Development of a holistic, strengths based, family mental health promotion therapy project, in a student led practice in a challenging rural community

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ABSTRACT: The purpose of this paper is to highlight the work that has evolved to date of reconceptualising the practice of mental health promotion, prevention and early intervention in a challenging, culturally diverse, low socioeconomic community in northern rural NSW. The limitations of the biomedical model approach with a focus on individuals, illness, medications, compliance and individualised bioethical foundations have been resented by many people in this community. A health ecology approach of holistic family oriented mental health promotion focused around identifying and harnessing individual, family and community strengths, resources and capacity building is emerging as an alternative. The social concept of family is also challenged in a practical way in this community, with family often meaning kin (single parents, nuclear family, extended family), friends, social acquaintances, drug dealers, gangs, school mates and so on.

A nursing student led practice developed by Stuhlmiller (UNE) has been operating in this community since mid-2013. Within this structure, a mental health promotion team and a Nurse Practitioner who identifies as Aboriginal, have been exploring family oriented therapeutic engagement with the community. This includes cross referrals, a holistic set of integrative therapies including Tai Chi/Qigong, Laughter Yoga, core fitness/aerobics, mindfulness, cultural/artistic expression, gardening therapy, systemic family therapies, CBT, basic hearing, eyesight and speech testing of local primary school children (improves engagement with the centre and facilitates learning of social skills), and mini documentary making with ABC Open.

A holistic therapeutic learning community is emerging that embraces active input from community members, researchers, mentors, students, and practitioners. Engagement with this community (that includes a significant population of Aboriginal people) has been expanding, with therapeutic outcomes focused on wellness, reflecting a level of rapport, trust and confidence in the student led practice and its focus away from individual clinical illness based interventions towards identifying and harnessing peoples' strengths.

Keywords: Health Ecology; Family therapy; Nursing student clinic; Tai Chi/Qigong, Laughter Yoga, Mental health promotion.

Introduction

In 2013 the University of New England under the leadership of Professor Cynthia Stuhlmiller from the School of Health, began a project that included leasing the Coledale Community Centre in South West Tamworth in NSW Australia to develop a Nursing student led practice. The evolution of this practice has not been without challenges from many different directions. Coledale has been frequently described locally in the media, by council and health and welfare services as an area of low socioeconomic disadvantage, poor health and educational outcomes and high domestic violence, drug and alcohol abuse and crime rates.

Coledale was first settled in the 1830’s. The original inhabitants of the Tamworth area of NSW were the Kamilaroi Aboriginal people and many Aboriginal people who live there currently identify as tribal members of the Kamilaroi Nation. Surrounding Tamworth and
Coledale are the Liverpool Plains considered as the ‘bread basket’ of NSW but where increasingly large scale Open Cut and underground Coal Mining and Coal Seam Gas operations are being developed. According to the Australian Bureau of Statistics (2001):

- The Census population of Coledale (West Tamworth) in 2011 was 3,041 people. 31% of the population (943 people) identified as Aboriginal and Torres Strait Islander ethnicity and 89.4% of the population (2,717 people) overall identified themselves as Australian.
- Only 2.2% (67 people) of the population spoke a language other than English at home and only a few Aboriginal people were able to speak or understand their own Aboriginal language.
- The average household size was 2.75 persons and 1,095 people or 89.8% of the population lived in private dwellings, though the vast majority were rental accommodation.
- Public Housing comprised the largest part of Aboriginal housing in Coledale. Most people lived below the poverty line, and many people survive on disability allowances or pensions.

Describing Coledale in a negative way however has created stigma and stereotypes people in this community. It does little to enhance the broader social perceptions, integration, welfare, prospects and self-determination of a majority of people trying to live well in this community. So in a broad sense a challenging social and cultural paradox exists.

Map 1 below cited from the Tamworth Council Urban Renewal draft map of Coledale provides some context to this place. The Community Centre is outlined on the map by a red star.
The Coledale Nursing student led drop in practice in 2014 has plans to also engage other health related students and mentoring professionals to practice there (e.g., dentists, nurse practitioners, general practitioner, physiotherapists, exercise physiologists, dieticians, psychologists, counsellors, social workers, Aboriginal Health Workers, Tai Chi/Qigong/Laughter Yoga/Yoga practitioners and teachers, personal trainers and fitness instructors, mental health and drug and alcohol professionals, public health and health promotion professionals/educators). Various Non-Government Organisations also service the community from the Centre offering counselling and health education services. They include Anglicare, Medicare Local, Tamworth Family Support Services (TFSS), The Coledale Community Gardens Inc., Older Men Network Inc., the Tamworth Regional Wellness Network Inc., Wallhollow Aboriginal Health. Hunter New England Local Health District (HNELHD) now also provide community health and limited community mental health services at the Centre.

The Mental Health Promotion and Prevention Service of HNELHD (Alan Avery, Joe Miller & Aditya Menon) has had a slightly longer association with the Coledale Community Centre, mostly related to the provision of family therapy and Tai Chi classes. Family Therapy
including structural and systemic forms of family therapy and utilising therapies such as CBT in a family therapy framework remains an important focus of mental health promotion because referrals for such therapy provide the initial engagement of people from all over the region with the centre and form a catalyst for people to actively participate in other forms of family based health promotion such as Tai Chi, Laughter Yoga, Gardening Therapy, fitness, progressive muscle relaxation and mindfulness as well as events, forums and seminars. The Centre itself comprises: a carpark & landscaped native gardens; a reception area; administration area; university staff room; small staff tea room and storage room; public toilets, staff toilet; garbage and recycling bins; various counselling rooms; drug and alcohol counselling, education and support room; a family therapy room; physical clinical room; treatment room; a commercial kitchen area; one large events room that can be divided into two sizable events rooms by large sliding folding doors and containing a store room and large lockable cupboards, dining tables and chairs; a large Youth room with storeroom and lockable cupboards, basic functional fitness equipment, white boards, lounges, small tables and chairs, painting materials, kitchenette and so on; inter-active teaching room with 3 telemedicine video link machines and ARNET access with board room tables, chairs, lockable cupboards, smart board and kitchenette; outside community large food gardens, a Community/Men’s Shed, water tank, shipping containers with garden equipment and supplies, a large covered area in the garden area and security fencing. Outside the centre is ‘Granny Munro Park’ maintained by Tamworth regional Council, basketball courts and an Aboriginal art trail and murals.

Next to the community centre are a preschool on one side and Aboriginal Housing Department on the other within a community of residential housing. A multimillion dollar Youth Centre is currently being constructed nearby by a publicly funded consortium led by Tamworth Regional Council and will include many NGO services including Headspace and Youth Life Wise activities as well as various counselling rooms, functional gym, basketball court and more.

For the Coledale drop in mental health promotion clinic, therapy is a much broader ‘upstream’ approach that includes coaching, prevention, early intervention, wellness oriented perspective rather than a standard ‘downstream’ or ‘bandaid’ individual/problem focused
clinical interaction within a sit-down clinical counselling room environment. Coaching as therapy focuses on exploring strengths and resources to potentiate thriving. In the Mental Health Promotion ‘Clinic’ at the Coledale student led practice coaching as therapy includes fostering engagement and interactions with the local community, with the health carers and getting involved with morning walks in the community (talking, laughing, meeting people on the way), fitness in the youth room, fitness and mindfulness outside in the community gardens area with Tai Chi/Qigong, Yoga and Laughter Yoga, gardening demonstrations for food security, nutrition, healthy cooking (e.g., Community Soup Kitchen night using produce grown in the community food gardens including some bush tucker), gardening as a functional exercise, and social engagement, filming for mini documentaries (e.g., Mental Health Month activities; R U Okay Day), of people, places and activities, and mentoring and teaching of students to assist them in their autonomous practice. Avery’s Health Ecology Model © (1989, 1996, 2001) has formed the basis on which family and community centred mental health promotion and wellness therapy activities are being designed, evolved and conducted in a holistic way and visiting health professionals and students are educated in this approach. The term ‘Clinic’, thus takes on a salutogenic meaning because it no longer reflects a cold, medical, clinically loaded problem saturated four walled environment in a bland building. The concept of ‘Clinic’ can still mean this but there is a philosophy of sharing spaces that are more mobile and become mutually agreed meeting places. A clinic here may include places to foster yarning around a campfire or walking in the bush or walking the talk around the neighbourhood, during physical activities in a park, at a school event or functional gym area, or in a room with natural surrounds (scenic pictures, Aboriginal dot paintings, plants and flowers, sculptures) and somewhere to relax, somewhere for the kids to play and a place to have a coffee or tea during conversation.

A mental health promotion clinic therefore includes multipurpose, diverse, satisfying, safe, relaxed and interesting places where people feel free to open up, share stories and enable conversations to naturally occur. In addition it is a place to conduct events, seminars, forums, conferences, art and craft exhibitions for promoting health to the community, schools, health workers and professionals and so on. The commercial kitchen operates on a Tuesday night as a soup kitchen for the community with local cooks, and people from all over Coledale come together to eat and socialise for free using the vegetables and herbs grown in the community food garden at the Centre. Enabling families to learn about the potential of their lives, about
what social determinants of health and thriving might mean to them and how to sustain this through coaching and mentoring is a major focus of mental health promotion at Coledale. Despite the positive developments a relatively small section of the community are actively engaged in some crime or anti-social behaviours (vandalism, illicit drug dealing, break and enters, arson, car stealing/joy riding and so on). Often the offenders are children or teenagers. Sometimes the level of domestic abuse, homelessness or family aggravation is great and the Department of Community Services do remove children deemed by them and community members as being at risk of their families. The latter is a contentious and disturbing issue that can almost always be balance sheeted back to significant social, educational, financial and environmental disadvantage and hardship that goes back many generations. It is hoped that the various initiatives being put in place in Coledale with community backing will help to change the culture and gradually foster ownership of the initiatives by people from all over the region – to break the marginalisation and stigma that has occurred.

Review of the Literature

There is increasing evidence in the research literature of significant associations between physical, social, environmental and mental health. On the one hand, poor nutrition, lack of exercise and overweight/obesity have all been identified as some of the key risk factors contributing to the poor physical health status of people with mental illness (Dickerson, Brown, Daumit et al., 2006; Coghlan et al., 2001, Davidson et al 2000, Wallace & Tennant, 1998). Alternatively the importance of nutrition and physical activity in promoting good healthy lifestyles and preventing disease (e.g., heart disease, diabetes, stroke, cancer) is also well established, with research also indicating a range of mental health benefits to be gained from regular exercise and good nutrition (Framingham longitudinal study; Carter, Callaghan, Khalil & Morres, 2012; Blank, Grimsley, Goyder, Ellis & Peters, 2007; Paluska & Schwenk, 2000).

Paradoxically however Lysaker, Roe and Yanos (2007) discussed how having insight or awareness of one’s illness or a diagnosis in an informed way leads on the one hand to improved function outcomes but on the other hand often leads to reduced hope and self-esteem, especially when the process mainly involves targeting and saturating life and health
Lysaker, Roe and Yanos (2007) focused on people with schizophrenia and explained this paradox from their quantitative research findings (mostly men in their 40’s all involved with treatment) suggesting that meaning making of their condition also included acceptance of stigmatising beliefs about mental illness known as internal stigmatisation. Lysaker, Roe and Yanos (2007: 197) in discussing schizophrenia stated:

One possibility is for research to study ways to facilitate the efforts of persons with schizophrenia to replace self-stigmatizing beliefs and transform their narratives and experience themselves as active protagonists in their own lives with realistic appraisals of their strengths and deficits.

The findings (despite some methodological issues) provide a guide for exploring mental health consumer narratives and ways to overcome negative self-beliefs that often beset narratives and focus on more positive self-beliefs including hope for the future. Mezirow (1994a, 1996) and Freire (1972a, 1985) explained how people were often incapacitated or domesticated in their lives because of myths about ‘who’ and ‘what’ they should be and behave like in their socially and hierarchically ordered world. Through critical self-reflection and discourse with others, people are capable of removing their blinkers, to enable them to explore an expanded rather than a narrow world view. This is often a frightening and disorientating experience as long held beliefs, attitudes, and values are challenged (Mezirow, 1994a, 1996), but remains necessary so that transformation to a new world view or schema can be realised. Ongoing research in transformative learning has identified emotions and subconscious responses as also critical in the direction of any transformation or critical learning.

Daley, A.J., (2002) argued that there is significant evidence to promote the use of exercise (albeit more research is needed to explore what type of exercise is most suitable) for people with mental health problems or for people seeking how to improve their mental health in their lives as an adjunctive therapy because it significantly improves mood and reduces anxiety and stress. Daley strongly advocated (citing other research) that exercise therapists should work alongside psychologists and psychiatrists in providing therapy for people with mental illness or for people seeking how to improve their mental health. Motivational interviewing techniques (O’Halloran, 2009) used alongside solution focused brief therapy (Iveson, 2002), narrative therapy (Waugh, 2004) relaxation and mindfulness are certainly ways in which people can learn to actively contemplate engaging with exercise. Daley (2002) cited the
research findings of Faulkner & Biddle (2001) suggesting that the physical health promoting and disease reduction cost aspects of exercise for people with mental health problems have largely been ignored by health authorities (referring to the UK) and need to be actively pursued. Carless & Douglas (2008) described an interpretive account of two case studies where returning to sport and exercise constituted intrinsically meaningful activities following serious mental illness that lifted mood and self-esteem. The Centre for Mental Health, Australian National University (2009: 1) contend that ‘...muscle tension is usually associated with stress and anxiety, which are strongly associated with depression.’ They cite randomised controlled trials of relaxation therapy for people who have depression and whilst it is more effective than placebo, is not as effective as psychological treatments such as Cognitive Behavioural Therapy (CBT) (Keshavan, Vinogradov, Rumsey, et al., 2014). Relaxation often is seen as a complementary approach to other physical and mental health therapies. CBT as a learning therapeutic approach can also be used to assist in schema change for people who may be habitually depressed, stressed or anxious or confused about their life and this together with relaxation, physical exercise, motivational interviewing, aesthetics change and systemic family therapy approaches such as solution focused brief therapy and narrative therapy can help to reorientate and reframe a family’s understanding of their world and their lifestyles so that they participate sustainably.

There is also increasing evidence of the importance of counselling on physical activity to promote mental health, prevent mental health problems and if affected to recover from such problems with greater motivation, self-esteem, realistic goals, an ability to use learning to create change and fostering hope for the future and self-determination (Beaulac, Carlson, Boyd, 2011). Counselling outside of the clinical counselling room is also being investigated as having significant therapeutic outcomes. Why engage with a client or family in a stuffy room, when a garden, gym, park, saleyard, quiet cafe, walking track or some other place can enable meaningful brief conversations to occur that can help to change perspectives and ways of understanding the world and achieve physical health goals as well (Giles-Corti & King, 2010; Frank & McKay, 2010). The medical model human built environment is not necessarily the most effective or therapeutic environment for learning and change for people. Ecotherapy, described by Newton (2007), is a term and design process being explored in the literature focusing on the benefits of including the natural and human built environment in
promoting health and wellness. This certainly has influenced design for family therapy and family mental health promotion purposes at Coledale.

Other forms of therapy that are known to be health promoting include massage as an effective complementary therapy assisting exercise tolerance, muscle relaxation, and mindfulness (Garner, Phillips, Schmidt, Hans-Martin, Markulev, O’Connor, Wood, Berger, Burnett, McGorry, 2008; Khilnani, Field, Hernandez-Reif, & Schanberg, 2003). There is also increasing and well established evidence to support the use of Tai Chi, Qigong, and some forms of Yoga as not just physical exercises, but also forms of mindfulness in motion (Sun, Buys & Jayasinghe, 2014; Wang, Man, Othelia Lee et al., 2013; Deshpande, 2012; Zhang, Layne, Lowder & Liu, 2012; Wang, Bannuru, Ramel et al., 2010; Wall, 2005; Thornton, Sykes & Tang, 2004). When combined with the aesthetics of natural environments (ecotherapy), telling the ancient stories of the various Tai Chi/Qigong/Yoga forms (guided imagery) during movements, combined this with relaxing music (low heart rate speed), meditation or self-hypnosis (deep relaxation) this has been found to lead to reduced levels of stress or distress, anxiety and blood pressure (Cheung, Lo, Fong et al., 2005). It also provides a distraction from and reframing of the negative self talk habits typical of depression, similar to CBT, however motivating people who are majorly depressed (or exhaustively stressed) remains a challenge.

Bora, Leaning, Moores & Roberts (2010) argued for a wellness-focused approach to health care services, using recovery coaching with mentoring for people who have experienced mental health problems. They state:

Skills of listening, questioning and building trusting relationships are common to therapy, counselling, mentoring and coaching, as is promoting awareness, responsibility and self-belief (Whitmore 2002). Both mentoring and coaching may make use of counselling skills, but whereas in counselling proper they are usually focused on resolving particular problems, coaching and mentoring are focused on goal or role-related achievements, from ‘arriving’ to ‘surviving and thriving’, and thus include optimising success and fulfilling potential.

In that sense coaching can also be useful in promoting mental health in the community generally, focusing on and harnessing strengths and resources to potentiate thriving. Thriving is not just about using strategies to feel better for a time, but rather to focus on developing sustainable health and lifestyle changes that enable people to learn and develop lifelong knowledge and skills for themselves as individuals and for promoting wellness in their families, with friends, work or school acquaintances and so on.
The Health Ecology Framework of Mental Health Promotion at Coledale

The Coledale Mental Health Promotion Clinic has as its basis Avery’s Health Ecology Model (1989, 2001/2). Based on Qualitative analysis of 48 participant interviews in a town in North Coast NSW, a reflective field journal, and a literature review of wellness including Indigenous cultures (Avery, 2001/2), six (6) dimensions of wellness categories were identified. Dimensions can be Micro, Meso or Macro in scale. They include:

- **Personal Human Physical/Biological Wellness.**
- **Personal Human Psychological & Emotional Wellness.**
- **Spiritual Wellness** (an interactive, interdependent bond between the human mind and body, religion, culture, other life forms and collective environments).
- **Personal Lifestyle Wellness** (psychosocial and environmental).
- **Human Social Wellness** including cultural, religious, family, economic, political, community, group systems .
- **Environmental Wellness** (Natural & Human Built).

According to the Health Ecology Model, for people generally, and that includes their natural and human built ecosystems, there are various fundamental aspects of life that relate to the 6 Health Ecology Dimensions. Those fundamental aspects of life vary depending upon the perspectives from person to person, family to family, community to community and so on being considered. Each fundamental aspect of life inevitably is linked to other allied aspects of life including various social determinants of health, but for the purposes of this paper, the focus is on fundamental aspects. Each fundamental aspect of life can be interpreted as having some level of wellness or health depending upon many factors. Maslow for example identified various fundamental aspects of life according to Hierarchy of Needs Model (1954).

The wellness or health of each fundamental aspect of life is fully interdependent on other fundamental aspects of life (General Systems (GS) Theory, von Bertalanffy, 1968). This reflects the importance of ecosystems in understanding wellness or health including interventional care. Each aspect of life is in a dynamic phase of change and the constant ebb and flow of negative and positive energy is always a part of life. Thus a person e.g., cannot be
referred to generally as healthy or unhealthy because inevitably people, environments, communities have elements of both all the time in some sort of dynamic balance. If ecosystems are out of balance in say a negative way then the chances of significant aspects of life being out of balance in a negative way increases and the same if things are out of balance in a positive way.

The engine that drives or mediates human wellness is ‘Learning’ which is itself a fundamental aspect of and cycle throughout life. Learning can enable fundamental aspects of life to change – i.e., to move from one level of wellness to another. If strengths and resources are assessed to be in a favourable mix the learning for some or all fundamental aspects of life for a person, a group, a family, a community and so on has the potential to become positively re-energised and to change an aspect or aspects of life in the direction of a higher level of wellness (towards negentropy in GS Theory).

If strengths and resources are assessed as not in a favourable mix the learning for some or all fundamental aspects of life for a person, a group, a family, a community and so on has the potential to become negatively energised and to change an aspect or aspects in the direction of a lower level of wellness (towards entropy in GS Theory).

Those strengths and resources are termed either as Energy Regeneration Factors or Energy Degeneration Factors and ultimately determine the health of the Learning Cycle and the potential direction of the level of wellness of each fundamental aspect of life.

In the Health Ecology Model identifying and harnessing strengths and resources including motivation, creativity, hope, self determination, mindfulness and so on are at least as significant as the process of problem solving. Without the former, problem solving cannot exist. Indeed solving is not necessarily synonymous with problems at all. Generation of creative solutions may have nothing at all to do with identifying or dealing with problems but may refer to ideas, needs, wants, desires, hopes and so on that can be harnessed.

Indeed according to salutogenic theory (Antonovsky, 1996) and research (Eriksson & Lindström, 2010) moving away from a focus on problem saturation and problem solving obsessions in the dominant health care field that we know from research at least in mental health can lead to stereotyping and stigma, enables people to explore their potential, to heal, grow and develop a sense of hope and purpose for the present and the future. Problems do exist but of themselves they do not offer a solution.
### SUMMARY OF WELLNESS LEVELS AND THEIR THEORETICAL DERIVATION

<table>
<thead>
<tr>
<th>Levels of Wellness</th>
<th>Theoretical Derivation</th>
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<tr>
<td>Non-living (Entropic Forces Level)</td>
<td>(Closed System or Entropy, von Bertalanffy, GS theory, 1968)</td>
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<tr>
<td>Wellness Exhaustion Level</td>
<td>(Selye, GAS Theory, 1956, 1979)</td>
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<tr>
<td>Wellness Protective Level</td>
<td>(Selye, GAS Theory, 1956, 1979)</td>
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<tr>
<td>Alarm-Reaction Level</td>
<td>(Selye, GAS Theory, 1956, 1979)</td>
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<tr>
<td>Wellness At-Risk Level</td>
<td>(Epidemiological Research)</td>
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<tr>
<td>Functional Wellness Level</td>
<td>(Dunn, 1959; Maslow, 1954)</td>
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<tr>
<td>Potential for High Level Wellness</td>
<td>(Dunn, 1959; Maslow, 1954; von Bertalanffy, 1968 - maximising negentropy or living energy)</td>
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<tr>
<td>High Level Wellness</td>
<td>(Seligman, 2011; Dunn, 1961; Maslow, 1954)</td>
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**Key:**
- GS = General Systems
- GAD = General Adaptation Syndrome

The findings of Avery (2001) indicate that there is a definite link (a cycle) between learning and wellness or health. Health should not be defaulted to illness, because in health ecology illness is simply a descriptor of some fundamental aspect or aspects of life that is/are out of ecological balance with other fundamental aspects of life. Health is therefore not at some linear opposite end of a scale to Illness. Like yin and yang in Taoist Chinese philosophy, there is always a dynamic and not a static balance between the negative and the positive. A rebalancing of energy, strengths and resources may well be needed including rebalancing or balancing the learning cycle for each and every fundamental aspect of life.

Getting this mix balanced for change to occur may require help and expertise from others, be they family, spiritual leaders, workmates, health professionals, governments, social or environmental action groups. Relationships are fundamental to human life (Bawden, 2002).

The Health Ecology Model can be represented as a map that shows the holistic health or wellness of a person, a family, a group, a business, an environment – whatever one chooses. The levels of wellness (7 that are living) can be represented as a 7 descriptor Likert Scale for each of the Fundamental Aspects of Life e.g., of a person - such as Physical Health & Fitness, or Family, Social & Cultural Health, Financial Health, Spiritual Health, Environmental
Health. It is a situated perceptual Model that can be mapped according to the context or situation.

Furthermore, Health Ecology Maps can be forecasted utilising data that can be predicted or expected in the future – similar to weather maps or economic forecasting. Thus the health of a person’s Physical Health and Fitness could be mapped on the basis of forecasting physical health status using an exercise plan for 6 months hence – a higher level of wellness could be predicted as an outcome if a client were motivated to adopt a particular program of stress reduction, exercise and diet suited to their goals and needs. Viewing such an illustrated forecasted map can be a motivator for change or adaptation – just as a weather map or climate model can provide a guide for intervention in agriculture, industry or climate science developments, or what to wear to work, school, sport or to the beach. Please refer to Figure 1: Example of a Person’s Health Ecology Model Map:

- In Fig. 1, the model shows just a few of the possible different Fundamental Aspects of Life relevant to a person.
- The Map also shows the 8 different levels of Wellness and these can also be viewed as a Lickert Scale indicating the wellness of each of the Fundamental Aspects of Life.

Included in the map are:

- the Adaptive Learning Cycle (ALC) – the engine that enables change in the wellness system;
- ERFs which are Energy Regeneration Factors such as motivation, resources, personal strengths, social skills and so on;
- EDFs or Energy Degeneration Factors of which many social and environmental determinants of ill health could be included;
- Energy Regeneration Pathways (ERPs) – the direction of change towards negentropy due to Learning and Balancing/Harnessing the mix of ERFs and EDFs; &
- Energy Degeneration Pathways (EDPs) – the direction towards entropy due to things like barriers to learning and being unable to effectively Balance/Harness the mix of EDFs and ERFs.
Although one might assume that people in this community would be at lower levels of wellness regarding their most fundamental aspects of life, there are many people who in fact possess great strengths and resources. Family and spiritual ties are often strong, and people share resources amongst themselves when in trouble. Maslow’s (1954) self-actualisation hypothesis (possess a set of attributes of higher order reasoning, empathy, displaying creativity and originality of thought, kindness and desire for peace, capable of deep intimate relationships, independent and self-determining, possess and value peak moments of happiness and elation, seeking own potential, acceptance of others) originally focusing on individuals could also be generalised across to families, to groups, to communities, to environments, and societies (Mathews, 2013; Seligman, 2011; Dorji (2010) – discussing Gross National Happiness in Bhutan also explored by Seligman; Dunn, 1959 – High Level Wellness). There is ample evidence to suggest that many people living in poverty, homeless and destitute have an extremely hard time just trying to survive each day and often include trying to help their children survive (to eat, have shelter, warmth, safety). That does not mean that people cannot self-actualise and be happy or contented in such environments as attested by many Indigenous peoples, creative artists, students, sages, academics, monks, writers, poets, farmers, martial artists
and others, around the world, where they live frugally without the presence of wealth or extensive material resources.

**Discussion**

From this review and from the perspective of the Health Ecology Model, opportunities for mental health promotion exist in Coledale to explore the possibilities of working with people using strengths based approaches.

Coledale Mental Health Promotion Clinic incorporates a portfolio of knowledge and skills aimed to help people in the community, families, students and others learn about wellness and how to sustain wellness. A major focus has been the collaboration of the Nurse Practitioner with the Mental Health Promotion and Prevention Service of HNELHD, employing holistic family therapy as a means of socially engaging with people in the community. The Nurse Practitioner is also an established Aboriginal dot painting artist and she runs workshops for students, health professionals and other staff as part of a reconciliation process. Her holistic approach to what could be called generalist GP type services has gained support from this community who have not had any local access to such services before. Referrals to the Mental Health Promotion team from the Nurse Practitioner, the Aboriginal Coordinator for Mental Health in the Hunter New England Local Health Service, Tamworth Family Support Services and the students leading the practice over the past 12 months have included: 49 client families. 32 client families have been once only visitations to the family therapist with minimal interventions required beyond assisting with pragmatic issues such as employment, housing or legal advice and information. 4 client families are long term and also participate in other mental health promotion activities such as Tai Chi/Qigong, Laughter Yoga, and assisting with the soup kitchen night. 13 family clients visit irregularly and require some counselling, referrals to local services, assistance with transport. Nursing students attend family therapy sessions to learn about assessment & counselling skills, narrative and brief family therapies, Tai Chi/Qigong and Laughter Yoga, and gardening therapy sessions (Clatworthy, Hinds & Camic, 2013). Video records for family therapy, documentation and the process of supervision/mentoring are further skills that students learn by experience with supportive mini tutorials that they can incorporate into their Nursing Practice elsewhere. The Aboriginal Coordinator for Mental Health (Joe Miller) is
also a crucial player in family based mental health promotion therapies and activities, particularly helping with:

- Identifying and actively engaging with local people (Indigenous and non-Indigenous) in need of counselling, care and guidance;
- Organising much needed community transport to the centre or to the Tamworth Hospital or local NGO’s, or medical practitioners for appointments;
- Acting as a co-therapist with the family therapist especially for Aboriginal people who need culturally sensitive counselling, psycho-education, guidance and support;
- Organising and participating in major mental health promotion, educational and social events and liaising with local schools, community groups and workplaces;
- Liaising with the University (UNE), local councillors, politicians to lend support to proposals for sustainable public/private initiatives in the Coledale area;
- Acting as a mentor for Aboriginal and non-Aboriginal kids in learning life and Aboriginal skills.

The Mental Health Promotion Clinic operates on a regular basis every Tuesday and Wednesday but often the practice becomes extremely busy and new referrals sometimes require attendance on Mondays as well. The Tuesday is primarily a drop in clinic with people seeking family therapy, psychotherapy, Qigong with mindfulness and Laughter Yoga. On Wednesday’s the Mental Health Promotion team works with the Medicare Local team to run Tai Chi/Qigong lessons with group story telling over a healthy lunch for a group of approximately 20 Aboriginal Elder Women though numbers vary week by week. Medicare Local staff members participate in the Tai Chi lessons as well. These classes have been operating since 2012 and are the most successful long term activities that have been run at the centre. Formal evaluations are not considered appropriate by the group as this is their weekly get together to enjoy a social outing, to tell yarns (normally considered women’s business but the male Tai Chi teacher (Alan Avery) is considered so integral to the group now that he is totally accepted), to share their weekly experiences and lives and to learn how to relax and become fitter. However agreed to outcome evaluations have established some interesting findings.

**Evaluation methodology**
The methodology for evaluating Family Mental Health Promotion programs including family therapy is an important process in exploring and determining what works and what doesn’t. **Evaluation methodology** (qualitative/quantitative) at Coledale for family and individual solution focused brief therapy with some elements of narrative therapy has to date included:

- **Sampling** (convenience (drop in), snowball (drop in), theoretical (choosing sample based on literature researched themes)) and informed written ethical consents;
- **Videoing data collection of family or individual psychotherapy sessions with consents** (videos used for clinical purposes, evaluation and supervision purposes (solution talk and not slipping into a problem talk dialogue - to improve therapy approaches), for education/publication purposes.
- **Genograms** – understanding family relationships where culturally appropriate,
- present/future orientated **circular questioning**,
- identifying **strengths and resources**,
- **scaling questions**,
- **miracle questions** (de Shazer, Dolan, Korman, Trepper, McCollum, Berg, 2006)
- **compliments** (Berg & Dolan, 2001)
- **reframing narratives** (reflection, discourse) for present/future change,
- **setting goals**,
- **homework**.

**Goals of Evaluation** - analysis of programs such as family therapy to date include:

1. Understanding how dominant and less dominant narratives in families help to design:
   - family relationship thinking and culture,
   - family and community relationships,
   - gender power relationships,
   - emotional and lifestyle behaviours,
   - home and community physical environments;
   - How designs could be reframed through collaborative reframing of the family narrative.
2. How positive mental health promoting change agency occurs for families and individuals through learning and therapy.

Descriptive and critical interpretation via qualitative analysis at this stage are the main methodological approaches for evaluation and includes:

- Video analysis by transcribing video data verbatim and conducting paragraph by paragraph content analysis and overall critical discourse analysis of data with team which includes family/individual participants (participatory action research).
- Interpretive analysis of scaling questions, success of miracle questions, success of goal setting over time, referral to other services such as functional fitness training, Tai Chi, Laughter Yoga, Gardening as Therapy.

Often hybrid family therapy narrative/solution focused brief therapy sessions, which are free of charge for participants at Coledale, help to maintain engagement with participants over a longer term. Sustainable engagement in this community is critical in order to foster trust, rapport, participation and collaboration with other activities offered at Coledale, and change agency.

**Family Mental Health Promotion Therapy Exemplar**

The following is an exemplar of family mental health promotion practice. Identifying aspects of the case exemplar have been changed in order to maintain confidentiality and privacy as much as ethically possible. Instead of using a genogram as such, as this family identifies as being Aboriginal and seeks only to be described in a very simple 2 generation way, an outline of the immediate family is included as follows:

**Family Profile**

**Parents:**

(C) = Mother (age 37) Identifies as Aboriginal

(R) = Father (age 41) Identifies as Aboriginal – with high functioning Intellectual Disability

**Children:**
(V) = Older Daughter (age 8)

(J) = Younger Daughter (age 4)

**Grandparents:**

(S) = Grandmother (age 63) Identifies as Aboriginal

(M) = Grandfather (age 69) Non-Indigenous.

Family Mental Health Promotion Therapy was commenced in mid January 2014. C was referred to see myself (Avery) and my team (Miller, Menon) re family therapy from the Nurse Practitioner, about C’s personal crisis. This included R pressuring C for sex, not helping with housework, not looking after children or helping them with school work, or taking them to school etc, R hitting C on arm and swearing at C when he doesn’t get his way especially re sex, R playing computer games until late at night, R following C everywhere, R demanding when he wants money including demanding and spending C’s pension money on junk food, electronic games etc, and R’s almost paranoid accusations (according to C) of C maybe desiring other men.

C expressed that the grandparents side with and believe only what their son (R) tells them, and that she was being marginalised in the family, accused of being lazy, not looking after the children, not doing the housework properly, wasting her money and being threatened by the grandparents who told her that they would go to Community Services so that she would lose her children. C said that she wanted to run away and take the children with her, although acknowledging that she would have no other family supports, no income, no-where to stay and would be scared for her children’s welfare if this happened. Suicide was mentioned though C said that this was against her Christian upbringing. ‘I just want to go, get away from R and his family, anywhere but here, even if I have to lose my kids, I can’t take this anymore. I don’t want to live if this is all I have. He hits me and tells tales to his family about me that aren’t true.’

I asked C where this crisis would fit on a Catastrophic Scale I showed her (0-100, 100 = totally catastrophic) and she indicated about 70 but only after reflecting on far worse things that could happen in her life. I indicated that this was still pretty high on the scale and she
agreed. We discussed whether the whole situation was a bit overwhelming for C and she agreed. I suggested instead that we focus on just one or two things at a time and see whether these were in fact catastrophes or things that could be controlled or changed. C agreed and we focused at first on her self esteem and confidence, especially in the company of R. C had stated that R, who would often talk over her as if she wasn’t in the same room, was still capable of listening, had given up alcohol, tobacco and had never taken drugs. R is also a committed Christian as indeed C is and the grandparents as well.

I indicated that these were positives and asked her whether there were periods of exceptions where she could talk with R and he would listen. She said that he sometimes listens and will change when she is a bit more assertive or when he really wants something – though lately she has become quite downhearted. I said that this was also a positive and asked her if she became more assertive with R – e.g., No stop R I don’t want sex now, I want to relax after looking after the children all day – how might he respond? C was unsure though did say that R would not try to hurt her based on her previous experience.

I suggested to C that she gradually increase her assertiveness with R as homework, and try to get him to start behaving like a husband and a father rather than another child in the family. C was to report back to me and the team each week to see how this simple strategy might work. After a few weeks it was clear that the strategy was working well, R had, albeit reluctantly at first, changed his more aggressive behaviours when C told him to stop and then telling him that she was not seeing other men. R was at first a bit shocked and confused but gradually after C reinforced her assertiveness each time he acted out, he had begun to change a bit, stopping and then listening to C. Ineed he even started helping with the cleaning and playing with the children – relieving C and giving her a rest.

After a couple of months, the grandparents had begun to notice a change in the family, and that R was not telling tales to them anymore about C, and that C had also become more assertive in her interactions with the grandparents. Indeed C had also become more assertive and less dependent on her children, acting now in a parent rather than a friend role. V had been missing school because she just didn’t want to go and because C would always relent. Indeed V would get aggressive with C, hitting her and yell at her if C wanted her to go to school. V had developed substantial power in the family and played parent off against each other and grandparents as well. With C’s new assertiveness, boundaries of behaviour were
created within the family and despite V’s protestations, C stood firm and ensured that V attended school regularly. This was an important milestone for C and the family, whose relationships now changed from game playing, manipulative enmeshments to one where communication and daily behaviours changed from damaging to well.

C stated:

‘Without this therapy I would not be alive today. I feel like I am confident to say what I want without being laughed at, always scared to say anything and ignored. For the first time in my life I have control over my life and I know how to do this now. S actually talks with me now and is like a mother and not an enemy and likes me. We go to the local supermarket on a Wednesday and sell raffle tickets together for the school, help out together with the soup kitchen on Tuesday nights and ...we have a cup of coffee and chat with friends and laugh. She respects me now because she knows that I am important in this family and I can stand up for myself. R still talks over me sometimes and still acts like a teenager, but he now stops and listens properly to what I have to say and helps out. Last weekend we got in together with the kids and cleaned up the house, got a skip and threw out lots of rubbish. That took pressure off us from our nosey neighbours. R cleaned the house from top to bottom and I told him I was proud of him. My life is getting better.’

J the younger daughter is going to preschool 5 days a week now and V is at school 5 days a week. C is now planning to go out more without R hanging around her all of the time, so C is starting to meet new friends and maybe start a course at the local adult education centre. C stated that she still loves R and can see that R is changing and becoming a bit more adult now in his conversations with C and is not obsessively demanding of her re sex anymore.

**Interpretation of Exemplar:**

In a bit over 6 months C’s life has changed dramatically, she exercises daily and is losing weight as she was overweight when I first saw her. She does Tai Chi/Qigong and loves this especially the chance to relax and forget about any daily problems at home. Furthermore the family relationships have changed so that more adult communication is the norm now, and there is no victim blaming anymore and the family is working together. C’s self esteem and
self worth has risen significantly, and she is capable of setting her own goals that are realistic and achievable for the future and for the family.

R is also seeing a male counsellor at Anglicare and is learning about fatherhood, controlling aggressive behaviour, about developing his own life and meeting friends outside of the family, particularly with male friends – fishing, camping, telling yarns around the campfire. Solution focused brief therapy, albeit not so brief, has been a catalyst for change in C’s life.

**Evaluation Methodology of Tai Chi/Qigong and Laughter Yoga as Therapies**

*Tai Chi/Laughter Yoga Evaluation Goal:* Understand how Tai Chi or Laughter Yoga improves participants’:

(a) lower body physical strength (observations only – no. of squats, lunges for 1 standard form each of Tai Chi Qigong/Laughter Yoga), (b) Energy (c) Mood, (d) Optimism, (e) Level of Friendship amongst group (f) Level of Relaxation.

*Evaluation methodology – Data collection*

So evaluation data collection methodology for Tai Chi and Laughter Yoga has included observations and simple questions and Lickert rating scales as well as qualitative questioning. Please refer to evaluation tool below. Where literacy issues exist the facilitators (a) talk with the participants about what they would rate re the statements and (b) complete the form for them as they rate it/comment (Reflexivity).
Tai Chi/Qigong or Laughter Yoga Participant Evaluation

(Please rate yourself on the following scale of 1-10)

**Energy Level**

Before the session: 1 2 3 4 5 6 7 8 9 10

After the session: 1 2 3 4 5 6 7 8 9 10

<Worst Best> <Worst Best>

**Mood**

Before: 1 2 3 4 5 6 7 8 9 10

After: 1 2 3 4 5 6 7 8 9 10

<Worst Best> <Worst Best>

**Optimism**

Before: 1 2 3 4 5 6 7 8 9 10

After: 1 2 3 4 5 6 7 8 9 10

<Worst Best> <Worst Best>

**Level of friendship with the group members**

Before: 1 2 3 4 5 6 7 8 9 10

After: 1 2 3 4 5 6 7 8 9 10

<Worst Best> <Worst Best>

**Level of relaxation**

Before: 1 2 3 4 5 6 7 8 9 10

After: 1 2 3 4 5 6 7 8 9 10

<Worst Best> <Worst Best>

**Evaluation Analysis Outcomes**

The evaluation outcomes from the Lickert Scale questions (no pre-test/post-test) regarding Tai Chi/Qigong participation are included in Table 1 and those for Laughter Yoga in Table 2.
below. Despite lack of methodological rigour and a small sample size in this pilot evaluation which are clear limitations, there nonetheless remains evidence that both Tai Chi and Laughter Yoga at least for this group of Aboriginal Elder women has been positive on the whole. There are some dissenting views on some of the descriptors for Tai Chi/Qigong such as optimism and energy level but most of the respondents were positive. One area in particular that was significant for Laughter Yoga in a dissenting sense was that of energy level. Qualitative interview data indicated that a significant number of participants found the Laughter Yoga activities as too aerobically energetic and tiring, especially for participants suffering arthritis and lower back pain. They also found Laughter Yoga a bit embarrassing in front of their peers and felt uncomfortable. Tai Chi/Qigong on the other hand was regarded by the same participants as gentle and relaxing. Optimism was not as high as for other descriptors in undertaking the two activities and qualitative interview data from dissenting participants indicated that although the activities were healthy they did not greatly alter their life situations, arthritis and pain.

Table 1: Overview of Evaluation of Tai Chi/Qigong

Summative Evaluations of Tai Chi collected over 1 session, 2013 (%), n = 15

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Table 2: Overview of Evaluation of Laughter Yoga

Summative Evaluations of Laughter Yoga collected over 3 separate sessions, 2013 (%), n = 15

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Evaluator observations and simple descriptive qualitative analysis of video data (interviews, photos) collected, although not methodologically rigorous because there were no pre-tests to compare, did indicate some interesting phenomena as follows.

Muscle strength has increased significantly for most regular participants, evidenced by improvements in posture (ability to stand naturally without head forward posture), balance (ability to stand on toes, lowering body, stand on one leg for up to 5 seconds whilst doing the movements ‘wild goose in flight’, ‘lotus flower blossoms’, ‘monkey offers a fruit’ & ‘Peeping at the Moon’ that are part of the Beginning Shibasi Qigong, the Lotus Qigong and the Tao Yin respectively). Ability to squat and do a Qigong lunge as part of some of the movements has increased substantially over that period for at least 8 of the women, including one woman who now discards her walking frame to stand independently and correctly do the
movements (3 times for each movement in the 18 movement Beginning Shibasi). In addition 12 participants have expressly described how they enjoy listening to the stories of the Tai Chi and Qigong forms that the teacher (Alan Avery) re-tells during the sessions with traditional Chinese music – tales of ancient Chinese observers describing the activities of birds, trees, plants, dragons, people, clouds, sun, moon, wind and water surrounded by sacred snow capped mountains such as Mount Wudang in Northern China. The movements, the stories and the music are valued by the women who recognise similar Indigenous themes to their own culture and are now well practised in doing meditation in motion. Indeed they have ordered their own polo shirts with their own Aboriginal design and Logo and it is called ‘Aboriginal Women’s Tai Chi’.

Conclusion

The Health Ecology approach is becoming a catalyst for people in this community, staff and students and NGO’s to better understand the benefits of health promotion in a much broader and sophisticated way for a challenging rural community. In addition it has helped to conceptualise ways in which the marginalised culture of this community could be redefined so that the stigma and stereotyping embedded in the minds of many people in the broader Tamworth community could be broken down and the strengths and value of the Coledale community could be made more transparent and dominant. Currently people (men, women and families) from all over the region are visiting the drop in clinic for both basic health needs and to experience healthier lifestyle options. This potentially represents a change agency model that could be explored for mental health promotion practice in other communities (Wand, 2011). A more sophisticated research project is being envisioned for Tai Chi/Qigong, Laughter Yoga, Physical Fitness and Mindfulness in 2015 using psychological tests (including the 4 item subjective happiness scale (Lyubomirsky, & Lepper, 1999) and 14 item resilience tool (Wagnild & Young, 1987), physical fitness assessments (including Queens College Step Test, Modified 10 item Borg Rating Scale for perceived Exertion, and salivary cortisol testing for a proposed larger sample size and split into 4 groups including
controls. As yet digital social media has not been as high a priority in this community because many people in this community lack access to basic technology for social media although that is changing rapidly with smart phones and tablets becoming more prevalent. The plan is to develop technology stewardship through social media education at the Centre/Clinic to open up new spaces for community engagement and development and research (O’Mara, 2012).

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Burnout, Wellness and the Natural World

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ABSTRACT: Caring for people with mental illness or disabilities involves multiple burdens for professional caregivers and patient’s relatives alike. Research has demonstrated that individuals in the human services and care professions are subject to unique stressors that may lead to burnout syndrome. Salutogenic health approaches in the form of workplace wellness programs have revealed how positive work environments reduce factors responsible for burnout. As a growing body of literature is establishing the salutary effects of regular spiritual practices, this suggests it is possible to design more holistic preventive measures that will more effectively counter burnout. While the majority of workplace wellness programs currently focus on physical activity, these could be expanded to include a range of activities that encourage spiritual wellness. Research and theory exploring the benefits of the natural world has provided different perspectives to explain how natural environments and nature-based experiences enhance many of the domains of wellness. In particular, research has provided support that when used as an intervention interaction with nature provides multidimensional benefits. These in turn augment spiritual wellness. In this paper we argue that both professional and private health carers will benefit from implementing ecopsychological practices that will encourage them to interact with the natural world. We support this notion by providing practical case examples of how salutogenic environments, wellness programs and the implementation of individual wellness practices would be beneficial across professional and private health care sectors.

Keywords: mental illness, carers, wellness, natural world, ecopsychology, spirituality

Introduction

Health care professionals and the organisations they work for are continually assessed on their standards of care and service excellence (Kaur et al., 2013). Similarly quality health care for people with mental illness or disabilities is of crucial importance for consumers and families. With an ageing population putting strains on health system resources there is likely to be an increase of ‘ageing-in-place’1 home care (Lilly et al., 2012). Research has demonstrated that individuals in the human services and care professions are subject to unique stressors that lead to burnout syndrome (Angermeyer et al., 2006, Maslach, 2003, Schaufeli et al., 2009). Within Australia there are 2.7million unpaid carers, over 1.5million carers are of working age (18 – 64) with an estimated 1.32 billion hours of unpaid care provided in 2010,

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1. “Ageing-in-place” is a current term in ageing policy, defined as “remaining living in the community, with some level of independence, rather than in residential care” (Davey, Nana, de Joux, Arcus, 2004).
with productivity losses estimated at $6.5 billion (Carers Australia Incorporated, 2012). On average carers spend approximately 40 hours per week providing care, however it is estimated that carers of someone with a mental illness spend on average 104 hours per week in the caring role (Carers Australia Incorporated, 2012). Caring for people with mental illness or disabilities involves multiple burdens with intense and chronic stressors which coupled with the common caregiver trait of paying little attention to their own needs, exacerbates the development of burnout (Angermeyer et al., 2006, Jevne and Williams, 1998).

It is important that caregivers learn not only how to avoid burnout but how to incorporate personal wellness strategies that promote the integration of emotional, physical, social, intellectual, occupational and spiritual facets of their lives. A wellness orientated approach will assist caregivers to focus on strengths as well as offer methods for prevention of problems (Myers, 2003). A growing body of research is providing support as to how natural environments and nature-based experiences enhance human wellness through the development of a relationship with the natural world which subsequently results in personal renewal and growth (Brymer, Downey, & Gray, 2009). Concurrently another body of literature is establishing the salutary effects of regular spiritual practices and how these influence caring behaviours by reducing stress, relieving compassion fatigue, improving psychological states and emotional intelligence (Kaur et al., 2013, Koenig, 2004). Previous research has documented how viewing, interacting and immersing oneself into the natural world provide multidimensional wellness benefits that progressively lead to increased spiritual wellness. Research with caregivers has indicated that they prefer preventive wellness programs that are simple, convenient and inexpensive (Loi et al., 2014). As fate would have it, some of the main benefits of the natural environment are the simplicity of nature-based experiences with many nature-based activities being both convenient and inexpensive. So this paper will establish, by using specific practical case examples that reveal how salutogenic environments, nature-based wellness programs and the implementation of individual nature based wellness practices, would be beneficial across professional and private health care sectors.

**Burnout and mental health care workers**

Burnout -the word was originally defined in 1940 to refer to the cessation of operation of a rocket engine when there was no more fuel available (Schaufeli et al., 2009). Three decades later, a more colloquial meaning evolved with burnout being used to describe the
devastating effects of chronic drug abuse (Schaufeli et al., 2009). From his observations within the free health clinic environments where chronic drug users were being treated, New York psychiatrist Freudenberger, adapted the term burnout to describe the gradual emotional depletion, loss of motivation and reduced commitment he observed with the volunteers working at the clinics (Schaufeli and Enzmann, 1998). Simultaneously yet independently, social psychologist Maslach and her colleagues discovered the term while interviewing Californian human services workers (Schaufeli and Enzmann, 1998). Their research yielded similar findings of workers who expressed being emotionally exhausted, who developed negative feelings and perceptions about clients / patients and who experienced personal crises pertaining to professional competence (Schaufeli et al., 2009). By the late 1970’s and early 1980’s burnout became an important social and organisational psychological concept and an emerging psycho-social phenomenon (Schaufeli et al., 2009). It became synonymous with capturing something critical about people’s experience with work and is almost universally accepted with the word burnout being adopted across many cultures (Schaufeli and Enzmann, 1998). Burnout became an easily visualised and powerful metaphor. It conjures images of a once burning fire being reduced to a flickering flame, representing the loss of energy, passion and dedication individuals commenced their careers with. Researchers continually documented people who experienced burnout as describing themselves feeling like, ‘they were running on empty’, ‘their battery was drained’, ‘their circuits were overloaded’ (Maslach, 2003). They felt burnt out. The dynamic equilibrium between demand and supply is drained as an individual’s personal energy and resources are not successfully replenished and are gradually depleted over time. Burnout is experienced in the body, the intellect and the spirit permeating every aspect of life and relationships, both personal and professional (Jevne and Williams, 1998). Specifically burnout is different from normal work stress or feelings of fatigue. Burnout is a multidimensional psychological syndrome consisting of three key characteristics of overwhelming emotional and physical exhaustion; feelings of frustration, anger and cynicism (depersonalisation) and a sense of ineffectiveness and failure (feelings of inefficacy) (Maslach and Goldberg, 1998).

There are key themes pertaining to burnout that underlie the impact of the job and environments for carers of mentally ill individuals; 1) the imbalance of resources, 2) the chronic nature of stressors, 3) the conflicts that occur between colleagues/ family / role demands and personal core values including the social disconnections that ensue (Maslach and Goldberg, 1998). Professional and private carers of individuals with mental illnesses or disabilities are exposed to a complex combination of physical, emotional and social burdens.
Physical burdens for professional and private carers, while somewhat different, can easily create physical exhaustion. The severity and degenerative nature of the illness along with the greater the intensity and the number of tasks required to care for an individual governs the level of care required and determines the physical burden on caregivers. During acute stages of mental illness, when home care becomes impossible, the majority of care is provided by professional carers in hospitals and mental health facilities. Professional care is usually recommended for those individuals whose care involves high intensity and high volume tasks (Angermeyer et al., 2006). Whenever there are improvements in the patient’s health, relatives often resume care duties as the individual is reintegrated into familial life. Private care usually involves more limited time for care, with carers having to be flexible with personal commitments as the need arises, assuming caring responsibilities during their leisure time thereby limiting personal downtime and making holidays nearly impossible (Angermeyer et al., 2006, Lilly et al., 2012). The informal caregiver faces all the demands of caring for the individual along with managing their own employment and other family or personal responsibilities. Compared to private carers, professional mental health carers choose to work as a caregiver on a continuous basis with their caregiving service being somewhat regulated in the context of employment, with predetermined working hours and holiday breaks.

Physical and mental burdens are often inextricably interwoven by a range of factors across professional and private care-giver contexts. While in hospitals and care facilities the caregiving relationship is more formalised, professional caregivers may be responsible for many patients in a psychiatric ward. While they share this responsibility with other trained health professionals, the patients they are attending to usually suffer from dramatically fluctuating or deteriorating conditions (Kaur et al., 2013). Professional carers face multiple extreme mental illness situations daily, while they also have to manage personal emotional responses in regard to the nature of the patient’s condition and history, as well as having to attend to the multitude of organisational responsibilities that are part of their role (Angermeyer et al., 2006, Myers, 2003). In contrast, informal caregivers are usually responsible for one mentally ill person but have limited professional support available on a daily basis with the physical burdens increasing when there is a lack of task sharing with others (Myers, 2003). The specific mental burdens experienced by private carers originate from their very personal and emotional closeness to the person being cared for (Angermeyer et al., 2006). While some caregiving terminates with recovery, many mental illnesses are
always prone to relapse while other mental disabilities or incapacities will be ongoing, making physical and emotional respite even more difficult to attain (Angermeyer et al., 2006).

Professional and private caregivers experience great social burdens as a result of intrapersonal conflicts, conflicts within the care industry system and from their networks of colleagues, family and friends. Often both groups experience little social support and minimal public appreciation for the work they do. Both professional and private carers make massive time commitments to their caring duties which in turn are responsible for the decrease in contact with family members, friends, and acquaintances (Solomon and Draine, 1995). Shift work, emergency changes in working hours and around-the-clock care duties make it difficult for professional carers to establish and maintain social contacts outside their place of work (Angermeyer et al., 2006). More specifically, in the case of mentally ill people, often relatives and professional staff feel exposed to discrimination from their environment through courtesy stigma thereby increasing the social burden of caring duties (Angermeyer et al., 2003).

As the three key features of burnout are overwhelming exhaustion; feelings of frustration, anger and cynicism and a sense of ineffectiveness and failure, the multiple burdens of caring for a mentally ill / disabled individual could easily lead to carer burnout. Especially for informal caregivers for whom caring duties and responsibilities are more like a second occupation. Both types of caregivers experience high workloads, time pressures, role conflicts, a lack of social support and poor coping strategies (Myers, 2003). In many cases, carers of mentally ill or disabled individuals may only see minor improvements and more likely to see deterioration in the condition of the person they are caring for, regardless of their efforts, thus effecting personal feelings of efficacy. Burnout is especially tragic for professionals who entered their profession or caring role with positive expectations, enthusiasm and dedication to helping people. The norms for any caregiving role while not stated explicitly, are clearly embraced by care-givers the world over; ‘to be selfless and put other’s needs first; to work long hours and do what whatever it takes to help the ill person; to go the extra mile and give one’s all’ (Maslach and Goldberg, 1998).

While many of the factors affecting caring behaviours have yet to be comprehensively investigated and identified, it is the very nature of caring behaviour by health care professionals and private carers that contributes to the individual / patients’ satisfaction and well-being (Kaur et al., 2013). In professional contexts, caring behaviours are usually one of the main indicators of the performance of healthcare organisations. Caring behaviours contain a complex interaction of physiological, psychological, sociocultural, developmental and spiritual factors (Kaur et al., 2013). Therefore it is necessary to address the different needs
any caregiver may have in each of these domains so as to assist with replenishing their personal resources that allow them to continue to care for others. The multi-dimensional concept of wellness is a practical workable model for optimal health that can assist caregivers with visualising the areas of their lives that need replenishing so that they can more successfully and easily better manage their own health.

**Human wellness**

Wellness is an active holistic and multidimensional process of optimal health essentially characterized by an individual’s awareness and realization of their fullest potential, allowing them to make choices that enable them to live a more successful existence (Dunn, 1959; Hettler, 1980 as cited in Jerome et al., 2013). Hettler (1984) developed a hexagonal model of wellness which is usually presented as six inter-related dimensions that, when integrated effectively enhance an individual’s quality of life and their ability to contribute to society. Specifically, wellness aims to promote the integration of the emotional, physical, social, intellectual, occupational and spiritual facets of life (Brymer et al., 2010). While freedom from illness in each of these dimensions indicates good health, wellness is characterised by an individual’s journey to achieving optimal functioning across these domains (Corbin et al., 2009).

Emotional wellness is conceptualised as “an awareness and acceptance of feelings, as well as a positive attitude about life, oneself and the future” (Roscoe, 2009). Emotional wellness is not simply the lack of affective distress or mental illness. Emotional wellness relates to the process of constructively and positively managing personal feelings in response to daily events and stressors. Emotional wellness is taking responsibility for your own behaviours, being self-aware, self-accepting with an ability to form interdependent relationships. The social dimension emphasises the quality of interactions with others. A person who is optimising their social dimension cultivates effective relationships that enhance the quality of life for all people involved, and who is willing to both receive and give support (Corbin et al., 2009, Horton and Snyder, 2009). Social wellness is having the ability to recognize needs for leisure and recreation and ensuring that time is allocated for those activities. Physical wellness involves proactive efforts to maintain physical activity and good nutrition, coupled with the maintenance of healthy lifestyle choices. However this dimension is also about acceptance of physical states with a focus on the journey towards realising personal potential (Roscoe, 2009, Sackney et al., 2000). An individual who is optimising personal physical wellness will be undertaking regular physical activity, making healthy
dietary choices and effectively utilising medical services. The intellectual dimension emphasises learning and other mental stimulation for its own sake, where an individual uses their mind constructively (Horton and Snyder, 2009). This dimension embraces metacognitive processes, encouraging individuals to be aware of not only their thoughts but also how these thoughts affect their lives. It also consists of discovering challenges, overcoming barriers and reflecting on experiences. Occupational wellness describes the fit between workplace and worker. High levels of wellness in the occupational dimension correlate with high levels of work satisfaction and life enrichment (Scheer and Lockee, 2003). Incongruity between professional and personal lives is often the cause of deterioration in the physical, emotional and spiritual domains of wellness (Dorn, 1992) and in many cases can lead to burnout.

Spiritual wellness focuses on the realisation of a shared connection to a greater power and a determination to fine purpose and meaning in life. It encourages an individual to develop a personal faith, fosters courage, generosity and gratitude. It also includes the discovery and incorporation of a personal set of values and beliefs. A spiritually well person feels fulfilled (Roscoe, 2009) and engages a faith that promotes justice. This dimension is typically construed as being fundamental to all other wellness dimensions (Chandler et al., 1992). The main goal of any wellness activities or programs is to keep the body, mind and spirit working in harmony. Wellness is not described in terms of a desired end point; rather it is a journey that changes over time (Global Spa Summit LLC, 2010). While wellness is presented as a process that is pursued on an individual level, environmental conditions and experiences also affect wellness levels. As a multi-dimensional concept, holistic wellness requires recognition of the interaction between a person and their environment whether that is physical (e.g. natural world) or social (e.g. work, culture). Personal awareness and responsibility is also part of the proactive health approach where individuals are encouraged to pursue and maintain effective lifestyle behaviours.

Theoretical foundations of the Nature-Wellness link

Research and theory exploring the benefits of the natural world have provided different perspectives to explain how natural environments and nature-based experiences enhance the different domains of wellness. The pressures of work, stressors of modern day life, urban noise and city lifestyles drive many people to seek relief through nature-based activities (Hartig et al., 2003). Research supports activities that involve viewing, interacting and immersing oneself in nature provide a plethora of benefits for humans. Viewing nature has been shown to increase pleasurable emotional states to such an extent that there are
reciprocal reductions in desires to engage in unhealthy behaviours (Lawrence, 2004). The most obvious health benefit is that interaction with nature increases physical activity and physical wellbeing (Booth et al., 2000, Pretty et al., 2003). However it also responsible for reductions in physical pain, speeding-up healing processes and improving recovery times (Lechtzin et al., 2010, Ulrich, 1984). Research exploring the relationship between nature and mental health demonstrate that exposure to nature provides improvements in emotional wellbeing and reductions in stress levels (Leather et al., 1998) and increases in positive mood (Maller et al., 2006). Nature also assists with the reduction of mental fatigue, improvements in attentional capacity and cognitive functioning (Maller et al., 2008), reductions in the tendency for aggressive behaviour (Kuo and Sullivan, 2001) and enhances life skills (Mayer and Frantz, 2005). Research has also demonstrated that the natural world can foster enhancements in the social and occupational dimensions of wellness (Greene, 2009; Ruter, 2009). Studies have found that workers report less stress and higher job satisfaction if their workplace includes views of nature (Kaplan, 1993; Kaplan & Kaplan, 1989).

The most well-known and researched theories on the relationship between mental health and nature are Wilson’s biophilia hypothesis and Kaplan’s Attention Restoration Theory (ART). From an evolutionary perspective humans are perceived to possess a deep connection with the natural world as the majority of human existence has been embedded in the natural environment. Biologist E.O Wilson’s (1984) biophilia hypothesis proposed that there is a subconscious urge to connect with all other life and all of the dimensions of the natural environment; plants, animals, streams, ocean waves, wind, landscapes even the weather. Evidence of biophilia is everywhere. It is evident on all of our computer or mobile phone screensavers. Images of sunset beaches, snowy mountains, cascading waterfalls all depict how intently we seek the beauty of the natural environment even when we cannot be present in those environments (Greenleaf et al., 2014). Kaplan and Kaplan’s ART suggests that nature possesses special characteristics that induce a unique restorative effect. Kaplan and Kaplan suggest that for a natural environment to be truly restorative it must include fascination (an effortless and involuntary form of attention that peaks curiosity), a sense of being away providing a temporary escape, compatibility for an individual’s preferences/inclinations and a sense of extent that gives the individual the sense of being part of something much larger and richer than everyday life (Greenleaf et al., 2014).

Ulrich’s psycho-evolutionary theory (PET) proposes that human behaviours, attitudes, cognitions and emotions are shaped by what proved adaptive during human evolution and are the result of the forces of natural selection. With the growth of the industrialised society and
modern urban environments, humans have become alienated from this deep and vital connection with nature while concurrently developing an apparent need to control and exploit its resources (Hay, 2005). Ecopsychologists propose that this condition constitutes a kind of ‘existential shock’, thereby producing a sense of denial and disconnectedness that can only be remedied by direct experiences in nature-based environments. Roszak (1992, as cited in Snell et al., 2011) outlined how ecopsychology focuses on the disconnection occurring between psychology and ecology. Psychology in general emphasizes the importance of personal relationships – person-to-self, person-to-person, person-to-family, even person-to-work. Ecopsychology determines that the person-to-nature relationships are just as important. That the connection between humankind and nature is deep, powerful and essential for survival (Roszak, 2001).

Research by Kjellgren & Buhrkall (2010) identified how nature induces altered states of consciousness. These altered states of consciousness provide an array of exceptional human experiences (EHEs) (Palmer and Hastings, 2013). Within the field of transpersonal psychology these experiences are studied for their meaning and their transformational potential. Phenomenological analysis has identified six categories of positive experiences that natural environments offer: intensified sensory perception; a feeling of harmony and union with nature; well-being and quality of life; renewed energy and awakening; a ‘here and now’ thinking and a ‘sense of tranquillity’ (Roscoe, 2009). Peak experiences, (described as states of optimal mental health), wilderness experiences and adventure experiences also all possess ecopsychological elements that can evoke transpersonal experiences (Davis, 1998, Brymer, 2005). These experiences can range from momentary events with minimal lasting effect to intense events with life-transforming consequences. Peak experiences are often characterised by awe and reverence, a feeling that the world is unified, ineffability, and a sense of bliss and ecstasy (Davis, 1998). Schreyer, Williams and Haggard (1990) highlighted the role of such wilderness values in the process of self-concept formulation, concluding that wilderness settings are important for the enhancement of human wellness.

Incorporating nature into a range of activities, from viewing landscapes and wildlife, to actively participating in different kinds of environments, produces a comprehensive array of wellness benefits. While theory and empirical research demonstrates how different experiences in the natural world improve the individual dimensions of wellness, research also indicated how nature is also able to provide multidimensional wellness benefits. These benefits include a combination of restorative states, reflective conditions, altered states of consciousness or peak experiences – all of which, in any number of combinations lead to
integrated holistic wellness outcomes. It is the combination of multidimensional benefits which are responsible for the augmentation of spiritual wellness.

**Spirituality, the natural world and caring**

As both the natural environment and the activities individuals engage in while in nature are conducive to furthering one’s spiritual development, professional and private carers will benefit from adopting wellness practices that increase their experiences in the natural world. Transpersonal psychology provides the interface of psychology and spirituality by bringing the full range of human experience into other psychological perspectives, focussing on self-transcendence and mystical states of consciousness (Davis, 1998). Spirituality in essence can be defined as an individual’s inner experience and / or belief system that they use to give meaning to existence and which subsequently allows an individual to transcend beyond their present context (Kamitsis and Francis, 2013). Kamitsis and Francis’s (2013) research found that a stronger spiritual orientation predicted better psychological health. However it is important to note that spirituality and religiousness are distinctly different yet can also be interrelated. It is totally possible for a non-religious person to have a high level of spiritual intelligence and wellness. Spiritual wellness manifests itself in various ways such as positive self-concepts, unselfish giving, higher moral character and personal transcendence (Kaur et al., 2013, Chandler et al., 1992).

Emerging research is connecting regular spiritual experiences with increased spiritual intelligence, which is turn is associated with improving emotional and social intelligences (King, 2012, Kaur et al., 2013). Kaur et al., (2013) determined two very important connections; that spiritual intelligence influences emotional intelligence and that emotional intelligence plays a central role in both caring behaviours and potential for burnout. Managing complex emotions is an essential skill for professional and private carers as the level of care they are able to provide is directly linked to the quality of their emotional wellbeing (Jevne and Williams, 1998, Kaur et al., 2013). In the same manner social intelligence and carers’ abilities to relate to other people, including being able to discuss difficult issues related to caregiving, is essential for carers performing their responsibilities as well as for attending to their personal health (Myers, 2003). Holland and Neimeyer (2005) found links between daily spiritual experiences and the reduction of burnout across the three key dimensions of physical fatigue, cognitive weariness and emotional exhaustion.

The natural environment often triggers or provides a catalyst for experiences that transcend ordinary experiences (Williams and Harvey, 2001, Davis, 1998). Ashley (2007)
reported that certain features of natural landscapes provoke deep, affective and spiritual associations. Mountains, rock formations, forests, deserts, limestone landscapes, water in all its guises (e.g. waterfalls, mist, crystalline pools, deep water, white water, whirlpools, still water, oceans) are features that inspire spirituality (Ashley, 2007). However transcendental spiritual experiences in nature are as much of a result of nature itself and as a product of the activities people participate in while in nature (Marsh, 2008). Activities that produce “flow” qualities or “peak” experiences produce a sense of union where self and ‘the other’ (a loss of self) marge, feelings of power, timelessness, and moments of complete, yet effortless focused attention (Csikszentmihalyi, 1992; Maslow, 1976 as cited in Comeau, 2012). Immersive experiences promote the changing experience of the self and assists individuals with refocussing their attention (Kjellgren and Burkhall, 2010, Kaplan and Talbot, 1983). Being immersed in the natural environment produces a greater altered state of consciousness than exposure to a simulated environment (Kjellgren and Burkhall, 2010). Such altered states of consciousness are often described by individuals as mystical and blissful feelings and are treasured as uniquely personal spiritual experiences (Marsh, 2008, Ashley, 2007). Research by Weinstein, Przybylski and Ryan (2009) explored if immersion in nature can actually make individuals more caring. They found individuals who were immersed in natural environments with a complete lack of human intervention, made those individuals feel closer and more generous to others. In contract human-made environments were more likely to orient personal goals towards more self-interested and selfish ends (Weinstein et al., 2009).

**Nature-based salutogenic health approaches**

Until recently, the health industry has been driven by pathogenesis; however the introduction of salutogenesis as a conceptual approach to health focuses on the importance of other characteristics of health aside from the mere absence of disease and infirmity. Salutogenic health approaches focus on the notion of a health-illness continuum, where during the life-course individuals traverse back and forth along the continuum. Combining outcomes from two growing synergistic bodies of literature pertaining to the salutary effects of nature-based experiences and regular spiritual practices offer practical and empirically proven measures that are capable of addressing the multidimensional needs associated with burnout. Due to what we know about burnout, human wellness, interaction with the nature world and spirituality, we propose that professional and private health carers will benefit from an increase in ecopsychological practices designed to increase their regular interaction with the natural world. Salutogenic environments, nature-based wellness programs and the
implementation of individual nature based wellness practices all offer practical and empirically recognized preventive health measures that will assist with reducing the factors responsible for causing burnout.

Nature based environments provide truly salutogenic environments for humans. Growing research supports significant links between spending time in a natural environments and high levels of psychological, emotional, physical and spiritual well-being (Louv, 2008, Wilson, 1984, Burls, 2007, Pryor et al., 2006). Individuals who live with close access to nature have a better quality of life and greater wellbeing, while a lack of access to green space has been linked with stress, anxiety and other DSM-IV-TR disorders (Greenleaf et al., 2014). As there are high stress levels of caring for mentally ill or disabled individuals, encouraging carers to live close to nature or increase the amount of access they have to green spaces would be highly beneficial, especially for those providing long term care or who choose a career as a health care professional. Nature-based spaces also potentially increase the opportunity for social interaction and increased social support (Greenleaf et al., 2014, Burls, 2007). As both professional and private carers often experience limited social interaction with people outside of their caring responsibilities, natural world environments may offer new opportunities for relaxed social interaction and increased social support.

Salutogenic health approaches in the form of workplace wellness programs have revealed how positive work environments reduce factors responsible for burnout and facilitate organisational changes such as reduced absenteeism and increased productivity. Currently the majority of workplace wellness programs focus predominantly on increasing physical activity, providing nutritional advice, cessation of smoking or stress management for employees. New wellness initiatives being offered by some organisations focus on mindfulness, building resilience and improving emotional intelligence (Workplace Wellness, 2012). Given the relationship between frequency of spiritual experiences and burnout, mental health care organisations would be best served to create a workplace atmosphere that encourages spiritual expression amongst employees (Holland and Neimeyer, 2005). While individuals may feel reticent in sharing their religious / non-religious beliefs, it is more likely that discussions about nature-based experiences would be more freely shared and openly discussed. Organisations could liaise with any number or eco-nature-tourism organisations to design staff incentive programs that will encourage staff to spend time in nature on their rostered days off or holidays. Either spontaneous conversations about nature based EHEs may ensue upon their return to work or accordingly managers could prompt staff to discuss their personal experiences in nature.
Both professional and private carers report that high levels of caregiving responsibilities, being too busy, being away from the individual/s they are supposed to be caring for and the added burden regular participation in preventive health programs generates for them are very real barriers to them undertaking preventive health measures (Myers, 2003, Loi et al., 2014). The beauty of nature-based wellness activities for carers is that the simplest activities will provide them with effective solutions for breaking down those barriers. Activity in the presence of nature, usually referred to as ‘green exercise’ has demonstrated to have significant mental and physical health benefits that are superior to exercise alone (Pretty et al., 2003). Just walking in nature as opposed to a walk in a shopping centre demonstrated that a walk in the country significantly counteracted depression and increased self-esteem (Barton et al., 2009). Kaplan et al. (2009) showed that an hour’s walk in a park at any time of year can increase attention and memory by twenty percent. Such a simple activity provides a completely accessible and inexpensive restorative experience for carers. Meta-analysis of across a range of green exercise activities (walking, gardening, cycling, fishing, boating, horse-back riding and farming) improved both mood and self-esteem (Greenleaf et al., 2014). Carers of mentally ill / disabled individuals may also experience regular feelings of inefficacy simply due to the type of condition of the person they are caring for (Myers, 2003). Any nature based activities such as private or community-based gardening that is responsible for inducing a sense of accomplishment and pride will assist with replenishing personal resources of efficacy. Interestingly, carers and the individuals they care for could mutually benefit from participating in gardening activities together. Nature-based activities such as gardening and horticultural therapy offers carers a vibrant, safe and inexpensive activity that allows them to undertake both their caring responsibilities while simultaneously providing a renewal of personal resources.

**Conclusion**

Current research has successfully identified that increased physical activity, emotional resilience, social interaction and daily spiritual experiences are responsible for the reduction of burnout syndrome (Myers, 2003, Kaur et al., 2013, Angermeyer et al., 2006). Nature-based environments and activities offer increased physical green space activity, restorative experiences responsible for improving emotional resilience, increased opportunities for social interaction and the ability to provide individual and meaningful spiritual experiences (Kaplan and Kaplan, 1989, Pretty et al., 2003, Davis, 1998, Maller et al., 2008). A growing body of research is lending strong empirical support for embracing nature-based approaches to
enhance wellness. More importantly, nature-based environments and activities allow for the integration of wellness experiences which combine to improve overall spiritual wellness (Davis, 1998, Brymer et al., 2010). Current research with health professionals is demonstrating how regular spiritual practices improve psychological health, specifically emotional and social intelligences, thereby replenishing resources that enable high quality and resilient caring behaviours (Kaur et al., 2013, Holland and Neimeyer, 2005). Carers across professional and private sectors have indicated that they would prefer simple, convenient and inexpensive preventive health activities. Nature-based environments and activities offer a diverse range of simple, convenient and inexpensive activities with multidimensional preventive health benefits. Therefore it would be sensible to incorporate a range of nature-based salutogenic health approaches for carers incorporating any combination of increased exposure to natural environments, nature-based workplace wellness programs and daily individual nature-based preferred activities.

Future research into using nature-based activities for burnout prevention strategies could yield critical information that would assist professional and private carers with learning new, inexpensive and effective methods to further improve spiritual wellness in their lives. As recent research has indicated, this would subsequently assist with replenishing personal resources across multiple wellness domains thereby enhancing their caring behaviours. As burnout is likely to affect certain personality types (Ghorpade et al., 2007) there may be unique proclivities in the way carers prefer to connect with nature. Future research is required by psychologists to explore the ameliorative impact of nature-based experiences in relation to personality types as well as a range of specific disorders and syndromes. As mental health professionals begin to better understand the benefits of nature connectedness and ecotherapy, professional and private carers who experience very little opportunity for respite may be the first to truly demonstrate and experience the benefits of regular interaction with nature.
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Cultural Diversity and Health Education-Illness Prevention in Culturally and Linguistically Diverse (CALD) Background Communities
Bilingual Community Education Program (BCE)

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Cultural Diversity and Health Education-Illness Prevention in Culturally and Linguistically Diverse (CALD) Background Communities

WSLHD Bilingual Community Education Program (BCE)

ABSTRACT: Migrants and refugees settling in a new country, such as Australia, experience unique mental health issues. How can health service provision ensure CALD background clients obtain the same outcomes as other non-CALD clients?

The Western Sydney Local Health District (WSLHD) Multicultural Health Unit focuses on providing equitable and accessible services to CALD background communities by addressing their cultural and linguistic needs, exploring the relationship between health literacy, culture and language and through initiatives such as the Multicultural Health Workers and The Bilingual Community Educators (BCE) Program.

The BCE Program is one of the major health education programs WSLHD Multicultural Health. The program aims to improve the health and mental wellbeing of CALD background communities by developing and providing health and mental wellbeing programs in a range of topics. The program employs trained sessional bilingual community educators to facilitate groups in the first language of the participants. The program trains and supports over 60 bilingual educators, who run sessions in more than 30 different languages. These programs are designed to target individuals from non-English speaking backgrounds who, in some cases, may not have strong literacy even in their own language.

Changing Life Keep your Balance and Living with Choices programs focus on Mental Wellbeing.

For migrants change can be a stressful experience exacerbated by the immigration process and the loss of family and support networks. Perceiving choice in your life and being self-determining is a life skill that can develop a sense of wellbeing. These programs are built to educate communities about poor mental health and are designed to strengthen people’s inner resources and for them to understand that they have choices in their lives that they have the right to make.

This presentation aims to discuss strategies to ensure the cultural and linguistic needs of CALD background communities are addressed, and showcase initiatives implemented by the BCE Program.

Keywords: Multicultural Health; Bilingual Community Education (BCE) Program; Anoop Johar; Culturally and Linguistically Diverse (CALD); Western Sydney
Introduction

Western Sydney Local Health District (WSLHD) has unique features that influence how local health services are provided. There is a culturally diverse and growing population, with significant needs in treatment of illness and significant challenges and opportunities in the promotion of good health.

The Western Sydney Local Health District serves a population of around 832,000 people, and covers a geographical area of around 774 square kilometres. It includes Westmead, Blacktown, Mt Druitt and Auburn Hospitals, mental health services (incorporating Cumberland Hospital), and drug health, as well as comprehensive community and population based services, and population and public health.

There are well-regarded education and training programs as well as highly regarded research programs. All of these services play a critical role in the provision of health services to the community.

The WSLHD Multicultural Health focuses on providing equitable and accessible services to CALD background communities by addressing their cultural and linguistic needs, exploring the relationship between health literacy, culture and language and through initiatives such as the Multicultural Health Workers and The Bilingual Community Educators (BCE) Program.

The BCE Program is one of the major health education programs of Multicultural Health WSLHD. The program aims to improve the health and mental wellbeing of CALD communities by developing and providing health and mental wellbeing programs in a range of topics.

The program employs trained sessional bilingual community educators to facilitate groups in the first language of the participants. The program trains and supports over 60 bilingual educators, who run sessions in more than 30 different languages. The BCEs are mainly women from the same background and speak the same language of the participants. Having women only groups allows trust to develop between the BCE and the participants, especially, in programs that may cover what is seen in some cultures as “forbidden” topics. The BCE’s are trained in group and adult education skills, and there is ongoing professional support and regular in-services to ensure excellence in service provision.

These programs are designed to target individuals from non-English speaking backgrounds who, in some cases, may not have strong literacy skills, even in their own language. For these individuals common health promotion strategies may have a limited effect. These programs are designed to have minimal reading and writing and are constructed to promote good health and wellbeing through verbal communication strategies.

The goals of the BCE Program are to improve the health of individuals by:
- Building on knowledge about preventative health care
- Motivating individuals to take greater responsibility for their own health
- Encouraging individuals to enjoy learning about health
- Increasing access to existing health services
- Strengthening social networks and support systems
- Enhancing self-esteem, confidence and wellbeing
- Affirming positive cultural and individual experiences.
Background

In 1985, the NSW Women’s Health Policy Review Committee highlighted the need for social services and programs for non-English speaking background (NESB) women. The Committee acknowledged that NESB women have greater difficulty communicating with health professionals than Australian-born women and are more likely to be isolated at home or working in occupations where they are not required to speak English. It also reported that while women of non-English speaking backgrounds have similar health concerns to Australian-born women, these are complicated by language and cultural differences. In response the Bilingual Community Education Program was developed by Women’s and Migrant Health Education Officers in 1990. In February 1997 the Healthy Women Community Education Program was revised and later in 1997 the Bilingual Community Educator Training Course was adapted.

Since these early stages the WSLHD Multicultural Health has developed this community service and has been running the Bilingual Community Education program within the community since 1990. These BCE programs have been extended to not only target women but also contain programs that branch out to reach NEBS men.

About the BCE Program

Currently a number of BCE programs are run in a wide range of languages. Through these programs the BCE Program aims to reach its organisational goals to provide a more equitable and accessible health care system which values the diversity in Western Sydney and facilitates programs in languages other than English for the benefit of CALD background communities.

All programs are designed to encourage CALD background communities to take responsibility for their own health and illness prevention in by focusing on

- Physical Health
- Emotional Health
- Psychological Health

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¹ For many years 'non-English speaking background' (NESB) has been used as a broad term to describe the target population group. Currently, the term 'culturally and linguistically diverse’ (CALD) has come into common usage.
All programs are structured for 2 hours duration per week for number of sessions according to particular program requirements.

**Physical Health Programs include;**

- New Healthy Women (8 x sessions)
- Living Well in the Middle Years (2x sessions)
- Women Growing Older: Caring For Ourselves through Change (8x sessions)
- Diabetes Awareness…in Your Community (3x sessions)
- Healthy Eating and Physical Activity (5x sessions)

**Emotional & Psychological Health Programs include;**

- Changing Lives -Keep your Balance (7x sessions)
- Living with Choices (6x sessions)
- Women and Children Growing Together in the New Country (6x sessions)
- Family Harmony and Healthy Relationships (2x sessions)

In this paper I will highlight the *Changing Life Keep your Balance and Living with Choices programs* that focus on Mental Wellbeing for CALD communities.

Mental health 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.²

With the growing cultural diversity in Western Sydney the services need to respond to changes in the local communities they serve. These changes include the emergence of immigrants whose values, culture, traditions and religious beliefs are different from the Australian culture.

Other factors contributing to increased risk of mental health problems in CALD background populations include low proficiency in English, loss of close family bond, racism and discrimination, stresses of migration and adjustment to a new country, trauma exposure before migration, and

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limited opportunity to fully utilise occupational skills. Factors that appear to be protective of mental health include religion, strong social support and better English proficiency.³

As a result of migration they may have language difficulties and have to rely much more on their individual skills to adjust to their changing living situations. These experiences can have significant effect on women’s self-confidence and sense of identity. The BCE mental well-being programs enable participants to acknowledge their capacity to rebuild their lives. Prevention is the best treatment for emotional and mental health. In addressing the problems associated with change and loss, participants are encouraged to examine strategies that are suitable to their social and cultural needs. The programs use active learning skills where the participants can think through the issues for themselves and relate them to their own and others experiences while maintaining their cultural values.

Learning methods of reading and writing are kept to a minimum in these programs as some may not have strong literacy skills, even in their own language. For these individuals standard health promotion strategies may have a limited effect. Non-verbal and practical learning ways are encouraged; for example, jigsaw puzzles, magazines pictures and play dough are used to express and convey ideas. This way, participants are better able to explore stressful issues and identify their strengths in dealing with these situations. These BCE programs enable them to make positive changes to promote social and emotional well-being.

_Changing Lives -Keep your Balance Program (7x sessions)_

The community education program _Changing Lives- Keep your Balance_ builds on women's strengths in dealing with change. The program consists of seven sessions (one optional) of two hours duration, usually run once a week in the first language of the women in the group. The sessions cover:

- Stress- What is it?
- Dealing with stress
- Making changes
- Dealing with loss (optional)
- Women and stress
- Women and self esteem

³ Alizadeh-Khoei, Mathews & Hossain, 2011; Chakraborty, McKenzie, Hajat, & Stansfeld, 2010; Reid, 2012; Sawrikar & Hunt, 2005
- Being in control

BCEs that are trained in this program have completed their core training course and run at least one *New healthy women* group. A continuing feature of the *Changing Lives* Training Course is the use of a model BCE who conducts the program with the BCEs in training. This gives the opportunity for the BCEs to directly participate in a group and to see and experience the education strategies and the group process in action.

Because this program deals with changes and loss it inevitably raises issues which are distressing both for the group participant and the group facilitator and Session 4 is therefore optional. It is particularly important that the BCE has the support of health professionals when running the program. Such support will include, for example, information on referral networks and guidance and debriefing for the BCE.

*Living with Choices Program (6x sessions)*

The community education program *Living with Choices* aims to enable participants to draw on their inner resources in order to be self-determining, to create opportunities for change for themselves and to model those changes in the communities in which they participate. The program consists of 6 sessions of two hours duration usually run once a week in the first language of the women’s group. The sessions cover:

- What is self-esteem?
- Identity
- Feelings
- Our Personal Rights
- Taking Care of Ourselves
- Ways of Relating to Others

For migrants change can be a stressful experience exacerbated by the immigration process, loss of family and support networks that women often face and absorb. Perceiving choice in your life and being self-determining is a life skill that can develop a sense of wellbeing. These programs are built to educate communities about poor mental health and are designed to strengthen people’s inner resources and for them to understand that they have choices in their lives that they have the right to make.
Evaluations from the groups and the feedback from service providers have been very positive toward this program. We continue to get requests from many service providers to deliver programs to their groups. Due to increased demand the BCE Program which was initially designed for women have been delivered to mixed groups of men and women.

BCE model is highly regarded and recognised by stakeholders as best practice in supporting and educating CALD background communities. Its quality of community delivery strategies is greatly acknowledged by the stakeholders and the community. BCEs are a valuable resource across the health system and provide value for money in delivering a large number of programs on small budget.
Attitudes about Suicide:
Community Perceptions, Stigma and Awareness of Suicide Risk

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Attitudes about Suicide: Community Perceptions, Stigma and Awareness of Suicide Risk

ABSTRACT: This paper investigated attitudes and beliefs about suicide and explored awareness of suicide risk among the community to better inform prevention initiatives. Participants comprised of members of the general public and undergraduate psychology students. A total of 91 males and 210 females (M= 27.12 years) completed the online survey. Stigmatising language did not affect participants’ attitudes towards suicide. Participants who had exposure to clinical education were less stigmatising than participants who did not. Although stigmatising attitudes were not considerably high among the sample, stigmatising attitudes were associated with reduced suicide risk awareness. Suicide risk awareness was generally low, and participants were more likely to recognise “overt” risk factors rather than subtle signs of suicidality. When suicide risk was expressed through “acting out behaviour” (alcohol use and promiscuity), participants did not recognise suicide risk when risk was potentially present, but perceived the individual to be effectively coping (positive growth). This study showed that stigma inhibited awareness of suicide risk, and provides evidence of a lack of community knowledge about what represents risk, providing further opportunities for future research.

Keywords: attitudes, prevention, risk, stigma, suicide

Introduction
Suicide is a major public health issue that accounts for almost one million deaths annually worldwide (World Health Organisation [WHO], 2013). Approximately 2,000 Australians die by suicide every year and for every suicide, it is estimated that 30 people attempt suicide (Lifeline Australia, 2010). In 2011, suicide was one of the leading causes of death among 15-24 year olds and accounted for more fatalities than traffic accidents (Australian Bureau of Statistics [ABS], 2013). Suicide prevention must therefore be appropriately addressed through campaigns that enhance community awareness of suicide risk (Dumesnil & Verger, 2009). Many national suicide prevention strategies have been developed in an attempt to inform and educate the public, but despite efforts, suicide risk awareness remains unacceptably low, suggesting that current programs are missing vital strategies in their approaches (Suicide Prevention Australia [SPA], 2010).
Current approaches promote the importance of recognising the signs of suicide in order to identify individuals most at risk (SPA, 2010). Suicide rates rapidly rise among adolescents and young adults, placing this age group at a greater risk of suicide than any other age group (ABS, 2013). Male suicide occurs at a much higher rate than female suicide, placing males at a greater risk generally (Australian Bureau of Statistics, 2010). Research suggests that 90% of people who died by suicide suffered from a psychiatric illness, and of this 60% had an existing mood disorder such as depression (Oquendo et al., 2004). Substance use has been associated with suicide, and individuals who have previously attempted suicide or have a family history of suicide are placed at a greater risk (Kutcher & Chehil, 2007). Experiencing interpersonal stress, particularly rejection from a loved one, is suggested to be one of the most significant suicide risk factors (Joiner & Rudd, 2000).

Suicide risk factors are reflected through theories that attempt to explain the causes of suicidal behaviour. The Interpersonal Theory of Suicide (IPS) asserts that people who die by suicide acquire the capability and desire to do so (Joiner et al., 2002). According to the theory, those who have experienced enough physical and/or emotional pain in the past, become used to pain and fear to the point where it prevails over the need for self-preservation (Joiner et al., 2002). The individual must also have a strong desire to die, resulting from the co-occurrence of perceived burdensomeness and failed belongingness. For this study, IPS encapsulates the best fit for individuals most at risk such as adolescents and young adults, those individuals experiencing depression and interpersonal stress, and people who have previously attempted suicide.

Although risk factors and theories of suicide assist families, friends and the wider community to understand suicidal behaviour, the signs of suicidality are not understood at the individual level. Despite current prevention initiatives, suicide risk awareness remains unacceptably low in Australia, evidenced by a recent survey prepared for the National Mental Health Commission (2013). When identifying a suicidal individual, participants stated that they would be unaware of a single sign to look out for (National Mental Health Commission, 2013). Furthermore, stigmatising attitudes and beliefs are argued to result from poor knowledge about suicide (Joiner, 2011).

Stigma shapes the wider community’s beliefs and accentuates negative attitudes about suicide (Batterham et al., 2013). Joiner (2011) argues that ‘suicide myths’
reinforce stigma, and are a compilation of common misunderstandings including the perceptions that suicide is a sign of weakness, or a cowardly act. According to Eagles et al (2003) a reduction of stigma is suggested by suicidal patients to be the most effective approach to prevention.

In an attempt to reduce stigma, some prevention campaigns have emphasised the importance of inhibiting the use of stigmatising language when addressing suicide (Alberta Mental Health Board, n.d). Stigmatising terminology includes: committing suicide, successful suicide and when suicide does not result in death it is often recognised as a failed suicide attempt. Beaton (2013) proposed that in order to effectively alter negative perceptions, stigmatising terminology must be replaced with neutral words such as died by suicide and suicide attempt (Alberta Mental Health Board, n.d). However, there is no substantive evidence to support the efficacy of using non-stigmatising words in prevention campaigns.

Factors likely to protect against suicide such as effective coping strategies have received little research attention. Josepho and Plutchik (1994) investigated the relationship between interpersonal problems, coping and suicide risk among a population of psychiatric inpatients, and found that increased thought suppression and reduced thought replacement were associated with suicide risk. Furthermore, Carver et al (1989) proposed the COPE scale which comprises of 13 distinct coping categories. Of these, active coping has some correspondence with replacement coping, while mental disengagement reflects thought suppression coping (Josepho & Plutchik, 1994). However, limited research has identified protective factors for suicide such as coping strategies, leaving considerable gaps in knowledge and practice.

The present study was developed to investigate attitudes and beliefs about suicide, examine the impact of stigma, and explore awareness of suicide risk among the community. Gaining insight into community attitudes and perceptions of risk is likely to better focus prevention campaigns to enhance suicide risk awareness (Pompili et al., 2003). Based on the current literature, the following hypotheses were developed:

1. Participants who are exposed to stigmatising, rather than non-stigmatising words will report higher scores on stigmatising attitudes and on suicide myths.
2. Participants will generally endorse stigmatising attitudes and believe in “suicide myths”.


3. Participants exposed to clinical education (mental health workers/psychology students) will report less stigmatising attitudes.
4. Participants will generally show low suicide risk awareness.
5. Participants who hold highly stigmatising attitudes will show poor suicide risk awareness.
6. Participants’ predicted coping responses will differentially reflect stigmatising attitudes.

**Method**

**Participants**
The sample consisted of 329 participants who voluntarily participated in an online survey. More than 91% completed the survey, and a total of 28 participants were excluded from analysis as they failed to complete the majority of the survey (8.5%). Participants consisted of 91 males and 210 females, and aged between 18-74 years (\(M=27.12, SD=11.19\)). Participants studying psychology comprised of 41.2% of the sample and 17.3% of participants work or have worked in mental health. The majority of participants were Australian (80.1%). Responses were anonymous.

**Measures**
Demographic questionnaire: Participants provided their age, gender, country of residence, occupation, whether they study psychology, and whether they currently work or have worked in mental health.

Stigma of Suicide Scale (SOSS): The Stigma of Suicide Scale (SOSS) (Batterham et al., 2013) examined participants’ attitudes toward suicide and consisted of 58 items. The SOSS provided participants with several words that may be applied to a person who suicides, and participants rated each item on a 5-point Likert scale (strongly disagree to strongly agree). The SOSS comprised of three factors: stigma, isolation/depression and glorification/normalisation. The SOSS has previously been statistically validated (Batterham et al., 2013), and reliability analysis in this study showed that the overall SOSS had high internal consistency (\(\alpha=.93\)).

Myths about Suicide Scale: The Myths about Suicide Scale (Abbott, 2012; Joiner, 2010) assessed participants’ agreement with commonly held suicide myths. The scale consisted of eight items that were rated on a 5-point Likert scale (strongly disagree to strongly agree). No psychometric properties were reported in the initial study (Abbott,
2012). The scale was used as it was theoretically relevant and showed high face validity, however it showed low internal consistency ($\alpha = .639$) in this study.

Fictional scenarios - Greg and Penelope: Separate scenarios depicting a male and female exhibiting characteristic suicidal behaviour examined participants’ suicide risk awareness. Risk factors of the Greg scenario included: young male, previous suicide attempt, family history of suicide, emotional childhood trauma, depression and substance use. Risk factors of the Penelope scenario included: young person, relationship breakdown, burden, “partying behaviour” (alcohol use and promiscuity), and history of mood disorders. Four questions followed each scenario: the first item assessed participants’ perception of risk by asking participants if they believed the character would end their life. The next two questions were derived from Joiner (2010) and examined participants’ attitudes toward the characters. The final item was derived from Carver et al (1989) COPE scale and assessed what participants believed the characters’ “next move” would be (predicted coping). All items were rated on a 5-point Likert scale (strongly disagree to strongly agree), except for the final question where participants chose one item or answered in free response format.

Experimental manipulation - non-stigmatising and stigmatising condition: Words in the original scenarios were altered to stigmatising words to examine the impact of language on participants’ attitudes.

Fictional Scenario - hypothetical friend: A scenario depicting a hypothetical friend exhibiting characteristic suicidal behaviour assessed participants’ suicide risk awareness. Nine questions in response to the scenario followed. Two questions assessed severity of risk by asking participants if their friend needed professional help and if he/she wanted to die. The final seven questions examined actions participants would take if their friend confided that they were contemplating suicide. The first item measured ignorance of risk. The next item measured participants’ openness to discuss suicidal thoughts, while the next two items measured participants’ fear of discussing thoughts. The next two items measured distraction behaviours. The final item assessed participants’ willingness to seek professional help.

Procedure
Participants accessed an online survey of approximately 30 minutes duration. The online information page provided contact details for the researchers and ethics committee, and participants were warned of the distressing nature of the questions and
provided with referral information. An informed consent statement followed, and participants assented before proceeding. Participants provided demographic information, and then completed the SOSS (Batterham et al., 2013) and Myths about Suicide Scale (Joiner, 2010). Participants were directed to either the stigmatising or non-stigmatising condition. One hundred and eighty-five participants were directed to the non-stigmatising condition and one hundred and sixteen participants completed the stigmatising condition. All participants then responded to the friend scenario.

**Results**

*Factor analysis of SOSS items*

As the SOSS is a new Australian stigma scale, an initial Principal Component Factor Analysis was performed to assess the factor structure of the scale in this study. The principle components analysis revealed a three factor solution consistent with the factors identified by Batterham et al (2013).

*Descriptive information*

Table 1 presents descriptive information for the overall sample, the scenario language conditions, gender of participants, participants studying psychology and working in mental health across the dependent measures.
Table 1: *Mean (SD) for Myths Scale, SOSS and SOSS Factors*

<table>
<thead>
<tr>
<th>Measures and SOSS Factors</th>
<th>Overall Sample</th>
<th>Scenario Condition</th>
<th>Gender of Participants</th>
<th>Studying Psychology</th>
<th>Working in Mental Health</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Stigmatising</td>
<td>Non-stigmatising</td>
<td>Male</td>
<td>Female</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Myths Scale</td>
<td>22.23 (4.62)</td>
<td>21.6 (4.55)</td>
<td>22.62 (4.63)</td>
<td>23.61 (4.47)</td>
<td>21.63 (4.56)</td>
</tr>
<tr>
<td>Overall SOSS</td>
<td>159.21 (25.56)</td>
<td>157.61 (28.34)</td>
<td>160.21 (23.67)</td>
<td>163.74 (25.83)</td>
<td>157.25 (25.24)</td>
</tr>
<tr>
<td>Stigma</td>
<td>74.43 (22.04)</td>
<td>.</td>
<td>.</td>
<td>81.66 (20.88)</td>
<td>71.3 (21.83)</td>
</tr>
<tr>
<td>Isolation/depression</td>
<td>63.08 (9.18)</td>
<td>.</td>
<td>.</td>
<td>60.39 (9.08)</td>
<td>64.25 (9.0)</td>
</tr>
<tr>
<td>Glorification/normalisation</td>
<td>25.8 (6.5)</td>
<td>.</td>
<td>.</td>
<td>25.7 (6.36)</td>
<td>25.85 (6.58)</td>
</tr>
</tbody>
</table>

*N = 301*
Stigmatising and non-stigmatising language

Hypothesis one proposed a statistically significant difference between stigmatising attitudes and myths across the stigmatising and non-stigmatising language conditions. This was not supported. Independent samples t-tests found no significant difference for the SOSS scores across the stigmatising and non-stigmatising conditions ($t_{(299)} = 8.61, p=.390$) or the Myths scores ($t_{(299)} = 1.880, p=.061$) across the conditions. Therefore, the two conditions were collapsed into one for further analysis.

Stigmatising attitudes and endorsement of myths about suicide items

Participants were expected to hold stigmatising attitudes and believe in myths about suicide. This hypothesis was partially supported. For the stigma factor the most common endorsement was that people who suicide are selfish (38.5%), while the most commonly endorsed myth was that suicide is a cry for help (65.5%).

Gender and age differences were assessed for the SOSS and Myths scale. A one-way between groups analysis of variance (ANOVA) was performed. Males scored significantly higher than females on the overall SOSS ($F_{(1,299)} = 4.141, p=.043$) and Myths scale ($F_{(1,299)} = 12.175, p=.001$). Age was split into three groups: (1) 15-29, (2) 30-45, (3) 46-74, using the “visual binning” method to examine the effect of age on the SOSS factors. A significant effect was found for the stigma factor only ($F_{(2,298)} = 5.372, p=.005$). Post hoc comparisons using Bonferroni correction indicated that the younger age group ($M= 76.79, SD= 21.63$) had significantly higher scores than group two ($M= 67.67, SD= 21.76, p=.042$) and group three ($M= 66.89, SD= 22.33, p=.041$). A one-way between-groups ANOVA found a significant effect for age on the Myths scale ($F_{(2,298)} = 5.262, p=.006$). Post hoc comparisons using Bonferroni correction indicated that the younger age group ($M= 22.71, SD= 4.47$) endorsed significantly more myths than group two ($M= 20.60, SD= 4.49; p=.02$) but not group three ($M= 20.94, SD= 5.12; p=.105$).

Perceptions of scenario characters and attitudes toward suicide

The relationship between age, the response questions reflecting participants’ perception of the scenario characters, and attitudes toward suicide (SOSS factors) was examined using Pearson’s $r$ correlation. The correlation matrix is shown in table 2.
Table 2: Pearson’s r Correlation Matrix for Age, Contextualised Response to Scenario Characters (Greg and Penelope) and SOSS Factors

<table>
<thead>
<tr>
<th></th>
<th>1.</th>
<th>2.</th>
<th>3.</th>
<th>4.</th>
<th>5.</th>
<th>6.</th>
<th>7.</th>
<th>8.</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Age</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Weak (Greg)</td>
<td>-0.261***</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Cowardly (Greg)</td>
<td>-0.213***</td>
<td>0.738***</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Selfish (Penelope)</td>
<td>-0.159**</td>
<td>0.347***</td>
<td>0.299***</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>5. Inconsiderate (Penelope)</td>
<td>-0.079</td>
<td>-0.043</td>
<td>-0.052</td>
<td>0.030</td>
<td>1</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>6. Stigma</td>
<td>-0.202***</td>
<td>0.533***</td>
<td>0.557***</td>
<td>0.359***</td>
<td>-0.079</td>
<td>1</td>
<td></td>
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<tr>
<td>7. Isolation/depression</td>
<td>0.045</td>
<td>-0.131*</td>
<td>-0.162**</td>
<td>-0.162**</td>
<td>0.006</td>
<td>0.301*</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>8. Glorification/normalisation</td>
<td>0.036</td>
<td>-0.079</td>
<td>-0.109</td>
<td>-0.068</td>
<td>0.065</td>
<td>0.129*</td>
<td>-0.002</td>
<td>1</td>
</tr>
</tbody>
</table>

N= 301, *p <.05. **p <.01. ***p <.001 (2 tailed)

Note: Perceptions of characters in response to scenario questions derived from Myths about Suicide scale (Joiner, 2010): Greg (weak, cowardly), Penelope (selfish, inconsiderate).
Age negatively and significantly correlated with the stigma factor and the perceptions of characters as weak, cowardly and selfish. The stigma factor positively and significantly correlated with the perceptions of weak, cowardly and selfish.

Attitudes about suicide: Mental health workers and students

Psychology students and mental health workers were expected to be less stigmatising and this was partially supported. Separate one-way between-groups ANOVAs were performed for students and mental health workers on the SOSS. A significant effect was found for students and the SOSS ($F_{(1,299)} = 5.596$, $p=.019$). Mental health workers endorsed significantly less stigmatising attitudes than non-mental health workers for the SOSS ($F_{(1,299)} = 5.765$, $p=.017$).

Awareness of suicide risk

Participants were expected to show low awareness of suicide risk. This hypothesis was partially supported through thematic analysis and partial correlations analysis. Thematic analysis on the free response coping items showed that 51 participants (Greg scenario) and 27 participants (Penelope scenario) provided comments. Responses were coded and cross checked for accuracy. Although themes remained relatively consistent across both scenarios, the most common themes varied. For Greg, high suicide risk without appropriate support (23.5%) was most commonly endorsed, while positive growth coping (18.8%) was most common for Penelope. While seeking support was perceived to be important for both characters, Greg was perceived to have a higher risk of suicide and required more support, while Penelope appeared to be capable of “getting better on her own accord” (positive growth).

Partial correlation analysis was conducted to further explore the relationship of risk awareness and participants’ predictions of how the scenario characters would cope, while controlling for scores on the stigma factor. The prediction that Penelope ($r=-.394$, $p=.01$) and Greg ($r=-.551$, $p=.01$) would use behavioural disengagement coping negatively and significantly correlated with awareness of risk. For Greg, active coping ($r=.298$, $p=.01$) and seeking support ($r=.266$, $p=.01$) positively and significantly correlated with increased awareness of suicide risk. For Penelope, mental disengagement coping positively and significantly correlated with increased awareness of suicide risk ($r=.244$, $p=.01$).

Stigmatising attitudes and perceptions/awareness of suicide risk
Highly stigmatising attitudes were expected to reduce awareness of suicide risk and this hypothesis was partially supported. The relationship between participants’ perception of suicide risk, their choice of actions toward the friend, and stigmatising attitudes toward suicide (stigma factor) was examined using Pearson’s $r$ correlation. The correlation matrix is presented in table 3.
Table 3: *Pearson’s r* Correlation Matrix for Perception of Suicide Risk, Action Choices and Stigma Factor

<table>
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<th>6</th>
<th>7</th>
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</thead>
<tbody>
<tr>
<td>Perception of risk</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Need to seek professional help</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Awareness of suicide risk</td>
<td>.187**</td>
<td>1</td>
<td></td>
<td></td>
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<td></td>
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<tr>
<td>Actions</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>3. Ignorant of risk</td>
<td>-.136*</td>
<td>-.204***</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Openness to discussion</td>
<td>.215***</td>
<td>.106</td>
<td>-.151**</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Fear of discussion</td>
<td>-.190**</td>
<td>-.075</td>
<td>.284***</td>
<td>-.424***</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Distraction</td>
<td>-.055</td>
<td>-.142*</td>
<td>.421***</td>
<td>-.055</td>
<td>.244***</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Seek help</td>
<td>.223***</td>
<td>.020</td>
<td>-.060</td>
<td>.086</td>
<td>.074</td>
<td>.153**</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Stigma Factor</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Stigmatising attitudes</td>
<td>-.200**</td>
<td>-.081</td>
<td>.336**</td>
<td>-.244**</td>
<td>.302**</td>
<td>.191**</td>
<td>.007</td>
<td>1</td>
</tr>
</tbody>
</table>

*N* = 301, *p* < .05, **p** < .01, ***p*** < .001 (2 tailed)

Note: Scenario questions responding to a hypothetical friend exhibiting characteristic behaviours associated with suicide risk.

*Stigma factor derived from SOSS scale (Batterham et al., 2013.)*
Stigmatising attitudes positively and significantly correlated with ignorance of risk, fear of discussion and distraction, and negatively significantly correlated with need to seek professional help and openness to discussion. Although stigmatising attitudes did not significantly correlate with awareness of risk, low awareness of risk was shown by stigmatising attitudes significantly correlating with increased ignorance of risk, and by participants not recognising the need to seek professional help for the friend. Awareness of suicide risk positively and significantly correlated with need to seek professional help, and negatively and significantly correlated with ignorance of suicide risk and distraction.

Effect of gender on suicide risk awareness
As males held significantly more stigmatising attitudes, the effect of gender on awareness of suicide risk of the hypothetical friend was examined. A one-way between groups analysis of covariance (ANCOVA) was performed, controlling for scores on stigma. Females had significantly higher suicide risk awareness (M= 2.9, SD= .874) than males (M= 2.58, SD= .798, F(1,298) = 7.596, p=.006).

Predicted coping and stigmatising attitudes
Predicted coping responses were expected to differentially reflect stigmatising attitudes. This was partially supported. The impact that different coping styles had on stigmatising attitudes was examined using separate one-way ANOVAs. Participants who predicted positive growth coping for Penelope scored significantly higher on the stigma factor (F(1,94) = .5.672, p=.019).

Discussion
This study investigated attitudes and beliefs about suicide and suicide risk awareness among the community. The first hypothesis proposed that the use of stigmatising language would increase stigmatising attitudes and myths endorsed by the sample. This hypothesis was not supported. Although non-stigmatising language has been written into policy and practice (Alberta Mental Health Board, n.d) there was no significant difference between the stigmatising and non-stigmatising conditions. This study cannot answer why this occurred thereby setting a future research agenda to further explore the effects of stigmatising words in an Australian context.

Partial support was shown for hypothesis two which proposed that participants would generally hold stigmatising attitudes and believe in suicide myths. Although the frequency of endorsement of stigmatising attitudes (stigma factor) was generally rated low on the scale, the most commonly endorsed attitudes were that suicide was selfish.
In this study younger males (15-29) were more stigmatising and believed in more myths than the rest of the sample, which is the same group that the ABS (2010) identifies as the most at risk for suicidal behaviour. This study shows that younger participants were more likely to perceive the scenario characters as weak, cowardly and selfish. Holding stigmatising attitudes may inhibit young people, particularly males, from offering support to peers or seeking support in times of crisis, which supports Eagles et al. (2003) that stigma inhibits help being sought and offered in times of crisis. Therefore, although the overall sample did not hold particularly strong stigmatising views, stigmatising attitudes were apparent among younger participants. Stigmatising attitudes were strongly associated with greater endorsement of myths about suicide and highly negative perceptions of the scenario characters. This study provides additional support for the validity and reliability of the Australian SOSS. Through exploratory principle components analysis, the present study identified the same three factor solution as Batterham et al. (2013).

The third hypothesis proposed that participants who have been exposed to clinical education would be less stigmatising. This was partially supported. Mental health workers and students were less stigmatising, providing support for Joiner (2011) who argued that stigmatising attitudes result from poor knowledge and understanding about suicide. This also reinforces the importance for prevention campaigns to increase knowledge among the public to reduce stigma.

Partial support was provided for hypothesis four which proposed that participants would show poor awareness of suicide risk. Thematic analysis suggested that without seeking support, Greg’s risk of suicide was high, which shows participants’ intuitive understanding and awareness of suicide risk in this scenario (i.e. drug use, previous suicide attempt and family history of suicide). However, the majority of respondents stated that Penelope would “improve herself” (positive growth coping). Therefore, it could be concluded that when suicide risk is expressed through risk-taking behaviour (e.g. alcohol use and promiscuity), participants were less likely to recognise risk and instead perceived the character to be coping. However, partial correlations analysis showed that participants who predicted that Penelope would turn to work or other activities (mental disengagement/distraction) to cope were more likely to recognise suicide risk, suggesting that Penelope’s behaviour was interpreted as a means to distract herself. This finding provides some support for the suggestion that thought suppression, the tendency for the Penelope character to avoid distressing or uncomfortable thoughts and situations, is associated with a
greater risk of suicidal behaviour (Josepho & Plutchik, 1994). The findings in this regard are not conclusive, merely suggestive, so the question remains for further exploration in future research.

Signs of suicidality embedded within the Greg and Penelope scenarios reflected the general tenets of the Interpersonal Theory of Suicide (Joiner et al., 2002). Greg showed higher acquired capability to enact lethal self-harm through his previous suicide attempt, brother’s suicide death, and emotional childhood trauma. Penelope, according to the theory, showed a stronger desire to die through the belief that she was a burden (perceived burdensomeness), and by experiencing isolation due to a relationship breakdown (failed belongingness). However, participants’ perceived Greg’s risk of suicide to be higher than Penelope’s, suggesting that capability to enact lethal self-harm is associated with the perception of increased suicide risk. Participants perceived Greg to experience more significant life stress than Penelope, and it is likely that a relationship breakdown was perceived to be insignificant when compared to Greg’s life experience. From this study, it could be suggested that individuals are likely to recognise “overt” risk factors, rather than subtle signs of suicidality. However, it is unlikely that the wider community will have access to a suicidal individual’s life experiences; therefore, the need to recognise subtle signs of suicidality is important in identifying “at risk” individuals.

Furthermore, a common theme identified through thematic analysis was participants’ perception that the scenarios did not provide sufficient information to assess risk, and confirms that signs of suicidality embedded in the scenarios were not recognisable, confirming participants’ poor suicide risk awareness. This study shows that suicide risk awareness remains low, and supports SPA (2010) that efforts to enhance community awareness of suicide risk have had little or no effect.

Hypothesis five proposed that participants who held highly stigmatising attitudes would show poor awareness of suicide risk. This was partially supported. In response to the hypothetical friend, participants who held highly stigmatising attitudes avoided discussing suicide with the friend and were less likely to seek professional help. Distracting the friend and remaining ignorant of risk was also strongly associated with stigma. This supports Eagles et al. (2003) that stigma inhibits help being offered in suicidal crisis. Participants who showed high awareness of suicide risk were more inclined to openly discuss suicide with the friend and recognised the need to seek professional help. Therefore, results suggest that individuals who are comfortable with supporting a friend through a time of crisis are more
likely to recognise suicide risk. As research suggests that suicidal individuals are more likely to confide in friends rather than professionals (Dunham, 2004) this study offers support for the importance of friends to remain open to discussion of suicide to appropriately assess risk.

Male participants showed lower awareness of suicide risk than females. Males are widely believed to avoid discussing emotions. Therefore, holding highly stigmatising attitudes and showing low suicide risk awareness places this group at increased risk. Further research is clearly warranted if there is to be any reduction in suicide rates, particularly amongst young males in the higher risk group.

Hypothesis six proposed that participants’ predicted coping responses would differentially reflect stigmatising attitudes. Partial support was provided for this. Predicting that Penelope would use positive growth coping was associated with increased stigmatising attitudes. In this study, positive growth coping was related to low suicide risk awareness. Therefore, not recognising risk and assuming that the character would effectively cope was strongly related to stigma. This finding provides further evidence of a lack of community knowledge about what represents risk and supports a conclusion that stigma can blind participants to or inhibit suicide risk awareness.

Limitations, Implications and Future Research

The principle and most obvious limitation of this research was that the study attempted to represent “real world” situations with scenarios of individuals displaying behavioural signs of suicide. This approach represents a second-best approach given the ethical barriers to conducting such a study with suicidal individuals or their closest family and friends. Furthermore, the majority of the sample consisted of females aged 18-24 years, which is unrepresentative of the overall population. Due to the method of recruitment (social networking site messaging), individuals who did not have access to the internet were not recruited. Manually distributing the survey and having the option to access it online could have resulted in a more accurate representation of the population, although this may have increased socially desirable responses.

Findings of this study provide implications for current suicide prevention campaigns. This study demonstrates the importance of showing a willingness to approach, discuss, and assist people who are potentially suicidal. The present study offers some evidence of the detrimental impact that stigma has on suicide risk awareness, and provides evidence for the importance of prevention approaches to focus on recognising subtle signs of suicidality. Furthermore, this study demonstrates the need for prevention initiatives to target young males
in an attempt to recognise potential risk among peers. Further research should explore the impact of stigmatising language on individuals, and within broad community awareness campaigns, as this study could not support this suggestion. Further research that aims to address community perceptions of suicide risk will provide additional understanding into common misconceptions about risk in order to enhance suicide prevention competence among the community.

References


Take Charge of Your Life

Bette Blance

President William Glasser Institute-New Zealand

PO Box 42, Morrinsville, New Zealand

Paper presented at the

15th International Mental Health Conference

Surfers Paradise, Gold Coast (QLD) 25 – 27 August 2014
Abstract: Take Charge of Your Life

The late Dr William Glasser, psychiatrist, international speaker and author, left a legacy that significantly impacts the way in which we interpret mental health. Dr. Glasser believed that external control, the present psychology of almost all people in the world, is destructive to relationships and to people’s mental health. He posited that the source of almost all human problems, commonly described in terms such as mental illnesses, addiction, domestic violence, crime, and school failure are disconnects from intimate relationships. A new William Glasser International training program, Take Charge of Your Life: How to get what you need has the potential to improve the lives of those experiencing mental health issues. This international study explores the potential for change in thinking, through pre and post training questionnaires completed by participants in this six hour program. In this poster and paper, the program outline and how the data gathered demonstrates a shift in the participants desire to take more effective control of their life.

Keywords: mental health, choice theory, Glasser, internal control/external control, motivation

Introduction

In 2005, Dr. William Glasser, released a small booklet entitled, Defining Mental Health as a Public Health Issue; a new leadership role for the helping and teaching professions. In the forward of this book he challenged the current world view that defines mental health as mental illness. Most clinicians, when asked, would describe their work in mental health as diagnosing and treating mental illness. When asked for a definition of mental health, many find it difficult to define, describe or explain mental health or mental well-being.

Dr. William Glasser (2005) defined mental health as…

You are mentally healthy if you enjoy being with most of the people you know, especially with the important people in your life such as family, sexual partners and friends. Generally, you are happy and are more than willing to help an unhappy family member, friend, or colleague to feel better. You lead a mostly tension-free life, laugh a lot, and rarely suffer from the aches and pains that so many people accept as an unavoidable part of living. You enjoy life and have no trouble accepting other people who think and act differently from you. It rarely occurs to you to criticize or try to change anyone. If you have differences with someone else you will try to work out the problem; if you can’t you will walk away before you argue and increase the difficulty. You are creative in what you attempt and may enjoy more of your potential than you ever thought possible. Finally, even in very difficult situations when you are unhappy - no one can be happy all the time - you’ll know why you are unhappy and attempt to do something about it.
As early as 1961, as a board certified psychiatrist, Dr. Glasser refused to prescribe psychiatric drugs to his patients. He saw his patients as being able to take responsibility for their own mental health and chose counselling as his approach to help them take control of their lives. His work focused on discovering the underlying reasons of personal unhappiness and training students in a counselling process called Reality Therapy. This original training was aimed at teaching participants the process of Reality Therapy underpinned by Choice Theory® Psychology, a theory ascribed to Dr. William Glasser. This new Take Charge of Your Life pilot program, inspired by the title of Dr Glasser’s last published book, augments training that has already been undertaken by many people around the world, since the first certification in Reality Therapy in 1975.

Choice Theory® and Reality Therapy training has, to date, expanded to over thirty-five countries. There are 77,405 people who have taken at least a Basic Intensive Training and a total of 10,851 people have become Choice Theory Reality Therapy Certified. In New Zealand we have 1520 people who have completed at least one level of training. These programs include Choice Theory®, Reality Therapy, Lead Management and Quality Schools. The establishment of William Glasser Institutes around the world continue to evolve with William Glasser International (WGI) as the overarching body responsible for policies and procedures.

A more compact, concise training, Take Charge of Your Life introduces participants to Choice Theory®, putting the spotlight on personal choice and internal motivation. In this way it has the potential for participants take on responsibility for personal mental health and well-being.
Take Charge of Your Life Pilot Program

Take Charge of Your Life program has been piloted to diverse populations in the US, Canada, Australia and New Zealand. The pilot study presented in this paper involved a small group of people in New Zealand who undertook the Take Charge of Your Life program in June 2014.

Program

The following six one hour workshops were presented over one day.

Table 1: Six Major Concepts

<table>
<thead>
<tr>
<th></th>
<th>Shift Your Mental Model</th>
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<tbody>
<tr>
<td>1</td>
<td>Outside-in and Inside out</td>
<td>Exploring whose behaviour can we control?</td>
</tr>
<tr>
<td>2</td>
<td>Basic Needs, Wants &amp; Quality World</td>
<td>How do we satisfy our Basic Needs and, in doing so, lead a quality life?</td>
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<tr>
<td>3</td>
<td>Why you want what you want</td>
<td>How our habitual behaviours impact the way we get along with others.</td>
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<tr>
<td>4</td>
<td>Honey really does work better than vinegar!</td>
<td>Exploring how our perceptions are formed by filtering information from the real world.</td>
</tr>
<tr>
<td>5</td>
<td>What you see is what YOU see</td>
<td>How our behaviour system works.</td>
</tr>
<tr>
<td>6</td>
<td>A new meaning for being TOTALLED</td>
<td>Establishing a personal plan for Taking Charge of your life.</td>
</tr>
</tbody>
</table>

Take Charge of Your Life | Choosing a path with new purpose. |
Evaluation tools

Two types of tools were used to gather data to evaluate the program.

The first were comment sheets collected at the end of the first and the last workshops.

Table 2: Evaluations tools

<table>
<thead>
<tr>
<th>Shift Your Mental Model</th>
<th>What I now realise …</th>
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<tr>
<td></td>
<td>I want to be more effective by…</td>
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<td></td>
<td>A change in my thinking is…</td>
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<tr>
<td>Take Charge of Your Life</td>
<td>What do you appreciate about the last six sessions?</td>
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<tr>
<td></td>
<td>What has been your most significant insight of the whole program?</td>
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<td></td>
<td>How will you use this insight to take charge of your life?</td>
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<td></td>
<td>WHAT IS YOUR PLAN?</td>
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</tbody>
</table>

The second was a pre and post session questionnaire.

**Question before training**

**Question 1**

How much are you in control of your life?

0% __ 20% __30% __40% __50% __60% __70% __80% __90% __100%

**Questions after training**

**Question 1**

How much are you in control of your life?

0% __ 20% __30% __40% __50% __60% __70% __80% __90% __100%

**Question 2**

How much do you now believe you are in control of your life?

0% __ 20% __30% __40% __50% __60% __70% __80% __90% __100%

**Question 3**

How much do you think that Choice Theory will help you in your future interactions?

0% __ 20% __30% __40% __50% __60% __70% __80% __90% __100%
Pilot Program in New Zealand

Auckland Regional Coordinator for the William Glasser Institute –New Zealand advertised and hosted a pilot Take Charge of Your Life program in the Whangaparaoa Library for 5 people on June 23, 2014. Of the group, only one person had previous knowledge of Choice Theory®. The age range of the group was from late 60s through to the oldest, 91.

The purpose of the program was to

- Pay tribute to William Glasser for his generous and lifelong contribution to the preservation of human choice, leading to mental health and wellness for all people around the world.
- Present a shorter six hour course introducing personal well-being through the concepts from his many books including his last book “Take Charge of Your Life”.
- Promote further training.

The following sample of data was gathered from the participant’s feedback after the first session.

What I now realise …

- Being happy is a choice, not dependent on circumstances.
- That you can only control your own behaviour.

I want to be more effective by…

- accepting responsibility for my own behaviour.
- By practising and being aware of this so I can change the ways I deal with things.

A change in my thinking is…

- I am aware that I can change.
- I don’t need to put up with some of the behaviour I experience.
- That I don’t have to let people control me.

Following the final session the participants commented:

What is it that you appreciate about the last six sessions?

- I appreciate the experiential learning of what I know is a way for me to have a positive relationship that I struggle with at times because feel I am always ‘giving in’.
- The realisation that the positive approach always is the best, not to react negatively.

What do you think has been the most significant insight of the program?
• What I do is a choice to keep a balanced relationship rather than a confrontational one.
• We can control our own circumstance and things that have happened in the past need not affect or future.

*How will you use these insights to take charge of your life?*

• I will use the skills to make changes and take charge of my life.
• I have a very controlling family member and will use what I have learned in dealing with this person.

*What is your plan?*

• To use these skills learned to improve my relationship.
• To believe in myself.
• I’m going to read all through this manual again and keep it at hand to reinforce my choices in how I react in bad times.

Table 3: Data from the questionnaire is as follows.

<table>
<thead>
<tr>
<th>Question 1</th>
<th>How much are you in control of your life?</th>
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<tr>
<td>Pre program</td>
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<th>Question 2</th>
<th>How much are you in control of your life?</th>
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<td>Post program</td>
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<th>Question 2</th>
<th>How much do you now believe you are in control of your life?</th>
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<tr>
<th>Question 3</th>
<th>How much do you think that Choice Theory will help you in your future interactions with others?</th>
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Discussion

From this very small group a general pattern of results suggests that people do change their thinking and make plans to do something different. This particularly relates to their relationships. This result is not unexpected as over many years, participants in Basic Intensive Training over 27 – 30 hours, have given similar responses. However, what is interesting is that this shortened training is yielding similar results.

While a number of people indicate a change in belief about the amount of control they perceive they have over their lives, translating that belief into action will be important. Some of the habits chosen by these people have been developed and practised over a long period of time. If the knowledge gained during the training impacts on those habits and the changes made are significant enough to enhance the way they relate to those who are important to them, this would mean the program was beneficial.

Limitations

- The sample size of this study is small. The study covers only one program with six people. There are other groups internationally that are completing the program and this data will add to the sample size.
- The refinement of the type of questions that are asked will improve the validity of the data. Once finalised, the program may include different research questions to improve the research focus.
- The Program Committee of the William Glasser International Board is closely monitoring the research from the pilot program.
Conclusion

The Take Charge of Your Life program is creating a great deal of interest from the William Glasser International Community. Those who currently teach WGI training programs are interested in the results of this program and the condensed format design. Past WGI training restrictions on participant numbers have made the training expensive to groups. In addition to restricted class size, duration of time required to spend in training has been a barrier to people attending.

On releasing the final program to instructors within the organisation, more people will be able to present this program to any individuals or groups who are interested.

Roy (2014)

In developing Choice Theory Psychology, Glasser took ‘complex ideas and simplified them” giving us a clear and logical understanding of how and why we do what we do.

This program is designed to bring Choice Theory® in an easily understandable, affordable way to all who want to take charge of their lives.
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William Glasser Institute-Australia www.wgia.org.au

William Glasser Institute-New Zealand www.glassernz.org.nz
The Impossible Task of Controlling the Brain, the Emotions and the Behavior during Mental Crisis

D.K. Mak

Paper Presented at the
15th International Mental Health Conference
Surfers Paradise, Gold Coast (QLD), 25-27 August 2014
The Impossible Task of Controlling the Brain, the Emotions and the Behavior during Mental Crisis

ABSTRACT: ‘Control yourself’ was often what I was told to do when I was in distress; if only I could. I was given several diagnoses for my mental condition; they were Borderline Personality Disorder, Adjustment Disorder and Major Depression. Regardless of the diagnosis, I experienced intense mental pain which led towards suicidal thoughts and self-harm. I was also introduced to many therapies; all were effective when I was in a stable state but the techniques from each therapy became a blur when I reached mental crisis. Although I was aware of what was happening during distress, I had no control over the painful thoughts that were circulating in my brain and the more I tried to stop these thoughts, the more the pain escalated. It was as if there was a child screaming in my head. The emotions were so strong that it took over all logic; as such, ‘suicide and self-harm to help ease or eliminate pain is a good option’ became a logical solution. What came out during this time were behaviors that were unacceptable to mental health clinicians who were assigned to help me. They saw someone who was manipulative, help-rejecting, difficult, and disruptive instead of viewing me as a person in distress, who was temporarily immobilized and at that moment, could not comprehend logic, be agreeable and compliant, and most of all, behave ‘normally’.

It took five years for me to reach recovery in a sense that even though the pain still surfaces, it is no longer intense and it is controllable. In this paper, I would like to elaborate on my mental state when I was in distress, to discuss why I rejected help from those who did not understand me and also to identify the methods my therapist used to help me during my unstable state.

Keywords: Mental health crisis, patient account, therapy methods.

Background

Many of us seek help or are forced to seek help when we have reached mental crisis. Usually at this time, we are transported to a hospital facility or an emergency appointment with a mental health provider. Because we cannot behave as we are expected, restraint and isolation may be used. We are then labeled as 'difficult' (Russell, Koekkeok, Roberts, Miksanek, Serour) or even worse, 'hateful' (Groves) patients.
Views of the care providers on 'difficult' patients have been widely published. Most articles described us in a negative manner while others were more polite. The term 'difficult' is applied when patients display qualities which ‘evokes strong negative emotions in clinicians’ (Boekkoek) or ‘kindle aversion, fear, despair or even downright malice in their doctors.’ (Groves). As identified in many research papers, mental health patients who clash with their caregivers generally have disorders which fall within the non-depression category. This includes personality disorders such as borderline and narcissistic personality disorders, and psychotic disorders such as schizophrenia. (Roberts). The caregivers' perception of us, the 'difficult' patient, range from failure to comply with medical advice, engaging in self-harm, possessing a personality disorders or resisting recovery. (Russell, Weiss). While Russell’s paper presents an alternative view to the patient’s behaviors in that the clinician needs to take into account the events which the patient experiences, she also noted that ‘what is best for patients’ lives is rarely addressed in literature.’ (Russell)

Despite what was written about us, the sensations and the pain were real and overpowering; it was not something that could be controlled. This paper describes my personal experience as a mental health patient. I describe in depth not only how I felt physically, emotionally and mentally during mental crisis but the impact of being misunderstood, mislabeled, and inaccurate intentions assigned to my behavior.

**What I felt physically, emotionally and mentally during mental crisis**

In Bray’s analysis of the observations made by Erving Goffman, he noted:

"The client is characterized as either a compliant recipient of service, a self that fits the total institution’s definition of what makes an appropriate patient which Goffman suggests is rare or she is a countervailing self that rejects the service and behaves in defiance of its definition by playing ‘shameless games’ of self-destruction and reconstruction."

This describes perfectly how I felt about the medical system during mental crisis and I fell into the latter description where the caregivers saw me as a defiant and help-rejecting patient. While this may be the perception of the help providers, this was clearly not the case. What they do not understand is that I was incapable of following their instructions and behave in the manner they expect from the patient.

Although I was doing things and thinking thoughts outside of the 'norm', it was not meant to be disrespectful or manipulative towards the mental health clinicians. What I was doing was I was trying to tolerate the pain as the waves of pain intensity overwhelmed me. I would
sit on floor and try to curl up into a ball. Rocking myself, hitting my head or scratching my
face, arms and legs were actions I used to help decrease the uncomfortable feelings. The
relief was for a brief period but it was still relief.

Tears were part of the norm and sometimes I even wonder why the tears were there. It
just comes and it does not stop. I am often asked what I was crying about. They are just
there; and I can feel it coming on without cause. I dislike the tears as it adds to the pain and I
always try to suppress it; but when I do, the pain is worse. So regardless if I hold back the
tears or let them pour out, I am still left with the pain. Between the two options, the least
painful one is to let out the tears. At least, when it's finish I would have release it instead of
having to hold onto it.

Most times, I am asked where I feel the sensation of pain. For me, it is all over; but
mostly in my head. The body sensation which I described to the medical staff would leave
them puzzled and distant. The pain was difficult to describe. I saw it as a combination of a
screaming child in my head, massive amounts of spiders crawling up my skin and being
whipped across my back all at the same time. There was no relief as the sensation was
continuous and I was trapped in this torture with no way out. The pain and sensation was so
strong that it took up any energy I had to control it and at the same time, I needed to look and
behave 'normally'; normally in a sense of societal norms. Usually by the time I sought help
there was no energy left and I was exhausted. That is, all logical and illogical thoughts and
emotions just blended together. At this time, I would laugh, I would cry, I would show
coherence, and I would scream. I basically showed every type of behavior and emotions ever
known. All thoughts and brain functioning became raw.

An analogy to the sensation of being in crisis is similar to having to urinate and a
washroom is not within sight. Most of us start looking for a place to relieve ourselves when
we feel the urge. As young children, we learn to control the sensation. While this is
considered a relatively simple task, imagine having to control this urge and at the same time,
being forced to consume more liquids. While all this is happening, you are expected to
behave and interact with others as usual. That is, maintain composure and coherence and not
let anything leak. Most of us would have a difficult time with this situation and most of us
would focus on getting relief. Now, imagine having to maintain this composure for days,
weeks or months.

While the analogy may be humorous, in reality, it is a difficult task to do. Being in
mental crisis has the same sensation. Normally we can hold our emotions while we look for
methods or activities to relieve this discomfort. When emotions from negative events linger, we try to control them. And we continue to control the emotions as they escalate. Usually by the time we do seek help, we have expended all our energy in maintaining composure and in preventing the emotions from leaking out. We are exhausted and because control does not exist anymore, everything just comes out; similar to the brain telling the bladder to wait when it cannot wait anymore.

In my case, I did whatever it took to make the pain bearable. Such things included sitting on the floor in the corner of the psychiatric emergency room while rocking back and forth. The feel of the cold floor helped with the grounding. The reason behind this was I cannot fall any further, such that I had reached a ground state. The same reasoning applied to being in the corner of the room. It helped contain the pain, like swaddling a baby. (However, the same effect cannot be obtained with the use of restraints.) The rocking back and forth motion was also a soothing effect. The rhythm of the motion distracted the brain away from the screaming in the head.

Passive and aggressive behaviours were difficult to control when I was in crisis. It was not because I did not want to control it. It was because I could not. In Dialectical Behaviour Therapy (DBT) (Koerner), the concepts of rational, wise and emotional minds described different states of the brain. Unlike how DBT described that the patient would be in either rational mind or emotional mind during crisis was not true. In crisis, all three existed but not as a blend. At this time, the pain consumed all of the wise mind in de-escalating the pain intensity. The passive behavior surfaced when the emotional mind took over and the aggression behavior fought over control of events in rational mind. In some ways, it was like have three beings trying to control the behavior mechanism in the brain – the emotion being dramatic and manipulative; the wise being locked out and engaged in pain control; and the rational showing the black and white thinking and seeing only right and wrong.

Why I rejected help from those who did not understand me

When the separation of the rational, wise and emotional minds occurred, the presentation of the patient would be exactly as the literature described. The patient was seen as manipulative, disrespectful and untreatable. However, this was not the intention of the patient as identified in accounts of patients’ experiences. (Gaillard, Nehls, Holm) These patients described their experiences as not been heard and having their words misinterpreted by the
mental health providers. (Gaillard) Others feel fearful as described in Schneider where Laurie felt obligated to do as the therapist says due to fear; the fear where if she would not comply with the therapist she would be denied help. (Schneider) Others were given a diagnosis and instead of being helpful, the diagnosis became a negative label to the patient which again hindered the treatment process. There would already be a preconceived judgment from the caregiver due to the negativity published details about the diagnosis; for example, borderline personality disorder. (Nehls) Still others noted the importance of trust and feeling safe with the caregiver. This was crucial to the recovery process but often lacking in the therapeutic process. (Holm).

My first couple of visits to the emergency department of the local hospital was a good experience and all tried to help me. However, after I was given the diagnosis of borderline personality disorder, I was permanently labelled and most medical staff were reluctant to help. This was because of what had been published and what was probably heard ‘through the grape-vine’ on people who have this disorder. Most saw me as manipulative and untreatable; I was a person who was a burden to the medical system and I was taking resources away from those who ‘really needed help’. However, what these medical staff failed to see was an immense amount of pain despite not having any wounds. While my illness lingered I soon detested asking for help when I was in crisis because the help would be iatrogenic. It became a huge dilemma on whether I call someone or bear the pain by using self-harm techniques.

Thoughts during this time were distorted and while there was a sense of coherence, this sense could not surface as all focus was on pain control. It became difficult to communicate to those trying to help as there was no control on how the words, the tone, and the body language were projected. Applying respect and cordialness to the communication was non-existent and impossible. Therefore what came out became aggressive, manipulative, dramatic and repulsive behaviours to the receiver. What may seem like obvious statements and helpful suggestions to the helper would become illogical, hurtful and irritating statements to the patient as during the time of crisis, it was impossible to follow instructions. Statements such as ‘Control yourself’, ‘You need to be less sensitive’ or ‘You wear your emotions on your sleeve’ were interpreted as judgmental and useless words. These were the common suggestions I would receive from those who tried to help me.

For example, in answering the nurse’s question to why I was again at ER, I tried to tell her it was the same event which caused my illness that spiraled me to the crisis state. Her
belittling response was ‘It’s been two years, why isn’t it done?’ in reference to concluding the event. Her interrogating and disgusted tone drove me further into my pain and I responded by screaming into the bed sheets and telling her to ‘kill me now’. I rejected any further help from her and requested for someone else to help me. She responded by telling me that I either talk to her respectfully or I would not get any help at all. At that point I chose not to talk to her and instead, she put me on sedatives as a way to not have to ‘deal with me’. While it may seem obvious to the nurse that all I needed to do is get rid of the stressor which was causing my distress she failed to understand I was incapable of moving away from the stressor and it is help to remove the stressor which I needed. Thus the words from the nurse were accusatory and belittling.

Another time, I went to see a counsellor; she was probably in training as she refused to listen to what I was saying. Instead it seemed she had her own agenda in that she told me I needed to empower myself by ‘taking back a room in my house’. I was experiencing intense suicidal pain and what I wanted her to help me with was to reduce the intensity to a bearable level. She did not listen to me and after forty minutes in her office, I told her the session was useless. I paid her and walked out of her office overwhelmed with tears. She chased me down to the elevators and threatened to call the police if I would not go back to her office. The threats were useless as I left anyway. Later that evening, the police arrived at my door and I was forcibly taken to the local emergency room. What this counsellor also failed to understand was I was incapable of doing as she requested. Any suggestions became just words which I could not translate to logic and take action against these suggestions. Continuing to force me to hear her further increased the pain.

The same was true when a psychiatrist asked me ‘you don't want to stay in therapy for the rest of your life, do you?’ while I was in complete meltdown. I yelled at him because it was a thoughtless question and he was treating me like a child. At that time, my therapist was in the same session and explained to him that now was not the time to prescribe long term goals. She compared my state to having a heart attack and the immediate remedy was to get the heart pumping which was to de-escalate my pain. She said asking the question was similar to telling the patient what lifestyle changes need to be made while the heart attack was occurring.

Probably the most humiliating thing about being in crisis was the intimidation from the security guards. In this incident, the security guard refused to retrieve additional blankets for me and told me to behave like an adult because I was in tears. When I needed to use the
washroom, I got up from the hospital bed and walked away. She threatened me but I refused to follow orders from her and yelled out aloud to tell her to stop intimidating me. And because I was in the main emergency room area, all patients and medical staff heard me. The security guard’s demeanor changed and she pretended to be nice to me. The lack of training was the excuse which I received from the nurse when I told her of the security guard’s behaviour. She also indicated that it was not only me who received such treatment from them; this was puzzling because it gave them permission to intimidate those who were not well.

There were also other offers of help that I rejected when I was in a suicidal state. This included a psychologist insisting that she needed my family history before she would help me with the suicidal pain; a psychiatrist asking me how I wanted him to help me and as I cannot articulate my needs, the solution provided was to increase my medication dosage; the nurse who refused to help me unless I got up from sitting on the floor; and another nurse who kept asking ‘what is wrong’ and all I could is cry.

**Methods used to return me to the stable state**

Proposed published suggestions on working with difficult patients included ‘listen(ing) to patients and accept them as experts in their own lives and their health choices’ (Russell); ‘address(ing) abundant patient feelings of being misunderstood and foster greater understanding and acknowledgement of the individual’ (Guillard); ‘learn(ing) and relearn(ing) how to listen to persons who have been assigned the label borderline personality disorder’ (Nehls); and ‘carefully manag(ing) the fine line between a therapeutic, and an (inappropriately) personal, relationship.’ (Carsky). To put these suggestions into practice, LaRocque described the method she used to train social work students by placing them in group therapy training as the participant observer. (LaRocque) The result was the future therapist took away a better understanding of the patient’s condition by experiencing the therapeutic process themselves.

Many people tried to help me during the times I reached mental crisis. They ranged from social workers, psychiatric nurses, psychiatrists, psychologists to ER doctors and ER nurses. Yet, I could only reach the stable state with the help of only two of them. They knew exactly what I needed and they conveyed the message that they understood what was happening to me. One was an Emergency Room nurse, Lita and the other was Sarah, the therapist who helped me shred the pain I was experiencing and truly led me to recovery.
What was different between Sarah and the ER nurse from the rest of the medical clinicians was Sarah and Lita interacted with me as a person. This was in contrast to being a ‘case’ and a job to the medical staff where they failed to see that the patients were human like themselves and what the patient felt was reality.

Sarah’s approach to helping me was to fit the DBT to my needs; rather fitting me to a sometimes rigid DBT protocol. She defined concepts which the patient would be capable of grasping and accomplishing. One important concept Sarah shared with me was ‘fighting reality causes suffering’. I wondered if this statement applied to those who were trying to help me. They were fighting my reality because I could not behave as they expected and in turn, both I and the medical staff suffered from the results of the help; I rejected their help and they labelled me as difficult.

Sarah and Lita were the only two people who made me feel better after being with them when I was in mental crisis. Both took the time to let me be as I was; I was allowed to cry, to talk, to laugh, to be silent, to be logically/illogical, to be fearful, and to be angry all at the same time. They would intervene only if I was physically harming myself. In turn, I did not need them to say anything, I just needed them to be in close proximity to me. My behavior and my needs were not to draw them into the roller coaster ride of my mental instability. I needed them to understand what I was experiencing and to allow me to draw energy from their presence. Both knew that whatever words or behaviours which came out were not directed at them and neither disciplined me as a child nor criticized me. Validation of my pain and my distress instead of judgment was the norm.

Lita helped me during one of my visits to the emergency room. I was again caught by police officers and taken there against my wishes. By this visit, I hated all medical staff and my goal was to be silent. Lita was assigned as the nurse attending to me. When she came to see me, she sat at the end of the bed and despite her busy schedule, she took the time to talk to me. She listened to me and she encouraged to me to cry. When I told her of the event that was causing my distress, she did not dismiss it or berate me; instead, she shared her personal experience. What she shared was not full disclosure of what she went through but it was enough to validate my pain. Lita comforted me not as a child but a person in distress. She did not take care of me because that was her job; she helped me reduce some of my pain by simply listening, being there and being non-judgmental. I did not feel a sense of urgency from her as I did with other medical staff in that she needed to move onto the next patient. With the others, I felt I had to ‘hurry up and finish being in distress’ so they could leave.
Her simple gestures of bringing me food and laying it out on the hospital tray table made me feel safe and helped calm the pain intensity.

Sarah was my therapist who led me to recovery. Sarah’s methods to help me reach the recovery stage was very different from the other mental health practitioners. She facilitated the process and allowed me to make choices in how I want to work towards recovery. (Mak) Sarah had experienced many of my mental crisis episodes and each time, she was always there to help me de-escalate the pain. I would arrive at her office in tears and sometimes wailing while I laid on the settee in her waiting room. She did not start the therapy session by reprimanding me for not behaving like a normal adult. Instead, she would sit with me and let me cry. When she felt I was ready to answer questions, she would ask me to explain what triggered my distress. Sarah would listen to me and change the subject for a short time when I would tell her the current topic we were discussing was too intense; she allowed me to tell her when I could come back to the subject instead of grilling me as I have experienced by other therapists.

There are times when the tears will not stop and Sarah would offer to go for a walk outdoors with me. As always, the fresh air and her presence helped stop the tears and brought the pain level to a bearable state. My coherence returned as we walk back to her office. During this time, usually no words were exchanged; and if there are any, it would be describing what we were doing in the moment which was walking.

Since my crisis could happen anytime on any day, Sarah allowed her patients to call her. Sometimes, she answered right away; other times, a message was left with her to call back. These calls did not last long and they were not therapy sessions. The purpose of these calls were to help bring the distress to a tolerable state. What was discussed in these calls was what triggered the spiraling and Sarah would try to help me reframe the triggering event.

I had asked Sarah what techniques she used to tolerate the triggering from the patient. She described a story of the woman serving tea at her grandmother’s funeral at the funeral home. This woman was able to serve tea and stay calm despite the grief that surrounded her. Sarah mentioned that being able to understand the patient’s distress without being pulled into the distress was crucial to helping the patient. And this was what I experienced from Sarah and Lita.
**Last words**

Having a mental illness is an extremely difficult time in a person’s life. This is different from a physical illness where there are medical staff to care for the patient and those close to patient are supportive and allow the patient to talk about the illness. That is, the patient does not have bear the pain of a physical illness alone. However, with mental health illnesses, this is completely opposite. Not only is there stigma from the general public where the patient gets shunned, the same is received from those who the patient seek help. The result is most suffer in silence and some will end their lives as a way to relieve the pain.

My goal of this paper to inform those providing help to understand the side of the patient; that is, to understand that the behaviours of the patient are not meant to question the ability of the therapist and that the behaviours surface due to triggers of pain the patient is experiencing. The patient looks to the therapist for help but the help needs to be something the patient can understand and accomplish. I hope there will be a few therapists who will accept my explanation of the impossible task of controlling the brain, the emotions and the behaviours.

**Acknowledgement** – Without Sarah’s help, I would not be alive to write this paper. Sarah LaRocque is a social worker trained in psychotherapy at Bluestone Therapy located in Cochrane, Alberta, Canada.
References:


“To My Mind... From Me”:
Creative Engagement to Address Wellbeing

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Paper Presented at the
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Surfers Paradise, Gold Coast (QLD), 25-27 August 2014
ABSTRACT: “To My Mind... From Me” was a pilot project involving 7 young women in Years 9 and 10 attending Kapunda High School in 2011. The program was supported by Inner North Country Health Service, Northern Domestic Violence Service and Kapunda High School Wellbeing Staff. “To My Mind... From Me” evolved from the Kapunda Respectful Relationships Group which aimed to cover topics around intimate partner abuse, domestic violence, healthy relationships and relationship warning signs built on a foundation of developing self-esteem and positive body image. Based on a youth participation model, the project encouraged participants to guide the format and content of the sessions. The project eventually focussed on creating a photobook resource designed and created by the participants for their peers on the topic of anxiety and depression. Evaluated via ongoing feedback from the participants and formal final evaluation methods engaging participants and school staff, outcomes included participants reporting development of insight, empathy towards peers, increased coping strategies, increased engagement with schoolwork and staff and an increase in community connections. School staff reported a ripple effect via participants sharing knowledge of skills gained in the program with the wider school community. Grant funding was secured to help pay for a small print run for the photo book with the aim of it being used with other groups of young people to enhance the sustainability and outcomes of the project. Despite the program finishing in a different place than was envisaged by the facilitators, feedback pointed to the success of the program achieving its revised aims. Due to the success of the project, further arts based health promotion projects focussed in de-stigmatising mental health and building the capacity of young people have been supported by the Kapunda community. The pilot program demonstrated the importance of youth participation strategies in program design and implementation and provides further evidence to arts based mental health promotion interventions.

Keywords: youth participation, arts based, health promotion, rural communities, sustainability
Introduction

Kapunda, with a population of 3200 people is a rural community located in the Mid North of South Australia, approximately 70kms from South Australia’s capital city, Adelaide.


- Total of 284 young people (between the ages of 12 – 18) listed Kapunda as their chief place of residence, which is 9.09% of the total population of Kapunda.
- 3.17% of the population was born in a non-English speaking country
- 0.29% of the population between the age of 10 – 19 identify as Aboriginal or Torres Strait Islander

According to statistics from the 2010 Social Health Atlas in regard to the population of the Light Local Government Area (of which Kapunda is a part of) (Public Health Development Unit, 2010):

- Highest percentage of children developmental vulnerable in emotional domain
- Equal highest percentage of children developmental at risk in communication domain
- High percentage of smoking during pregnancy

In 2009, Inner North Country Health Service (INCHS) Youth Work staff facilitated a school based program at Kapunda High School (KHS) which focused on creating a resource for young women which would work towards empowering participants and developing their skills as peer educators. Participants in years 11 and 12 created a booklet titled “Behind The Door of Room 74” which was launched during Drug Action Week 2009. Although the booklet had limited release, the strength of the underpinning principles resulted in further requests for similar school based programs facilitated by INCHS staff.

Background

“To My Mind… From Me’ was a pilot project involving 7 young women in Years 9 and 10 attending KHS. The program was supported by INCHS, Northern Domestic Violence Service (NDVS) and KHS.
“To My Mind… From Me” evolved from the Kapunda Respectful Relationships Group which aimed to cover topics around intimate partner abuse (IPA), domestic violence (DV), healthy relationships and relationship warning signs built on a foundation of developing self esteem and positive body image. The need for this group was identified by INCHS staff based upon the following statistics:

- Higher rates per population of DV, sexual assault, murder occurring in rural areas than metropolitan areas (Hastings & Maclean, 2002)
- Domestic violence may be less likely to be disclosed in rural and remote areas due to the ideology of self-reliance, and informal sanctions and social control. (Costello, Chung & Carson in Mitchell, 2011)
- Women in rural and remote areas may also find it harder to seek help or leave a violent relationship. Factors such as access to services, a perceived lack of confidentiality and anonymity, stigma attached to the public disclosure of violence and lack of transport and telecommunications may compound the isolation victims of domestic violence already experience as part of the abuse (Morgan and Chadwick in Mitchell, 2011)
- Some 18 per cent of females living outside capital cities experienced violence by a previous partner since the age of 15, compared with 13 per cent of females in capital cities. (ABS Personal Safety Survey in Mitchell, 2011)

In 2010, the Kapunda community experienced a major critical incident involving the death of a young woman and her parents which highlighted a community need for more information and awareness of DV/IPV.

**Pilot Project Aims and Objectives**

Following the commencement of the pilot project, the participants chose to take the group in a different direction, instead of focussing on DV/IPV. The participants identified anxiety and depression as a major issue in their community and expressed the need for information, strategies and resources appropriate for young people. The group continued to have a foundation on developing self-esteem and positive body image but also incorporated self-
reflection, emotional regulation strategies and relationship building. The revised objectives were as follows.

- Promote positive body image
- Provide opportunities for participants to improve relationship with self
- Develop concept of respectful relationships
- Provide relevant social and emotional well-being information
- Develop skills in peer support and peer leadership
- Develop life skills

**Pilot Project Methodology**

INCHS and NDVS staff met with KHS staff mid-2011 to discuss the implementation of a project focusing on IPV/DV with female students. 7 participants were recruited from Years 9 and 10 by KHS Wellbeing staff (comprising of Student Counsellor and Christian Pastoral Care Worker). The original program was modelled on the “Respectful Relationships” program designed by Melinda Temple and Natasha Harvey, Women’s Health Workers at INCHS. The program was planned to run during Term 3 and 4 of 2011 onsite at KHS, totalling 17 sessions (1 session of 90 minutes per week). Facilitators included INCHS Health Promotion worker, INCHS Youth Worker, NDVS Child and Young People’s advocate, with additional support provided by KHS Christian Pastoral Care Worker. Opportunities for young people to provide feedback were available every session via formal and informal means. The “Respectful Relationships” program was initially implemented, however feedback from participants suggested limited relevance for them at that time. Instead, they elected to focus on issues of anxiety and depression which they felt was an unmet need in their community. This method of addressing mental health issues through peer interaction has been identified by Jorm, Wright & Morgan (in Berridge et al, 2011) as a best practice method, due to young people’s reluctance to seek professional support for health issues, instead relying on peers and key adults in their lives. The concept of developing a resource made for young people by young people harnesses young people’s genuine concern for each other’s well-being, as identified by Rickwood et al (in Berridge et al, 2011). The participants also had keen interest in arts and creativity, so all sessions incorporated art making activities. The use of art making to address well-being and mental health issues in this program is based upon evidence that the
use of such strategies results in reduction of stress, improvement of mood and development of interpersonal skills and increased involvement of isolated communities (Jermyn, 2001; Karkou & Glasman, 2004). The facilitators adjusted the program to reflect this, including a focus on developing a resource for young people as a way of addressing individual concerns and areas for development in a non-confrontational manner. The facilitators suggested various resources that could be created and the participants chose to create a photobook resource that included information on anxiety and depression as well as photos and quotes that the participants had collected that reflected the issues. The collection of photos by participants was facilitated by a loan of INCHS digital cameras, acquired through a grant specifically for this kind of group work. Participants loaned the cameras through the duration of the group to take photos specifically for the project, completing a “loan contract” to ensure safe use of the equipment and images captured. Images collected by individuals were then shared with the whole group at the next session, with discussion of themes that would make up the photobook. Each individual session was planned during post-session debrief, thereby ensuring all feedback from participants was incorporated in the week-to-week design of the program, resulting in an organic and reflexive response.

**Evaluation of Pilot Project**

Evaluation methods included:

- Feedback collected each session from “Twitter Bags” where comments and 5-point Likert scale ratings of activities could be given anonymously by the participants.
- End of program evaluation session where participants could feedback to facilitators as a group.
- Anonymous end of program formal evaluation form completed by participants
- Anonymous end of program formal evaluation form completed by school staff
- Informal conversations with school staff during program implementation.

**Pilot Project Outcomes**

The pilot project resulted in a number of unexpected outcomes, due to the change in aims, objectives and focus. Program participants reported development of insight including the reality of opinion of self and understanding the feelings and experiences of others and how it differs from the individual. Another unexpected outcome involved the highlighting of the importance of the use of multi-media in engaging young people. As a result a separate project
involving the purchase of digital cameras emerged, so that multi-media can be used within a primary health care approach with other groups facilitated by INCHS.

Participants reported the development of reciprocal and respectful relationships between program participants, despite differences in age, year levels and life experiences which can be magnified by the school environment.

Feedback from the school was encouraging, with staff asking for the program to be run on an annual basis. Feedback from school staff included that the group had created a “ripple” effect by participants sharing knowledge and skills gained in the program with the wider school community, resulting in the messages reaching a larger audience than just 7 female participants in years 9 and 10. Furthermore, the pilot project also facilitated the development of a collaborative relationship between all the different organisations involved, laying a foundation for future projects.

The pilot project presented a number of challenges. It was difficult for facilitators to gauge how much participants were enjoying the program whilst it was happening, although attendance remained stable. This was due to feedback from participants often being tainted by personal issues and leading to the facilitators feeling disillusioned about any gains that were being made. However, the acknowledgement of this situation enabled both participants and facilitators to develop skills in identifying when “baggage” gets in the way of the process, enabling forward movement to occur.

Finally, the development of a relevant resource by the participants for their peers was one of the best outcomes of the pilot project. The resource, titled “To My Mind… From Me” was embraced by the school and INCHS staff alike. Grant funding was secured to help pay for a small print run for the resource book with the aim of it being used with other groups of young people to enhance the sustainability and outcomes of the project.

**Future Developments and Continued Work with Kapunda Community**

The school’s request for an annual program to be run mirroring the aims from the pilot program was continued through 2012 and 2013.

The INCHS Girls Group implemented during 2012 built upon the work completed during the pilot project. This group consisted of Year 9 female students who had been selected by school counselling staff for participation in the group due to vulnerabilities including sexual behaviours, developing and maintaining respectful relationship and emotional regulation. This group also elected to create a photobook although in a different style than “To My Mind… From Me.” The book created by the 2012 Girls Group, titled “Hay. How Are You?”
featured photos taken by participants from places throughout their community, including quotes that held meaning for the participants and pages where notes and thoughts could be recorded by the reader.

In 2013, INCHS successfully applied for a Mental Health Week grant in order to showcase the arts based interventions implemented at KHS between 2011 and 2013. An art exhibition, including work from previous INCHS groups, was developed and ran at the Kapunda RSL during Mental Health Week (6 -12 October) and continued on as part of the inaugural Kapunda Music and Arts Festival, until 20 October 2013. The secondary goal of the exhibition was to highlight mental health as an ongoing issue in this community, stimulating thought and discussion in order to increase understanding and reduce stigma. This project succeeded in taking the work that INCHS has been engaged in outside of the school environment and developing further links with the community.

INCHS ran a further two groups at KHS during 2013, one with year 9 girls and one with year 9 boys. Once again, these groups included elements of art making to explore wellbeing and engage participants, who had been selected on the basis of multiple psychosocial needs. The art making during the group run with girls incorporated the “Tree of Life” used within Narrative Therapy in order for participants to connect with different elements in their lives.

**Conclusion**

Despite the pilot program finishing in a different place than was envisaged by the facilitators, feedback pointed to the success of the program achieving its revised aims, and furthermore, lead the way for further groups being implemented at KHS. The ongoing school support for participants of all programs between formal sessions was crucial to their success, including outcomes demonstrated following the program’s end. This ongoing support has been embedded into the continued work with the Kapunda community that followed the pilot project, demonstrating the positive outcomes that come from formal agreements about the level and form of the school-based support for participants. The flexibility that was afforded to all programs, in regards to the duration and focus, enabled the program to be adjusted to suit the needs of the participants. The facilitators recommend that future programs are able to accommodate this, in that programming is loose enough to enable extra sessions to be included if necessary.

Finally, the work with KHS has demonstrated that the processing of events, such as those that sparked this body of work, is dependent upon time and the commitment of staff to remain engaged with individual communities. In 2013, three years after the critical incident
involving a young community member and her family, young people attending INCHS programs at KHS began talking about the incident and other such events that they had witnessed or were aware had taken place. Despite INCHS providing support to this group of young people directly after the incident, this outcome suggests that opportunities for reflecting on such events and building capacity to address its precipitating factors need to be available on a long term basis and are dependent upon trusted engagement of service providers.

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What makes you happy? Happiness for individuals, the community and planet

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What makes you happy? Happiness for individuals, the community and planet

**ABSTRACT:** A solution focused approach to managing individual challenges and strengthening communities is of broad interest. Clinicians can use a strength-based approach to questioning and managing challenges. Managers can use positive approaches to support staff and organisational planning. Policy makers can promote wellbeing and social inclusion to help individuals to flourish.

‘What makes you happy?’ (Robards, 2014) is a positive psychology book that helps promote happiness and wellbeing by combining the happiness literature, including the ‘World Happiness Report’, and a solution-focused approach to promote wellbeing for individuals, communities and the environment. This paper outlines the academic basis of ‘What makes you happy?’.

**Keywords:** happiness; mental health promotion; wellbeing; World Happiness Report; What makes you happy?

**Introduction**

If asked “What do you want most in life?”, most people answer “I just want to be happy.” But what makes for happy people, happy communities and a happy planet?

Happiness is the way people evaluate their overall wellbeing and quality of life. Our wellbeing is a state where we can realise our abilities, cope with the normal stresses of life, work productively, and make a contribution to our community.

What makes us happy varies for each of us. But there are things we have in common - meaningful experiences, connection with friend and family, gratitude and compassion that brings value to our lives.

The World Happiness Report commissioned by the United Nations (Helliwell and Wang, 2013), reminds us that happiness - or life satisfaction - is also a measure of social progress.

Gallup polls from 150 countries measure people’s assessment of their quality of life. In the polls from 2005 to 2011, people from Denmark, Finland, Norway, the Netherlands, Canada, Switzerland, Sweden, New Zealand, Australia and Ireland rated their quality of life highest (Gallop, 2012). Countries who scored highly have good social support systems.
(enabled by high taxation levels), comparatively evenly distributed incomes and low crime rates.

However there is cause for concern. As inequalities in wealth widen, our obsession with economic development is damaging the natural environment and our unhealthy lifestyles result in chronic illness, mentally and physically. We know how to promote mental health, yet so many people struggle with mental illness. We have increasing wealth, yet so many live in poverty.

If we value wellbeing and happiness, we need a new approach. In the World Happiness Report Sachs (2012) says:

We live in an age of stark contradictions. The world enjoys technologies of unimaginable sophistication; yet has at least one billion people without enough to eat each day. The world economy is propelled to soaring new heights of productivity through ongoing technological and organizational advance; yet is relentlessly destroying the natural environment in the process. Countries achieve great progress in economic development as conventionally measured; yet along the way succumb to new crises of obesity, smoking, diabetes, depression, and other ills of modern life.

Fortunately the solutions, promoting wellbeing, social inclusion and environmental sustainability, are intrinsically linked. Things that protect the environment also bring a better quality of life and promote wellbeing.

This paper considers “What makes us happy?” and “How can we care for individuals, communities and the planet?”

1. Health and wellbeing

We've become too preoccupied with repairing damage when our focus should be on building strength and resilience. Martin Seligman

Health is more than avoiding being sick; in positive terms it is the capacity to grow to our full mental, physical and emotional potential - and flourish. Happiness, health and life expectancy are all connected (Chida and Steptoe, 2008). Put simply, healthiness affects happiness and happiness affects health.

Many of the illnesses we experience are preventable (WHO, 2009). Our health is largely influenced by our lifestyle and the environment we live in. If we are to focus on wellbeing, rather than only treating illness, this means taking active responsibility for our own health. It also means helping to make our community healthier places in which to live.
We need to build the strength of our minds and bodies so we are more resilient during tough times, making it less likely that problems will occur and we can intervene early if they do. Our lifestyles need improving and our communities need strengthening.

**Mental Health**

Being healthy includes having a mind and spirit that is nourished and resilient. Yet there are growing numbers of people who experience depression, anxiety or drug and alcohol problems. Mental health problems affect one third of families globally (Helliwell et al, 2012). Every forty seconds someone in the world dies of suicide (WHO, 2012). In Australia, one quarter of young people aged 12-24 have mental health problems (AIHW, 2011).

The *World Happiness Report* (Layard et al, 2013) reminds us that mental health is the most important factor that determines our happiness. Mental health problems make it hard to flourish and live a full life. Our relationships are affected and we are less able to function well when we are living with mental health problems. Mental health problems affect individuals and families.

We can promote positive functioning so that we all flourish in our daily life. Protective factors for individuals include confidence, managing stress and adversity, communication skills, physical health and fitness (Layard et al, 2013).

Although effective treatments exist, many who need help do not receive support. The *World Happiness Report* (Layard et al, 2013) says we need to both support those in need and intervene earlier. We need to find better ways to promote access to services, especially for the young and provide support early in the illness trajectory.

We also need a much greater focus on prevention and the promotion of mental health and wellbeing (Hosie et al, 2014). Prevention is a key way to promote the happiness of our society (Layard et al, 2013). The community as a whole needs to be more aware of how to promote good mental health.

Preventing the development of mental health problems means we not only free up mental health professionals, our population is healthier and happier. If the right resources are made available many people are able to help themselves and don’t need to see a professional (Hosie et al, 2014).

Young people in particular, often have difficulty accessing services because they feel embarrassed or uncomfortable about doing so. Young people with mental health problems feel more comfortable seeking information, advice and support online and from friends compared to other sources like community agencies, magazines, parents, relatives, school
counsellors or teachers (Ivancic et al 2014). Using technology to access information and services is particularly important to young people, especially in rural areas because accessing face-to-face services may involve travelling great distances.

When individuals can cope better and are more resilient, care for themselves and others more, we have a more caring society. So a focus on healthy lifestyles and good mental health benefits individuals and communities.

Physical activity and healthy weight

Obesity rates are increasing - nearly doubling across the globe in the last thirty years. More than a third of the global population is overweight and one in ten are obese (WHO, 2013). There are also many health risks with being overweight, including many chronic illnesses like diabetes, cardiovascular disease, cancer, sleep apnoea and muscular skeletal problems (Backholer et al, 2012). The result of increased illness is a loss of economic activity and a financial burden due to rising health care costs (WHO, 2010).

Many people do not eat enough vegetables or fruit, nor get enough physical activity (WHO, 2013). As nations become wealthier they consume more and their diets change: they move away from nutritious traditional home cooked meals to buy processed junk food, high in fat and sugar. Instead of shopping locally, walking and cycling, we are becoming more car dependent. Consequently, there are rising rates of people who are overweight.

Time spent in front of the TV or at the computer contributes to being overweight or obese, particularly in children. Children and young people should spend less than two hours a day sitting in front of a screen (Hardy et al, 2010).

While we have an obsession with weight and body size, research shows the effects of unhealthy lifestyles are more of a concern. Increased fitness can make overweight people healthier (Moore et al. 2012).

People who exercise regularly are happier (Headey et al, 2010). Although exercise can elevate mood, around 40% of people worldwide to not get enough physical activity (WHO, 2010).

As well as promoting psychological wellbeing, regular physical activity can help prevent physical health problems. Physical activity reduces the risk of cardiovascular disease, some cancers and type 2 diabetes and it can also improve musculoskeletal health, control body weight and reduce symptoms of depression (WHO, 2009).

Body image and confidence
Concern about body image and anxiety about appearance is so widespread it is almost considered normal (Gingaras et al, 2004).

Although obesity is often influenced by our environment, rather than individual choices, the media takes a blaming approach. Media images of larger people are seldom flattering. Discrimination of larger people leads to increased body image worries, unhealthy eating and low self-esteem (Annis et al, 2004).

When we are self-conscious about how we look we might avoid doing things we enjoy, wanting to camouflage ourselves from the world (Tiggemann and Andrew, 2012).

There are good reasons our self-esteem is taking a blow. As a society we are getting heavier, but societal norms of female attractiveness are getting thinner. For example, images of female playboy models are significantly thinner than forty years ago (Owen and Laurel-Seller, 2000). Similarly, the male ideal is becoming musclier over time as depicted by playgirl centerfolds (Leit et al, 2001) and action toy figures (Pope et al, 1999).

The fashion industry creates ideals beyond reach for most of us. We absorb the media images around us automatically without conscious cognitive appraisal (Watts et al, 2008). After viewing media images, women are typically more depressed and dissatisfied with their bodies (Fallon and Hausenblas, 2005).

When overweight people feel less negative about their body and engage more in life rather than feel ashamed of their body, they have improved psychological functioning, self-esteem and eating as a result – even if their weight has not changed (Rosen et al, 1995). In contrast, women who are dissatisfied with their bodies take less care of themselves (van den Berg and Neumark-Sztainer, 2007). Men who are dissatisfied with their bodies can exercise to excess and take performance-enhancing drugs like steroids (Nowell and Ricciardelli, 2008).

When parents over emphasize weight and appearance, this can lead to less healthy eating in children (Kluck, 2010). Young women with high body satisfaction live with families who encouraged healthy eating and exercising for health and fitness, rather than dieting for weight control (Kelly et al, 2005).

We need to promote better body appreciation – this includes rejecting unrealistic images in the media, particularly thin models.
Religion

Hugh MacKay (1999) says happiness comes from living a life we value and has meaning. Many people find their spirituality or religion helps guide their actions according to a sense of what is right or best action, for example what is the kindest way to respond to a situation.

A Gallop poll of more than 150 countries found that half of the world population had visited a place of worship in the week prior to the survey (Layard et al, 2012). People who are spiritual or religious are happier and more satisfied with their lives (Davidhizar and Hart, 2006). People who are religious tend to prioritise their family, helping others and doing voluntary work, all leading to greater happiness (Headey et al, 2010).

Spirituality has both personal and social aspects. Religious people have a greater sense of meaning in their life and feel more respected. The spiritual or religious community can also offer a source of support and a sense of belonging, although sadly some religious organisations have not always welcomed all groups of people equally.

2. Strengthening our community

A person with Ubuntu is open and available to others, affirming of others, does not feel threatened that others are able and good, for he or she has a proper self-assurance that comes from knowing that he or she belongs in a greater whole. Archbishop Desmond Tutu

The World Happiness Report (Layard et al, 2013) identifies boarder protective factors to include the support of family and friends, good parenting, physical security and safety, economic security, educational attainment, satisfaction and success at work.

While happiness is linked to being free to shape your own future, we also need a sense of belonging and intimacy. People who are connected to others have better supports and are happier (Steptoe, 2008). On the other hand separateness, or not needing to relate to others, is associated with increased isolation and depression.

As a society other important protective factors include access to basic services, social justice, tolerance, integration, physical security and safety (Layard et al, 2013).

Many people do not get a fair go in life. Every night too many people experience some form of homelessness. People are victims of robbery, physical assault or sexual assault. Some groups of people have poorer health, lower life expectancy and are more likely to be victims of crime compared to others.
Inequalities in wealth have been increasing. Worldwide, it is estimated that the richest one per cent own almost half (46%) of total global wealth (Credit Suisse, 2013). Equity promotes a sense of fairness and equality, more trust – and overall people are happier. The reverse is also true: happiness declines when inequalities increase (Layard et al, 2012).

**Money**

Many believe that society is too materialistic with too much emphasis on money and not enough on things that really matter. Being able to spend more time with family and friends and having less stress and pressure in life, are more important than having money to buy things (Eckersley, 2004).

How important is income for happiness? To a point income is very important. When money buys a way out of homelessness, and you don’t have to worry about the next meal, it means a lot. Many live in poverty and experience daily hardship - and for the world’s poor, and those poor on our doorstep, the value of extra income is greater for the poor than the world’s wealthy (Sachs, 2012). For wealthy people, a little extra money doesn't make a lot of difference.

Raised living standards have meant access to healthy food, health care, clean water and stable housing. But beyond a certain point, increasing a country’s wealth does not bring greater happiness (Easterlin et al, 2010). Many countries in real terms have become richer and on average people live longer. But while we are financially better off, overall we are not getting any happier.

So, should we pursue economic development when economic growth does little to increase our wellbeing and happiness? To an extent, yes: the happiest countries in the world have high incomes - but they also have high social equality, trust and high quality governance and this is the main point of difference.

The *World Happiness Report* (Layard et al, 2012) says: *The first lesson of happiness research is that GDP is a valuable goal but that other things matter greatly.* It advises that increasing GDP should not be pursued if this compromises economic stability, community cohesion, ethical standards or the environment. Economic growth needs to be environmentally and socially sustainable. The vibrancy of communities and mental health of people are more important.

Some governments have taken on the challenge of improving national happiness by boosting social systems, supporting cultural activities and the protecting the environment.
Work

There are many factors that influence how much we value our work. Most people value high income, flexible working hours, promotion opportunities, job security, interesting work, being able to work independently, helping others, and being useful to society (Layard et al, 2012). But once you get to a certain level of income, extra riches make little impact on a person’s overall happiness (Layard et al, 2012). The underlying values that affect people at work include pride, generosity, caring and honesty (Warna et al, 2007).

Sadly, many people sacrifice family for income and personal success. People who prioritise goals relating to their family or helping others are happier than those who prioritise their career and material success (Headey et al, 2010).

People who perceive a large gap between what they have and want – money, job, friends, health - are unhappier, than those who perceive the gap is smaller (Davidhizar and Hart, 2006).

And if we can use our passions and strengths at work, this can bring great benefit. Flow states that come from being engaged in self-directed, goal-oriented, meaningful activity - and can produce a high level of happiness (Csikszentmihalyi, 1991).

Consumerism

Consumerism promises happiness, but it can never work for two reasons. First, we adapt to what we have and want more. Second, we experience the problem of comparison: when we compare ourselves to others we feel worse off. People who have won the lottery have been known to become happier, but only for a limited period (Davidhizar and Hart, 2006).

Many studies have found consumerism is not associated with increased happiness, but with more negative emotions like dissatisfaction, depression, anxiety and anger. People who consider their relative income to others is important, are less happy than those who do not see this as important (Layard et al, 2012).

Instead, we would be better off to focus more on our own feelings of competence and self-worth, our relationships with others and safety in the community. People who care more about money are less happy (Layard et al, 2012).

Relationships

Love and belonging are some of our most important needs. Good relationships are important to our wellbeing. People who regularly see friends, relatives or neighbours are happier
(Headey et al, 2010). People who have meaningful conversations are happier than those who make small talk (Mehl, et al 2010).

For many, marriage is a life event that results in much happiness (Layard et al, 2012). Life satisfaction often peaks in the years before and after marriage, and for most their happiness levels remain higher than before marriage. People who are married have better financial security, better physical and mental health, less substance use and live longer.

Because marriage involves connection, trust and companionship the happiness of spouses is often interdependent (Layard et al, 2012). If one partner is happy, this influences the other to also be happier. The equality of happiness in a marriage is important for stability.

But married people are only happier if they perceive their relationship to be a quality one (Layard et al, 2012). For those in a poor quality marriage, they are generally happier once separated. Similarly, single people are happier than those who are unhappily married.

A UK study of five thousand people found the secret to sustaining relationships is making time to be together on their own; saying ‘I love you’ to each other; ‘being there’ for each other; talking to each other about everything; and pursuing shared interests (Gabb et al, 2013).

A safe and caring community

In a well-functioning society there are high levels of trust. Social connection and trust are important to life satisfaction (Layard et al, 2012). It is easier to connect with people who are similar to us, share identity and values. But we also want to trust people we perceive as different to us. High trust among people goes beyond social groupings like whether people are young or old, male or female, gay or straight, or from different cultural backgrounds (Layard et al, 2012).

A sense of safety is important to create trust in the community, and feelings of confidence and freedom. Violence, including physical assault and sexual violence, threaten our actual and perceived safety.

Given most violence happens at home by people known to the victim, community attitudes towards violence are vitally important; for example, recognising violence is a crime and that people have the right to personal safety are important in creating a safe community.
Enriching environments for all

The United Nations Declaration of Human Rights (1948) says: *All human beings are born free and equal in dignity and rights.* An inclusive society where everyone can participate as fully and equally as possible is important.

The concept of *social inclusion* is concerned with how much people can participate in daily life. Particularly for those who are more vulnerable in our community, such as children, young people, elders and those with disabilities, we have a responsibility to help shape a world that enables all to freely participate.

Children thrive in enriching environments. A child friendly community is one where children are valued, supported, respected, provided for and actively included. Children who can play safely, are welcomed and feel valued, have the best opportunities to develop and grow. Children who feel justice is upheld at school, feel safe and more positive about being at school (Samdal et al, 1998). Support from teachers significantly increases student’s happiness (Natvig et al, 2003).

Young people with a chronic illness or disability say they achieve a sense of wellbeing when they can live a life integrated in society, feel supported and have opportunities for personal growth (Berntsson et al, 2007).

There are many ways we can make a difference to people with disabilities. These include supporting all people to be able to take part in sports and leisure activities, education and work.

An elder friendly community is one where the strengths and capacities of older people are valued and encouraged. Older people are increasingly involved in the care of grandchildren, teaching values in children and young people. Elders have valuable knowledge that can be handed down to younger generations.

By understanding the needs of all the groups in our community we can help everyone fully participate in living a rich and fulfilling life.

3. Caring for the environment

*We know it well that none of us acting alone can achieve success. We must therefore act together as a united people.* Nelson Mandela

Without radical changes across broad patterns of human behaviour, the prospects for our environment appears bleak. In particular, the current pattern of economic growth is simply
not environmentally sustainable. Sitting with the reality of this can trigger a strong sense of vulnerability, and that vulnerability can get a lot of people sticking their fingers in their ears and hoping it will all just go away.

On the upside, there is a lot of information available about real changes we can make. Once we can get past our own anxiety long enough to find the inner strength to act on our awareness, we can regain a sense of control by making changes in our daily lives.

Overall, people are starting to become disillusioned with economic advancement as the key to a better world and are looking for a new set of values. We can make real and sustainable changes when we are more thoughtful of the planet’s needs and the needs of future generations, beyond our own.

The quest for happiness is intimately linked to the quest for sustainable development. The World Happiness Report (2012) says:

If we continue mindlessly along the current economic trajectory, we risk undermining the Earth’s life support systems – food supplies, clean water, and stable climate – necessary for human health and even survival in some places. On the other hand, if we act wisely, we can protect the Earth while raising quality of life broadly around the world. We can do this by adopting lifestyles and technologies that improve happiness (or life satisfaction) while reducing human damage to the environment.

Changing our lifestyle to become more environmentally friendly is not just good for the big picture of the future; it may help us to live healthier and happier lives right now. By refusing to deny what we know to be true we live more authentically in ourselves and our communities. By reducing the pollutants we contribute to the world, we often make choices that are also healthier for us as individuals, like walking, riding bikes, and using fewer chemicals.

**Ethical purchasing**

In the early days advertising focused on why we needed a product. These days advertising is about promoting desire for things we don’t need – including pressure to keep up with the latest model of phone or the latest technology. Obsolescence is planned so that we consume at a greater rate. Fast fashion means we can buy the latest, and discard clothes before they are worn out.

Many of us work long hours so we can buy all this stuff - and when we do have leisure time we watch TV (with advertisements to make us buy more stuff) and shop.
Production processes are often harmful to people, animals and the environment, especially in poorer countries where goods can be produced cheaply. We are using resources at a greater rate than we are renewing them.

We need to change as individuals and join together as a community so that we can protect the environment. We need to make significant changes to the way we eat, live, travel and do business if we are to live more sustainably. Recycling and reusing products is important, but we need to reduce our consumption too.

One of the first steps is getting closer to nature and appreciating its natural beauty, otherwise sustainable living is simply an academic exercise in self-preservation.

Although the future may seem bleak, ignoring the reality is not a positive solution. We do know about many of the changes we can all make towards sustainable living. And many of these solutions are not only good for the planet, they are good for the community and individuals. Lifestyle changes like walking and cycling more, green cleaning, reducing consumption and waste at home and work are all good for us, while joining with others to take action, strengthens our community.

Fortunately many of the things that are good for us, are good for the community and the environment. If we walk or cycle to school or work, for example, we are physically healthier and driving less saves pollution and fossil fuels. If we travel with others and form closer social connections we further increase our wellbeing.

We can create cities and towns that are safe and promote exercise: for example by creating bike paths and inviting open green spaces. Local shops encourage people to walk, rather than drive to a large shopping center.

Conclusion

Our wealth has expanded greatly; we are healthier because many of the diseases of developing nations such as communicable diseases have reduced. This is due to better living conditions. But what we now see are the diseases of affluence, due to poor diet and lifestyle. Our excessive consumption is not good for us or the planet.

Due to inequalities in wealth, there are still many people who are poor and hungry. For those who are becoming richer, this extra money is not buying them happiness. There are many people who have a nice house and car, but something is still missing. In fact they would be happier giving their funds to people in need.

While focusing on external development, we are neglecting our mental health and inner wellbeing. Too many people suffer from loneliness and depression, despite the material
progress we have made. Even in a developed country like Australia, we have large numbers of homeless.

Developing mental health and wellbeing, and strong communities where people feel they can trust others and are connected, are important. Engaged living where we can be creative, participate in community activities and in sport, are important.

When we focus on wealth as our measure of social progress, we overlook wellbeing as our goal. Increasing wellbeing, reducing inequality and reducing environmental risk would result in increased happiness. Increasing GDP will not. Should we be aiming to increase our GDP every year when the source of growth is through using limited material resources and damaging the environment?

Many of us live in cities, disconnected from nature. We need to remember that economic growth based on increased consumption is not sustainable. Simple strategies include keeping possessions for longer, reducing consumption and waste.

The solutions to promote wellbeing, social inclusion and environmental sustainability are intrinsically linked. That which protects the environment, also brings a better quality of life and promotes wellbeing. If we focus on the things that promote wellbeing – for us, for others and the environment - we can stress less and live calmer, happier lives.

References


Guided Meditation –  
A Useful Therapy: Description of therapy  
treatment in Sabah (Solace) addiction recovery and treatment centre.

Jeffrey Po PhD  
Regional Human Skills  
Singapore

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15th International Mental Health Conference  
Surfers Paradise, Gold Coast (QSLD), 25-27 August 2014

Guided Meditation –  
A Useful Therapy: Description of therapy
ABSTRACT: Addiction and relapse are in many instances intimately linked. Approximately 70% recovering addicts relapsed after a short period of seemingly recovery. Relapse prevention is usually a combination of both medical and some form of psychotherapy or counselling. There are many significant and substantial steps that can be taken for relapse prevention. It is well known that stress is a major contributing factor in relapse because of the inadequacies of the patient’s coping mechanism. Extensive researches have indicated that Guided Meditation engaging mindfulness/awareness techniques have shown promising results with regards to addiction relapse prevention. The author has however developed a therapy skill – Meditative flow-Psychotherapy. This therapy skill have been used under prison settings and was found to be successful in inculcating those incarcerated with the higher values and meaning of life. This paper attempts to show that the employment of such skills in Solace (Sabah), a private and exclusive addiction recovery and rehabilitation centre located in Kota Kinabalu (Sabah) lends support to his previous activities in this direction and also those done by other researchers in the direction of guided meditation.

Keywords: addiction relapse prevention, guided meditation, mindfulness, meditative flow-psychotherapy.

Introduction

What is meditation?

Meditation, or the process of inner self exploration into the psyche of the person for the enhancement of better health and the investigation into the higher meaning of life itself (Corsini, 2001) has long been practiced by ascetics, spiritual mystics and religious masters throughout the ages. It was seen as a spiritual path towards the attainment of enlightened mental, emotional and spiritual state that releases the aspirant from the clutches of constant cycles of rebirth (Vajiranana Mahathera, 1975). Today, the practice of meditation has been re-packaged and dressed in various garbs – one of them being the engagement of meditation as a
therapy for bodily, mental and emotional ailments (Po, 2013). The traditional meaning of meditation – a spiritual path, seemed lost.

Guided meditation:

Traditional meditation practices entail the aspirant exploring into his inner most thoughts. The teacher or guru merely prescribes a topic of meditation and then student is then left to pursue his own exploration and processing (Po, 2003). The author has however found this to be rather ineffective as a therapy because the practitioner is left to process himself/herself. He therefore employs the technique of “guided meditation”. Guided meditation is a process whereby the meditator is verbally guided into a state of consciousness either by the teacher’s live voice or by a recording of the voice. This process and practice of meditation requires an individual to follow verbal instructions that progressively guides the individual how to relax the entire body, clear the mind, concentrate on breathing and focus on one’s awareness and attention (Batalion, Nathan & Elliot, 2012).

Background of guided meditation:

In 2nd Asian Pacific Rim Counsellors Conference (2011), the author who is practicing Buddhist meditator introduced concept of adopting the ancient skills of Buddhist meditation into the present day scenario. “Psychosynthetic Buddhist Psychotherapy” was well received by the audience. This concept was a merger between Assiagoli’s “Psychosynthesis” and Buddhist meditational practices. Since 2011, that psychotherapy technique had been used by the author to those incarcerated in the Singapore prison. To date altogether five groups participated – each group comprising from 15 to 24 participants. Each weekly session lasted for two hours and each programme comprised of 10 sessions.

The sessions were divided into three segments:

1. The psycho-education
2. The guided meditation period
3. Processing and sharing of meditation experiences

Participants were then required to continue practicing meditation during the ensuing week and were asked to report their experiences.

**Findings of guided meditation used by the incarcerated:**

Verbal reports by participants indicated that:

- They have found guided meditation more effective than the traditional meditational practices. The main reason was that with the verbal instructions, they are forced to listen and follow the scripts whilst in the traditional meditation practices they find difficulties to be mindful or concentrative.
- Many admitted that they become more aware of their actions and behaviours
- Many mentioned that they felt more relaxed and that they had developed a more congenial personality

Verbal reports by the prison authorities:

- The incarcerated are better behaved after completion of the programme
- They appeared more relax and less “troublesome”.

*The concept of “flow”*

Mystics, spiritual gurus and great religious teachers have all admonished people to “flow” with the universal life energy/force. When personalised, this universal life energy is usually referred as God, Allah, Brahma and so forth. As an impersonal force, its energy referred to as “prana” (Indian) or the “chi” (Chinese) permeates all of existence – from the universe to the planets, constellations, plants, animals and humans (Brennan, 1988). This concept of “flow” – of immersing oneself within and into this life energy was introduced by
the author as he believed that such a methodology ensure greater success in emotional, mental, spiritual healing than the current specific therapeutic methodology i.e. cognitive behavioural therapy (CBT), Rational Emotive Behavioural Therapy (REBT), Solution Focus Therapy and so forth. In “flow” psychotherapy the client is made to adopt a stance of being forgiving, humble and compassionate – to himself/herself and to others also. In the existential aspect, the client is constantly reminded that he/she is merely an “organism” in this immense and vast cosmic theatre. From the psychological perspective an integrated therapy methodology is used – Reality/Choice therapy (Glasser); Existential therapy; Gestalt (Perles); Logotherapy (Frankl), Psychosynthesis (Assagioli) and Buddhism.

**Literature review**

*Traditional meditation:*

Traditional meditation techniques involve two fundamental Buddhist styles (Sujiva, 2000):

- **Samatha** – translated as tranquillity and calmness. It engages the meditator to experience varying absorption mental states called **Jhana**
- **Vipassana** – translated as “insight” whereby the meditator focuses onto discovering and experiencing the state of impermanence (**anicca**), unsatisfactoriness (**dukkha**) and insubstantiality (**anatta**).

In those two styles as well as in the Hindus meditation regime of **Raja Yoga or Jhana Yoga**, the meditator is usually left to himself/herself to discover or uncover some experiences.

*Guided meditation:*

As mentioned, in guided meditation, either live or recorded, the meditator is voiced-guided step-by-step through a meditative experience.
There are many different approaches to guided meditation. Each has its own purpose and goal. Some have specific purpose such as healing or self-improvement with goals such as creating prosperity (Ponder, 2008), improving relations, developing forgiveness (Ponders, 1987), or any number of other goals. Other guided meditation is more general, aimed at quieting the chattering mind and producing mental calmness and relaxation (Benson, 1984). Some are designed to “awaken” the psychic and energy centres (chakras) of the practitioners (Martin and Moraitis, 2003) and to evoke them to a “higher states of consciousness”

- Traditional meditative techniques derived from Buddhism and Hinduism.
- Buddhism adopts two basic techniques (Sujiva, 2000):
  - **Samatha** - tranquillity, calmness meditation that brings the practitioner to an altered state of consciousness referred to as *jhanas* (state of mental absorption).
  - **Vipassana** - insight meditation that engages the meditator to investigate and experience the situation of impermanence (*anicca*), unsatisfactoriness(*dukkha*) and insubstantiality(*anatta*)

**Hence meditational techniques have been used long time ago**

- Buddhist meditation techniques include the expressions of high ethical and moral standards of the practitioner (Po, 2003). It is all-encompassing and holistic therapy.
- Mindfulness based cognitive therapy (MBCT: Segal, Williams and Teasdale, 2002) is now advocated by both the National Institute of Health and Care Excellence (2009) and the American Psychiatry Association (2010).
- Mindfulness based Relapse Prevention (MBPR), a meditation protocol benefitted those participating in this research study when using this skill as against treatment using the standard 12-step programme and Cognitive Relapse Prevention method (Bowen et al. 2014).
- Mindfulness based Relapse Prevention (MBPR), originally developed by Alan Marlett in the 1970 had used the Indian transcendental meditation and Buddhist *vipassana*
meditation style for the further development of numerous interventions and studies on mindfulness and accept-based treatments for substance used disorders. MBRP is designed to help clients increase awareness of triggers and subsequent physical, emotional and cognitive experiences, learning to respond skilfully rather react habitually (Bowen and Viten, 2012).

*Meditative flow-Psychotherapy:*

Meditative flow-Psychotherapy is different from meditative psychotherapy. It is an improvement of the “Buddhist Psychosynthetic Therapy” methodology that I had designed to assist the incarcerated and the elderly some three years ago. This had been introduced during the 2nd Asian Pacific Rim Psychotherapist and Counsellor Conference and again in the Australian Counselling Association National Convention in Melbourne in 2011. However, the term “Buddhist” was seen in negative light and I then redesigned this form of therapy to be more secular in direction. I have also added many other practices that appeal to clients and the general audience.

Unlike other modalities of meditative psychotherapy, Meditative flow-Psychotherapy possesses the following features:

- It is holistic as it deals with not only the Mind-body interaction but the Mind-body-spirit relationship and their independencies upon each other.
- It is soft and mellow in approach and practitioners will not feel threatened. Challenges to current cognitive distortions and dissonance are dealt with conscious subtleness.
- Breathe-work is essential and practitioners are made aware that breathe-work do not necessarily mean focussing on “breathing in-out” but to realise that air do not only consist of particles of oxygen, hydrogen, helium etc but also the waveform of vital life force (prajna in Hinduism, chi in Taoism, jivitindriya in Buddhism, nous in western mystic’s terminology).
- Practitioners are taught to be immersed in the “flow” of the nature and essence of life. Hence the term “meditative flow-psychotherapy”.

• “Meditative flow-Psychotherapy” can be likened to immersing and experiencing the flow of water of a stream or the dance of plants in a corn field during a windy day. It sways with non-resistance.

• “Meditative flow-Psychotherapy” is more than mere mindfulness of the body or events. It encompasses focussing, mindfulness, reflection, contemplation, transformations and prayer cantering. It is therefore multi-dimensional and multi-disciplinary.

Components of Meditative flow-psychotherapy:

Meditative flow-psychotherapy methodology can be divided into three basic practices.

1. The acceptance of values and beliefs
2. The preparations
3. The practice itself

In “Acceptance of values and beliefs” the practitioner is offered psycho-education of the following:

- that all in creation from the smallest sub-atomic particles and waveforms to the constellations of stars, planets and galaxies are all construction of similar building blocks and made of the same stuff. There is “connectedness” amongst us
- that our realities of our external world are actually mind-constructed
- that human are physical, mental and spiritual in composition
- that human existence is fundamentally full of tension and anxieties
- that happiness is a human endowment
- that prosperity is a human endowment

In the “Preliminary preparations” practitioners are asked to cultivate the following:

- 1<sup>st</sup> Preliminary : preparation of the body for meditation
- 2<sup>nd</sup> Preliminary : cultivation of forgiveness to self and others
- 3<sup>rd</sup> Preliminary : cultivation of love to self and others
• 4th Preliminary: cultivation of compassion to self and others
• 5th Preliminary: cultivation of affirmation and faith
• 6th Preliminary: cultivation of resonance
• 7th Preliminary: cultivation of reality acceptance
• 8th Preliminary: cultivation of attitude towards removal of fear of death
• 9th Preliminary: cultivation of sense of urgency

In the “Practice” practitioners are taught awareness of their physical, mental and spiritual sensations, emotions and feelings. Past traumatic events can sometimes surface but can be dealt with accordingly. The situation of calmness, tranquillity, peacefulness and equilibrium are elicited. Finally a balance state of the mind is achieved. We find ourselves connected with each other and to the cosmic vibrations (Haisch, 2006).

At higher (or deeper) levels, reflection and contemplation of the nature and essence of life itself are required. Practitioners are also required to explore their own mortality and upon the topic of death and life after death (Narada, undated). It is recognised that the person possesses many sub-personalities (Rowan, 1999) and the later practices will engage those sub-personalities especially the less desirable types. The path along this higher level is without psychological pitfalls though and they are described in Buddhagosa’s Path of Purification (undated).

Nonetheless, under the watchful eyes of a skilful and trained meditative teacher cum therapist, the practitioner ought to be in good hands.

One of the dangers of deep meditations is the realisation that the mind-constructed worlds of experiences that people live in are actually illusions and according to ancient texts are “veiled by Maya”. David Bohm (1980) proposes the notion of implicated and explicated order of realities. Buddhism speaks of conventional realities (samuttivohara) and ultimate realities (paramathavohara) (Bhikkhu Bodi, 1999). It is therefore not unusual for everyday normal working people when confronted with such notions to collapse into depression, shock and anxiety (Pa-Auk Tawya Sayadaw, 2003). Hence the importance of one adopting a serious cultivation of the nine “preliminaries”.
Emerging role of Buddhism in clinical psychology

Methodology

This research adopts a qualitative narrative approach and therefore no control group is used for comparison. To test the efficacies of the “guided meditation” programme a population comprising of the counsellors/therapists themselves and the addicts (clients) undergoing the programme are engaged. All counsellors/therapists have undergone some sort of relaxation meditation exercises prior to participating in this programme so as to be able to describe the difference effect experienced between normal meditation methodology and guided meditation.

All clients have undergone some sort of relaxation meditation exercises (mostly unstructured) prior to participating in this programme at one point of their lives as hobbyist.

The population comprised of four male counsellors and four male clients. Each period of sitting (session) was as follows:

- Counsellors - 2 hours
- Clients - 2 hours x 3 sittings (total 6 hours)

Meditational aids in terms of soft meditational music were used. Participants had the choice of either sitting cross-legged on the floor or on upright chairs. The psycho-education of Meditative flow-Psychotherapy involved discussions and instructions drawn from the following sources:

- Buddhism
- Reality/Choice therapy (Glasser)
- Existential Therapy
- Gestalt (Perles)
- Logotherapy (Frankl)
- Psychosynthesis (Assagioli)
- The concept of spirituality

In addition clients are asked to reflect upon the meaning of their own lives – the past and the future. They are they require to share with others. Scripts used are selected to evoke
relevant imageries and visualisations objects and scenes. Each session ended with four types of simple yoga exercises being introduced and practiced.

Individual interviews are then carried out. Only pertinent question is asked – whether or not they have found the therapy tool useful for each of them to use in situation of impending relapse. All answered in the positive. Strength of assertiveness and positiveness are not measured.

During each session all participants are constantly reminded of the need and essentiality of constant and consistent daily practice if the therapy is to considered as a tool for relapse prevention.

**Findings**

This paper is not meant to report a quantitative evaluation of the programme. At best it relies mainly on testimonies of the participants of how people feel after completing the programme. For instance, under the prison setting, it is almost impossible trying to formulate some sort of statistical results. The use of pen and paper is disallowed and prison authorities shy away from private research and surveys done within environment. Within the Sabah (Solace) setting, all statistical information is considered confidential. Admittedly findings under such circumstances cannot be scientifically validated or reliable. Nonetheless, testimonies do play important roles in the expression of feeling, emotions and thoughts of the person.

Judging from the many positive testimonies received the author is confident that his model of “Meditative flow-psychotherapy” delivered in the guided meditation process can help the healing of emotional, mental and spiritual wounds experienced during one’s journey through life.

**Solace (Sabah) CEO:**
“Thank you very much for your visit to Solace (Sabah) in Kota Kinabalu.

“The workshop you conducted with our clinical team comprising of psychologists, counsellors and doctor on 17th March to 18th March was extremely useful. The Mindfulness Meditation workshop is very much in line with treatment approaches we are currently employing. We have been receiving healthy feedback from the clinical team and request for a follow up to the workshop. The management will be pleased if you are willing to propose a series of similar workshops which will be beneficial to the team.”

**Report from client A:**

“Dear Jeffrey (Dr. Po),

“Thank you so much for your guided meditation course. After the sessions I found a tranquil peace within myself for the first time and I was able to find direction from my inner guide. It was truly an honour and a privilege to learn from you. Through you I am more certain than ever that there are really no coincidences in this impermanent existence and for this I feel truly blessed. I hope to hold on to what I have learned from you for all days.

“Until we meet again,

“Your friend....”

**Report from client B:**

“To Jeffrey,
“It was great getting to know you and learning meditation from you. I feel like a better human being due to this experience. I believe I can experience a better life – thanks to you. You’re a god’s valued teacher and you’ve got a great gift to help others see that life in ways unimagined.

“I wish you all the best and with a blessing from God. I pray that we will meet again real soon.

“Salom…”

**Report from Therapist A:**

“It was so powerful – very relaxing and almost like when under drugs…”

**Report from Therapist B:**

“I can’t carry on – I went back to some very harsh and traumatic memories …. I had to stop before I break down…”

**Limitations and discussion**

Like most researches, limitations exist.

One of the arguments against the use of guided meditation is that scripts or verbal narrations by the meditation instructor may be unsuitable to some audiences. Hence to be effective, the group commonality needs to be ascertained and determined. For instance, the instructor may use scripts that involves the engagement of “being one with nature”. However such topic may not reflect on the actual needs of some meditators.
Guided meditation invariably reflects the background and orientation of the instructor. If a meditation guide has a background with some meditation traditions that will invariably influence the style of the guided meditation. They might reflect a particular religious or spiritual tradition, such as Buddhism or Christianity, since meditation in one form or another is practice in most religion.

The issue of reliability and validity cannot be validated in this research because no control group is used. Again, the methodology of Meditative flow-Psychotherapy is one that had been designed by the researcher himself and therefore there can be no comparison. Hence further research is needed.

Many research carried out involving one aspect of meditation – mindfulness do not include the element of spirituality. Once again, obtaining evidence based comparison is difficult.

**Conclusion**

Though lacking in objective evidence of the validity and reliability of Meditative flow-Psychotherapy, the author feels that his therapy modality can be usefully engaged for the improved mental, social, emotional and psychological health of the client. He is convinced that the many positive testimonies reported by clients who had undergone this modality of therapy are sufficient encouragement that Meditative flow-Psychotherapy warrant greater notice and usage by counsellors and therapists. It is hoped that participants can carry this tool with them during their recovery journey and to engage it whenever necessary.

**References**


Trauma in the workplace, a framework for early intervention

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Paper Presented at the
15th International Mental Health Conference
Surfers Paradise, Gold Coast (QLD), 25-27 August 201
Trauma in the workplace, a framework for early intervention.

ABSTRACT

Aim: Using evidence-based understanding of trauma, develop a framework which is adaptable for most workplaces and can help reduce the impact of vicarious trauma.

Content: As there becomes an increasing understanding of the impacts of vicarious trauma on individuals, so should the understanding of its impact on the work environment. Some workplaces are at higher risk of vicarious trauma than others, in that their job roles place them in contact with traumatised people or information. Other workplaces may not have this risk, but with rates of sexual assault being so high, and other types of trauma such as family violence and traffic collisions, bushfires and floods, they are still susceptible to impact. A workplace experiencing vicarious trauma can see impacts such as burn out, high job turn over and loss of income due to illness. Early intervention is always the best method to prevent such long term impacts. Working from knowledge of trauma and recovery, and the nature of vicarious trauma, this framework serves to be adaptable to each environment, offering a basis for understanding, a chance to build resilience in the workplace, and opportunities for intervention.

Conclusion: Most adults spend a large percentage of their time at work, so it makes sense that work provides an opportunity for early intervention. It also makes sense that the workplace can serve to increase the vulnerability of the individual if appropriate action is not taken. By having an adaptable framework in place it can serve help workplaces identify gaps and goals; strengthening their resilience, supporting their staff and reducing financial and mental impacts.

Context and Introduction

The very nature of the human experience implies that at some time in our lives we will experience at least one traumatic event. The form of this trauma varies from more acknowledged events such as sexual assaults and surviving natural disasters, or the less
obvious traumas of serious illness and relationship breakdowns. Two aspects of trauma, which play a role in how communities handle are discussed in Dr. Judith Herman’s *Trauma and Recovery* (1997):

Firstly, those who suffer trauma are often stigmatised as representing a trauma that the population in general would prefer to avoid, such as sexual abuse, torture or war.

Secondly, trauma is often assumed to be short-lived. Those who are still affected by a trauma longer-term can be seen as a reminder, meaning they do not receive the on-going assistance they need.

Vicarious trauma is typically seen within the context of individuals who work with the traumatised. Social workers, emergency services personnel, nurses, doctors, and many others. As the understanding of trauma and its impacts increases, there needs to be some consideration given to the other workplaces who may be at risk of vicarious trauma. With rates of sexual assault so high (Commonwealth of Australia, 2010) it would not be unusual to find someone in a workplace who has been significantly impacted by abuse. Less acknowledged, but possibly more common forms of trauma, such as the sudden death of a family member, or a relationship breakdown, can be impactful on the individual and on their workplace. This leaves the potential risks in non-trauma-focused workplaces higher than first considered. This idea of vicarious trauma could be used to explain how some workplaces can have higher rates of workplace turnover, burnout, and bullying and harassment cases – especially in those workplaces who previously had none of these issues.

Through various studies over the years, we know that vicarious trauma is real, and does have significant impacts on the individual, the organisation and the community at large. For example, two studies have been undertaken on solicitors and interpreters, and those who had work with people who had experienced trauma (criminal solicitors and interpreters for refugees from warzones), incidences of vicarious traumatisation and coping strategies had been experienced (Vrklevski & Franklin, 2008; Splevins, Cohen, Joseph, Murray & Bowley, 2010). In a study of judges in America, it was discovered that all had low levels of symptoms associated with vicarious trauma, burn out and other safety concerns, directly linked to their workplace experiences (Chamberlain & Miller, 2009). Vicarious trauma has also been recorded amongst members of the public whose only exposure to trauma was through media coverage of bushfires (Byrne, Lerias & Sullivan, 2006).
It should not be assumed that within all organisations, vicarious traumatisation is ignored or disbelieved. Certainly some are ahead of the rest in terms of addressing this issue, especially within those organisations who deal directly with the traumatised. Many such organisations accept it as a possibility, but typically it is only addressed when the symptoms in the individual have progressed to a point when aggressive interventions may need to be taken (Maslach, 2003). If these are the methods organisations who are aware of trauma and vicarious trauma are handling the issue, it leads to the problems which may be going unnoticed in places with less understanding.

Early intervention may be the best way to address vicarious traumatisation, with the focus being on developing an environment where steps are automatically taken to support the worker other than external counselling services. It may also help employees attend counselling if they are significantly affected, as explained above by Judith Herman (1997), the culture in the organisation may be one where seeking help for trauma is viewed as ‘weak’, which may have encouraged the employee to seek negative coping methods like drugs and alcohol, or may target the individual who is traumatised in bullying and harassment campaigns. Not addressing trauma impacts in a workplace runs the risk of increasing this community’s vulnerability to burn out, workers compensation and high turnover of staff.

This framework works from the assumption that vicarious trauma is a risk in any workplace, and that the workplace is the best means of intervention. Primarily this is because of access, and time individuals spend at work. Workplaces are a culture in and of themselves and vary from one place to another. People can be significantly impacted by their work colleagues trauma, or indeed play a role in helping or hindering the traumatised individual’s recovery. By building a more resilient workplace, it can help to reduce workplace burnout, and build a more supportive environment, so when one individual experiences a trauma, the whole workplace can support the recovery, rather than suffering the vicarious effects.

**Practice Framework**

This section will explain the guiding theories to the framework, finishing with an explanation of how to use the framework detailed in diagram 1.

*Community Development*
Community development is a crucial aspect of the project framework. Aimed at seeing the work environment as a working community rather than a system to control or resent, is supported by social work literature (Goetschius, 2000; Payne, 2005; Munford & Walsh-Tapiata, 2005). Building supports, strengths and shared connections in communities could help to reduce the impact of trauma on members.

Asset-based approaches work with the assumption that communities already have some form of resources available and strengths to call upon, rather than they are devoid of such capacity (Kenny, 2011). For example, in the emergency services context, long-service personnel as identified by Violanti (2004) have managed to withstand multiple trauma events, displaying either deliberate or unconscious coping strategies to overcome the potential trauma symptoms. Such experience cannot be overlooked, and should be apart of any intervention as these individuals may hold the key to this specific cultural environment’s way of building resilience. The life experiences of trauma and coping tools are useful assets. Equally so, a careful community developer will know the importance of acknowledging their initial lack of information about how an environment operates, and therefore will need to rely upon, and respect, the expertise of those who operate within it in order to build the best approach.

It is important that adequate enough time is given to get to know the environment in which people work. By being present within the organisation, and even active within it, may generate a better relationship between the worker who intends to create change, and the staff members. Twelvetrees (2008) suggests the best approach to community development is to, “walk, not ride,”; that it is better to be seen in the community and make yourself available, as an active part of the community, rather than be seen as a professional fly-in.

Ecological Systems Theory

Ecological systems theory sees the individual not as an independent person, but as a person who operates, influences, and can be influenced by, various systems within their life (Payne, 2005; Trevithick, 2005). Maslach (2003) notes that the typical treatment for those suffering from job related stress is to remove the individual from the workplace to work on building up individual resilience. However, the structure of the workplace can be a larger factor in stress than the individual, suggesting an organisational approach would be more suitable. An example of the need to consider the systems, comes in the use of Critical Incident Debriefing; one on one debriefing of those who have experienced trauma. This insistence on isolating an
individual, while it may seem beneficial, has shown to have potentially negative effects (Reynolds & Wagner, 2007; McNally, 2004). The intervention could be improved by using it within a group setting, rather than one on one, and by coupling it with a crisis management plan. Thereby expanding the idea of one on one to include the community in debriefing allowing the community itself to form supports. This approach is an example, and should only be used where appropriate for the workplace involved.

Understanding environments outside of work is also essential. Systems theory suggests that stress in one’s work and home life not only interact, but that they can form a feedback loop. This runs contrary to many work place cultures of ‘leaving your personal life at the door’ and the assumption that work and home life should not interact.

The use of ecological systems theory is not calling for high levels of self-disclosure between staff members, or to ask a person to share their private lives. The necessary aspect is the broader understanding that the workplace is simply one system of many that people are involved within, and needs to be respected for any intervention to be successful.

Resilience

Resilience is a possible intervention strategy when working with clients after a major disaster (Masten, 2007). Resilience can be developed and built upon to help withstand the effects of psychological stress disorders when individuals make sense of their purpose and create meaning in their job role (Tehrani, 2010).

Violanti (2004) found in his study that police officers with more service time had lower risk of PTSD and suicide ideation, despite higher trauma exposure. One explanation for this is that those officers who have been seriously affected have left the service. Those who remain have already generated enough resilience to withstand trauma and may have the appropriate supports in place. Consideration may need to be given to connecting the client with programs and services to help build their supports and provides the ability to ‘bounce back’, and is an important part of resilience based interventions.

The positive aspects of experiencing traumatic events can be included from a strengths perspective. As suggested by Shakespeare-Finch et.al. (2003), encouraging the building of resilience and the positive aspect to their occupational environment, rather than treat work-relevant trauma as an entirely negative event, could see improved resilience to traumatic events.
Culturally Sensitive Practice

Typically this aspect is used when working with cultures that experience some form of discrimination (Payne, 2005), such as the appreciation and understanding required to work with culturally and linguistically diverse (CALD) groups or members from Aboriginal or Torres Straight Islanders decent. While the individual cultural backgrounds of the staff members should be considered when framing specific interventions, there needs to be a broader appreciation for the culture of the workplace. Within community development and ecological systems theory approaches, an understanding of the community and their environment is crucial to working with the individual and the organisation as a whole (Maslac, 2003; Vogel et.al., 2004).

Education and Training

Trauma awareness education is a founding stone to the framework, and it is suggested it is on the first steps taken when developing an approach into a workplace. Helping employees understand their reactions and the reactions of their colleagues is a means to fight the stigma surrounding seeking help and building appropriate change into the environment (Shakespeare-Finch et.al., 2003; Reynolds & Wagner, 2007; Vogel et.al., 2004). Trauma and its impact is a subject rarely taught at school, and it is likely there are many people and organisations who have never considered the possibility. By giving importance to removing ignorance, and creating a training and workshop which is appropriate for the service can help make any transition easier if done appropriately. Education and training is the first step and indeed a continuing process, in any intervention with a workplace.

Broken Windows Theory

The ‘Broken Windows’ theory is usually used in explaining crime, and proposes that tolerating smaller crimes such as vandalism leads to an increase in more violent crimes (Hesketh, et al., 2003). Applying this theory to trauma suggests that small incidents of trauma symptoms should no be tolerated, as they can lead to an increase in more severe symptoms. A study investigating the prevalence of violence towards nurses in Canada found that violence increased when the nurses were not reporting what they considered to be less important
incidences of abuse. Couple this with higher workloads, and nurses were more likely to encounter acts of violence, even from patients and their families who had no past history of violence. Hesketh, et al., (2003) explains this as the acceptance of violence creates a culture of violence, and unless there is a line drawn, the violence only increases.

Broken windows theory, in the workplace context, could be used to argue the acceptance of a ‘small’ symptom of trauma-stress could then lead to increased levels of stress to the point that it interferes in work performance and the individual’s life. Therefore the implied approach is to take all incidences of trauma-stress seriously so as to prevent a potential increase in the individual and in their community.

*Using diagram 1*

In diagram one, these theories and interventions have been expanded into potential practice considerations. They have been separated into Guiding Theories, Professional Knowledge, Values and Ethics and Suggested Practice Skills. The following points under each heading are intended as guidelines, to be developed an expanded as appropriate to each new environment. The overall aim of this framework is for it to remain flexible and allow for different approaches depending upon the need of the workplace culture and the focus of the intervention.
Diagram 1: Practice Framework

Guiding Theories

Organisational
- Service Culture
- Legislation
- Context
- Policy

Ecological
- Systems Theory
  - Trauma
  - Multidimensional practice
  - Adult learning theories

Resilience

Culturally
- Sensitive Practice
  - Culture
  - Values
  - Beliefs

Broken Windows
- Theory
  - Critical Reflection
  - Self
  - Awareness

Education and Training

Community Development

Ecological Systems Theory

Resilience

Culturally Sensitive Practice

Broken Windows Theory

Education and Training

Professional Knowledge

Organisational
- Service Culture
- Legislation
- Context
- Policy

Theoretical
- Trauma
- Multidimensional practice
- Adult learning theories

Research
- Trauma and Recovery
- Journals
- Conferences

Personal
- Culture
- Values
- Beliefs

Practice Wisdom
- Critical Reflection
- Self
- Awareness

Clients
- Service culture
- Families
- Participation
- Equity/Rights

Values and Ethics

Respect for Persons
- Right to well being
- Self fulfilment
- Self determination
- Right to privacy

Social Justice
- Fairness
- Access
- Equity

Respect for Persons
- Participation
- Appropriate use of authority

Professional Integrity
- Honesty
- Professional development
- Transparency
- Reliability

- Empathy
- Self-awareness
- Discernment
- Competence
- Commitment

Suggested Practice Skills

High level of interpersonal skills
Communication skills

Case management
Group work skills
Critical reflection

Adult learning cycle
Decision-making skills
Respectful engagement
Report writing skills
Advocacy
Limitations

The practice framework is a purely theoretical model. Additional qualitative and quantitative research on the applicability and usefulness of the framework, whether it can be as adaptable as theorised, and how early such an intervention would need to take place in order to be effective. Above all, willingness to experiment with methods of building trauma resilience is required for further development.

Another limitation to the model is the lack of research into vicarious trauma within workplaces that do not directly work with those suffering from trauma, or with traumatic information. While there is logic behind the hypothesis that vicarious trauma is a risk in every workplace – it is not something that has been documented or investigated in any meaningful way currently available.

Lastly, this framework is initially working from an early intervention perspective. While it could potentially be adapted for use in groups experiencing high levels of vicarious trauma or its impacts in their workplace, it is not its intended use. This approach may not be suitable for all workplaces, and care, consideration and flexibility should always be applied when working with trauma. This framework is not a replacement for current methods, but is a supporting measure to help potentially increase a workplace’s resilience for reducing the impact of trauma. Only with further research and careful testing could this framework be confidently used.

Conclusion

With the numbers of people who have experienced significant trauma high in our community, there is a strong possibility that a number of workplaces are dealing with the impacts of vicarious trauma. Some may be aware of this, and actively seeking ways to support their workers, others may have no knowledge, and attribute difficulties to other issues. Through early intervention methods, with focus on the impacts of vicarious trauma, can help to build a resilient workforce. Use of a framework that incorporates community development approaches, cultural diversity, education and training, and bring a systems approach, can help build resilience and reduce risks of burn out and high staff turn over. This framework aims to provide a basis to create a resilient organisation, which can support, and retain its staff regardless of the type of trauma they may experience.
Reference List


Caring for people who experience mental illness in acute medical settings

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Caring for people who experience mental illness in acute medical settings
ABSTRACT: Research suggests that some healthcare professionals in medical care settings reflect the negative attitudes of the general public in regards to stereotyping and stigmatising people who experience mental illness. The aim of this research was to explore the phenomenon of the healthcare professional’s experience when caring for this vulnerable patient group in a non-psychiatric acute medical care setting. A qualitative, phenomenological design was used with 6 participants representing both nursing and medical disciplines. The results produced the emergent themes of fear, scope of practice and a conflict of duty of care. The findings of this study have the potential to contribute to health professional’s knowledge of working with those who experience mental illness in an acute medical care setting. It has the potential to reduce the likelihood of discriminatory care through the inclusion of such information in teaching modules and clinical role modelling for clinicians working in complex and demanding work environments.

Keywords: acute care, co-morbidity, healthcare professional, mental illness, physical illness

Introduction

Acute medical settings generally comprise of emergency department (ED), intensive care units (ICU), medical-surgical and general-medical wards. These are of themselves complex environments related to physical care of people and this can be exacerbated when a patient presents with co-morbid physical and mental illness. People living with a mental illness are more likely to have a physical illness when compared to people without a diagnosis of mental illness (Edward et al., 2012, van der Kluit and Goossens, 2011, Scott et al., 2012). In fact, people with serious mental illness (SMI) such as schizophrenia have a mortality rate of up to four times compared to people without SMI in the general population (Bressington et al., 2014). In Australia, one in five people are affected by a mental illness (Australian Bureau of Statistics, 2007) and an estimate of 30-50% of patients admitted to acute medical care settings experience co-morbid physical and mental illness (Sharrock and Happell, 2006). Furthermore it is well known that people experiencing mental illness often have difficulty in seeking and accessing appropriate and timely physical healthcare (Edward et al., 2012). Once patients with co-morbid physical and mental health are admitted to acute medical wards their physical care needs are often of an emergent nature and of high acuity and these patients may experience adverse events, longer length of stay and increased surgical complications (Zolnierek and Clingerman, 2012).

There still exist many challenges to the management of the physical care of people with a co-morbid mental illness in acute medical settings and these may be attributed to the generalist nurses’ approach to care including their personal experiences, knowledge and attitudes towards mental illness (Hahm et al., 2008). Zolnierek (2009) found in a systematic review
that when patients with a SMI were hospitalised in general and medical-surgical hospital wards for a non-psychiatric condition nurses would label the patient as ‘difficult.’ Patients with a co-morbid mental illness were considered disruptive to ward routines, unpredictable and many generalist healthcare professionals experienced a sense of apprehension or fear in providing care for this patient group (Brinn, 2000, Liggins and Hatcher, 2005, Adewuya and Oguntade, 2007). Negative attitudes towards caring for such patients are often exacerbated by feeling ill-prepared, unsupported and perception that mental health care was out of their scope of practice (Harrison and Zohhadi, 2005). Some generalist nurses, however, held more positive attitudes towards working with patients with mental disorder, and felt they tried to ‘do the right thing’ but lacked the requisite skills or knowledge to do so (Sharrock and Happell, 2006, Reed and Fitzgerald, 2005). For the majority of healthcare professionals factors such as stigma and discrimination and fear of aggression potential were found to ensue negative attitudes towards people with a mental illness (van der Kluit et al., 2013). In light of these challenges the aim of this study was to describe the experience of caring for complex patients with physical and mental co-morbidity from the perspective of the health professionals working in acute medical settings.

Method

The study undertook an empirical existential phenomenological design. This methodology and methods allows for the essence of the real-life experience by the in-depth examination and re-examination of the experience as it is described by the research participant. The methods which was employed for this study was an extension of Colaizzi’s phenomenological method of inquiry, developed by (Edward and Welch, 2011).

Participants and Recruitment

A purposive sample of health professionals employed in non-psychiatric medical wards was recruited. Participants were recruited by advertisement flyers and subsequent snowball sampling. Data saturation was achieved at six participants in this study.

Data Collection
Data was collected via one-on-one semi-structured interviews allowing for the generation of unanticipated information whilst controlling for the generation of useless data which may be accessed using a semi-structured interview. The focus question to begin interviews was “Can you describe an experience you have had on your acute ward where you have cared for a patient experiencing co-morbid mental illness?” Any subsequent questions in the interview were recursive in nature.

**Ethical Considerations**

The study was conducted in accordance with human research ethical guidelines. Ethical clearance was obtained by the University Human Research Ethics Committee.

**Data Analysis**

The narrative transcript data was analysed guided by the extended version of Colaizzi’s phenomenological method, developed by (Edward and Welch, 2011). The eight steps included in this method of data analysis are shown in Table 1.

Table 1. Extended version of Colaizzi’s Phenomenological method

<table>
<thead>
<tr>
<th>Step</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Interview transcripts read to attain a feeling for them</td>
</tr>
<tr>
<td>2.</td>
<td>Significant statements are extracted [statements that directly relate to the phenomenon under investigation and form the basic unit of analysis]</td>
</tr>
<tr>
<td>3.</td>
<td>Formulated meanings are attached to each statement [researcher attempts to identify meaning to each statement]</td>
</tr>
<tr>
<td>4.</td>
<td>The formulated meanings are grouped into theme clusters</td>
</tr>
<tr>
<td>5.</td>
<td>An exhaustive description of the experience is developed [comprehensive description of the experience as described by the healthcare professionals]</td>
</tr>
<tr>
<td>6.</td>
<td>Added Step – the researcher interprets the symbolic representation of the lived experience presented in the interview</td>
</tr>
<tr>
<td>7.</td>
<td>Identification of the fundamental structure of the phenomenon</td>
</tr>
</tbody>
</table>
8. Return to participants for validation and any new data revealed at this time is included to the final data collection

Qualitative Research Rigour

The rigour of the research was tested upon the four criteria developed by Lincoln and Guba (1985) – credibility, transferability, dependability and conformability – and these are considered gold standard of assessing trustworthiness of qualitative research. To maintain credibility of the findings the interview transcripts were validated (i.e. member checking) by the participants. Triangulation was undertaken by peer debriefing, where both researchers validated findings to address possible prejudice, inaccurate interpretation and pertinent omissions. To increase rigour the fundamental structure developed from the significant statements was triangulated against the fundamental structure developed from the interpretation of participant’s symbolic representation. To maintain dependability an audit trail with a clear description of how the research was conducted and how decisions were made in the research process was documented throughout the research process (Lincoln and Guba, 1985).

Findings

There were six participants involved in this study. The participants were 3 female and 3 males, with 4 being registered nurses and 2 males being medical doctors, of which one was in his final year of studies. The age range of the participants was between 21 and 37 years of age. The findings produced the main emergent themes including fear, scope of practice and a conflict of duty of care.

Emergent theme- Fear

Participants expressed a fear attached to caring for people who had physical and mental health co-morbidity. One participant stated –

P1 – “[I feared for my safety] in the emergency department, god yes, all you had to do was turn your back and [a patient with a mental illness] has come through the ambulance bay and has pushed over the agency nurses or specials....When patients were restrained well [I]
thought that [I] was pretty safe then...When [I] had to go inside that seclusion room in the emergency department - I have to say I hated it, I absolutely hated it, and I avoided it if there was someone else to do it.....I was always worried that something terrible was going to happen [between a person with a mental illness and a staff member in the emergency department], thankfully nothing did but there were others that [I] know of that were assaulted.”

While another participant described a situation where they were not physically assaulted but did feel a physical threat to their safety with the need to call hospital security –

P3 – “[I] heard a really loud bang and crash followed by swearing and I was confronted with a [patient with co-morbid physical and mental illness/dual diagnosis] and he was charging out of his room, he made eye contact with me and started coming towards me, I called a code grey I needed to get security...I wasn’t assaulted by the patient but I did feel threatened.”

Further, a participant described a fearful situation yet felt some reassurance from having had experience in working in a psychiatric setting –

P6 – “Patients with a co-morbid physical and mental illness...are trying to spit and hit at you, and especially when you are holding sharp objects near them are dangerous to treat... I am more comfortable treating these patients because I have done my psych rotation if I did not I would be running in the opposite direction and saying call a code grey.”

Emergent theme – Scope of Practice

Matters related to scope of practice emerged in the findings of this study in relation to undertaking a role in care delivery that participants felt unprepared for. One participant remarked –

P2 – “I don’t really go into [patients with a co-morbid physical and mental illness] whole psychiatric history, I just don’t. That is not really our job as nurses in the emergency department. [I] make sure [patients with a co-morbid physical and mental illness in emergency department] are medically stable you know I hook them up to the cardiac monitor, do the ECGs but really do nothing to deal with their mental state, that is all kind of left to the psychiatric nurses.”

In support of this view participants stated –

P5 – “[I] didn’t really see any attempt of non-psychiatric staff to manage or get involved in the management of ‘psych’ specific problems... I really feel like there is a distinction made by other medical specialties that this is ‘psych’s’ thing and this is our thing.” [On the general-medical ward] there doesn’t really seem to be any recognition of connection between mind and body which is a moderately established phenomenon - the disconnection between mental health and physical health.”

Another participant agreed by saying –

P4 - “Schizophrenia, drug abuse and things like that we don’t have enough experience and we are not qualified to deal with it, we don’t know enough how to manage each mental illness.”
Emergent theme- Conflict of Duty of Care

A conflict of duty of care emerged as a theme in the findings of this study. This conflict related to a desire to care for people on the ward conflicted with a lack of knowledge, skills and support with which to do so. One participant stated –

P4 – “I remember feeling apprehensive about looking after the [patient with a co-morbid physical and mental illness] because I felt like I was going to be in an unsafe situation. It was really [a fear of] the unknown I had never cared for anyone in alcohol withdrawal and I just knew from that they could be physically and verbally aggressive but didn’t really know how to deal with it, I was adept with what would I do, I wouldn’t have known how to act. I didn’t want to avoid caring for the patient and I am glad that I got to look after this patient and got to see for myself that it isn’t really that scary caring for this patient.”

P4 – “I wanted to take the time to talk to people [with co-morbid physical and mental illness on medical-surgical ward] but it just came down to time. You know we need to do the meds, dressings and everything else first.”

Another participant said -

P3 – “[It] was just too hard to keep an eye on the patient [with a co-morbid physical and mental illness] all the time; he really had to be in a locked ward. [The] medical care the patient received was adequate it just meant that we had to be more vigilant because he would pull out his [IV] cannula and be resistive to care at times, it just took a lot of reasoning with him so it ended up that it really was more of a time thing and we didn’t have the man power on the surgical ward.”

While another commented –

P1- “It was really hard when [patients with a co-morbid physical and mental illness came into emergency] because not only are they aggressive people and were hard to manage but the people who came in with personality disorders and they were time consuming and in saying that I just don’t know enough about it, they were really hard to deal with because again I just did not have the time.”

Discussion

The findings of this research for the majority suggest that healthcare professionals describe the experience of caring for patients experiencing mental illness in acute medical care settings as a challenging experience. The main themes revealed by analysis of the data were
the experience of fear, concerns related to scope of practice and experiencing an internal conflict of duty of care.

Fear in this group of healthcare professionals related to caring for in-patients with physical and mental illness co-morbidity is not new. Some evidence exists supporting that healthcare staff in acute medical wards held concerns of fear towards patients with a mental illness due to a perception of unpredictability and dangerousness causing healthcare staff to be hyper-vigilant and concerned for their own safety and that of their other patients (Adewuya and Oguntade, 2007, Lethoba et al., 2006). Edward and colleagues (2014) found in their systematic review in health settings serious mental health problems and a history of assault predicts a higher potential of causing assault. Healthcare professionals reported feeling wary, apprehensive and sometimes avoiding patients when their own personal safety was threatened. The potential for inequitable care practices due to a the label of a mental disorder is often exacerbated in care settings that lack appropriate support and strategies that assist staff (Chow et al., 2007) and results in under reporting (Edward et al., 2014). Certain diagnoses such as dual diagnosis and SMI where patients may be exhibiting unusual behaviours and/or are a disruption to the normal ward routine generated the greatest amount of fear and suspicion in healthcare professionals in this study. Similar to the findings of Liggins and Hatcher (2005), fear was particularly profound when little was understood about a mental disorder and this lack of knowledge allowed misconceptions and negative stereotypes about people who experienced mental illness to ensue. Other studies suggest that despite health professionals having requisite training in mental illness and care, they are not immune to stigmatising and wrongly stereotyping people with a mental illness (Adewuya and Oguntade, 2007, Björkman et al., 2008). Contrastingly though, in support of some of our findings some research suggests that familiarity through experience and exposure to patients with a mental illness results in more positive attitudes developing amongst healthcare staff (Arvaniti et al., 2009). The notion that experience and exposure leads to more positive attitudes is not conclusive as Brinn (2000) found in her sample of nurses that more experience lead to nurses feeling more prepared but not necessarily having more positive attitudes towards these patients. Nonetheless, nurses often report the lack of understanding, skills and expertise to manage patients who can be unpredictable, leading to high levels of uncertainty (Plant and White, 2013), fear for one’s safety and working in an environment in which they are constantly on guard (Zolnierek and Clingerman, 2012).
Matters of mental health care are often considered outside of the scope of practice of the generalist care nurse. The findings of this study suggest that amongst nursing and medical staff on acute medical wards there is a general perception that mental health care is not within the scope or expertise of generalist healthcare staff. This often meant that physical health care was prioritised over the mental health care of patients, which was also found in a study by nurses caring for older patients in acute care settings (Arnold and Mitchell, 2008). Harrison and Zohhadi (2005) found that nurses had a sense of role conflict on the general hospital ward when caring for people with comorbid mental illness, where mental health care was not considered part of their role. Mental health care is often perceived as a distinct set of skills or knowledge and in general health care settings the reality is that person-centred care is often competing with task-oriented care (Sharrock and Happell, 2006). Healthcare professionals perceptions related to training and skills can often lead to feelings of frustration or helplessness (Reed and Fitzgerald, 2005). When healthcare staff feel like they are working outside of their expertise, knowledge or skill set they can feel disempowered, frustrated and burnout can result having negative consequences for both the staff and the patients in their care (Plant and White, 2013, MacNeela et al., 2012).

While some healthcare professionals in this study felt that mental healthcare was not part of their role, others expressed more positive sentiments about caring for patients experiencing comorbid physical and mental illness, saying they strived to care each person equally. These findings are supported by Sharrock and Happell (2006) where nurses had expressed attitudes such as doing the “right thing” by their patients but acknowledge that the challenges such as preparation and the acute medical environment were also impacting. Some of the participants described when they experienced caring for the patient for themselves their apprehension faded. While healthcare professionals strive to do their best the very label of a mental illness can impact care (Liggins and Hatcher, 2005). Exposure and experience may be moderators to feelings of fear and apprehension and notions about scope of practice. The findings of this study suggest the healthcare professionals who had experiences with patients experiencing mental illness, reported more acceptance of patients experiencing mental illness and would often see the patient beyond the label of their mental illness.

Study Limitations
Using phenomenological methodology and heterogeneity of the sample the data is not generalisable, however the intent of this research was not to generalise but to give an in-depth description of the phenomenon for caring for patients with co-morbid physical and mental illness from the perspective of Australian health professional. The participants of this study may have found it difficult or shameful to articulate their experiences where they may have delivered substandard care and this may have influenced their responses. The difficulties for the researchers to remain completely reflexive throughout the data interpretation and analysis must be acknowledged.

Conclusion

The findings of this study support previous findings where healthcare professionals working in secondary acute care settings find it challenging to provide care for patients who are experiencing co-morbid physical and mental illness. Generalist health care professionals, describe a fear of patients and practice avoidant and cautionary care when they are caring for patients experiencing mental illness. Often physical care takes priority over mental health care as staff are underprepared for mental health care eventualities. Moderators to reducing negative experiences and ill-informed attitudes towards patients experiencing mental illness include increased professional experience and exposure to a variety of patients with different diagnoses and also the assistance of psychiatric liaison staff.

Clinical Implications

Mental illness is profound on a global level, and in order to suitably care for this vulnerable patient group, hospital staff need to be equipped supported to provide appropriate and timely care. It is recommended that healthcare staff receive ongoing annual mandatory training in the mental health care to improve mental health literacy, increase staff confidence and provide staff with tools that will assist them in reflecting on their practice and in particular improving their self-awareness. Of consideration the training for all generalist healthcare staff should be provided by mental health staff and consumer representation would be of value.
References


Beyond symptoms: Defining primary care mental health clinical assessment priorities, content and process

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Abstract

The assessment of undifferentiated psychological distress is a daily aspect of primary care practice. Primary care practitioners' underlying values influence the priorities, process and content of assessment. Currently, there is a lack of definition of these values in primary care clinical mental health assessment. This paper presents the case for adopting the philosophical values and principles of holistic transdisciplinary generalism to influence practice worldwide. Furthermore, it raises awareness of current constraints on practice, including an overreliance on the psychiatric paradigm of care and resulting criteria-based diagnoses. Finally, the paper seeks to promote discussion among primary care practitioners and researchers globally about how to define primary care clinical mental health assessment priorities, process and content.

Keywords:
Primary care
Mental health
Assessment
Transdisciplinary
Generalism
General practice

Introduction

Clinical mental health assessment of psychological distress in primary care is part of everyday practice (Buszewicz, Pistrang, Barker, Cape, & Martin, 2006; Cape, Barker, Buszewicz, & Pistrang, 2000; Dowrick, 1992). Encounters with this highly prevalent presentation, involving depression and other undifferentiated psychological and somatic disturbances (Arnow et al., 2006; Delany, 2007; Stone & Clarke, 2007) are integral to the role of primary care practitioners. The way in which psychological distress is assessed: the 'expertise of knowing when, where and how to look' (Gregory, 2009), determines not only what questions are posed but also the quality of the assessment and subsequent management and care.

Despite calls from the World Health Organisation to integrate mental health care into primary care (Ivbijaro et al., 2008; Palmer et al., 2010;), clear theoretical or practical frameworks do not exist to guide this process globally. In addition, threats to generalism, and the traditional values of general practice, in what some call a reductionist age (Gillies, Mercer, Lyon, Scott, & Watt, 2009; Gregory, 2009), suggest that perhaps it is time for primary care to define what core values, skills and priorities it proposes to offer to the community in mental health assessment.

A reported rise in the diagnosis and treatment of clinical depression suggests a change in how we address normal human sorrow (Horwitz & Wakefield, 2007). The controversy over primary care practitioners' diagnostic skills (Armstrong & Earnshaw, 2004) with claims of both under-diagnosis and under-treatment (Shedler, Beck, & Bensen, 2000), and over-diagnosis (Mitchell, Vaze, & Rao, 2009) suggests that the quality of such assessment needs to be clearly defined. There is a concern that psychiatric criteria-based diagnoses of depression and the symptom reduction treatment goals they spawn, do little to affect clinical outcomes that matter to patients (Dowrick, 2004; Hutschemaekers, Tiemens, & De Winter, 2007; Tyrer, 2009). Patient dissatisfaction and the concept of treatment resistant depression may also point to inadequate assessment and subsequent treatment (Gask, Rogers, Oliver, May, & Roland, 2003; Souery, Papakostas, & Trivedi, 2006).

This paper draws on clinical and theoretical literature pertaining to clinical assessment in mental health worldwide to argue that the field of primary care should define its own clinical assessment priorities (why assess?), process (how do we assess?) and content (what are we assessing?). Defining and honing primary care values, process and content in mental health assessment may have far reaching effects on both individual treatment outcomes and on primary care delivery globally.
A call to generalism

Generalism is a core value and competency in primary care. It situates the biopsychosocial model within the unique cultural and existential milieu of each patient (Freeman, 2005). As Gunn et al. (2008) state, the generalist must know and understand the interplay and influence between each life story and social context, and physical and emotional health, linking the biomedical and other aspects of being human.

Primary care clinical assessment of people with undifferentiated psychological distress requires an intentional examination of the many aspects of their lives. The cause and progression of most morbidity is multidimensional and is influenced by each individual’s unique experiences (Small, 2003). Benson and Thistlthewaite (2009) remind us that patterns of interaction with family, community and wider society are part of the aetiology of despair and hopelessness. Multiple problem management is an assumed norm in primary care (Britt et al., 2008), as is the focus on the person within his or her context (person-centred care). Klerman, Vaillant, Spitzer, and Michels (1984) remind us that for research in psychiatry the unit is the disorder, while for general practice and primary care the unit is the individual.

For example, the much-used diagnosis of depression is an individual response to multiple biological, psychological, social and cultural factors (Wright, 1999) with limited usefulness in primary care (McPherson & Armstrong, 2009). It has been proposed that this complexity lends itself to a generalist holistic approach to assessment, set within a collaborative relationship between patient and practitioner (Plsek & Greenhalgh, 2001; Dew, Dowell, McLeod, Collings, & Bushnell, 2005; Kenny et al., 2009). Furthermore, Barry, Stevenson, Britten, Barber, and Bradley (2001) have suggested that primary care clinical mental health assessment should not limit its assessment paradigm to that of symptomatic pathology or disordered behavioural responses.

Holism in health care requires a transdisciplinary approach (Bernard & Anita, 2006). This enables the practitioner to understand each contributing discipline’s underlying assumptions (Martin, 2003) and to ‘integrate the natural, social and health sciences in a humanities context, and in so doing, transcend their traditional boundaries’ (Choi, 2008; Soskolne, 2000). This clearly evokes the primary care context and core values. Freeman (2005, p.154) defines the scope of primary care in the general practice context:

“An approach to health and medicine that is not reductionist is an implicit part of the comprehensive care provided by general practitioners. We are not doctors for particular diseases, or particular organs, or particular stages in the life cycle – we are doctors for people.”

Clinical assessment – what we choose to measure, the questions we ask or pose (Sadler, 2005), and the observations made within the consultation process, are informed by the culture of the practitioner. Tradition and training create paradigms of care with assumed, unexamined decision-making criteria (Sadler, 2005; Thompson, Ostler, Peveler, Baker, & Kinmonth, 2001). A transdisciplinary approach can inform the process of examining and integrating information from many research traditions, paradigms, cultures and disciplines of care, as well as assisting in the integration of information from each person’s past and present. Consequently, we suggest that transdisciplinary generalism could become a guiding principle in determining priorities, content and processes in primary care clinical mental health assessment as well as determining treatment goals. This approach may facilitate thorough assessments that look beyond symptoms to whole person care.

Current constraints on primary care mental health assessment

Despite calls to value the culture and strengths of primary care (including holism) and policy changes to move from hospital to primary led care worldwide (Lester, Glasby, & Tylee, 2004), the questions that are posed in primary care mental health assessment (hereafter called primary care assessment) are currently constrained by secondary care assumptions about the meaning of good quality care (Lester et al., 2004). Primary care assessment is made in a very different and unique physical and clinical setting to that of tertiary or secondary care (Gillies et al., 2009). Nevertheless, it is commonplace to assess the diagnostic validity of primary care assessment based on its congruence with specialist psychiatric diagnostic criteria (Maurice-Tison et al., 1998; van Weel-Baumgarten, van den Bosch, van den Hoogen, & Zitman, 2000).

Many primary care practitioners have considerable experience and expertise in assessing and managing depression (Harman, Veazie, & Lyness, 2006; Mitchell et al., 2009). Nonetheless, general practice and other primary care providers’ mental health assessment skills have been criticised (Lester et al., 2004) and been found to mismatch when compared against psychiatric criteria-based diagnosis (Armstrong & Earnshaw, 2004). There have been calls for education programs to train primary care practitioners in mental health skills (Armstrong & Earnshaw, 2004), calls to increase primary care screening for mental health disorders (Vazquez et al., 2006), and, in Australia, quality control measures and primary care funding linked to psychiatric criteria-based diagnoses (Medicare Australia, 2010). Much of this criticism of primary care excellence in diagnostic frameworks should be the gold standard for primary care assessment. Proponents endorse the use of psychiatric criteria as a way to ensure that primary care practitioners are not distracted by many presenting complaints or blinded by foreknowledge (van Weel-Baumgarten et al., 2000); a greater focus on symptoms is perceived to be a way to simplify primary care assessment (van Marwijk & Terluin, 2008) and ensure communication in a shared language (Hutschemaekers et al., 2007).

The paradigm of care represented by one of these psychiatric diagnostic frameworks, the Diagnostic Statistical Manual (DSM), has been described as ‘mapping the outside world from an ascendant position’ (Verhaeghe, 2004). The authors of the DSM intentionally position themselves as atheoretical observers (Cole, McGuffin, & Farmer, 2008), choosing not to participate in discussions regarding aetiology, theories, or context (Ghaemi, 2009). Instead, the authors limited their assessment to what could be described and categorised by observation (Sadler, 2002). These values underpin psychiatry’s care for the severely unwell patient, as well as research communication and comparisons of treatment (Shepherd, 1991). Currently, this paradigm of care defines the questions that are posed in primary care. Even though the DSM is multiaxial, in practice it focuses on observable symptoms and psychiatric categorising, ignoring the internal world of the patients or their context (Summerton, 2004).

General criticism of the psychiatric diagnostic approach has questioned its validity (Kirk & Hutchins, 1992) and its taxonomy (Haslam, 2003). The DSM has been described as an ‘enumeration of symptoms that produces negative value judgements, promotes conformity and has no meaning for treatment’ (Verhaeghe, 2004). Even the much discussed and measured diagnosis of depression is labelled ‘an over-inclusive term with a lack of conceptual clarity between symptom, syndrome, episode and illness’ (Casey, Dowrick, & Wilkinson, 2001). Some criticise the criteria-based process – arguing that it is a hospital-based diagnostic code (Shepherd, 1991), that it lacks relevance (Tyrer, Higgs, & Strathdee, 1993), and does not
acknowledge the unique setting of primary care (Wilhelm, Finch, Davenport, & Hickie, 2008). Others warn that the focus on symptoms risks dehumanising the patient (Sadler & Hulgu, 1992). Alternative models, such as those that see mental illness as dimensional, have been proposed as more precise and comprehensive ways to classify psychopathology, with greater epidemiologic validity and relevance to primary care assessment and treatment (Haslam, 2003; Thompson et al., 2001; Widiger & Sankis, 2000).

Despite all this debate, use of the psychiatric diagnosis as gold standard has persisted (Pilgrim, 2007), and the practice of those primary care practitioners who do not adhere to this standard is declared not conventionally evidence based (Small, 2003). Some primary care practitioners have developed their own taxonomy (Clarke, Cook, Smith, & Piterman, 2008) or diagnostic constructs for mental health assessment (Armstrong & Earnshaw, 2004). Congruence amongst general practitioner assessments has been found to be higher using their own idiosyncratic but recognisable multidisciplinary framework than by criteria-based categorisation (Shepherd, 1991). In addition, primary care practitioners frequently resist diagnostic frameworks that medicalise what they see as problems that are part of life (Macdonald et al., 2009). Armstrong and Earnshaw (2004) suggest that general practitioners may be identifying aspects of psychological distress that are uniquely grounded in the primary care context. This suggests the existence of an undefined and undervalued generalist approach to psychological distress that is not merely tertiary psychiatric care relocated into the community (Hickie, 1999).

In addition to the significant structural and logistical time constraints of primary care internationally, and the variability of competence, training and interest amongst individual generalists (Cape et al., 2000), guidelines indicate a narrowing of primary care tasks in the assessment of psychological distress to either prescribing medication or referring to specialists (Palmer et al., 2010). This constrictive role assumes that case-finding of mental disorders (Boardman & Walters, 2009) is the main role of primary care practitioners. However, using the psychiatric value system in mental health care conceptualisation and therapeutic decision making is not based on proven patient outcomes or alignment with primary care values or context (Moncreiff, 2008).

The current dominance of assumptions from secondary and tertiary care about best practice, despite queries about their alignment with primary care values or context (Moncreiff, 2008), has been declared not conventionally evidence based (Small, 2003). Some primary care practitioners who do not adhere to this standard is declared not conventionally evidence based (Small, 2003). Some primary care practitioners who do not adhere to this standard is declared not conventionally evidence based (Small, 2003). Some primary care practitioners who do not adhere to this standard is declared not conventionally evidence based (Small, 2003). Some primary care practitioners who do not adhere to this standard is declared not conventionally evidence based (Small, 2003). Some primary care practitioners who do not adhere to this standard is declared not conventionally evidence based (Small, 2003). Some primary care practitioners who do not adhere to this standard is declared not conventionally evidence based (Small, 2003).

A call to self-definition

Primary care practitioners need to define their own paradigm of mental health care, maintaining their generalism and valuing their position with their patients in community, rather than as ascendant observers (Verhaeghe, 2004). Primary care commentators urge for clarification of the role and scope of primary care (Dowrick, 1992; Marshall, 2009) and affirm that it is possible to ground this within the values and built on its recognised strengths (Lester et al., 2004). Without self definition, primary care risks losing its unique generalist role, as Balint (1993, p. 17) forewarned:

“It is the unfortunate fate of generalists that everyone else seems to have a clear idea of how they should be spending their time… “the GP is ideally placed” has become an almost ubiquitous phrase in medical literature. With its own main characteristics poorly defined, the face of general practice becomes common ground for all who pass to etch out a reflection of their own particular interests.”

The overall values of primary care have been carefully defined, including access and equity, prevention and early intervention, advocacy, generalism and whole person care within the community (Greenhalgh, 2008). Assessment in primary care involves the skills of managing complexity and uncertainty (Gregory, 2009; Wilson, Holt & Greenhalgh, 2001), using intuitive judgement (Greenhalgh, 2002), and the use of foreknowledge (van Weel-Baumgarten et al., 2000). It also values not foreclosing too early on diagnosis or premature categorisation (Todres, Galvin, & Dahlberg, 2007), and gives primacy to considering the patient’s perspective (Summerton, 2004). Whole person patient centred care – seeing the person and his or her perspective – has been defined as central to primary care worldwide. This approach has even been operationalised in the language of Reason for Encounter that is part of the International Classification of Primary Care (ICPC). ICPC values the language and patient perspective, allowing social, psychological and physical symptoms, as well as diagnoses, to be part of primary care professional formulations (Lamberts & Wood, 2002). Primary care also relies on interpersonal continuity (enabling diagnoses to be developed over time) and community awareness, in order to construct a thorough and realistic assessment (Baker et al., 2007; Gilbody, Sheldon, & Wessely, 2006; Summerton, 2004).

Some of these skills and the primary care values of holism are currently being constrained or neglected in primary care mental health assessment. This does not mean that primary care practitioners are not already providing many of these aspects of care, rather these skills and values lack definition, which risks the imposition of other values and agendas. This imposition may come in the form of critique, changes in funding or public policy, pragmatic or logistical constraints, or even community opinion about what the primary practitioner role should be in the care of undifferentiated mental distress.

Perhaps it is time for primary care to define and value its own skill set and role in mental health assessment. Unclear values affect standards (Gillies et al., 2009) and the outcome of patient assessment influences treatment priorities and outcomes; the questions constrain the answers. Ideal measures of quality include aspects of outcome sought, process, and structure (Mercer & Howie, 2006). So as part of promoting discussion within the discipline of primary care worldwide, we pose the following three key questions for discussion:

1. Why assess? What are the priorities of primary mental health care clinical assessment?
2. How should we assess? What are the appropriate processes for mental health care assessment that embody the core values and principles of primary health care?
3. What should we assess? What content is adequate to ensure that assessment leads to a comprehensive understanding of the individual, the individual’s problem and his or her context?

Defining primary care values in mental health assessment

WHY assess? Defining priorities in primary care clinical mental health assessment

The ultimate aim of primary care assessment is to ensure that the whole person is seen, understood, and connected with, in order to facilitate thorough care and comprehensive treatment options. A key priority is to lay a relational foundation for ongoing therapeutic process. Primary care assessment priorities may be influenced by more relational and contextual treatment goals than those of tertiary care. Primary care practitioners aim not to identify psychiatric disorders and eliminate them, rather to help each
person cope, and if possible thrive, within his or her context, managing personal limitations while building on strengths. These integrative concepts are not foreign to the primary care literature and reflect the real complexity of working with people within their community.

Based on the literature, we suggest that the definition of practical clinical priorities for mental health assessment in primary care should include establishing a safe working relationship, understanding the individual, facilitating hope, ensuring physical and psychological safety, defining joint treatment goals, and doing no harm (Fig. 1).

Some researchers have described what they see as priorities or goals for assessment in primary care. These include Cape et al. (2000), who identified core goals of primary psychological care as establishing a positive therapeutic relationship; developing a shared understanding of the problem and promoting change in behaviour, thoughts or emotions. Buszewicz et al. (2006) notes goals of ‘developing a working relationship’, which he defines as showing interest, listening, showing understanding and acceptance and providing continuity, and ‘facilitating change’, defined as making sense of problems, advise and facilitate decision making and support action and progress. Korner, Bendit, Poik, Tuckwell, and Butt (2010) mention enhancing therapeutic engagement, again restating the centrality of relationship to therapeutic outcome. A further objective of assessment is to enable the primary care roles of gatekeeper and advocate (Trinch, 2001). These descriptions may represent the start of discussion in the literature regarding priorities in primary care mental health assessment.

The key word ‘understand’ implies a shared process and comprehensive scope, both highly valued attributes in primary care. As Harris asserts: ‘the desire to understand is an indispensable characteristic of every good general practitioner’ (Harris, 1986). Being understood is linked with patient satisfaction (Gask et al., 2003). Safe communication is also highly valued in assessment, as it has direct effects on patient disclosure, affecting information gathering and therefore therapeutic outcomes (Sankar & Jones, 2005). Primary care can provide a safe place to be heard (Buszewicz et al., 2006). This literature values a patient centred approach, rather than priorities that are driven by practitioner-defined symptom lists or disease orientation. We agree with Jacobson and Greenley (2001) that facilitating a sense of safe connection, hope for change, and empowering the person to take active responsibility for his or her growth within his or her personal context are essential elements of primary care assessment.

**HOW should we assess? Defining process in primary care clinical mental health assessment**

Many of the values underpinning the process of primary mental health assessment are undermined by economic realities, health care structures, decreasing loyalty to and trust in the local primary care practitioner, as well as changes in how individuals relate to each other in the general community. Nevertheless, relationship, collaboration and shared language are core values shared by many primary care practitioners. We hope that defining and validating these values will increase primary care practitioners’ resolve to continue to offer them to the community.

A definition of the process of primary care assessment should include the development of a safe and empowering collaboration between patient and practitioner through the use of shared language and empathic attunement to the needs of the patient (Fig. 1).

In primary care, an assessment is not an isolated diagnostic event, but a therapeutic encounter where the patient has initiated seeking care. Thus, relationship building is an ongoing process as well as a key goal. These elements create a unique situation where trust and interpersonal connectedness can be built into a therapeutic relationship or working alliance (Oades et al., 2005) between therapist and patient. These concepts go beyond person-centred consumerism (Todres et al., 2007) to the development of a partnership (Marshall, 2009) with responsibilities as well as rights. Such a partnership recognises ‘the patient’s need for self-expression and [the practitioner’s] need to achieve pattern recognition, action and closure’, where both the patient’s narrative and the practitioner’s normative style contribute to the relationship (Clark, 2008). This approach clearly makes the person and the therapeutic relationship the focus of care, rather than the disease (Starfield & Horder, 2007).

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<td><strong>What are the priorities of assessment in primary care?</strong></td>
<td><strong>What process of assessment is best in the primary care setting?</strong></td>
<td><strong>What content is adequate to ensure assessment forms a comprehensive understanding of this person, their problem and their context?</strong></td>
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<td>• Establish a safe working relationship</td>
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<td>• Transdisciplinary integration of many paradigms of mental wellness</td>
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<td>• Understand the people we care for</td>
<td>• Safe and empowering collaboration</td>
<td>• Holistic awareness of context and history</td>
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<td>• Facilitate hope for their recovery and growth</td>
<td>• Communication in a shared language</td>
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<td>• Check on their physical and psychological safety</td>
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Fig. 1. Suggested definition of primary care clinical mental health assessment priorities, process and content.
Attending to the lived experience of each person is not straightforward. This therapeutic relationship is influenced by the practitioner’s assumptions and values (Halling & Goldfarb, 1996), and his or her attunement to the psychosocial concerns and the voice of the sufferer (Salmon, Dowrick, Ring, & Humphris, 2004). The attachment and neurobiological literature reiterate the importance of the connection between patient and practitioner, and the relationship that modulates change in both, contributing to ‘interrelational repair’ (Schore & Schore, 2008). Indeed, the impact of therapeutic relationship has been linked to outcomes (Haggerty, Hilsenroth, & Vala-Stewart, 2009; Hilsenroth & Cromer, 2007). General practice research has confirmed the importance to patients of the role of listening in the ongoing context of primary care relationship (Johnston et al., 2007).

The process of assessment requires shared communication. Treatment goals and assessment priorities that are acceptable and understandable to both patient and primary practitioner are a vital part of collaborative interaction and require a shared language (Clark, 2008). This necessitates intentional management of the potential problem of the power, knowledge and influence that the therapist wields (Cattan & Tiford, 2006). As Todres et al. (2007, p 54) warn:

“…medical and technical conceptions of health and illness have become a language which is used in very powerful ways to perpetuate the depersonalising and dehumanising practices of care.”

Speaking in the language of the patient—consciously adapting to match the language of the sufferer, validating them and allowing them to feel heard and understood—is an acquired primary care skill (Clark, 2008). Language is a vital part of the commitment to being with the individual in their context (Korner et al., 2010). Perhaps this intentional ‘being with’ the individual in a shared collaborative relationship and language is the challenge and the privilege: the key therapeutic tool of primary care.

**WHAT should we assess? Defining the content of primary care clinical mental health assessment**

The generalist focus of whole person care within his or her context needs to be defined with regard to the content of assessment, since content has been dominated by a disorder-focussed tertiary specialist paradigm. The generalist is challenged to cultivate curiosity (Harris, 1986) and attend to information from paradigms of care that may have contradictory evidence or ways of seeing. These may not be from a traditional mental health discipline, and include the literature written by patients on what they consider quality care. This area requires further research, and theoretical analysis of many bodies of literature in order to provide useful generalist (rather than psychiatric) clinical assessment tools. The increased breadth of understanding in assessment will influence the quality of treatment available.

We suggest that in order for primary care clinical mental health assessments to be formed with a comprehensive understanding of the individual, the individual’s problem, and context, there needs to be a deliberate integration of many paradigms of mental wellness, so that the patient is assessed in a holistic manner, aware of context and history, and attending to the patient, their relationships and sense of meaning (Fig. 1).

At present there are aspects of being human that are absent from primary mental health assessment content. Bowlby (1984) states that it has been ‘extremely unfashionable to attribute psychopathology to real life experience’. Awareness of each person’s life experience has not been a standard part of assessment. The trauma and abuse literature asserts that the impact of trauma on individuals is marginalised by mainstream services (Humphreys & Thiara, 2003) and is not included in mental health training (Courtis & Ford, 2009). Despite loss being a universal experience (Murray, 2001), a significant issue in primary care (Clark, Marley, Hiller, Leahy, & Pratt, 2005), a contributor to depression (Hedelin & Strandmark, 2001) and later life function (Holmes, 1993), understanding the losses faced by each person and their impact is not part of current standard primary care assessment (Enns & Cox, 2005). In addition, an assessment of the mental health effects of early childhood experiences noted in the fields of attachment and neurobiology (Cozolino, 2006; Holmes, 1993; Maudner & Hunter, 2001, pp. 556—567, 2009) is not routinely evaluated in primary care.

As well as this information about each person’s history, we can be more thorough in whole person assessment in the areas of social, somatic and behavioural experiences (including addiction and neurobiological symptoms of trauma), mood regulation, sense of self, hope, meaning making and spirituality. In all of these areas, generalist primary care would do well to look for strengths and resilience and growth as well as disorder (e.g., Blanch, 2007; Calhoun & Tedeschi, 2006; Haggerty et al., 2009; Mikulincer, 1995; Neimeyer, Herrero, & Botella, 2006; Schore, 2003).

The growing body of recovery literature written by patients/consumers outlining internal and external factors they have found helpful in recovery (Brown & Kandirikiri, 2007) has yet to be incorporated into clinical assessment content. These include hope, healing, empowerment and connection (Jacobson & Greenley, 2001); movement from despair to hope, passive to active sense of self, others in control to being in personal control, and disconnection to connectedness (King, Lloyd, & Meehan, 2007); finding meaning in life, redefining identity, and taking responsibility for recovery (Andresen, Oades, & Caputi, 2003).

Integrating these many disciplines into a scheme of assessment needs to be intentionally transdisciplinary, and yet practical and scientific and globally applicable. How these issues can be incorporated into primary care assessment is not currently outlined and remains a subject for future research.

**Limitations**

Many of the values discussed above already exist within the discipline of primary care, and yet are undervalued or constrained. This state of affairs will not be easy to address. Many of these ideas are not new; whole health systems have tried to address them (Hutschemaekers et al., 2007), yet powerful forces and discourses including economic and hierarchical ones maintain the status quo (Mitchell, 2009) worldwide. What is new, is conceptualising concerns in the primary care context as opposed to tertiary care, which might justify a new valuing of the transdisciplinary generalist primary care way of seeing undifferentiated psychological distress.

This approach to the diagnosis of mental distress may appear impractical. However, it fits well with the multi-faceted approach to the whole person that is the hallmark of primary care. It requires the practitioner to consider multiple perspectives of the problem. The longstanding relationships that are part of primary care enable gradual disclosure and thus an understanding of the individual’s mental health problem. Treatment is also delivered as part of that relationship.

This paper proposes a conceptual framework for a definition of primary care mental health assessment, and only alludes to how primary care values could influence treatment priorities, outcome measures and clinical practice. We suggest that primary care as an international discipline needs to develop its own research agenda in mental health, grounded in its own values. It points to further discussion and research that could include observational studies of
primary care consultations, trials of primary care-based mental health interventions (Cape et al., 2000), and more in-depth consideration of the place of several theoretical paradigms of care in primary care mental health assessment. These could include loss and grief, attachment theory, trauma, abuse, recovery and health promotion.

Conclusion

This discussion paper seeks to promote thought and debate on how primary care clinical mental health assessment would benefit from a clear definition and validation as a unique skill set. This approach to the assessment of psychological distress includes the robust concepts of patient-centred care, collaboration between patient and practitioner, and generalism, and is safeguarded from bias and assumptions by an intentional transdisciplinary approach. This multi-faceted approach to the whole person is the hallmark of primary care, and rests on longstanding patient-provider relationships and delivery of care. Intentionally valuing and honing these priorities could make a significant difference in the clinical setting worldwide.

Acknowledgements

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References

Coping and resilience development of Australian immigrants:

The nautilus theory

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Coping and resilience development of Australian immigrants: The nautilus theory

ABSTRACT: There has been little investigation on Australian immigrants who have maintained good mental health despite immigration. The literature ignores largely the immigrants’ understanding and development of resilience. This research aims to provide an understanding of the strategies immigrants in rural and regional areas used for successful settlement. The objectives were to: 1) determine the enablers (facilitators) and challenges (barriers) to successful settlement by immigrants; 2) identify immigrants’ specific health beliefs and how these have provided resilience and assisted the maintenance of health and well-being; 3) explore self-care health practices and strategies immigrants use in managing their mental health; and 4) gain an understanding of the immigrants’ concept of resilience and how this might be fostered.

A qualitative grounded theory approach was used in this study. Data were collected from 10 in-depth semi-structured interviews. The participants consisted of primary applicants or their spouses with permanent residency or work visa in regional South Australia who had settled within the last five years (2007-2012). Social/cultural groups with large numbers of immigrants were identified as a potential source of participants. Letters of invitation were circulated, follow-up calls were made and interviews were arranged. The interviews were digitally recorded and transcribed verbatim. The transcripts were coded using NVivo version 10.

The enablers to successful settlement according to immigrant participants were due to a number of interrelated factors including: learning from and experiencing the new environment, relationships, and a good command of the language. Limited social network was an important challenge (barrier) to successful settlement by immigrants. The immigrants had specific health beliefs that assisted the maintenance of health and well-being. The majority exercised regularly or engaged in sport, and had a healthy diet and lifestyle. In exploring self-care health practices and strategies immigrants used in managing their mental health, observing a healthy lifestyle including exercise as well as practices that promote and maintain mental, psychosocial and emotional health and well-being were emphasised. Being happy, having fun and keeping one’s sense of humour were some popular ways of caring for one’s mental health. The immigrants’ specific health beliefs helped in developing resilience and assisted the maintenance of health and well-being.

Various theories of coping have relevance in the coping and development of resilience amongst Australian immigrants. These coping strategies and stages of development are encapsulated in what we have called “the nautilus theory”, as the development of resilience amongst immigrants has many facets which can be compared to the chambers of a nautilus shell.

Keywords: Immigrant health, Health promotion, Mental health, Coping strategies, Resilience, Health and community services, Primary health care
Introduction

More than 300 ancestries are represented in Australia, as per the 2011 Census (Australian Bureau of Statistics [ABS], 2012). The Census also highlights that more than a quarter of the Australian population consists of people born overseas (26 per cent). Traditionally immigrants have settled in large metropolitan areas in Australia. However, with government initiatives and planned immigration policies, this trend has been changing and regional areas have experienced growth in the immigrant population. This fact is amplified by the statistical comparison between June 2007 and June 2012 figures for Net Overseas Migration (NOM) in South Australia (Department of Immigration and Border Protection [DIBP]), 2013).

Table 1: NOM- South Australia

<table>
<thead>
<tr>
<th></th>
<th>June 2007</th>
<th>June 2012</th>
</tr>
</thead>
<tbody>
<tr>
<td>Capital City</td>
<td>12700</td>
<td>8900</td>
</tr>
<tr>
<td>Balance of SA</td>
<td>1200 (8.6% of SA)</td>
<td>2100 (19.1% of SA)</td>
</tr>
</tbody>
</table>

The immigration process is considered a ‘major stressful life event’ that could influence psychosocial and emotional well-being of individuals; this experience may have long term effects on health (Ponizovsky et al, 2009, p.68). Immigrants face various challenges including: social isolation; distance from family, relatives and friends; exposure to new cultural values; and adjustment requirement to a new place and culture. These and other associated factors could create stress and result in the maladjustment in new settlers (Ponizovsky et al, 2009).

Research in the area of mental illness on immigrants has concentrated on differential definitions, symptomatology and the treatment of a variety of illnesses. Although immigrants experience stresses associated with immigration from home country to the country of destination, not all immigrants will suffer from mental ill health. Many are able to sustain and retain good mental health. A body of literature points out better mental health status for racial and ethnic immigrant communities as compared to their counterparts who are born in the host country (Mossakowski, 2007, p. 290). This indicates that the process of migration and associated stresses and challenges with the transition process do prepare immigrants to cope with adversities better than their native counterparts. However, there has been little investigation on those who have maintained good mental health despite immigration. The literature ignores largely the immigrants’ understanding and development of resilience.
Resilience is defined as the capacity to adapt and recover from traumatic life experiences (Ziaian et al, 2011). According to Fraser et al (2004, p. 22) “resilience refers to a normal or even exceptionally positive developmental outcome in spite of exposure to major risk for the development of serious social or health problems”. Individual beliefs and attitudes toward a life event influence the response towards it. Thus, there could be differences in response and coping strategies employed by individuals faced with adverse circumstances in life (Ward et al, 2009). On the other hand, coping is defined as “the constantly changing cognitive and behavioural efforts to manage specific external and/or internal demands that are appraised as stressful or exceeding the individual’s resources” (Lazarus and Folkman, 1984, cited in Ward et al, 2009). Both resilience and coping contribute to maintaining and promoting good mental health which this research is hoping to highlight – the experiences and strategies used by immigrants who happily and successfully settled in regional South Australia.

It is imperative that immigrants maintain a good mental health in order to realise their own potential, cope with normal stresses of life, work productively and make a contribution to society. “Mental health is not just the absence of mental disorder. It is defined as a state of well-being …” (WHO, 2014). Mental health promotion strategies give emphasis to enhancing the capacity of individuals and communities to take control over their lives and improve their mental health (Khanlaou, 2008). It refers to a broad array of activities directly or indirectly related to mental well-being.

Aims and significance

The aim of this research project was to provide an understanding of the strategies immigrants in rural and regional areas have used for successful settlement. The objectives included:

1) Determine the enablers (facilitators) and challenges (barriers) to successful settlement by immigrants in this group;
2) Identify immigrants’ specific health beliefs and how these have provided resilience and assisted the maintenance of health and well-being;
3) Explore self-care health practices and strategies immigrants use in managing their mental health; and
4) Gain an understanding of the immigrants’ concept of resilience and how this might be fostered.
Research design and methodology

The study used a qualitative grounded theory approach. Qualitative method is used because it is “… best suited for eliciting a ‘thick’ description” (Geertz 1973, as cited in Tummala-Narra et al, 2012); grounded theory specifically is used because this approach yields rich data that may provide explanations about immigrants’ ideas and behaviour relating to successful settlement. The foundational question in grounded theory is “What explanation (theory) emerges from an analysis of the data collected about the phenomenon?”, the phenomenon being the development of resilience amongst Australian immigrants in rural and regional areas.

Participants

Information concerning the experience of immigrants in successful settling into regional South Australia specifically focusing on the self-care practices=strategies they employ for their mental health was gained from individual interviews (see Appendix 1, Interview Questions). The grounded theory approach helps provide answers to the questions of how and why something operates as it does, in this case, the development of ‘resilience’ by immigrants in rural and regional areas. Two pilot interviews were conducted to check the clarity of questions.

Recruitment included widespread collaboration with multiple community settings to ensure wide publicity of this research amongst diverse cultural groups. Social/cultural groups with large numbers of immigrants were identified as a potential source of participants. The leaders of such groups were provided with a letter of invitation to circulate a ‘Project information sheet’ advertising the project, asking volunteers to make contact with the Project Officer (telephone number provided). All participation was entirely voluntary. The Project Officer followed up each contact by telephone and provided them with further details by mail or email. An interview date, time and place were added to a schedule.

Those immigrants eligible were primary applicants or their spouses with permanent residency (as well as those on work visas) in regional South Australia who settled within the last five years (2007-2012). Other inclusion criteria were: over 18 years of age, able to speak conversational English (although a bilingual interpreter would be made available on request). Participants were those who had responded to an invitation and written information sent to them because they were identified and approached by key stakeholders as meeting the criteria.
Approval from the UniSA Human Research Ethics Committee was sought for the research protocol. Participants were asked to provide informed consent including for the recording of data. They were provided with information about the aim of the project, the methods being used to collect information, risks, inconveniences, discomforts, and possible outcomes, so that an informed voluntary choice could be made. The interviews were conducted face-to-face and held in a jointly agreed venue. Most interviews averaged about 1.5 hours.

Data Analysis
A Project Officer was employed to overview the research process. The interviews were digitally recorded and transcribed verbatim. The interviewers’ understanding of the content was discussed with the participants at the interview, providing verification of the material. The transcripts were coded using NVivo version 10. This assisted in data management, retrieval, coding, and identification of specific and recurring themes within the texts (QRS International, 2006-2008; Richards, 2000) for content analysis.

The analysis of data was undertaken through triangulation by individuals in the team separately examining the data (Dongre et al, 2009). This established credibility, accuracy of representation and trustworthiness of the researchers, which meets Sandelowski’s (1993) criteria for credibility, auditability and objectivity in qualitative research.

Findings
The characteristics of the ten participants are shown in Table 2. As can be seen, they resided in three regional centres and represented seven different countries of origin.
<table>
<thead>
<tr>
<th>Gender</th>
<th>Age range</th>
<th>Country of origin</th>
<th>Residence (Region)</th>
<th>Duration living in Australia</th>
<th>Duration living in the region</th>
<th>Highest education</th>
<th>Visa category</th>
<th>Employment</th>
<th>Marital status</th>
</tr>
</thead>
<tbody>
<tr>
<td>F</td>
<td>35-40</td>
<td>Papua New Guinea</td>
<td>Whyalla</td>
<td>2.5 years</td>
<td>2.5 years</td>
<td>Metallurgy</td>
<td>457</td>
<td>Metallurgist</td>
<td>Married</td>
</tr>
<tr>
<td>M</td>
<td>35-40</td>
<td>Papua New Guinea</td>
<td>Whyalla</td>
<td>4 years</td>
<td>2.5 years</td>
<td>Surveyor</td>
<td>457</td>
<td>Surveyor</td>
<td>Married</td>
</tr>
<tr>
<td>F</td>
<td>30-35</td>
<td>Philippines</td>
<td>Whyalla</td>
<td>3 years</td>
<td>2 years</td>
<td>BSc Nursing</td>
<td>457</td>
<td>Aged Care Nurse</td>
<td>In a relationship</td>
</tr>
<tr>
<td>F</td>
<td>35-40</td>
<td>Portugal</td>
<td>Port Pirie</td>
<td>3 years</td>
<td>3 years</td>
<td>B Psychology</td>
<td>PR</td>
<td>Student</td>
<td>Married</td>
</tr>
<tr>
<td>F</td>
<td>20-25</td>
<td>South Africa</td>
<td>Whyalla</td>
<td>5 years</td>
<td>5 years</td>
<td>3rd year SW student</td>
<td>457 for parents</td>
<td>Student</td>
<td>In a relationship</td>
</tr>
<tr>
<td>F</td>
<td>50-55</td>
<td>England</td>
<td>Port Augusta</td>
<td>5</td>
<td>4</td>
<td>Master in Nursing (Mental Health)</td>
<td>457</td>
<td>Mental Health Nurse</td>
<td>Married</td>
</tr>
<tr>
<td>M</td>
<td>25-30</td>
<td>India</td>
<td>Port Augusta</td>
<td>4 years</td>
<td>4 years</td>
<td>Diploma in Business Management</td>
<td>PR</td>
<td>Manager private company</td>
<td>Married</td>
</tr>
<tr>
<td>F</td>
<td>25-30</td>
<td>India</td>
<td>Whyalla</td>
<td>4 years</td>
<td>4 years</td>
<td>Graduate Diploma in Psychology and Engineering</td>
<td>Spouse visa</td>
<td>Work Placement</td>
<td>Married</td>
</tr>
<tr>
<td>F</td>
<td>30-35</td>
<td>India</td>
<td>Whyalla</td>
<td>2 years</td>
<td>2 months</td>
<td>Master in Economics</td>
<td>PR</td>
<td>Teacher</td>
<td>Married</td>
</tr>
<tr>
<td>M</td>
<td>25-30</td>
<td>Pakistan</td>
<td>Port Augusta</td>
<td>5 years</td>
<td>4 months</td>
<td>Master in Marketing</td>
<td>Bridging</td>
<td>Team leader</td>
<td>Married</td>
</tr>
</tbody>
</table>
Table 3 sums up the responses concerning participants’ coping and resilience.

**Table 3: Summary of responses to questions probing on coping strategies and resilience**

<table>
<thead>
<tr>
<th>Open question</th>
<th>Response</th>
<th>N*</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is your experience in settling in rural/regional SA?</td>
<td>Feel like home, support experienced</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td>No friends</td>
<td>5</td>
</tr>
<tr>
<td>What is your understanding of a successful settlement?</td>
<td>Participating in the community</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>Cultural/self-adaptation</td>
<td>4</td>
</tr>
<tr>
<td>How did you cope with the challenges of immigration?</td>
<td>Keep learning/experiencing the new environment</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>Developing good relationships</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>Addressing language issues</td>
<td>4</td>
</tr>
<tr>
<td>What is your notion of resilience?</td>
<td>Learning from past experiences</td>
<td>7</td>
</tr>
<tr>
<td></td>
<td>Built-in, part of character</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>Feeling part of community, adapting</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Being positive</td>
<td>3</td>
</tr>
<tr>
<td>Tell us about your beliefs and practices about health?</td>
<td>Exercise + sport</td>
<td>7</td>
</tr>
<tr>
<td></td>
<td>Healthy diet</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>Healthy lifestyle</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>Mental health (being happy, fun, humour)</td>
<td>5</td>
</tr>
<tr>
<td>What do you do to maintain your health?</td>
<td>Exercise</td>
<td>8</td>
</tr>
<tr>
<td></td>
<td>Good diet</td>
<td>7</td>
</tr>
<tr>
<td></td>
<td>Healthy lifestyle – physically/mentally</td>
<td>7</td>
</tr>
<tr>
<td>What makes you happy? How do you maintain or promote happiness?</td>
<td>Having the family around them, watching them grow in a safe surrounding</td>
<td>10</td>
</tr>
<tr>
<td></td>
<td>such as Australia</td>
<td></td>
</tr>
<tr>
<td></td>
<td>God as a main source of their happiness and support</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>Giving to their community was what made them most happy</td>
<td>3</td>
</tr>
</tbody>
</table>
| **What things do you do differently from your compatriots?** | Felt they were not different  
Felt they sought Australian company instead of their own cultural ties and that was different to the mainstream immigrant  
Others felt they were not as strict on schedules for prayers and they did not smoke / alcohol like others in their culture | 5  
5  
4 |
|---|---|
| **How did you manage in stressful situations?**  
**Give examples?** | Calming down through leisure activities like beach, sports, music, reading, books, socialising and movies  
Prayers and faith in God  
Being positive | 6  
3  
3 |
| **What advice might you give other immigrants?** | Be accepting  
Adapting  
Becoming part of the community  
Respecting other cultures | 7  
6  
5  
4 |

*Number of times the item was identified*
Discussion

The psychological theories described in this section, specifically self-efficacy, hope, goal and identity control theories, emerged as appropriate to the data after a comprehensive analysis of the same as directed by grounded theory. This methodology provided a thorough approach of understanding and integrating the codes and themes from the data to develop a framework of how resilience develops amongst Australian immigrants. Consequently, the researchers were driven to further examine relevant theories as they provided a lens to explain the findings of the study. In so doing, a homogeneous blending of these theories resulted in a multidimensional conceptual framework of the reality of coping and resilience development for which we coined the term “nautilus theory”, which will be explained later.

The body of knowledge underpinning the four theories is summarised briefly. Self-efficacy refers to an individual’s belief in his or her capacity to carry out behaviours necessary to “attain designated types of performances” (Bandura, 1986, p. 391). Self-efficacy levels can enhance or impede motivation (Reeve, 2001). Bandura (1997) states that people with higher self-efficacy are healthier, more motivated and more successful. They perform challenging tasks, set higher goals and stick to them. When challenges occur, they recover more quickly and uphold their goals. Weiner (1992) contends that self-efficacy allows individuals to choose challenging settings, explore their environments, or create environments. The following excerpts support this theory:

I think we coped pretty well considering that we were in a different country, but I think that we had a sense of excitement at the beginning so it wasn’t seen as, you know, it didn’t stop us from doing things ...we were just embracing all the new things and that was how we coped with it ...
(S5)

... my brother helped me and he just told me everything about Australia and then I searched on the net, googled it, tried to search various jobs and the qualification, whether I’m eligible for the skills that are required here in Australia and what are the things that I should be needing to update myself. So I did a lot of research work on my own plus my family supported me which were here two years before me. (S9)

Akin to self-efficacy is goal theory which proposes that human beings are goal-motivated. This means that individuals who are goal motivated are more enthused to act when there is a reward at the end of the performance of a task.

... Not only that, I keep focusing on the positive things in life. I am always positive ... ah, a lot of sense of humour. Seeing the happy side of life. Staying happy and healthy. ... more importantly, I keep focusing on my goals, I am really goal-driven. (S4)
... I always tell myself my goals and so come over it [difficulty] finished the subject and eventually we have to get a job and so resilience to me means after the difficult times finally you’re rewarded for that for all your hard work so um looking at the positive side of things and coming over the challenges ... (S8)

Congruent with self-efficacy theory is hope theory, which refers to the ‘can do’ beliefs people have to harness resources within to cope effectively with a given situation. Self-talk includes statements such ‘I can do this’ and ‘I am capable of finishing this task’ (Weis and Speridakos, 2011). Hope theory posits that hopeful individuals are characterised by high academic achievement, physical health, psychological adjustment and psychotherapy (Snyder, 2000; Weis and Speridakos, 2011). Associated with the theory is the pathways thinking which refer to one’s perceptions of ‘how’ to attain the goal and the active development of ways to achieve the goal, for example, belief that ‘I can find the way to finish this’, as some participants exemplified in these quotes:

*For us, probably resilience is when you [go] through a lot of experience or bad experience in your life like war, ... moving to a different place and trying to adjust or get used to the different and new environment or the place of a different culture and trying to adopt is a challenge. Language, food and culture and climate and you have to get used to these challenges me and my family are going through or have gone through and to adapt to where we are.* (S2)

*My notion and that I have gone through something and how did I recover from that fully initially I went through a lot of things ... that we are coping well we are resilient. ... it’s adapting to new culture, new values, new norms, although it doesn’t go align with your own personal values and collectability.* (S10)

Based on traditional symbolic interaction, identity control theory considers that individuals choose their own behaviours and how their behaviours correspond to the meanings of their identity. An important aspect of the self pertains to one’s identity, which refers to the “internalised positional designation” composed of the beliefs and meanings about oneself in one’s social role (Stryker, 1980, p. 60). The self is comprised of multiple identities and defines who one is in a group and as a unique individual (Stets and Burke, 2005). While individuals may have their own individuality and unique personality traits, they are also members of social and cultural groups, assuming roles that provide a basis for their identity. With this understanding, social interaction can proceed as long as both identities can agree on their meanings of self and on the definition of the situation as they go about their lives. When there is a discrepancy between the way people view themselves and the feedback that they get from others, distress results (Stets and Burke, 2003; Burke, 2006). This could lead to individuals experiencing a range of negative emotions and behaving in ways to reduce the discrepancy.
Well, I do consider myself resilient. I think that I’ve made a success of, you know, transitioning and I feel like I’m a part of the community now. I don’t see myself as a South African anymore and ... you know the nuclear family is the South African family I’ve sort of moved away from that and now I’m part of an Australian relationship so you know I think that I’ve been resilient. ... I focus not so much on the differences in the cultures but between the similarities and where I can fit in in that yeah so that was how I coped with that. (S5)

... I came the hard way, my life since childhood until now I am working, it didn’t come easy. It’s sort of in-built in me, I would say. ... I brought my resilience with me. And though it was challenging coming into a new country, new environment, new work, you know with everything was new here, but with that background, I was able to cope I would say. (S1)

Conceptualisation of the nautilus theory

The development of resilience amongst immigrants is comparable to a chambered nautilus shell, the logo for the Scholarship of Teaching and Learning Commons Conference (Georgia Southern University, 2014). Contextualising from their description, the nautilus is “self-propelling” in an “unfolding spiral as it develops steadily over time”. The direction opens outward and its chambers continuously spiral, developing into resilience, which is represented by this elegant piece of nature. The nautilus can be regarded as reflecting composite theories of coping and resilience for Australian immigrants, the chambers representing personal attributes, health beliefs and practices, community settlement, cultural integration, and goal attainment.

First chamber: Personal attributes
The first chamber reflects attributes possessed by immigrants that are conducive to helping them achieve successful settlement in a regional area. Important for resilience were the immigrants’ innate attributes such as honesty, hard work, ability to learn language, ability to work, strong-mindedness, time management skills, problem-solving skills and forgiving attitude that helped them focus on their goal of life.

Consider this participant’s valuing of honesty, hard work and English proficiency as these related to successful settlement:

*Successful settlement in Australia here the first key I think to be settled in Australia to be settled in the environment of Australia is honesty, most of Australians we find they are really honest ... the second one is hard work and the third one is your language – how do you learn the things if you like everyone struggles with English when they come here in Australia but I think if you learn day by day ...* (S7)

**Being strong-minded was equally important, according to another participant:**

*I’m a very strong-minded person – I don’t shy away from confrontation, in actual fact I challenge confrontation and I believe that’s what’s helped me get through that first year ...* (S6)

Educating themselves and being prepared to work were the other attributes that were conducive to successful settlement as expressed in this excerpt:

*... but for me going to work education is very important and I am a very, very academically inclined person from the beginning, so education is important, working is important and also taking care of family is important, so I want to have a balance ...* (S8)

Time management skills, organising work, and prioritising tasks were also considered important in achieving successful settlement experience, according to participant S5.

*... well for me a stressful situation at the moment would be, you know, assignments that are due ... so I have to work with them and, you know, to manage my time and to prioritise things and I think I’m also very organised when I’m planning things to get done ...* (S5)

Problem-solving skills assisted in managing stressful situations that may be faced during settlement:

*In stressful situations, I try to focus on positive things ... It is so important to have a structured problem-solving approach – this means that you break down the problem into smaller pieces so they are manageable. I also believe in one step at a time in problem solving and goal setting. Small goals ... one step at a time ... you know. I need to mention also having lots of patience in managing stressful situations. (S4)*

Immigrants also possessed attributes such as being forgiving that helped them accept people and persevere with relationships, as the next quotation signifies:
I actually think I’ve got a very forgiving personality. You know, sometimes people I’ve looked at situations I’ve been in and kind of said to me, you know, I would never ever have gone back to that particular event or situation and I’ve just walked past and moved on whereas me whatever’s happened I’m a very forgiving nature I don’t let it get to me, I don’t bear grudges, I don’t hold grudges ... so I think that’s one of my traits as well that gets me through ... (S6)

Second chamber: Health beliefs and practices

The immigrants have a preventative focus on health as reflected in their health beliefs that assisted their maintenance of health and well-being in a new environment. To maintain a healthy life-style they also practised a healthy way of living that included exercise or some sport, a healthy diet and looking after their mental health. Moreover, acceptance and integration with the host community, having family and friends to talk to, socialising and having fun, and having a sense of humour were also identified as helpful by the interviewees.

Sometimes you exercise, you need to eat good food, like vegetables. We try to limit as much as possible fatty foods, sugar, greasy food and a lot of sugary food and drinks, we try to avoid them as much as possible and be a simple, having water, fresh food. It keeps you and makes you happy. Makes you healthy as well. (S2)

A person is healthy if he feels safe in his environment, if he is part of his community and he is able to achieve his/her goals. I mentioned political stability because health is not possible in war-torn countries where there is persecution, torture, incarceration and so forth ... It is not just physical health, it is more than being physically healthy, ... Everybody should be health conscious. I think that having regular check-ups is a good way to prevent many health issues. Prevention is so much better than cure, as the saying goes. (S4)

Um well in South Africa I used to, you know, I used to do sport and I consider that was important in keeping healthy and having a healthy lifestyle was to have a balance between hard work and play. (S5)

Third chamber: Community settlement

The settlement experiences of immigrants are an important factor affecting their psychosocial wellbeing. Successful settlement is viewed by the participants as seamless transition to another culture, work and place; being able to participate in the community and being able to adapt to the culture and environment.

My understanding of it is a seamless transition from one cultural background to a different cultural background without being thwarted in any way or compromised in any way whether that be a spiritual belief or physical issues ... (S6)

The first thing for settlement meant to us was the permanent residency, because before that you got lots of struggle you had to pay your college fees which is very higher than normal student normal Australian students and so the first thing is permanent residency. (S7)
... successful settlement means coming to a place and establishing yourself in terms of work, in terms of community, building social network and then establish relationships with the community and also getting with the culture here ... (S8)

Successful settlement is dependent on a number of factors that are interrelated. The enablers of a successful settlement include: learning from and experiencing the new environment, relationships and good command of the language. As immigration is a significant stressor, the ways the immigrants coped included a variety of strategies:

Smooth settlement, smooth transition, you know, this can be organised by the work or company that you are with as well as yourself ... I had a job here already, HR sort of organised everything. So we came here straight and we had a place to sleep. We were given a car for one month. (S1)

... But at work, I have challenges because some question me because I am Asian, or the way I speak. ... so I realised this and kept asking questions, if I give instructions to my co-workers, I asked them if they understood me or not, if not, I repeat my statement so they can understand me. ... I listened to the radio, I followed how they talked and helped myself learn the language more. (S3)

I think we coped pretty well considering that we were in a different country but I think that we had a sense of excitement at the beginning so it wasn’t seen as, you know, it didn’t stop us from doing things ...we were just embracing all the new things and that was how we coped with it ... (S5)

Fourth chamber: Cultural integration

Immigrants valued forming interpersonal relationships with host communities. They reiterated cultural adaptation, knowledge of host community, making friends and developing social networks with Australian community as key aspects for successful settlement. The range of actions supporting this theme is reflected in these quotes:

A successful settlement is when we feel we are respected and valued as a person, free from discrimination from the community. This respect is very important as it impacts on our self-worth and self-esteem. Also, successful settlement is when we are able to participate and feel part of the community and having the opportunity to accomplish our goals. ... (S4)

My understanding of successful settlement is to be integrated in the community and become part of the community so to see yourself as part of it and not an outsider ... (S5)

... In Australia ....how you make Aussie friends, that’s really important thing to us because you know I have met lots of people they’re living here from 10 to 20 years but they still don’t know like how to go out with Aussies because there is a big difference ... (S7)

OK um I think the best thing is self -adaptability that you should be bold enough and should be smart enough to cope with any culture..... (S10)
It was considered important to know the community, its people and their culture prior to migration. Many participants mentioned that they did a lot of research to find out about the place, people and culture. Some watched movies and listened to media.

Yeah, I think before coming you should know which place you are coming and you should have an idea to whichever country you’re coming that what is the country like, what are the physical and geographical features plus what are the different things that you are going to face in a country, so you should be well prepared for that ... (S9)

Although immigrants made all efforts to integrate into the community, it was not always easy as there were many difficulties and challenges, as exemplified in this excerpt:

My initial experiences were a little bit uncertain and you know I still felt like I was struggling to break through and you know to be involved in the school and those types of things like you know making new friendships was difficult at the beginning and also the language barrier is quite you know even though I could speak English it’s a different way of speaking and different way of expressing yourself so I think that that was something that I struggled with was for people to understand me it was quite difficult to get my message across all the time ... (S5)

Fifth chamber: Goal attainment

The participants in the study presented varying understandings of achieving resilience and extending further to that is identity, happiness and self-actualisation.

First, be clear about what you want in life. Establish your goals for your lives. When you have the goals, actions follow. Stick to those goals. Sometimes they are difficult to achieve, but just press on.... Also, successful settlement is when we are able to participate and feel part of the community and having the opportunity to accomplish our goals. Life’s goals you know? Like me, I wish to study now, so that’s my goal and I am able to do it ... (S4)

I have the courage to try something new so I used to tell myself it’s OK if I don’t become a big person and stay in the same field, at least I’ve tried something, you know, you should not fear failure, what’s the point of feeling failure, it’s OK for me to make mistakes – you learn after making mistakes. (S8)

Valuing past and present beliefs, practices and values is key:

Yeah, I would say stick to the good values that you bring from your home. You bring good and bad as well, so you stick to the good ones, and you adopt the good ones from here and filter the bad ones from both cultures, and use the good that you brought and accept the good from here and that will make you survive, I would say here. (S1)

Also, never undermine your [own] culture because that’s what you are and where you come from. Clarify these cultural beliefs and practices, hold on dearly to those you wish to keep, but respect other people’s beliefs and practices. Respect others even if sometimes it is hard to understand them. Not understanding them doesn’t make them wrong or inferior or bad. (S4)

Think about your country before you do something bad so that’s one bad thing we do, it’s going to give us all of us a bad name. (S7)
Faith in God is one significant factor in achieving resilience and even happiness according to a number of participants:

We tell them [the children], only two things are important, one is God and two is education.....Ah, maintaining of happiness is you know believing in God, maintaining the church beliefs and trusting in the Lord all the time who would take care of our problems and living a prayerful healthy life. (S1)

... the religion makes a big difference in our life as well, like especially we belong to a Sikh religion and there are lots of examples in religion to fight with the problem of life. (S7)

Having faith in the self, a positive outlook and focusing on others are immigrant people’s ingredients for happiness:

You know when you’re so far away from your family, that’s the only down side and God forbid something happens – you’re just too far away to help them and that’s the problem, um but I have to look on the positive side that, you know, this was my choice – I’ve made my bed, so I have to lie in it really and my resolve ... (S6)

I think for me my inner self is the first thing that how is my connectivity with my God and then what are my priorities in life, am I doing the right thing, am I answerable to anyone and do I have peace? ... (S 9)

It is also important that you are not so self-centred. That means you just don’t focus on yourself, because the world is not all about you. It does not revolve around you. What I am trying to say is focusing on others as in helping others make me happy. (S4).

**Conclusion and future directions**

The aim of this research project was to provide an understanding of the strategies immigrants in rural and regional areas have used for successful settlement. The objectives included the determining of the enablers (facilitators) and challenges (barriers) to successful settlement by immigrants in this group; identify immigrants’ specific health beliefs and how these have provided resilience and assisted the maintenance of health and well-being; explore self-care health practices and strategies immigrants use in managing their mental health; and gain an understanding of the immigrants’ concept of resilience and how this might be fostered.

The study used a qualitative grounded theory approach out of which ‘the nautilus theory’ was developed. The Nautilus is comprised of chambers which in the theory represent personal attributes, health beliefs and practices, community settlement, and cultural integration. The spiral of the Nautilus represents how goal attainment was formulated to explain coping and resilience development amongst Australian immigrants.
This research is significant because it has elucidated how resilience is developed by immigrants in the Upper Spencer Gulf region of South Australia, and could assist other immigrants. It raises awareness and understanding for health professionals and educators of enablers and challenges to successful transition to settlement in regional areas. Importantly, it also provides appropriate strategies for government, non-government agencies and local communities to support immigrant groups. In addition, it provides evidence for comparing and contrasting immigrant health practices in urban areas in future research.

This project provides evidence on which to build a broader study of the successful settlement of immigrants to other rural and regional areas in Australia. Further collaboration with multicultural communities, migration and refugee research networks should be pursued to understand more about resilience development by different cohorts of immigrants.

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References


Appendix 1 (Interview Questions)

The interview was guided by the following questions:

1) What is your experience in settling in rural/regional South Australia?
2) What is your understanding of a successful settlement?
3) How did you cope with the challenges of immigration?
4) What is your notion of resilience?
5) Tell us about your beliefs and practices about health?
6) What do you do to maintain your health?
7) What makes you happy? How do maintain or promote happiness?
8) What things do you do differently from your compatriots?
9) How did you manage in stressful situations? Give examples?
10) What advice might you give other immigrants?
Ready, willing and able to have THAT conversation:
A conversation for life

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ABSTRACT: Suicide prevention is a factor of well-being. It is always contextual and it is always personal. Sadly, it is more easily identified and labelled as suicide prevention when a crisis occurs and urgent intervention is required. By then the task for a bystander is more difficult, the burden more severe and the responsibility more acute. For any individual, even those with professional qualifications in health and medical fields, this is onerous.

The causes of suicide are complex and vary among individuals and across age, cultural, racial and ethnic groups. Suicide risk is influenced by an array of factors – sociological, psychological, environmental, cultural and biological. Nonetheless, this complexity masks the reality that almost all people who attempt or complete suicide had one or many more warning signs before their death. Research demonstrates that a large proportion of the population remain poorly informed in regard to suicide risk. They are unable to talk about suicide or suicidality and cannot read-the-signs of someone who is suicidal and trying to communicate their sense of hopelessness.

Suicide prevention initiatives should be multi-modal and complementary, targeting a wide range of at-risk and high-risk groups. Within the Lifeboat suite, Conversations for Life provides the skills and resources to understand, enhance and respond to challenges to well-being, and assist others. In the context of the Conversations for Life program, this is about reducing risk and increasing protection in a community.

The Conversations for Life training program provides an introduction to the issues surrounding poor mental health and suicide and awareness of individual and general community attitudes. It provides resources to identify suicide risk, and communication skills for crucial conversations. It informs community resources and networks, and enables better support people who may be experiencing a personal crisis.

Keywords: suicide prevention; early intervention; prevention; conversations; community well-being

Introduction

Suicide risk is complex and crisis driven responses have been largely ineffective in responding to the constellations of factors that might propel someone to consider suicide as a solution. The numbers worldwide for completed suicide are staggering, nearly 1 million deaths per year or one suicide every 40 seconds (WHO, 2014). Suicide is among the top 20 leading causes of death for all ages. In 2012, the preliminary data from the Australian Bureau of Statistics show 2,535 deaths for adults over 16 years. This is a death every 3.5 hours and more than 2.2 times the national road toll (ABS, 2014).
The evidence for risk factors is consistent across the international literature. The most prevalent concerns are social and educational disadvantage, psychopathology, family dysfunction and adversity, exposure to stress, and the personal and contextual factors that may affect an individual (Beautrais, 2001; Clifford, Doran, & Tsey, 2013; Suresh Kumar, Rajmohan, & Sushil, 2013). The constellations of factors are complex and the cascade of circumstances will vary from individual to individual, however the outcome is that suicide is considered as an effective solution (Shneidman, 1993).

As a response, suicide prevention strategies have focussed on the pathways closest to completion and have often waited for clarity of intent before action. In that regard the focus has been upon screening for at-risk individuals, treatment of psychiatric disorders, restricting access to lethal means, and responsible media reporting (Beautrais et al., 2007; Berlote, 2004; Cox et al., 2013; Mann et al., 2005).

Sadly, the prevention of suicide has not been adequately addressed due to a lack of understanding of the constellations of factors that augur towards suicide as a solution, the temporal aspects of suicidal thinking and planning, and the stigma attached to its discussion (Robinson & Pirkis, 2013). While suicide prevention strategies exist, in the large part they offer simplistic solutions to complex problems, and crisis driven attention rather than early intervention (Clifford, et al., 2013; Klimes-Dougan, Klingbell, & Meller, 2013; Robinson et al., 2013; York et al., 2013). In addition, the reliability of suicide data lags behind the research, and suicide prevention activity (particularly at government levels) remains a health sector problem rather than the required multi-sectoral approach (DeLeo et al., 2013). Even in indicated areas of concern such as suicide in indigenous populations, the focus has been on gatekeeper programs and education rather than the cultural and socio-economic drivers that lead to despair and being overwhelmed (Clifford, et al., 2013).

Mann et al, (2005) describe suicidal ideation as a combination of stressful life events and a mood (or other) psychiatric disorder. In addition, the constellations of factors that might contribute towards a suicidal act are described as impulsivity, hopelessness or pessimism, access to lethal means and imitation; and they describe a range of interventions that address all the components except the stressful life event. Similarly, most gatekeeper programs (York, et al., 2013) focus on risk factors, attitudes towards suicide and a knowledge base that aims to reduce risk. The drivers of stress and the personal and contextual factors are rarely addressed, but remain the earliest opportunity for effective intervention.
The current training landscape

Most public awareness programs are directed at improving the recognition of suicide risk and improving help-seeking behaviour. To their credit, there are underpinning strategies to reduce the stigma associated with mental illness and oppose suicide as a solution to life’s problems (Suicide Prevention Australia, 2010). Nevertheless, while the links between mental illness (especially depression) and suicide are understood, public education in this regard has not been systematically evaluated (Jorm, Christensen, & Griffiths, 2005). Unfortunately, there is a widening gap between what we know and regard as ‘best practice’ and the indicators that suggest that suicide prevention awareness campaigns have had little impact (Mann, et al., 2005).

Specific education programs aimed at young people (e.g. Burns & Patton, 2000) remain focussed on risk factors, behaviours and events. In many cases youth focussed programs are effective in raising awareness, and increasing knowledge about risk factors, but do not account for or influence the personal and contextual factors that might lead someone to consider suicide as a solution (Guo & Harstall, 2002). More encouraging are the studies (e.g. Eggert, Thompson, Herting, & Nicholas, 1995) that show efficacy in improving coping with stress, problem solving and improved resilience. In concert with conjectured protective factors for suicide these early, strengthening programs are encouraging.

Community gatekeeper programs assume a component where contact with a potentially suicidal individual takes place. Suicide is a relatively rare event and the opportunity for timely intervention even more unlikely. Nevertheless, gatekeeper programs are popular and attractive to those who find comfort in the training and the purposeful warrant (Isaac, Elias, Katz, Belik, & Deane, 2009). Gatekeepers are typically those employed in institutional settings (e.g. schools) or who have a direct contact role with the public (e.g. caregivers). The programs typically have components to facilitate knowledge, skills and attitudes about suicide, but there is little evidence that this translates into decreasing rates of suicidal ideation, suicide attempts or completions. General Practitioner (GP) gatekeeper training has a different focus where risk factors, depression and referral pathways are central. The opportunity for positive contact with GPs is understandable, but often this contact is not in the context of a multifaceted suicide prevention exploration (Mann, et al., 2005; Pfaff, Acres, & McKelvey, 2001).
A Conversation for Life

Most definitions of mental health describe a biological and social interaction resulting in the successful performance of mental function, productive activities, fulfilling relationships with other people and the ability to adapt to change and cope with adversity. Suicide risk is not a list of risk factors. It is always contextual and personal and the constellations of factors are often complex and layered. A conversation for life is an early intervention strategy and best described as an opportunity to improve coping and to improve personal and community connections.

Suicide prevention training has in recent years centred on suicide crisis intervention with key elements focussed on risk and protective factors, suicidal thoughts, feelings and behaviours, levels of intention to self-harm, and access to means.

While these are all important characteristics of a suicide prevention and risk assessment, it is less about suicide prevention per se and more about intervening in a suicide event. There is a growing need to shift this focus to suicide prevention. There is a mounting body of evidence in regard to the social determinants of suicide (Macdonald, Monaem, Sliwka, Smith, & Trezise, 2010), but programs of suicide prevention rarely address these in a comprehensive manner. In fact these determinants are an assumed category of intransigent risk.

There is also a growing recognition that Australia’s suicide prevention strategy over the past two decades has done little to diminish the problem. There is greater awareness that suicide intervention programs do not address the precipitating components and characteristics, and vague best practice models lack objective standards for comparison. There is a paucity of upstream programs that address the conditions in which suicide risk emerge. In that context there is a need to improve suicide prevention efforts through implementing effective interventions based on proven public health strategies.

The evidence to support early intervention is also very strong, particularly in areas such as youth psychosis and the debate as to the merit of investment in early intervention has already been won (Edwards & McGorry, 2002). The same cannot be said for promotion and prevention. While lip service has been given to the importance of these matters, as far back as the first National Mental Health Policy in 1992, this has somehow consistently failed to translate into any kind of coordinated implementation, sustained services or national strategy.

Mental health promotion is about improving wellbeing for all people, regardless of whether they are currently well or ill. It is about optimising people’s mental health by
developing environments that are universally beneficial. Mental health is affected by the events that happen in our ordinary lives, as well as by significant stressful events that occur such as loss and grief, relationship breakdown and physical ill-health. Mental health can be promoted by making sure that public policies support the social and emotional wellbeing of individuals and groups. All environments, social, physical, economic, and cultural, need to be supportive of mental health. Community life is important and communities need to be empowered to take the actions required to build their capacity to support their members. All people should be supported to develop skills to understand, enhance and respond to their mental health needs. The prevention of mental health issues, by definition, should have the potential to prevent the onset of a mental health problem or illness and suicidal behaviour. Prevention interventions require the identification of risk and protective factors for mental health.

Despite numerous nations across the world having specific suicide prevention strategies (including Australia) and many decades of research and investigation into the complex range of causes of suicidal behaviour, there is still limited high-quality, defensible evidence regarding the most effective and efficient approaches for preventing suicide. Clearly the causes of suicide are complex and vary among individuals and across age, cultural, racial and ethnic groups. Suicide risk is influenced by an array of factors – sociological, psychological, environmental, cultural and biological. Nonetheless, this complexity masks the reality that almost all people who attempt or complete suicide had one or more warnings signs before their death. This complexity, if we are to better target our suicide prevention efforts, requires a sustained, strategic and transparent program of investment in multiple service interventions, service co-ordination and ongoing research to build the evidence base on effective and practical ways to prevent the loss of life.

There is often a fear expressed, particularly by parents of adolescents, that merely talking about suicide increases the risk of suicide (Hunter Institute of Mental Health, 2012). However this is not supported by the evidence that talking about suicide is harmful. This fear is also reported among health professionals talking about suicide with their patients for fear of increasing suicidal behaviour (Feldman et al., 2007). Other studies have shown either neutral or positive effects on young people who were at an elevated risk of suicide (Gould et al., 2005). What is also clear from the literature on suicide, is that majority of people who suicide or attempt suicide directly and or indirectly communicate their suicidal ideas and intentions to people in their social network prior to the event (Owens et al., 2011).
The Conversation for Life program is an introduction to suicide prevention focusing on positive communication before a crisis intervention is necessary. It is informed by sound models, principles and evidence drawn from four key areas: 1) population health and mental health promotion, 2) suicidology, 3) adult learning, and 4) social marketing and communications. It locates the health and well-being of the individual at the center of the program of care and allows that:

- Individuals vary in their personal vulnerability and resilience;
- Effective programs of support are always personal and contextual;
- Programs should reduce risk and promote protection;
- Programs should use networks of support and care;
- Programs should do no harm.

Training for a Conversation for Life enables the concerned individual to observe and respond. It provides the strategies to link and assess the level of concern, and develop a plan that is contextual and personal. A Conversation for Life will contribute to the individual's capacity to balance multiple pressures in life, and build robust and available support systems. Rather than a crisis intervention, the program focus is to develop effective personal coping strategies and improve personal resilience. It is an early opportunity to understand there are numerous solutions available.

Each conversation will be contextual and personal but can include problem-solving strategies, the identification of personal resources and goal setting. A Conversation for Life will strengthen social networks and build an awareness of community resources and services. For improved well-being, it is often enough to begin the process of change.

A Conversation for Life can be practised and mastered in order to have a shared purpose or goal. It is important to find the right moment for the conversation and be sensitive to the context. Respectful, non-judgmental engagement allows thoughts and feelings to be aired without fear of consequences. By carefully choosing the conditions that allow a conversation to take place, a conversation for life can take place.
References


Adversity and Identity:
Self-Defining Stories about Trauma and Recovery

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Adversity and Identity:  
Self-Defining Stories about Trauma and Recovery

ABSTRACT: How adversity impacts on identity is important for understanding mental health and designing interventions. This research aims to record the narratives of people who have experienced adversity, to describe factors that are important to the individual dealing with adversity and to analyse the influence of adversity on identity through self-narratives. Using McAdam’s (2006) self-defining stories as a methodology this research asked participants who had experienced adversity with ill-health, work, relationships and migration to talk about how the experience affected their sense of themselves.

Analysis of the stories revealed that the participants engaged with the problems that were presented with the adversity using their imagination in a process called dark creativity’, changed their actions and behaviours and negotiated varied relationships at many levels. In this process they evolved a new identity better suited to future challenges. According to their self-assessment these participants successfully survived adversity. Revenge and anger did not appear significantly in these self-defining stories. The participants used their inner personal resources to move their lives forward constructively.

From a theoretical point of view this research builds on resilience, life events, and post-traumatic stress/growth literature in three ways, self-defining stories expand the contextual environment for life events’ studies, research with adversity captures accumulation factors that are part of real life experience, conducting research years after adversity allows the long term impact to be demonstrated.

This research assists the mental health practitioner to recognise how self-healing occurs. The self defining stories indicate the usefulness of tackling problems, changing behaviour and gaining from worthwhile relationships. Withdrawing from destructive relationships conserves energy that is wasted on revenge and anger.

Keywords: Adversity; Identity; Life-narrative; Dark Creativity; Self-healing.

Introduction
The impact of adversity has interested mental health professionals for a long time. Lindemann’s (1944) early research, Frankl’s *Man’s Search for Meaning* (1959) and Mandela’s *Long Walk to Freedom* reflect the wide concern about adversity and how people manage. Mental health professionals have been interested in understanding the impact of adversity on identity so as to relieve human suffering that is often associated with it.

Adversity is defined as profound suffering or disastrous experience in the face of calamitous biological, relational, social, economic, and political change and this definition identifies the domains of adversity. The types and configurations of adversity all contribute to the enduring effects of past events on people’s lives.

**Background**

Psychology has researched human reaction to adversity, but this perspective has mainly had a pathological focus-attempting to explain individual and social behaviour in response to major stressors (O’Leary 1998). Part of this pathologising adversity is the notion of personal and group crisis and consequently developing crisis intervention strategies. Crisis theory as developed by Parad and Caplan in 1960 was envisaged as a psychological theory to explain the impact of acute stressful situations on people. Crises have peaks or sudden turning points in which people respond with rising tension that stimulates the mobilisation of previously hidden strengths and capacities. Crisis also has the potential however to precipitate deterioration in mental functioning.

Thoits (2013) has defined self as that aspect of a person that has experiences, reflects on experiences, and acts on self-understandings derived from those experiences. Self is usually considered unified, singular and whole. Identity is a specific understanding of our self and it is a social or public self as a specific object, such as, I am a student, a woman. Self-esteem is self-understanding of one’s quality as an object, such as I am a good student, I am an active woman. Self-esteem may be global in aspect, such as I am a good person, or domain specific, such as I am good at gardening.

Using the Symbolic Interaction Theory, sociology considers that the self and identity are created and maintained through the process of communication. Stress is defined by Lazarus and Folkman (1984) as inability to cope with a perceived threat or as Thoits says (2013, p. 361) as an appraisal of harm/loss, threat, or challenge to the self. It is in the
communication with others and reflecting on that communication self-defining stories are created that shape identity in the face of adversity.

The cumulative inequality theory states that social systems generate inequality that is demonstrated over the life course as demographic and developmental processes. Personal trajectories are shaped by the accumulation of risk, available resources, perceived trajectories, and human agency (Ferraro & Shippee, 2009).

The Agency-Structure dialectic deals with the dynamic of the active human component within the possible choices and constraints available in the social structure and culture of the time. Human agency plays an important role in how people interpret and respond to adversity (Schafer, Ferraro & Mustillo, 2011). The Agency-Structure dialectic is not polemic or static but more intertwined and dynamic as Schafer, Ferraro, and Mustillo (2011) discuss with the concept of biographical structuration. Biographical structuration refers to the constraining influence of a person’s past for his or her present and future life chances. It is through the capacities of memory and narration that biographical details from across the lifespan are woven together and remain consequential for the present and the future (2011, p. 1081). A coherent life narrative is a result of this internal interpretative phenomenon. Giddens (1991, p. 54) makes the point that this personal coherent narrative, rather than behaviour or reactions with others, is what makes identity. According to McAdams (2006a) a coherent life narrative exists to be told or performed in specific social contexts and consists of the following characteristics: 1) it provides convincing causal explanations for the self, 2) it reflects the richness of lived experience, and 3) advances socially valued living action. Consequently, narrative identity is taking a central place in our understanding of personality. McAdams’ (1995, p. 301) framework of personality consists of three levels:

- Level 1 consists of those broad, decontextualized, and relatively nonconditional constructs called traits that provide a dispositional signature for personality description.

- At Level 2 (called personal concerns), personality descriptions invoke personal strivings, life tasks, defence mechanisms, coping strategies, domain-specific skills and values, and a wide assortment of other motivational, developmental, or strategic constructs that are contextualized in time, place, or role.
Level 3 presents personality psychosocial constructs that constitute identity which takes the form of stories of the self-internalized and evolving life stories that integrate the reconstructed past, perceived present, and anticipated future.

Research on resilience is concerned with uncovering protective factors and vulnerability processes that if targeted in interventions could substantially improve at-risk people’s odds of doing well in life (Luthar & Zelazo, 2003). Norman Garmezy (1993) is regarded as the pioneer of resilience theory focussing on promoting competence rather than pathology and he looked at aspects such as cognitive skills, motivation and other protective factors that might offer some insights about promoting mental health. Recent research has revealed the complex and dynamic nature of resilience. Greene in 2002 developed a list of key theoretical assumptions that are driving contemporary resilience research and practice.

Resilience:
• is a biopsychosocial and spiritual phenomenon
• involves a transactional dynamic process of person-environment exchanges
• encompasses an adaptational process of goodness-of-fit
• occurs across the life course with individuals, families, and communities experiencing unique paths of development
• is linked to life stress and people’s unique coping capacity
• involves competence in daily functioning
• may be on a continuum—a polar opposite to risk
• may be interactive, having an effect in combination with risk factors
• is enhanced through connection or relatedness with others
• is influenced by diversity including ethnicity, race, gender, age, sexual orientation, economic status, religious affiliation, and physical and mental ability
• is expressed and affected by multilevel attachments, both distal and proximal, including family, school, peers, neighbourhood, community, and society; consequently,
  • resilience is a function of micro-, exo-, mezzo-, and macrofactors
• is affected by the availability of environmental resources
• is influenced by power differentials

Life-events research has been plagued by many different methodological problems in its process to uncover a connection between life events and mental and physical illness.
(Dohrewend & Dohrewend, 1980). Even the definition of a life-event is problematic. A life event is regarded as any change in lifestyle routine that prompts a need for readjustment (Holmes & Rahe, 1967). This definition has a subjective dimension and life events could be major/minor; desirable/undesirable; low threat/high threat; independent/dependent; congruent with development and social context/ not congruent; recurring/ non-recurring (Murray & Zautra, 2007).

Various inventories of life events have been compiled. The Life Event Inventory (LEI) has been developed from earlier work by Homes and Rahe in 1967 (Jackson, 2007). In this inventory there are 55 items and the highest 10 ranked life events are:

1. Death of spouse  
2. Jail sentence  
3. Death of an immediate family member  
4. Immediate family member attempts suicide  
5. Debt  
6. Homelessness  
7. Illness in family  
8. Unemployment  
9. Divorce  
10. Breakup of family

The problem with assessing life-events is that this research and the various inventories do not take into account the contextual factors, the accumulation factors and the time span since the life-event.

In the Diagnostic and Statistical Manual of Mental Disorders (DSM-5), published in May, 2013, PTSD is classified as a trauma- and stress-related anxiety disorder. It states a number of criteria that the person must have:

1. Exposure to a traumatic event  
2. Experience persistent symptoms of the event  
3. Emotional avoidance and emotional numbing  
4. Hyperarousal  
5. Experience symptoms of at least one month duration  
6. Show signs of significant impairment
According to the National Collaborating Centre for Mental Health (2005) post-traumatic stress disorder is common. There is a lifetime prevalence rate of 7.8%. There is an 8.1% risk for men and a 20.4% risk for women of developing the disorder after experiencing a traumatic event. Nevertheless, most people do not get post-traumatic stress disorder when exposed to trauma.

Tedeschi and Calhoun (1996) have studied the beneficial effects that some people experience after trauma and refer to this process as Post Traumatic Growth. The term *post traumatic growth* refers to positive psychological change experienced as a result of the struggle with highly challenging life circumstances (Calhoun & Tedeschi, 1999, 2001). After researching a range of trauma they found that some people experienced changes in self-perception, changes in interpersonal relationships and a changed philosophy of life.

Post traumatic growth occurs at the same time as one attempts to adapt to highly negative situations that can cause high levels of psychological distress. Unlike resilience, hardiness, optimism and sense of coherence, post traumatic growth refers to a change in people that goes beyond an ability to resist and not be damaged by highly stressful circumstances; it involves a movement beyond pretrauma levels of adaptation. From Tedeschi and Calhoun’s (1996) work on the Post Traumatic Growth Inventory five factors that define the major domains of post traumatic growth were found: greater appreciation of life and changed sense of priorities; warmer, more intimate relationships with others; a greater sense of personal strength; recognition of new possibilities or paths for one’s life; and spiritual development.
In Table 1 the model of post traumatic growth, the development of a revised life story or narrative and post traumatic growth may be mutually influential (McAdams 1993; Tedeschi and Calhoun 2004).

Social support has long been regarded as offering a buffering effect to life stresses (Cohen McKay, 1984). Social relationships offer different sorts of support. It may be tangible
with food, clothing and housing. Intangible support can be in the form of assisting cognitive processes by offering appraisal of the situation, and the coping mechanisms of the person. Emotional support may take the form of enhancing self-esteem and feelings of belonging and decreasing the traumatised person’s sense of isolation. Thoits (2013, p. 360) says that: “our sense of self, our identities and our self-esteem are derived, at least in part, from social relationships and are sustained in social interaction”.

Inequalities in income, power and prestige are part of the social stratification and Mirowsky and Ross’s (2003) book *Social Causes of Psychological Distress* makes the case that psychological distress or misery is the essential inequality across the social stratification. A sense of personal control is the link between societal structural conditions and psychological stress or comfort. A sense of personal control relates to the sense of power one has to control one’s life and it is enhanced with socio-economic status-education, income, employment status, work and occupations.

**Methodology**

*Obtaining, analysing and validating life narratives about adversity*

With a purposeful sampling technique nine participants were recruited to give their stories about adversity that dealt with illness (2); work (3) relationships (3) and migration (1). They were interviewed in three capital cities and three regional towns in Australia.

The life story is a descriptive account, albeit a subjective one, of an individual’s experience. A life story changes as the individual considers his position and he comes to terms with society, and the story’s content, structure and expression depends on the given culture. There is a tension that exists in the story between the self and its relationships and its place in the contemporary socio-cultural context. Life story construction according to Pals (2006) is an interpretative process of self-making that operates to produce coherence through the formation of meaningful connections between past experiences and the self.

The self-defining stories were tape recorded, transcribed and analysed individually. The self-defining stories and their analysis were validated by presenting the stories and analysis to the individual participants asking them two questions:

*Is there anything in the transcript of your story you would like to change?*

*What suggestions do you have to make the analysis more truthful?*
Only one participant changed the self-defining story significantly, but he allowed both versions of the story to be published. The reason for the significant changes in this transcript was some annoyance that details in the oral story were not told in chronological sequence and other people who were important were not mentioned sufficiently in the oral story.

Changes were regarded as significant when the changes affected the tone, theme or complexity of the narrative. Minor changes usually dealt with protecting identity in a way that did not change the story to any great extent. The analysis of their story was acceptable to all the participants. Some saying that the analysis captured them ‘to a T’.

**Results**

*Overview of the self-defining stories about illness*

*It’s not how it should be by Lue*

Lue’s husband Pat titled her story as he was expressing his disappointment that he could not care for her with her cardiac by-pass surgery as she had cared for him during his recent stroke. Such is illness and its unpredictability.

Lue is very clear talking about her need of ‘getting on’ with life while at the same time ‘letting go’ of parts of her old life. Between getting on and letting go she feels that she is wearing down which is negative side of acceptance of what is.

At a personal level Lue’s story deals with the trauma of losing a partner as he was, undergoing life-prolonging surgery and the death of her mother. Her own health vulnerability precipitated her life unravelling and she is now seeking how to do it differently, how to live differently.

*Re-storying your life: Turtle dreaming-like swimming across the Pacific by Pat*

It is very easy to love Pat, indomitable loving and fragile. He has taken more blows than most and certainly lived and loved more than most.

One wonders if his relentless seeking inner meaning for misfortunes is not tinged slightly with Irish-Catholic guilt. He constantly blames his ceaseless striving for his downturns. But one cannot deny his success in finding strength in vulnerability.

The two outstanding aspects in his story are his ferocious intellect and his generosity and lovingness towards the characters that have interacted with him in life. Pat is the bloke you want to party with and he is certainly the bloke you want on your side in a fight.

*Overview of the self-defining stories about work*

*Justice is a fickle thing by Bruce*
Justice is a fickle thing because the connection between how people treat each other and mechanisms of society’s legal instruments is rarely made. This story very clearly makes the statement that justice depends on one’s internal sense of right and wrong behaviour. Indeed the adversity occurred when people treated each other badly and in order to strengthen their viewpoint society’s legal instruments were manipulated.

The workplace is particularly important as a setting for social relationships because of the length of time people spend together and the competition for advancement that exists in most workplaces as well as management’s task to extract profit out of employees’ time and efforts. Studs Terkel’s view of work (1972, p. xi) captures the chronic nature of the work situation that is in stark contrast to any simplistic assumptions about work:

Work by its very nature is about violence to the spirit as well as the body. It is about ulcers as well as accidents, about shouting matches as well as fist fights, about nervous breakdowns as well as kicking the dog around. It is above all (or beneath all), about daily humiliations. To survive the day is triumph for the walking wounded among the great many of us.

There is no doubt that triumph is in this story, but it is triumph of the single man and not triumph for the work collective. He moved himself away from the violence to his spirit and through great efforts found a better situation for himself.

There is no God but there is only God by Peter

What happened to Father Peter Kennedy and St Mary’s is well known through Australian media coverage. This story deals with more than the public facts and events. It deals with the man himself.

Many adversities are associated with changes in social status. Some changes in social status run to the core of identity because the outsider’s perception is internalised and contributes to our perception of ourselves. So the public and private aspects of identity are mixed together like adding tints to make different colours of paint. Once mixed it is impossible to pull out the tint from the base paint.

The job of being a Catholic priest is a life time commitment to celibacy and priestly duties but we are accustomed to men leaving the priesthood to marry. The Church puts
forward the notion that it is epitome of charity and forgiveness. So being more inclusive than the Church towards the poor, disenfranchised, criminal, ill, disabled, gay and sexually abused placed Father Peter Kennedy in direct conflict with his employer. His employer also has the unique power to control entry to heaven. Peter Kennedy embarked on a journey to care for the poor as a naïve do-gooder. He challenged the public face of the Church and so he was vanquished.

As the journey progressed he read books. He studied ideas. He thought about social problems and their causes. He talked. He did things. His private thinking became his public presence. He fused his concept of himself and God. In ceasing to react he exposed all and became all he is. Similarly in ceasing to define God he found only God. The ‘dullness’ along the journey is the effort, aloneness and the grief of detachment.

*What defined me three of four years ago doesn’t define me now by Jim*

The stories of redemption are heroic and part of the American psyche…. The American psyche is marked by Individualism and Self-determination in the pursuit of wealth by self-made men. It is not surprising then that an Australian businessman, trained in America, identifies his struggles in that way. The interesting feature of this story is how high to place the bar as a measure of one’s redemption, proving oneself in overcoming adversity. In this story in defining oneself differently we see the power of setting the bar oneself.

Aussie battlers are usually working class but in this story of a privileged Australian we feel the anxiety of the effort and fear of failure as the inner battle to achieve goes on. These emotions come through in their raw state freed from any anger or reaction against the oppressive system that takes up space in the typically Aussie battlers’ stories. The fear of recurrent failure is palpable.

It is a story in which we can reflect on the notion of self-made adversity. No matter how spurious, it is easier to consider this concept in the wealthy than the poor. From this story however, the source of the adversity whether internally or externally generated does not seem to reduce the pain of its impact or the harshness of the struggles to find a future that is more comfortable.

*Overview of self-defining stories about relationships*

*But other people keep you where you are by Ingerid*
This story takes us into the world of heterosexuality and homosexuality. Usually these worlds are separate but in this story they existed in the same house, within the same family and in the one married couple. Staying together or separating is the common dilemma that couples in this situation face. There are issues of: infidelity, discrimination, deception and naivety on the negative side, and love, caring, tolerance and dignity on the positive side.

Apart from these obvious problems and issues this story makes us aware of the pressure from outsiders to stop change, or as it is put here: to keep you where you are. This concept confronts the reality of changing lives and questions the role of honesty and disclosure in relationships.

This is an honest story told by a loving woman. The interview ended when a middle aged well-dressed daughter and the teenage grandson came to visit. The grandson had a green blazer on with a gold school crest embroidered on the breast pocket.

_I just had this mean mongrel thing in my head that just said, ‘Watch me’ by Sheryl_

This story is about a shameful Australian disaster in which Indigenous kids were forcibly placed with white families. Between the end of the nineteenth century and the late 1960s there were two periods involving the removal of Aboriginal Children from their families. Up until the 1940s the children were removed with the intention of ‘breeding out their colour’. The second (post war) phase, replaced raced based policies with a social policy of assimilating Aboriginal children by placing Black children with White foster families (Zierott, 2005).

Indigenous people obtained full voting rights in all states in 1965. This Indigenous life was stolen in urban Brisbane in the 1970s. The years of childhood were stolen and Indigenous identity was stolen. She grew up with a white way of thinking in a black body and subsequently was victimised by Indigenous people.

The only insight we gain about how she overcame these adversities have something to do with her emotional intelligence and some protection from her biological sister who could not however save herself. What is remarkable about this story is the ability to contain herself within ongoing relationships with her two mothers both of whom harmed her-one through abuse and the other through neglect.
The integrity of character in which she stands whole in the midst of violence is the fundamental leadership that she brings to the world. We are left in awe wanting to emulate it but not knowing how.

*It’s really hard, because it just all rolled into one, in a way by Meg*

It would be hard to find another story filled with so much death. The story rolls like waves over a swimmer who continues to float no matter what.

All the deaths except that of the mother occurred at least 20-30 years short of the Australian expected lifespan. The first death, the fathers, occurred when she was a child and so the story is stamped with the impact of adversity on developing identity.

Death is non-negotiable and she recognises this and seeks a safe haven with friends. Saving the planet may be a utopian dream but she has learnt enough lessons in life to start out on this dream in her own backyard which is a small part of the world she can control. Sustaining herself with friends, and saving the planet by growing plants are her ways of negotiating with life.

*Overview of self-defining story about migration*

*Taking doesn’t count by Rahim*

‘Taking doesn’t count’ is not just a migrant’s narrative; it is also a collection or snippets of wisdom from the ages. Rahim’s voice carries the accent of his homeland, but his mind and body have been part of the new cultural life of Australia over the last three or four decades. Over this period, Australia has moved from maintaining the white Australia policy to embracing multiculturalism. At 30 June 2011, 27% of the estimated resident population was born overseas (6.0 million people) (Australian Bureau of Statistics 2013).

The gems of wisdom dealing with honesty and acceptance of self are tied together in the more complex notions of appreciating the moment and giving and allowing others to give. These factors make up the central core of one’s being and contribute to making one a ‘mu’min’-a trusted one, a holy one.

The exploration of God and Gods is a delightful comic book rendition of a significant theological debate. The separation of God from religion is done in an artful way.

*Discussion*
These self-defining stories are complete in that they are the individual’s understanding of major trauma in their lives. Each person is still integrating the experience and planning their future. By the owner’s assessment these are success stories. The impact of adversity on development was seen in three of the stories, (Pat, Sheryl and Meg) because adversity began in childhood, and the remaining six stories dealt with adversity that began in adult life.

The stories have two parts, the details of the adversity and the subsequent impact. The nature of the adversity varied, but it was severe by any standards. Adversity stretches a person beyond what one has previously dealt with and one encounters new traumas not envisaged. It is the newness and the unpreparedness that hits as a shock: disbelief that life can be so hard. The duration of the adversity was lengthy and in most instances it was drawn out over years—the long tail of adversity in real life. The nature of the adversity became intertwined with its impact as people struggled with both of these factors.

Analysis of the stories revealed that the participants: 1) engaged with the problems presented with the adversity; 2) changed their actions and behaviours; and 3) negotiated varied relationships at many levels.

Engaged with the problems presented with the adversity

Engaging with the problems presented with adversity involved trial and error and a process called ‘dark creativity’. Finding a path forward was confusing because each individual had to decide what to tackle, when to approach that problem and how to manage it. It was essentially a process of dark creativity. The process of working from that dark space inside oneself to make something better requires great imagination, because there is no blueprint offered for the way out of the dark space. What problems to engage with and how to engage with them is a creative process.

The creativity involved in problem solving one’s way through adversity is emphasised by the counter-intuitive process seen in several stories. It is counter-intuitive because usually perseverance is valued when one strikes obstacles to goals. For several people adversity meant that they had to give up on former cherished goals and ways of living. They had to disinvest their energy in highly prized aspects of themselves or what they saw as they station in life or their future and embrace other qualities, ideas and expectations.

Changed their actions and behaviours
As these people experienced adversity and engaged with the problems they were involved in changing themselves and their life circumstances. There was a compulsion to change because their old ways of coping were just not applicable to the new situations brought about by adversity. However although compelled to change all nine storytellers accepted the need to change and did not fight against it.

In dealing with negative life events the negative to positive transformation involves two processes of acquiring and using wisdom. Wisdom is defined by Bluck and Glück (2004, p. 545) as an adaptive form of life judgment that involves not what, but how one thinks. It is a combination of experiential knowledge, cognition, affect, and action that sometimes occurs in social context. Wisdom is a personal resource to solve problems and live a better life.

In generalising the lessons learnt from the experience of one event to other events and in unifying lives by relating life events to the life story wisdom-from-experience must offer temporal and causal coherence. In temporal coherence the wisdom used in short-term events may also be linked to other generic memories that recur or exist over time in the person’s life. Causal coherence means that the wisdom acquired previously is meaningfully related to later events in the person’s life or life story. Several stories demonstrate the wisdom involved in making life transitions.

*Negotiated varied relationships at many levels.*

The relationships in the self-defining stories are invariably complex and impact on the individual at different levels. Generally there are three types of interactions in the relationships in the stories. The first type of interaction is of a practical nature in which the person experiencing adversity is the beneficiary of kindness and practical assistance to lessen the impact of the adversity. This is an immediate and automatic response and the storyteller passively accepts the help. The next level involves a two way interaction between the person experiencing the adversity and the person with whom they have a relationship. In this interaction the two people actively negotiate their new relationship in the light of the adversity. The final level deals with the person who has suffered the adversity as he reflects on reactions, remarks and feedback from others and his own feelings and perceptions and re-shapes and re-defines his identity. The more intimate the relationship the more there will be contributions to each of these levels of interaction. In this schema both relationships and identity are dynamic in the face of adversity.
Sometimes conflicted relationships played a significant role in the trauma that is described. In all instances worthwhile relationships assisted in managing adversity and re-defining identity. Conflicted and worthwhile relationships are differentiated simply by those that on balance harm and those that on balance help. In this process they evolved a new identity better suited to future challenges. Revenge and anger did not appear significantly in these self-defining stories. The participants used their inner personal resources to move their lives forward constructively.

**Conclusion**

This research explored the impact of adversity on identity through the methodology of self-defining stories. This research builds on resilience, life events, and post-traumatic stress/growth literature in three ways: 1) self-defining stories expand the contextual environment for life events’ studies; 2) research with adversity captures accumulation factors that are part of real life experience; and 3) conducting research years after adversity allows the long term impact to be demonstrated.

The self-healing process of story making and storytelling can be aided by health interventions that parallel the constructive process of: dealing with problems; changing actions and behaviours; and negotiating varied relationships at multiple levels. Revenge and blame have little value in this self-healing process.

**References**


Outcomes from the implementation and evaluation of an integrated Early Psychosis Program

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Outcomes from the implementation and evaluation of an integrated Early Psychosis Program

ABSTRACT: The Early Psychosis Program (EPP) at St Vincent’s Hospital (Melbourne), Mental Health Service, is an evidence-based clinical program. The program has adopted key knowledge from international best practice literature and clinical guidelines through the robust development of protocols to facilitate, monitor and evaluate quality practice as standard care. The integrated service model focuses on access and inclusiveness for all adult consumers in the early stages of psychosis and contact with services, rejecting the more prevalent 'youth' model of specialist teams exclusively for people 16-25 years.

The program has been in operation for 8 years. It has been evaluated, with findings published in four papers in international journals in the last 3 years. Benchmarked against interstate and overseas fidelity studies, the EPP demonstrated superior results for client engagement, physical examination and monitoring, atypical antipsychotic medication use, consumer and family psycho-education and GP involvement. Further, audited against an historic cohort, there are statistically significant improvements in outcomes for consumers in experience of care, reduced numbers admitted to hospital, and reduced use of involuntary status and a locked ward.

Family work too has been an important emphasis. Group psycho-education was found to achieve statistically significant improvements in carers’ understanding of psychosis, recovery and relapse prevention. The EPP has also been innovative in the provision of an inpatient psycho-education meeting for first-episode carers. For a consecutive sample attending inpatient psycho-education meetings, consent was obtained and a semi-structured phone interview was conducted 6 months later. There was 100% uptake for the psycho-education, and 90% participation at follow-up. A combination of verbal information, fact sheets, medication and carer information booklets, and DVD information to keep was valued by families. Family interventions in the acute setting were useful to support meaning-making, reduce stigma, and assist the recovery of the family system in the months that followed.

Keywords: early intervention, first episode psychosis, outcomes, practice-based research.
INTRODUCTION

The last fifteen years have led to greater optimism about better outcomes for people with schizophrenia and related psychoses, with increasing evidence of better outcomes achieved with early intervention (McGorry, 2006; Addington, 2005; McGorry and Edwards, 1998). Over the past decade international clinical practice guidelines have emphasised early detection of new cases (Chong, 2008; Conus et al., 2007), shortening delays in effective treatment (Chong, 2008; Amminger, 2002; Reed, 2008; Archie et al., 2008), and optimal treatment provision in the ‘critical period’ of the first three years of illness (McGorry, 2003; Archie et al., 2008) as best practice.

Implementation has been in specialised teams (O’Donnell, 2004; Fisher et al., 2008; Friis et al., 2005; Norman et al., 2001), with few studies examining fidelity to guidelines (O’Kearney et al., 2004; Gorrell, 2004; Moss et al., 2006; Hanson et al., 2006; Reilly, 2007). Prior to our publication in October 2010 no published study had examined fidelity in an integrated model in an area mental health service and across the adult age range. The suggestion that a discrete team approach is required to support quality intervention is not substantiated by long-term evaluative literature (Bosanac et al., 2010; Craig, 2003; Gafoor et al., 2008; Bertelsen et al., 2008; Gafoor et al., 2010). Moreover, it has not been established that restricting access to evidence-based intensive service to 16-25 year olds is clinically justified (Pelosi, 2009; Bosanac et al., 2010).

Studies on family group work suggest that families supporting a consumer experiencing a first episode of psychosis (FEP) require intensive support initially to understand what is happening to the consumer and to navigate the service system. Carers of individuals experiencing FEP report high distress levels (Gibbons, Horn, & Powell, 1984; Gopinath & Chaturvedi, 1992; Martens & Addington, 2001) and greater carer burden (Bulger, Wandersman, & Goldman, 1993) associated with stigma, fears regarding the future for the person they support, and feelings of loss in the changed relationship they have with the person (Lowenstein, Butler, & Ashcroft, 2010). The symptoms and challenging behaviours displayed by their family member can produce anxiety, distress and confusion for carers (Addington, Coldham, & Jones B, 2003; Jeppesen, Peterson, & Thorup, 2005).
A clinical program, utilising an integrated model of case management for early psychosis consumers, commenced as a pilot in 2006 with management support, a project officer and dedicated consultant psychiatrist time. The Early Psychosis Program (EPP) within the service is unusual in Australia in that it is accessible to adult service users over the age of 25 years. The program seeks to recognise that first episode presentations can occur throughout the adult life span, and a bi-modal presentation is evident. Case management is provided for up to 3 years, as per international best practice guidelines (Addington et al., 2005). After that time service users continue to receive case management within the service as indicated, through an internal transfer to the ongoing continuing care team for the geographic area. The case management provided is recovery-oriented, and is delivered utilising the ‘Strengths’ model of practice (Rapp & Goscha, 2006) that has been adopted at the service (Chopra, Hamilton, Castle, & Smith, 2009).

In 2008, with government funding, the EPP was rolled out service-wide. The program now includes senior clinicians embedded within each team to both hold a clinical load and act as a resource for secondary consult, monitoring and training of other case managers regarding work with early psychosis service users. Early engagement with the service user and family is an important priority. Program implementation was further enhanced after the introduction of a specific early psychosis nurse in the inpatient unit setting, to support acute service staff in identification of early psychosis cases and assist in timely referral to community and completion of care pathway documentation.

**Referral Criteria to the Program:**

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<th>Referral criteria</th>
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<tr>
<td>1) No prior history of psychosis, or early psychosis treated for less than 18 months</td>
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<td>2) Age 16-65 (*16-18 can be referred to Child &amp; Adolescent Mental Health Services or St Vincent’s)</td>
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<td>3) Experiencing active psychotic symptoms, or suspected to be experiencing in ‘at risk mental state’ for psychosis</td>
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<td>4) Misuse of substances is not an exclusion criterion.</td>
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AIM: To evaluate the effectiveness of the Early Psychosis Program (EPP) in meeting the program’s aims of phase and stage-specific treatment, meeting clinical evidence-based best-practice, reducing trauma and improving outcomes for consumers, and supporting and proving education to carers to enhance outcomes for consumers, through a sustainable model within a public mental health service, within the existing budget.

The specific objectives of the St Vincent’s EPP evaluation were:

1. To evaluate the implementation of clinical practice guidelines, through use of a care pathway, in the initial stages of treatment of first episode psychosis (FEP), in a public mental health service.
2. To examine treatment outcomes for consumers with early psychosis two years after the introduction of an integrated model compared with an historic cohort.
3. To investigate the model of multiple family carer group work most responsive to the needs of carers of consumers experiencing FEP.
4. To longitudinally evaluate the impact and utility of an inpatient psychoeducational meeting designed for families of consumers experiencing FEP.
5. To examine early and late onset FEP presentations to an integrated service model using an expanded age criteria 16-65 years.

METHODS

Implementation of clinical practice guidelines
The Australian Clinical Guidelines for Early Psychosis (ACGEP) and published international research were operationalised into a Pilot Early Psychosis Care Pathway. The pathway focuses on key tasks delivered to prioritise timely management in the acute setting and as seamless a transition to community care as possible. The document is a ‘checklist’ of the first three months of care. While designed to serve as a clinical prompt to support quality individualised patient-centred care, it proved a useful instrument to audit guideline concordance (Joanna Briggs Institute 2002, Benton 1999).

Reducing trauma in first episode psychosis
A standard care historical cohort of early psychosis consumers in 2001 (Yung et al. 2003) was compared with those within the first 2 years of EPP treatment as pre- and post-intervention groups. Electronic and case file audits included demographic information, service use indices and clinical indicators (Joanna Briggs Institute 2002, Garland and
Corfield 1999). There were steps to ensure inter-rater reliability. Statistical Chi2 analyses were conducted using STATA.

**Investigating the model of multiple family carer group work**

The facilitated multi-family psychoeducation and support group for carers evolved using an action research methodology, with qualitative semi-structured interviews with carers who continually attended, dropped out and never attended the monthly group in 2009 (Oxley, Bloom & Petrakis 2011) informing a shift from an open support group format to five structured sessions. Case managers and early psychosis clinicians were also interviewed. In 2010 a pre- and post-test questionnaire was administered to quantitatively measure the participants’ changes in perceptions of knowledge regarding mental illness and its treatment through attending the group. Qualitative items were included.

**Evaluating an inpatient psychoeducation meeting for first-episode carers**

For a consecutive sample attending inpatient psychoeducation meetings, for FEP families consent was sought for a semi-structured phone interview 6 months later to determine the usefulness of the meeting and its content; what was recalled and how it had been utilised since.

**Examining early and late onset first episode psychosis presentations**

A database was developed to capture the demographic and diagnostic characteristics of all patients presenting in the early stages of psychosis between the ages of 16 and 65 years. The characteristics of those with an onset under 26 years were compared with those who experienced a later onset.

**RESULTS**

**Implementation of clinical practice guidelines**

Care Pathways were completed with 55 of 60 consumers (91.6%). Excellent adherence (over 80%) was achieved for therapeutic alliance, comprehensive bio-psychosocial assessments, medical investigations, increased orientation to the service and mental health systems of care, and contact with family. Only a handful of other studies – two from New South Wales (Gorrell et al 2004; O’Kearney et al 2004) and one from Canada (Hanson et al 2006) – have attempted to evaluate fidelity to guidelines in FEP; St Vincent’s EPP achieved superior results (Table 1).
Reducing trauma in first episode psychosis

In the 2001 historic cohort there were a high number of consumers requiring admission (81%), largely involuntary admissions, frequently with police. Length of stay in hospital was long (mean of 46.5 days), use of a locked area was high and for lengthy periods, and the seclusion rate was high (Yung et al. 2003). These are potentially traumatic events for consumers in addition to first experience of psychosis itself. Compared to the historic cohort, consumers in the EPP were 24 per cent less likely to have been admitted (p = .004). There were statistically significant reductions in involuntary status and use of a locked unit (Table 2). Rates of police involvement in admission, use of seclusion and average length of stay were also reduced.

Table 1: Percentage of clients receiving guideline concordant treatment

<table>
<thead>
<tr>
<th>Engagement with client</th>
<th>Physical examination</th>
<th>Atypical antipsychotic medication</th>
<th>Client psychoeducation</th>
<th>Family psychoeducation</th>
<th>GP involvement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gorrell et al 2004</td>
<td>O’Kearney et al 2004</td>
<td>Hanson et al 2006</td>
<td>Fraser South EPIC Program, Canada</td>
<td>St Vincent’s HCMHS, Victoria</td>
<td></td>
</tr>
<tr>
<td>North Sydney Health AMHS, NSW</td>
<td>Southern Area First Episode (SAFE), NSW</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>91.3</td>
<td>86</td>
<td>85</td>
<td>100</td>
<td></td>
<td></td>
</tr>
<tr>
<td>65.7</td>
<td>23</td>
<td>22</td>
<td>60</td>
<td></td>
<td></td>
</tr>
<tr>
<td>87.1</td>
<td>61</td>
<td>-</td>
<td>89.7</td>
<td></td>
<td></td>
</tr>
<tr>
<td>55.7</td>
<td>37</td>
<td>100</td>
<td>97.4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>47.1</td>
<td>28</td>
<td>83</td>
<td>77.8</td>
<td></td>
<td></td>
</tr>
<tr>
<td>65.7</td>
<td>56</td>
<td>66</td>
<td>69.2</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Investigating the model of multiple family carer group work

A qualitative study in 2009 regarding group participation by carers found:

Benefits from group participation:
- reduced isolation,
- sense of collective experience,
- opportunity to speak and feel heard by peers,
- reduced stigma and shame,
- increased knowledge about mental illness, and
- enhanced skills in supporting their care recipient

Barriers to participation:
- competing family and work commitments,
- questioning direct applicability of content to own family experiences of caring,
- discomfort with a social situation, revealing emotions,
- discomfort with hearing emotions in others, and
- a belief that in fact their experiences are private family matters


In 2010 the programme achieved statistically significant improvement in carers’ understanding of psychosis, recovery and relapse prevention.

Evaluating an inpatient psychoeducation meeting for first-episode carers

The consumer lived with a carer in 70.4% of cases so carer psycho education is important, to support consumer recovery and support carers themselves. There was 100% uptake for carer
inpatient psychoeducation (N=30 families), and 90% participation at follow-up approximately 6 months later. Sessions were individualised; mean timing was at day 8 and mean duration was 1 hour 40 minutes. A combination of verbal information, fact sheets, medication and carer information booklets, and DVD information to keep was valued.


Examining early and late onset first episode psychosis presentations
A large proportion (55%) of those who presented with FEP presented after the age of 25 years. There were a higher number of cases of depression with psychotic features in the older onset patients (in particular for those presenting over 40 years of age), and a trend towards greater metabolic morbidity within the older sub-cohort (Table 3).

Table 3. Comparison of under 26 and over 26 years of age

<table>
<thead>
<tr>
<th>Diagnosis at 3 months</th>
<th>Total Sample</th>
<th>&lt; 26 Years</th>
<th>≥ 26 Years</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number</td>
<td>Number (% of age group total)</td>
<td>Number (% of age group total)</td>
</tr>
<tr>
<td>Schizophrenia/Schizophreniform/Delusional Disorder</td>
<td>87</td>
<td>36 (48.7%)</td>
<td>51 (56.7%)</td>
</tr>
<tr>
<td>Psychosis Not Otherwise Specified</td>
<td>23</td>
<td>12 (16.2%)</td>
<td>11 (12.2%)</td>
</tr>
<tr>
<td>Bipolar/Schizoaffective Disorder</td>
<td>15</td>
<td>6 (8.1%)</td>
<td>9 (10.0%)</td>
</tr>
<tr>
<td>Major Depression with Psychotic Features</td>
<td>15</td>
<td>3 (4.1%)</td>
<td>12 (13.3%)</td>
</tr>
<tr>
<td>Brief Psychotic Disorder, Drug Induced Psychosis, At Risk Mental State</td>
<td>15</td>
<td>12 (16.2%)</td>
<td>3 (3.3%)</td>
</tr>
<tr>
<td>No Psychosis Diagnosis</td>
<td>9</td>
<td>5 (6.8%)</td>
<td>4 (4.4%)</td>
</tr>
<tr>
<td>Gender (% of males)*</td>
<td>94</td>
<td>49 (66.2%)</td>
<td>45 (50.0%)</td>
</tr>
<tr>
<td>Metabolic Issues (diabetes, weight, lipids, cholesterol)**</td>
<td>25</td>
<td>6 (8.1%)</td>
<td>19 (21.1%)</td>
</tr>
<tr>
<td>Duration of Untreated Psychosis for Schizophrenia**</td>
<td></td>
<td>Number (% presenting in timeframe)</td>
<td>Number (% presenting in timeframe) &lt; 6 months</td>
</tr>
<tr>
<td>&lt; 6 months</td>
<td>50</td>
<td>27 (79.4%)</td>
<td>23 (50.0%)</td>
</tr>
<tr>
<td>≥ 6 months</td>
<td>30</td>
<td>7 (20.6%)</td>
<td>23 (50.0%)</td>
</tr>
</tbody>
</table>

*Comparison p value < 0.05

**Comparison p value < 0.01
DISCUSSION

Despite a number of services internationally creating specialised teams for FEP treatment over the past 10 years, it has not been established that quality intervention requires separate teams. This risks increasing fragmentation within services and is not substantiated by long-term evaluative literature; in fact consumers experienced difficult transitions leaving ‘specialist’ teams (Bertelsen et al. 2008, Friis 2010). Moreover, it has not been established that criteria limiting service to ‘youth’ are clinically justified (Bosanac et al. 2010; Craig 2003). Following the care pathway audit the EPP was found to benchmark well on engagement and consumer and carer psychoeducation. The service then focused on enhancing consumer re-integration to the community, carer wellbeing; physical health assessment and enhancing primary care liaison.

Some previous international literature noted the reluctance of carers to take up psychoeducation interventions available in the community (Gerson et al., 2009), however this was not the experience at St Vincent’s. Findings indicated that carers are open to receiving psychoeducation at first contact with psychiatric services, both in the community and at the inpatient unit. Our qualitative findings revealed benefits for carers from group participation: reduced isolation, sense of collective experience, opportunity to speak and feel heard by peers, reduced stigma and shame, increased knowledge about mental illness, and enhanced skills in supporting the consumer. This feedback influenced the approach in the inpatient unit in working with carers. At the time of the evaluation 58% of EPP consumers were referred through an inpatient admission. The inpatient EPP clinician is thus pivotal in early identification to liaise with community teams and provide psychoeducation to families.

Despite feeling overwhelmed by a consumer’s acute presentation, and encountering the service system, carers are interested in psychoeducation if provided in the acute setting. The high (100%) uptake for the psychoeducation offered by the EPP in-patient clinician pointed to a desire for the intervention. The high level of participation in the evaluation suggested: an interest in continuity of support from someone known to them at the time of the
acute admission, an interest in participating in evaluation for themselves and the consumer, and a willingness to contribute to service evaluation and improvement.

Higher rates of metabolic issues were noted in older consumers with FEP. These findings should be noted in medication choices. The increased likelihood of depression with psychotic features in the older group, particularly for females, should also be considered in diagnosis and treatment. Clinical management needs to respond to the life-stage and context of an individual. Clinical programme experience is that ‘youth’ needs are typically different to those issues for the ‘early adult group’ (26–40 years).

Returning to or looking for employment, developing a suitable career trajectory, managing work responsibilities and dealing with employers and financial challenges were prominent themes. Family issues often related to dealing with a partner or exploring the illness impact on relationships and young children. Some patients who were not partnered or parents themselves even raised the question of whether they would cope with marriage and families after the onset of their illness. Some of these themes were prominent in the acute treatment phase. Others became more apparent during the medium to longer term recovery period where patients and their families planned for broader goals.

(Selvendra et al. 2014, 239-40)

The EPP is systematic in its process of case review, including the structured early psychosis clinical pathway, family engagement, psychoeducation, a structured metabolic monitoring programme, recovery work and multidisciplinary team management. These processes facilitate a tailored ongoing management that is responsive to age and life stage.

In the last 3 years Victorian, interstate, New Zealand and Canadian services have approached St Vincent’s to support their adoption of a similar care pathway to implement and evaluate quality care. The EPP plans to continue to implement evidence-based practice, and increasingly offer leadership to others interested in an integrated approach.

CONCLUSION

Just over half (approximately 55%) the consumers presenting to the service with an initial episode of psychosis were over the age of 26 years. There are trends towards an increase in metabolic comorbidity, mood disorder morbidity and a longer DUP in older presenters. The introduction of an integrated model for consumers experiencing early psychosis has contributed to treatment advances including reduced admissions, involuntary status, and use of a locked ward. There have been a number of addition gains from the EPP: increased
scrutiny of practice and monitoring practices that have enhanced the broader service culture of quality and accountability (Petrakis, Penno, Oxley, Bloom & Castle 2012). The data suggests that generic services are well placed for treatment of FEP consumers and capable of enhanced care if resourced.

REFERENCES


Quality of Life: Dementia Caregiver Experience

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Quality of Life: Dementia Caregiver Experience

ABSTRACT: The current study sought to identify the perceived burden and quality of life factors indicative of high burden and burnout in Australian informal carers of persons with Dementia, and which may result in the need to institutionalise the care recipient. Additionally, a comprehensive measure to identify highly burdened carers was developed, and a conceptual model of Dementia caregiver burden proposed. Caregivers completed a survey detailing carer and care recipient characteristics and context, perceived health of the carer, relationship dyad, carer levels of social support and formal resources, respite and recreation, carer attitudes and beliefs, religion/spirituality, and unmet needs. Carers who self-reported being highly burdened identified several stressors resulting in high perceived burden and reduced quality of life. Half of the carers reported the need to institutionalise their care recipients. Interventions that address these pressures may improve the well-being of carers, the quality of care their care recipients receive, and may also delay or eliminate the need for institutionalisation of Dementia care recipients.

Keywords: Dementia; quality of life; carer burden; care recipients; institutionalisation of care recipients

Introduction

Dementia, of which Alzheimer’s disease is the most common type accounting for between 60 and 80% of cases, is more than loss of memory. It is a chronic, progressive and irreversible neurodegenerative disease that causes deterioration in all areas of mental ability and functioning, and is accompanied by changes in personality and behaviour. As the disease progresses, patients transform from healthy independent members of society to being completely physically and mentally dependent on others. Moreover, caregivers are frequently elderly, and their ability to cope with caring for a relative with Dementia may be limited by their own health concerns (Alzheimer’s Association, 2011; Georges et al., 2008).

Three years ago it was estimated that 266,574 Australians had a diagnosis of Dementia and a projected figure of 942,624 by 2050 (Deloitte Access Economics, 2011). Dementia is the third leading cause of death in Australia, after heart disease and stroke, and the fastest growing source of major disease burden (Access Economics, 2009; Alzheimer’s Australia, 2011). Nearly 3 million carers provide 1.32 billion hours of care each year at a value exceeding $40 billion per annum. Nevertheless, informal family caregiving remains one of the lowest subsidised forms of care, and carers remain under-resourced in terms of

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1 Dementia is a general term that includes Alzheimer’s disease (AD), vascular dementia, dementia with Lewy bodies, and frontotemporal dementia. While these diseases are distinct entities, they can occur together and often share similar symptomology.
information and education compared with formal care workers (Moore, 2010). Currently, 7% of Australians care for family or friends suffering from Dementia (Alzheimer’s Australia, 2010).

The first of the baby-boomer generation reached 65 years of age in 2010; a time when Dementia cases began to emerge. It is thought that by 2020 approximately 75,000 Australian baby-boomers will be afflicted with this chronic disease. The coming decade will therefore witness an acceleration of the impacts of ageing on Dementia prevalence owing to the baby-boomer bulge in Australia’s demographic profile. Considerable care shortfalls are predicted over the coming decade as patient demand outstrips supply (Access Economics, 2011; Moore, 2010).

Research that has scrutinized the literature on formal placement of care recipients, including systematic reviews (Caron et al., 2006; Luppa et al., 2008), point to socio-demographic variables, interrelationships between carer and care recipient, caregiver stressors and resilience including coping style and self-efficacy, and resources such as finances and service availability. In an Irish study, Gallagher et al. (2011) found three variables, namely, caregiver burden, depression and nonspousal status to be indicative of possible institutionalisation of Dementia care recipients. A German study (Luppa et al., 2012) found 30% of Dementia cases were placed in nursing homes. Recipient characteristics exacerbating placement included not being in a relationship, and high cognitive and mobility impairments. It is worth investigating whether similar findings hold for an Australian sample of carers who may consider institutionalisation.

The impact of caregiving on the lives of carers can be substantial, and is generally overlooked by health services and policy makers who erroneously view informal caregiving as a free resource (Quinn et al., 2008). Family members frequently provide care for a decade or more prior to formal institutionalisation or demise of the care recipient (Wackerbath & Johnson, 2002). Furthermore, a trend towards earlier diagnosis of Dementia suggests that family members may need to undertake the caring role at an earlier stage, thereby impacting considerably on their lives and futures (Quinn et al., 2008).

Research has demonstrated that carers experience a number of adverse psychological, physical, social and financial consequences compared with non-caregivers. These include anxiety and depression, poorer health, isolation, and direct and indirect financial costs. Carers have consequently been referred to as hidden patients, as providing care places the caregiver at risk for negative outcomes, even death. Moreover, survival and quality of life of the care recipient is linked to the health of the carer (Brodaty & Luscombe, 1998). Carers are
therefore crucial for retaining those affected with Dementia in the community, however when carers are stressed and overburdened the likelihood of formal institutionalisation of the care recipient rises sharply (Brodaty et al., 2003; Caron et al., 2006; Yilmaz et al., 2009). Understanding the origins of caregiver burden is therefore essential.

A review of previous research has revealed that the impact of Dementia on informal caregivers has traditionally been conceptualised in terms of carer perceived burden or quality of life (Coen et al., 2002). Additionally, much of the empirical research on caregiving has relied on Lazarus and colleagues’ exploration of stress, appraisal and coping, and Bandura’s work on self-efficacy to provide a framework within which to operationalise important constructs (Lawton et al., 1991). Theoretical models have therefore generally viewed caregiving stress as a dynamic multidimensional process, where stressors and (lack of) resources interact to mediate or moderate outcomes, such as declining mental and physical health, and feelings of burden. High levels of stressors and low or inadequate resources have therefore been considered risk factors for adverse outcomes (Zarit et al., 2010). Furthermore, previous studies have tended to focus on aspects of the disease, characteristics of the caregiver, or factors specifically related to caregiving. This has resulted in fragmented, incomplete, and at times conflicting understanding of the origins of caregiver burden and the mechanisms that sustain it. In addition, the conceptual models developed by Pearlin; Lawton; Yates; Chappell and their colleagues, which describe the factors impacting caregivers, and the measures used to identify highly burdened carers, in particular the Zarit Burden Interview (ZBI) (Zarit et al., 1980), are now outdated, with more recently identified caregiving stressors not considered within the existing frameworks. This places in question the results of current studies utilising these models as guidelines for their research. Moreover, it highlights the urgent need for more current measures and conceptual models, particularly those not normed.

![Figure 1: Conceptual model of Dementia caregiver burden](image-url)
on Caucasian North American samples. A dearth of Australian studies has also been revealed. In light of this, and in order to explore the relationship between carer perceived burden and quality of life, and to enhance understanding of the Dementia caregiver experience, a conceptual model of Dementia caregiver burden is proposed (See Figure 1).

It departs from the earlier frameworks with the inclusion of the provision of Dementia-related information as a primary stressor. Moreover, the primary appraisal of hours of informal care has been replaced with carer perceived impact on health, forfeited life, unmet needs, and isolation. Additionally, the mediator of caregiving satisfaction replaces conventional formal and social support, while the traditional secondary appraisal of overload or burden has been retained with the addition of carer quality of life. The proposed model therefore treats caregiver perceived burden and quality of life as separate concepts (Chappell & Reid, 2002). Furthermore, while the outcome variables of depression, burden, quality of life or well-being provide information about the psychological adjustment of the carer, they do not necessarily identify carers’ requirement to institutionalise their care recipients. The current model consequently proposes the need for formal placement of the care recipient as the outcome variable.

While it is not within the scope of this study to test all of the variables within the proposed conceptual model, it will examine the relationships between the secondary appraisal variables (carer perceived burden and quality of life) and the outcome variable (caregiver need to institutionalise the care recipient). The remaining factors will be used to explore these relationships further. It is hypothesised that the higher the reported carers’ perceived burden the more likely their requirement to formally place their care recipient. Furthermore, institutionalisation of care recipients is also likely the poorer carers’ perceived quality of life.

**Method**

**Design**

Although this study employed both quantitative and qualitative methodology, this research paper will focus on the quantitative component. The study comprised a research survey design utilising a web-based self-administered questionnaire. Questions were posed in yes/no and multiple choice formats, with the option of ‘other’ to provide qualitative responses.

**Participants**

Participants consisted of 59 volunteer self-selected informal caregivers of family members diagnosed with probable Dementia residing in Australia. These individuals were recruited via links on the Carers Australia website, the Alzheimer’s Australia’s *Dementia* e-newsletter, and
advertisements placed in major Australian newspapers. Five carers were excluded as they were not currently caring for a Dementia patient. The participant group therefore consisted of 45 female and 9 male caregivers, whose ages ranged from 18 to 82. With the exception of one reported Aboriginal or Torres Strait Islander (ATSI) care recipient, all carers and care recipients who participated in this study were Caucasian, and most were born in Australia. Participants represented a broad range of educational and social backgrounds, with many describing themselves as full-time carers who were retired and/or living on a pension.

Measures
The questionnaire consisted of 96 questions divided into ten domains. Domains examined both objective and subjective stress, and included carer and care recipient characteristics and context, the perceived health of the carer, the relationship dyad, carer levels of social support and formal resources, respite and recreation, their attitudes and beliefs, religion/spirituality, and their unmet needs.

Carer negative emotion was assessed using the Depression and Anxiety Stress Scale (DASS) (Lovibond & Lovibond, 1995). The DASS is comprised of three 14-item self-report scales that measure the negative emotional states of depression, anxiety and stress, and contain items such as I just couldn’t seem to get going, I was aware of dryness of my mouth, and I found myself getting upset by quite trivial things, respectively. Subjects rate the extent to which they experienced each state over the past week on the measures’ 4-point Likert Scale, which ranges from did not apply to me (0) to applied to me very much, or most of the time (3). The measure has been shown to have good internal consistency, with alpha coefficients for the three scales reported by the authors as being: .91 for depression, .84 for anxiety, and .90 for stress (n = 2,914). Aggregated DASS (Lovibond & Lovibond, 1995) scores identified that carers in this sample were located within the normal range for the subscales. Alpha coefficients for the three scales were .94 (depression), .77 (anxiety), and .93 (stress), respectively.

Ethical Issues
Approval for the study was obtained from the relevant local research ethics committee.

Results
Table 1 presents frequency distributions for caregiver and care recipient characteristics and context.
Table 1: Caregiver and Care Recipient Characteristics and Context

<table>
<thead>
<tr>
<th>Caregiver</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td>Male: 16.7%</td>
</tr>
<tr>
<td></td>
<td>Female: 83.3%</td>
</tr>
<tr>
<td>Age</td>
<td>18 – 82 years</td>
</tr>
<tr>
<td></td>
<td>MAge: 59.1 (SD=13.35)</td>
</tr>
<tr>
<td>Ethnicity</td>
<td>Caucasian: 100%</td>
</tr>
<tr>
<td>Origin</td>
<td>Australia: 68.5%</td>
</tr>
<tr>
<td>Relation to care recipient</td>
<td>Male carers: spouses/partners: 66.6%</td>
</tr>
<tr>
<td></td>
<td>parents/in-laws: 22.2% family</td>
</tr>
<tr>
<td></td>
<td>other relatives: 11.2% only family</td>
</tr>
<tr>
<td></td>
<td>Female carers: parents/in-laws: 52.1%</td>
</tr>
<tr>
<td></td>
<td>male &amp; spouses/partners: 39.2% family</td>
</tr>
<tr>
<td></td>
<td>other relatives: 8.7% family</td>
</tr>
<tr>
<td>Education</td>
<td>Degree: 37%</td>
</tr>
<tr>
<td>Employment</td>
<td>Retired/pension: 57.4%</td>
</tr>
<tr>
<td></td>
<td>Full-time employment: 18.5%</td>
</tr>
<tr>
<td>Income per week (after tax)</td>
<td>$180 - $1300</td>
</tr>
<tr>
<td></td>
<td>&lt;$350: 28.5%</td>
</tr>
<tr>
<td>Additional dependents</td>
<td>35.2%</td>
</tr>
<tr>
<td>Caregiving status</td>
<td>Sole carers: 48.1%</td>
</tr>
<tr>
<td></td>
<td>Share with family: 22.2%</td>
</tr>
<tr>
<td></td>
<td>Share with spouse/partner: 13%</td>
</tr>
<tr>
<td></td>
<td>Share with nurse/aid: 9.3%</td>
</tr>
<tr>
<td>Residence</td>
<td>Co-residing: 61.1%</td>
</tr>
<tr>
<td>Caregiving hrs per day</td>
<td>24hr care provision: 31.5%</td>
</tr>
<tr>
<td>Years spent caregiving</td>
<td>MYears: 4.78</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Care Recipient</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td>Male: 50%</td>
</tr>
<tr>
<td></td>
<td>Female: 50%</td>
</tr>
<tr>
<td>Age</td>
<td>53 – 95 years</td>
</tr>
<tr>
<td></td>
<td>MAge: 78.5 (SD=9.65)</td>
</tr>
<tr>
<td>Ethnicity</td>
<td>Caucasian: 90.7%</td>
</tr>
<tr>
<td></td>
<td>Aboriginal or Torres Strait Islander (ATSI): 1.9%</td>
</tr>
<tr>
<td>Origin</td>
<td>Australia: 63%</td>
</tr>
<tr>
<td>Education</td>
<td>High school: 46%</td>
</tr>
<tr>
<td>Level of Dementia</td>
<td>Stages 4 - 7: 81.5%</td>
</tr>
<tr>
<td>Impairment</td>
<td>(moderate to very severe cognitive decline)</td>
</tr>
<tr>
<td>Level of dependency</td>
<td>Mild – Total</td>
</tr>
<tr>
<td></td>
<td>Severe: 27.8%</td>
</tr>
</tbody>
</table>

Frequency distributions for the variables from the conceptual model are presented in Table 2.
Table 2: Frequency distributions of primary stressors, primary appraisals, mediators, secondary appraisals, and outcomes

<table>
<thead>
<tr>
<th>Category</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Care recipient behavioural problems (Primary Stressor) - yes</td>
<td>31</td>
<td>62.0</td>
</tr>
<tr>
<td>Provision of Dementia-related information (Primary Stressor)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>What Dementia is?</td>
<td>24</td>
<td>49.0</td>
</tr>
<tr>
<td>What you could expect to encounter, as a carer, as the disease progresses?</td>
<td>15</td>
<td>30.6</td>
</tr>
<tr>
<td>What drugs or other treatments are currently available?</td>
<td>24</td>
<td>49.0</td>
</tr>
<tr>
<td>That Dementia is currently fatal?</td>
<td>9</td>
<td>18.4</td>
</tr>
<tr>
<td>GP or specialist did not provide any information.</td>
<td>20</td>
<td>40.8</td>
</tr>
<tr>
<td>Perceived impact on carer health (Primary Appraisal)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Low impact</td>
<td>23</td>
<td>46.0</td>
</tr>
<tr>
<td>High impact</td>
<td>27</td>
<td>54.0</td>
</tr>
<tr>
<td>Forfeited life (Primary Appraisal)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Your employment or business?</td>
<td>12</td>
<td>25.5</td>
</tr>
<tr>
<td>Former activities (i.e. church)?</td>
<td>17</td>
<td>36.2</td>
</tr>
<tr>
<td>Socialising with friends?</td>
<td>24</td>
<td>51.1</td>
</tr>
<tr>
<td>Sports (i.e. walking, tennis, golf)?</td>
<td>11</td>
<td>23.4</td>
</tr>
<tr>
<td>Interests (i.e. hobbies, groups)?</td>
<td>18</td>
<td>38.3</td>
</tr>
<tr>
<td>Nothing, my life is much the same as before.</td>
<td>12</td>
<td>25.5</td>
</tr>
<tr>
<td>Unmet Needs (Primary Appraisal)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Help with activities of daily living (ADL) (bathing, dressing, feeding)</td>
<td>15</td>
<td>31.3</td>
</tr>
<tr>
<td>Assistance with instrumental activities of daily living (IADL) (shopping, cooking, household chores)</td>
<td>20</td>
<td>41.7</td>
</tr>
<tr>
<td>Help with managing care recipient behaviour (memory loss, wandering, personality change)</td>
<td>14</td>
<td>29.2</td>
</tr>
<tr>
<td>Assistance with care at night or at special times during the day</td>
<td>18</td>
<td>37.5</td>
</tr>
<tr>
<td>Assistance from formal support (case management, training, counselling, legal or financial services)</td>
<td>19</td>
<td>39.6</td>
</tr>
<tr>
<td>Information (medical, Medicare, about Dementia, about nursing homes)</td>
<td>19</td>
<td>39.6</td>
</tr>
<tr>
<td>More support from your family and friends</td>
<td>25</td>
<td>52.1</td>
</tr>
<tr>
<td>Isolation (Primary Appraisal) - yes</td>
<td>24</td>
<td>48.0</td>
</tr>
<tr>
<td>Caregiving satisfaction (Mediator) - no</td>
<td>26</td>
<td>56.5</td>
</tr>
<tr>
<td>Perceived burden (Secondary Appraisal)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Low burden</td>
<td>26</td>
<td>56.5</td>
</tr>
<tr>
<td>High burden</td>
<td>20</td>
<td>43.5</td>
</tr>
<tr>
<td>Quality of life (Secondary Appraisal)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Good</td>
<td>16</td>
<td>32.0</td>
</tr>
<tr>
<td>Poor</td>
<td>34</td>
<td>68.0</td>
</tr>
<tr>
<td>Requirement of care recipient institutionalisation - yes</td>
<td>23</td>
<td>50.0</td>
</tr>
</tbody>
</table>

Note. N and corresponding percentages change according to the number of participants who answered the questions.

Chi-square ($\chi^2$) tests of contingencies were undertaken to analyse the relationships between caregiver stressors; namely care recipient Dementia-related behavioural problems.
and provision of information associated with Dementia (primary stressors), perceived impact on carers’ health, forfeited life, carer unmet needs, isolation (primary appraisals), caregiving satisfaction (mediator), and carer perceived burden and quality of life (secondary appraisals) on the requirement for care recipient formal institutionalisation (outcome). Table 3 presents these results.

Table 3: Chi-square ($\chi^2$) test of contingencies of caregiver stressors on need for care recipient institutionalisation

<table>
<thead>
<tr>
<th>Dependent Variable</th>
<th>Independent Variable</th>
<th>Control</th>
<th>$\phi$</th>
<th>$p$</th>
<th>Var%</th>
</tr>
</thead>
<tbody>
<tr>
<td>NCRI</td>
<td>PB</td>
<td>-</td>
<td>.35</td>
<td>.017</td>
<td>12.25</td>
</tr>
<tr>
<td>NCRI</td>
<td>PB</td>
<td>BP</td>
<td>.42</td>
<td>.025</td>
<td>17.64</td>
</tr>
<tr>
<td>NCRI</td>
<td>PB</td>
<td>EMP</td>
<td>.71</td>
<td>.013</td>
<td>50.41</td>
</tr>
<tr>
<td>NCRI</td>
<td>PB</td>
<td>SOC</td>
<td>.39</td>
<td>.05</td>
<td>15.21</td>
</tr>
<tr>
<td>NCRI</td>
<td>PB</td>
<td>HUN</td>
<td>.56</td>
<td>.036</td>
<td>31.36</td>
</tr>
<tr>
<td>NCRI</td>
<td>PB</td>
<td>I</td>
<td>.56</td>
<td>.007</td>
<td>31.36</td>
</tr>
<tr>
<td>NCRI</td>
<td>PB</td>
<td>CS</td>
<td>.44</td>
<td>.024</td>
<td>19.36</td>
</tr>
<tr>
<td>NCRI</td>
<td>QoL</td>
<td>-</td>
<td>-.46</td>
<td>.002</td>
<td>21.16</td>
</tr>
<tr>
<td>NCRI</td>
<td>QoL</td>
<td>BP</td>
<td>-.52</td>
<td>.006</td>
<td>27.04</td>
</tr>
<tr>
<td>NCRI</td>
<td>QoL</td>
<td>NWAD</td>
<td>-.55</td>
<td>.008</td>
<td>30.25</td>
</tr>
<tr>
<td>NCRI</td>
<td>QoL</td>
<td>NWCE</td>
<td>-.44</td>
<td>.014</td>
<td>19.36</td>
</tr>
<tr>
<td>NCRI</td>
<td>QoL</td>
<td>NWD</td>
<td>-.59</td>
<td>.005</td>
<td>34.81</td>
</tr>
<tr>
<td>NCRI</td>
<td>QoL</td>
<td>NWADF</td>
<td>-.48</td>
<td>.003</td>
<td>23.04</td>
</tr>
<tr>
<td>NCRI</td>
<td>QoL</td>
<td>NPWI</td>
<td>-.60</td>
<td>.011</td>
<td>36.00</td>
</tr>
<tr>
<td>NCRI</td>
<td>QoL</td>
<td>HHI</td>
<td>-.39</td>
<td>.05</td>
<td>15.21</td>
</tr>
<tr>
<td>NCRI</td>
<td>QoL</td>
<td>SOC</td>
<td>-.49</td>
<td>.017</td>
<td>24.01</td>
</tr>
<tr>
<td>NCRI</td>
<td>QoL</td>
<td>INT</td>
<td>-.50</td>
<td>.034</td>
<td>25.00</td>
</tr>
<tr>
<td>NCRI</td>
<td>QoL</td>
<td>HUN</td>
<td>-.70</td>
<td>.009</td>
<td>49.00</td>
</tr>
<tr>
<td>NCRI</td>
<td>QoL</td>
<td>I</td>
<td>-.47</td>
<td>.025</td>
<td>22.09</td>
</tr>
<tr>
<td>NCRI</td>
<td>QoL</td>
<td>CS</td>
<td>-.45</td>
<td>.020</td>
<td>20.25</td>
</tr>
</tbody>
</table>

Note. Only significant relationships are listed. NCRI = need to institutionalise care recipient. PB = carer perceived burden. QoL = carer perceived quality of life. BP = care recipient AD-related behavioural problems. NWAD = provision of information: what AD is, not provided. NWCE = provision of information: what to expect to encounter, not provided. NWD = provision of information: treatment/drugs available, not provided. NWADF = provision of information: AD is fatal, not provided. NPWI = information provision: not provided with any AD-related information. HHI = carer high health impact. EMP = carer forfeited life areas: employment/business. SOC = carer forfeited life areas: socialising with friends. INT = carer forfeited life areas: interests. HUN = carer high unmet needs. I = isolation. CS = caregiving satisfaction.

A Mann-Whitney U analysis was undertaken to compare carer perceived quality of life to the presence, or absence, of feelings of isolation. This analysis revealed a significant difference ($z = -3.412$, $p = .001$, $r = .48$) in carer perceived quality of life between carers who felt isolated, and those who did not.
Discussion
In addition to identifying caregiving stressors that impact informal carers’ perceived burden and quality of life, and which may necessitate the need for institutionalisation of care recipients, the study proposed a conceptual model of Dementia caregiver burden, and also examined the relationships between the secondary appraisal variables; carer perceived burden and quality of life, with the outcome variable; the carers’ need for formal placement of their care recipient. Results suggest that carer perceived burden (PB) explained 12.25% of the variance in carer need for institutionalisation of care recipient (NCRI). Moreover, carer perceived quality of life described 21.16% of the variance. The implication of these findings provide support for the hypotheses that the higher the reported carers’ perceived burden and poorer their perceived quality of life, the more likely their care recipients will be placed in formal care. Additionally, aggregated scores from the DASS (Lovibond & Lovibond, 1995) corroborate the low levels of perceived burden self-reported by 56% of carers in the sample. The remaining factors; namely care recipient Dementia-related behavioural problems, provision of information associated with Dementia, perceived impact on carers health, forfeited life, unmet needs, isolation and caregiving satisfaction were used as control variables in order to explore these relationships further.

Care recipient Dementia-Related Behavioural Problems
Behavioural problems associated with Dementia, such as aggression, wandering, incontinence, agitation and depression are often reported as being among the most challenging and stressful aspects of caring for persons with Dementia. They also rank among the most important predictors of high levels of carer distress and formal care placement (Mittelman et al., 2004). Furthermore, managing large numbers of care recipient behavioural problems has been found to be associated with greater carer burden (Montoro-Rodriguez & Gallagher-Thompson, 2009). More than 60% of the care recipients in this sample were reported as displaying a number of Dementia-related behavioural issues. Consequently, when used as a control variable in the relationship between PB and NCRI, care recipient behavioural problems explained 17.64% of the variance. Likewise, they detailed 27.04% of the variance in the relationship between quality of life and NCRI. These results are consistent with findings from a number of earlier studies (Coen et al., 1997; Mittelman et al., 2004; Papastavrou et al., 2007), and provide support for care recipient Dementia-related behavioural problems as a significant contributor to caregiver burden and reduced quality of life.
Provision of Information Associated with Dementia

Despite general increases in service availability, informal carers often undertake their roles without outside information or support (Wackerbath & Johnson, 2002). Moreover, the diagnosis of Dementia is known to be frequently poorly communicated, with carers often dissatisfied with the little information or support they receive (Georges et al., 2008; Quinn et al., 2008). Lack of understanding of Dementia in its early stages, if left unremedied, may potentially impact on carers’ coping ability, may lead to attribution errors, and may impact on carers emotional and behavioural reactions to their care recipients (Paton et al., 2004; Quinn et al., 2008). A number of caregivers in the sample reported several deficits in the provision of Dementia-related information. Of particular concern, is that 20 carers reported that their general practitioner (GP)/specialist had not provided any Dementia-related information at the time of initial diagnosis. Not surprisingly, not being provided with any Dementia-related information accounted for 36.00% of the variance in QoL-NCRI. These results are consistent with Coen et al.’s (2002); Georges et al.’s (2008); Montoro-Rodriguez and Gallagher-Thompson’s (2009); Paton et al.’s (2004); Quinn et al.’s (2008); and Wackerbath & Johnson’s (2002) earlier research outcomes, and suggest that lack of provision of information related to Dementia adds significantly to reduced caregiver quality of life (Georges et al., 2008).

Caregiver Health

Dementia caregivers frequently experience emotional, physical, social and financial losses which increase as the disease progresses. As a result, high rates of caregiver depression and anxiety have been identified by large numbers of studies (Serrano-Aguilar, Lopez-Bastida, & Yanes-Lopez, 2006). Evidence linking Dementia caregiving to negative mental health outcomes appears compelling; however the association between caregiving and negative physical health outcomes is more equivocal. Nevertheless, perceived impact on health has important implications particularly as negative health outcomes may compromise caregivers’ ability to provide continued care (Connell, Janevic, & Gallant, 2001). More than half of the carers in the current sample reported that their care recipients’ illness had impacted considerably on their own health, with self-reported highly burdened carers identifying high health impact and multiple symptomology. High health impact was consequently found to account for 15.21% of the variance in QoL-NCRI. This implies that poor self-rated mental and physical health may result in a reduction in carer perceived quality of life, and an increased requirement for institutionalisation of the care recipient.
Caregiver Forfeited Life

Caregiving is also known to limit carer participation in a number of roles as the disease progresses (Serrano-Aguilar et al., 2006). This can result in financial strain, stress on personal relationships, and negative changes in carers’ emotional and physical health (Roberto & Jarrott, 2008). Carers in this study reported forfeiting their employment/businesses, socialising with friends, and sacrificing sports, activities and interests. When used as a control in the relationship between PB-NCRI, the forfeited aspect of employment/business accounted for a substantial 50.41% of the variance. This implies that sacrificing ones employment/business impacts considerably on caregiver burden, and subsequent longevity in the caregiving role. While the burden resulting from loss of livelihood and its corresponding financial pressures are more clearly identified, other forfeited areas of life are not so easily quantified. This is particularly true of aspects of life that would also be considered stress mediators, such as socialising with family and friends, and participation in sport, social activities and interests. The various areas of caregiver forfeited life therefore appear to add significantly to caregiver perceived burden, reduced quality of life, and the increased likelihood of care recipient institutionalisation. These results provide support for Black et al.’s (2010); Roberto & Jarrott’s (2008); and Serrano-Aguilar et al.’s (2006) earlier findings.

Caregiver Unmet Needs

Unmet needs relate to the conditions that exist when the burden of providing care exceeds carer resources or creates deficits in their life. Unmet needs can therefore be both objective and subjective, and in addition to impacting caregivers, may also be an important indicator of quality of life for care recipients (Gaugler et al., 2004; Gaugler et al., 2005). Carers in this study who reported high unmet needs also reported deficits across a number of areas. Of particular interest, is that more than half of the carers in the sample reported additional support from family and friends as their most important unmet need. High levels of unmet needs was consequently used as a control between PB-NCRI, and was found to account for 31.36% of the variance. Similarly, it described a sizeable 49% of the variance in QoL-NCRI. These findings corroborate earlier research outcomes (Gaugler et al., 2004; Gaugler et al., 2005; Quinn et al., 2008). Moreover, results suggest that multiple areas of deficit have a large negative impact on carer perceived quality of life, and time subsequently spent in the caregiving role.

Isolation

The demands of caring for a person with Dementia can lead to carers becoming isolated and experiencing relational deprivation owing to loss of relationships, normative roles and social
contacts (Roberto & Jarrott, 2008). This can severely impact carers at a time when they may need support the most, with carers who report high limitations in their social lives also found to experience an increase in degree of burnout (Almberg et al., 1997; Quinn et al., 2008). Caregiver perceived isolation was therefore used as a control between PB-NCRI, and was found to explain 31.36% of the variance. It also described 22.09% of the variance in QoL-NCRI. Moreover, results from Mann-Whitney U analysis suggest that isolation significantly reduces caregiver quality of life. Findings from this study provide support for isolation as a significant stressor impacting carer perceived burden, quality of life and requirement to institutionalise the care recipient. Moreover, these outcomes are consistent with Papastavrou et al.’s (2007) and Roberto and Jarrott’s (2008) earlier observations.

**Caregiving Satisfaction**

Informal carers of persons with Dementia experience both positive and negative experiences during the course of caregiving. Moreover, satisfaction and reciprocity within the caregiving relationship has been identified as one of the strongest buffers against negative stress. While investigations have predominantly focused on the negative aspects associated with informal caregiving, more recent research has included explorations of its rewards and satisfaction (Andren & Elmstahl, 2005). Results from this study identified that self-reported low burden carers tended to view caregiving as a positive satisfying experience, while high burden carers did not share in this belief. Consequently, when used as a control between PB-NCRI, lack of caregiving satisfaction described 19.36% of the variance. Likewise, it explained 20.25% of the variance between QoL-NCRI. These outcomes suggest that the presence of caregiving satisfaction can be viewed as a stress mediator, whereas lack of caregiver satisfaction appears to contribute towards carer perceived burden and reduced quality of life. Results therefore provide support for caregiver satisfaction as a mediator in the proposed conceptual model.

The ability to see opportunities for personal growth in the midst of hardship may consequently distinguish carers who thrive from those who are overwhelmed by the demands of caregiving (O’Rourke et al., 2010). Individual differences in carer responses indicate that some carers adapt well to challenges over time, while others experience continuing and increasing burden and strain, even after institutionalisation and/or the demise of the care recipient (Serrano-Aguilar et al., 2006). This may result in burnout; a state of emotional exhaustion brought about by excessive emotional and psychological demands. Highly burdened informal carers of persons with Dementia are therefore at considerable risk of burnout, and subsequent need for formal placement of their care recipients (Yilmaz et al., 2009). Not surprisingly, a common reason for admission of Dementia care recipients to
formal institutions is the need to relieve informal carers of their caregiving responsibilities. This suggests that if primary caregivers are provided with adequate support, care recipient admissions to nursing homes or hospitals may be delayed or even prevented (Rees et al., 2001). It is therefore proposed that addressing care recipient behavioural problems associated with Dementia, and providing carers and care recipients with ample Dementia-related information and needs assistance at time of initial diagnosis, and throughout the various stages of the caregiving journey, could significantly decrease the deleterious impact on carers’ health and feelings of isolation, and may also restore many of the forfeited areas of their lives. Moreover, it would most likely improve their caregiving experience, thereby diminishing perceived burden and increasing quality of life. This could reduce, if not eliminate, their need for formal institutionalisation of their care recipients. Additionally, as research indicates that caregiver burden continues following informal care, interventions should therefore address caregiver needs until such time as they are no longer required by the caregiver instead of automatically ceasing at time of care recipient institutionalisation or demise (Gaugler et al., 2004).

Undoubtedly the responsibility of caring for a family member with Dementia rests almost entirely on informal caregivers. Without their valuable contribution, the encumbrance on healthcare and social services would be overwhelming. The long-term well-being of carers should therefore be a major concern for governments, particularly in countries such as Australia, which will experience high rates of ageing and scarcity of formal and informal resources to support the needs of caregiving families and friends (Burns, 2000; Serrano-Aguilar et al., 2006).

A number of limitations to this study have been identified. The small sample is representative only of the carers who responded to this survey, and therefore findings cannot be generalised to all caregivers of persons with Dementia. Moreover, the moderate response rate may reflect response bias. Additionally, a criticism of survey-based research is that it is unable to control for extraneous variables, and may therefore lack internal validity. As it is both unethical and impractical to undertake laboratory-based experimentation to ascertain caregiver burden, this type of research design is better suited to the purpose. This study is therefore predominantly descriptive in nature, and the resulting observations serve only to identify interesting associations and not causal linkages. The cross-sectional design also limits its ability to examine changes over time. Additionally, while non-parametric analysis is less statistically powerful than the parametric alternative, it is more appropriate for data that does not meet the assumption of normality. Furthermore, information provided by carers
relied on their self-reported subjective experience without any independent observer-based assessment. It should be noted, however, that it was an aim of this study to ascertain caregiver perceptions of their situation. Moreover, responses on self-administered questionnaires may not be entirely truthful, however research has identified that web-based surveys tend to elicit more honest responses than face-to-face interviews. Additionally, the length of the questionnaire may have resulted in some drop-outs. Future research may therefore benefit from addressing these issues, together with exploring the remaining variables within the proposed conceptual model of Dementia caregiver burden.

This study contributes to existing knowledge through the development of a comprehensive measure based on established research outcomes to identify highly burdened Dementia caregivers. Moreover, a conceptual model of Dementia caregiver burden that builds on the existing stress, appraisal and coping frameworks was proposed. Furthermore, this is one of a few Australian studies beginning to examine factors related to Dementia caregiver perceived burden, quality of life, and the requirement to institutionalise the care recipient. It is also one of very few studies examining the Australian informal Dementia caregiver experience.

References


Pilot Skills Group for Teen Girls who Self-Harm

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Surfers Paradise, Gold Coast (QLD), 25-27 August 2014
Pilot Skills Group for Teen Girls who Self-Harm

ABSTRACT: While suicide is the leading cause of death among people aged 14-24 (ABS, 2012), around 300 young Australians died by suicide in 2010, a much larger number deliberately injure themselves. It is estimated that about 7% of young people harm themselves each year, mostly young females, and that up to a quarter of young people will harm themselves during their lifetime (De Leo & Heller, 2004). Boyce et al. (2003) found that, beyond immediate emergency medical and psychiatric care, psychological interventions that focus on teaching new coping and problem solving strategies were effective in reducing morbidity associated with self-harm behaviours. These interventions included cognitive behaviour therapy, which helped reduce morbidity, and dialectical behaviour therapy (DBT) reduced self-harm behaviours, and group interventions were particularly helpful (Ougrin et al., 2012). This paper describes a pilot service innovation project that delivered a clinical intervention for self-harming teen girls (n=7) aged 13-18 within a community psychology clinic. The intervention taught DBT skills in a small group of teens not meeting diagnostic criteria for borderline personality disorder over 10 weeks, and we examined its effect on psychological distress, DBT skills usage, maladaptive coping, and mindfulness, predicting these would change in the healthy direction. One participant was excluded from analyses due to severe psychopathology that affected her ability to participate in the group. Repeated measures t-tests showed that dysfunctional coping decreased significantly (p = .02) and mindfulness significantly improved (p < .01), however psychological distress and use of DBT skills change in the positive direction but did not reach statistical significance. Qualitative data also demonstrated a benefit of group interaction akin to peer coaching and some participants ceased self-harm. This pilot represents a very limited sample and research is ongoing.

Background
Increases in youth suicide has been evident since the 1960s and research expanded appropriately (De Leo & Evans, 2003), however it is only in the last decade that focus has turned to the vastly more prevalent and growing problem of adolescent self-harm (Fox & Hawton, 2004). For example, it is estimated that young people are 40 to 100 times more likely to engage in self-harm than complete suicide (Fox & Hawton, 2004), with significant associated morbidity and increased risk of death by suicide or misadventure (Boyce, Carter, Penrose-Wall, Wilhelm, & Goldney, 2003; Zahl & Hawton, 2004). Research also indicates
that self-harm is much higher among adolescents than adults, with 6% to 7% of Australians aged 15 to 24 years engaging in self-harm over a 12 month period (De Leo & Heller, 2004). Furthermore, the incidence of adolescent self-harm is rising, with a 43% increase in ten years to 2006 (Eldridge, 2008), and peak onset appears to be related to puberty rather than chronological age, suggesting a developmental risk associated with sexual maturation (Hawton, Saunders, & O'Connor, 2012). Gender also appears to play a role in self-harm, with reports that females are 3 to 4 times more likely to engage in this behaviour (De Leo & Heller, 2004; Moran et al., 2012; Wright, Hooke, Neupert, Nyein, & Ker, 2013; Fox & Hawton, 2004). There is also evidence that females are more likely to persist with self-harm behaviour (Moran et al., 2012), and this may be associated with an increased risk of developing an affective disorder (Fergusson, Horwood, Ridder, & Beaurtrais, 2005), suicidal intent, completed suicide, as well as some emerging support for reduced life expectancy from accidental death and digestive-system disease following alcohol consumption and self-harm (Wilkinson et al., 2011; Hawton et al., 2012; Caine, 2012). While this research is a recent development, adolescent self-harm is now considered a serious health problem with multiple negative consequences and serious risks especially among pubescent females.

Despite progress in the psychological assessment and treatment of suicidal thoughts and behaviours (e.g., Linehan et al., 2006; De Leo & Heller, 2004), self-harm continues to be poorly understood (Joiner et al., 2005; Nock, Prinstein, & Sterba, 2009). This has prompted contemporary researchers to more closely examine elements of self-harm. A recent study conducted by Nock et al. (2009) assessed suicidal and non-suicidal self-harm in real-time to further explore the fundamental aspects of this behaviour. It appears that self-harm may be used by some adolescents as a strategy for coping with distress in response to negative life events and to alleviate rumination. For example, Scoliers et al. (2009) studied 30,477 self-harming adolescents across seven countries and found that self-harm was commonly used to obtain relief from a difficult state of mind. Furthermore, Hall, Elliott, and Place (2010) found an association between self-harm (cutting) and tension reduction, non-coping, and self-blame. Other factors found to be involved with self-harm include interpersonal difficulties, including peer influences and family problems (Conte, 2004; Nixon, McLagan, Landell, Carter, & Deshay, 2004; Nock et al., 2009; Wright et al., 2013).

Practise guidelines for management of self-harm (Boyce et al., 2003) emphasise therapeutic interventions that focus on increasing coping behaviours and problem solving, and problem-solving has shown particularly promising results in reducing self-harm, hopelessness, and levels of depression in participants that self-harm (Townsend et al., 2001;
Hawton et al., 1998). However, reports of findings are limited, and confounding factors, such as interpersonal issues, have been suggested to mediate the reduction in long-term repetitive self-harm (Townsend et al., 2001). Other strategies have been shown to be helpful. For example, Gratz and Gunderson (2006) found emotion regulation strategies helpful for individuals with borderline personality disorder who self-harm. They showed positive effects on problems with emotion dysregulation, experiential avoidance, and self-harm. Additionally, there is emerging support for mindfulness, a form of simplified directed meditation, in assisting those who self-harm (Nixon et al., 2004), and Lundh, Karim, and Quilisch (2007) found that increased self-harm was associated with poor adoption of mindfulness. Additionally, while there are no reports of mindfulness interventions for self-harm in adolescents (Thompson & Gauntlett-Gilbert, 2008; Burke, 2010), a report by the Garrison Institute showed some promise for mindfulness in young people aged 5 to 18 years, including increased self-reflection, emotional intelligence, social skills, and self-awareness (Schoeberlein & Koffler, 2005).

One intervention that has been successful in reducing chronic self-harm and suicidality associated with Borderline Personality Disorder (BPD) is Linehan’s (1993) Dialectical Behaviour Therapy (DBT) programme. DBT involves teaching effective coping strategies for regulating emotions and managing distress. It includes group and individual training in mindfulness, distress tolerance, emotion regulation, and interpersonal effectiveness. There is substantial support for DBT as an effective therapy for BPD (Linehan, Armstrong, Suarez, Allmon, & Heard, 1991), and there has also been good effect shown in reducing self-harm (e.g. Linehan et al., 1991; Goldstein, Axelson, Birmaher, & Brent, 2007; James, Taylor, Winmill, & Alfoadari, 2008). For example, James et al. (2008) examined the outcome of DBT on 16 self-harming adolescent females and found reduced self-harm, but also improved mood and general functioning, and reduced hopelessness, and these outcomes were maintained for 8 months. Several other studies have supported DBT applied to adolescents who self-harm and exhibit suicidality (e.g. Goldstein et al., 2007; James et al., 2008; Fischer, & Peterson, 2014). While, these studies show reductions in self-harm and suicidality, they do not examine whether the core skills are adopted by the young person, and most studies are limited to clinical samples of BPD. Finally, DBT is an expensive, long-term therapy that requires a substantial investment of client and therapist time; not well suited to general clinical practice with self-harming adolescents. The current study aimed to examine if adolescent females who self-harm are able to learn and use DBT skills taught in a brief group therapy programme. The programme taught skills in mindfulness, distress tolerance, emotion...
regulation and interpersonal effectiveness. We were also interested to observe whether their self-harm behaviour changed.

**Methods**

*Participants*

Seven teenage females agreed to participate in a pilot skills group for self-harm. One was excluded from the study due to severe psychopathology that affected her ability to participate in the group. Mean age was 15.17 years (SD = 1.60), ranging from 13 to 18 years. Participants were recruited after an intake interview, which screened for severity of symptomology and risk of harm. Participants with severe symptoms or high risk were referred to the local acute care team. Five participants were engaged concurrently in individual counselling, and all had access to individual and telephone counselling services if desired. While, several participants missed at least one session, there were no drop outs.

*Treatment*

Developed by Linehan as a psychotherapy to treat chronic suicidality, and later as a treatment programme for borderline personality disorder, DBT combines concepts of cognitive-behavioural therapy, distress tolerance, mindfulness, acceptance, and reality testing (Dimeff & Linehan, 2001). In this study, components of DBT were delivered to participants in weekly group therapy over ten 1.5hr sessions within a community psychology clinic. The programme was based on DBT skills training including four modules of core mindfulness, distress tolerance, emotion regulation and interpersonal effectiveness (Linehan, 1993; Miller, Rathus and Linehan’s, 2007). A youth reference group provided advice on youth relevance and acceptability.

Weekly sessions included learning activities and concept reviews, homework tasks and provided ample opportunity to practice skills. The first session introduced the therapists and clients, and programme concepts and boundaries, as well as states of mind. The second session introduced mindfulness, and involved activities associated with “what” and “how” DBT skills. Session three focussed on distress tolerance skills, including distraction techniques, self-soothing, and skills for improving the moment; receptive to a task involving holding an ice cube. The fourth session continued on distress tolerance, involving pros and cons of coping, introducing the half-smile and radical acceptance, and mindfulness activities. Session five introduced emotional regulation, focussing on emotions and their function, and skills in reducing emotional and cognitive vulnerability. The sixth session continued on
emotional regulation, with concepts of emotional balance, such as increasing positive emotions, reducing uncomfortable emotions, and concept of opposite to emotion action. The seventh session introduced interpersonal effectiveness, including sharing and listening skills. Session eight continued with interpersonal effectiveness and improving communication with family and friends, such as GIVE and FAST concepts, as well as Walking the Middle Path (Miller, Rathus & Linehan, 2007). The ninth session introduced behavioural chain analysis. The final session consisted of programme review, termination and celebration.

**Measures**

Participants completed pre and post treatment measures to assess dysfunctional coping and DBT skills, mindfulness abilities, and global distress. Participant comments on self-harm behaviours and interpersonal interactions were noted for later analysis.

The DBT-Ways of Coping Checklist (WCCL) was used to assess dysfunctional coping and uptake of DBT skills. The WCCL is a 59 item questionnaire with responses recorded on a 4-point Likert scale. The WCCL has shown good to excellent principal components, internal consistency ($\alpha = 0.84-0.96$) test-retest reliability ($r = 0.66-0.73$, $p<0.001$), and content validity (Neacsiu, Rizvi, Vitaliano, Lynch, & Linehan, 2010).

The Southampton Mindfulness Questionnaire (SMQ) measured facets of mindfulness, including keeping attention with difficult cognitions, being aware of cognitions, allowing cognitions to pass, and acceptance of difficult images and cognitions (Chadwick et al., 2008). The SMQ is a 16-item self-report questionnaire measuring mindfulness on a 7-point Likert scale. It was found to be internally reliable ($\alpha = 0.89$), with evidence of concurrent validity ($p < 0.001$). Chadwick and colleagues (2008) recommended the SMQ as a useful measure in practice and research.

Global distress was measured by the Kessler Psychological Distress Scale (K10). The K10 is a measure of psychological distress with ten items measured on a 5-point Likert scale. Andrews and Slade (2001) found the K10 was comparative to other mental health instruments, such as the quality of life instrument, GHQ, SF-12 and predictive of mental disorders. The K10 is considered a highly valid measure for psychological distress with excellent reliability ($\alpha = 0.93$) (Kessler et al., 2002) across diverse settings (e.g. Hides et al., 2007; Spies et al., 2009; Bert, Cornelius, Johan, Groothoff, van der Klink, & Brouwer, 2013).
Results
Pre and post treatment data were analysed using 2-tailed paired sample t-tests. Kolmogorov-Smirnov statistic revealed no significant abnormalities in distributions and there were no outliers in the sample. One participant did not provide a pre-treatment K10, and given the small sample size, results should be interpreted cautiously. Results are summarised in Table 1.

Table 1: Pre and Post Treatment Scores

<table>
<thead>
<tr>
<th>Measure</th>
<th>Pre-Treatment</th>
<th>Post-Treatment</th>
<th>t</th>
</tr>
</thead>
<tbody>
<tr>
<td>DBT Skills</td>
<td>1.4</td>
<td>1.77</td>
<td>-1.88</td>
</tr>
<tr>
<td>Dysfunctional Coping</td>
<td>2.11</td>
<td>1.61</td>
<td>3.29*</td>
</tr>
<tr>
<td>Mindfulness</td>
<td>41.30</td>
<td>49.17</td>
<td>-5.69**</td>
</tr>
<tr>
<td>Global Distress</td>
<td>31.40</td>
<td>28.00</td>
<td>1.38</td>
</tr>
</tbody>
</table>

Note: *p < .05, **p < .01

All results were in the predicted direction, with participants’ use of dysfunctional coping behaviours decreasing significantly over the 10 weeks of treatment (Cohen’s d = 1.90). Similarly, participants reported mindfulness abilities improved significantly (Cohen’s d = 3.29). While, participants’ global distress and DBT skills usage trended towards improvement, these results were not statistically significant and cannot be relied upon. Analysis of qualitative data revealed that some participants had ceased or reduced self-harming behaviour over the course of the treatment, and some appeared to form supportive interpersonal relationships within the group; however, further comment is unwarranted and requires additional investigation. Generally, the treatment was well tolerated; however some concepts (i.e. chain analysis and cognitive vulnerability) required multiple explanations and homework compliance was poor.

Discussion
This study sought to examine whether adolescent females who self-harm were able to learn and utilise DBT skills, mindfulness, distress tolerance, emotion regulation and interpersonal
effectiveness, taught in a brief group therapy programme pilot. We were also interested to observe whether their self-harm behaviour changed. Limited data supported a reduction in self-harm behaviour for some participants, and while this is consistent with previous research (James et al., 2008), requires more structured scientific investigation to make a reliable finding. As predicted, analyses revealed a positive change in the use of dysfunctional coping. These results were encouraging given known association between the use of dysfunctional coping strategies and self-harm (Nock et al., 2009; Hall et al., 2010). Additionally, results indicated an increase in the use of mindfulness, one of the core DBT targets. This finding is also encouraging as mindfulness has been associated with improved psychological functioning and reduced self-harm, as well as having potential in aiding in emotional intelligence, self-reflection, social skills, and self-awareness (Nixon et al., 2004; Schoeberlein & Koffler, 2005). The failure to find other statistically significant findings may be attributable to the small sample size in this study, a considerable limitation to this project. Additionally, the lack of a control group prevents the attribution of positive changes directly to the intervention. However, the results of this pilot suggest that a brief group intervention for self-harming teen girls based on DBT skills training is at least plausible as a cost effective early intervention. Further research should attempt to replicate these findings in a larger and more representative sample with a full experiment.
References


