, feelings, tastes, smells, sounds) that may have contributed to your overall mental health and well-being?

3. What feedback do you recall (either formal or informal) from other people about the impact of this experience on you?

4. During your experience away, were there special ways in which others accommodated your needs? (Consider particular people who may have been made a difference)

5. How do you see that these people assisted you?

How can environments be best designed to facilitate effective communication?

Interview Questions

6. Are there ways in which you see this setting assists yourself and others freely open up and communicate about themselves?

7. What was it about this setting that made you feel at ease/comfortable in communicating?

8. Have you received any feedback from others (either formal or informal) around what made them feel at ease or comfortable communicating?

9. If you could design the ideal place where people who were highly stressed could communicate safely and openly with others, what would this place look like?

How can environments be designed reflecting the underpinning value of recovery?

Interview Questions

10. What do you notice/ pay attention to in the environment to determine whether it is warm and friendly?

11. What messages are conveyed and how?

12. What impact does this have on you?

13. Are there ways in which aspects of the design have impacted upon your individual mental health and well-being? In what way?

How can environments be designed to reflect a holistic connection between mind and body and between individual and community?

Interview Questions

Often, people spend time trying to get different aspects of their needs met e.g., health care, family needs, shopping, exercising.

14. What does being treated in a holistic way mean to you?
Can you give an example in which someone treated you in this way?

What have others done to create a warm, welcoming environment?

Interview Questions

15. How have others created an immediate impression of a warmth and welcome? for you?

What are the ideal features of a good relationship in the hospitality industry?

Interview Questions

16. Describe something that someone did to make your break away really special? What did they do that made the difference? What feedback did you give them?

17. Imagine the ideal hospitality worker in this setting. What would that person be like? Describe the relationship they may have with guests.

To what extent have hospitality workers engaged in the lifeworld of the client?

Interview Questions

18. How important is it that a hospitality worker takes an interest in you as a person and what you do? If so, how did someone fully engage with you to understand your needs and circumstance and everyday life?

19. If you can, recall a situation in which you felt excellent rapport was established?

How important is it that hospitality workers believing in what they do?

Interview Questions

20. What attitude or approach do you think is important for hospitality workers to maintain in this industry? How is this attitude/approach reflected?

21. Are there ways this attitude/approach as been reflected in your feedback (either formally or informally) to them?

How important is a holistic approach towards client need?

Interview Questions

22. How important is it for tourism operators have a holistic knowledge about their clients? Why?

How have workers demonstrated the ‘hospitality instinct’?

Interview Questions

23. How have others gone about making you feel comfortable and welcomed?

What have workers learned about themselves and what do they most want to share with others?

Interview Questions

24. Based on your experiences, what have you learned most about your own need for rejuvenation?

25. What do you think rejuvenation is for you, and can you maintain it?

Appendix J: Thesis Update

Thesis Update – Promoting Healing in Mental Health through Nurturing Environments and the Facilitation of Inner well-being.

By Carolyn Perry

1. Introduction

The second phase of data collection for my thesis has involved interviewing a series of hospitality providers and tourists to elicit more information on the experience of rejuvenation and mental health and well-being.

Participants were interviewed about what they perceived was quality service, and experiences of rejuvenation, both in terms of the environments that they were in and the relationships of which they were a part.

In order to gain a diverse range of responses on this topic, hospitality providers were chosen from a range of types of holiday locations. These included country motels, international hotel chains, bed-and-breakfasts, a rainforest retreat, a country retreat, a backpacker's hostel and two spiritual retreats, (one with an Eastern and one with a Western influence).

Experiences were captured from people from the age of 18 to 78. A varied understanding as to what constituted rejuvenating experiences included isolated places with no amenities, luxury hotels, overseas backpacking, extended camping/caravanning, commercial tours and self-directed extended overseas travel.

The following summary endeavours to draw out key themes that emerged that contributed to a sense of rejuvenation, from the perspective of both hospitality providers and tourists.

2. Environmental Factors

Key environmental factors that emerged were:

- The beauty and appreciation of the natural unspoilt environment, e.g., coral reefs, fascination with different animals and plants, wildlife habitats, underwater worlds, natural smells of rainwater, rainforests, the sea and sand, natural eco-systems and habitats, stargazing in the evenings, admiring the beauty of gemstones and parrots and the personality of animals, e.g., dolphins.
- Environments that were devoid of pollution and intrusive elements, e.g., no city smells and noise or 'concrete jungle', no uncleanliness, no crowds and no traffic. For some people this was also enhanced by the absence of intrusive technology, and no bright

lights. Other enhancing factors were pleasant climate and temperature with natural lighting and good ventilation, and the use of natural as opposed to chemical products.

- A level of simplicity and unclutteredness. Being uncontactable and removed from the outside world, free from all distraction.
- Open designs with space as opposed to a feeling of confinement e.g., space for personal luggage, space for balconies and separate bathrooms, windows, kitchen space, adequate space between tables when dining.
- Environments where everything was in working order and clean.
- Flexibility in room design so it could be adapted to a variety of configurations depending upon needs and numbers of people.
- Places that allowed for peacefulness, serenity, quietness and tranquillity.
- The capacity for choice in terms of dress and diet, level of privacy or interaction with others.
- A sense of fascination in seeing something new, being away from routine responsibilities and a structured day. For some people this meant being immersed in an environment to the extent that everything else disappears and they become aware that their relationship with the environment is part of a unique experience.
- Quality sleep could be obtained as needed.
- A general sense of comfort and safety, e.g., paths well-lit at night.
- Easy access/private access, e.g., people could avoid reception and the hustle and bustle of public areas if they felt like it.
- Expressive use of space, artistic works that say something about the personality of the artist.
- Blending of accommodation and nature – using the flow of the land and trees, water features, calming spaces, gardens, lots of greenery and natural timbers to tastefully mix nature with modern conveniences.
- Environments that enabled people to think about happy childhood or warm friendly memories.
- Soft calming and soothing colours that suggest subdued elegance. These generally contributed to a warm embracing, safe cocoon-type feeling.
- Environments where people felt they could relax without being worried about putting their feet up or breaking something.
- Special spaces with meaning attached to them allowing communication, meditation, or celebration.

3 Relationships

Key factors that contributed to the mental health and well-being of tourists in terms of relationships with hospitality service providers included:

- Immediate warmth, welcome, and acceptance so that people could feel quickly included in a new setting.
- A feeling of being treated as ‘special’ and that one’s arrival is important and awaited. The staff are genuine as opposed to mechanical, and guests are more than just names in a book. Guests are remembered, recognised, appreciated and valued.
- A level of generosity and hospitality, e.g., being offered a beverage or pre-empting other potential needs, e.g., maps, transport information.
- No assumptions made about guests by providers, and a level of guest anonymity is respected.
- Team-work and cooperation between staff is clearly visible.

- A positive energy, love of the job and enthusiasm – people like what they do, feel good about their work and know why they do the work that they do.
- Staff demonstrate high level of patience and tolerance by responding to the same questions of guests, each being given adequate time and importance.
- A capacity to read people with an awareness of what is happening so that people are treated with sensitivity, humility and empathy, e.g., listening if someone has had a bad flight or lost their luggage, taking note if someone is having a bad day.
- Staff see themselves as part of something bigger.
- There is a high level of responsiveness with concerns straight away, with the capacity to walk through an issue with someone if something goes wrong.
- Staff are positive role models in working with people, e.g., relaxed and confident, open body language.
- Staff take initiative and look for something they can do for someone without 'going over the top.'
- There is a level of flexibility in communication style – staff can adjust so as to engage people to the level that they want to communicate. They may be helpful in facilitating relationships with others through activities or humour, yet they also respect people needing quiet time and space.
- Staff have a good level of self-awareness – they know when they need a break and lead a balanced lifestyle.
- There is a high level of professionalism within the role to ensure that boundaries are not overstepped and that the reputation of the destination remains high.

Individual Sense of Self

For people who had viewed themselves as having rejuvenating experiences through their experiences within the hospitality industry or through retreats, a number of themes emerged:

- People felt that their senses were heightened, in that they were more observant and able to admire and appreciate beauty, e.g., waves lapping on boats, colours of light, the details of architecture or the smell of impending rain.
- There was time just to 'be' rather than to do.
- Their problems at work seem not as big – issues seemed more in proportion, being away from them, and nothing seemed urgent. There was a capacity to step back and think outside the square away from pressure.
- There was an increased appreciation of uncomplicated lifestyles.
- People felt they had permission to be on their own spiritual or life journey. This meant having personal space, time for inner work, reflection or meditation, gaining more peace of mind or internal balance. For some people, this meant ridding themselves of toxic emotions or unhealthy thinking to find an inner calmness.
- Rejuvenation allowed people to feel energised yet also quietly reflective – there was an increased feeling of awareness as well as wakefulness.
- A feeling of being reinvigorated with a new lease of life, ready to go forward and take on new challenges.
- A feeling of being healthy in terms of physical fitness, while intellectually more able to learn new things and grow personally.
- Feeling connected with the inner self at a higher level of intuition, e.g., better mind-body-spirit connection.
- Feeling lighter in spirit, e.g., less aggravated, more tolerant, able to take life at a calmer pace, less worried about details, a capacity to go with the flow.

- A higher level of awareness and intuition.
- A heightened sense of belonging in the world, e.g., sense of meaning and purpose.
- An enhanced appreciation of others and the commonalities of people regardless of cultural differences or lifestyle.
- More open and willing to listen to others and more flexible in one's own behaviour.
- A feeling of total physical and mental relaxation
- A sense of excitement, of exhilaration, and optimism about the world.
- A sense of hope that things will work out.
- A preparedness to take responsibility for actions and to take ownership of decisions.
- A greater level of cheerfulness and spontaneity.
- The capacity to allow opportunities to unfold rather than becoming anxious or highly strung.
- The motivation to do something outside of ordinary world experiences to expand ideas.
- Increased self-confidence within self and with regard to approaching others.
- Feeling restored – like after a good night's sleep
- Time and space to reflect, think differently, generate clarity, make major life decisions, and decide on direction in life.
- The attitude to be able to start afresh, taking one day at a time.
- Having a sense that one's spirituality provides tools and coping resources to work with stress.
- A respect for teachings based on love, caring, kindness and compassion.
- A need for a longer-term understanding of the world rather than band-aid solutions – the capacity to find a major turning point to help solve problems.

5. Summary

The themes discussed here, are only a brief summary of what has emerged to date, but would tend to suggest that people may need to experience therapeutic environments and relationships and a heightened sense of inner well-being to experience a sense of rejuvenation or renewal before they can fully participate in a journey towards recovery or re-discovery of themselves. Interestingly, this research has continued to highlight the importance of spirituality in maintaining individual mental health and well-being.

Appendix K: Questions for Natural Therapy Providers

Meta-Questions – highlighted, followed by related interview questions

What features of the environment (both natural and built) in this environment facilitate mental health and well-being?

Interview Questions

1. Feeling rejuvenated and refreshed is often an important part of mental health and well-being for those visiting a natural therapist. How do see that this setting/place facilitates mental health and well-being?

2. Describe the features of this place/s. (consider sights, feelings, tastes, smells, sounds) that may contribute to overall mental health and well-being?

3. What feedback do you recall (either formal or informal) from people feeling refreshed or rejuvenated? What do you think feeling rejuvenated or refreshed meant for them?

4. In what special ways have you accommodated individual needs? (Consider in particular people who may have been in highly stressed circumstances.)

5. How do you see that you assisted these people in their respective situations?

How can environments be best designed to facilitate effective communication?

Interview Question

6. What ways do you see this setting assists people freely open up and communicate about themselves or with others?

7. What is it about this setting that assists people made feel at ease/comfortable?

8. Have you received any feedback from clients (either formal or informal) around what made people feel at ease or comfortable communicating?

9. If you could design the ideal therapy setting where people who have been highly stressed could freely communicate safely and openly with others, what would this place look like?

How can environments be designed reflecting the underpinning value of recovery?

Interview Question

10. What do you pay attention to in the environment to design a warm and friendly environment? (Think about colours, décor, design, atmosphere, furnishings)

11. What messages do you try and convey?

12. What impact do you think this has on people? (consider formal or informal feedback)

13. Are there ways in which aspects of this design have impacted upon individual's mental health and well-being? In what way?

How can environments be designed to reflect a holistic connection between mind and body and between individual and community?

Interview Question

Many people spend time trying to attend to various parts of their needs. E.g., attending the doctor/dentist, attending to family, exercising, shopping.

14. What does treating people in a holistic way mean to you?
Can you give an example how you have helped facilitate that?

How do you create a warm, welcoming environment?

Interview Question

15. What do you do to create an immediate impression of a warm welcome in this environment?

What are the ideal features of a good relationship in the natural therapies industry?

Interview Question

16. Describe something that you have done to make someone feel really special? What did you do that made the difference? What feedback did you receive?

17. . Imagine the natural therapist in this setting. What would that person be like? Describe the relationship they may have with clients.

To what extent do natural therapists engaged in the lifeworld of the client?

Interview Question

18. Describe the importance of understanding the world of your clients and their everyday lives? If understanding their 'lifeworld' is important, how do you engage with people to do this? What do you do to create rapport with people?

19. If you can, recall a situation in which you felt you established an excellent relationship with a client or received positive feedback indicating this?

How do you keep believing in what you do?

Interview Question

20. What attitude or approach do you think is important to maintain yourself in this industry? How do you do that?

21. Are there ways your attitude/approach as been reflected in feedback?

How important is a holistic approach towards client need?

Interview Question

22. Can you recall a situation in which you addressed a client's need in a very holistic way? What occurred and what feedback did you receive?

How have workers demonstrated the 'hospitality instinct'?

23. How do you go about making someone feel comfortable and welcomed, particularly if they appear to be under stress?

What have workers learned about themselves and what do they most want to share with others?

Interview Question

24 Based on your experiences, what have you learned most about people skills in this industry? And how (has this been through intuition, training, experience)

25 What advice would you give to others in the industry in relation to optimising the mental health and well-being of clients, so that they go away with memories of a rejuvenating experience?

Appendix L: Questions for Natural Therapy Recipients

Meta – Questions – highlighted, followed by related interview questions

What features of natural therapies setting (both natural and built) facilitate mental health and well-being?

Interview Questions

1. Recall a time when you visited a natural therapist and you felt rejuvenated or refreshed afterwards in terms of your mental health and well-being. How do see that this setting/place benefited/facilitated your mental health and well-being?

2. Describe the features of this setting (consider sights, feelings, tastes, smells, sounds) that may have contributed to your overall mental health and well-being?

3. What feedback do you recall (either formal or informal) from other people about the impact of this experience on you?

4. What did the natural therapist do that made a difference?

5. How did this therapist assist you?

How can environments be best designed to facilitate effective communication?

Interview Questions

6. Are there ways in which you see the natural therapy setting assists yourself and others freely open up and communicate about themselves?

7. What was it about this setting that made you feel at ease/comfortable in communicating?

8. Have you received any feedback from others (either formal or informal) around what made them feel at ease or comfortable communicating?

9. If you could design the ideal therapy setting where people who were highly stressed could communicate safely and openly with others, what would this place look like?

How can environments be designed reflecting the underpinning value of recovery?

Interview Questions

10. What do you notice/ pay attention to in the environment to determine whether it is warm and friendly?

11. What messages are conveyed and how?

12. What impact does this have on you?

13. Are there ways in which aspects of the design have impacted upon your individual mental health and well-being? In what way?

How can environments be designed to reflect a holistic connection between mind and body and between individual and community?

Interview Questions

14. Often, people spend time trying to get different aspects of their needs met e.g., health care, family needs, shopping, exercising.

15. What does being treated in a holistic way mean to you?
Can you give an example oh how you have been treated in this way?

What have others done to create a warm, welcoming environment?

Interview Questions

16. How has your therapist created an immediate impression of warmth and welcome for you?

What are the ideal features of a good relationship between worker and client in the natural therapy industry?

Interview Questions

17 What should the relationship between natural therapist and client be like?

18. . Imagine the ideal natural therapist in this setting. What would that person be like? Describe the relationship they may have with clients?

To what extent have hospitality workers engaged in the lifeworld of the client?

Interview Questions

19. How important is it that a natural therapist takes an interest in you as a person and what you do? If so, how did a natural therapist fully engage with you to understand your needs and circumstance and everyday life?

20. If you can, recall a situation in which you felt excellent rapport was established? What happened for you?

How important is it that natural therapists believe in what they do?

Interview Questions

21 What attitude or approach do you think is important for natural therapists to maintain in this industry? How is this attitude/approach reflected?

22. Are there ways this attitude/approach as been reflected in your feedback (either formally or informally) to them?

How important is a holistic approach towards client need?

Interview Questions

23. How important is it for natural therapists have a holistic knowledge about their clients? Why?

How have therapists demonstrated the ‘hospitality instinct’?

Interview Questions

24. How have therapists done to about make you feel comfortable and welcomed?

What have clients learned about themselves and what do they most want to share with others?

Interview Questions

25 Based on your experiences, what have you learned most about your own need for rejuvenation?

26. What do you think rejuvenation is for you, and how can you maintain it?

Thesis Update – Promoting Healing in Mental Health through Nurturing Environments and the Facilitation of Inner Well-being.

By Carolyn Perry

25/02/07

Introduction

The third phase of data collection for my thesis has involved interviewing natural therapists and natural therapy recipients to elicit more information on their experience of rejuvenation and mental health and well-being.

Participants were interviewed about what they perceived were therapeutic relationships and environments.

In order to gain a broad range of responses on this topic, a range of natural therapists and natural therapy recipients were chosen. The natural therapists interviewed often provided more than type of therapy. Altogether, skills held by the natural therapists interviewed were: massage, aromatherapy, herbal remedies, homeopathy, naturopathy, Bowen therapy, Reiki, kinesiology, touch for health, counselling, crystal healing, acupuncture, chiropractic, weight-loss coaching, energy healing and psychic healing. Of the ten therapists interviewed, three were men.

The recipients of natural therapy providers included people who had experienced guided visualisation, hypnotherapy, colour therapy, cranial therapy spiritual healing/counselling, psychodrama, massage, yoga, crystal healing, aromatherapy, kinesiology, touch for health, meditation, reflexology, Bowen therapy, Reiki, energy healing, music therapy, homeopathic, herbal remedies, Chinese medicine, acupuncture, crystal healing, flotation and osteopathy.

Massage was certainly the most common natural therapy sought out by recipients, but all recipients had received more than one type of natural therapy and were very aware of the type of therapies they could seek out to meet their specific needs. Of the ten people interviewed who attended natural therapies, nine were women. The age range of clients interviewed was between 27 and 54.

The following summary will endeavour to list the key themes that emerged that contributed to a sense of rejuvenation, from the perspective of both natural therapy providers and recipients.

1. Therapeutic Landscape

In the therapeutic landscape, the following key factors have been identified:

- Environmental factors.
- Time factors.
- Therapeutic relationship factors.

This report outlines these factors and discusses the feelings they assisted in generating for clients.

Environmental factors in the Therapeutic Landscape

- Privacy and being removed from all distractions was vital. For the natural therapy space to be effective, it needed to have a positive welcoming yet restful energy and be immediately recognised through music, scents and aesthetics as ‘a chill out’ zone.
- Natural environmental factors such as plants and bushes, running water, earthy colours, adequate lighting, windows, natural sounds, large crystals, flowers and fish aquariums were seen to assist people immediately to slow down and remove themselves from the hustle and bustle of their everyday lives.
- A simple environment that was clean and uncluttered was viewed as cleansing.
- That immediate comfort factors were taken into consideration, e.g., seating arrangements, whether the person needed a drink, or to lie down because they were tired, or adequate towels or cushions to provide a nurturing setting.

Time in the Therapeutic Landscape

- Being given time was important for people to feel valued. There was a need to feel that ‘their time’ was really ‘their time’ with no rush or pressure – with time to adjust before and after the therapy session.

2. The Therapeutic Relationship

In the therapeutic relationship, the following factors were identified:

- Communication style
- Client focused flexibility
- Holistic values
- Attitude and approach

Communication style within the therapeutic relationship

Several of factors were viewed as important in the communication between natural therapist and client. These included:

- The need for the client to ‘own’ the communication process in relation to how much verbal interaction occurred. It was up to the therapist to ‘read’ the client and determine whether the person needed to engage verbally or not.
- Language used was not complicated, was based on sharing of ‘real human experiences’, and was gentle and supportive.
- Confidentiality was assured and a sense of genuine trust engendered.
- All emotions were to be seen as ‘OK’ – with the freedom given to the client to just ‘be’ with full acceptance and no judgement. People need to feel that they could ‘let their guard down’ and not fear for their vulnerability.

- The therapist was viewed more as a facilitator or a guide helping the person explore their everyday life experiences that might assist giving insight or promote their general health and well-being. The therapist could instil motivation and help people awaken their own resources.
- A good therapist was one that was seen to 'listen with the heart' and show empathy, humour, compassion, and concern, remaining fully present at all times.
- A sensitive level of calmness, patience and re-assurance was also appreciated.
- For some clients, the most beneficial communication occurred when there was a real 'turning point' or new level of insight achieved, especially in the supportive presence of the therapist. This may have meant a new way of looking at themselves, the world around them, or learning new ways of coping or self-maintenance. There was a distinct sense of discovery and the capacity to view issues in a new light.

Client focused flexibility within the therapeutic relationship

Natural therapists seemed to be appreciated for their level of flexibility which was demonstrated through:

- The capacity to adopt different healing modalities or techniques according to client need.
- Giving people alternatives and negotiating goals based on what was reasonable and achievable for the client.
- Responding to crisis when it occurred, giving people time when they most need it.
- Showing a general easygoing approach demonstrating a willingness to accommodate to client need.

Holistic values within the therapeutic relationship

- Clients appreciated links made between their physical body and their psychological, emotional and spiritual well-being, e.g., considering emotional stress as a contributing factor to particular health issues.
- Clients appreciated being asked questions that would lead to a deeper understanding of issues in holistic sense, but gained the most when the therapist took a general interest, rather than experiencing questions that were invasive or standardised.
- Clients generally felt that a level of balance and awareness was a way forward towards personal growth and self-development.

General Attitude/ approach within therapeutic relationships

A positive and motivated approach was viewed as essential by both therapists and clients with the following attributes valued highly:

- An attitude of hope and belief in others.
- An appreciation of human diversity yet common humanity.
- That the first approach to a client in the day needs to be as important and helpful as the last.
- That life experience and 'being real' contributes to growth for self and others.
- That the way one works needs to be the way one conducts life – taking up natural therapy is often about a lifestyle choice that is not about ego or making money.
- That one has to be honest and know their own limits, possessing a high level of awareness and not anticipate that they have all the answers.

- Therapists who sought out opportunities for personal and professional development demonstrated a commitment to themselves and their practice.

Feelings generated the therapeutic space through therapeutic relationships

Many of the feelings discussed by people experiencing natural therapies was that they began feeling:

- more 'in tune' with the world,
- more uplifted yet anchored,
- more balanced and centred and,
- able to move on and face day-to-day life pressures.

Several people discussed a dreamy state of relaxation or one of soothing calmness. Feeling welcomed into the environment was also important – that the first point of contact was warm and hospitable. Several people described the importance of feeling nurtured, protected, safe and accepted.

The experience of spiritual connectedness

For some people, their depth of experience was about connecting with a spiritual or divine presence such as a higher self, a oneness with the universe or nature, a high energy source, or their understanding of God.

4. Summary

While this data only outlines a small sample of information gained from natural therapists and natural therapy recipients, a significant number of different types of natural therapies are discussed. For both clients and therapists, their entry into the field has been quite intentional – to seek help or help others in ways that departed from the general health system. There was an appreciation of a different type of setting and style of interaction. Many clients said they still sought medical advice to 'gain quick answers' or a 'diagnosis' about their health issues, but would work with alternatives to assist them in gaining longer term health and well-being outcomes. These outcomes were often negotiated with the client viewing the therapist as an ally or guide in their own healing, rather than gaining a treatment or a cure from an 'expert' who 'controlled' the consultation.

Thus, for clients of natural therapies, a sense of empowerment, and a sense of freedom to 'be themselves' was important. This was matched by the attitude of therapists who viewed themselves as navigators of the client's journey, working with people while accepting their diversity and humanity.

Appendix N: ARAFMI Focus Group Summary

1. Introduction

The following is a summary of points that emerged from ARAFMI carers and consumers in the context of discussing my current research in the areas of rejuvenation, mental health and well-being.

It was important to explain that my purpose in exploring the experiences of people in the hospitality industry and natural therapies industries was to draw out those factors that contribute to mental health and well-being in a very general sense. On a mental health and well-being continuum, we all experience different levels of mental health and well-being at different times. By examining factors that contribute to enhanced mental health and well-being, it may broaden our thinking to consider how we may assist people who have been diagnosed with a mental illness, as well as their family carers.

The framework that was used to explore the facilitation of mental health and well-being was:

- An exploration of the concept of rejuvenation and inner well-being;
- Therapeutic environments;
- Therapeutic relationships;
- Therapeutic tools and processes; and
- The importance of the attributes of people who have a role in facilitating the well-being of others.

2. The Concept of Rejuvenation

The concept of rejuvenation was explored, because in the natural therapies and hospitality industries, it highlights the importance of vitality, freshness and aliveness. When people feel rejuvenated from an experience, they tend to be able to step back from what has been happening in their lives, gain a different perspective, and have more of a capacity to make important decisions or feel more able to take on challenges in their lives. Carers could relate to this with ease. This concept does not take away from the importance of the notion of recovery, but perhaps encourages the need for rejuvenating experiences while on the recovery journey. It was particularly recognised by mental health consumers that mental illness depletes energy and motivation significantly, so that experiences that could replenish this were important.

For people who are continuously plagued by severe symptoms, the goal may not be a need to feel particularly energised, but to gain a sense of freshness and renewal though a feeling of being at peace. It was also noted that some consumers have a real fear of never recovering, believing that their mental health has deteriorated over the years and may continue to do so. Thus, for these people it would seem particularly important to look at ways their mental health and well-being may be replenished, as opposed to how they perceive it as being continuously depleted. Thus, for people who believe they have deteriorated, the concept of rejuvenation and how to seek it may add some value in their lives.

3. Therapeutic Environments

In terms of therapeutic environments for people with a mental illness and their carers, the following three themes emerged as significant.

3.1

Firstly, the safety of the environment in terms of external stimuli. While natural settings and sounds are appreciated by most people, it was important to recognise that for consumers who are sound sensitive, sounds such bird calls in a natural environment could seem overwhelming or even threatening. Similarly, while most people associate water with tranquillity and a feeling of being refreshed, for those who have been traumatised around water, the prospect of being near water may create stress and anxiety. Thus, this research re-affirms the importance of understanding how clients associate with particular stimuli (whether it be negative or positive) in order to set up a safe therapeutic environment.

3.2

Secondly, a therapeutic environment was one where people could be free of everyday responsibilities and daily routines. It was an opportunity to be well away from the usual pressures and have time out. While consumers were quick to acknowledge that the mental illness does not leave them when they leave their environment, being away from external stresses, having someone to cook meals, and generally 'giving over' responsibility around running a household was helpful. For carers too, it was being away from responsibility that was a most valued part of carer retreats. For consumers, it was indicated that the most dangerous time for them is returning home after hospital. This is when responsibility comes flooding back, and people are not able to manage it. The importance of transitional accommodation was discussed here as an important need, to bridge the environment between hospital and home.

3.3

Thirdly, a therapeutic environment was one that welcoming and homely in furnishings and atmosphere – where people could walk in and feel valued. This was important for consumers and carers. The interviews to date have highlighted strongly the different 'vibes' they have felt from places they have entered. In particular, it has highlighted how factors such as entranceways, reception areas, comfortable furniture and access to privacy, and clean amenities make a significant impact on people.

4. Therapeutic Relationships

Three key factors came to the fore here.

4.1

Firstly, that people should be acknowledged when they come into contact with others to request assistance. The aspects of the hospitality industry which involve remembering names, showing respect, smiling and letting someone know their needs will be attended to shortly, seem far removed from many clinical settings. Carers and consumers identified that they were often made to feel 'invisible'.

4.2

Secondly, a therapeutic relationship was seen as one that was mutual, where the person felt they could be treated as an ordinary person that had a variety of valuable lived experiences, rather than a 'patient' who needed controlling by a mental health professional.

One story emerged from a consumer who stated that when she was in hospital she was called into a room to be interviewed by 17 doctors. Her permission was not asked and she had no power in the situation. This was perhaps a good example of 'being done to', rather than 'working with'. Similarly, carers expressed concerns about how their lived experience of living with a family member was not 'worked with' in a constructive way, but instead treated as insignificant. There was recognition that when this occurred, there was less of an opportunity to be treated in a holistic way recognising mind, body, emotions and spirit.

4.3

Thirdly, both consumers and carers confirmed the difficulty they had accessing someone to 'work with.' It was acknowledged there were systemic factors about time, eligibility criteria, prioritising crises, long waiting lists, and lack of resources; it was also acknowledged that as long as people are denied therapeutic relationships, they are denied an opportunity for self-development and personal growth.

5. Therapeutic tools/processes

For most people, the only therapeutic tool they had been offered was medication. Again this restricted the focus of the person on their illness rather than on the whole well-being or potential of the person.

A concept that emerged here was that of 'connected agreement'. This relates to the person and the therapist working together to identify the processes and tools that are to be used. Often these agreements are unspoken, and it often is left up to the intuition of the therapist about what the clients wants and how this will be helpful. In the natural therapies industry, there tends to be more open negotiation around what the client is looking for from a holistic perspective and how they want to achieve it. In the case of the mental health sector, these agreements tend to be 'skewed', with the mental health professional in control.

One example of this emerged in the discussion when a consumer stated he no longer wished to proceed with psychotherapy as he felt it was making him more vulnerable. The psychiatrist continued to proceed with psychotherapy by continuing to explore the consumer's fear of vulnerability. The consumer continued the treatment for some years, but eventually terminated the psychotherapy after feeling more damaged by the experience.

It was evident that the variety of therapeutic tools and processes consumers had access to was limited. One lady experiencing anxiety and depression was denied day leave to have a massage, as she believed this would be the most helpful way to calm herself. She had to wait until she could have leave from the hospital to access what she felt would benefit her mental health at the time.

Consumers and carers also need to have their own tools and processes acknowledged, rather than just textbook tools. While for some people calling on what they have learned in CBT may be helpful, for others calling on their spiritual beliefs in times of distress may be most helpful.

A key factor in relation to therapeutic tools and processes is safety. For some clients, forms of meditation and relaxation can be dangerous as it increases their vulnerability and opens them up to more stimuli, which may be overwhelming. Thus, connected agreements about tools and processes that respect the client's wishes and promote safety seem vital. Too often, the wishes of the client and family appear disregarded.

6. Attributes of people who have a role in facilitating well-being

Important attributes which resonated with both consumers and carers were authenticity and genuineness. It was the genuine care and compassion of people that consumers and carers appreciated the most. Any kind of superficiality or 'fakeness' could be recognised. Support workers were generally highly regarded for being very sensitive and caring individuals.

I shared with consumers and carers that, in my interviews with managers in the hospitality and natural therapies industries, the main factor that would determine the recruitment of new staff was personality. There seemed to be a similarity in that these roles also needed to relate to people in a very caring manner to enable people to feel at ease.

Mental health professionals were viewed generally to have fairly low morale and be 'somewhat tired.' Consumers and carers generally had high expectations of mental health professionals initially, but often felt disappointed at the end of a consultation. It was interesting to note, however, that a range of excuses seemed to be given around how mental health professionals had a difficult time in performing their roles. It was almost as if consumers and carers at some level have internalised a stigma that they are 'problematic'.

7. Implications

The implications of the research seem very encouraging for the non-clinical mental health sector in terms of what is already being done, e.g., retreats, homely environments, and the importance of the role of the support worker. For organisations like ARAFMI, the sense of safety that is given to people cannot be underestimated. Consumers in particular regarded Jerendine as a safe and valuable life-line in times of stress, and greatly preferred it to hospital.

This research highlights the need, however, for more transitional accommodation and access to a greater range of supports and therapeutic tools that are not limited to crisis situations and that encourage personal growth through meaningful connected agreements with others. It poses many issues for the clinical settings on many levels – I won't go into that here – I leave it for the thesis.

EXAMPLE 1 – Impressions around spirituality

During the course of the interviews, it has been interesting to note how much the importance of spirituality entered into the lives of people. For one 82-year-old man who was a member of the Salvation Army and who prayed every morning, organised religion and scripture, involvement and church activities and music was of utmost importance in helping him have something consistent and meaningful to look forward to each Sunday. For another older couple, spirituality gave them the trust and acceptance of the recognition that they were not in control and they could 'hand over' the responsibility to God. For another carer, sitting in church enabled her to 'blank everything out' 'experience peace' and 'gain some inner strength' and feel 'grounded 'again.

To another carer seeking a sense of spirituality, meditation developed awareness and intuition and offered a sense of 'inner calm', peace and healing. For another, philosophical readings enabled a fresh perspective, and the ability to stay in the moment and look over and beyond points of conflict or contention. For the mother who was interviewed over the phone because her daughter was too unwell for me to come to the house, she described how reading the Bible was of comfort in difficult times. Another mother described how the church brought her a sense of calmness and inner peace and that she valued her Catholic faith, and in particular the sense of 'spiritual community' her faith offered. For another carer, spirituality was about the meaningfulness of family. After the first report was sent out identifying the importance of spirituality, more people opened up about this over the phone during some follow-up phone calls that I made.

One consumer described how he would feel ‘a hollow being’ without his spirituality, and that being a practicing Catholic for the last 10 years had brought structure and meaning to his life. He said his belief system enabled him to ‘accept and tolerate both the good and bad times’, come to terms with the ‘rough times’ and give him a sense of guidance. For him it was vitally important that he viewed that there was a power ‘beyond himself’. In this way, it was possible to ask for help to get rid of negative thoughts, and in so doing, gain a sense of ‘divine healing’. He described conversations with God as informal and that this conversation was a part of his everyday life.

Another consumer said that, without his spirituality, he doubted much whether he would still be alive. Reading the Bible in a structured way was important and his spirituality had enabled him to ‘grow as a person’ and be a ‘more complete human being’ knowing that God and individuals are ‘connected’ and that the divine offers ‘inner strength’

Another consumer discussed her ‘prayer journal’ and that she sees the values of Christianity influencing her every day actions. Often she said she would pray in private because not everyone at the church was accepting, and sometimes she would not feel included; she had been previously. She had been to church regularly from the age of 14 to 23, but then no longer attended church formally.

Another consumer said although she was an atheist, she prayed each night ‘just in case there was a heaven.’

EXAMPLE 2 Quote from letter received from tourist

Dear Carolyn,
Forgot to mention the great therapy of a pet. Yeti (the cat) does forget he is 9 years old, sometimes has a mad dash through the house or a game

We liked the idea of environmental factors being important and consider for many people it would make for an ideal healing situation; as long as there was diversity of choice.

The degree of help would depend on the mental trauma the person had suffered, the type of surroundings required, family contact and regard to the amount in the purse.

For temporary or light stress or strain for instance; a change of location, touring by bus or train or a walking tour might be adequate; or a retreat. Time in the bush.

As you know, the upheaval of retirement was dealt with by an extended caravan and fossicking 4 and half years happily, by us.

After severe illness, death of someone close or other trouble, pleasant peaceful surroundings – and people. Company and entertainment if and as required. Someone to listen.

If unable to leave home the old saying 'change is as good as a holiday'. Perhaps a new hobby, gardening music and meditation would go a long way as long as worries such as family, money and health can be dealt with, reasonably beforehand.

Have heard of cases of severely traumatised people who have found peace by finding opportunities to help others.

Maybe it isn't comfort for the body that is needed for the mentally harassed but comfort for the soul.

(From a tourist)

EXAMPLE 3 – Photos that illustrate welcome and hospitality at country retreat at Grandchester

Appendix P: Example of Open Coding Transcript

Interview Transcript –carer 7	Open Coding
INTERVIEWER: It is the 26th of November and I am with [carer 7} Some people have special places that they like to go and that is because they feel rejuvenated or refreshed and it helps them feel healthy. I am wondering if you have a special place where you like to go or maybe it is a place that you have created for yourself that helps you feel rejuvenated and refreshed?	
RESPONDENT: I love getting my body into the sea I find that I don't do it as often as I would like.	The sea/ocean
RESPONDENT: I love the salt water and being in the sea and I find that really therapeutic other than that if I can get with friends and play cards. A good game of Canasta with my friends or even just offloading with friends I find is very good.	Feeling of salt water/therapeutic/friends/card games/being able to off load
INTERVIEWER: With going into the sea what does it do to your senses what does it do for your feelings when you immerse yourself in the water what is that like?	Carefree/floating/blow away the cobwebs/everything floating away/lightness/ therapeutic
RESPONDENT: It is very carefree as if the salt and the wind blow out all the cobwebs. And that lovely feeling that you get when you get out of the sea. I find it very therapeutic you can just float there and just let everything float away from you.	
INTERVIEWER: When you think about the feeling that you get from being I the ocean and that kind of feeling of rejuvenation is there anything that you think can be taken from that kind of setting into mental health settings? Is there anything that you would like to see different in the Psychiatric Disability Environments that might give you that feeling?	
RESPONDENT: Perhaps the… when you say the Mental Health environment that word Mental Health is thinking of it as a healthy environment rather than a mental health environment taking the word mental health out of it. So what perhaps makes a therapeutic environment.	Take the 'mental' out of mental health Healthy environment/therapeutic
INTERVIEWER: If you could think about the ideal place and you could design that ideal place or environment do you have any thoughts about what that might look like?	Being away/no hustle bustle/rustic cottage, rambling brook/ trees/ peaceful
RESPONDENT: The first thought that comes to mind is perhaps somewhere away from the hustle and bustle of everyday life, I am thinking of a very rustic cottage by a rambling brook and the brook is somewhere where there are lots of trees and somewhere that is just	

peaceful.

INTERVIEWER: Can you describe a place that you felt that you have been as a carer where you have felt that you have really been able to open up and talk about yourself?

RESPONDENT: Being a person who is never lost for words and I can feel free to do that anyway. But I find the peer support groups and the ARAFMI? Group is the one place where no one is going to judge you or your family member. Because I find that hurtful if I am talking to someone about, or when we are going through our traumas if you talk to people who didn't understand and they circled you without supporting you or judging your family member I found that really disturbing. So I guess it is difficult to find people who understand all that so that is where the ARAFMI? Group is good and my immediate family they are really wonderful and non-judgemental but still very supportive.

INTERVIEWER: In terms of if there has been a special place.

RESPONDENT: My family doctor too because he was truly amazing. I find the GP too.

INTERVIEWER: If there was a special place where you felt comfortable in opening up about your issues was there anything in the environment that helped in that place? Like the layout or?

RESPONDENT: No because I don't think I took notice of the environment. Because everything is so internalised that I don't see the environment, mind you if there is a lovely environment like we have today or somewhere that was very peaceful I guess it must have an impact but I don't think you are as aware of it. If it was very busy and distracting it may be different but I don't see it as the…? As necessarily being helpful or unhelpful.

INTERVIEWER: Do you think like if we had a hand in designing any kind of place where carers and people with a mental health problem could communicate openly and safely with each other. Is there any kind of places that you think would be nice to design to assist that process or facilitate that happening?

RESPONDENT: I think peace and harmony is the atmosphere we need to create because life is so unpeaceful and not very harmonious then when you re with somebody when they are unwell. So yes just I think that would be the first priority being very calming and peaceful.

INTERVIEWER: When you go into some environments they can feel quite cold and unfriendly and sometimes that is because of the design or even the signs or messages conveyed on the walls. Have you ever been

Non-judgemental group/peer support/judgement is hurtful and disturbing/need support/immediate family non-judgemental/ caution about who to confide in/ supportive sometimes difficult to find/be selective/
Need understanding

Family doctor supportive

Environment is not priory/not conscious of it/everything is more internalised/as long as not distracting or too busy. No notice of environment/not conscious of it/
only if distracting/busy

Peace/harmony important/mental illness is not peaceful or harmonious/calming environment would be priority

The people make the place. People more important than place.

in a place that you have walked through and you thought -oh this is particularly unfriendly and cold?

RESPONDENT: (laughs) The dentist. No because I think it is people that make the place.

INTERVIEWER: No? So if I asked you the opposite question if you can think of a place that you have been in that you thought was really warm and friendly because of the colours or the design, the messages and decor, furniture and it kind of gave you the sense of hopefulness and caring. Can you describe an environment that you have been in that you felt was really warm and friendly?

RESPONDENT: I am thinking of a restaurant I walked into that was very homely and thinking about the clothes I guess stainless steel and glazed…? Are cold. Like stark environments but the one I am thinking of was very cottagey with lovely printed curtains and tablecloths and a roaring fire. Very Chintzy, and not that we all find different things inviting but it was so homely. …? Rather than stainless steel, glass and grey, which have their place.

INTERVIEWER: So when you think about walking into that restaurant and seeing the curtains and the way the tables are laid out in the room and the roaring fire and the atmosphere, what feelings did it generate or what impact did it have on you? How did you feel?

RESPONDENT: I thought it is really nice to be here. It is a lovely experience.

INTERVIEWER: So if you think about that place is there anything about that place in that environment that you think could be placed into the Mental Health setting?

RESPONDENT: Not clinical, homely.

Homely/warm vs. stark stainless steel and glass/cold/Cottagey/prints/tablecloths/curtains/warm fire/chintzy/homely not stark/steel/grey.

Feels lovely/nice

Not clinical/homely

Appendix Q: Example of Memos

MEMO EXAMPLE 1– Hospitality data

I was impressed by the level of connection and authenticity provided by some hospitality providers – nothing was too much trouble. There was a genuine homely atmosphere associated very strongly with the Bed and Breakfast at Ipswich and the country motel in Mt Isa. A level of tending to people needs holistically and attending to the personal touches.

In both cases these providers really gave of themselves to develop relationships through their demonstration hospitality. Whether this was through making cups of tea, driving someone to the hospital, paying special attention to the needs of children.

The implications were often they were provided a pseudo counselling service in the way they joined with people to meet their needs. These providers commonly received amazing feedback and were seen as vital and respected members of the community. The feedback commonly indicated that after people had stayed they were refreshed. The relationships played a big role here, but more importantly it was the way these providers conducted themselves with people and their thoughtfulness that made me feel inspired!

IMPORTANT CONCEPTS:
Connection
Authenticity
Holistic
Hospitable manner
Consciously yet discretely revitalising people.

MEMO EXAMPLE 2 – Hospitality data

The authenticity of place was evident in Springbrook –the significant connection with mother earth. Everything else seemed to revolve around the connection with nature. Significant effort was put into making sure the cleaning products mimicked the scent of the rainforest, with nothing toxic being used.

The use of wood was used purposely to bring the forest inside and cultivate the connection with the environment. The buildings are positioned to allow the flora and fauna to meander around them do that nothing is viewed as artificial. There is every attempt made to ensure people feel harmoniously connected to and captivated by their environment.

IMPORTANT CONCEPTS
Authenticity
Connection
Captivation

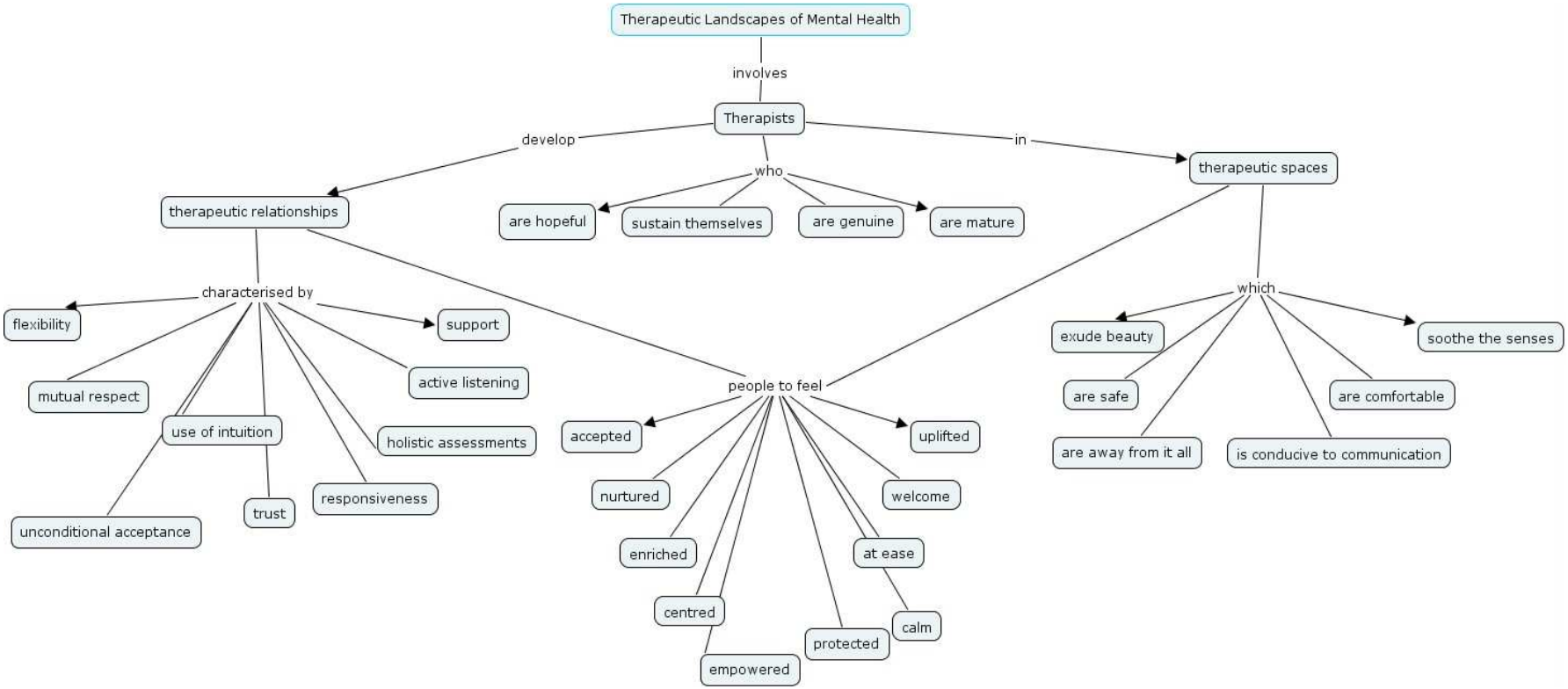
MEMO EXAMPLE 3 – Both Substantive and comparative data

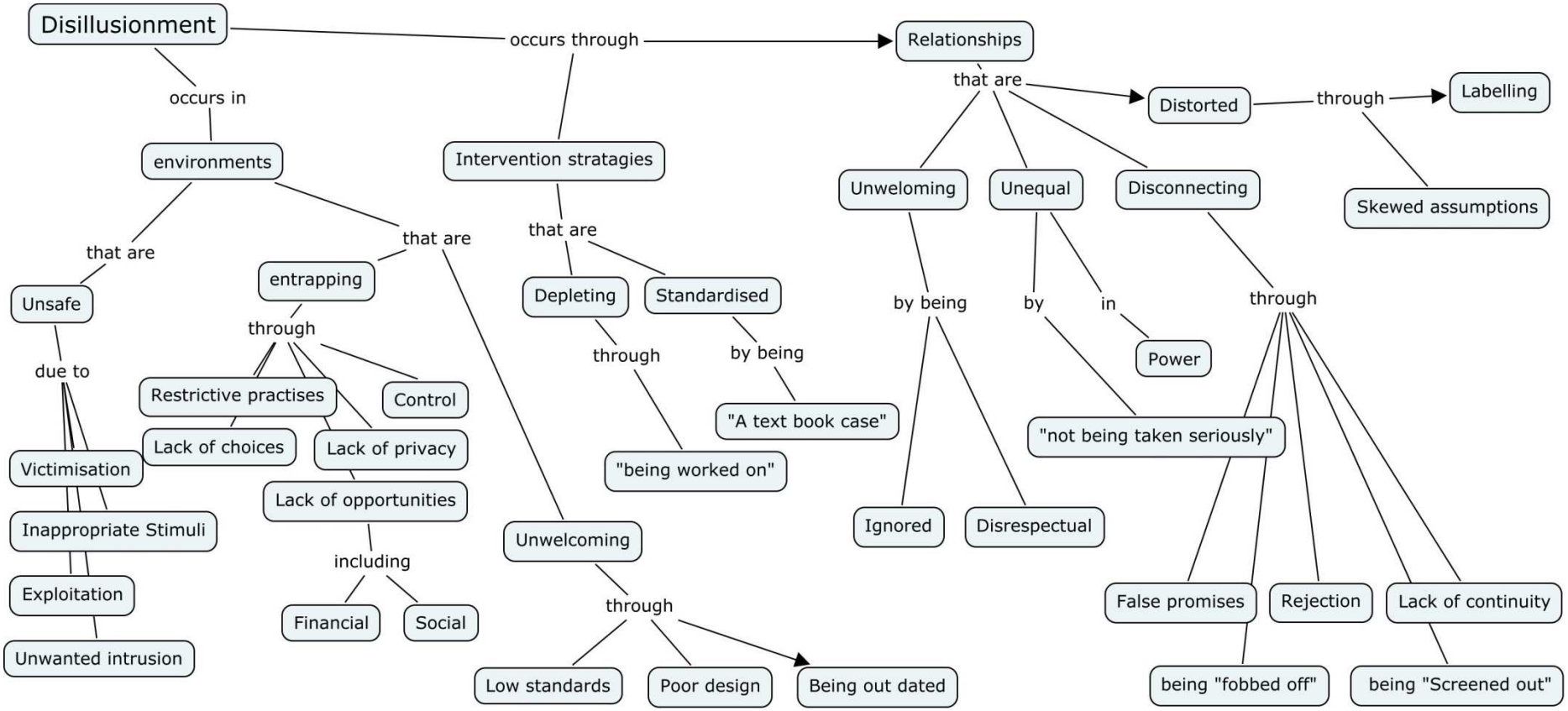
In trying to put together the processes involved with what is happening for people when they their perspective is being enhanced or being lost or diminished, these are some the factors that seem to contribute. What is emerging conceptually is the need for authentic tailored engagement, connection and hospitality as opposed to feeling treated like a lesser being disconnected, treated as unwelcomed.

MEMO EXAMPLE - Diagram The Facilitation of Mental Health (through therapeutic relationships, therapeutic spaces, therapeutic practitioners and through client experience of therapeutic rejuvenation and through using therapeutic processes/tools)

Dimension	Therapeutic Relationship	Therapeutic Space	Therapeutic Attributes	Internal Client Process	Therapeutic process/tools
Healing	Acceptance Respect Trust that allows connection & emotional release Allows time	Comfortable Pleasant Stimuli Safe Nurturing Positive Energy	Authenticity, Genuineness Warm, mature Life experience, Welcoming Practical Humble Grounded Intuitive	Feels accepted, validated, centred calm, supported, recharged, uplifted gains insight, awareness empowered, enriched	Holistic Assessment Being fully present Flexibility to stay with or look beyond Empowering communication
Hurting	Judgement “us and “them” Lack of Rapport And connection, Inability to speak up Rushed	Uncomfortable Unpleasant to Senses Unsafe Uncaring Negative vibe	Superficial Cool, lack of life experience, detached egotistical living in own world with inability to enter into another’s.	Feels rejected, Discounted, Unsupported, Tense, drained, confused, objectified, devalued	Concentrated in one area, distance client, routine, mechanical, Disempowering communication

Appendix R: Cognitive Mapping




Disillusionment
occurs through
Relationships
occurs in
environments
that are
Unsafe
due to
Victimisation
Inappropriate Stimuli
Exploitation
Unwanted intrusion
that are
entrapping
through
Restrictive practises
Control
Lack of choices
Lack of privacy
Lack of opportunities
including
Financial
Social
Intervention stratagies
that are
Depleting
Standardised
through
by being
"being worked on"
"A text book case"
Unwelcoming
through
Low standards
Poor design
Being out dated
that are
Unweloming
Unequal
Disconnecting
Distorted
through
Labelling
Skewed assumptions
by being
by
in
Power
through
Ignored
Disrespectual
"not being taken seriously"
False promises
Rejection
Lack of continuity
being "fobbed off"
being "Screened out"