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A Place for Healing in Mental Health Care and Recovery

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Abstract

This research utilises an autoethnographical approach to explore aspects of place that facilitate healing in mental health care. The work challenges the dominant paradigm of evidence based medicine, and its hierarchy of evidence which diminishes the value of the voice of experience. Autoethnography provides representational space to explore my plural and sometimes contradictory voices as service user, psychiatrist and researcher. Foregrounding my personal experience, in dialogue with that of 10 other service users, the data comprised historical writings (mine) and in-depth individual interviews, which were analysed thematically.

Descriptions of place were contextualised, with accounts of what it was like to be unwell and then how that changed, providing a way of understanding how place is implicated in healing. Mental illness is experienced as an existential disruption characterised by disconnection, fragmentation and suffering. Healing, understood as the intensely personal experience at the heart of recovery, is conceptualised as a journey of exploration that is hard work and takes time. Facilitating connections, we developed understanding; with time and practice, we integrated our hard earned wisdom, developing meaning and becoming whole: our suffering was transformed.

A place that was healing was one that provided safe haven; metaphorically holding us in a collaborative environment of care, hope and trust, while creating space and opportunities to develop and test the connections that underpinned healing. Opportunities place the possibility with the explorer, implying we are not passive (or even active) recipients of care; rather we are active participants, creating or making use of the multifarious opportunities available to us. More than the physical location and the people and structures within, place is an accumulation of interacting experiences. On these journeys of exploration we come to know places inside and out: redrawing our internal landscapes these places come to reside within us, integrated into our sense of ourselves.

Exploration of the subjective experience of illness and place offers the potential to better understand and inform service delivery and development. This thesis ends with reflections on the multivocality of autoethnography, and its potential extrapolation to multiperspectival contributions to wiser mental health care.

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This research has been immeasurably enriched by the contributions of the other participants; thank-you for your generosity, bravery, and wisdom. I hope your words will move and inspire others, as they have me.

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Part I: Setting the Scene for the Journey Ahead



Chapter one: And so it begins

June 1990: that is when I began my journey back to me.

On 21 June 1990 I was admitted to Ashburn Hall, a (private) psychiatric hospital in the southern regions of New Zealand. My anticipated two week stay stretched to a year; a year of exploration, and of healing. To make sense of that journey I need to go further back. Who can really say where it all began. For years my life had been limited by panic attacks. Now, I am able to understand their origin in my lack of confidence, in my struggles for self-esteem, but back then the panic was just incredibly frightening. I remember where it started, sitting having dinner in a restaurant with friends; I had been working hard, was probably sleep deprived as many of us were in those early house surgeon years. I remember beginning to feel unwell, hot and sweaty with a rising sense of anxiety and nausea. Scared that I was going to be sick, I made my excuses and headed out into the cool night air. With a sense of relief, I felt better. Initially I thought I must have a virus, but a few weeks later, again socialising over dinner, the same thing happened. Like so many with panic, I looked for a medical explanation: I must be hypoglycaemic, so I'd eat before I went out; maybe it was spicy food, or alcohol or... But change what I might, the episodes became more frequent and intense. It is hard to describe just how terrifying panic is; how strong is the urge to run. I never felt, as some do, that I would die (except of shame); my panic was that, sitting there at the dinner table or in that room full of people, I would faint or something more dramatic: I would lose control in the most basic way. Try as I might to sit through it, the fear inevitably drove me to leave the room; and then I began to avoid. Initially limited to dining out, I became very good at making excuses to arrive after dinner (my workload made that easy) but then my anxiety spread to other social situations.

The solution was to bury myself deeper in my work. The life of a junior doctor was an arduous one and it was easy to ignore the difficulties I was having; I was good at my job and there was always an excuse that let me avoid those more social and personal situations that filled me with anxiety. Even now it astounds me how competent I could be in some areas of my life, and how dysfunctional in others. There were periods of unhappiness, sometimes misery and perhaps depression, but generally I just 'got on with it' ... until I couldn't get on with it any more. I was working particularly long hours, training in obstetrics and gynaecology with a demanding and disparaging boss. I wasn't the first to fall over in that job; I woke up one morning and couldn't get myself to work.

I decided I needed some time out. Travel was to be the next solution and initially that seemed to work; I went months without a panic attack and enjoyed exploring new countries. With a pack on my back, and no timetable, I travelled on my own; firstly overland from Singapore to northern Thailand, then into Burma, trucking my way from Rangoon to Mandalay. I trekked to Everest base camp in Nepal, rode camels in Rajasthan, and sailed the coast of Turkey. I enjoyed the freedom, meeting new people in that fleeting, no expectations way that you do when travelling. But it couldn't go on for ever and not surprisingly, nearly a year later as I turned for home and a job in General Practice, my panic returned.

The next three years did not go well. I sought professional help; before long I was profoundly depressed, on increasing amounts of medication and then electroconvulsive therapy (ECT), or 'shock therapy' as it is colloquially known. A brief period of mood elevation while taking a new antidepressant earned me a diagnosis of bipolar disorder, eventually with the label of 'treatment resistance' (in medical terms this means that my illness was resistant not me). Looking back now it is hard to remember the desperation, and despair, of that time. Over those three years my periods of depression became longer, I was prescribed different drug combinations, and throughout repeatedly turned to ECT to give me relief, to get me (shock me) out of the black hole into which I descended (or maybe retreated). We tried all sorts of things: I travelled overseas to a specialist mood disorders unit, returning home to begin another round of ECT. My psychiatrist speculated on a seasonal effect, so religiously I sat in front of a light box morning and evening, as well as taking all my medications of course, but nothing seemed to work for long. Initially I would return to work between episodes of illness, but eventually that was lost to me too.

By early 1990 I was having regular ECT, was unable to work, and couldn't get out of my head that I wanted to die. I had lost my job, lost my home, and I had lost me. After three years of multiple medications, repeated admissions to hospital, inpatient and outpatient ECT, I needed to try something different. I went to Dunedin, a university town at the other end of the country from home, to be admitted to Ashburn Hall, a private psychiatric hospital utilizing a therapeutic community approach to treatment of mental illness. I would like to say that it was a well thought out decision. It wasn't; it was born out of desperation, and based on very little understanding of what I needed or where I was going. My reasoning, such as it was, was that I knew I had 'issues'; I needed to sort 'me' out, because if I couldn't deal with 'me' then how could I possibly deal with my illness. And so began my journey back to me. I went for two weeks, stayed for a year and my experience of that year forms the foundation of

this thesis and its question: ‘what makes a place a place of healing for the treatment of mental illness?’

After 12 months in hospital, I returned home to pack up and move back to Dunedin, having decided to continue my psychotherapy as an outpatient, and to begin re-establishing my life. This was no simple matter; I had been away from medicine for several years and, although stronger in some ways, the road was still rocky. The transition took time and support; with the assistance of a training agency for people with disabilities, I found supported work on a local herb farm. After six months I felt ready to take the next steps. While studying part-time at university (to get my brain going again, but also papers for ‘fun’: social anthropology, phenomenology of western religions and feminist theory, rather than the biochemistry, anatomy and physiology of medical school) I began sitting in at medical clinics, progressing in time to attending a General Practice training programme. Each step needed people that recognised my potential, offering their support, time and teaching. It also required me to take risks, to be disclosive; I couldn’t hide the facts of the previous few years if I was to get the support I needed.

In 1996, after several years of working in family medicine and five years after leaving the Hall, I decided to specialise in psychiatry. I had not intended, in my professional life, to keep my experiences secret (I thought they might be helpful) but that is in effect what happened. I remember as a junior psychiatric trainee I was invited, by a friend and fellow patient from the Hall, to speak to his support group. I was very strongly given the advice by my supervisor not to speak too openly about my experiences ‘until I had established myself as a psychiatrist’. So I declined the invitation and continued to stay quiet for many years; not hidden, just quiet.

My first position as a psychiatric registrar (trainee) involved after-hours visits to Kingseat Hospital, a 1920’s psychiatric institution in rural south Auckland. Kingseat’s closure and move, six months later, to a purposely built acute mental health unit in the grounds of the regional general hospital was part of the shift to community based care. Embracing shorter hospital stays, the latter’s emphasis seemed to me to be on containment of risk, medication management, and sometimes diagnostic clarification. I love my work but have long been aware of the difference between my last hospital experience and that available to the patients I treat. In 2009, nearly 20 years after I left the Hall, I was on holiday in France (en-route to the World Congress of Biological Psychiatry):

It is June 2009; we have spent the day driving through the countryside of Provence (Southern France), arriving in St Remy-de-Provence in the late afternoon. Our pension is across the road from Saint Paul de Mausole, the mental hospital, or asylum, where the artist Vincent Van Gogh spent the last year of his life, 1889-90. This was to be one of the most prolific periods of his painting career completing over 150 canvases, many capturing the views and light of the local surroundings. We visit the asylum, olive groves border the long driveway – are these the same olive trees that Van Gogh painted? The tourist information suggests they are. The asylum itself is an old stone-block building, still functioning as a psychiatric hospital today. We have access to one wing, now a cultural centre, climbing the wide sweeping staircase to a 1st floor room that replicates Van Gogh's bedroom. I remember the light pouring through the windows as we climbed the stairs, and from his bedroom the view across the lavender fields and valley to the distant hills. It feels good; I feel uplifted and I am flooded with memories of Ashburn Hall. But then we cross the corridor to a room displaying the history and implements of psychiatric treatment of the time: tin bathtubs with restraining boards take centre stage in the shuttered-window space. The room is dark and I feel cold and heavy.

This region has a long history of healing. Adjacent to the asylum are the remains of Glanum, a Gallo-Roman village built on the site of a natural spring. Dedicated to Valetudo, the goddess of health, pilgrims have come to this spring for several thousand years to beg the goddess to grant them good health, leading in turn to the growth of the village of Glanum and subsequently, in the 11th century, a monastery tasked with the care of the sick, including those who were considered insane. During the French revolution of 1789 the monastery was nationalised and subsequently sold, becoming a psychiatric hospital, which continues today.

This visit to Saint Paul de Mausole began my PhD journey. I left the asylum reflecting on my reactions to the differing spaces within the building, the location's long-standing associations with healing and pilgrimage, and most significantly I began to question again my experiences at Ashburn Hall. What was it about the Hall that worked so well for me, when admissions to other places/hospitals had been (kindly) less successful or indeed (I could argue) detrimental? The research question 'what makes a place a place of healing for the treatment of mental illness?' has its origins in my concern that we still do not have it right with respect to the places in which we provide mental health care. In my work as a psychiatrist I continue to grapple with this concern, worrying that the opportunities that I had are not available to most service users within New Zealand's predominantly publically

funded system. I have also experienced family and friends being admitted to our acute mental health units, and wished for something different. But what indeed is it that I want for them?

Simplistically I could argue that everyone needs the opportunity of an ‘Ashburn Hall’; but what would that mean, and what would it look like? The environment in which I received care (a residential therapeutic community) has been in decline throughout Western mental health systems: Ashburn Hall is the last of its kind in New Zealand. Prolonged hospital admission is expensive and it seems unlikely, unless there is another seismic shift in health care provision, that Ashburn Hall-like services will be available to everyone who experiences mental illness. Rather than being constrained by existing structures this thesis endeavours to think more broadly. But where to start? I believed that there was something we could learn from my story; the place to begin was within my own experience.

A road map for the thesis

This thesis explores the subjective experience of place in mental health care, with an interest in aspects that facilitate healing. Situated in the discipline of psychiatry, the thesis sought opportunities to learn from other disciplines, exploring and integrating understandings and concepts, and engaging in dialogue, in albeit a limited way, with those disciplines. Autoethnography, as methodology, further troubled the notion of what counts as evidence and knowledge in the medical speciality of psychiatry, encouraging me to access the personal experience of mental illness and care in its depth and richness, with the added complexity of my niche position as service user and psychiatrist.

Part I provides an overview of relevant literature, including the historical context of places of treatment. Although initially focussing on facilities provided under the rubric of mental health services, unwilling to be bound by existing structures (the research question deliberately left the definition of place wide open) the literature will look more broadly, exploring the notion of place, and concepts at the intersection of geography and mental health. No discussion would be complete without a consideration of recovery, the guiding philosophy of most Western mental health services; but the recovery I knew as a health professional did not capture the quality of my experiences at the Hall, an experience I identified as healing. This tension is discussed in the final section of the background literature.

Methodology is visited in chapter four, firstly dipping into postmodernity and postpsychiatry which gave me permission to question the dominant discourses of evidence-based medicine within which my personal experience is of no value. A postmodern sensibility in psychiatry is one that values the voice of lived experience, creating space for multiple stories, multiple discourses, and multiple lenses. Service user research, and specifically autoethnography, provides a vehicle for exploring this multivocality, getting us to the heart of my and our experiences. Autoethnography is discussed as methodology, method, and as writing within which the practicalities of the research itself, including ethics and engaging with the data, are discussed.

Part II, 'Healing Journeys', is the first of the results sections of this thesis. Healing itself was not initially a focus of enquiry, but participants, in telling their stories, told me about more than simply the places they had been: they described what it had been like to be unwell, and what healing meant to them. This led to a consideration of the healing journey, and provided a context for understanding the places that became healing. Healing, in this thesis, is conceptualised as the intensely personal experience at the heart of recovery. As a process and a destination, healing is necessary when there has been a disruption of integrity and wholeness, experienced as suffering. Healing is a journey of exploration that takes time and is hard work, facilitating connection and integration, understanding and wisdom. It is in the exploration that healing can occur, implying that we are not passive (or even active) recipients of care; rather we are active participants creating or making use of the opportunities available to us, developing a story that is uniquely ours.

Part III considers the aspects of place that facilitate healing. A place that is healing is one that provides safe haven, holding us enough in a collaborative environment of care, hope and trust, while providing space and opportunities for exploration. It is in the latter aspect that our places diverge: a healing place provides safe haven; a place that facilitates healing is that and more, providing opportunities to explore our selves, and that may not be an easy place to be. The landscapes we come to know, in all their richness, become the stories we tell: the expression of our healing. While there can be artificiality in separation, these results chapters are divided into 'Where did we find healing?' discussing where and what these places were, and 'The physical environment', both built and natural; 'Sharing the journey with others', which considers the interpersonal relationships within these places; and 'A place of opportunities', which considers the formal and informal, doings and beings which are the opportunities for exploration.

Part IV is an opportunity for integration and reflection, weaving together and making sense of the sometimes disparate elements of place described in Part III, as viewed through the lens of a journey of healing. The methodology of autoethnography exposed tensions in my positionality as service user and psychiatrist. These tensions are explored: while healing finds a place at the heart of recovery, other tensions are not so easily resolved, suggesting the need for space to explore the complex interplay between differing perspectives and competing discourses. Part IV finishes with the question ‘where is my white coat now?’: a reflection on the impact of this research on me, the psychiatrist, and giving thought to future directions.

Resisting fragmentation in multivocality

A recurring theme in writing this thesis was my multivocality: if and how to acknowledge my positions as researcher, psychiatrist and service user. Autoethnography aims to make overt the multiple layers of consciousness or multivocality of the researcher (Ellis & Bochner, 2000; Mizzi, 2010). Some authors use devices such as change of font to demarcate their voices (Chatham-Carpenter, 2010), but I resisted; as will become clear it was in integration I found healing: ‘this is me, and I am mine’. Re-creating the separation of my identities risked mirroring the fragmentation of my ill self; instead I chose to conceptualise my presence in the research and writing as foreground and background. This may make for unsettling reading; sometimes the reader will recognise and be comfortable with a particular style of discourse – academic, medical, service user – and at times left wondering who is speaking now, with attendant demands for validity or referencing. In this discomfort sit the tensions between objective and subjective; evidence and experience; and knowledge and wisdom.

Part I, in considering existing structures and deciding what was relevant, foregrounds me as researcher in conversation with psychiatrist; service user-me makes her presence felt as the methodology section progresses. Parts II and III foreground my service user experience in conversation with others, although it would be naïve to consider that psychiatrist-me wasn’t occasionally stirring the pot. Part IV is where I begin to hold hands with myself, standing together and making ourselves heard: a space for negotiated dialogue.

This is an autoethnographic thesis; it is intentionally evocative, endeavouring to take the reader to the places in which we found ourselves; to ‘show’ not just ‘tell’, encouraging the reader to engage emotionally as well as intellectually. My story is foregrounded, running the length of the thesis, and crafted to fit the themes of the chapters. While all but the other

participants' voices are in the same font, my story as 'data' for the research is indented and coloured blue as a point of difference, allowing the reader the opportunity to simply flick through the thesis following the flow of blue to remain immersed in the story. The participants' stories, also indented, are presented in italic font, to demarcate them from my own. The body of the results chapters (Parts II and III) are kept deliberately free of references to literature, to limit distraction from the wisdom within our stories, the literature being integrated in the discussion sections at the end of each chapter.

Attending to language

Most post-modern mental health theses need to address the issue of language: during the 1900's the now historic lunatic or inmate became patient; the last thirty years has seen patient become alternatively client, consumer, survivor, or service user; and mental illness or disorder reclaimed as madness, with little agreement on which to use (Rose & Beresford, 2009). These terms or labels can represent competing discourses, dependant on your point of view (Church, 1995). The aim of this thesis is not to argue for one view or another, one set of language over another; rather my intent is to bring us all, all my selves to the table. As such I have chosen to ignore the either-ors of the language debates; or perhaps rather than ignoring, it is an embracing: using the language of the worlds in which we were situated, using the language of the speaker: patient/service user/client/guest and mental illness/unwell/mad. When the speaker is 'the writer of the thesis', I have opted to use 'service user' and 'mental illness' as these have resonance for me.

In writing this thesis I needed to consider the question of who is my audience; the obvious answer is my examiners who need to see a substantial body of work that has theoretical integrity. But autoethnography strives to open readership to a wider audience: I write for myself, for participants, for others who recognize themselves, our families, friends, acquaintances, and for anyone who cares to be interested and evoked. This thesis is the story of my and our journeys towards healing.

Chapter two: The psychiatric literature

There is no well-defined body of literature to review relating to the question of this thesis. Interrogating aspects of place as they relate to mental health care and healing, the research question investigated the experience of healing in a context in which the dominant discourse is that of recovery. With its origins in the apparent dissonance between my service user experience and my professional training, the research further resisted being limited by existing structures of mental health service delivery: the definition of place was left deliberately vague, not wanting to make assumptions about places that might be healing for others. The methodology utilised is unusual in the psychiatric literature, giving primacy as it does to the service user voice, being further challenged by the service user being both mental health professional/psychiatrist and researcher: multiple roles, multiple voices, multiple lenses. In gathering literature for this thesis I have read widely, perhaps unwilling to be bound by the discipline of psychiatry and the established ways of doing things.

This chapter, after briefly visiting asylum history, considers the current system of mental health care with its emphasis on community-based services. I particularly focus on the acute mental health unit as it is this environment with which I am most troubled in my day-to-day work. New Zealand mental health services have moved away from the longer stay therapeutic community concept of care (see page 34). Ashburn is now the only one of its kind, and predominantly operates in the private sector: as it was 20+ years ago when I was unwell, the primary place of treatment if we can no longer manage at home is the acute inpatient unit. I have needed to consider what I mean by place and this has led me into the geographic literature; this will be discussed in chapter three. The multidisciplinary nature of my reading has also been reflected in consideration of healing, a concept not often discussed in the psychiatric literature where the dominant discourse is recovery; the general medical literature contributed to a discussion of healing (chapter five). Bringing together the concepts of healing and place has required delving into medical literature on psychoneuroimmunology, architecture and its interface with medicine, and the geographic literatures on health geography, therapeutic landscapes and enabling places.

I have struggled with the enormity of trying to review or bring together the resulting literature; how can I do justice to it all? As much as my journey of healing was an eclectic exploration, taking what made sense and putting aside the rest, I will present the literature as my way of beginning to make sense of my and our experiences of place and healing.

Utilising the 'I' and being selective about what I present, I will approach the literature from my point of view to explore, challenge, and ultimately develop an understanding. While not claiming to have reviewed all the possible literature, a general critique is the relative absence of the service user voice; I will discuss this in more depth later in this chapter and chapter four.

A journey through Ashburn Hall and asylum history

An interest in the role of place in the treatment of mental illness is not new: the moral treatment movement of the 17-18th century asylums was predicated on the (Quaker) belief that a calm, tranquil, ordered environment could cure insanity (Edginton, 2007). In more recent times treatment has focussed on psychopharmacology and psychological therapies, with a relative neglect of the environment in which mental health care is provided (e.g. Markowitz, 2008). As I read the history of psychiatric hospitals, I developed a concern about simply re-inventing the wheel or change for change's sake. Sine (2008) suggested that early alienists believed that, to be cured, psychiatric patients must be separated from their home and community environment: "a lunatic can be cured only in an institution" (p.1060). Based on my experience at Ashburn I could argue the same: this was an institution in the countryside away from my home. Superficially these seemed to be essential elements, but asylum history might suggest otherwise: rather than its therapeutic value the rural isolation of the asylum was perhaps driven by society's need to create separation from the insane (Moran & Topp, 2007).

Without consideration of this history, I risk another turn of the wheel (T. Brown, 1980). Fagin (2007), in his narrative history of inpatient care in Britain, identified this risk, suggesting that the history of psychiatric inpatient care could be viewed as "a recurring cycle of stages, moving from neglect to custodial, repressive regimes, on to enlightened liberal and humane care and then back to a mixture of neglect and highly regimented and controlled environments"(p.8). Thornicroft and Tansella (2009) similarly summarised this history as recurring cycles of optimism, building, disillusionment and control. Allderidge (1979), a Maudsley Hospital archivist, was perhaps more blunt in her lecture 'Hospitals, Madhouses and Asylums: Cycles in the care of the insane' providing an overview of 750 years of care. She suggested "plus ça change..." (p.332), the remainder of the quote usually being 'plus c'est la même chose'; translated this means 'the more it changes, the more it's the same thing'.

My journey to healing began and begins with my admission to Ashburn Hall, the only 19th century ‘lunatic asylum’¹ still admitting patients in New Zealand (Moon, Joseph, & Kearns, 2005).

My taxi from the airport came the back way over Three-mile Hill, avoiding the city; only later would I find the bus stop just down the road, a short 10-minute bus ride would get me to town. Turning in through the gate, we headed up the driveway beneath towering conifers. On one side were old moss-covered dry stone walls, on the other a swathe of lawn, lushly green, flanked by trees and the shrubs that I would come to know as rhododendrons that will always signify for me Dunedin and the Hall². The original building was a farmhouse, some of the outer walls still stand. Now it is like an old manor house – a rabbit warren of corridors – as it has been added to over the years. Later in the day I would be shown around the grounds with its collection of outbuildings: the old brick washhouse/laundry (now-psychodrama room), a two-storey weather-boarded hostel for visiting families, the Edwardian Villa/medical residence and the newer gymnasium. I’m not sure how much I took in of these surroundings at the time, but they remain vivid in my memory.

Ashburn Hall was the turning point of my service user journey, and arguably the beginning of my journey as psychiatrist: the 19th century asylums are credited with the beginnings of the profession of psychiatry, a hospital based practice (Ovsiew & Munich, 2008). Opened as New Zealand’s only private lunatic asylum in 1882, Edward Alexander (a General Practitioner with experience working in Parisian asylums) and James Hume (a book-keeper and non-medical superintendent of the Dunedin Asylum) bought the Ashburn Estate on the outskirts of Dunedin complete with “a large stone house with ten rooms, farm buildings, an orchard and an established water supply, [the Ashburn Stream]” (Duder, 2007, p.16). An extension added to the original house provided single rooms for forty patients and dining and sitting rooms: “each patient... had their own furnished bedroom... the rooms gave views of the grounds and surroundings. The grounds included natural bush, flowerbeds, an orchard, a vegetable garden, a bowling green, and a stream” (Duder, 2007, p.16). These descriptions of the buildings, bedrooms and grounds echo my experience a hundred years later and their significance will be discussed in later chapters of this thesis.

¹ A number of terms have been used historically to denote psychiatric hospitals. The 1800s saw the official use of the term ‘lunatic asylum’; this changed in 1905 to ‘mental hospital’ (Brunton, 2005).

² In my personal reflections I refer to Ashburn Hall as simply ‘the Hall’ as this is what I have always called it. In 2001 it was re-named Ashburn Clinic.

Influenced predominantly by British models of institutional care, and in common with New Zealand's public asylums, psychiatric care at Ashburn Hall in the late nineteenth and early twentieth centuries was described as 'moral treatment', which in part emphasised the therapeutic qualities of physical aspects of place (Knewstubb, 2012).

Set away from the city in a rural setting, with large and attractive grounds and buildings, Ashburn Hall fulfilled the moral treatment ideal of a peaceful, comfortable and healthy environment in which patients could recover away from the distractions and pressures of city life. (Duder, 2007, p.25)

Moral treatment had its origins in the late 1700s. William Tuke, in response to the death of a fellow Quaker in the 'squalid and inhumane conditions' of the then local York Asylum, established the (private) York Retreat in 1796 to provide 'a supportive and healing environment' for members of the Society of Friends (Quakers) who were experiencing mental distress (The Retreat, n.d.). Borrowing the term from the French reformer Pinel's 'traitement morale', Samuel Tuke later described The Retreat's methods and philosophy as moral treatment, meaning 'treatment of the morale' rather than 'rights and wrongs'. This philosophy had its origins in the Quaker's spiritual belief that the insane, retaining their essential humanity, could be cured by placing them in civilised surroundings (Digby, 1985) or "a therapeutic environment in which 'sane' sensations, ideas and behaviours were encoded in a design that would transform the actions of its patients" (Edginton, 2007, p.86) .

According to Edginton (2007), "implicit in the work of those associated with The Retreat was the belief that the building and its design would create a healing space", and "the curative power of pure, romantic nature itself... was to heal insanity like all other problems caused by chaotic social progress" (p.86). The emphasis was on the belief that a physical environment reflecting calm and order was therapeutic: "This was a space in which... the attachment to a soothing environment would treat madness. This space would also instill in the patient, both physically and mentally, a new set of habits, allowing the patient to become a new person: a sane person" (p.100). Drawing on Tuke's publications, Davidson, Ralfeldt and Strauss (2011) suggested that rather than moral treatment, the Retreat applied moral management to correct the "perversions of reason, 'erroneous views' and 'wayward propensities'"(p.45) that underlie mental illness. Here we have a hint of how a society's beliefs about mental illness influence the services that are provided; these descriptions carry an implication that patients are passive recipients of cure, with care designed to impose social regulation and restraint (Edginton, 2007; Parr, 2008).

Samuel Tuke, the grandson, seems to have taken the more philosophical and spiritual Quaker ideas that underpinned the environment of the Retreat and operationalized them in his book “Description of The Retreat” (1813) and then “Practical hints on the Construction and Economy of Pauper lunatic Asylums” (1815). These publications contained specific building instructions including the orientation and size of rooms and courtyards. As Edginton (2007) commented, “there is no stated reason why these particular designs would affect the treatment of the insane” (p.96); as I will discuss later in relation to recovery, this quantification of design perhaps objectified and risked losing the values that underpinned moral treatment. Supporting this view, Digby (1985) argued that as the 19th century progressed the “creative act of healing“ that was moral treatment evolved into moral management, a more repressive “series of techniques” (p.69). This change was attributed to the increasing importance given to the role of medical science in treatment at the Retreat and other asylums. Digby suggested that the prospects of recovery for patients at the Retreat were higher in its early years, raising “the fascinating but unresolvable question of whether... the Retreat’s moral treatment did not rely for its efficacy, at least in part, on an unseen kernel of spiritual healing” (p.69).

Built on the outskirts of York, on a hill with views of the countryside, the York Retreat became the model informing much of the development of public asylums in Britain through the 19th Century, and of the colonial New Zealand. An emphasis on the physical aspects of place were seen in the words of the 19th century Scottish asylum-reformer, Dr WAF Browne (1837) with his promotion of the benefits of nature for those who are mentally unwell: “If the building is placed upon the summit or the slope of a rising ground, the advantages are incalculable... the mere extent of country affords delight; to some the beauty of wood and water, hill and dale, convey grateful impressions” (quoted in Hickman, 2009, p.429) (see also Brunton, 2011).

It wasn’t until the mid-1820s that the principles of moral treatment began to influence public asylums (Smith, 2007). Until this time, asylums in England tended to be situated in the centre of town often connected to the general hospital. Rather than its purported therapeutic benefits, an argument is proffered that a move to more isolated rural settings for asylums was driven by society’s desire to segregate or exclude those who are different (Parr, 2008), Foucault (1984) describing this period as ‘The Great Confinement’. Philo (2004) interrogated this history arguing that Western society had developed over the centuries a ‘space reserved for insanity’: a channelling of those who were deemed insane into distinct and often separate spaces, and that this divide was both social and spatial. Others offer

evidence that there was perhaps a more humane motivation, or at least that these were contested spaces (Hickman, 2009; Parr, Philo, & Burns, 2003). Allderidge (1979) stated that:

[N]o one who has read the 1807 Committee's report [a Select Committee to enquire into the state of criminal and pauper lunatics in England and Wales] can doubt the good faith – indeed, the touchingly naïve faith – of the planners. They really believed that asylums were going to cure insanity. (p.333)

The embracing of asylum-based care for the insane led to an exponential growth in patient numbers, some authors suggesting the resultant over-crowding doomed the realisation of moral treatment (L. Davidson et al., 2011; Sederer, 2010). In the early to mid-20th century it was time for change. An explanation of this change, which has come to be known as deinstitutionalisation, is beyond the scope of this overview but remains contested (Glasby & Lester, 2005). Reasons given include the development of antipsychotic and antidepressant medications, a social reaction to war-time shell-shock³, arguments from the anti-psychiatry movement about the effects of long-term institutional care, and perhaps more controversially, the political-economic argument that community care would be cheaper than asylum based care (Curtis, 2010; Parr, 2008; Thornicroft & Tansella, 2009).

The debates continue with complexity added by so-called revisionist history, the reinterpretation of understanding of historical events. Moran and Topp (2007), argued that “[w]ith each wave of reform... a modified version of psychiatric space was embraced as the final answer, while the history of previous spatial solutions to insanity was rewritten, caricaturing these solutions as crude, irrational and unsuccessful” (p.2). Davidson, Rakfeldt and Strauss (2011) were similarly cautionary; while I might have superficially likened my experience at Ashburn to the 19th century Retreat, they hope that I will be “disabused of the notions that we reached the pinnacles of psychiatry during this period and that all our answers for the future lie in resurrecting this past” (p.58), suggesting my re-visiting of psychiatric history needs to be done with an open mind.

Where is the patient?

Notably absent from my reading of the academic literature on asylum history is the voice of the patient. Porter (1996) acknowledged this lack, suggesting that when the patient was heard it was usually to “decode what mad people said, wrote and did in the light of some or other psychiatric theory, to reveal what disease or syndrome they really had or even to

³ Brunton (2005), a New Zealand historian suggested that there was post World War I pressure for a fresh approach, for those experiencing shell-shock, that would avoid the stigma of mental hospitals.

discover the ‘real’ (that is unconscious) meaning of their actions” (p.1). With particular forms of knowledge legitimated at the expense of others, medical records privileged the voice of psychiatrists and tended “to report patients’ voices as signs of illness or cure, rather than communication in their own right” (Davies, 2001, p.267).

My first job, in 1995, as a psychiatrist-in-training was with a community crisis team tasked with referring patients for admission to Kingseat Hospital, the then mental hospital for South Auckland which had first opened its doors in 1932. My interaction with the institution was limited, my abiding memories being the drive through the countryside on a Saturday morning to begin my on-call shift, and the wide sweeping driveway lined with phoenix palms. It seemed a peaceful place but I am aware that I didn’t really know what it felt like for patients being admitted there. Over the years since, I have heard and read personal accounts of people’s experiences in the various mental hospitals of that institutional era in New Zealand; stories told in clinical interactions, in auto/biographies (e.g. Janet Frame , Robin Hyde, Vincent Van Gogh), in fiction (e.g. Janet Frame’s ‘Faces in the Water’, Charlotte Randall’s ‘The Curative’), film (e.g. ‘Mental Notes’, and ‘Asylum Pieces’) and in official enquiries e.g. The Confidential Forum (Satyanand, Mahoney, Dowland, Helm, & Greig, 2007). The stories commonly tell of hardship, and describe care that was considered abusive, but also elements and experiences that for some were more positive.

From Janet Frame’s (1984) autobiography:

The six weeks I spent at Seacliff Hospital in a world I’d never known among people whose existences I had never thought possible, became for me a concentrated course in the horrors of insanity and the dwelling place of those judged insane, separating me for ever from the former accepted realities and assurances of everyday life... I felt as if my life were overturned by this sudden division of people into ‘ordinary’ people in the street and these ‘secret’ people whom few had seen or talked to but whom many spoke of with derision, laughter, fear... I grew to know and like my fellow patients. I was impressed and saddened by their-our capacity to learn and adhere to and often relish the spoken and unspoken rules of institutional life... There was a personal, geographical, even linguistic exclusiveness in this community of the insane who yet had no legal or personal external identity – no clothes of their own to wear, no handbags, purses, no possessions but a temporary bed to sleep in with a locker beside it, and a room to sit in and stare, called the dayroom. (p.72-3)

[a later admission] Very quickly, in my panic, I was moved to a back ward, the Brick Building where I would become one of the forgotten people... It was recognized that I was now in hospital for life. What I have described... is my sense of hopelessness as the months passed, my fear of having to endure that constant state of physical capture where I was indeed at the mercy of those who made judgements and decisions without even talking to me or trying to know me. (p.109)

Janet Frame's Seacliff Hospital was a Victorian asylum in the countryside north of Dunedin (New Zealand) on a hillside with views towards the sea. In 1991, not long after reading Frame's autobiography, I visited the by-then-derelict Seacliff; walking up the hill from the train station I climbed the fence and wandered, peering through old, often broken, windows. The hairs on the back of my neck stood on end; the place seemed haunted and bleak. This asylum may have been in the countryside, and close to the sea, but I remember nothing of that.

In contrast, I have described, in the introduction, my reaction to visiting Saint Paul de Mausole, a similar response to that of Vincent van Gogh, written in a letter to his brother.

I think I have done well to come here... I have never been as peaceful... I have a small room with greenish-grey paper with two sea-green curtains with a design of very pale roses... one can see so much further than at home... I never get tired of the blue sky. (Naifeh & Smith, 2011, p.747)

The Confidential Forum for Former In-Patients of Psychiatric Hospitals (Satyanand et al., 2007) was a New Zealand Government funded endeavour established in 2005, providing former patients, their family members and hospital staff with the opportunity to describe their experiences of psychiatric institutions in New Zealand in the years before November 1992. These accounts were heard by a panel of three, the Forum being viewed as a reconciliation initiative.

Former patients approached the Forum for various reasons including wanting to make sense of their experiences, wanting Government to know of their experiences and the effects upon them, and hoping that others might benefit from the Forum. For many, it was the first opportunity for them to fully tell their stories. The individual narratives revealed certain themes in common, mostly negative in nature, concerning institutional culture and treatment regimes. Examples include experiences of fear and distress at admission; unsanitary, overcrowded conditions; unanswered questions arising from a

lack of communication between health professionals and patients and family members of patients; occurrences of physical violence and sexual misconduct; inadequate complaints mechanisms; fear and humiliation when held in seclusion; extreme distress caused by the use of electroconvulsive therapy (ECT) and some other treatments no longer in use such as deep sleep therapy; doubts over use of particular medications and treatment regimes, and the possible lasting effects; and lack of support on discharge from institutions (p.2).

It continues to rankle with service user advocates involved in this initiative, that the formal report of the Confidential Forum has never been ratified by the government of New Zealand⁴.

So has deinstitutionalisation produced improvements, is admission to hospital a more positive experience for service users? I well remember the excitement and optimism with which our mental health services made the shift from Kingseat Hospital to a new purpose built acute mental health unit on the grounds of the local general hospital. Perhaps mirroring the recurring cycles of optimism, building, disillusionment and control, some years later I question that optimism.

The hospital in an era of community based care

Deinstitutionalization has seen, at least in the Western world, a change from the long-stay hospital/asylum based care for mental illness, to a community-based model of care, with admission to hospital expected to be the exception rather than the rule. Through the second half of the 20th century, inpatient services shifted to acute admission wards; no longer sited remotely from the communities they served, most are now situated within urban general hospitals (Lelliott, 2006). There have been radical changes in the purpose of inpatient hospital admissions (Munich & Greene, 2008); bed numbers have decreased dramatically (Abas et al., 2003; Eisenberg & Guttmacher, 2010), as have lengths of stay (Glick, Carter, & Tandon, 2003; Lelliott, 2006; Muijen, 1999). With the embracing of community-based psychiatric care, a reasonable question asked in the literature is whether there is still a place for psychiatric hospital beds. The answer seems to be ‘yes’ (Lasalvia & Tansella, 2010; Thornicroft & Tansella, 2009). In a review of literature prepared for the World Health Organization, Thornicroft and Tansella (2004) stated that “there is no evidence that a

⁴ Personal conversations with service-user advocates, and <http://www.patientsrights.org.nz/the-confidential-forum>

balanced system of mental health care can be provided without acute beds” (p.286), a view supported by others (Lelliott & Bleksley, 2010; Muijen, 2002). Concern was however expressed, suggesting that while “few would argue for the abolition of hospital care” (Muijen, 2002, p.342), the concept of ‘hospital’ needed reforming.

Hospital inpatient services remain the most expensive component of mental health care, and account for the bulk of funding in many countries (Papoulias, Csipke, Rose, McKellar, & Wykes, 2014). This cost may in part explain the development of alternatives to acute inpatient care in some countries (Geller, Guzofski, & Lauterbach, 2008). These alternatives include acute day hospitals, crisis facilities, and home-based crisis resolution teams; with different countries and services having varying emphases (Geller et al., 2008; Thornicroft & Tansella, 2009). World Health Organisation statistics (2011) suggest that day hospitals/treatment facilities, offering programmes and treatment to those with serious illness as an alternative to admission, are significantly more utilised in Europe, with only very limited availability in New Zealand and other Pacific countries. Crisis facilities vary markedly in setting and staffing but are generally community based for brief stays only, with a focus on crisis resolution rather than ongoing treatment.

In New Zealand there is access to longer-stay, often diagnosis-specific, specialist units for a small number of service users with on-going and severe dysfunction (e.g eating disorders, and borderline personality disorder), and limited access to rehabilitation units (inpatient or residential) primarily for those with severe and enduring psychotic disorders. For most people ongoing treatment continues at home, with a mixture of appointment based medical and psychological input, and brief admissions to acute mental health units or respite in crises; these options being based on a community-based model of care, the dominant paradigm in New Zealand mental health services. As a service user with repeated admissions to acute and specialist mental health units, and outpatient appointments with a psychiatrist, I do not recognise these services as having ‘worked’ for me.

The acute mental health unit

The research evidence for and evaluation of the quality of inpatient care is limited with “a relatively weak evidence base” (Thornicroft & Tansella, 2004, p.286) (also Muijen, 1999). Some authors suggest that this neglect is due to a focus on community services, with the community portrayed as good and hospitals as bad (Bowers et al., 2006; Glasby & Lester, 2005; Gleeson & Kearns, 2001). There is however considerable commentary on the state of

acute inpatient psychiatry, predominantly expressing concerns (Fitch, Daw, Balmer, Gray, & Skipper, 2008; Lelliott, 2006; Sainsbury Centre for Mental Health, 2006).

North American authors describe hospital units that are overcrowded with short lengths of stay, averaging 3-10 days (Glick et al., 2003), and high patient turnover; they lament the dominance of pharmacotherapy over psychotherapy and the milieu (Hanrahan, Aiken, McClaine, & Hanlon, 2010; Markowitz, 2008; Shattell, 2007). A similar picture is painted in commentary from the European literature; Muijen (2008) described “appalling conditions” (p.480) in some psychiatric hospitals in Central and Eastern Europe, while also commenting that “we cannot be complacent about conditions in some hospitals in Western Europe” (p.480). Having earlier described inpatient units as atherapeutic and providing a care vacuum (Muijen, 1999), he echoed the North America concerns of high bed occupancy rates, scarcity of therapeutic interventions, boredom, lack of privacy and violence (Muijen, 2002). New Zealand mental health units are perhaps no different, developing a reputation for becoming increasingly overcrowded and difficult to work in (Lapsley, Nikora, & Black, 2002; Nakarada-Kordic & McKenna, 2011).

Lelliott and Quirk (2004), of the Royal College of Psychiatrists (RCP) Research Unit, suggested that the quality of care on acute wards was under threat, with “the most pessimistic view [being] that acute psychiatric ward hospitals have become a nontherapeutic ‘dumping ground’ for service users who cannot be managed by community services” (p.297). In a limited review of qualitative research relating to life on acute psychiatric wards, they identified a number of problems common to units internationally. These included staff being preoccupied with management of dangerous behaviours, and the throughput of patients; both staff and patients expressed dissatisfaction with the ability to form therapeutic relationships and the centrality of pharmacological interventions.

A number of authors comment that the role of inpatient care is ill-defined (Bowers, 2005; Bowers, Chaplin, Quirk, & Lelliott, 2009; Glick et al., 2003; Lelliott, 2006; Lelliott & Bleksley, 2010; Sainsbury Centre for Mental Health, 2006). Sederer (2010) defined acute inpatient care as “crisis intervention for safety or treatment requiring 24 hour medical and nursing care in a locked setting (p.292)”. Drawing on a structured examination of the literature (Bowers, 2005), Bowers et al (2009) offered a similar view: that inpatient admission is indicated for assessment and medical treatment, to manage dangerousness, difficult behaviours and self-care deficits associated with mental illness; while adding the function of respite for carers and patients (also Glick et al., 2003). These descriptions of the

purpose of inpatient care are consonant with the Royal College of Psychiatrists' observation that inpatient units are for crisis stabilisation and are likely to only admit those who are most disturbed, distressed or unwell (Khan & Daw, 2011). It is also consistent with my hospital admissions prior to Ashburn Hall, which were usually for the purpose of administering ECT when I was most profoundly depressed. In much of this literature there is an acceptance of the status quo, rather than an attempt to define the purpose and function of psychiatry wards as they could or should be.

A recent debate in the psychiatric literature questions where inpatient services should be placed (Lasalvia & Tansella, 2010; Totman, Mann, & Johnson, 2010). Historically the old asylums were located rurally, separate from the communities they served. Deinstitutionalization sought to bring treatment of mental illness back into the community, and inpatient care within the general hospital. In 1961, when deinstitutionalisation had a UK commitment, "Enoch Powell said... "we know already" where they [psychiatry beds] ought to be: within general hospitals" (Totman et al., 2010, p.282); these sentiments were enshrined in government policy 14 years later. The World Health Organisation supported this position, with an implied assumption that changing the location of services solves the problems of inpatient care.

Psychiatric hospitals have a history of serious human rights violations, poor clinical outcomes, and inadequate rehabilitation programmes. They also are costly and consume a disproportionate proportion of mental health expenditures. WHO recommends that psychiatric hospitals be closed and replaced by services in general hospitals... (World Health Organization, 2009, p.25)

In many European countries psychiatry wards remain embedded within the general hospital (Lasalvia & Tansella, 2010), but more recently in the United Kingdom the argument has been made for smaller stand-alone structures (Totman et al., 2010), which would be built for purpose. With suggested attention being paid to the physical environment of the ward and access to outdoor areas, there are hints of the philosophy of moral treatment: another turn of the wheel may be imminent.

The service user perspective

The service user experience is increasingly being seen as an important element in the development of general and mental health services (Bate & Robert, 2006; Gilbert, Rose, & Slade, 2008). Possibly in response to concerns with the state of inpatient psychiatry, the last decade has seen a burgeoning of reviews and research reports investigating the service user

experience of being an inpatient. Much of this to be found in the nursing literature, often focussed on particular aspects of care such as containment, safety and the interpersonal relationship. While the researchers are predominantly health professional/academics, there are a small number of studies involving or led by service users, which arguably offer an alternative view of the service user perspective (Gillard et al., 2010). The basis for service user research will be discussed in chapter four. Service user accounts are also to be found in organisational research, for example 'Ward Watch' (Mind, 2004) and 'Users' Voices' (Rose, 2001), in publications such as 'Experiences of Mental Health Inpatient Care: Narratives from service users, carers and professionals' (Hardcastle, Kennard, Grandison, & Fagin, 2007), and in the lay literature (e.g. Taylor, 2014; Thomson, 2013).

With literature presented from different points of view, and with varying emphases and interests, it can be a challenge to bring together a coherent summary. My interest in this selected review is on hearing the service user voice, either as author or as participant, this being found predominantly in qualitative research. With the over-riding tenor of the psychiatric literature being negative aspects of the acute ward setting, I was also interested in reports that discussed care in a more positive light. Schroder, Ahlstrom and Larsson (2006), investigating the concept of quality of care from a service user perspective, prompted me to think about who determines what is quality care. Their interview-based study of 20 adult in- and outpatients, suggested that quality of care was a positive phenomenon that included dignity, security, participation and the care environment; people wanted care that helped reduce shame, and to be looked upon as like anyone else. Likewise, Crawford et al (2011) asked service users what outcome measures were important to them, with many participants expressing concern about the ability of commonly used outcome measures to reflect their experience.

There is consensus among researchers, clinicians and service users that there is widespread dissatisfaction with inpatient psychiatry; common concerns include safety, distrust, a lack of staff-service user interaction, boredom and the physical environment (Bowers et al., 2006; Evans et al., 2012; Hem, Heggen, & Ruyter, 2008; Lelliott & Quirk, 2004; Walsh & Boyle, 2009). Although not pervasive, for some service users these factors have the potential to exacerbate existing difficulties or create new ones (Mind, 2004). Mental health units are perceived by many as volatile and risky places: service users witnessed and experienced aggression and violence with resultant fear and vulnerability (Gilburt et al., 2008; Jones et al., 2010; Lelliott, 2006; Mind, 2004). Some people use a strategy of discharge or escape from hospital as a way of managing this risk (Quirk, Lelliott, & Seale, 2004); antithetically

however, service users expect, need and sometimes find mental health units to be places of refuge or sanctuary (Gilburt et al., 2008; Hopkins, Loeb, & Fick, 2009; Walsh & Boyle, 2009).

Intense boredom is an often reported complaint of the ward environment, with limited therapeutic interventions other than medication, and few recreational activities (Antoniou, 2007; Mind, 2004; Quirk & Lelliott, 2001; Rose, 2001). Shattell, Andes and Thomas (2008) described staff and patients being “confined in a prison-like world [where] time stood still for patients, but moved quickly for nurses. Patients were bored and nurses were busy” (p.245). Busyness, as a consequence of the administrative demands of modern mental health unit work, was given as a rationale for the often reported lack of staff-patient interaction and communication. Rose, Evans, Laker and Wykes (2013) argued that from a service user perspective this experience was nothing new, similar complaints being made in the asylum era. They suggested instead the influence of social factors hinging on an ‘us and them’ dichotomy. Despite this, service users identify the interpersonal therapeutic relationship as integral to their recovery (Gilburt et al., 2008; Gilburt et al., 2010).

In my reading, several studies stood out because either the studies were overtly service user led or the experiences described resonated with mine. Gilburt, Rose and Slade (2008) reported one of the earliest service user led (the first two authors) studies to investigate the experience of life on psychiatric wards. Recruiting through service user networks and utilising a participatory research approach, they interviewed 19 service users who had experience of admission to psychiatric units throughout England. The interviews opened with the request “tell me about your experiences of being an inpatient” (p.3). Their key finding was the centrality of relationships in defining participants’ experiences: “when participants talked about their experiences of hospital, they did so largely within the context of the people they had encountered during their admission” (p. 3).

Five themes identified were related to relationships: communication, coercion, safety, trust, and culture/race. The process of talking was the most prominent aspect of communication, and was described as therapeutic, but only if the service user felt listened to and understood. All participants reported coercive experiences; linked to the concept of trust, coercion was seen as the main barrier to formation of a therapeutic relationship. Participants viewed coercion as an inherent, but unacceptable, aspect of being an inpatient. Most participants described being fearful while in hospital, with trust and mistrust being an important determinant of the hospital experience. The authors commented that the physical

environment of the inpatient units was little referred to and only when the quality was poor, the emphasis being on emotional aspects of their experience. I was struck by the depth of feeling in the participants' quotes, perhaps supporting the suggestion that peer-researchers are easier to talk to about emotional concerns, and encourage participation from those who might not otherwise engage (Godfrey, 2004).

Walsh and Boyle (2009), both identifying as service users, reported a qualitative study utilizing focus groups to investigate the experience of current inpatients across eight hospital sites. Focussing on strategies for coping, and ways in which the inpatient environment is facilitative to recovery, their findings suggested "the inadequacy of psychiatric hospital services in providing therapeutic environments continues" (p.36). Aspects identified that promote recovery included relationships, access to information, improved communication, promotion of self-help, and activities, the latter being seen as a means of distraction but often boring and predictable. Relationships were fundamental to the experience of the ward environment, service users highlighting the need for relationships with staff built on trust, empathy and mutual respect. Hospital was viewed by participants as a haven from the pressures of the outside world, providing personal safety with time and space for reflection. Unlike Gilbert et al, who recruited through user networks, access to participants in this study was often controlled by ward staff.

More recently Rose, Evans, Laker and Wykes (2013) who are all service user researchers, investigated life in acute mental health units in a South London (England) Trust from the perspectives of both service users and nurses. In keeping with other studies, the findings were predominantly negative: "the overwhelming perception of service users was that the ward was 'untherapeutic'" (p.3), this being attributed to a lack of routine, and available and helpful staff. The nurse participants were aware that they provided less than perfect care, citing the daily demands of administrative tasks and bed management. Although nurses remained committed to the need for improved communication and interaction, the study authors identified an underlying theme of avoidance or interaction anxiety, possibly arising as a protection against the complexities of individual service user needs. Recognising an imbalance of power between service users and staff, the authors suggested that nurses also viewed themselves as powerless, "working in the frontline under intolerable conditions... [i]t is hardly surprising that they experienced demands from patients as extreme and the ward atmosphere as volatile" (p.5).

The centrality of relationships was reinforced in a phenomenological study of inpatients in a Canadian inpatient unit (Thibeault, Trudeau, d'Entremont, & Brown, 2010). Although a small study (six participants), I have included it because the study explicitly investigated the broader milieu (defined as “the psychological, physical, social, political, and spiritual components of the hospitalization” (p.220)), incorporating aspects identified as healing. Suggesting that “discussion of the concept and role of the psychiatric unit milieu has almost disappeared from professional discourse, except in reference to patient satisfaction” (p.217), the researchers investigated a project “designed to enrich the spiritual, physical, and psychosocial environment of two acute inpatient units and to create a more holistic and client-centered vision in acute care psychiatry” (p.218). The research team included two mental health consumers, the authors suggesting this allowed team discussions to “take on the character of a merging of horizons in a manner similar to the conversations of the interviewer and study participants” (p. 220), consistent with their phenomenological stance. A main finding of the study was that patients experienced relationships as the key aspect of the inpatient milieu, their stories suggesting that it was social interactions that created meaning for patients.

This paper is one of the few to overtly discuss healing, although it is not clear whether ‘healing’ was a researcher or service user generated concept: “one patient described healing as “being in remission of some kind of pain... less psychological symptoms”” (p.223). Neither the illustrative extracts nor the research questions contained the word healing, suggesting it was a researcher derived concept which was not further defined. The authors reported the most intense descriptions as relating to the experience of seclusion: described as pain, violation and abandonment. Included in experiences identified as healing were opportunities for recreation, and time in a restful, relaxing space. The authors’ conclusion was that the unit milieu created possibilities for recovery that were dependent on healing relational experiences in a comforting and healing physical space.

The Norwegian experience was investigated in a hermeneutic-phenomenological study involving 15 patients admitted voluntarily to a psychiatric hospital offering pre-planned admissions for patients experiencing long-term mental health problems (Borge & Fagermoen, 2008; Borge & Hummelvoll, 2008). With patients staying for an average 12 weeks, and treatment including individual and group psychotherapy, the purpose of this hospital seemed different to the acute units described earlier, having more in common with my experience at Ashburn. Patient interviews took the form of a dialogue, beginning with the open question “[t]ell me about a concrete experience from the hospital stay, which has

been especially important to you” (Borge & Fagermoen, 2008, p.195), and participants were encouraged to talk about positive as well as negative experiences, including learning experiences and contextual factors.

Two main categories of experience were identified: wholeness and self-worth, and time and space. Patients described experiencing wholeness arising from professionalism, kind heartedness, and the aesthetics of the environment (old Swiss buildings in the countryside with an emphasis on beauty and pleasure); these factors contributed to a sense of self-worth. Time was often mentioned in interviews with differentiation between the daytime “therapy time”, and evening “leisure time”. The authors suggested that being hospitalized over a period of time was crucial to the therapy process; time enhanced the potential for self-reflection. The place had significance both in its beauty and the atmosphere which was connected to the people who were there; “being away from home and coming to calm and safe surroundings was an important deviation from their everyday life” (p.202).

In a re-analysis of the data from this study, Borge and Hummelvoll (2008) focused on patients’ experience of learning and gaining personal knowledge. Their key finding was the importance of environmental factors on motivation to learn, and on self-esteem, conceptualising the therapeutic milieu as a “landscape for learning, where the relational aspects are emphasized stronger than the individual processes” (p.369). Participants emphasized the importance of a safe, pleasant environment where they were met on an equal basis in a predictable and structured way. Concluding that the option of inpatient treatment for persons suffering from mental health problems may still be useful, they identified a need for further research to determine the optimal therapeutic milieu and its effect on recovery processes.

In stark contrast to these previous studies, Hummelvoll and Severinsson (2001) reported a qualitative study of nurses’ working conditions in another psychiatric hospital in Norway (utilizing participant observation and interviews) in which patients were described as often in a state of crisis and mean length of stay was eleven days. Their analysis showed the unpredictable nature of the acute ward environment, which in combination with short stays resulted in nursing care characterized by ‘therapeutic superficiality’. These two Norwegian studies point to differences in hospital environments, and raise questions about the functions of inpatient psychiatry.

Alternatives to hospital

In an era promoting community-based care, (hospital bad, community good) not only do many service users view admission to hospital as a moral failure rather than a positive step towards wellness (Quirk, Lelliott, & Seale, 2006), there is also widespread pessimism about the benefits of admission. So are community alternatives better? It is beyond the scope of this literature review to investigate each option in depth, but an extensive study in England provided a useful overview (Byford et al., 2010; Gilbert et al., 2010; S. Johnson et al., 2009; S. Johnson, Lloyd-Evans, Howard, Osborn, & Slade, 2010; Lloyd-Evans, Slade, Jagielska, & Johnson, 2009; Osborn et al., 2010; Tansella, 2010). The Alternatives Study was a national investigation of residential alternatives to standard acute inpatient care in England. Beginning with a survey (S. Johnson et al., 2009) and then literature review (Lloyd-Evans et al., 2009), this study aimed to identify, describe and then investigate existing residential alternatives to standard acute inpatient care, using quantitative and qualitative methods.

The survey identified 131 services in England that met their criteria of serving “adults aged 18-65 years who would otherwise have been admitted to an acute ward and involved the patient staying overnight in the service” (S. Johnson et al., 2009, p.456). The study developed a typology identifying eight service categories, including both community and hospital based alternatives to acute inpatient care. Community-based service types were clinical crisis houses (high proportion of nursing staff and providing a care programme approach), specialist crisis houses (catering for particular groups e.g. women or people with early psychosis), crisis team beds (very small bed numbers) and non-clinical alternatives (usually managed by the voluntary sector). The hospital-based service types included general therapeutic wards (usually utilising a specific therapeutic model), wards for specific demographic groups (e.g. mother-and-baby units), therapeutic wards for specific diagnostic groups (a small number who were predominantly in the voluntary or private sector), and short-stay wards and general wards for specific groups (a residual cluster of hospital services). The authors estimated there were approximately 1,300 occupied beds in alternatives, compared with 12,400 typical acute adult beds in England, thus a relatively small number with only 250 of these outside of hospital.

These typologies were used to inform a systematic review assessing the clinical effectiveness and cost-effectiveness of, and satisfaction with, residential alternatives (Lloyd-Evans et al., 2009). Twenty-seven studies were identified of which nine were considered moderate quality and none were high quality. Current research was considered insufficient to show convincing evidence about effectiveness or acceptability of residential alternatives, although for some

people community-based alternatives may be as effective, more acceptable and cheaper than standard inpatient care. The authors commented that research provided no contraindication to any type of alternatives in the review, though the evidence was limited. The review noted the limitation that residential alternatives were not clearly defined or described by a consistent terminology.

Gilburt et al (2010) reported the qualitative component of the study. Forty service users from six residential alternatives (and who had previous experience of a hospital-inpatient stay), were recruited to participate in in-depth interviews exploring their subjective experience of both the residential alternative and traditional services. Consistent with previous studies, relationships were the most frequently reported theme in both alternative and traditional settings. With respect to the relationships between staff and patients there were no clear differences between the hospital and alternative settings, but over half the respondents identified that those people treated in hospital-based services were more acutely unwell, and that this impacted negatively on their experience.

Coercion was reported more in hospital-based services, and patients described greater freedom in alternative settings. Safety was again a dominant theme, with over half the participants experiencing fear for their safety in a hospital setting. Interestingly, with regard to the physical setting there was no clear difference between the two settings; participants appreciated a setting that was 'a bit more like home', but more than half referred to 'people make a place'. In their discussion the authors suggested that alternative settings can be recommended but carry the risk that this may impact on hospital-based services by concentrating patients with higher levels of disturbance and risk. "There remains the question of how to create environments that contain and yet promote recovery in the least restrictive manner" (Gilburt et al., 2010, p.s30).

The study's summary article concluded that service users had a preference for residential alternatives which was influenced by the quality of relationships, with less coercion and a greater sense of safety because of the absence of more disturbed patients (S. Johnson et al., 2010). The authors were however unable to make a case for any particular type of alternative, indeed saying that an acceptable approach may be to focus on improving therapeutic contact for all patients admitted to acute facilities. The authors recommended research aimed at identifying critical ingredients in successful services with a particular emphasis on factors that promote or impede therapeutic relationships. This study suggests

there remains a lack of consensus and evidence for what type of place people need when acutely mentally unwell.

Where to now?

The psychiatric literature identifies serious concerns about the state of acute inpatient psychiatric care internationally, including safety, treatment, coercion and the quality of therapeutic relationships. There remains considerable debate about where and what facilities should be when mental health care is provided away from home; what seems clear is that in the era of post-deinstitutionalisation, psychiatric inpatient units serve the purpose of risk management, but with little evidence for, or agreement on, the therapeutic advantages, purposes and models of care for admission beyond this. There remains a consensus that many wards are atherapeutic and with the role of inpatient care poorly defined, some suggest that hospital based psychiatry has lost its way (Bowers, 2005).

Recent attention has focussed on identifying negative aspects of the treatment environment; the literature suggests that improvement in this aspect of services is overdue. While much of the preceding literature described rather bleak images of inpatient psychiatry, the Canadian and Norwegian examples present a more hopeful picture. However, the emphasis in most studies has been on the experience of being in hospital, with little discussion, other than hypothetically, about whether an improved inpatient experience alters the longer term course of one's illness or facilitates recovery. In a similar vein, residential alternatives provide respite and may be more acceptable to some patients, but do they alter long-term outcomes? With limited evidence as to the necessary attributes for promoting recovery, the risk is that these community based facilities go the same way as firstly asylums and then acute units.

Many studies assume the status quo: acute units provide relatively brief admissions for safety, containment and resolution of a crisis; alternatives accommodate even briefer stays for crisis resolution. I am faced with a conundrum: services as they are currently configured, focussing on outpatient care and brief admissions to hospital for medical treatment, are relatively unchanged from those available in the public sector when I was unwell. These were services that did not aid my recovery. My recovery was supported by a lengthy stay in a hospital whose location in the countryside in some ways suggested a step back into the asylum era and moral treatment; but I recognise that for many people asylums were associated with hardship and loss. So I am still left wondering what it was about this place that was healing for me. Ashburn Hall was somewhat unique in New Zealand mental health services utilising a particular model of care, the therapeutic community; in the next chapter I

will briefly consider models of care as they influence psychiatric treatment environments, before putting aside existing structures to consider broader aspects of place.

Chapter three: Ways of thinking about place

I suggested in the previous chapter that an interest in the role of place in the treatment of mental illness is not new: moral treatment proposed that the physical environment, built and natural, of the asylum was of cardinal importance in achieving cure (Paine, 1999; Porter, 2002). For many reasons, including social, political and economic, mental health care moved on, albeit with a few services still offering care akin to the original vision of the York asylum (e.g. Ashburn Hall, the York Retreat). The 20th century saw a shift to interpersonal processes being paramount in mental health care with the emergence of psychotherapeutic approaches (Porter, 2002), and then in the latter half of the century, an increasing focus on medical (biological) treatments (Koivisto, Janhonen, & Väisänen, 2004). There have been moves particularly within nursing to adopt a more holistic approach to general and mental health. Reflected in various models of care, these approaches have generally continued to place emphasis on the therapeutic relationship (Browne, Cashin, & Graham, 2012); investigated and instigated particularly in the nurse-patient dyad, there is only minimal application to the doctor-patient relationship which continues to focus on diagnosis and pharmacological treatment.

The therapeutic environment

With an increasing focus on medical approaches to treatment, and a philosophical commitment to community based care, there has been decreased interest in the environment of hospital based mental health care, and to a lesser extent the alternatives to admission. The language used in the psychiatric literature to describe these environments is varied, being referred to as the therapeutic environment, ward atmosphere, and psychiatric or therapeutic milieu. The latter becomes more confusing referring to a specific treatment modality (milieu therapy) and applied in a more general sense.

Thibeault et al (2010), defining milieu as meaning the psychological, physical, social, political, and spiritual components of the hospitalization experience, asserted that this critical aspect of psychiatric treatment has become neglected with little research. Mahoney, Palyo, Napier and Giordano (2009) concurred, suggesting that “either we continue to refer to the therapeutic milieu as important to inpatient care or we do not. If we do not, we are left with a care environment that is strictly focused on safety, symptom reduction, and cost containment” (p.424). One response to perceived inadequacies in both general and mental

health environments has been the development of a range of models of care, philosophies and guiding principles, these terms often being used interchangeably (Hungerford, 2014). Literature is predominantly to be found in the nursing and allied health literatures, with remarkably little written by medical professionals. Some studies evaluate particular therapeutic strategies in both inpatient settings and residential alternatives; others describe and promote general approaches to care.

A model of care defines how mental health services are delivered, and is based on theoretical assumptions about illness and care (P. Davidson, Halcomb, Hickman, Phillips, & Graham, 2006; Hungerford, 2014). A recent explication of what constitutes a model of care suggested the need for grounding in evidence; as will be discussed in the next chapter, this raises questions as whose and what evidence counts (P. Davidson et al., 2006). Ashburn Hall had a particular model of care: the therapeutic community, now rarely utilised in New Zealand mental health services. Therapeutic communities were developed in the 1940's to treat servicemen returning from World War II, as an alternative to the then predominantly custodial care of large psychiatric hospitals (Duder, 2007). Perhaps recognising the origin of their particular distress in the trauma of war, the therapeutic community concept provides "a consciously designed social environment" (Haigh, 2002, p.65), in which the community becomes the primary therapeutic instrument. Social and group processes are harnessed with therapeutic intent; patterns of behaviour and relating are identified to facilitate awareness and potential for change (Schimmel, 1997). This model of care, traditionally a lengthy residential program, lost favour in the Western world in the 1970s as psychiatric services moved away from long-stay hospitals and towards psychopharmacology (Duder, 2007).

In the UK in recent years, there has been a revival in the form of therapeutic community-informed day hospitals and in prisons (Haigh, 2007; Haigh, Pearce, & Diamond, 2010). The relatively small number of outcome studies show positive efficacy for treatment of personality disorders and substance abuse, neither of which were diagnoses I earned (Haigh, 2002; Lees, Manning, & Rawlings, 2004). Mistral, Hall and McKee (2002) evaluated a project to use therapeutic community principles to improve the functioning of a high care psychiatry ward in the UK. These principles included improved communication with daily ward meetings, an improved physical environment, clear messages about safety, and improved clarity of aims and structures including rules. Implementation resulted in significant improvements in communication, decrease in use of seclusion and in short-term staff illness. In a think-piece from the UK literature at a similar time, Holmes (2002) argued for a return of psychotherapeutic principles to the inpatient ward.

A uniquely New Zealand approach to health, and more specifically mental health care, arose in the 1980's in the form of Maori⁵ cultural units (Durie, 2001). Located within larger psychiatric hospitals, the units aimed to provide a treatment environment based on Maori cultural values, processes and beliefs. These services, which continue today in various forms, were intended to be managed by Maori for Maori, incorporating cultural assessment and traditional healing practices, with values emphasising links to family (whanau) and tribal groups (whanaungatanga), and spiritual practices (wairuatanga). Te Whare Tapa Wha, a model of health first articulated in 1982, continues to inform these culturally based services (Durie, 1994; Rochford, 2004). This model compared health to the four walls of a house (whare), each "being necessary to ensure strength and symmetry" (Durie, 1994, p.70); the walls represent "taha wairua (the spiritual side), taha hinengaro (thoughts and feeling), taha tinana (the physical side) [and] taha whanau (family)" (p.70). Taha wairua is generally considered by Maori to be the most essential element for health, with a particular emphasis on spiritual aspects of one's relationship with the physical environment. This holistic conceptualisation of health and healing, with its emphasis on the wider environment and spirituality, has similarities to other indigenous models (Agnew et al., 2004), and has a grounding in cultural values that is perhaps lacking in the modern biomedical paradigm and general mental health services in New Zealand.

A report into the quality of care in psychiatric wards in England, 'Acute Problems' (Sainsbury Centre for Mental Health, 1998), recommended that patient-centred care should be "the fundamental principle underpinning the planning and delivery of acute care" (p.6). Now referred to variously as patient/client/person-centred care (Slater, 2006), reflecting changing societal attitudes to the health professional/service user relationship, this approach is promoted in clinical guidelines (NICE Clinical Guideline, 2011) as person-centred care. Originating as a general health care philosophy, many definitions of person-centred care exist and similarly many components have been described (Dewing, 2004). Primarily discussed in relation to the nurse-patient dyad, person-centred care implies a shift in the locus of power by providing care that endeavours to understand the person's outer and inner worlds from their frame of reference (O'Donovan, 2007), and is centred on a person's individuality (Slater, 2006).

Recovery-oriented practice (Hungerford, 2014) and Trauma-informed care (Muskett, 2014) have also been proposed as approaches to improve the therapeutic milieu of mental health

⁵ Maori are the tangata whenua (indigenous people) of New Zealand

treatment environments; the latter approach is predicated on a belief that trauma is associated with adverse mental health outcomes (Substance Abuse and Mental Health Services Administration, 2014). The Psychologically Informed Environment (R. Johnson & Haigh, 2010), Milieu Therapy (Gunderson, 1978), the Tidal Model (Barker, 2001; Barker & Buchanan-Barker, 2010) and Nidotherapy (Chamberlain & Sampson, 2013; Tyrer, Kramo, Miloseska, & Seivewright, 2007), have each argued their case as models to define the environment of mental health facilities. Focussing to a varying degree on the interpersonal processes, activities and treatments in these environments, Lloyd-Evans et al (2009) make the point that although a range of innovative acute services have been developed internationally none have become widely established, casting doubt on their sustainability or usefulness.

Architecture meets psychiatry

Shifting from an emphasis on interpersonal processes as the determinant of therapeutic environments, and perhaps reflecting another ‘turn of the wheel’, in the last decade there has been a growing interest in the therapeutic value of physical aspects of mental health facilities including architecture, interior design and landscaping. This coincides with a similar focus in general healthcare environments with contributions from architecture, environmental psychology, and, interestingly, psychoneuroimmunology. This shift in interest is perhaps a response to dissatisfaction with an increasingly impersonal and technological medicine. In one of the first healthcare papers of the modern era to investigate the role of physical environments in healing, Ulrich (1984) demonstrated that surgical patients nursed in rooms with a view to nature required less pain relief and were discharged from hospital earlier, suggesting more rapid healing. Since then, multiple factors have been implicated in improved outcomes on general healthcare including privacy (single rooms), ambience (reduced noise, light, air quality), sunlight, views to nature, way-finding and personal control over the environment (Lawson, 2010; Schweitzer, Gilpin, & Frampton, 2004; Ulrich et al., 2008). This research contributes to a growing body of evidence that facility design can directly affect health outcomes (Ulrich, 2006).

While a major focus of healthy general hospital design remains infection control, Ulrich (2013) suggested that psychiatric hospital design was interested in a different type of control, being “viewed through the prism of security” (p.1). Connellan et al’s (2013) literature review pointed to security being the focus of the largest proportion of studies at the interface of architecture and mental health. The study of the physical environment of psychiatric units is

still considered to be in its infancy (Karlin & Zeiss, 2006), several literature reviews and commentators referring to the relative scarcity of mental health specific studies with often inconclusive data (Connellan et al., 2013; Papoulias et al., 2014; Sine & Hunt, 2009). There are however accepted commonalities with findings from the general health sector. Not dissimilar to early ideas underpinning moral treatment and asylum architecture (Arya, 2011), there is evidence for the importance of sunshine, natural light, proximity of windows, and access to the outside and garden spaces, in modulating mood, distress and satisfaction with the environment (Beauchemin & Hays, 1996; Connellan et al., 2013; Nakarada-Kordic & McKenna, 2011).

Single bedrooms are preferred for privacy, with a homelike or familiar environment perhaps contributing to well-being (Connellan et al., 2013; Papoulias et al., 2014). While privacy is sought, social interaction is also desired and requires spaces for this to occur; flexible spaces allow users to control their level of social contact (Daykin, Byrne, Soteriou, & O'Connor, 2008). Elements of interior design have come in for review with evidence for positive effects of artwork on the walls, although the art form is open to interpretation, some e.g. abstract art potentially adding to stress (Daykin et al., 2008; Nanda, Eisen, Zadeh, & Owen, 2011). Numerous studies have considered the effect of colour on healing, some arguing for example that bright colours can be beneficial while blue-green colours are undesirable for people with depression, although here too there are questions of quality, with studies generally making no allowance for confounding factors (Nakarada-Kordic & McKenna, 2011; Papoulias et al., 2014).

An issue raised by reviewers is that multiple studies produce lists of disparate factors with little attention given to providing a coherent way to approach design (Connellan et al., 2013; Nakarada-Kordic & McKenna, 2011). When findings were related to outcomes, these tended to be expert or clinician determined, with a lack of consideration of how aspects benefit service user recovery, except as measured by satisfaction, itself a problematic term (Golembiewski, 2010; Hopkins et al., 2009; N. H. Perkins, 2013). A New Zealand review of literature pertaining to the physical environment of mental health units pointed to a paternalistic approach to design considerations, with little evidence of a service user perspective (Nakarada-Kordic & McKenna, 2011). Gross, Sasson, Zarhy and Zohar (1998), in their much quoted reflection on a new mental health unit, identified “clinically desirable behaviour change” as an “encouraging result” (p.108), but I wonder by whom the behaviour change was desired. Much of the design research is directed at reducing aggression and violence (Connellan et al., 2013); while I assume this would be appreciated by most service

users and staff, without consideration of the subjective experience of the service user, we risk a lack of depth in the knowledge or wisdom that informs building guidelines (Golembiewski, 2013).

The evidence for causal links between the environment, design and clinical outcomes is limited (Papoulias et al., 2014). Sternberg (2009) argued for a scientific basis, specifically neurobiology, for the association between place and healing. Explaining how what we see, hear, touch and smell influences our neurotransmitters and consequently the immune system, she suggested that environments can be designed to promote particular psychoneuroimmunological changes and hence health and healing. Golembiewski (2010), an architect with an interest in mental health unit design, drew on salutogenesis to understand the link between the physical environment and healing. Salutogenic theory argues that improved health results from a state of mind with a fortified sense of coherence, that arises in “people’s ability to assess and understand the situation they were in [comprehensibility], to find a meaning to move in a health promoting direction [meaningfulness], also having the capacity to do so [manageability]” (Lindström & Eriksson, 2005, p.440). Golembiewski suggested that salutogenesis can inform architectural design if the environment is understood as a source of meaning and sphere of influence for service users, staff and family.

The significance of the physical environment to mental health care was captured in a Canadian case study reporting a participatory design process (N. H. Perkins, 2013). The study’s unambiguous finding was that the environment (particularly the natural surroundings) was “read as a place of meaning” (p.382). Involving patients, staff and designers, the study resulted in a master plan for redevelopment of a large psychiatric hospital. A series of design imperatives were generated to guide all future development; these imperatives included settings that facilitated a sense of exploration, discovery and achievement. Participants wanted to be able to manipulate and control their environments, giving the example of being able to re-arrange seating to suit changing social needs. Engagement, connection, and ceremony or ritual were identified as important aspects of the environment, perhaps helping create meaning. In the same report, a second case study utilizing client focus groups identified a desire for calm, refuge and connection to the natural environment. In advocating a participatory design process, the authors suggested that “staff and patients... often have unique and well-informed knowledge about their local environment, their behavioural preferences and their needs” (p.388).

The notion of design principles had resonance for me and my hopes for this thesis. Hospitals, mental health units, asylums or whatever we choose to call our health facilities reflect and concretize, in their designs, society's assumptions about illness, care and healing, and what it means to be a clinician and a patient (Bromley, 2012). As I discussed this project with colleagues, I was repeatedly asked if my research would tell services how to build a new mental health unit, some reflecting with nostalgia on the old buildings and open spaces of the asylums where they began their training. Rather than investigating concrete aspects of place such as room size, colours and door handles, I hope to contextualize healing aspects of the environment, and place, within the service user experience of recovery and healing. Golembiewski (2015) suggested that "the silver bullet won't be a colour or texture of a wall, but complex combinations of schemata that combine to tell a more complex story" (p.206), and it is perhaps in our stories of healing that we can find the coherence to bring together disparate aspects of place that facilitate recovery.

Beginning to explore place

Ashburn Hall was, for me, a place of healing, where other modern mental health environments had failed. The residential therapeutic community approach to treatment in mainstream psychiatry is in decline, and I am aware from personal experience that as a treatment option it doesn't work for everyone. Given my concerns about 'another turn of the wheel' and supported by the lack of clarity exposed in the psychiatric literature I chose to step back from the concept of mental health facilities as they have been and are currently, to think about the notions of place more broadly.

Ashburn Hall worked for me; the trajectory of my illness journey changed. In endeavouring to understand the significance of place in facilitating a positive healing experience, it is worth considering what I mean and what is meant by the notion of 'place'. This necessarily also demands a consideration of space; as argued by Tuan (1977), it is difficult to talk of place without also understanding space: place begins with space. Although these are terms that we use almost unthinkingly, definition is not easy. Cresswell (2009) stated that "the common-sense uses of the word place belie its conceptual complexity", defining place as "a meaningful site that combines location, locale and sense of place" (p.169). Likewise, Elden (2009) suggested that "one of the reasons space is so difficult to define is that it has many uses and a complicated history".

The concept of place is discussed very little in the recent psychiatric literature (Andes & Shattell, 2006; Lengen & Kistemann, 2012). Yates, Holmes and Priest (2011), described the

relationship between mental health and environment as complex and multifaceted and lamented the lack of rich descriptions of place in the recovery literature, suggesting this “dislocates recovery from its geographical location and the wider political and economic system in which it occurs” (p.140). Defining place as “the local physical and social environment in which a person lives and the conditions and resources within it” (Yates, Holmes, & Priest, 2012, p.105), the authors proposed understanding recovery as an ecological process: a transaction between a person and their physical and social environment.

In the geographic literature, authors distinguish between conventional understandings of space and place, and a more recent consideration of social or relational determinants (Cummins, Curtis, Diez-Roux, & Macintyre, 2007). Curtis (2010) described the conventional view of place as “parcels of space... positioned relative to each other in Euclidean space” (p.9) or as articulated by Kearns and Joseph (1993) “the geometric construct of space as container and places as locations” (p.716). This rather static view of place is often represented as being neutral from a socio-cultural point of view (Curtis, 2010). Relational and social views of place propose that the characteristics of place are more dynamic and fluid, being “complex cultural and symbolic phenomenon constructed through relationships between people and their settings” (Andrews & Moon, 2005, p.56). The notion of place takes on greater complexity when these views are melded: Gieryn (2000) suggested that places are “doubly constructed”, being both physically bounded and “interpreted, narrated, perceived, felt, understood and imagined” (p.465). This conceptualisation suggests that the determination of place occurs within the subjective experience, and as such is open to re-interpretation.

So what might this all mean for my research question? When I began my PhD journey I tended to think of my experiences of Ashburn Hall in terms of the physical place that I went to, with an emphasis on the natural and built aspects of the environment, and the people that I met there. But my understanding of place has needed to have greater complexity. I have been particularly taken by Tuan’s (1977) notion that place is space that has become known to us, that has meaning attached to it, with attributed value; leading me to reflect on how we come to experience, know and understand ourselves and the places in which we live. Tuan suggested that space is that which allows movement, whilst place requires a pause; Massey (2005) described space in similar dynamic terms as “always in the process of being made. It is never finished, never closed” (p.9). This sense of movement in space will become important in explicating the journey of healing.

The therapeutic landscape

The geographic concept of therapeutic landscapes proved a useful framework for considering the association between place, health and healing; Curtis (2010) suggested that “the ‘moral treatment’ movement could be considered as an early articulation of what makes for a therapeutic landscape for mental health care” (p.188). The concept’s four elements, the natural, built, social and symbolic environments were described by Gesler (1992) and applied to places of pilgrimage that had an “enduring reputation for achieving physical, mental and spiritual healing” (Gesler, 1993, p.171). Further development and critique has broadened the concept to consider a range of places that promote well-being and maintain health, with an increasing interest in emotional, cultural and spiritual aspects of place (Gesler, 2005; Williams, 2007a, 2010).

Although the original concept suggested that places have an intrinsic therapeutic quality, more recent literature has argued that therapeutic landscapes are dynamic and relational. Perceptions of what is therapeutic may alter in time, influenced by social and economic factors (Gesler, 2005). This would seem to have particular relevance to the landscapes of medical/psychiatric treatment and places such as Ashburn Hall, which are influenced by changing economic imperatives, social and political structures (Moon, Kearns, & Joseph, 2006). Conradson (2005) emphasised the experiential nature of the landscape, commenting that what is therapeutic for one person may not be for another. This idea of a relational therapeutic landscape will be an interesting concept to consider as I investigate individuals’ experiences of therapeutic mental health places, and is consistent with the postmodern view of there being no universal truth, no one ‘true’ experience.

The therapeutic landscape concept has its origins in cultural ecology, structuralism and humanism (Curtis, Gesler, Fabian, Francis, & Priebe, 2007; Williams, 2007a). Cultural ecology provided the idea that nature has the power to heal; structuralism informed ideas about social interactions, and power dynamics in the health setting. Humanism emphasised the importance of our beliefs about illness and treatment, the role of experience and emotions in our sense of place, and the symbolic power of stories (Curtis et al., 2007). The concept and components of therapeutic landscapes have stood the test of time, enduring in the literature and embraced by other disciplines including landscape architecture, environmental psychology and anthropology (Williams, 2007b) but with rare mention in the psychiatric literature.

The natural environment, the first of the four components of the therapeutic landscape, refers to those aspects of the physical environment that are not human-made. Gesler (2003) commented that “we know that many, if not most, societies around the world believe nature has healing powers... many people feel that they can attain physical, mental and spiritual wellbeing simply by spending time outdoors” (p.8). Many societies through the millennia held water, and more specifically spring water, in high therapeutic regard. Travelling through Europe, I visited a number of towns whose existence can be traced back to pilgrims’ belief in the healing power of the local spring e.g. the sacred spring of Glanum in Provence, the Chalice well in Glastonbury, and Lourdes in the Pyrenees. An interaction with nature, albeit through the written word, perhaps explained the pleasure, and concomitant sense of well-being I felt reading Conradson’s (2005) paper on therapeutic encounters in rural England. He used the setting of a rural respite care centre in England to investigate and emphasize the role of relational dynamics, i.e. the relationship between the individual and the environment, in determining therapeutic effect. “My argument then is that the therapeutic landscape is best approached as a relational outcome, as something that emerges through a complex set of transactions between a person and their broader socio-environmental setting” (p.338). Contrary to the fundamental beliefs of moral treatment, he asserted that settings are not therapeutic in and of themselves; rather, environments will be experienced in different ways by different people.

The built environment, the second component of the therapeutic landscape concept, refers to buildings and other human-made constructions. Florence Nightingale, in considering hospital design, recognised the importance of features such as low ward densities, circulation of fresh air, light and cleanliness in promoting healing (Gesler, 2003). The idea that buildings can be therapeutic has had a long history in landscape architecture (Williams, 2007a), although Schweitzer, Gilpin and Frampton (2004) suggested that a recent turn towards inclusion of aesthetic aspects in hospital design had the intent of attracting customers rather than enhancing healing. Kearns and Barnett (1999) extended this tension in consideration of my local children’s hospital, suggesting that utilising design to help consumers feel welcome may be an important consideration for both the health benefits of a physical facility, and its potential to attract philanthropic investment.

The concepts of natural and built environments were relatively easy for me to grasp; the richness of the physical environment of the Hall is vivid in my memories, but the symbolic and social environments may prove to be the most important (Gesler, 2003). The symbolic refers to the meanings that arise in, and/or people apply to, the environment; and influences

an individual's perception of and response to both concrete and abstract aspects of place. Contributing to one's sense of identity, security and belonging, spirituality and religious beliefs may be associated with illness and health benefits; for some people, illness is perceived as a spiritual crisis (Schweitzer et al., 2004). It has been suggested that the spiritual should be a fifth landscape type (Sperling & Decker, 2007), although Gesler's (1993) original explication would seem to include spirituality within the symbolic landscape.

Symbolic meaning has particular relevance in mental health care. Quirk, Lelliott and Seale (2006) reported that patients in an English psychiatric unit viewed admission as a "moral failure rather than a medical event, and as a process that adversely affects their sense of identity" (p.2111). For some people the locked door of a psychiatry ward may symbolise a prison (incarceration, punishment), for others it signifies a fortress providing protection from a hazardous world (Curtis, Gesler, Priebe, & Francis, 2009). Gesler (2003) suggested that the way mentally ill people are treated and related to is determined in large part by the culturally based meanings attached to mental illness: "they are [thought of as] 'deviants', 'a threat to society' or 'children' to be taken care of" (p.13). This is consistent with the extensive literature on mental illness stigma identifying themes of dangerousness and unpredictability applied to those with mental illness (Hayward & Bright, 1997; Liggins & Hatcher, 2005). A number of authors identify the tension between providing psychiatric environments that enhance autonomy, and meeting society's expectations to be kept safe: the 'carceral' role (Curtis et al., 2007; Lelliott & Quirk, 2004). These tensions arise partly in response to the negative meanings society applies to mental illness.

The social environment, and final component of the therapeutic landscape, refers to the social relationships that exist in the healing environment (Gesler, 1992). This usually implies interpersonal relationships, but Conradson (2005) encouraged readers to consider wider relational complexities between people and objects, and people and other biological entities (e.g. animals and trees), arguing that these relationships also have emotional dimensions. Gesler (2003) suggested that Lourdes 'works' for many people because of the sense of community and support they experience. He also made the perhaps contentious observation that "what is particularly important for healing is that there be equality between healer and healed, feelings of mutual respect and trust" (p.15). As will be discussed in the next chapter, while not dismissing the importance of respect and trust, modern medicine would not usually be described as embracing equality between professional and patient.

A rare mention of the therapeutic landscape concept in relation to mental health care was a series of papers reporting the outcome of a qualitative study investigating a new mental health unit in London, the findings interpreted in the context of therapeutic landscapes (Curtis et al., 2007; Curtis et al., 2009; Wood et al., 2012; Wood et al., 2013). The study concluded that hospital design is important for patient well-being, with social and symbolic factors being mentioned more often than physical elements of the environment. In keeping with other studies, patients identified a desire for a home-like environment with access to nature and spaces of refuge; and with considerable debate about the tension between nurses' desire to supervise, and patients' right to privacy. Respect and empowerment were identified as important relational issues for both patients and staff; respect had strong symbolic value, and was influenced by social interactions e.g. patients being shouted at or spoken down to by nurses. The smoking room emerged as a vehicle for social capital and resistance to institutional control. This was a similar finding to Thomas, Shattell and Martin's (2002) description of "the 'inner sanctuary' of the patient smoking room" (p.243), where patients could connect with each other without the oversight of staff. Consideration of these social and symbolic aspects of place may help explain the challenges encountered in recent moves to create smoke-free hospitals in New Zealand⁶.

Enabling places

Duff (2011, 2012) provided a useful development of the therapeutic landscape concept investigating the role of 'enabling resources' and 'enabling places' in recovery from mental illness. Suggesting that the causal or explanatory mechanisms of therapeutic or restorative environments are uncertain, and drawing on actor network theory, he argued that enabling places are created in, or facilitate, a series of encounters with the resources generated or made available within place: "[t]hese resources... support the myriad therapeutic processes that shape everyday experience" (2011, p.150). He identified three classes of resources: social, material and affective: social resources are the "varied processes and interactions... which support the creation and maintenance of social networks" (2012, p.1389); material resources include objects, assets, benefits and material affordances available within and made possible by, the network or community; affective resources "capture something of the resonant 'feeling' of place" (2012, p.1390) such as hope and optimism which may be generated both in the physical and social experiences of place.

⁶ e.g. the court action taken and ultimately lost: 'Psychiatric patients fight ban on smoking'; May 19, 2013. http://www.nzherald.co.nz/nz/news/article.cfm?c_id=1&objectid=10884573

Using this framework to investigate community places identified by participants as supportive, an array of resources were identified as aiding their 'work' of recovery, participants often tracing the significance of their favourite places to the feeling states generated within. Sometimes these places were unexpected: a cemetery that prompted the thought "it's great to be alive" (2012, p.1392) , or a setting that afforded the opportunity to do handstands, this latter being likened by the participant to the contest with one's fears and anxieties that is part of recovery. While much of the therapeutic landscape literature does not explore the intrapersonal experience of healing, the notion of enabling resources potentially allows a greater consideration of the individual's subjective experience of an environment, and the development of meaning.

Towards an understanding of place in healing

The concepts of therapeutic landscapes and enabling places argue that place, and more specifically the interaction with and experience of being in place, influences the process of healing. This is consonant with my assumption that the place of Ashburn Hall was implicated in my recovery: the process that I called healing. But place, like its associated space, remains a contested notion, with implications for its application to healing and mental health. Earlier notions of place as simply a physical location or "passive container" (Kearns & Moon, 2002) have been given greater complexity with consideration of place as a construct arising from experience, suggesting that it is the personal lived experience that defines place, i.e. place is a subjective rather than objective phenomenon (Seamon, 2015).

As already discussed, the attribution of healing potential to place is not new in psychiatry being a foundational belief in moral treatment. This approach to care placed emphasis on both the physicality of psychiatric hospitals (asylums) and their operational structures, but with little attention to the personal experience of those contained within the structures. The 20th century shift to an emphasis on the therapeutic relationship could be understood as placing greater emphasis on subjectivity but only with respect to the interpersonal (usually clinical) relationship, with a perceived lack of interest in the material and other relational aspects of place. Geographers have offered more nuanced considerations of mental health places and their healing potential (Curtis, 2010; Curtis et al., 2007; Duff, 2012), but although hospitals and other physical facilities remain an integral part of mental health services, there is a paucity of research exploring associations between these places and healing or recovery.

Recent conceptualisations of place have argued that physical aspects of place cannot be separated from the socially constructed: "place must be understood as a primary ontological

structure that subsumes both human experience and the material world in which that experience happens” (Seamon, 2015, p.41); as such place is inextricably entwined with who we are. Malpas (2001) articulated this relationship as:

... what we are as living, thinking, experiencing beings is inseparable from the places in which we live – our lives are saturated by the places, and by the things and other persons intertwined with those places, through which we move, in which our actions are located, and with respect to which we orient and locate ourselves (p.231).

It is this notion of place as a complex and inseparably recursive interplay between our selves, the material or physical, the people and activities of place that will be taken forward into this thesis and that will have relevance for healing in place. The subjective experience lies at the heart of this understanding of place, and it is in the exploration of the lived experience of mental illness that we may develop a richer understanding of place and its association with healing.

This understanding of place as related to mental illness and healing brings me to the final part of this literature overview: the notion of recovery. Exploring my original decision to investigate healing rather than recovery, this discussion will begin to expose the recurring tensions in my positionality as psychiatrist and as service user, and the understandings each brings to bear. These tensions will be further explored in the next chapter, with implications for the methodology adopted for the research.

Does recovery have a place in this thesis?

In 1998, two years after I began my psychiatry speciality training, New Zealand adopted a ‘recovery approach’ to guide its mental health service delivery. The Mental Health Commission, established as a result of the 1996 Mason Inquiry into Mental Health Services, described recovery in its ‘Blueprint for Mental Health Services in NZ: How Things Need to Be’ (Mental Health Commission, 1998) as occurring when “people can live well in the presence or absence of their mental illness” (p.1). But what did and does this mean? As a service user I was now living well in the absence of mental illness, therefore by this definition I had recovered. As a psychiatrist my practise was informed by ‘recovery competencies’ (O'Hagan, 2001), but when I came to do this research, the recovery that I knew as a health professional did not capture my experience as service user. I resisted describing my journey as one of recovery, except in its outcome of amelioration of

‘symptoms’. In making sense of this tension I have needed to interrogate what is meant by recovery.

This is not a simple question to answer. Anthony’s (1993) definition of recovery continues to be the most widely accepted: “a deeply personal, unique process of changing one’s attitudes, values, feelings, goals, skills, and/or roles. It is a way of living a satisfying, hopeful, and contributing life even with limitations caused by illness” (p.527). But in his and others’ advocacy for recovery being a guiding vision for mental health services, recovery moved in the 1990’s from being a personal experience to variously a vision, a philosophy, a process, an outcome, an attitude, a life orientation, a model, a movement and a doctrine for change (Bonney & Stickley, 2008; Leamy, Bird, Le Boutillier, Williams, & Slade, 2011; McCranie, 2010).

Debate continues in the literature and recovery remains a contested concept, the term being used inconsistently with varying implications for policy and practice (L. Davidson, Borg, et al., 2005; Slade, Leamy, et al., 2012). Recent literature has endeavoured to synthesize these views and develop conceptual clarity on recovery (Bonney & Stickley, 2008; Leamy et al., 2011; Onken, Craig, Ridgway, Ralph, & Cook, 2007), but to understand the ongoing debates it has been useful to consider the origins of the recovery concept. Some authors suggest that recovery can trace its origins to the moral treatment of the asylum (McCranie, 2010; Roberts & Wolfson, 2004), and later to the field of addictions, but most consider that mental health recovery had its beginnings in the growth of consumer/survivor organisations in the era of deinstitutionalisation, amid growing dissatisfaction with mental health services (Anthony, 1993; L. Davidson & Roe, 2007). This was a time when civil rights movements were taking centre stage and as such recovery could be viewed as a political response or doctrine for change. Recovery challenged the idea of professional power and expertise in services that emphasised chronicity and maintenance, and encouraged service user agency and empowerment (Bonney & Stickley, 2008; Shepherd, Boardman, & Slade, 2008). Davidson (2012) suggested that “we owe the concept of personal recovery to persons with serious mental illnesses who decided that they need not wait until they were ‘cured’ of the condition by others in order to pursue a meaningful and self-determined life” (p.366).

One of the earliest to write of recovery in its modern form was Deegan (1988), providing a first-person account of her illness and recovery experience. Distinguishing recovery from the more passive process of “get[ting] rehabilitated”, she described recovery as “the lived experience of people as they accept and overcome the challenge of the disability” (p.11).

Deegan suggested recovery was an elusive phenomenon; a journey of “small beginnings and very small steps” (p.16) during which people “recover a new and valued sense of self and purpose” (p.11). Rather than merely achieving stabilization or returning to baseline, she later described recovery as “a transformative process in which the old self is gradually let go of and a new self emerges” (Deegan, 2002, p.5). The emphasis in this writing was on the personal, subjective experience, Deegan suggesting that “the recovery process cannot be completely described with traditional scientific, psychiatric or psychological language” (Deegan, 1988, p.12).

Often conceptualised as a journey (Lapsley et al., 2002), personal recovery is described as an active, non-linear process that is unique to the individual and involves change (Leamy et al., 2011; Onken et al., 2007). Processes inherent in recovery include finding and creating hope, personal growth, re-establishing a positive identity and building a meaningful life (Andresen, Oades, & Caputi, 2003; Bonney & Stickley, 2008; L. Davidson, Borg, et al., 2005; Kogstad, Ekeland, & Hummelvoll, 2011; R. Perkins & Slade, 2012). The development of self-determination and agency are supported in recovery by an awareness that change is possible; Onken et al (2007) linked this to potentiality: “the notion that what you seek or desire is achievable” (p.12). The processes of recovery are expressed in mnemonic form by some authors. The outcome of a narrative synthesis of the first systematic review of the personal recovery literature developed CHIME to describe the recovery process: Connectedness; Hope and optimism about the future; Identity rebuilding and overcoming stigma; Meaning in Life including but not exclusive to the meaning of mental illness experiences; and Empowerment (Leamy et al., 2011; Slade, Leamy, et al., 2012).

‘Kia Mauri Tau!’ (Lapsley et al., 2002), a New Zealand narrative research study of recovery, resulted in the mnemonic RECOVER+HEART. Suggesting that most narrative research in the health arena focussed on illness rather than recovery, the researchers interviewed forty past service users aiming to describe their journeys to mental health and identify key themes in the recovery process. Recovery occurred across a number of dimensions including issues preceding illness, the symptoms and associated fears of mental illness, and the consequences of the mental health problem and treatment, including stigma and loss of self-esteem, trust and hope. The authors identified strategies that participants found helpful for recovery: Reading/researching and learning, Emotional growth, Change of circumstances, Others/social support, Virtues: practising them, and Repeating strategies that work (RECOVER). Recovery involved “fundamental processes of change” (p.46) in identity and

relationships; these processes were grouped together as HEART: Hope, Esteem, Agency, Relationship and connection, and Transitions in identity.

The narratives in this study were rich and evocative, one of the few research reports I found that reflected aspects of my personal experience; yet this was not the literature that guided my work as a clinician. In this next section I will begin to tease out tensions in applying the concept of recovery to mental health care and service delivery.

Recovery as a guiding vision

Most scholars credit Anthony (1993) with the original articulation, in 1993, of a recovery orientation for mental health services. He suggested that “recovery from mental illness is to be the guiding vision for mental health services” (p.521) and at least in the Anglophone countries this claim seems to have been born out (Leamy et al., 2011; Slade, Leamy, et al., 2012). Recovery principles are now an important part of mental health policy throughout much of the English-speaking world, including New Zealand. Recovery has “come of age” (Slade, Williams, Bird, Leamy, & Le Boutiller, 2012, p.99) but with this mainstreaming of a once emancipatory movement comes risk, some commentators suggesting that recovery has been ‘hijacked’ or appropriated by health professionals (Slade et al., 2014).

It is perhaps the translation of a ‘deeply personal process’, a ‘lived experience’, into service provision that has resulted in tensions and debates, and why applying the term recovery to my experience and my research question did not feel right. These tensions have been discussed and framed in a variety of ways. A recurring debate is that of ‘recovery from’ versus ‘recovery in’; these are usually taken to mean: the definition (and aim) of recovery is to live well despite symptoms (recovery in), or to live well by achieving remission of symptoms, by returning to ‘normal’ (recovery from) (L. Davidson & Roe, 2007; L. Davidson, Schmutte, Dinzeo, & Andres-Hyman, 2008; Slade, Leamy, et al., 2012). These differing perspectives have also been characterised as personal versus clinical recovery, being typified as a tension between the service user perspective (recovery in) and health professionals (recovery from) (Gordon, 2013; Slade, Leamy, et al., 2012).

A related tension is the implication in some literature that personal recovery is only relevant for those with a severe and persisting illness (L. Davidson, O’Connell, Tondora, Lawless, & Evans, 2005; Gordon, 2013). Anthony (1993) also implied this in his definition of recovery: “[i]t is a way of living a satisfying... life even with limitations caused by illness” (p.527). My illness was severe but eventually not persisting, so does the concept of personal recovery not

apply to me? My recovery risked being marginalised not only by my profession, but also by the service user community.

Roberts and Wolfson (2004) have characterised these perspectives as generating two different types of research evidence, one focussing on clinical and social recovery, which can be measured objectively and expressed as approximations of cure; the second emphasising the more subjective personal and existential dimensions of recovery. This difference has also been characterised as nomothetic (recovery is a measurable and generalizable process) versus idiographic (the recovery journey as uniquely individual but not necessarily generalizable to others) research perspectives (Gill, 2012). The way that these different types of evidence are valued and utilized by mental health services can have implications for service provision. Slade (2012) argued that evidence-based medicine (discussed further on page 54) that emphasises nomothetic knowledge, while downgrading the significance of personal experience, is a poor fit with recovery and mental illness given the latter's fundamental subjectivity.

Bonney and Stickley (2008) suggested that the uniquely personal aspects of recovery can be diluted as they are converted to the rhetoric of policy, losing the subjectivity that lies at the heart of lived experience. The emphasis shifts to service provision, with its seemingly inevitable requirement for evidence and measurable statistics, and this had been my professional experience. Recovery became a tick-box of competencies as defined by New Zealand's Mental Health Commission (O'Hagan, 2001) which tell me, the clinician, the skills and knowledge I need: "[t]he term competencies is defined broadly... to include attitudes, skills, knowledge and behaviour required of the mental health workforce" (p.3).

These competencies were intended not as "an add-on to current curricula or training standards [but rather signalled] a fundamental change to all aspects of the education of mental health workers" (p.3). My experience was that they became another thing to learn rather than the desired fundamental shift; and an outcome measure for which we counted attendance at staff training. In my interactions with service users, my focus 'still needed to be' on diagnosis that informed treatment; I had decisions to make about risk and assessment forms to be completed. We counted the number of bed-days and readmissions, clinic visits

and no-shows, and HONOS⁷ scores as markers of effective services: objectivity trumped subjectivity.

So can recovery be both a personal experience and a philosophy for mental health services? A decade and more on from the mandating of a recovery orientation for services in New Zealand, the tensions remain. Adopting a recovery perspective requires an epistemological stance that user subjectivity has relevance in developing knowledge (Kogstad et al., 2011): my story, my experiences would become relevant to my practice of psychiatry, and to service development. My medical education encouraged objectivity; service user-me failed to see my experiences reflected in my psychiatrist's version of recovery. For now as in the beginnings of this project, recovery sits: not rejected but to one side. As the thesis progresses, a deeper understanding of these tensions will emerge, one that allows for a merging of horizons and placing healing at the heart of recovery.

This discussion of the tensions I experienced in the concept of recovery underscores a major critique of the psychiatric literature: where in the professional literature am I? I have said that I rarely see my service user experience reflected in the mental health literature. The readership is assumed to be mental health professionals and academics, written to present evidence, to provoke thought, reflection and discussion, and to guide clinicians, services and policy makers; but if I cannot recognise myself in the literature, then will I be present in the services they guide? Occasional academic publications begin to communicate and explicate the experience of being unwell and of recovery, but to my mind they rarely capture the depth and complexity of the experience and the interaction between myself, place and healing.

The service user's voice has been missing for too long; in part this is an epistemological issue in mental health: what counts as evidence, and who decides what we know. The experience of mental illness is subjective, and I would argue that exploring that subjectivity more explicitly from the service user perspective has the potential to add knowledge and understanding of what helps and hinders in mental health care.

⁷ Health of the Nation Outcome Scales: a clinical outcome measure of the health and social functioning of people with severe mental illness. See: <http://www.tepou.co.nz/outcomes-and-information/honos-family-of-measures>

Chapter four: Valuing the voice of lived experience

Perhaps there is something that we can learn from my experience: referring to my service user experience, this was the premise upon which my thesis was based. For 15 years, firstly as trainee and then as psychiatrist, I had remained relatively silent about that time of my life. While I am confident that covertly they shaped my clinical practice, these experiences had no voice in my professional life; nor could they influence service development. I feared being dismissed as ‘it was different for you’ or perhaps more likely ‘they just got your diagnosis wrong’ (Muncey, 2010). Over time, becoming increasingly frustrated with what I felt able to offer patients in the context of existing services, I wondered (again) was there something I and we could learn from my experience of mental illness and treatment?

When I originally articulated this premise, I was referring to my service user experience, but as the thesis progressed I recognised the significance of the psychiatrist experience that I bring to bear. I trained in psychiatry several years after leaving Ashburn, and it was the tensions that this training and subsequent professionalism exposed, albeit for a long time subtly and subconsciously, that led me to want to understand my earlier experiences in greater depth. My family upbringing, my education, and my medical training all honed my skills in the positivist logic of diagnosis and treatment, but my personal experience of being mentally unwell did not seem to resonate with this professional work. There was something missing: where was my personal sense of what it was like to be depressed and hospitalised reflected in this medical paradigm, and could my professionalism expand to accommodate these other experiences? In this chapter I explore firstly what counts as knowledge in the medical speciality of psychiatry, and then recent challenges in the form of postpsychiatry and more specifically the emergence of service user research. Together these build an argument for my choice of autoethnography as research methodology: valuing the voice of lived experience.

Psychiatry has its origins in modernity, developing as a hospital-based medical speciality in the 19th century asylums (Ovsiew & Munich, 2008). Much has been written on the biomedical emphasis of modern medicine and psychiatry (e.g. Engel, 1977; D. B. Morris, 2000); the second half of the 20th century has seen an increasing emphasis in psychiatry on biological explanations and treatments, with a focus on genetics, brain research, pharmacology and neuroimaging (Bracken et al., 2012). Demonstrating this emphasis, in 2013 the US National Institute of Mental Health announced its new Research Domain

Criteria based on several assumptions: “[m]ental disorders are biological disorders involving brain circuits that implicate specific domains of cognition, emotion, or behaviour... Mapping the cognitive, circuit, and genetic aspects of mental disorders will yield new and better targets for treatment” (Insel, 2013).

A recent development in psychiatry and healthcare in general has taken the form of evidence-based medicine which is “the conscientious, explicit and judicious use of current best evidence in making decisions about the care of the individual patient. It means integrating individual clinical expertise with the best available external clinical evidence from systematic research” (Sackett, Rosenberg, Gray, Haynes, & Richardson, 1996, p. 71). Current best evidence is assessed utilising a ‘hierarchy of evidence’ with the systematic review of randomised controlled trials having supremacy (Grade I) and expert opinion and anecdotal evidence being the least recognised (Grade V) (2009). Consistent with a view that subjective perspectives are inferior to objective measures (Giacomini, 2001), most systematic reviews incorporate only quantitative research, with only very recent development of strategies for inclusion of qualitative research⁸. These formulations of desirable evidence have the effect of disempowering alternative and often unquantifiable forms of evidence (Zeeman, Aranda, & Grant, 2013).

Within the current evidence-based medicine framework the personal story and service user opinion are considered, at best, as Grade V evidence (Rose, Thornicroft, & Slade, 2006), confirming my fear that without further investigation, and critique of existing structures, the knowledge I have gained from my personal experiences would be disregarded. Yet I believe that we can learn from my experience. Perhaps anticipating this challenge, Silagy, the then Chair of the Cochrane Collaboration, identified the influence of service users on the continued development of evidence-based medicine and healthcare as the ‘post-Cochrane challenge’ (Silagy, 1999, cited in Rose, Fleischman, & Wykes, 2008). The ability to learn from personal experience has inherent assumptions: that my experience has value, and that any learning can be valid or credible, an assumption that questions the nature of knowledge.

Psychiatry and postpsychiatry

Psychiatry as a medical speciality has had critics since its emergence in the early 19th century (Dain, 1994), most well-known in the form of the so-called antipsychiatry movement from the 1960’s (Berlim, Fleck, & Shorter, 2003). In contrast to earlier criticism by

⁸ The first systematic review of qualitative research by the Cochrane Collaboration was published in 2013. <http://www.cochrane.org/about-us/history>

predominantly lay people, the most prominent exponents of this later critique were psychiatrists including Ronald Laing, David Cooper and Thomas Szasz. Although theirs' was not a unified view, critique centred on the fundamental validity of the concept of mental illness, and hence diagnosis and treatment (Double, 2006; Fulford, Thornton, & Graham, 2006); arguing that mental disorders were not medical illnesses, the movement was perceived as questioning the legitimacy of psychiatry as a medical speciality (Berlim et al., 2003).

While not as radical as antipsychiatry, a more recent challenge to the positivist biomedical approach to evidence in mental health care has emerged in psychiatry. Prompted by the emergence of a service user voice and more recently service user-led research, development of the recovery concept and perhaps shaped by the same social, political and philosophical processes, postmodernism has taken more specific form in psychiatry in the last decade as postpsychiatry, with repeated calls for a paradigm shift (Bracken, 2003; Bracken & Thomas, 2005; Bracken et al., 2012; Lewis, 2000, 2006). It is suggested that postpsychiatry represents “a growing impatience with conventional approaches to psychiatric care” (Brookbanks, 2014, p. 1) and arises from a “profound doubt about the ability of science and technology to resolve human and social problems” (Rose et al., 2006, p. 112).

Postmodernism has been described as a collapse of certainty, and a crisis in the status of knowledge (Lewis, 2000). In contrast to modernity's quest for objective, universal truth, Bracken and Thomas (2005) described postmodern thought as representing “a struggle to free ourselves from the idea that there is only one path to the truth, one way of using reason, one form that science and serious reflection could take”, arguing that “no single analytic frame will explain the world and all its contradictions” (p.95). In the postmodern era there is “a disillusionment with the unifying ‘big stories’ offered by science, religion or politics to explain the way reality is. Instead people look towards the narratives of individuals or local communities, which are seen as less tyrannical...” (Laugharne & Laugharne, 2002, p. 2018). Lyotard (1984) argued that simplified to the extreme postmodernism was characterised by incredulity towards the metanarrative.

Postmodern thought embraces the recognition of ‘and/also’ rather than ‘either/or’ opening the door to the possibility of valuing differing forms of evidence and knowledge (Lewis, 2000). Much in psychiatry is contested: the meaning and very existence of mental illness or disorder and its causes or antecedents, the treatment of illness, the societal perception and rights of those diagnosed with mental illness. Postpsychiatry is conceived as a means to

apply postmodern philosophy to psychiatry, potentially opening up new ways of thinking about mental illness and health care, with a move away from an “insistence on consensus to an appreciation of divergence” (Brookbanks, 2014, p. 10).

For the post-psychiatry “movement” postmodernism is concerned with facing the contradictions and difficulties of our situation as human beings without having to resort to a belief that there will always be true and false ways of understanding and correct and incorrect ways of acting and behaving. (ibid, p.4)

Postpsychiatry has clinical, policy and research implications, suggesting “a need to actively engage with the interests and contributions of users, it emphasises social and cultural contexts, it seeks to minimize medical control and coercion, and it encourages doctors to redefine their roles/responsibilities” (Rose et al., 2006, p.112). Postpsychiatry, in its critique of modern medicine and psychiatry, suggests that there are other ways of developing knowledge and understanding beyond the randomised controlled trial; but there are challenges that come with this stance:

Indeed the challenge for post-psychiatry will be precisely to advance the agenda of consumer empowerment while limiting the impact of post-modernist anxiety through new forms of practice which are attuned to both the advantages and dangers of a post-modern critique (Brookbanks, 2014, p. 10).

For me as psychiatrist, the reclaiming of my service user voice came with tensions and anxiety: the threat to both my identity as doctor and the knowledge that guided my practice.

Service user research

Shortly after I began my thesis I received an email, with flyer attached, advertising the inaugural ‘Symposium for Service Users in Academia’ being held in my University; this was my introduction to service user research. Initially this was a local affair but each year subsequently I have attended, being held alternately in New Zealand and Australia. With speakers and delegates coming from as far afield as England and Canada, last year the group also established a web-based discussion forum. I remember my sense of excitement; I was not alone (well actually still a little alone: I have yet to meet anyone who overtly has a foot in the multiple camps of researcher, service user and psychiatrist). Here I was with people who knew what it was like to be unwell, and were talking with academic rigour about experiences that I could relate to, in language I could understand. This doesn’t mean that I cannot understand my professional language and literature; I am referring to a deeper form

of understanding, incorporating objective and subjective, intellectual and embodied knowing and understanding.

Traditionally, service users have been the subjects of research projects conceived, developed and carried out by others (Faulkner, 2012). The last few years have seen a steady increase in the involvement of mental health service users in the research process, not just as participants but as researchers (Beresford, 2005; Rose & Beresford, 2009; Sweeney, 2009). Service user/survivor/user research⁹ has its origins in the 1980's survivor movement, as a means of addressing issues of power and control. Originally taking the form of testimonials as a means of communicating experiences, the survivor movement aimed to develop an alternative discourse that challenged mainstream knowledge (Sweeney, 2009). Much of this research appeared in alternative or grey literature, beginning to also appear in mainstream and peer-reviewed literatures in the 1990s. Towards the end of that decade in England two large programs of research were developed within the mental health charity sector by the Sainsbury Centre for Mental Health and the Mental Health Foundation. As a result of these developments service user involvement in research was set into the policy framework in the UK, but still with the rider 'where possible' (Faulkner, 2012).

Many service users now choose research as their core endeavour for involvement and change, involvement taking a number of forms including consulting, collaborating and controlling (leading) research processes (Faulkner, 2012; Sweeney, 2009). What counts as service user research is up for debate with some suggesting only the latter two should be considered (Sweeney, 2009). Often expressed as a continuum of power, an increasing move to the latter end of the spectrum reflects a desire for a shift in the balance of power, Faulkner suggesting that "it is not simply enough to do the same research with different characters playing the parts" (Faulkner, 2012, p. 45). Service user research usually has aims of being emancipatory, empowering service users to set the research agenda, encouraging development of user-defined outcomes and with an ethical imperative to change things for the better (Beresford, 2009; Faulkner, 2012; Gordon, Banfield, Lampshire, & Russell, 2014; Rose, 2009; Rose et al., 2008; Thornicroft, Rose, Huxley, Dale, & Wykes, 2002).

Sweeney (2009) suggested that service user research differs from mainstream research by its different priorities, approaching research questions from a different perspective, typically defining mental distress in different ways, and with a greater emphasis on researching

⁹ Service user research, survivor research and user-research are all terms used in this literature. Consistent with my decision to use service user as my preferred term, I will refer to service user researchers, while respecting the reasons why others prefer different terms.

alternatives to the psychiatric system while also exploring mainstream services. Emphasising the first-hand experience of users, the methods used in research tend to be qualitative (Rose, 2009); it is perhaps this emphasis on the subjective experience as a source of knowledge that is the greatest divergence from mainstream mental health research (Beresford, 2005; Beresford & Rose, 2009, p. 12). Questioning the ability of researchers to be objective, Glasby and Beresford (2006) suggested that “[b]eing distant from the experience... can lead to the distortion and misunderstanding of such experience...” (p. 274), this occurring as the result of a commitment to particular ideologies and models of understanding. Service user research provides space for alternative explanatory frameworks for mental distress (Walsh & Boyle, 2009).

Service user research represents a fundamental shift from traditional approaches, various claims being made about the nature of knowledge produced (Beresford, 2005). Arguing, unlike the positivist assumptions of much medical research, that first-hand experience has value and integrity as a unique source of understanding, Beresford (2005) suggested that knowledge produced by service user research is likely to be the most authentic because of the shorter distance between experience, interpretation and knowledge. Rose (2009) referred to “alternative knowledge” (p. 38), while Straughan (2009) suggested that “the user researcher is the perfect translator of understanding and meaning from a user perspective” (p. 116).

As in postpsychiatry, service user researchers draw on a number of different philosophical standpoints to challenge traditional notions of evidence, with most refuting the assumptions inherent in positivist-inclined evidence-based medicine and its hierarchy of evidence (Aarmes, 2009; Faulkner, 2012; Rose, 2009). More particularly they ask who decides what counts as evidence (Rose et al., 2006). A number of the leading, particularly British, service user researchers have jointly authored papers with health professional/academics to critique or disrupt established biomedical norms and normativity (Glasby & Beresford, 2006; Zeeman et al., 2013). Rose (2009) suggested that such collaboration in research and writing can serve to open and develop the dialogue between user and professional, perhaps disrupting Foucault’s (1967) “monologue of reason *about* madness” (cited in Rose, 2009, p. 38). In collaboration with Thornicroft (psychiatrist) and Slade (psychologist), Rose (2006), proposed a multiple perspectives paradigm to integrate varied sources of evidence and understanding. Framed within postmodernism and more specifically postpsychiatry, they argued for research that utilizes both meta and micro-narratives paying attention “to the

uncertainties, experiences, differences in views and multifaceted perspectives of the realities of those whom it studies” (p.112).

It is interesting to reflect here on the identity of service user researchers; when writing alongside other academics are they user researchers or academics? Usually they are both: not an either/or, rather a this/and. Cresswell and Spandler (2012) described this as being “*doubly located* insofar as they remain within the social movement field but also within academia” (p. 5); I am perhaps *triply located*, given my involvements as service user, academic/researcher and as psychiatrist in the services that this research critiques. Managing, or perhaps negotiating, these multiple locations or perspectives is the challenge in service user research, and more particularly this project: the struggle against ‘monogamies’, as articulated by Church (1995) (a psychologist/sociologist) describing her research project with psychiatric survivors.

Service user research is now established on the mental health research landscape; critically valuing the lived experience of people like me, it provides a frame for accepting my original premise that we can learn from my personal experience of illness. But this type of research still comes with challenges: practical, philosophical, intrapersonal and attitudinal (Faulkner, 2012). I am reminded of the conversations I had with a member of the Department of Psychiatry at my alma mater, and the resulting decision to move my base to a department more versed in qualitative methodologies; it had felt like we were talking a different language. Glasby and Beresford (2006) question why “academics from different backgrounds have such divergent views about what constitutes valid research” (p. 278). Service user research is still considered by some to be biased and of “diminutive value” (Walsh & Boyle, 2009), being met with “outright hostility” (Callard & Rose, 2012).

Despite the increasing investment and interest in service user research over the last decade, an Italian systematic review of the international literature in 2005 (Salvi, Jones, & Ruggeri), found only three SU-led studies in mainstream literature, all from these UK researchers. There is perhaps hope to be found in commentary by the then editor of the British Journal of Psychiatry: having expressed concerns eight years earlier about service user involvement in research, in 2010 (3 months after I began my PhD journey) Tyrer (2002, 2010), admitted he was wrong. In an editorial titled “Service users centre stage” he said:

Not so long ago I felt that the growth of the user movement might handicap research in mental health because consumerism might take over from evidence, “accelerate out of control and drive mental health research into the sand”. It has not done so, and I am

pleased to admit I was wrong... When all the data, both qualitative and quantitative, point in the same direction then we have a powerful combination indeed. (Tyrer, 2010, p. 340)

There is also the potential that service user research might offer new directions for our understanding of illness and mental health care.

A methodology for the heart

Postpsychiatry and more particularly service user research offer support for my premise that we can learn from my experience. I could have simply told my story satisfying the part of me that wanted to reclaim my service user voice, but I wanted to do more. I wanted to think more widely and deeply about our services, to develop an understanding particularly as it related to place and healing, and to reconcile my experiences as service user and psychiatrist, wondering if in this reconciliation there may be elements applicable to wider services. To be honest, I also hoped it would be harder to dismiss my experience if I added academic rigour to my service user and psychiatrist voices. This fear is consonant with the ranking or value given to service user opinion in the knowledge structures within which I worked.

When I reflected on my experience of illness, treatment and recovery I felt little connection with the psychiatric literature with which I engaged as a clinician. I do not think about myself having ‘a diagnosis’; I am not even sure what diagnosis I would now ascribe to my unwell self. I do not identify either with bipolar disorder or unipolar treatment-resistant depression, although I met criteria for both (American Psychiatric Association, 2000). The outcome studies for these diagnoses, and for ‘serious mental illness’ (criteria for which I would also have met), do not resonate with my experience. I am not a mouthpiece for a particular therapeutic modality, though I want others to have the opportunities I had. I do not recognise myself in much of the mainstream academic literature, so was it that I was different? I doubt it; I recognise aspects of my experience in the testimonials or autobiographies of others (e.g. Frame, 1984; Hyde & Paul, 2011; Leibrich & Adams, 1999; Saks, 2007). Rather, the mainstream psychiatric literature fails to capture the subjective, heartfelt quality of my experience, tending to anonymise and objectify, even in qualitative research (Grant, 2014), the highly embodied experience of mental illness and its treatment. Hence my search for a research approach that would take me to the heart of my/our experiences, subverting the dominant discourse (Muncey, 2010), and inviting myself and potential readers to be more fully present (E. Foster, 2014).

Heart is a recurring theme in this thesis: I have referred to the heartfelt quality of my experience, and wanting in this research process to get to the heart of our experiences. Later I will talk of ‘getting to the heart of me’ as a metaphor for an experience that was healing. Our hearts are more than the physical pumps that keep us alive; whose cessation allowed me, as a junior doctor, to declare ‘time of death’ as I listened with my stethoscope for the absence of sound. Throughout human history the heart has been considered as the source of our deepest emotions, “the metaphorical and literal center of human culture” (Perloff, 2010, p.1502). It is my beating heart that tells me I am alive: it thumps, it races, it flutters; it breaks, it pains me, it warms me; it wonders, it feels and desires. My heart may be open or closed, light or heavy; and I become disheartened. I speak from the heart, and my heart is in my mouth; I may be wholehearted in my endeavours, or empty-hearted in my despair. My heart is at my core, the seat of my emotions and my wisdom, encapsulating body, mind, emotions and spirit: the embodied experience of what it is to be human.

My and our stories of illness and healing were steeped in metaphor, as we endeavoured to convey the emotional intensity and meaning of our experiences. Metaphor, essentially a comparison conveying an understanding and experience of one thing in terms of another, is a linguistic device that enables us to partially communicate an unshared experience (Lakoff & Johnson, 1980; Ortony, 1975). Conveying emotional, as well as sensory and cognitive, characteristics that might otherwise be inexpressible, Ortony (1975) argued that metaphor carries emotional vividness and lies much closer to perceived experience than a non-metaphorical equivalent. As such there is risk in explicating metaphors; potentially losing the depth and breadth of experience they convey, subjective becomes objective, and experience becomes simply words on a page.

This chapter makes an argument for ‘valuing the voice of lived experience’ and it was perhaps in metaphor that we came closest to the expression of our experiences as lived. Lived experience is a term that has had increased usage in service user-developed literature to identify someone who has experienced being mentally unwell, often with the corollary of use of mental health services. Traditionally lived experience is regarded as the “immediate, pre-reflective consciousness of life: a reflexive or self-given awareness which is, as awareness, unaware of itself” (Van Manen, 1990, p.35). Lived experience is the moment before consciousness and reflection (Grant, 2014); it is effectively inaccessible, for once accessed it has come to consciousness, intersecting with our situated mind and its interpretations.

The degree to which researchers believe they can explore lived experience is an epistemological question. Richardson (2000) suggested that rather than language reflecting social reality, it produced meaning and created social reality: “language constructs the individual’s subjectivity in ways that are historically and locally specific” (p.8). Grant (2014) likewise troubled the assumptions inherent in researching lived experience of mental illness, suggesting that unlike the phenomenological quest to “transform lived experience into a textual expression of its essence” (Van Manen, 1990, p.36), the voice we give to these experiences is always provisional and contingent. Valuing the voice of lived experience in this thesis implies an understanding that the voice is not the experience; it is an interpretation of the experience.

Autoethnography as methodology

With my intention from the beginning to draw on my personal experiences, the choice of autoethnography as methodology was ‘easy’. Well, easy in a sense; described by long-time proponents Ellis, Adams and Bochner (2011) as “an approach to research and writing that seeks to describe and systematically analyse (graphy) personal experience (auto) in order to understand cultural experience (ethno)” (p.1), autoethnography gave me permission to foreground my experiences to investigate mental health care (Chang, 2008). I considered other methodologies, particularly hermeneutic phenomenology with its intent to develop an understanding of the lived experience through intersubjective interpretation (Giacomini, 2010). Hermeneutics as a research method of analysis has similarities to autoethnography which I will touch on later, but I kept on coming back to autoethnography, because it felt the most honest, giving me an active reflective presence in the research and writing. I resonate with Wall’s (2006) comment: “I find that the relentless nudging of autoethnography against the world of traditional science holds wonderful, symbolic, emancipatory promise. It says that what I know matters” (p.148)

Autoethnography is an approach to research and writing (Ellis et al., 2011) that places emphasis on the self as “a subject to look into and a lens to look through to gain understanding of a societal culture” (Chang, 2008, p.49). Gaining acceptance as a research methodology in mental health, autoethnography is found predominantly in social science, nursing and allied health literatures (Ettorre, 2010); its continuing absence in medical journals is perhaps symptomatic of the traditional positivist medical view of knowledge. The methodology has been used to investigate, particularly, individuals’ experiences of mental illness, including depression (Gallardo, Furman, & Kulkarni, 2009), bipolar disorder (Grant, 2010a), psychosis (Gregory & Thompson, 2013), bulimia (Tillmann-Healey, 1996;

Tillmann, 2009), anorexia nervosa (Chatham-Carpenter, 2009), obsessive-compulsive disorder (Brooks, 2011; Fox, 2014), and Asperger's syndrome (Farrell, 2013; Hughes, 2012). As is common with most published autoethnographies, these authors have focused on their own story to investigate wider social and political meanings. Occasional autoethnographies have investigated the experiences of health professionals with mental illness (Grant, 2010a; Short, Grant, & Clarke, 2007); others have taken autoethnography a step further to investigate more systemic issues: Kidd (2008) investigated the experience in the workplace of nurses with mental illness, described as a collective autoethnography (Kidd & Finlayson, 2010), and Foster (2010) examined her experience alongside others, as children of parents with mental illness.

I came to the research in part because I felt my clinical work had 'lost its heart'; trained to focus on diagnosis, treatment and management of mental illness and risk, I perhaps had less time and capacity for the person who was unwell. Autoethnography encouraged me to embrace subjectivity and emotionality not only in the research but in the writing, "to analyse [my] experience in the world in a way that enlightens the experience of others" (Ettorre, 2010, p.492). I know my story has the potential to move people, to engender hope – it is not a stretch to claim that when all seemed lost, I regained my life – so I resonated with a methodology that allowed me to examine and tell that story in a way that was accessible, that engaged people emotionally, in effect to demonstrate the potential for the personal story and evocation to provoke change. Autoethnography has at its heart stories and storytelling, but goes beyond mere narration by engaging in cultural analysis and interpretation (Chang, 2008). It shows and tells, inviting the reader to enter the experience both subjectively and objectively (Ellis et al., 2011), encouraging us to reflect more deeply on our social experience and world; enlightening the experience of others creates the potential for developing new understanding.

Autoethnography, first used as a research term by Hayano (1979), describes research in which the researcher has an active, reflexive presence in the research and writing (Anderson, 2006; Ellis & Bochner, 2000). The 'crisis of representation' of the 1980s saw sociologists questioning traditional methods of research in which a neutral observer/researcher provided an objective depiction of 'others'. A form of resistance to being other-ed (K. Foster, McAllister, & O'Brien, 2006), autoethnography reformulates "the traditional binary emic [me] and etic [other] positions" (O'Byrne, 2007, p.1384); replacing this either/or positioning with both/and, making it possible to be both subject and object (K. Foster, McAllister, & O'Brien, 2005, p.6). Overtly breaching the traditional separation between researcher and

researched, autoethnography challenges and effectively dismisses notions of neutrality and objectivity. Rather than being “those marginalized individuals who might typically have been the exotic subject of more traditional ethnographies, [autoethnographers] have the chance to tell their own stories” (Duncan, 2004, p.30). Moreover, as researcher and participant, I am considered best placed to interrogate that experience being as close as anyone can get to the process or experience being investigated (Beresford, 2005). O’Byrne (2007) identified the potential for the binary to be erased completely or for the two perspectives to be “doubled back onto each other to produce an even deeper understanding” (p.1382).

Postmodern thinking argues that we bring assumptions and biases into research, be it quantitative or qualitative, and that these biases can be overt or hidden. My bias in this project was clear: I did not trust that the environments in which we provide mental health care were therapeutic, a view that I argue is supported by the literature. In autoethnography, bias is acknowledged and anticipated: my positionality is as overt as I can make it. Rather than claiming objectivity, autoethnography embraces subjectivity (Ellis et al., 2011), making it particularly useful in investigating the experience of mental illness, which is a predominantly subjective experience.

The desire to reclaim my service user voice was a direct challenge to the hegemonic evidence-based biomedical discourse that had shaped me professionally over the previous 15 years. With its origins in the postmodern/poststructuralist paradigm, autoethnography endeavours to disrupt traditional and dominant ideas about what counts as research and how it should be done (T. E. Adams & Jones, 2011), while challenging the belief in universal or singular truths (Richardson, 2000; Spry, 2001). The focus of research is often topics that are kept private (Chang, 2008; Ettore, 2010; O’Byrne, 2007). This has particular relevance for mental health research as patient privacy, power dynamics and stigma can all limit access to intimate information. With its emphasis on the personal story as the focus of research interest, autoethnography is well placed as an approach for service user research; with aims of being emancipatory, the ‘insider’ stance allows the often silenced voice of the stigmatised to be heard (Liggins, Kearns, & Adams, 2013). Moreover, Boylorn (2014) suggests that autoethnography can be “a powerful and strategic tool for bridge-building across difference” (p.325) facilitating connections that span the spaces that seem to separate us: autoethnography as ‘connective scholarship’ (Poulos, 2014).

Although beginning my training with no intention of keeping my personal experiences secret, over time those experiences became marginalised; I put them to one side becoming silent. I was not alone in this experience as a health professional: with respect to mental illness, “silence remains the order of the day” (Hinshaw, 2008b, p.5). Although psychiatrists have one of the highest rates of psychiatric morbidity among hospital doctors, most do not disclose this in their workplace citing stigma as the reason (E. F. M. Adams, Lee, Pritchard, & White, 2010; White, Shiralkar, Hassan, Galbraith, & Callaghan, 2006). The then president of the American Psychiatric Association said in 2002: “We have a long way to go in the house of medicine when psychiatrists and other physicians with mental illness are still forced to overcome stigma directed at them by their colleagues” (Hausman, 2002, p.3). There is still limited published literature addressing the particular issues facing the unwell psychiatrist, the main focus being managing impairment (E. F. M. Adams et al., 2010; White et al., 2006).

More importantly, there is little consideration of positive aspects of the experience of mental illness for psychiatrists and their work. Not much has changed since Lindow and Rooke-Matthews (1998) wrote: “[w]hether or not to be open about past mental health treatment was a central dilemma for user employees. This means that the existence of user employees remains a partly hidden resource among mental health workers” (p.1). Hinshaw (2008a), in his summation chapter of ‘Breaking the Silence: Mental health professionals disclose their personal and family experiences of mental illness’ (Hinshaw, 2008c), says of this aspect “although we seldom hear about this perspective, experiences of mental illness may well produce strength and compassion, in addition to deep pain and despair” (p. 348). Interestingly no psychiatrists are included in this edited book. Although the influence of my experiences on my clinical work is not directly a focus of this research and thesis, it is perhaps my relatively unique situatedness (Esping, 2010) that lends support for the methodology of autoethnography: breaking the silence personally and professionally, disrupting the ‘us-them’ binary (Grant, 2010b).

Autoethnography as method

Autoethnography utilizes the personal experience of the researcher to investigate social and cultural phenomena (Ellis & Bochner, 2000), the researcher reflexively scrutinizing and reworking their own self-understanding to “shape understandings of and in the wider world” (Butz & Besio, 2009, p. 1660). Although gaining an increased presence in the academic literature over the last decade, there remain several areas of debate which relate to autoethnography as method. These include the presence of other research participants, the degree to which analysis is overt or implied, and the style of presentation. Underlying the

debates are philosophical differences between those authors who align autoethnography with analytic ethnography and those authors who are more revolutionary in its form.

Ellis and Bochner (2000, 2006), two early and enthusiastic supporters, describers and developers of autoethnography, embrace a style that has been labelled by some authors as 'evocative autoethnography' (they dispute the descriptor saying that all autoethnography is by definition evocative) in which the researcher is often the only subject (although not exclusively). There is a revolutionary element to their view of autoethnography wanting it to be dangerous and rebellious, to move ethnography away from the gaze of the distanced and detached observer. The analysis may be overt or implied, in part depending on "where in the continuum of art and science you want to locate yourself" (Ellis & Bochner, 2000, p.750). They encourage writing, or presentation, that is highly evocative, engaging the audience with action, emotion, and self-consciousness and vulnerability on the part of the researcher/writer.

Anderson (2006), while supporting the role of researcher as subject, demanded a return to more traditional ethnographic roots proposing the model of analytic autoethnography. He did not overtly claim that analytic autoethnography should be the only form with authority, though that, in subsequent literature, was the threat felt by proponents of the more evocative style (Burnier, 2006; Denzin, 2006; Ellis & Bochner, 2006). Anderson identified five criteria for this proposed methodology. In addition to the requirements of complete member research, analytic reflexivity, and narrative visibility of the researcher's self, users of this methodology must also have informants beyond the self (i.e. other participants) and a commitment to and demonstrate theoretical analysis. He believed that 'evocative' autoethnographers, by rejecting traditional social science values and styles of writing, risked being marginalised. His intent was to bring autoethnography back into the fold of traditional symbolic interactionist-informed ethnography, arguing that this is where Hayano (1979) placed it originally. By adding the requirement for overt analysis and theorizing, Anderson claimed the value-added quality of broader generalization.

Some authors see this debate as an either/or, "[a]pples and oranges – are we dealing with two different things?... so we part ways, reluctantly and respectfully" (Denzin, 2006, p.422); Ellis and Bochner (2006) argued that "Leon [Anderson] wants to ... bring it [autoethnography] under the control of reason, logic and analysis.... [T]he 'I' we hear is a disembodied authorial academic voice that argues and tries to persuade" (p.433). Chang (2008) described the argument as a "war between objectivity and subjectivity" (p. 46) which she predicted would continue to shape the discourse of autoethnography. Both sides of the debate have

convincing arguments: I am moved by the evocative, learning from others' stories; I also exist in a world of academia that has 'ways of doing things' but it is these latter forms of writing that leave my personal experience unrecognisable.

Perhaps in response to this debate, autoethnography has continued to evolve, developing a number of forms with varying emphases on the researchers self and interaction with others (Ellis et al., 2011). For many, the researcher is the only participant, some suggesting that autoethnography has become synonymous with the study of one person (Chang, Ngunjiri, & Hernandez, 2013). Occasionally, researchers include other participants; one approach being to embed the researcher's experience as an autoethnography within a wider research process, such as in Foster's (2010) narrative enquiry of children of parents with mental illness, and Morris's (2010) ethnography and autoethnography of blood donation. Unlike me, and perhaps explaining their approach, neither researcher set out to utilise autoethnography, this becoming necessary later as a way of grappling with their positionality.

I set out with the intent of using autoethnography as the research method, with my personal experience of mental illness and treatment being the starting point. Swayed by Anderson's (2006) plea for broader examination, I also wanted to include others who might have had a similar experience, allowing me to further question my experience and examine assumptions I might make if limited to my experience, and potentially moving the analysis beyond the particular place of Ashburn Hall. The challenge became how to make sense of that engagement. Both Kidd and Finlayson (2009), and Wall (2006) commented as novice autoethnographers on the lack of information about the research processes particularly when others are involved as participants. This absence of concrete advice perhaps reflected the methodology's intention to be rebellious, to disrupt canonical ways of doing things.

More recently there has been a shift to development of autoethnographies overtly involving others, in the form of collective (Kidd & Finlayson, 2010) and collaborative autoethnographies; participants become fellow researchers, involved not just in data collection but throughout the analysis and writing, requiring a lengthy commitment to be true to the method (Coia & Taylor, 2009). Consistent with the starting point of this project, my experiences being central to the thesis, rather than adopting these methods I committed to autoethnography as my method. The means by which I worked with the experiences of other research participants is discussed in a later section.

The research process

The research question asked ‘what makes a place a place of healing for the treatment of mental illness?’ Originating in my concern that we do not yet have it right with respect to places in which we provide mental health care, this project intended to explore aspects of place that facilitate healing. Beginning with my experiences, the research process was broadened to include participants who self-identified as having been somewhere that they considered healing for them when unwell.

Ethics approval¹⁰ was sought and gained to interview up to 15 participants who were recruited through service user networks by word of mouth, and snowballing. To facilitate recruitment I met with service user leaders in several non-governmental organisations, and spoke about the research in forums such as the Service Users in Academia Symposium and TheMHS, an Australian mental conference with strong service user attendance. No direct approaches were made to potential participants; a participant information sheet was provided on request (appendix one).

Inclusion criteria for participation included: age 18-65 years, at least one admission to a mental health unit for more than a few days, and having been somewhere when unwell that the participant considered healing. When I began this research process I had a number of assumptions about what worked for me, and how this differed from our current services. To counter these assumptions the research question and inclusion criteria were deliberately broad, the definition of place and healing being left open to interpretation by participants. An initial premise was that people sometimes need to be somewhere other than home when unwell, therefore an early decision was made to exclude home as the place of healing; as the research progressed this exclusion became blurred. There were no inclusionary or exclusionary diagnostic criteria; the intention was to invite participation from people who would in the usual course of events be admitted to an acute adult mental health unit when unwell. Potential participants were asked to confirm that they currently felt mentally well enough to participate. Service-users who were or had been directly or indirectly under my professional care were excluded. No demographics were collected as these were not considered relevant to the research question or method.

Ten participants were recruited in addition to myself. I was keen to have a gender and ethnic mix. I did not need to engage in purposive sampling, with eight female and two males recruited; one participant self-identified as Maori, another as Samoan. Although ethics

¹⁰ University of Auckland Human Participants Ethics Committee: Reference 7934; approved 24 February 2012.

approval had been gained for up to 15 participants, by the end of the tenth set of interviews, in discussion with my supervisions I decided the depth and breadth of experiences were sufficient. Each participant consented to being interviewed on two occasions for 60-90 minutes; one participant was unable to attend a planned second interview, and with a second participant we negotiated a longer single interview because of the travel involved. Interviews occurred at a time and place of their choice, most choosing to be interviewed in their home; two elected to meet me in a local café with interviews occurring in a quiet back room over a cup of coffee.

The Participant Information Sheet explained the purpose of the research, and provided a brief summary of my experiences positioning me as researcher, psychiatrist and service user (see appendix one). This disclosure was an endeavour to lessen the hierarchical structure of the interview format (Ellis & Berger, 2002), yet I was “also aware of the inescapable position of power in my role as researcher” (Sword, 1999, p.274) and psychiatrist. Self-disclosure comes with risk; while potentially facilitating trust in the relationship, and encouraging participant disclosure, it has the potential to evoke unintended responses in the participant, being misinterpreted as self-serving, or evoking mental illness stigma (K. Foster et al., 2005). I was aware too of my self-stigma: I no longer use services so did that make me a ‘fake’ insider, and were my experiences ‘good enough’ to be accepted as service user? My sense was that, in general, participants appreciated and viewed positively my preparedness to disclose a personal history of mental illness.

Gathering data

The research process started with my experience. To begin this exploration I collected historical personal documents from before, during and after my stay in Ashburn. I had access to hospital records from several prior hospital admissions but little personal writing from this period. Subsequently, during my stay at the Hall, I developed a practice of writing self-reflective ‘letters’ to my doctor as part of my therapeutic process, and several months after leaving I wrote extensively as a way of making sense of my journey. At this time I also wrote, anonymously, an article about my experience of Ashburn for the Mental Health Foundation (NZ) magazine (Anonymous, 1992). Use of data from multiple sources as a form of triangulation is encouraged (Chang, 2008). In addition to these written narratives, early in the research process I was interviewed twice by a research-experienced colleague using prompts that I developed. The first interview gave me an opportunity to tell my story to a willing listener and enquirer. The second interview, after I had completed several participant interviews, was an opportunity to reflectively explore developing ideas with a focus on the

intersections between my experiences and theirs. Van Manen (1990) identified these two functions of a research interview as the gathering of and then reflecting on lived experience.

I adopted a similar sequence with the other research participants utilising a flexible interview format with a number of question zones informed by, but not limited to, the physical, social and symbolic aspects of the therapeutic landscapes concepts. After briefly introducing the purpose of the research, I asked participants where they would like to begin in telling me about their experience of a place that was healing for them. This open ended questioning style was adopted to elicit experiences in a way that made sense to them, while endeavouring to avoid making assumptions about what might have been important. The first interview focussed on hearing about their experience; the second interview, being more interactive and reflective, explored aspects of their experience with a particular emphasis on how their story may or may not relate to aspects of mine, thus continuing the autoethnographic thread.

The original intention was to work more collaboratively with participants by integrating my experiences more explicitly into the interview process, encouraging a dialogue akin to the hermeneutic circle within which a shared understanding is reached. With the first participant, however, I sensed that shifting the focus, even temporarily, to my experiences risked derailing the interview process. In subsequent interviews I engaged in an interactive process, such as described by Ellis and Berger (2002) as a 'reflexive dyadic interview', whereby I shared enough of my story to facilitate a process of developing but not necessarily sharing understanding. The lesson for me was that a truly collaborative process takes time to develop (Chang et al., 2013), and was made more challenging in this project by the power imbalance of my positions not just as researcher, but as psychiatrist. This imbalance was always going to be difficult to negate when not explicitly recruiting academics or health professionals.

Interviews were professionally transcribed within a few days, and reviewed by me while listening to the recording. With the primary purpose of checking for accuracy and developing areas for further exploration in the second interview, this listening also began the process of familiarising and immersing myself in their stories. The two interviews were two weeks apart, allowing time for participants to review their interview's transcript; the second interview began with an opportunity to directly discuss any matters arising.

Introducing the participants

- Alice** Alice spent several years in a locked mental health unit, one ward of which she identified as her healing place.
- Barb** Barb had multiple admissions to old-style institutions and acute mental health units being treated for psychosis. Eventually, deciding this was something she needed to do for herself, home – friends’ or her own – became her haven.
- Colin** Colin described a 20 year history of psychosis, with multiple admissions to hospital before being admitted to a forensic unit in which he ‘bloomed’.
- David** David self-identified as Samoan. He had been admitted to an acute mental health unit, depressed and immersed in his hallucinations. This admission was his turning point.
- Helen** Helen identified herself as Maori. She had been in and out of psychiatric hospitals, psychotic, for several years before being admitted to an old-style rural institution. Her healing place was the ‘Maori cultural ward’ within this institution.
- Emily** After multiple admissions to acute mental health units for medication changes and ECT, Emily had ‘completely given up’ when she was admitted to a therapeutic community: the psychiatric hospital that was her healing place.
- Sally** Sally’s healing place was an acute mental health unit in a town distant to home, coming after multiple admissions to her local hospital with depression.
- Lauren** Lauren’s healing place, when suicidal and desperate, was a particular respite facility, comparing this favourably to previous admissions to acute mental health units.
- Margaret** Margaret had been admitted a number of times to both old-style institutions and acute mental health units. Now when unwell with her ‘madness’, she preferred to stay with friends or utilise respite; her healing places also included more natural environments.
- Fran** Fran’s healing place, after several admissions to hospital, was an art studio. This was where she found her voice.

Ethical considerations

Prior to beginning the interviews I had spent time with my historical writings, immersing myself in their content, and compiling extracts that I was willing to share with the reader. This work began an ethical process that involved considering the (relative) confidentiality and safety of myself, and of others involved in my journey (Chatham-Carpenter, 2010).

Ethics is an area of debate in autoethnography; while the involvement of others in the research process has a relatively well developed set of ethical guidelines as reflected in institutional guidelines and application processes, autoethnographic research involving only the researcher as participant often does not require approval or consent. My obligations to participants were reasonably clear; for myself, some ethical issues were apparent from the beginning, others arose as the study progressed.

Tolich (2010) suggested ten foundational ethical guidelines for autoethnographers, falling into categories of consent, consultation, and vulnerability. These guidelines focus on the researcher/participant and others implicated in the research narrative, to which I would add ethical considerations with respect to the reader/listener. An inevitable result of utilizing autoethnography is that unlike other participants I cannot be anonymized. That does not mean there are no issues of confidentiality; I had active decisions to make as to how disclosive to be, considering which aspects of my experience the reader needed to know to judge the validity of the research. There are inevitable tensions between providing the rich data required and protecting myself from the potential personal and professional harm unfortunately still associated with disclosure of mental illness (Hausman, 2002). In this technological age, I am very aware that I cannot take back disclosures made in this thesis, and that I cannot control the (potentially critical) interpretations placed on it by readers (Ellis & Bochner, 2000; Wall, 2008). I have needed to be thoughtful about this, and also aware that I cannot predict my needs for the future.

Issues of confidentiality also extend to my family and others implicated visibly and invisibly in my story (Chang, 2008; Poulos, 2008); we live in a connected world, “self-revelations always involve revelations about others” (Ellis, 2007, p.25). Tolich (2010) identified the need to obtain consent from others who might appear in the research text; that is not always possible: both my parents are deceased; my siblings and friends journeyed with me and are connected by implication, and though they support my PhD endeavour their implied ‘consent’ is not necessarily informed. I did not seek their formal consent, I have instead been guided by another of Tolich’s (2010) principles: “autoethnographers should not publish anything they would not show the persons mentioned in the text (p.1607)”. In deciding which aspects of my story to tell, I made decisions to exclude some events that foregrounded family members. Although these might have enriched the data, I deemed them unnecessary to the developing thesis, and had the potential for unintended harm or distress. The reader might liken this censoring to falsity, but no story is ‘the’ story; rather there may be multiple

versions of a narrative consciously or unconsciously crafted to relate the story we wish to tell (Tullis Owen, McRae, Adams, & Vitale, 2009).

In some ways my situation was no different to that of other participants. In interview or written research, participants inevitably censor what they reveal; they also have the protection of trusting the researcher to strive for anonymity. Quite apart from striving for anonymity, I have wrestled at times with deciding whether to use aspects of participants' narratives; an important aim of autoethnography is to present research texts that are accessible outside academia, meaning that there is an expectation that this thesis may be read by those who provided their experiences for me to render. Likewise as I have begun to present this research, and my story, I have become increasingly aware of the potential for listeners (as with readers) to be reminded of their own experiences, with resulting distress. Tullis Owen et al (2009) tussle with this responsibility in 'truth Troubles', concluding:

[w]ith life writing, truth telling is a messy, risky endeavour. We do believe, however, that disclosure, when it's done with a helpful, hoping spirit, is essential to breaking up heavy, historical restraints of canonical narratives that perpetuate pain and paralysis of the human condition. By confessing the messiness of our existence, we validate the experiences of others whose stories might not fit hegemonic storylines. (p.194)

Autoethnographic ethics are a work-in-progress. Ellis (2007) critiqued responses she received to her autoethnographic work, including a narrative written about her mother: acknowledging that there are no definitive rules or universal principles to guide us with respect to relational ethics, she discussed the lessons she has learnt along the way suggesting "my experiences... have taught me that I have to live the experience of doing research with intimate others, think it through, improvise, write and rewrite, anticipate and feel its consequences. There is no set of rules to follow" (p.22). Ellis proposed co-constructing narratives as a solution to these tensions, which is perhaps a variant of collaborative autoethnography. These relational ethics are not unique to research; I am reminded of the title of the book by acclaimed New Zealand historian, Michael King (2001): 'Tread softly: for you tread on my life'. I took a long time to reach the point where I felt comfortable being disclosive and I have been thoughtful about what I disclose. Likewise, while not wanting to avoid being evocative or provocative, I hope I have been respectful of others implicated directly or indirectly in this thesis.

I haven't touched on ethics with respect to the reader. Autoethnography endeavours to engage the reader morally, emotionally, aesthetically and intellectually (Wall, 2008). This

contrasts with traditional scientific writing which, in objectifying the subject, tends to protect both researcher and reader from the sometimes grim emotional and intimate details of human experience (Muncey, 2005). Not only is it suggested the reader has an ethical obligation to read with moral care (Frank, 1997; Grant, 2010a), I have an ethical responsibility to be aware of the potential impact of my writing on others. I found myself repeatedly reflecting on the question of who is my audience for this work, wondering if this altered my ethical responsibilities. There is an implication in my question: that a service user audience might be qualitatively different from a professional audience; with an inference of vulnerability and need for care and protection. In the act of asking I continue the binary of us and them. Richardson (1988) warns of a risk of intellectual paralysis in the uncertainty of ‘truth’; here, in my concern at upsetting the reader, I could face ethical paralysis. My answer is a reader’s advisory: as in life, be prepared to be moved.

The to-and-fro of analysis

The process of analysis in autoethnography is usually described as the researcher using a back and forth gaze that focuses outward on social and cultural aspects of personal experience, then looking inward exposing a vulnerable self; in this to and fro process, distinctions between the personal and cultural become blurred (Ellis & Bochner, 2006). Ellis (2004) suggested three ways of engaging with an autoethnographic narrative or interview: narrative analysis, thematic analysis of narrative and structural analysis of narrative. Drawing on Frank’s (1997) ideas, she described narrative analysis as thinking with a story; analysis is implied, consistent with the poststructuralist view that the story that we tell has already undergone ‘analysis’ or interpretation: a good story is itself theoretical. This crafting of a story perhaps reflects the art of autoethnography, and I will discuss this in the next section. Thematic and structural analyses engage directly with the narrative, ‘thinking about the story’: analysis is overt. Ellis described structural analysis as analysing the form, strategies and processes of the narrative; I touch on this form of analysis only very briefly in chapter five, when reflecting on the way that each of us told a story. The predominant focus of analysis in this thesis is ‘thinking with a story’ (mine), which I will discuss shortly, and ‘thinking about a story’ with respect to its thematic content (mine and other participants).

As already discussed, the ‘how’ to engage autoethnographically with self and others’ narratives is not well defined. Ellis (2004) recommended “you may simply want to position yourself in your research by telling your story, then move to analysing the stories of others, which you connect back to your story” (p.198); this suggests separate processes for self and others. While on one level a thematic analysis might draw out general themes, I also wanted

to consider how other experiences develop my understanding of my own with the potential in the to-and-fro process to get even closer to my experience. The research interview transcripts can be considered as relatively static documents. As researcher, I have the advantage, in an iterative process, of continually re-engaging with my story; emotionally recalling (Ellis, 2004) and questioning my memories, my assumptions and interpretations of my experience, participants' stories sometimes tipping me back into memories long 'forgotten'. Consistent with the autoethnographic process, I wanted to be present reflectively throughout the analytic process to explore how their experiences developed my understanding of mine.

I turned to hermeneutic phenomenology, and in particular Gadamer's development of the hermeneutic tradition for assistance. Shifting from the interpretation of historical texts to emphasizing the interpretation of conversations (Kvale, 1996), Gadamer argued that understanding arises in the interpretive process that occurs within a conversation when participants bring and examine their experiences (Ezzy, 2002; Schwandt, 2000). This interpretive process is described as the hermeneutic circle, in which theory is developed through a continuous movement between the parts and the whole. Applied to a text, an interpretation begins with a general understanding of the text as a whole, informing an understanding of parts of the text, which in turn furthers an understanding of the whole, and so-on back and forth. Applied to a conversation, the back and forth movement occurs in the dialogue between the participants, informed by the experiences and pre-existing interpretive frameworks (including theory) that they bring to the conversation and resulting in a continually evolving understanding (Ezzy, 2002; Kvale, 1996).

The hermeneutic circle would seem, at least superficially, to be a similar process of interpretation to the back-and-forth gaze employed in autoethnography, in which the movement is a shift in attention between the vulnerable self, others, and the wider social and cultural context within which the personal experiences occur (Chang, 2008; Ellis & Bochner, 2000; Muncey, 2010). Multiple conversations occurred through this research process, with multiple perspectives being brought to bear. The interviews were situated conversations that potentially allowed for participants' stories to interact and develop, "where the examination and comparison of experience offers new insight into both lives" (Ellis, 2004, p. 66). I had conversations in supervision, sitting at the table in Seattle, the café not the city (Liggins et al., 2013), and arguably I engaged in conversation with the literature and organisational documents, resulting in a continually evolving understanding.

The process of analysis entailed many internal ‘conversations’ between service user-me, psychiatrist-me, and researcher-me (sometimes all three at the same time, pushing their point-of view). Mizzi (2010) described this multivocality as “providing representational space... for the plural and sometimes contradictory *narrative voices* located within the researcher, [with the potential] to provoke a deeper understanding of the often silent tensions that lie underneath...” (p. 2). Reed-Danahay (1997) referred to this process as ‘boundary-crossing’ between multiple identities; constantly shifting between personal and professional lenses, foregrounding the multiple nature of selfhood (Esping, 2010). In this research I was service user and psychiatrist, participant and researcher: repeatedly both experiencer and observer, and insider and outsider. These viewpoints afforded me “opportunities as well as challenges that might not be present if I were simply one or the other” (K. Foster et al., 2005, p.6).

Thinking about our stories

Working with my personal historical writings and our interview transcripts was a lengthy and iterative process of reading, re-reading and re-visiting as themes developed, with recurring attention to the importance of the stories within. This process (depicted in appendix two) was a continual back and forth movement between my narratives/data, through the participants’ transcripts, to other conversations and the literature and back again, as I adopted a reflexive stance throughout the process. A research journal helped me keep track of and further explore developing understandings. This process was neither straightforward nor predictable, nor were the findings final; Chang (2008) quoted Denzin and Lincoln (1994, p.479) to warn “[t]he processes of analysis, evaluation, and interpretation are neither terminal nor mechanical. They are always emergent, unpredictable, and unfinished” (p. 125).

The interview transcripts and my historical writings were read multiple times: an initial reading for accuracy, and again to generate future interview areas of interest, with 2-3 subsequent readings to develop the thematic analysis. Early in the analysis, I decided not to utilize a commercial software program such as NVivo. Autoethnography involves stories and storytelling, and a recurring issue was how to engage in analysis while not losing the richness of the stories that we tell. The risk with using software was of personally losing touch with the heartfelt quality of our experiences, and of reducing the stories to sound-bites (Kidd & Finlayson, 2009), the latter becoming a particular challenge in writing the results.

A thematic analysis of content led to development of an initial list of categories and themes. Informed in part by the concepts of therapeutic landscapes (Gesler, 2005) and enabling

places (Duff, 2012), the themes were subsequently merged into a conceptual framework with four main categories: ‘a journey of healing’ which informed Part II of this thesis, and ‘the place itself’, ‘relationships’, and ‘what happens there’, which informed Part III (depicted in appendix three). After developing the conceptual framework, the interview transcripts and my historical writings/documents were re-visited, collating extracts into master documents according to the main categories and themes. In telling me of their experiences most participants told me of places they had been, that were perceived as unhelpful when unwell, resulting in a further division of each master document to reflect ‘the other places’, allowing for later comparison. The Relationships category was also subdivided into staff and service users, though this produced its own difficulties with where to place family and more particularly support people who were service users, this tension being discussed more fully in chapter eleven. As an example of master documents ‘The Place Itself’ comprised compilations of ‘the physical environment’, ‘where and what it is’, and ‘the other places... where, what and physical’.

The next stage of analysis involved working within the compilations, revisiting the thematic analysis and landing particularly on those moments with emotional intensity, while attending to similarities and differences between our experiences. This process resulted in paper mind maps for each category, further coalescing into the themes discussed in the results sections. These themes neither reflect a fixed reality, nor are they final; rather they are created in the interpretation (Duncan, 2004). Accepting a postmodern stance that the outcome of any analysis can only be my interpretation, I am implicated throughout the analytic process. As will become clearer later in the thesis, my journey of healing was one of exploration; making use of multiple and repeated opportunities for connection and self-reflection, and developing new ways of understanding my experiences and my self. The developing research process can be understood as a similar process: a repeatedly reflexive, back and forth movement between my story and their stories; making connections and developing meaning.

Dealing with memory

In an early presentation of my proposed research I was asked how I was going to deal with the historical nature of my experiences. In any research interviews involving past events there are issues of memory: “[t]ruth troubles arise when we demand that stories and memories function as unedited video documentaries” (Tullis Owen et al., 2009, p.192). Other autoethnographers (Sparkes, 2000; Wall, 2008) have made the point that if I was interviewed for another’s research then my interview transcript would have legitimacy even though based on the same sets of memories as autoethnography. Being interviewed at an

early stage of the research allowed me to compare the story I told now with the story I wrote 20 years ago, in essence a triangulation of data. In retrospect, it perhaps served more as reassurance rather than a necessity to ‘verify’ my data. If we accept that all voice is a partial and situated interpretation and representation of lived experience, rather than depiction of the experience itself, then we accept that all narratives, spoken and written, are stories of the past (Ellis, 2004; Tullis Owen et al., 2009). What might change over time is the ever ongoing interpretation:

The heart learns that stories are the truths that won’t keep still. There is always another version, another eye to tell what it sees, another voice ready to speak... The heart learns that facts are the possibilities we pretend to trust. We have little other choice. They are our best hunches, our best inklings. (Pelias, 2004, p.171)

In actuality what struck me were the similarities, rather than differences in the version of the story I tell now compared to the past, the main difference being my later challenges in remembering the breadth and depth of emotion, which I interpret as a self-protective mechanism. As I endeavoured to investigate my experiences I needed to recognise that they can only be viewed through the lenses of discourses available to me (Richardson, 2000). I have my writings new and old, and I have my memories but these were already changed from the moment they found consciousness. The understandings I develop are inevitably shaped by my past; my present is my past, so the shaping continues. Consistent with postmodernism, recognizing my situational limitations, I can only have “partial, local, temporal knowledge – and that is enough” (Richardson, 2001, p.35).

Autoethnography as writing.

The final phase of analysis occurred in the writing of this thesis, reflecting a process of narrative analysis (Ellis, 2004) or, according to Frank (1997), thinking with a story. Pelias (2004) described autoethnography as a methodology of the heart; while this has much to do with the research process taking the writer into and exposing their vulnerable self, it also references the style of writing that is a defining characteristic of autoethnography. He desired to:

write from the heart, to put on display a researcher who, instead of hiding behind the illusion of objectivity, brings himself forward in the belief that an emotionally vulnerable, linguistically evocative and sensuously poetic voice can bring us closer to the subjects we wish to study (p,1).

Unlike other forms of social science and autobiography, autoethnography intends to provoke change by evocation, wanting “the reader to care, to feel, to empathize and to do something, to act” (Ellis & Bochner, 2006, p.433). The reader is invited to “enter and feel part of” (Ellis, 1999, p.674) the story, demanding writing that is well crafted, emotionally engaging and as well as critically self-reflexive (Spry, 2001). This is the artistry of autoethnography, the analysis implied in the craft of writing; according to Richardson writing is a way of “knowing”, a method of discovery and analysis (Richardson, 1994). The writing is almost always in the first person voice, in a text largely free of academic jargon, potentially making it accessible to a wider audience.

It is in this style of writing that I have occasionally found my experiences reflected in the academic literature; I am no longer an abstracted being, “narratively smooth[ed]... to conform to cherished professional ideas” (Woods & Springham, 2011, p.63). There has been a tension for me between the demands of theoretically-informed academic writing with its potential to objectify and distance the reader from the lived experience of mental illness, and the desire to share my journey in the belief that it is in the sharing that we can learn from each other. Ellis and Bochner (2000) commented with humour: “so many of our texts argue in postmodern abstract jargon for greater accessibility and experimental forms” (p.735). Burnier (2006) best summed up a resolution to this tension; writing as a political scientist steeped in a world of statistical methods and mathematical modelling, of “the abstract, detached, objective social scientific voice” (p.412), where the personal had been largely excluded from research and writing, she came to embrace the ‘I’ in her teaching and writing. As she suggested, I hope that my writing can be personal and scholarly, evocative and analytical, and descriptive and theoretical.

Autoethnography has at its heart stories and storytelling. I think with stories, it is how I do my work; in the absence of blood tests and x-rays that can help me diagnose, people tell me their stories. And storytelling is how I saved my life; in therapy I talked (and sat with) my life, again and again, gradually deepening, opening, and then there were the ah-ha moments when a connection was made, something made sense. But which or whose story do I tell? Autoethnography aims to make overt the multiple layers of consciousness or multivocality of the researcher (Ellis & Bochner, 2000; Mizzi, 2010), with writers using a number of devices to represent or demarcate the voices, such as change of font (e.g. Chatham-Carpenter, 2010) and asterisks (e.g. Mitra, 2010). This process of layering, however, created tensions for me; there were many discussions in supervision about which ‘voice’ I was using in particular parts of the text (Ronai, 1995). While accepting that I had multiple lenses

through which to view my and our experiences, each potentially offering a different interpretation, I resisted for it was in integration that I found healing.

I began the journey of this PhD with a desire to reclaim my service user voice; this needed me to bring that voice forth, bearing witness to those experiences in my mind and body, and quietening my then dominant professional voice. But I continued to work clinically, albeit sometimes uncomfortably; psychiatrist-me could not just go away: I am not, was not, either/or; I am this – and. I cannot isolate the voices, it is all my voice albeit viewed and spoken through differing lenses and discourses. Rather than demarcate, as others had done, I settled on foregrounding and backgrounding, accepting that my articulated voice is inevitably shaped by my varied experiences.

Multiple stories run through this thesis: my story(ies), their stories and the story of the thesis. The thesis as a whole foregrounds my service user experience, this running through the thesis as the story of my journey, crafted to reflect the themes of the relevant parts of the thesis. The stories of the other participants are presented in extracts throughout the thesis, disrupted enough to reduce the likelihood of recognition by a reader, but not so diminished that the quality of their experiences is lost. I resisted deconstruction, preferring the complexities that were our experiences to remain evident, and allowing participants' voices to be heard alongside mine. While bearing in mind that their voices may be shaped by both the interview process and my crafting of their stories, participants' words are sometimes left to speak for themselves with little interpretation: the stories they told are an expression of their wisdom. Throughout the thesis, the reader might note an apparently random flip between 'we' and 'I', reflecting the process of autoethnographic interpretation which allowed me to go deeper within myself to explicate a process that may not be apparent within participants' stories: this is my story and it is our stories.

Parts II and III of this thesis are the outcome of the research process. With an initial intent to explore aspects of place that facilitate healing for people with serious mental illness, the stories we told first necessitated a consideration of what we meant by healing. We framed our experiences of place with descriptions of what it was like to be unwell, and then how that changed, providing a subjective context for our associations of place and healing. Part II examines our experience of healing conceptualised as a journey of exploration.

Part II: Healing Journeys

As I sit to write, I feel the well of emotions: tears are not far away. These chapters are the heart of my thesis; the heart of my and our journeys. In preparation I have revisited many of my old writings: letters I wrote to my therapist but never sent; snippets of the diaries I began but never continued; the article “The Rhodos are flowering again” (Anonymous, 1992); and my attempt to write ‘my story’ six months after I left the Hall (perhaps I didn’t know how to finish it because the journey never ends, or maybe I just needed time). I have also read again the hospital records I obtained some years ago: records from the years leading up to the Hall, years that I struggle to remember.

These writings paint a picture of what that time was like for me. When I allow myself, I can open the door a little into the distress I felt. I feel it now as a pain in my chest, a heavy pain; but even that does not take me there. A year after I left the Hall I wrote ‘looking back, it’s difficult to remember the blackness of that time, the hopeless view I had of my world’; even then, I found it hard to remember the earlier intensity of my feelings. Perhaps in part this is a result of the amnesic effects of electroconvulsive therapy (ECT), but also my memories of despair have been overlaid by new experiences. This is the difficulty of working with memory, overlain from the moment it is formed. As soon as we begin to talk about an event, to tell a story, it has become a memory; forever influenced and changed in the process of telling. But words remain our main form of communication: words uttered at the time, or spoken a day, a year, a decade later; words written in prose, fiction or non-fiction, poetry or song – or in a thesis.

I set out in this project to explore the aspects of place that facilitate healing in mental health, but before considering place it was necessary to understand what I and the other participants meant by healing. When I began to work with my story in its multiple forms, written, spoken and read, I found it difficult to be objective, to take a step back and articulate the heartfelt experience of healing. As I will discuss later I had metaphors and analogies that I used to describe both the experience of unwellness and of healing, but as I entered into conversation with the other participants, and then their transcripts, I was able to engage in a deeper conversation with myself, this being the to-and-fro process of autoethnography. From this emerged my attempt at making sense of the experience of healing.

This Part, presented as four chapters, begins with my story, establishing a style continued through the thesis. After a discussion of the literature on healing, I further tell and discuss

my, and then our, story(s) framed as a journey (Muncey, 2010). Chapter six presents our experiences of what it was like to be unwell; chapter seven describes our experiences of healing; the final chapter of this part discusses particular aspects of the journey. The places, the people and activities involved will be discussed later in the thesis. There are a number of ways that these experiences can be framed; I chose the metaphor of a journey because of the implication of movement from one place to another, as I will argue healing involves movement and change, or transformation. These are journeys in time; sometimes involving a physical journey, but ultimately for us as individuals these were internal journeys: personal journeys of exploration and healing.

Chapter five: A story of healing

I had been sent South, complete with winter woollies, to be admitted to the Hall. I went there, not knowing what to expect. All I knew was that I was desperate; depressed and desperate. Before arriving at Ashburn Hall, I had had several years of aggressive treatment with multiple drugs and ECT. I was getting nowhere. I was 31 years old, and my life was a mess. I was unable to work, I was becoming increasingly dependent, there seemed to be nowhere to go but to die.¹¹

Three years frame the beginning of this journey: 1987-1990. Of course that was not the beginning; it is unnecessary in telling this story to pick over my life in its entirety, it is enough to say that I had struggled with panic particularly in social situations for a number of years. What is relevant to the research and this story is that I ended up with a diagnosis of serious mental illness (variously labelled recurrent major depression, seasonal affective disorder and, latterly, manic-depression) being treated aggressively with multiple medications and ECT; and, like the other research participants, I was repeatedly admitted to psychiatric hospitals. In 1987 I was living in a provincial town, in New Zealand, working as a doctor in a community medical centre as I completed my training in Family Medicine. Things were not going well; work was okay, but my panics had escalated and I became increasingly depressed.

The first hospital was terrifying; I was being admitted for ECT, and I had no idea; I had never had ECT before. I'm sure I turned up there as the big brave me; I could cope with this; depressed as I was I would cope with this. I have just been sitting reading my inpatient notes from that hospital. They make me feel sad, tearful, a little anxious, and angry. There is mention in my second admission of a patient threatening to throw a table in my direction – I am described as looking scared and anxious. I remember few of the actual events. On the one hand it is hard to recognize myself in the clinical notes, on the other I think I have a visceral and emotional memory – sitting with this I feel a heaviness in my chest, I want to hold myself and to cry.

Within two weeks of finishing ECT, I returned to work. This was to be my pattern for the next two years: 'there is nothing wrong with me now, I can cope'. Five months later I was

¹¹ In telling my story indented blue-text paragraphs are extracts from my historical writings, reflections on my clinical notes, and my personal research interviews and diary.

severely depressed again, and after a second admission for ECT, I moved in 1989 back to the city to be closer to the support of my family. I had successfully completed my training and continued to work, as I was able, as a locum family doctor in general practices. My episodes of depression continued, being treated with ever-changing combinations of medications and, over the next two years, several inpatient stays and many outpatient visits to a local private hospital for more ECT.

All I have left of [...] is a wad of receipts: outpatient ECT, \$80 a pop, or should I say a 'zap' (anaesthetist extra I am sure). I find the receipts for a two week stay in 1989 and again in 1990, and I am shocked (my goodness, the pun was not intended). I have no memory of these admissions (inpatient ECT is only \$25 – cheaper than a prescription perhaps!). My mother writes: “last year was hard to take for all of us – I think the doctor not knowing what to do and keep giving you ECT – 29 I think – and watching your poor brain getting all scrambled. You were very certain you wanted no more ECT and made me promise I would not let them give it to you again; very difficult as when you really got down you pleaded for it because it made you feel better.”

Nothing was changing, in fact over time it just got worse.

I was becoming more disabled, my episodes of depression longer and deeper; it became impossible to maintain the façade of my usual life. By early 1990 I was having regular ECT, was unable to work, and couldn't get out of my head that I wanted to die. I had lost my job, lost my home, and I had lost me. I was lost in a world that seemed black, intensely lonely and despairing, with little hope for the future; terrified of the place that I went to when depressed, and terrified of what was happening to my life. And so I decided to go to Ashburn Hall.

I remember it was Thursday: lying in bed, the only thought in my mind “I want to die” – round and round and round. Even then I knew that if I really wanted to do it, then I would, but it was the only thought I could have in my head. At 7.30pm taking some halcion so that at least I could get away from the thought for a little while; waking during the night and there it was again; incessant with no escape. And so it carried on over the next two days; on Saturday afternoon it came to me: I have to do something; I can't go on like this. I knew (what it was I didn't know, but I just knew) I had to go somewhere.

I (we) were getting nowhere; how could I cope with my illness when I couldn't cope with me. I just knew I had to go. That was Saturday

afternoon and for that moment I no longer needed to die. Seeing my psychiatrist on Monday, I said “I have to go somewhere and sort out my shit”. She asked if I had any ideas where? I said “how about Ashburn Hall”. And so the step was taken. It was arranged really quickly, they would admit me on Wednesday. I knew if I didn’t go straight away then I wouldn’t go. I was already starting to tell myself not to make a mountain out of a molehill, that I didn’t need to go away, that I could cope.

My decision to go to the Hall was not a well-considered decision on my part; I had an awareness that something needed to change, and the opportunity was there for me to go. This awareness was not accompanied by an understanding of what exactly I needed, but suggests that I was ready for change. Although not directly asked for in interviews a number of participants described a similar awareness; this will be discussed in chapter eight as the concept of ‘turning points’.

The snow was on the hills, the rhododendrons weren’t even hinting at their glory to come. I arrived with my skis over my shoulder – I was going to give them two weeks to get me sorted, cure my ills, and then I was going skiing. I don’t know how much I knew about what I would be offered; I went with the idea that unless I got myself sorted out, there was no way I could cope with this illness. I was going to give them two weeks and then I’d be fine; perhaps I expected them to tell me what to do; but dealing with this stuff is so much more than being told what to do.

Somehow, in those early days, I must have trusted them, and trusted the place enough to want to stay there. I don’t know how it happened, but there was a real sense, arriving at the Hall, that I got to leave my white coat at the gate¹².

I went for two weeks and stayed for a year: a place to go, to be and eventually to leave; a place that facilitated a process that was transformative: this became a journey of healing.

In July 1991, I left the Hall.

My skis came out from under my bed a year later. A year of seasons, a year of unpicking my self, and piecing myself back together; a year of ‘growing into my skin’. A week before I left the Hall it snowed – I put my skis on and I skied down the back field. That was me getting my life back really – getting back out, coming back out. That was an

¹² ‘Removing my white coat’ was a metaphor I used to convey my sense of being seen in my entirety, not simply the façade I presented to the world; that of a ‘competent white-coated doctor’. This metaphor will be revisited in the conclusion of this thesis: chapter thirteen.

amazing feeling. I have a photo album from that time and the first photo is of me sliding down the hill, in the snow, on the seat of my pants! With such a look of joy. When I look at that photo I want to laugh, my heart fills; I have my life back and more.

Healing means being able to get on with my life again – that’s the guts of what healing is and what healing was; that’s what they helped me do. I mean it didn’t stop there because another really important decision was that when I left the hall I decided to stay in Dunedin so I could continue in outpatient therapy. It all still needed to be consolidated; I was still finding my feet and I needed to keep my faith with everything I had learnt, and with what they saw in me.

That was 22 years ago, and in the intervening years I have got on with my life. I have had no more episodes of mental illness. That doesn’t mean there haven’t been times when I was distressed; that wouldn’t be life. I have had my sad times, particularly with the deaths of my parents and my older brother; times albeit brief when my world seemed to spin, when I threatened to ‘go away’ in my mind; but always time, talking and people have got me through.

Healing as a concept: the literature

When I wrote ‘The Rhodos are Flowering Again’ (Anonymous, 1992), I described the Hall as “a place of healing” (p.5). At that time I had no professional training in psychiatry, recovery was not a word that had entered my vocabulary. Two decades later, with all that I now knew professionally about recovery, healing was still the word I chose to represent my experience. Although I initially used the term in the research question because it felt right, through the PhD process it became necessary to interrogate the concept of healing. In the following pages I discuss the medical literature in relation to healing, and subsequently how this work informed my understanding of healing as interpreted through my and other participants’ experiences. For the purposes of this discussion, I have focussed on the general health literature; I will endeavour to reconcile the experience of healing in the context of recovery in the final chapter of the thesis.

Healing is not a term often used in relation to mental illness. While healing may be referred to as a desired outcome, particularly in the nursing literature, it is usually not defined or explicated; this is perhaps not surprising given the dominant discourse of recovery. A search of the textbook used in our psychiatric training (Sadock, Sadock, & Ruiz, 2009) revealed references to healing predominantly in two areas: the chapter on ‘Non-conventional

approaches in mental health care' and in the 'History of psychiatry'. This suggests to me that, at least in the medical speciality of psychiatry, healing has no currency in mental health, except on the fringes or in its conflation with spirituality (e.g. Culliford, 2005).

Medicine, of which psychiatry considers itself part, was traditionally considered a healing profession tracing its roots back to the Hippocratic medicine of Ancient Greece that melded a healing art with scientific discipline (Egnew, 1994). The Enlightenment of the 18th century saw a marked shift towards scientific evidence informing the understanding of illness and hence the role of a physician (Laugharne, 2004; Laugharne & Laugharne, 2002). More recently, in the face of increasing technological sophistication and disease focus, many authors argue that modern medicine has lost the art of healing (e.g. Cassell, 1976; Egnew, 2005; Kearney, 2009), becoming disconnected from the patients it treats. In this context, there has been renewed interest in the meaning of healing, and the role of the general health profession(al).

Although a commonly used term, what is meant by healing and the role it plays in our health system remains unclear and difficult to define (Egnew, 1994; Gesler, 2003; Glaister, 2001; Hsu, Phillips, Sherman, Hawkes, & Cherkin, 2008; Kleinman, 1973). Healing is written about in the health literature in a limited number of ways. Authors have offered, in books or opinion pieces, their understanding of what constitutes healing, its role and how to achieve it in the context of health care. Some authors utilise case studies of the writer's experience of patients' healing in their clinical work; much of this is written as a critique of modern medicine (e.g. Cassell, 1976; Kearney, 2009). Several authors present concept analyses of healing literature to aid definition (Glaister, 2001; Wendler, 1996) and lastly there are a small number of qualitative studies that investigate the concept and process of healing (Egnew, 1994, 2005; Hsu et al., 2008; Mount, Boston, & Cohen, 2007; Scott et al., 2008).

Curing or healing?

An interest in healing over the last 20 years has arisen from the contention that modern medicine became more interested in 'curing' than 'healing (Cassell, 2013; Egnew, 2005; Hutchinson, Hutchinson, & Arnaert, 2009)'. Kearney (2009) suggested that "Western healthcare has become very focussed on and good at "curing", as in "fixing" and "making better", on restoring the sick person to the status quo of how life was before [and] not really that concerned with the question of healing" (p.xix). As with the concept of recovery in mental health, there is argument about whether healing necessitates cure. Much of the research directed at an understanding of healing has occurred in palliative and end-of-life

care where there may be no expectation of cure; in contrast Hsu et al (2008), in a primary care based qualitative study, suggested healing involved returning “the person to as near as possible to his or her original state” (p.311).

Technology (to facilitate diagnosis) and pharmacotherapy (making cure possible) have supported a disease approach to ill health. A discussion of disease and illness, and curing and healing, raises questions about the use of language that has relevance for mental health: I talked of being unwell, and professionally I refer to mental or psychiatric illness to describe people’s experiences. The term disease, having an implication of causality, is rarely used in relation to mental illness. Instead the diagnostic manuals for psychiatric illness, the Diagnostic and Statistical Manual of Mental Disorders (American Psychiatric Association, 2000) and ICD-10 International Classification of Mental and Behavioural Disorders (World Health Organization, 1993), refer predominantly to disorders, given that the causation of most mental illness is yet to be elucidated. Boyd (2000) acknowledged the difficulties in clearly defining the difference between illness and disease; he settled on a widely accepted distinction, disease being “the pathological process, deviation from a biological norm” and illness being “the patient’s experience of ill health” (p.10).

Cassell (1976, 2013) made a similar distinction: the concept of illness encompassed the individual’s experience of and response to disease, a disease being something to be cured where possible, and illness was to be healed. Hutchinson et al (2009) described curing as an “action carried out by a health care practitioner to eradicate disease or correct a problem, while healing was a process leading to a greater sense of integrity and wholeness in response to an injury or disease...” (p. 845). While cure may be possible, in many situations people are not cured but no longer die of disease, living longer with chronic illness. Whether cured or not, these authors argue that medicine needs to pay attention to healing, Cassell (1976) suggesting that a focus on cure may leave aspects of the illness untreated.

Since the development of cure is dependent on knowing the what and the why of disease, it is clear that cure will be directed only against objective manifestations of illness that our science has defined as disease, thus curing the disease will be effective in resolving the illness in proportion to the degree that the illness is explained by the disease. (p.65)

So what is healing?

The word ‘heal’, derived from the Old English *haelen* (“the condition or state of being *hal*, safe or sound” (Egnew, 1994, p.1)), is defined as “to make sound or whole” (Stevenson &

Waite, 2011). I remember my white room: that place of nothingness where I ceased to exist, as I awoke from ECT (page 148); and I remember my profound sense of joy as I skied down that hill at the Hall. I have often described that journey as one of ‘growing into my skin’; as I will discuss later, I grew into my self, becoming whole: I healed.

While authors continue to aver that healing remains enigmatic, certain attributes are consistent in the literature. Healing is described as an intensely personal process or journey (Hsu et al., 2008), with each person’s experience of healing being subjective and unique (Egnew, 2005; Glaister, 2001). This may be perceived as a journey back toward a previous state (Hsu et al., 2008), or more commonly forward movement and transformation (Egnew, 1994; Glaister, 2001). Healing is multidimensional having physical, emotional, intellectual, social and spiritual aspects; implying deeper processes beyond the physical repair of a wound (Egnew, 1994). These processes include coming to wholeness, connection, and finding meaning. Some authors suggest healing is an active, energy-requiring process (Glaister, 2001; Wendler, 1996); others that it may be serendipitous in the context of relationship (Egnew, 1994, p.150).

Wholeness

Informed by grounded theory, Egnew (1994) investigated the concept and mechanisms of healing by interviewing seven physicians, all of whom he identified as having “expertise in areas relevant to the research” (p.77). He identified themes of wholeness, narrative and spirituality, and described healing as involving “a reconciliation of the meaning an individual ascribes to distressing events with his or her perception of wholeness as a person” (Egnew, 2005, p.255). While most authors emphasise this sense of wholeness, definitions are elusive (Boyd, 2000). Some refer to restoring or achieving balance across the physical, emotional, intellectual, social and spiritual domains (Glaister, 2001; Hsu et al., 2008), as did Elizabeth Kubler-Ross as participant in Egnew’s aforementioned study; Egnew (1994) himself suggested that wholeness can be different for each person.

Hsu et al (2008) conducted focus groups with primary care patients and health professionals to investigate the concept of healing, its facilitation and barriers. In keeping with others, healing was described as multidimensional and holistic, with participants often using the metaphor of a journey whose goal was recovery or restoration. Rather than wholeness the researchers identified a theme of reaching personal balance or harmony, which may be attained by gaining understanding and acceptance. The authors did not provide a definition

of these terms, but Mount (2003) explained acceptance in the context of healing as “not a passive giving up, but an active integration of reality” (p.42).

Connection

Connection is a recurring theme in the healing literature and is often expressed as a function of the healer-patient relationship (Hsu et al., 2008; Scott et al., 2008; Wendler, 1996). Hsu et al (2008), described healing as both a personal and interpersonal process, stressing the importance of relationships particularly with clinicians; the authors suggested healing is a journey that is not taken alone. Others broadened the concept of connectedness beyond the interpersonal. Frank (2009) described “deep illness” as “feeling literally dislocated, no longer fully connected to the ground on which [we] stand” (p.187). Similarly, Mount et al (2007), in a phenomenological study of people with a life-threatening illness, identified four types of healing connections: with oneself, others, the phenomenal world as experienced through the five senses, and with ultimate meaning. This widening of the experience of connectedness resonates with the concept of therapeutic landscapes (Gesler, 1992), considering physical, social and symbolic aspects of place, and with my experience of the Hall.

Suffering

The experience of suffering is integral to an understanding of healing. Mount et al (2007) conceptualised healing as being movement along a continuum from “suffering and anguish at one extreme to an experience of integrity and wholeness at the other” (p.373). Likewise Egnew (2005), in an attempt to operationally define healing, suggested that it is “the personal experience of the transcendence of suffering” (p.255). He described suffering as “an intrinsically disagreeable experience that is angst of an order different than pain, though it may involve pain... [that] subsumes nonphysical dimensions – social, psychological, cultural, spiritual – associated with being a person” (p.171). This existential view of suffering was captured in Cassell’s (1982) widely quoted explanation that “suffering occurs when an impending destruction of the person is perceived; it continues until the threat of disintegration has passed or until the integrity of the person can be restored in some other manner” (p.640), this suffering occurring in any personal domain. Frank (2001) believed that, when unwell, his suffering arose in a sense of disconnection from himself and life as he had been living it: “becoming other to the person as I had been and to those who knew that person” (p.354).

Finding meaning

Frankl (1962), reflecting on his experiences in concentration camps, suggested that “suffering ceases to be suffering in some way at the moment it finds a meaning” (p.115), arguing that a fundamental human quest is the search for meaning. Similarly, Cassell (1982) wrote that “suffering is reduced when it can be located within a coherent set of meanings” (p.644). These meanings relate to the illness itself, and to the disruption that illness causes to our life story; sometimes when unwell “we are summoned to wrestle with the purpose and meaning of life and death” (Harter & Bochner, 2009, p.116).

Associated with finding meaning, is the concept of spirituality. Most authors and researchers emphasise the multidimensional nature of healing, and thus far I have not directly addressed the spiritual domain yet it is integral to the experience of healing (Egnew, 1994, 2005). As a non-religious person it has been perhaps the most challenging for me to make sense of: despite my experiences, a lifetime of education makes me vulnerable to conflating religiosity with spirituality. Definitions of spirituality vary and remain contested; for some it is synonymous with institutional religion (Randal & Argyle, 2005), for others it is a more personal endeavour asking where and who we are as persons (Egnew, 1994). Spirituality may have a cultural component: in the Maori model of health, ‘Te Whare Tapa Wha’ (Durie, 2011), the spiritual dimension of taha wairua “recognised the importance of culture to identity as well as the significance of long-standing connections between people, ancestors, and the natural environment” (p.30).

Swinton (2005) offered a description of spirituality that fits with my value system:

Spirituality relates to the way in which people understand and live their lives in view of their sense of ultimate meaning and value. It includes the need to find satisfactory answers to ultimate questions about the meaning of life, illness and death. It can be seen as comprising elements of *meaning, purpose, value, hope, love* and for some people, *a connection to a higher power* or something greater than self. Perceived in this way, spirituality is not simply found in ‘religious patients’, but may be present in all patients. (p.1)

It is in this understanding of spirituality, and the idea of connections other than with a ‘God’, that I begin to recognise the spiritual aspects of my experiences. The concepts of wholeness (sharing a common old English root with holy), connection and finding meaning all potentially have elements of spirituality; but there is another concept, transcendence, that requires elucidation. Cassell (1982) argued that “transcendence is probably the most

powerful way in which one is restored to wholeness after an injury to personhood” (p.644). Although defined in the Oxford Dictionary (Stevenson & Waite, 2011) as ‘the action of surmounting or rising above’, Cassell suggested that transcendence is a deeply spiritual experience that “locates the person in a far larger landscape” (p.644). It is this definition that has resonance for me, my life developing a richness that I had not known before, and prepares the way for place to become a healing landscape.

In summary the medical literature suggests healing is a personal and subjective experience that can be related to, but is not dependent on, cure of disease. This discussion has paid scant attention to the physical aspects of healing, as does the literature I have reviewed, perhaps because this is the aspect that medicine already does quite well. Healing as I have presented it is multidimensional: physical, emotional, intellectual, social and spiritual, with varying individual emphases. Healing may be accompanied by a sense of wholeness and involves the relief or transcendence of suffering. It is a process, often described as a journey, that is supported by connection and finding meaning, perhaps understood and conveyed as a narrative or story. Healing remains enigmatic, the core component of wholeness being particularly difficult to articulate; it is perhaps its ineffable nature that has diverted the increasingly evidence-based discipline of medicine from consideration of healing.

The stories that we tell

Towards the end of my first year of PhD study I presented a paper at The Mental Health Services (TheMHS) conference, an Australasian event with strong service user representation both in organisation and attendance. The presentation was titled ‘I Think I have a Story to Tell’, my intention being to tell my story and demonstrate how we might use our stories to investigate aspects of mental health care. As I read further, and thought more deeply, I wondered if the story itself was part of the process of healing. As evidenced by the article I wrote (Anonymous, 1992) a year after I left the Hall, I had a story that I told that was a way of making sense of my experiences and communicating that understanding to others; connecting both to them and myself in a deeper way. Participants also told me stories. The research question asked about a place, but in conversation each person told me about more than their experience of that place; they talked about how they came to be there, what it had been like to be unwell, and something of what had happened subsequently. These were stories with a beginning, middle and end, although as my story suggests perhaps there is no end, just a point of pause for reflection.

We tell stories for ourselves and for others, stories being the principal means through which we make sense of the world (E. Foster, 2013). Finding meaning is a fundamental process in healing and, located within the context of an individual's life, is often expressed as an intensely personal narrative or story. Harter and Bochner (2009) asserted that there is an "inextricable connection between narrative and healing... unexpected life experiences call forth stories, and... narrative provides the hindsight to make meaning of the past and move toward a more hopeful future" (p.114). Telling stories is at the heart of our efforts to find and make meaning in our experiences and lives, and the lives of others (Charon, 2006).

Frank (2010) suggested a two-way process between stories and meaning: stories are the way we make sense, to ourselves and others, of events in our lives "ordering things in time and space, in priority, and in relations between actions and outcomes" (p.52); stories are also the mechanism by which we develop meaning. Throughout my stay at the Hall, and after I left, I wrote to try and make sense of my experiences, by which I "constituted the world and reconstituted myself" (Richardson, 2001, p.33). The story I constructed and continue to tell had purpose in communicating and connecting with others, but perhaps more importantly it is the story I tell myself. The story is the never-ending outcome of my search for meaning, this re-authoring being a pivotal task in recovery and healing (Frankl, 1962; Onken et al., 2007).

At the beginning of this chapter I told the bare bones of my story, setting the scene for a journey that began with despair and desperation, and ended with joy. In the next three chapters I will present data to support an explication of the elements of healing, conceptualised as a journey of exploration and discovery in which we transformed suffering, moving from fragmentation to wholeness, and gaining wisdom along the way. I have tussled with how to write these chapters. To present material thematically risked reducing participants' words to impersonal sound-bites, allowing the reader little opportunity to engage emotionally with people's stories. Instead I have utilised the journey metaphor, giving participants a voice for each stage.

Chapter six: What it was like to be unwell

I began the story of my journey describing a several year process of increasing despair and desperation; of becoming lost: 'I had lost my job, lost my home, and I had lost me.' There are many gaps in my memory of those years, and what memories I have are often two dimensional, lacking emotion and colour. Whether this is due to the effects of ECT, of depression, or simply the passage of time I cannot say. I do remember days of lying curled on my bed: not able to sleep, not wanting to eat, struggling to do the simplest of tasks. It was as if I ran away into a deep dark hole, and as I write this my chest hurts. I have no personally written material from this time, but my writings shortly after I left the Hall give a hint of what it had been like for me to be unwell.

I remember sitting in the lounge inwardly screaming at the noise, the voices, the activity. At the time I think none of it made sense. I was struggling with emotions that had no form, no recognition, no meaning. A maelstrom of confusion. So much running from what I didn't understand, and trying so hard not to run. Sometimes the only way out seemed to be to die; it was my escape route. It is really hard to describe, to really get a sense of that early time at the Hall. It is as if the rainbow had no colours, the world no subtlety; black and white, white and black. Stand up straight, curl up tight.

and...

Back to the darkness, a place where there are no colours, where there are no feelings.

I was struggling with experiences, sensations and emotions that I neither recognised nor understood. My way of dealing with this confusion was to run away, go away into the darkness: to disconnect. I wrote about my fear, as I worked in therapy, of becoming unwell again:

I raged against another fear that continued to lend all this work an air of unreality, a sense of 'ifs' and 'buts'. The returning threat of the autumn months¹³, and of my mind: what was mine and what wasn't? The returning threat of some uncontrollable illness that would inevitably take me away from myself, back into the black hole, the empty hole; me crying in the darkness where I couldn't hear myself. And I was terrified, I am terrified; terrified of that place, and again I

¹³ My illness had developed a periodicity, with the most severe relapses occurring in March or April each year.

feel like I am drowning in a sea where there is a lot of noise, angry waves, but no sound; where I cannot hear myself, and no-one can hear me. A lot of noise, and no noise. Drowning. Being battered but nothing can touch me. A place where I cannot be soothed, and I cannot soothe myself. I want to run fast, I want to stay still, I stand up straight, I curl up tight.

I remember my fear, every day – am I still here, have I gone away? Holding my breath – would this be the morning when I would wake up and find I'd been slowed to a crawl, switched off, gone away?

Suffering has been described as a disagreeable experience (Egnew, 2005) that occurs when impending destruction is perceived (Cassel, 1982); it is striking that 20 years ago I wrote of my terror, of being battered and drowning: I was suffering. In running away I was not only disconnecting from others, but also from myself: I couldn't 'hear' myself. There was also a sense of disconnecting sensorially from the phenomenal world: the world had no colour, I went to a dark place where there was a lot of noise, sound but no sound, where nothing could touch me. I have described how nothing was changing; my illness was relentless with no escape. I was stuck, with no hope for my life: there seemed nowhere to go but to die.

I was struggling not only with my illness and the fear of it, but also the effects this illness had on my sense of myself.

For much of those early months I struggled with what was 'me' and what was illness; I was manic-depressive therefore this is not me. Where did my illness end and I begin, as if I had no control over the effects of the illness? The biological process defined me, I could not define it; and how could I, if 'I' had no definition? For most of that time, the arguments went on in my head – is this me talking or my illness, am I feeling sad or is my illness feeling sad (with the ensuing panic these thoughts could provoke). I feel good or am I just high?

I experienced my illness as an entity that controlled my life, controlled me; that took me away from myself. I perceived it as somehow separate from me, with its own thoughts and emotions which weren't to be trusted. This separation had a different quality to disconnection and, after reflecting on others' experiences, I conceptualised this as fragmentation, a theme that is perhaps more overt in others' stories. I began the journey of healing seeking to strengthen myself so that I could control this illness. As I will discuss later, instead I integrated my illness experience; it became part of me, for me to explore and as I did, I began to trust myself.

Our accounts of illness

Participants gave varying accounts of illness and while our experiences differed, there were aspects that we had in common. Some told me they had been depressed, and at times suicidal; others described experiences that they called psychosis, or that I recognised as psychosis. I did not ask anyone what diagnosis they had been given, and it is interesting that while several people told me about being labelled with one or more illness, none overtly claimed the labels for themselves. In this section I will tell enough of each person's story to set the scene for the journey of healing. These excerpts describe, in a very limited way, experiences of being unwell¹⁴.

Alice

Alice had been admitted for a lengthy period (several years) to a locked mental health unit, a place that she identified as healing for her. She began by telling me about an earlier admission to hospital during which nothing changed.

The first time I was admitted to an acute psych unit it was really not a healing place. I probably came out of it as unwell as when I went in.

She went on to talk about being unwell.

I was having auditory and visual hallucinations. It was a spiritual battle and I thought for some reason God had chosen me. It's a jumbled process because you're doing things that you would not normally do but you're responding to what you think is your reality. You're terribly frightened because you're experiencing these horrible things which are as real as you and I sitting here talking; your vulnerability is raw... This was my experience of psychosis... [but] I didn't know that I was unwell at the time.

Alice painted a vivid picture of psychosis; she was seeing and hearing things that for her had a spiritual dimension. Although her illness manifested in different ways to mine, she too found it confusing, with perceptions and thoughts she did not understand and couldn't be trusted. She was uncertain of her reality, and was frightened by her experiences.

I wanted [the staff] to help me deal with the excruciating pain I was in: emotionally, spiritually. I had broken down completely, I was shattered [and] I didn't know how to make myself well.

¹⁴ Throughout the thesis, as I discuss each person's experiences, I have endeavoured to utilise the terms each person used to refer to their experiences: unwell/illness/madness/psychosis/depression etc.

You lose everything that you are. You often lose lots of people; you lose your freedom, you lose your trust in yourself; your whole sense of personal trust for yourself gets so smashed and broken. You're experiencing all this mental illness and you're trying to find yourself amidst it.

The words that Alice used – a battle in which she was shattered, smashed, broken – conjured a visual image of fragmentation, being broken into pieces. She experienced this as intensely painful: she was suffering. Loss was a prominent theme in Alice's story; there were external losses, losing her physical freedom and connection with people, and a personal loss of trust in herself. 'Trying to find' herself suggested a deeper sense of loss of identity: her sense of who she was.

Barb

Barb's experience had been of multiple and lengthy admissions to old-style institutions and acute mental health units; she now chose the familiarity of home when unwell. Like Alice, Barb described her fear, uncertainty and anxiety associated with psychosis, suggesting an element of distrust of herself and what she was experiencing.

I was very very agitated and deeply concerned about what was going on; I was having these very strange ideas which were often very fear provoking. I was just waiting for something to happen, but not knowing what it was... I don't personally find psychosis scary; I find going into psychosis much more frightening, because I know something is wrong. When I'm in the real throes of madness I can create a reality that makes it possible for me to sustain myself. [But] when I'm coming out I find it scary again: the aftermath of it, what I would have to deal with afterwards.

I was left wondering what Barb, in her madness, needed to sustain herself against. She perhaps answered this, going on to suggest that when unwell, she too went away from herself.

And my fear, I think my biggest fear really, was that I wouldn't come back this time. That was the thing: that I wouldn't be able to re-connect to myself this time. That this was how it was going to be from now on.

Barb's description of her fear that she 'won't come back' resonated with my fear of 'going away' to my deep, dark hole. She suggested that in her madness she went somewhere else in herself, and feared that she wouldn't be able to return; we experienced illness as disconnecting us from ourselves. Others also used words to describe being unwell that

suggested a sense of, if not disconnection at least, a disruption of relationship with ourselves and our world. Barb talked about the effect of medications on her illness experience; which exacerbated this disruption.

The problem when they give me the antipsychotics is I can't think. That's the scariest thing in the world to me, not being able to think clearly. Even if I'm having mystical, magical thoughts, that's preferable to not being able to string thoughts together. Having those very broken thoughts, when they're really scattered, it feels like I've lost my essence. Because my essence is being able to think things through.

Barb's use of the word essence suggested that, when her thoughts were scattered, she lost something integral to her sense of herself: perhaps her sense of wholeness. Barb also came to understand, as did I, that her illness was something outside her control, and that she was helpless. She suggested this belief developed through her contacts with mental health services

What I learnt was that I couldn't deal with it. And there's no way I could deal with anything... I learnt it in the institutions and also I think even in the acute unit, because just by virtue of being in the acute unit it means I'm not handling things. That's what it meant for me, that things had got out of control... And so the idea of exploring it and what I could do with it wasn't there; it was just about keeping things nice and still and steady and not getting too upset. It wasn't actually about sorting anything out... Yep, push it down.

Admission to hospital confirmed Barb's understanding: that her illness was outside her control. She foreshadowed, however, the idea that rather than pushing her experiences down, in effect disconnecting or denying, she needed to engage and explore.

Margaret

Margaret used the metaphor of a storm to describe her madness.

Madness really, I use the word quite willingly... Distress is always a precursor to the experiences I have. They're usually multifactorial stresses; and, usually I'm pretty good at navigating through the storms with the guy ropes in my teeth as I say. But, sometimes I lose the plot... my whole being became more and more challenged through that process and I got to the point where I just lost the plot literally; I then entered into this manic kind of panic... they could see how fragmented I was becoming... I realise when I get very scattered

with so many thoughts and creative impulses, that I do need some kind of containment.

She talked of becoming scattered and fragmented; suggesting that it was her 'being' that became fragmented. This supports the notion that mental illness can be experienced as posing a threat to the essence or heart of who we are; more than our identity, it is our 'being' that is under threat. Margaret's use of the word scattered was similar to Alice's shattered, although Alice's experience seemed to convey a greater sense of associated distress. Margaret talked later about how she hoped she never lost elements of her psychotic experiences.

Margaret did describe distressing emotions, arising from past treatments.

I had [a number of] years of institutionalisation... Now, I have deeply ingrained institutional PTSD trauma.... [A few years ago], I ended up in seclusion for days; it took me 18 months to get over that because it ignited every PTSD experience I'd ever had... a lot of my behaviours have been really avoidance at all costs of acute care.

Margaret reminded me that it was important to consider what we were healing from. The distressing emotions that we experienced were not simply a consequence of illness, for some people treatment itself was traumatic. My personal medical files noted my fear at times in the inpatient unit environment, and I struggled for a long time with the unrecognised anxiety of 'my white room, that half-remembered place of nothingness as I awoke from ECT' (page 148).

Margaret developed an understanding of her process that countered the sense of being disconnected and separate from her illness.

I think part of it is in how we talk about the experience. How we regard it as this huge sense of otherness, whereas in fact [pause] I have a little box that I call my magic box and it's the ideas and things that I have before I really become scrambled... When I'm hallucinating, voice hearing, and hearing music... all the things that I experience in my so-called mania, are kind of just extraordinarily heightened... partly of my being, of my creativity or whatever.

The metaphor of the box suggested an element of separation, or keeping separate, but Margaret implied that this was a 'box' that she engaged with, recognised and valued as part of her.

Fran

Fran identified an art studio as her healing place. She began by telling me about earlier admissions to acute mental health units. She hadn't found these helpful; as was my experience, things were getting worse.

My inpatient experiences haven't necessarily been pleasant... and with my major hospitalisations [there] is that sense of coming out in a worse position than before I was admitted.

She described the effect her episodes of illness and the treatment had on her. As with others she experienced a sense of being lost which, like Barb, she seemed to attribute in part to medication.

The first time I was in hospital was after a major self-harming episode. The year after that, my mood had headed very high into the elevated manic point, losing touch with reality somewhat. I was convinced I was building time machines and things... I managed to get myself sectioned... I went from sky high to very over medicated and quite lost. And that sense of the plan I had for my life being completely dashed and taken away from me, and not knowing, now what. Really feeling quite lost.

Fran evocatively articulated the loss of her hopes and dreams. The plan she had for her life, and perhaps more profoundly the way she defined herself, was 'taken away' from her implying a loss of agency. Fran didn't tell me much about her illness, but as with others, she described uncertainty and confusion; her world didn't seem quite real, she couldn't make sense of her experiences.

[When I am unwell]...it's a feeling that the world's not quite real; being unsure whether what you're experiencing is real or not. And that loss of connection within the world as well – my sense of where I was, what I was supposed to be and very much lost; you're not really sure who that self is.

Fran felt disconnected from her world, not knowing where or who she was; her identity was threatened. Although she didn't describe the emotions associated with 'being lost', Fran had earlier talked about becoming 'real low'; perhaps this reflected the suffering associated with the threat of destruction of self. Associated with her disconnection and uncertainty was distrust.

I was probably very distrustful of the whole world at that point... [That distrust] is a whole bunch of stuff; it's hard to kind of grasp.

[It's] an overwhelming feeling that something bad is going to happen and you've got no power to do anything about that.

I felt like I was being told that I didn't know my own body, myself, my own body, my mind. We know better... and that real kind of taking away of that sense of myself.

Fran distrusted herself, and her world; she also didn't feel trusted by others. She experienced this lack of trust by others as further taking away her sense of herself. Unable to put words to her experiences, Fran stopped talking.

Within a lot of that I found myself unable to articulate what was going on for me; I pretty much stopped talking for two to three months. Once you stop talking to people they stop talking to you, they stop initiating conversations so the opportunities to talk diminish.

Fran was becoming increasingly disconnected from others, exacerbated by their perceived disconnection from her. I was reminded of where I went in myself: 'a place where there is a lot of noise, but no sound; where I cannot hear myself, and no-one can hear me.'

Colin

Colin had multiple admissions to hospital before being admitted to a forensic mental health unit, the place that for him was a healing experience. As with others he described his illness as relentlessness, with nothing changing.

I was unwell for [many years] without a break. It was repetitive and going in circles: go to a general mental health unit for three months; come out as sick as I went in; manipulate the system and come off the community treatment order; do the same thing again. It just goes round in circles. I was a very angry man and I was so sick... I couldn't see past my illness. I was embroiled in it.

Colin was deeply immersed, 'embroiled', in his illness suggesting a disconnection from or loss of other aspects of his life. He told me about his experience of psychosis.

As soon as you hear a voice, it changes your life. Mine start with almost a silence, like a high pitched hiss – something's there. And suspicions are aroused – I was talking about angels, demons, gods; I was hearing voices, and I could converse just like I'm conversing with you. That was my reality, a dual conversation going on all the time... It was all very real for me and I'd see people doing things. I don't know what reality is, thinking back, I don't know what really went on.

Colin had many years of being unwell; his psychosis was life changing. Even now, he doesn't know what his reality was; the experiences seemed so real. Like me, Colin described an experience that became dark, in which he was trapped; he too felt suicidal.

And during my dark days I was suicidal every day. I thought about it all the time but I didn't have [pause]; I couldn't do it. So it was even worse; I was trapped here. I couldn't do anything about it and that's what led to my desperation in the final days.

Colin powerfully described his desperation; he was stuck with no way out, suggesting a sense of hopelessness and helplessness. As with others, there was a sense that Colin was losing something of himself in his illness; he told me he 'couldn't see past' his illness. I wondered if he couldn't see himself.

David

Unlike other participants, David had only one admission to hospital, but this followed several years of being unwell. This admission to an acute mental health was a turning point in his journey. David began our conversation by telling me what it was like for him, when unwell.

I think the place to start would be when I was rock bottom. I stayed in my room; I stayed on this continuum, still listened to my voices. I was talking to a wall, talking to my cigarettes, listening to my voices while doing all this... I was more or less able to puncture any words that came from people in my family by the hype in my fierce fire, that out of control fire that was in me... That rage only came from like hallucinations or voices... I believed what my voices were saying.

David used the metaphor of 'rock bottom' to describe the 'place' he had reached in his illness; this conjured images of a hard place into which he had descended and could go no further. He felt stuck 'on a continuum', immersed in illness experiences that generated fierce emotions over which he felt he had no control. In a later extract, talking of healing he referred to 'the blocks that were laid out scattered everywhere'; he, like others, used metaphor to convey a sense that his illness experience left him feeling fragmented, in pieces. David talked about nothing changing, being stuck:

It was like a cartwheel with 2 cogs, and it was just going to go over and over and over in this... I stayed rock-bottom for just like a timeline that was on a continuum. Just had no cliff to fall off and say snap out of it.

There was a feeling of hopelessness in being stuck at rock-bottom, with no way out. As I will discuss later, David did find his ‘cliff to fall off’. He found an opportunity to understand and view his experiences differently.

Helen

Helen’s healing place was a Maori cultural unit within an older institution. Prior to this lengthy admission, she had been in hospital several times.

I was in and out of psychiatric facilities; yeah it was existing, no life. I’d stay a few weeks and then be let out and get eventually a little bit better, quite a bit better. And then think to myself I’m so well, I don’t need these pills, chuck them away.

Although she would feel ‘better’ between admissions, Helen described these years as existing; she has lost her ‘life’. I identified with those lost years; I too had repeated episodes of illness. I would finish a course of ECT, feel better and quickly go back to what I had been doing. I did continue to take my medications, but nothing else fundamentally changed and I would become depressed again. A number of us have described this sense of being ‘on a treadmill’, ‘going in circles’, ‘a cog with two wheels’: nothing was changing, Helen describing this as ‘existing’ rather than living. She became unwell again:

I did something wrong when I was psychotic so I ended up in [hospital again]. When you do [things when unwell], it’s like someone taking over your body and it’s like you know you’ve done it but it just doesn’t feel like you’ve done it... I wasn’t sure what was happening to me. I’d think bizarre things, like I could read people’s minds. I’d think all sorts of things were happening that weren’t, as part of the psychosis and paranoia.

By the time I got to [my healing place] I was not psychotic any longer; I was just very depressed. I realised what [had happened] and that was awful.

Helen experienced herself differently when unwell: it was ‘like someone taking over your body’, suggesting a sense of disconnection from herself and loss of agency. She described her thoughts as ‘bizarre’ and, like others, didn’t understand what was happening to her; she was uncertain what was real. Distressed by the consequences of her illness, she became depressed.

Emily

In the years leading up to her lengthy admission to a therapeutic community Emily had, like others, repeated admissions to hospital. For her too there was a sense of nothing changing.

I'd spent several years in and out of acute facilities that had not been able to support a positive long-term outcome; I went into different places around the country. I was heavily, heavily medicated; so some people that met me during that time said they thought that I spoke slowly. They thought that was just part of my personality. Other people couldn't believe that I could actually walk on that level of medication. I had ECT during that time. Basically I pleaded to have it because I just wanted to get out of where I was.

Emily's story had many features in common with mine. I identified with her repeated admissions to hospital, and the focus on medication. She talked about pleading for ECT, and I was reminded of the letter that my mother wrote to me (page 84). Emily said that she wanted ECT 'because I just wanted to get out of where I was.' While I do not know if Emily was referring to a literal or figurative place, our use of the word 'pleading' suggested desperation.

Between admissions Emily would return to her usual lifestyle, as I did, and similarly there was a sense of nothing changing.

Essentially, every time I go into the services and have whatever done, change of meds or whatever, then I'd leave and try and pick up all those things again. Never during that time did I consider I might need to change my lifestyle, to manage my health better.

They were very medication or quick intervention focussed; and essentially the purpose of being in the unit would be to get that right or done, and get out again. If you think of a petrol tank and you're running on just empty, and then you dip below that – you go into the unit for a couple of weeks, and get back to empty so you can operate for a little bit longer before you dip below again. But you never really get [pause]. It's like a quick fix sort of thing which doesn't work.

Emily used the metaphor of a petrol tank to describe her sense of depletion when unwell, and while admission to hospital might restore her a little, it didn't take long to be depleted again: nothing essentially changed, nor did she consider a need for change. Emily indicated her awareness that quick fixes were not the solution to her difficulties. While emptiness seemed

to imply there being nothing, there was also a suggestion from Emily of disconnecting from that which was too hard to deal with.

I think the way to deal with everything was for me to disengage from everything. It was like what I'd done was got so much on my plate that I no longer had any capacity to engage with people or be in the world. Essentially if anything gets too hard that's the first thing I'll do – stop talking.

When things got too difficult Emily stopped communicating; she not only stopped talking to others, she disengaged from herself, and her life. Emily described her sense of helplessness and hopelessness when she arrived at the hospital that was to become her place for healing.

It's hard for me to reflect on that beginning place because I think I didn't even have any energy to [pause], I don't even know if the word's energy. For two years I'd been self-harming, engaging in quite significant self-harm and by the time I got there I wasn't doing that anymore. By that stage I was pretty messy, and I think I'd completely given up. So it was like: well, I don't really have any options left in some ways.

Like David, she had perhaps reached 'rock-bottom'; in chapter eight I will discuss the concept of 'turning points' that can be opportunities for the trajectory of our illness journeys to change.

Sally

After an early and positive stay in a hospital that subsequently closed, Sally had a number of admissions to acute mental health units. She told me that admissions were to 'keep me safe' at times when:

I've been trying for so long to keep fighting the fight and I just get to a point where... like a big sign for me is when I can't keep it together at work or in front of people. And so when I can't do that, I know that I no longer have control really.

'Keeping it together' was another metaphor that captured a sense of falling apart, fragmentation and at its extreme, disintegration. Sally said that in her illness she was 'fighting the fight' until she could no longer 'keep it together'. This reminded me of Margaret's metaphor of 'navigating through the storms with the guy ropes in my teeth', the guy ropes holding her together and in place until she reached a point where she became scattered. No longer being able to keep it together was Sally's sign that she needed help. She had come to understand her illness as depression.

I finally had a psychiatrist who worked out, who went back through all the years, and worked out oh my gosh, every time the suicidal stuff is extremely bad and self-harm is extremely bad, you're actually really depressed.

Sally said little about what it was like for her to be depressed, but I assume from her suicidality that there was an element of desperation. She later identified a facet of healing being 'getting the faith back in yourself', suggesting that when unwell she lost trust in herself.

Lauren

Lauren began our first conversation telling me about an admission to hospital, after she had attempted suicide. Explicitly using place as a metaphor for her distress, she told me:

I was pretty much at rock bottom and I tried to take my life... I've been in places, and I don't mean physical places, but places in my head where I could find anything to hurt myself. When I'm really distressed and really desperate I could probably find something to harm myself anywhere.

Like David, Lauren used the metaphor of rock bottom to articulate her experience of illness. She didn't tell me much about what 'rock-bottom' meant to her, except that it was associated with distress and desperation, and presumably despair. She went on to talk about trust:

[When I am unwell], no one trusts you anymore. And I mean no-one – actually therapists probably are more trusting; I don't know whether it's trust but it's something – but friends no, society no, hospitals no. [Do you trust you?] No, but at the same time I'm also more aware of where I'm at than other people. So maybe it shifts, sometimes I trust me, and sometimes I don't. I guess maybe my trust in myself is always rocky, like I may trust in certain things in myself, rather than like an overall something... I don't trust my ability to cope, but I trust that I'll get good grades at university.

Trust was an important theme for Lauren: she experienced distrust from those around her; she also didn't trust herself, but suggested that trust may be situation-specific and shifting.

Losing our selves

Cassell (1982) suggested that "suffering occurs when an impending destruction of the person is perceived" (p.640). Our stories were redolent with threat, fear and intense emotions described in terms such as maelstrom, battle, battered, rage, frightened, raw, desperate,

excruciating pain, fierce fire, rock bottom. We waited in fear for the often unknown and inexplicable to happen, taking us away from the selves that we knew; we were suffering.

Experiences of loss and being lost were prominent in all our descriptions of being unwell. We identified material and social loss: house, income, developmental milestones such as education, independence and relationships. More importantly perhaps, in our stories of illness we endeavoured to articulate the loss of our sense of self. In part this equated to a loss of our identity as we knew it or expected it to be: am I now my illness? Perhaps more so than with physical illness, there was also a quality in our words that suggested a fundamental existential threat, to our essential being: ‘am I still here, have I gone away’; ‘you lose everything that you are’; ‘I was lost’ and ‘my whole being became more challenged’. It is this threat that was at the heart of our illness stories and is the antithesis of wholeness. As I will discuss shortly, this can manifest in experiences of disconnection and fragmentation.

These were experiences that we struggled to make sense of. We identified feeling confused and uncertain, with respect to, variously, our thoughts, emotions, and perceptions; unable to make sense of these experiences, we perhaps struggled with a dissonance between our pre-existing perception of reality and the world we perceived through the lens of illness. When depressed, ‘I disappeared into a black hole and none of it made sense’. My black hole felt real, as did others’ experiences of psychosis; I didn’t visualise my black hole as might someone with psychosis, but I felt it emotionally and psychologically, and I didn’t understand the associated emotions and thoughts other than as a symptom of illness. Before I became unwell, before I entered my black hole, I thought I knew who I was; but in the context of my illness this sense of knowing was lost. This was in part a question of identity, more fundamentally it was a collapse of meaning: who, why and how I understood myself to be.

Most stories identified a loss of hope; we experienced our illnesses as relentless, with nothing changing, and beyond our control suggesting a loss of agency. For some, including me, this loss of hope was associated with suicidal thoughts and actions, for others ‘embroiled’ in their illness, this was how life was always going to be. We also lost trust; for me this was predominantly trust in myself: I no longer trusted my emotions, and did not trust my ability to cope; others lost trust in their thoughts and perceptions. Some lost trust in people: family, friends and health professionals; and not only did we no longer trust ourselves and others, we also were not trusted.

Disconnection was a recurring theme in our stories, and was experienced multidimensionally: we described disconnection from aspects of ourselves, from others and the physical realm. We also experienced spiritual and cultural disconnection. I described, when depressed, going away to a place ‘where I cannot hear myself, and no-one can hear me; a place where I cannot be soothed and I cannot soothe myself’. I metaphorically ran away/disconnected from myself, from thoughts and feelings that were painful; running away from friends and family to a place where they couldn’t reach me, leaving me alone and intensely lonely. Lost in a world that I did not understand, I couldn’t make connections between events, thoughts and feelings. I was disconnected from a sensory appreciation of my physical environment: a place of darkness, a world with no colour, black and white. Others described similar disconnection: the recurring themes of feeling lost or going away suggested a disconnection from oneself; running on empty and disengaging from everything, we experienced disconnection from others in the people we lost; thoughts that were scattered struggled to make connections; the sense that the world was not quite real perhaps reflected a disconnection between and within internal perception and external experience of our environment.

Fragmentation, usually defined as to be broken or separated into pieces (Stevenson & Waite, 2011), was a word used by Margaret to describe an aspect of her experience of illness; it was also used by Deegan and others writing of their illnesses (Deegan, 1990). I said of my illness that ‘my world would fall apart; I would fall apart’; others have captured this sense of fragmentation, or perhaps even disintegration, in their descriptors: scattered, shattered, broken. These words provoke a visceral reaction in response to this threat to one’s integrity or wholeness. The antithesis of integration, fragmentation captures the powerfully subjective threat that is at the core of suffering.

I argue that fragmentation has a different experiential quality to disconnection though both may be occurring at the same time and are linked. My experience suggested that fragmentation can sometimes be an active process, a way of dealing with a difficult and frightening illness. I came to experience my illness as something separate from myself; my rapid return to work after yet another course of ECT reflected the ‘well’ me, separate from the ‘unwell’ me. Nothing was changing perhaps because nothing needed to change: ‘that wasn’t me’ when I was unwell. The problem with this separation was that it became ‘this uncontrollable illness’, into and within which I disappeared, disconnected and lost. It was in these experiences of fragmentation and disconnection that we experienced suffering.

Before I went to the Hall, I experienced my illness as relentless, stuck with no escape. Not knowing how to get well, I had lost hope that my life could be different. My illness and that of the other participants, was experienced as an existential threat: to our sense of self. These were experiences we struggled to make sense of; our life's meaning had collapsed, and we were suffering. We felt lost, disconnected and fragmented, losing trust in ourselves and in our world. While loss of trust and hope were a consequence of our illness experiences, it was disconnection and fragmentation that lay at the heart of our loss of sense of self. This summation of my and our experience captures the themes that will recur in the remainder of this thesis, firstly as I conceptualise healing, and then the places of healing. These include hopelessness, distrust, disconnection and fragmentation, loss and confusion: suffering in the collapse of meaning. The journey of healing has as its purpose the resolution of these experiences; it seeks the restitution of integrity or wholeness.

Chapter seven: Our experiences of healing

As discussed in chapter four, six months after I left the Hall I wrote an article, anonymously, for the Mental Health Foundation (NZ) magazine, describing my experiences over the previous few years (Anonymous, 1992). I said then of the Hall:

All along the way, what I was doing was learning about myself. Learning about what makes me tick, what makes me sad, angry, happy, scared – and why; learning about my 'self'. With that knowledge/wisdom, I was able to leave the Hall, go back into the big, wide, world, look at my life again, and use that knowledge to change what I needed to... Some days are still hard, some steps seem enormous. But I am supported, and can, now, also support myself in taking them... I will probably trip over again one day. Life's inevitable crises will shake my world, but hopefully I've now learnt enough about my self that I will be able to pick myself up again, and see the world in front of me. (p.6)

In one of my research interviews, I said of healing:

Healing means being able to get on with my life again – that's the guts of what healing is and what healing was. That's what they helped me do.

There was much to heal from; I was recovering from more than my illness: there was also the impact of that illness on my life course and my sense of self; and I had the impact of my diagnosis and treatment. I also had to deal with the factors that may have led to my becoming unwell. Both of these extracts imparted some of what healing was; but neither did justice to its heartfelt qualities. Healing is multidimensional: physical, emotional, intellectual, social and spiritual (Egnew, 1994); all of which became apparent as I explored, more deeply, my experiences and those of others.

Metaphors of healing

Over the years I developed metaphors and expressions to try and explain, to myself and others, what my time at the Hall did for me. Each metaphor was a story in itself, articulating my understanding of a process that I experienced as healing, incorporating themes of integration and re-integration, connection and reconnection, movement, change and transformation, understanding and wisdom, developing meaning, and becoming whole. This process, and this journey, was not simply a return to before (re-connection, re-integration); it

required dealing with new experiences (connection, integration), and involved change, transformation and sometimes transcendence, which occurred as we developed understanding, gained wisdom and meaning evolved. The stories that we tell are the expression of that meaning.

Getting to the heart of me

I described my previous hospital care as impersonal; admissions were for treating my illness with drugs and ECT. My treatment at the Hall was very different.

It was about me, it was about me in my heart, not me out there... I needed to find my heart; and the things that they were getting me to do were connecting me with my heart, to the essence of who I am. And that was a very experiential thing... Spirituality for me is a heart thing... it is about how I connect to my heart, and then it's how my heart connects with the world.

My heart (my chest) is where I physically feel emotional pain, and where I feel joy and love; my hand goes to my heart when I am emotionally moved by something or someone. My heart is metaphorically the centre or core of me; encompassing mind, body, emotions and spirit, it is the essence of who I am. 'Getting to the heart of me' suggested that rather than my illness being the focus of attention, 'who I am' was of greater importance. The focus was subjective: on me and my experiences as I lived them; rather than the objective view of the 'me out there' that others observed.

Stuck in a life in which meaning had collapsed, I did not know who I was anymore; getting to the heart of me was a process of connection or reconnection: connecting with my emotions, my thoughts and how I made sense of myself and my world. There was an implication too that this metaphor of 'getting to the heart of me' had an element of spirituality, transcending me and perhaps connecting me to a larger landscape. I said this was an 'experiential thing'; by that I meant that this was a heartfelt experience of body and emotions rather than cognition. These were experiences that were difficult to put into words.

I was growing into my skin

The phrase I used about my process was that 'I was growing into my skin'. It's not that my skin had gone away, the skin was always there and the skin was what people could always see, but what I did was that I grew into it. I came to fill the nooks and crannies, those places of emptiness within the shell that was my skin; I grew into my self, becoming whole.... I remember the day the colours changed.

This metaphor captured the ‘emptiness’ of not only the dark and lonely place that I went away to when depressed, but also what had become of my life: my job and home had gone, and I felt like I had lost me, I was an empty shell. Of course, I wasn’t empty: I was in a place of intense, despairing and confusing emotions and thoughts; the perceived emptiness was the loss of connection with myself and my world. As I was offered and found opportunities to explore my experiences, I developed understandings and made connections that introduced colour and richness into my life, transforming black into purple and all the colours of the rainbow. The more I understood my emotional responses, developing confidence in experiencing them and trusting myself, the less I needed to run away; they became part of me, and in the process I reconnected with myself. And more than that, I found new potential; growing into my skin wasn’t simply a return to my prior way of being, I grew, expanded, as a person, becoming whole.

The places of emptiness within the shell that was my skin were not simply a consequence of illness; I came to understand them as part of what led me to becoming unwell. And over time, my understanding of those illness experiences enriched my life. Previously, I had experienced my illness as somehow separate from me: ‘I struggled with what was ‘me’; where did my illness end and I begin’. As I was encouraged to explore me, my illness became less important, and eventually disappeared; I integrated my illness experience. This was more than connecting; I began to experience my illness differently, beginning to understand it and my emotional, cognitive and behavioural responses as another facet of my life experience rather than:

...some uncontrollable illness that would inevitably take me away from myself, back into the black hole, the empty hole... It took a long time, with continued doubt and questioning, to even begin to own my feelings; the feelings that had become strangers over the years. I remember the importance of their constantly repeated reassurances that what I was feeling was normal and okay. I had denied my feelings for so many years, alienated them from my being, and then when I had tried to look for understanding of them, they had been converted to abnormality, so that my norms ceased to exist: I no longer knew what it was to feel sad, to feel happy.

Slowly I could let myself believe just a little bit at a time, that it wasn’t about to be all snatched away from me by some mythical beast (my illness): yes maybe the world is there for me to have if I want it. And ‘reality’ began to become reality, not some great dream. I started to really believe that I could get my hands around myself,

hold myself, and that what I was feeling was real... this is me and I am mine.

As I began to understand my illness as part of me, it became mine to explore, and with that came hope. I am struck by my expression 'I could get my hands around myself, hold myself'; this suggested a sense of being able to maintain my own integrity: this is me and I am mine. This movement from fragmentation to integration and integrity or wholeness is captured in the next metaphor.

I pieced myself back together

... a year of seasons, a year of unpicking my self, and piecing myself back together.

Written twenty years ago, when I re-read this extract recently I initially assumed I had meant a process of pulling myself apart and then putting myself back together; but as I reflected on how I had felt at the beginning of that year, there was already not much holding me together. I was standing upright but it didn't take much for me to crumble, to fall apart. Again, I found myself drawing on the metaphorical to try and convey the essence of this experience, to convey the vulnerability of being mentally unwell. I note that I used two phrases: I unpicked my self, suggesting I loosened the stitches, the connections, the understandings I had of myself that were not serving me well; and then I pieced myself back together, doing this in a way that was more robust.

I gained wisdom about me, and me in my world

For many people, like myself, our time at the Hall was a major turning point in our lives. Living in this therapeutic community helped me identify and confront major issues in my life. Those issues were in part related to my illness, but far more importantly, they were to do with the job of living!... I was helped, supported to look at why I felt the way I did, why I reacted in particular ways, why some things were difficult, some easy. I talked with others who did, or had, felt the same. And as we talked and shared, we gained wisdom; wisdom about ourselves and about those around us.

I remember the day the colours changed; black became purple. It is Monday morning and I'm sitting in the OT room, in art therapy. Jane asked us 'how are you feeling today?' I know that one! I feel heavy, dark, dismal – still in the darkness, that place where there are no colours, where there are no feelings. My hand automatically reaches for the black paint and I begin – but not today. For some reason the black is no longer right, I change to purple, and some red I think. At

the time I couldn't see any further than knowing I wanted to use a different colour to express what was inside me. Now I can see the shift. My feelings were starting to have some form, starting to have an identity within me, I was starting to own them... Purple for me has great depth, it is warm, it is sad, it is passionate, it is enfolding. Purple has hope. Black is hard, it is everything and it is nothing. Purple is life. I remember the day the colours changed.

These extracts described a process of understanding myself more fully; this wisdom developed through exploration. As I will discuss in chapter twelve, exploration was not simply about talking. I explored the physical world around me, walking each morning in the countryside. I explored what I later came to understand as more spiritual aspects of my life, developing rituals as simple as making a cup of tea, or a hot bath with accompanying candles and potpourri. Exploration broadened my horizons, opening up possibilities for new or different experiences. When I sat in that art therapy room, it was not simply the shift in colours that was important. I was making connections, beginning to develop an understanding of myself; understandings that became integrated into my sense of who I was and sometimes challenging long-held assumptions about me in my world. In this process, I developed wisdom about myself. That drawing sat on the wall of my bedroom for some time, and still sits in the cupboard of my study along with other relics of my time at the Hall, too important to throw away.

This was a journey of exploration that opened me up to new potential. I was gaining wisdom about myself, and as I skied down the back field the week before I left the Hall, I experienced joy. I was getting my life back and more; my suffering was transformed.

Exploring our journeys of healing

At the beginning of this research, what was meant by healing was left deliberately vague; participants determined this for themselves. The research question emphasised place rather than the experience of healing itself, and it was this approach that created divergence amongst participants. Each person talked about what healing meant for them but, as I will discuss in Part III, for some their healing place provided time for rest and recovery so they could continue their journeys at home; for others their place supported the necessary exploration that facilitated the journey of healing.

Alice

Alice had described feeling jumbled, shattered, emotionally and spiritually broken down as a consequence of her illness. She identified losing 'everything that you are'; her sense of trust

in herself being ‘smashed and broken’. She was uncertain of her reality, and didn’t know how to make herself well. These themes of loss of self, disintegration, suffering, disconnection, distrust, confusion and hopelessness are addressed in her story of healing.

She told me about her experience of healing:

I had lots of trauma and difficulty in my life, that’s one of the reasons why I went nuts in the first place... If I got the right support, I wanted to deal with it; face into it and heal it... Healing is actually facing into, and integrating; and it’s more than just accepting. It’s recognising that you want to depth things, you don’t want to just do things superficially; you want to do it substantially and with real change and development... And trying to transform; I really believe in transformation of difficulty, and to finding the good things as much as you can, and living life well, not just existing.

It’s coming to personal peace and acceptance; and growth and development and learning with whatever your situation is... It’s learning to love myself again; knowing that I’m worth making this effort for.

This extract is imbued with a sense of hope: that with the right support Alice could deal with her illness. She developed an understanding that her mental illness was related to trauma and difficulties in her life, and that the way to deal with this was by connecting with the experience, integration and transformation. She used the phrase ‘facing into’ to describe her process; she wanted to ‘depth things’ suggesting a desire not only to ‘face’ the trauma, but also to connect to deeper internal processes, much as my experience of treatment not being ‘about me out there’. She identified learning and growing as part of healing; a more substantial process than accepting, healing implied movement and change. By looking inwards and more deeply, Alice made sense of her experiences ‘finding’ ways to deal with difficulties, and ultimately finding herself. She transformed her ‘spiritual battle’ into personal peace, relieving her suffering.

Alice told me that this was a personal journey, but one that required support.

What you want is wellness; the person has to find their own wellness within themselves [but] your world becomes so shut down that staff need to help you... to say there’s a big wide world out there and you’ve got to grow towards it... Each of us have whatever journey it is that we’ve got [and] you can ultimately find yourself and be a better person through the whole thing; you can come out of it being

more caring, compassionate, capable, deep, able... But it takes a lot of work, and a lot of support.

As a result of illness, Alice's 'world' had become 'shut down'; and I am reminded of a building with the shutters down and lights off, the occupants gone away. Just as I was in a world with no colour or form, perhaps it was that she had shut down, disconnected emotionally and perceptually. She identified a need for others to help her recognise that her external world hadn't gone away, that reconnection was possible; she grew 'towards [the big wide world out there]' suggesting movement, both within and with-out. On this journey of growth, Alice identified the potential for transcendence: she became 'more'.

Barb

Barb also used the word 'facing' as she talked about her experience of healing. She had described her anxiety leading into and during her psychosis, her fear of losing herself and a sense of hopelessness. I will discuss later her developing awareness of the need for change (page 139), but for now, Barb knew that she needed to face her fears, her 'demons' and that this was something that she had to do for herself.

I honestly don't know what it was; it was just this kind of thing where you just have to face it, and that you're going to have to do this on your own... I wanted them to just fix me and make everything go away; but it was that thing of knowing that I had to face my demons; I just have to do it.

Rather than going away from herself in her madness, Barb turned to face her experiences; rather than disconnecting, her turning can be conceptualised as connecting; and I am reminded of my expression 'getting to the heart of me'. Barb identified healing as a process in which she began to understand her illness, and thus decreased its power over her. She was transforming her illness experience, rather than needing the psychosis to go away.

And that process explains the madness, and when you know why different things happen to you it doesn't have the same power over you. So it's trying to disarm the madness, or take the power away from the madness and reclaim your own stuff; which makes you not only vulnerable, but – the one thing that scared me the most – it made me ordinary.

In beginning to understand her madness, Barb was perhaps able to reclaim the self that she feared would be lost; although with this came vulnerability, the potential loss of her identity of madness. She prompted me to think about my own process, and perhaps what kept me

stuck for so long: the fear, in the act of ‘facing’, that I might not like what I saw. Barb developed a new understanding and relationship with her illness experiences.

I know my mind plays tricks and my brain plays tricks; and then, if I can haul it back, it just makes me feel completely in control. And that's what's at the core of it, [moving her hands towards her chest]. Yeah, it's a reconnection. It's like they've gone off there doing their thing, and it's like 'come on, in you come, in you come, I'm calling you in'... strand by strand, tying it together so it's firm and then putting it back where it belongs.

Barb now had a way of conceptualising her process in psychosis; she described reconnecting with her thoughts, but perhaps more than this: in the act of putting them back where they belong, she had a way of integrating them. The thoughts were no longer a separate entity that had ‘gone off’, they had again become part of her, and in this she was perhaps reconnecting with her essence. Barb went on to describe what healing was for her.

Healing for me is really those moments of contentment. And I don't mean contentment in a sort of metaphysical sort of way. It's just: I can do this; or if not, I can do this, then: I can stand this, I can tolerate it. When I'm mad I always have this mantra of 'this too must pass, this too must pass'. And in some ways that's the healing part: knowing that this is just a moment in time.

So for me healing is when I know, and I think maybe it's that trust in myself, that you can get through this. I can feel it in a physical way, just let it flow over you. It can feel nice like a shower, or it can feel like you're going to be washed away with the tide. So I choose it to be nice like a shower; you're not getting swept away or drowning, you are just letting it flow over you and you have the capacity to rise above it. So it doesn't have to be when I'm really good or that everything is going perfect, I can have moments like that when I'm actually at my worst.

Barb's ‘moments of contentment’ suggest a sense of trust in and understanding of herself. Earlier, Barb had feared that in her madness she would be lost, swept away and wouldn't return. With understanding she began to know it as ‘just a moment in time’; she had integrated the experience of madness into the journey of her life. Barb gained trust in herself, choosing how she would relate to and connect with her psychosis, transforming the experience. I too used the analogy of ‘drowning’ in my description of being unwell; and then talked about ‘slowly I could let myself believe... that it wasn't about to be all snatched away from me’, just as Barb came to understand that she didn't need to be swept away. She talked

of having the capacity to rise above her experience, suggesting not only transformation but transcendence.

Colin

Colin's journey to healing had similarities to Alice and mine. He too was in a hospital for a prolonged period of time. Colin had described being embroiled in his psychosis, unable to see past his illness and with nothing changing. After many years, and shortly before his transfer to this hospital, he became symptom free, attributing this to medication. Although important, being symptom free was only part of how Colin understood his experience of healing.

[What does healing mean to you?] Well there's the medication side of it, which is a chemical thing that might stop hallucinations; it has with me, so that's a big part of healing for me. But then again, there's the whole other side which is the education, the life skills, the trust, the collaboration; all of that chucked in almost outweighs the medication.

If I hadn't gone to that hospital I would have been a different person to a point; I wouldn't have matured in the same way. I accepted my situation and learnt early on that when I recognise and do the work, I move forward.

Even though Colin's admission was an involuntary one, he told me that he accepted his situation; like others he conceptualised the healing process as work, requiring him to recognise and engage in the opportunities available to him. In doing this work, rather than feeling trapped, he had sense of progress, of forward movement.

I'm a changed man. I applied myself and I was interested. If you're interested in something you're learning, and you bloom through the learning. I bloomed and the changes were quite obvious in me over a period of time. I used the place to the best of my ability; I have achieved a level of understanding of myself which is all good you know. That's what it's all about: learning.

Colin told me that in this place he experienced a change in himself. He suggested that for him, learning was at the heart of healing, and in this process he bloomed. This metaphor evoked images for me of a flower blooming from a seed or bud, implying growth, change and transformation; blooming also suggested that he became more: transcendence. Colin, extended the nature metaphor, perhaps as he learnt to garden, developing his 'cauliflower theory'.

I call it cauliflower theory. You have the basic stem and you branch out and branch out and branch out and get lost in it. But if you stick to the main stem you're not going to get lost. Branch a couple of ways, different perspectives, but it all reflects on the same thing... sticking to the main core, and that's a strength that I have; I always come back to myself.

Like my 'heart', Alice wanting to 'depth things' and Barb's 'essence', Colin talked of getting to and connecting with his core, coming back to himself.

David

David had told me about being stuck, his illness like 'a cartwheel with two cogs', with 'a fierce... out of control fire that was within me'. We were only able to meet on one occasion so I was unable to explore his experiences in more detail, but in our one conversation he painted a rich picture of the changes in his life that he experienced as healing. As I will discuss in the next chapter (page 140), David met a peer worker in hospital, and that for him 'was the light at the end of the tunnel... one of the biggest changes in my life'.

When that happened to me was when I started to take the hat off. You know it was a real tight hat; yeah I started taking the hat off. I realised real people like me can have this place called mental illness, and that's when the blocks that were laid out, scattered everywhere, started to come together... I realised damn, this is the chance man. I can say: yeah I am going to live the experience rather than live with stigma, you know what I mean?

I had a belief I could be on the other side of the fence, so I used those skills; I attacked this hallucination, I attacked these voices, and then it got to a point where I could believe it. I knew at the top of my recovery that the one that loves to have non-stigma, will overtake the stigma, so I hung in there. So the negative was chipped away with positive for so long that the one with no stigma has doubled its size; it's taken up the whole life and the stigma's been pushed out.

In meeting this person that he identified with, David gained hope. He started to believe that he didn't have to be stuck 'in this place called mental illness' where he experienced stigma: he recognised himself as a 'real' person. David decided to 'live the experience', embracing his illness as a positive rather than a negative, and beginning to use his skills to 'attack' his illness symptoms. His relationship with his illness changed and as it did so 'the blocks that were laid out, scattered everywhere' began to come together. Just as I 'pieced myself back together', and Barb re-gathered her psychotic thoughts 'strand by strand' and putting them

back where they belonged, perhaps David connected with and brought together his experiences, becoming intact or gaining integrity. He used the analogy of ‘taking off a real tight hat’: he was no longer constrained, or limited by his illness. ‘The one that was with no stigma doubled its size’ taking up ‘the whole life’: he was becoming whole.

Margaret

Margaret also described being ‘scattered’ and ‘fragmented’ when she ‘lost the plot’. She had come to recognise these experiences as ‘part of her being’, and that at times she needed ‘some kind of containment’ when she was unable to do this for herself. Both Margaret and Barb suggested that at times of unwellness, although still feeling scattered, they now had an understanding of what they needed to bring themselves back together. This supports the notion that healing doesn’t necessitate the absence of illness.

If I was to describe my sweetest psychosis, that was probably the best way that I’ve transitioned out of this state of hypomania. I was able to rest, and get back to taking up what I was trying to do in my adult working life relatively quickly. It wasn’t hugely destabilising. It’s not like I’m saying I don’t experience an illness, but I’m hoping the more skilled I become, the easier I’ll be able to do the rides. Because, whether they [services] come or they don’t come, I have to learn how to do the rides. [Is there potential for the rides to change?] Well, I hope I always have a bit of the music from planets to be perfectly honest.

Margaret’s ‘rides’ were experienced as part of her journey. She hoped to be able to modify them through her own skills, but also didn’t want to lose the experience entirely: ‘music from the planets’ refers to experiences she had when unwell.

I asked Margaret whether healing was the same as recovery.

I think healing is much more profoundly deep than recovery, the way the language and how recovery is used in mental health. Healing carries with it an integration of the self in a way that recovery doesn’t... I’ve got a whole wealth of skills and ability from my journey that I’ve made. And now I’m creating more and more space for that to happen. And, you know, it’s not a removal; the experience is not an abstracted removal from who and what I am.

Margaret articulated a similar concern to mine about how recovery is described and understood by mental health services. For her, healing was a deeper process involving integration of the self, a journey in which she gained skills and ability: she developed agency and, I suggest, wisdom. It is interesting that Margaret pointed out that her illness experiences

were not separate to herself, suggesting that she might once have considered otherwise. I did experience my illness as somehow disconnected from me, and it was in the process of healing that, like Margaret, I was able to integrate my illness experiences into the sum total of who I am. Margaret, telling me about various forms of therapy she had utilised, explained her experience of integration.

I think they kind of help me contextualise the reality of what happens when I do have psychosis, and that's really important. Because, understanding and placing the experience in the whole continuum and place of your life is important. It's not an isolated kind of thing that happens. It's part of the fabric of who and what you are actually. And, you know, if you're going to talk to me about, I have this illness, well actually I don't have an illness, I have a certain way of being. And other people call it an illness, I'm just learning how to navigate my way of being.

Margaret evocatively articulated her sense that understanding supports the process of integration, and with integration her psychosis becomes not an illness but part of 'the fabric' of her being, part of who she is.

Helen

Helen described her years of illness, with repeated admissions to hospital, as 'existing, no life'; she was stuck, hopeless and suffering. She, too, had a sense of being taken over by her illness, questioning her reality. Helen was then admitted for a lengthy period to a Maori cultural mental health unit, which helped her 'feel like a person again'.

I was unlucky with things that happened in the past, but lucky that I ended up in the Maori cultural ward because it made me feel like a person again... When I first went in I had my doubts, but then after a month or two I thought: gee, yeah, the best thing I ever did was come here.

The aspects of this place that reconnected Helen with her personhood will be discussed in the second half of this thesis, but were hinted at when she told me:

One of the older males taught us whakawhanaungatanga [a process of establishing relationships] where you say: where is your river, your mountain, your iwi [tribe], your sub-tribe; what your name is and where you come from. If you know where you're from and who you can connect with it's quite healing.

Helen learnt this mihi (speech of greeting), but more than this she learnt about, and connected with, who she was, her self-identity. She implicated connection as significant in the process of healing; this included connection to others and something more expansive: the land and her heritage. The time she spent in this ward changed things for Helen; in the subsequent years she had no further admissions to hospital. As with Colin, medication was an important part of her recovery, giving her confidence in the future; but her description of healing suggested other facets.

I thought, God I must have been really unwell; I must need something because that's not like me. All I could do is ensure that I have these injections for the rest of my life so that it doesn't happen ever again; that gave me a lot more confidence. [Since you left hospital have you been unwell again?] No, nothing that I'd need to be admitted for.

[What does healing mean to you?] Recover; having hope; thinking positive about things. And fixed in the head; yeah, fixed in the head, and remaining that way. Following a few rules. It's thinking much the same as people that are supposedly well; not living out-of-reality, living in the real world. Having emotions that you're not judged by, or with some sort of diagnosis, negative or positive symptom put to it. And having things sorted more, whether that's mainly in your head, or with your family and whanau [extended family]... being accepted.

Although some of this can be understood as not having symptoms of illness ('fixed in the head'), Helen also reflected on how she was perceived by others, and perhaps by herself. She understood herself as having been unwell with an illness that needed ongoing treatment, but healing meant also being seen, by herself and others, as more than her illness.

Fran

When unwell, Fran, like others, experienced a loss of connection with her self. Uncertain about her reality and distrustful of herself and others, she stopped talking, becoming silent. Fran's healing journey didn't occur in a hospital. While making use of community respite at times, Fran's healing place was an art studio; this was where she found her voice, an aspect of which was to be able to tell her story, and for it to have meaning.

The place that I associate with a healing place has been the art studio and feeling a part of that; where creativity is really celebrated in all its forms. That was a place that enabled me, with help, to find my voice.

I'm pretty comfortable talking about my story at this point in my life. I've had many years to reflect on it and put together pieces of that story; I don't know that I fully have all of those pieces yet, but there's time for that.

Fran suggested that her story was a work in progress; as this thesis is the next chapter in my story. She identified that developing her story involved self-reflection, bringing her experiences together in a way that made sense for her.

Healing: I guess it's coming to wellness. It's hard to define; I think at different times it's different things, and in my mind I go to physical healing as well... I think for me it's really about the journey – being on the journey and engaged and achieving. It's not necessarily recovery but it's living well with whatever's going on; just being as best I can and maintaining things as best I can within that.

Fran suggested that healing was not necessarily an end-point; rather it was a process or journey to be engaged with, in contrast to the disconnection, silence and loss of self that she experienced when unwell. She articulated some of the difficulties in defining healing: the difference emphasises between being cured, and living well 'with whatever's going on'. Engagement (implying connection) and achievement (perhaps the antithesis of being helpless) were important elements in Fran's description of healing.

Emily

Emily's description of healing also emphasised the importance of connection and reconnection, her illness story suggesting desperation, depletion and disengagement or disconnection. After two years of nothing changing, with repeated admissions to acute mental health units, she was admitted for a number of months to a hospital/therapeutic community.

I'd spent several years in and out of acute facilities... Then I went to [this other hospital] and I haven't had to use secondary mental health services since; that's now maybe 4 years. I kind of don't think I'll ever need [the hospital] again but then I always think that, so if I got unwell again that's the place that you need to go to have a good long-term outcome.

From a position of hopelessness when unwell, with nothing changing, Emily identified this place as giving her a different more positive future.

I don't really know how you know that it's working [but] your mindset does change. It's like everything has to be stripped right back; and then you build yourself up again. For whatever reason,

whatever the struggle is, there are a whole lot of maladaptive things that you've developed as a result of that struggle. You need to start again.

As mentioned earlier in this chapter, Emily's experience was similar to mine and she used similar analogies. As I 'unpicked myself and pieced myself back together', she 'stripped' herself 'right back' and 'built' herself 'up again. Healing involved her 'mindset' changing, suggesting that Emily came to think about, and perhaps understand, her illness and herself differently. Like Fran, Emily also stopped talking when unwell; she identified the importance of connecting and talking with others in her healing process, challenging her disengagement. Understanding the necessity to start again, Emily identified the need to repair (to continue her metaphor) and recover from the consequences of her illness. These consequences included strategies, developed to cope with her struggle, which she now identified as unhelpful.

Sally

Sally had told me about her differing experiences of admission to acute mental health units to 'keep her safe', some having aspects that were healing, some not. She told me that she came and went from a sense of healing.

Healing is really getting that faith back in yourself and your ability to be able to do things. Probably over the last three or four years I don't think that that's happened for me so much. In the past, at least, I had nice breaks from it where I could get that confidence back and that ability to really understand what was happening for me. And I think when you learn it and there's some understanding of what's happening, there is much more ability to live with it and feel like it's a strength; rather than feel like it's this hideous thing that sneaks up on you and makes no sense.

Sally lost trust in herself when unwell, she felt 'unsafe'; healing involved developing faith or trust in herself and her ability to do things, to live with her illness. In the past this had developed in gaining or regaining an understanding of her experiences, transforming the illness experience from something 'hideous' into a 'strength'. Acknowledging that a sense of healing wasn't permanent or complete, Sally talked more hypothetically about what healing meant for her.

I think sometimes [you need] the hitting rock bottom, and having to come back up, to work out that something needs to be different. [Healing happens when] you have people who value that whole of person approach, rather than just symptom management or getting

by... and seeing it as a journey that you're actively working towards, and that even once you've got it, it's still something that has to keep being actively explored. [The journey] doesn't just stop because you've got to that place; it's an ongoing piece of work. And I think that's probably easier to do when symptoms aren't such an issue any more.

Although supported by symptom reduction, like Colin, Sally described healing as requiring a whole person approach; perhaps she needed to be seen as more than her illness. She understood healing as an active journey of exploration and work; a journey that was ongoing. In using the metaphor of a journey she, like others, talked of getting to a 'place', a destination, but the journey didn't stop there. These placed-based metaphors were common in our accounts and will be discussed shortly.

Lauren

Lauren had described herself as at 'rock bottom', being in 'places' in her head where she was desperate and suicidal; losing trust in herself, and feeling not trusted by others. In describing what healing meant to her, she contrasted the concept of mental health recovery and healing.

Recovery feels like you'll go back to something that you were before your experiences, and that's pretty much impossible. Healing feels like a metaphorical nice warm bandage around my whole body or something, and then moving on; having that experience and getting something from it and being able to utilise that in positive ways.

Healing is a long-term thing, as opposed to a short-term thing that might happen in the space of 4 days in respite. Because it's healing in terms of traumatic things that have happened or whatever; but it's also developing a healing relationship with myself, or a healed relationship. And healing for me in that respect would mean that I would value myself more and wouldn't need to hurt myself, or even want to hurt myself maybe; that I would consider myself of value, or sufficient value.

A bandage is used to protect and hold together something that is injured or broken, suggesting that this is how Lauren had felt. An evocative metaphor, her warm bandage had connotations of being cared for: by others and perhaps herself; being comforted and held. Unlike her perception of recovery, healing was not a return to a previous state; no longer stuck at rock bottom, it involved movement and change. Lauren talked of 'getting something from it' suggesting, like others, that healing involved becoming 'more'. Healing was a

process in which Lauren's relationship with herself would change, valuing herself with no need or desire to harm. She suggested this journey took time; this aspect of healing will be discussed in the next chapter.

Getting to the heart of healing

Early in this research process I was asked what healing meant to me: healing was being able to get on with my life. Even then, I knew those words did not do justice to my experience. As I spoke the words, and still when I consider healing, my hand goes to my chest, to my heart, in an attempt to capture the heartfelt quality of healing; this was an experience that is difficult to put into words. Each participant similarly endeavoured to describe what healing meant for them; but there were limitations in this articulation: I still have a sense that aspects of our experiences were beyond words.

One way of dealing with this ineffability is the use of metaphor. I described healing as 'growing into my skin' and 'getting to the heart of me', and a process of 'unpicking my self and piecing myself back together'. Other participants described aspects of healing as 'a nice warm bandage'; 'blooming'; 'taking off a tight hat'; 'learning to do the rides'; 'stripping right back and building yourself back up again'; 'the blocks that were laid out, scattered everywhere, started to come together'; and, 'those moments of contentment' when we know 'this too must pass'. These phrases bring to life an experience: I can feel the warm bandage around my heart; my stomach almost lurches as I imagine the rollercoaster ride, and I feel the relief as the tight hat comes off; I visualise the blocks scattered on the ground, and begin to build anew although I do not yet know what. And within these experiences I know that this is 'just a moment in time'.

Healing is necessary when there has been a disruption of integrity or wholeness; often considered in relation to physical integrity such as a laceration or broken limb, in our mental illnesses we experienced an existential disruption: the loss of or threat to our sense of self. Before I became unwell, I thought I knew who I was; I had a sense of identity, albeit evolving and fragile, defined in large part by my family and career. As my illness developed and I became more disabled, I lost my job, my home, my independence, and I lost my sense of myself; I became defined by this illness of manic depression, both in label and experience. We often needed to heal from both the illness itself, and the impact this had on our lives; sometimes we needed to heal from the effects of treatment we received – the amnesic effect of ECT has left its scars – and perhaps we needed to heal from what had led us to becoming unwell in the first place.

Healing is a process and an experience; a journey and a destination and on this journey, I discovered or developed hope. As I explored, looking more deeply into myself, facing myself, I began to understand my emotions, my thoughts, my behaviours; I developed wisdom. My use of the word wisdom in my original writing is interesting (Anonymous, 1992). Deegan (1996), an early developer of the concept of recovery, exhorted mental health professionals not to settle for knowledge, but to strive for wisdom, defined as “the ability to see the form or essence of that which is” (p.91). Other participants captured this sense of seeking and gaining wisdom: Colin’s cauliflower theory, Alice’s desire to depth things, Margaret’s ‘skills and abilities’ and perhaps Barb’s ‘moments of contentment’. Like many such constructs wisdom remains a contested term (R. J. Sternberg, 2004), but I am drawn to an explication offered by Baltes and Smith (2008): “[wisdom] involves some combination of education, practice, apprenticeship, personal experience, and deliberate reflection about life matters” (p.57). Wisdom is not just learning or understanding; it implies a deeper experiential knowing, the acquisition of which requires both time and effort.

Exploration was a necessary part of our journeys, opening us up to possibilities, and facilitating the discovery and testing of the connections that underpinned our healing. Connection is defined as to join, or link together (Stevenson & Waite, 2011); in much of the medical healing literature, connection is discussed in terms of the therapeutic interpersonal relationship. Our experiences of connection were multi-dimensional: cognitive, connecting thoughts, developing understanding; emotional, beginning to recognise and link emotions and experiences; intra- and interpersonal, connecting and developing relationships with ourselves and with others; and phenomenal, connecting to our senses and the physical environment. In these connections we found ourselves, and re-engaged with our worlds.

Connectivity developed in the opportunities I created and was given to explore; the nature of these opportunities will be discussed in Part III. As I began to make and strengthen connections between my thoughts, perceptions, emotions and behaviours, I was developing a language that gave them meaning. I was making sense of and integrating all my experiences (illness and otherwise) into my sense of who I was. I wonder if connection is the first step to integration; like its antithesis, fragmentation, integration was a difficult concept to articulate, I just knew it happened. I no longer felt like I was falling apart, and my illness ceased to be ‘some mythical beast’ and uncontrollable; it became an experience that I had and could work with: ‘this is me and I am mine’.

Connection enabled me to hold hands with my self, but integration restored my integrity or wholeness. Integration is defined as ‘the making up of a whole by adding together or combining the separate parts or elements; a making whole or entire’ (Stevenson & Waite, 2011). I remember a psychodrama session early in my stay at the Hall. I had been asked to place myself in a chair and talk to my self.

But I am not sitting in a chair, I am curled up on the floor like a foetus. This was the depressed me, helpless and hopeless. Ten minutes of dialogue with my self, and I was able to get myself off the floor. We stood holding hands, me with myself; and in that moment, even if for just a short while, the darkness lifted and I felt the first hints of joy. I connected with myself. Over time we moved from holding hands, to me placing her on my shoulder, much as a child, so she could be with me as I explored the world. And eventually I tucked her away in my heart.

In that moment in psychodrama I connected with myself and my experience of being depressed. This was a pivotal moment when I realised I wasn’t completely powerless: I felt hope; but it took time and continued work for these lessons and experiences to be tucked away, integrated into my heart. Integration is one of those processes that is perhaps beyond explication, but I know it took time and practice. Maybe it is like learning to ride a bike; at first it feels so foreign, all arms and legs, threatening to unbalance. But then one day without noticing, you are away; riding becomes instinctive, naturally balanced; requiring practice but never really to be forgotten. Through integration, I filled the nooks and crannies of the shell that was my skin, becoming whole; just as Barb reconnected with her thoughts, then pulling them in strand by strand and tying them tight, she put them back where they belonged; and Alice faced into and integrated her experiences. Utilising Margaret’s words, through integration the experiences become part of the fabric of who we are as people, and in the process we become whole again; the gaps are filled, the cracks are mended. Although I wonder if anyone can be truly whole, perhaps we all are a work in progress.

Cassell (1982) said that “[suffering] continues until the threat of disintegration has passed” (p.640). As I stood holding hands with myself in psychodrama my suffering was diminished. The relief didn’t last and I suffered again but, like Barb, as I continued to develop understanding, my illness became less frightening. Perhaps I no longer needed to hold it away from myself, allowing me to integrate the experiences into my sense of who I was; my illness ceased to exist as a separate identity, and in that process somehow it lost its power to make me suffer. I experienced a cessation of illness symptoms; for others their symptoms

continued, but their relationship with them seemed to change: Barb disarmed her madness, and Margaret hoped to always hear the music of the planets.

Healing involves movement and change, perhaps transformation and sometimes transcendence. Some, through healing, seek a return to before; I experienced the change as being more than before. Not only was I transformed, changed in form and condition (Stevenson & Waite, 2011), I had extended beyond where I had been. Transcendence is a concept that initially I struggled to apply to myself, often being used in a religious or spiritual context. Some people had an overt spiritual aspect to their journeys, but taking transcendence in its more literal sense: to surmount, to rise above or surpass (Stevenson & Waite, 2011), I think like Colin I bloomed: we became more than we were before; our experiences were transcendent. Cassell's (1982) description of transcendence as locating "the person in a far larger landscape" (p.644) not only had resonance for me but also this research, as I will argue in later chapters.

Skiing down the back fields the week before I left the Hall, was a moment of transcendence; this was me accepting with joy, the challenge of continuing my life. Even though it was still scary and some days would be hard, things in me had shifted, I had moved from where I was: I was no longer stuck. I trusted myself enough; and, trusting others to help me when I needed, I trusted that we would continue to take care of me, not just my illness. What did this mean moving forward? It meant that when my panic attacks returned as I started back to work, I knew and trusted myself enough, to hold on; I knew that this would pass. I continued to gain confidence in dealing with the panics, and as I did they became less frightening, less intense, until one day I realised it had been months, and then years, since I had panicked. I would have times when I thought I was getting depressed again but I recognised the signs. I had skills: I would ask myself why, talk some more in therapy, and my mood would shift. Some days were hard, times when I felt very down, but I knew that it could change. And as time went by the difficult days got fewer, further apart, and less difficult, until they became a memory.

Healing, as process and outcome, is intensely personal, no one person's journey will be experienced or expressed in the same way as another. We each had a story that we told and tell, and this story is an expression of the meaning we found in our experiences; a meaning that 'fitted' our developing world views, that made sense to us. These are stories that develop and evolve, in those moments of connection; stories that constitute and helped re-constitute our selves; stories that we tell ourselves, as much as others; stories that remind us

about ourselves. These are stories that “reside within us and continue to shape the way we live our lives” (Whalen, 2014, p.59), and continue to hold us when our worlds threaten to fragment.

Chapter eight: Aspects of our journeys

I have suggested that exploration was a necessary part of the journey of healing; this will be examined further in the third part of this thesis when I consider aspects of place, and the exploration involved, that facilitated healing. Thus far, we have described our experiences of what it was like to be unwell, and of the process and outcome of healing. This chapter discusses aspects of the journey that have particular implications for our places of healing. These include notions of: the hard work of healing, it takes time, and turning points or right-timing; these being conceptualised as aspects of a journey of exploration.

It's hard work

The journey of exploration and healing was not an easy one; it was hard and sometimes painful, several of us referring to this as work. I have already written about my early experiences at the Hall: 'struggling with emotions that had no form, no recognition, no meaning. A maelstrom of confusion. So much running from what I didn't understand, and trying so hard not to run'. On this journey to healing I needed to not 'run away'; rather than disconnect, I needed to stay with the confusion, with the sense of being battered by emotions that I didn't understand. There were repeated times when I dreaded my therapy sessions, or psychodrama, because of the emotional turmoil that ensued; times when I ended up on bed-rest (as described on page 159): a time-out-of-sorts, to provide relief from the hard emotional work of getting to know myself again. And I am reminded of 'repeatedly turning to ECT to give me relief, to get me (shock me) out of the black hole into which I descended'. The journey of healing required me to get to know the black hole, to understand it, and why I ran there.

Alice similarly described the hard work and pain associated with her process, but powerfully identified her belief that this was necessary.

[T]his is dealing with deep, deep pain. I worked hard and I went through the pain and the difficulty, but it was worth it. I knew that I was either going to become a psychiatric cripple, or if I got the right support that I wanted to deal with it, face into it... I knew that I had to go through that process.

'Facing into' her experiences was painful and difficult, but Alice believed it was this process of looking into herself and at herself that would transform her illness; without it she risked

becoming ‘a psychiatric cripple’ with the helplessness and lack of movement this implied. Barb anticipated the pain she expected to go through in the process of facing her demons.

I felt my heart really in a tight grip and I don't want to, I don't want to. It's not that I didn't want to get well, it was this... I don't want to go through the pain that I thought would be involved and the discomfort of what I might have to deal with... It's almost an intuitive knowing that the process that you're going to go through is not going to be an easy one, but it's your only way out.

She acknowledged her fear of embarking on this journey, but knew it was her only way out. This journey was not an easy one as evocatively captured in Colin's words:

A sense of progress kept me going: breaking rocks, cutting track and moving forward.

As he talked, I had a visual image of the sweat required to break new ground. This sense of labour was apparent in David's description of the way he dealt with his hallucinations during his recovery.

Most of my days and nights were just thinking about emotionally putting positivity in the blackest negative. I attacked this hallucination, I attacked these voices, and then it got to a point where I could believe it.

David attacked his experiences day and night, suggesting that this required time and repeated effort with intent, to get him to the point where he could believe it: the positivity. Emily reminded me that it was easy to forget how hard this work was. She had been telling me about going again to the hospital she had been admitted to many years before:

When I went back there the second time I had quite positive memories, but I had forgotten how hard it was. You come to realise that getting recovery, or whatever, is actually very hard work.

This was one of the moments in the research when I had to stop and really reflect on my experiences. Because the narrative I tell is that the Hall was transformative for me, the risk was that I viewed the experience through ‘rose-tinted glasses’. Emily reminded me to reflect more critically, to remember the many times when it was hard and painful, when I had wanted to run away from my thoughts and feelings. This notion of the hard work of exploration suggests that healing did not occur serendipitously; it required intentful effort.

It takes time

We described the process of healing as taking time, and this was one of the differentiating features of the places that we identified as healing: places had the potential to serve different purposes and time was one of the distinguishing features. For some participants, their healing place was a haven, providing a time-out-of-sorts for a few days or weeks. For those of us who embarked on a journey of exploration, we had a lengthy association with our place of healing, measured in months or years.

This had been going on for three years – three years of terrible times and pretty desperate times; things just keeping on repeating themselves. I had felt like I was on a treadmill; it was always going to take time.

I went for two weeks and stayed for a year... for quite a while there wasn't any discussion about lengths of time; the weeks just slowly passed. I can remember at some point my psychiatrist told me he thought I needed to be there for a year: "let's get serious about this. If we are going to make a difference here, then this is what you need to commit to". I was really shocked that he thought it would be that long, but clearly I also went along with it. There was never any sense of fighting it, because you're just in something, you are just doing it... you know, some of it just takes time.

'June 1990: that is when I began my journey back to me'; this was how I began this thesis, and my story: I framed my story in time. Sometimes we used time to denote gravity or importance: 'three years of terrible times'; as I reflect on my words 'it just takes time', there was a sense of taking or giving something/someone the time it/they needed. This was time measured over months, but there was also time-within-time. I remember when I first realised that repeated episodes of illness were not necessarily my future. I went to buy myself some flowers to celebrate.

I got the flowers back to my room and I started to cry, and I couldn't stop crying. And I cried and I cried and I cried for about three days, and I spent most of that time, day and night, sitting down in the lounge. And people would come and just take turns to sit beside me, just be with me.

When I remember that moment, I don't feel sad or distressed; rather, I feel grateful that I took the time to cry, and people took the time to be with me. Throughout my stay at the Hall I was busily engaged in many forms of therapy, actively exploring: 'doing'; but this latter extract was about allowing 'time to just be'.

Alice had an ambivalent relationship with time. She had been compulsorily admitted for several years to the hospital that became her healing place, and she acknowledged and appreciated the need for a long duration of time to heal.

Because of the legality of it, you're actually forced to be there for a certain length of time. And I think it takes a long time to recover from something like that. You're living your life and practicing what you're learning; you need from week to week to develop that skill a bit more, and it goes down to another level.

Length of time gave Alice opportunities to process and practice, allowing her to consolidate what she was learning about herself; with this time and practice, her learning went 'down to another level', suggesting movement and integration. But time could also be experienced as difficult and uncomfortable.

The time was actually very hard because it wasn't all constructive therapeutic stuff. A lot of it you were just sitting around in the lounge; you sat there feeling absolutely like death most of the time, death warmed up really. It was just agony, because you weren't doing anything constructive; the time just dragged.

Although I had been shocked at the length of time I would be at the Hall, I had no sense of fighting it because I felt part of something, I was 'just doing it'. Alice was in hospital for much longer than me, and for at least some of her admission time dragged. She attributed this to a lack of therapeutic input, suggesting time can be experienced as purposeful and purposeless.

Barb reflected on her experience of time in the institutions.

The timeframes seem a bit blurred. I was quite young when I went out there and every day was just the same, so time was sort of irrelevant in some way. The way I used to measure time was by watching the clock because of my meals and that. Of course it was tricky, because the drugs were so sedating that you felt so tired. I think that's part of why I had no sense of time, because you slept most of your time away there.

Like Alice, Barb's time had no purpose: time was irrelevant suggesting it had no meaning. Her time was 'slept away'; though implying inactivity, this had a very different quality to my experience of 'time to just be': as will be discussed in chapter twelve, there was no sense of connection with the experience of being. Contrast this with Colin's perception of time during a similar lengthy admission to hospital. Even though Colin's admission was an involuntary

one, like me he committed himself to the work he was doing and the time that it took. A sense of progress made the time feel different.

Initially I thought I would only be there six months. But after six months passed I still wasn't stressing out about it, I accepted my situation.

Most people's stays, you're talking a week... it's ridiculous. Mental conditions in my experience, and not just going by my own condition but talking with other people, they go in there completely off the rails and they get medicated. Three days later they might be becoming symptom free but then they're out on the street again... Full blown psychosis needs time, for me it does.

Although his symptoms might have lessened, Colin implied that there was more to healing than becoming symptom free, and that this process took time. In keeping with Colin's reflection, some people commented on not having enough time: either being allowed enough time by services, or allowing themselves enough time. Sally felt limited in what she achieved during her relatively short admissions.

I think longer would have made much more sense, if you're going to work on the whole person and actually the bigger stuff. But I don't get that we think like that as a mental health service; we seem to just fix what's broken at the time and deal with whatever else once you get out.

I had talked with Sally about my experience of a lengthy stay in hospital and she reflected on the difficulty, now, of giving herself the time away from her responsibilities at home.

I think that's absolutely needed at times and I wish, probably, it had happened for me at some stage because I know it can often be a really big turning point. I probably would have been able to do it in the past because I didn't have kids and it would have short-cut how long it took me to get to the right place. We could have worked out what was happening a lot quicker.

Emily, too, had ambivalence about time. While acknowledging the need for it, she implied that it was difficult to allow herself enough time.

I think it's a slow process. It's very confronting and it's hard work having to address what's problematic and work through it, and stay there and give yourself the time and the space to do that.

After multiple ‘quick intervention focussed’ stays in hospital, Emily’s months-long admission to a therapeutic community gave her the time and space, and presumably the support, to undertake this personal work. These extracts suggest a reluctance to take time by both service users and services, articulating a recognised tension in the provision of mental health care. An argument against asylum care was the sequestering of people for many years, and I am reminded of Janet Frame’s (1984) words and the despair they invoke: “it was recognised I was now in hospital for life... [a] constant state of physical capture” (p.109). In the current incarnation of mental health units, opinion writers lament the short lengths of stay, while service users complain that time stands still, with boredom a common feature (e.g. Rose, 2001; Shattell et al., 2008). Grant (2006) talked of “the gift of time” (p.457) in his recovery from depression and Taylor (2014), in her autobiographical ‘The Last Asylum’, expressed concern about a fast-track system of time-limited interventions, in which ongoing care and support were undermined and devalued.

Our stories all suggested that time was a necessary aspect of the journey to healing. Time and movement are related; in a perhaps simplistic representation of the laws of physics, I understand one cannot occur without the other. A journey of healing connotes movement and thus takes time; this may be moments in time, or lengths of time; time with purpose and meaning, in contrast to time that is purposeless and meaningless; time that is given and taken. The theme of ‘it takes time’ acknowledges that the journey of exploration is a lengthy one, and as I will argue in chapter twelve, requires time for doing and time for being, facilitating processes of learning, connection and integration. Our stories were framed in time, and often it was only time that gave us confidence in our experiences of healing. Our stories took time to develop their coherence and meaning; but time remains a commodity in short supply in our provision of mental health services.

Turning points or right-timing

On our journeys there can be pivotal moments, some of which are conceptualised here as turning points. Several people described a point in their journeys where the trajectory changed, usually from ‘being stuck’ to forward movement towards an experience of healing. This moment was in varying ways associated with their healing place and, although not a focus of the research, warrants some discussion and may be an area worthy of further investigation. Although I initially conceptualised this juncture as: ‘being ready’ and ‘timing or right-timing’, I found reference in the literature to ‘turning points’ in recovery (Kogstad et al., 2011; Lapsley et al., 2002; Roberts & Wolfson, 2004). This concept captured the essence of our experiences and I was reminded of referring to the Hall as “a major turning point in

my/our lives” (Anonymous, 1992, p.6). In these turning points we found hope (Hobbs & Baker, 2012) .

Lapsley et al (2002) identified a turning point as: “often a rapid event or sequence of events whereby people took charge of their situation, gained hope, developed insight and a new sense of direction” (p.45). The turning point “established a direction for recovery, rather than making everything better right away” (p.54). Antecedents were often barely discernible, beginning “in the bleakest times, when people are held in thrall by mental ill health, losses and disruptions are many, and hope seems distant” (p.47). I am still left wondering if we do need to reach the bleakest times to provoke the movement implicit in healing. When I made the decision to go to the Hall, I ‘knew’ that something needed to change, this realisation coming at a time when I had ‘incessant’ thoughts of wanting to die. I did not know what it was that I needed, just that I needed to ‘sort myself out’, and at that moment I seized on the opportunity to go to the Hall as the answer to my difficulties.

Other participants who described transformative healing journeys have identified similar moments. Barb ‘knew’ that she needed to face her demons; rather than seeking help she decided she needed to do this on her own. She was unable to explain how and why she reached this point in her journey, but for her it was a turning point in the way she approached her illness.

I kept seeing the same people but I never saw anybody move on, myself included. I'd been reading these self-help books, but nothing really sort of clicked, and I honestly don't know what it was – it was just this kind of thing where you just have to face it... it's your only way out... it's an intuitive kind of knowing.

She described this as an ‘intuitive knowing’, much as I ‘just knew’ I needed to ‘sort myself out’, without being able to articulate what or how I knew. Whereas I described a sudden realisation, and resultant decision to go the Hall, Barb told me hers was a slow realisation.

I remember it slowly crept up on me, the idea that actually if anything was going to change I was going to have to do it. How much faith can you put in the mental health profession when all I'd ever done was really decline.

Although not describing a point of desperation, Barb identified things getting worse. She reached her turning point when she lost faith in her treatment; in contrast, Colin reached his when he became symptom free after a medication increase.

There was a time where I would have bucked the system, but because I'd recovered so well and become hallucination free, I was a believer in the system. And that was a big thing for me because I'd always had no trust for it and I didn't trust anyone.

I just noticed the silence in my head; it was amazing, I couldn't believe it. It was a revelation – almost in a religious sense I suppose – the fact was that I was unwell; I did need the medication, and the medication was a start for my recovery. So I committed myself to my situation in hospital, and that was the whole point of it: that's the difference between years ago where I slipped through the cracks, and this hospital.

The silence in Colin's head, the resolution of symptoms, was the turning point for his recovery. He realised he had been unwell; and instead of 'bucking the system' he committed himself to the process, and the opportunities he was offered in hospital. David's turning point came when he met a peer support worker during an admission to hospital. He had earlier been introduced to peer support workers in the community.

When key workers, and doctors and nurses came into my life, the biggest thing that was introduced to me was peer support. Well I'm not even near the end, I'm still on the tip. And I was like, wow, these are professionals, but it just didn't sink in. I was sitting on this side and I was going, yeah I've got a diagnosis, and I didn't see that I could say to myself I had lived the experience.

David described himself as 'still on the tip'; he hadn't yet made the connection that would alter the course of his illness journey. Then he was admitted to hospital.

She was in there [the mental health unit] as a guest, and I was like hey ain't she my peer, and she did present as acute; I was acute. But then I thought: wow that was a real person in there. I actually saw a person that had a hierarchy but was on the same level as me. And that is like the light at the end of the tunnel; seeing her was enough hope for me to start. And I started to [clicking his fingers]; that was one of the biggest changes in my life.

David suggested that his earlier contact with a peer support worker sowed the seed for his transformation, their subsequent meeting as fellow guests giving him hope and direction: 'the light at the end of the tunnel'. The clicking of his fingers implied a motivation to move forward. As I reflected on this, I remembered that some months prior to deciding to go to the Hall, a friend had told me about the place – a possibility I discounted as too far away/I didn't need it. Sometimes turning points appear to come from nowhere: I said I 'just knew', but

didn't know how I knew, that I needed to do something different; but perhaps the antecedents are visible if we look hard enough.

Emily's turning point came through more direct intervention from others. After several years of repeated admissions to hospital and a suicide attempt, her family persuaded her to go to the hospital that became her healing place.

And so what happened eventually, I took an overdose. I was in a coma for three days and I woke up with no long term damage which was pretty lucky. My family said right, we'd like you to go to [this hospital]. So I went and had an interview about it.

She went on to tell me that there were a number of times in hospital, when it was her family's insistence that persuaded her to stay on her journey.

Our turning points had different qualities: Colin's was in response to the cessation of his voices; Barb's was a gradual awareness that nothing was changing. For Emily and me, it came at a point of desperation: in my case, personal desperation; for Emily it was her family's desperation. Perhaps in our turning points we found hope, each of us then embarking on a journey that was ultimately healing. But I am aware that there had been earlier times when I had been desperate, and had the same sense of 'knowing' that something needed to change.

*I had kind of tried before. When I was having truckloads of ECT and stuff, I had taken myself off to a counsellor because I knew, I just knew I needed to sort **me** out, because if I couldn't sort me out then how could I deal with this illness. Basically that was a disaster because to be honest I just walked all over the counsellor. I did know I needed it, but I was far too defended to let her actually get into anything that I needed to deal with.*

I had actively sought this help, but still nothing changed; I was unable to engage in a way that was helpful. When I ultimately went to the Hall, not only was I moved to action, I continued to engage in the process resulting in positive change. I will argue later that at the Hall I was met with an environment and the opportunities I needed to support the journey of healing. Reflecting on my experiences and those described above, perhaps turning points occur when those moments of insight or hope occur in, or lead us to, environments that provide the necessary opportunities for exploration and recovery. Although these moments can be conceptualised as turning points, it could also be argued that for some, our healing places were available to us at the right time.

Going places

And so we move to consideration of place, and specifically to the role of place in facilitating this journey of healing. Our stories of illness and healing employed metaphor to capture and convey the intensity of our experiences. For me these were sometimes concretely placed-based metaphors: my ‘black hole’, the ‘white room of nothingness where I ceased to exist’, ‘a place where I cannot be soothed’ ‘drowning in a sea of angry waves’. I have described my fear of going to that place and losing myself; going to a place that was recognised, but not understood, and in the unknowingness I feared being lost. Others have also utilized, explicitly or implicitly, place-based metaphors: Fran’s sense of being lost had connotations of being in an unknown place; likewise Alice talked of trying to find herself when unwell; Barb talked of her fear of going away and not coming back; Colin couldn’t see past his illness, suggesting a limited landscape; Lauren went to places in her head in which she found desperation; David started his story ‘in a place’ where he was at rock-bottom; Margaret navigated the storms that were the stresses in her life, and had an internal place, her magic box, where she stored the ideas that arose in her madness; Emily wanted to get out of where she was.

We painted pictures in words of places, known and imagined, that conveyed to ourselves and others the experience of illness as if in place. On our journeys of healing we went to external places that we considered healing for us, and it was in the exploration of these places that we gained access to far larger landscapes, both external and internal. Aspects of the places that facilitated our healing will be discussed in Part III.

Part III: Our Places of Healing

In Part III our stories continue and are presented as aspects of place that supported our healing. Our articulation in Part II, of what it was like to be unwell and then the experience of healing, provides a context for and way of understanding the association between place and healing. Healing is conceptualised as a journey of exploration and transformation that takes time and is hard work. Through experience and connection we made sense of our illnesses, developing understanding and wisdom, and gaining hope and trust along the way. Given time for integration, we restored our integrity: becoming whole. We arrived in these places distressed, struggling with illnesses that we did not understand; disconnected and fragmented, we had lost our selves. If place is understood as inextricably entwined with who we are, then in the exploration of place we have the possibility of finding ourselves. We shape and are shaped by place; and the landscape we come to know, in all its richness becomes the story that we tell, the expression of our healing.

Divided into 4 chapters the material is presented thematically, in contrast to ‘The healing journey’. Chapter nine explores the ‘what’ and ‘where’ of our healing places, these being a focus of continued contention and cyclical change in mental health care. Drawing on the concept of therapeutic landscapes, chapter ten incorporates themes related to the physical environment, presented as built and natural. ‘Sharing the Journey with Others’ (chapter eleven) explores our experience of the social aspects of place as manifested in the interpersonal relationships with those with whom we shared our journeys. Chapter twelve discusses themes related to the activities and ways of being in these places, framed as ‘A Place of Opportunities’, facilitating the necessary exploration for healing. Adopting this structure has its tensions. While there is utility in this separation, identifying particular aspects of place that are opportunities for improvement or change, our experience of place is more complex. Place forms in relationship: material, social and phenomenal; these are relationships within and between. Subsuming both the material world and the human experience occurring within, these interrelationships result in place imbued with meaning.

Chapter nine: Where did we find healing?

We drove in the back way over Three-mile Hill, giving me a view across the town sprawled below me, to the harbour and the sea. It was the middle of winter; the snow was on the hills as we turned in through the gates – well, actually there wasn't a gate! There was an entrance way through the old low dry-stone walls. This was Ashburn Hall, a private psychiatric hospital on the outskirts of Dunedin, in the Southern extremities of New Zealand. Surrounded by farmland, bush, pine plantations, and wind-swept hills, it would be several days before I realised how close we were to town – a 5 minute walk took me to suburbia and the bus-stop to town.

The grounds were amazing, rhododendrons, azaleas, big old trees, sweeping lawns; daffodils in springtime, and in winter, the occasional snowfall. Coming up the driveway, there was the main building, the stone wall of the original farmhouse still discernible at the front. Further on were the gymnasium and various other out-buildings: the psychodrama room, group therapy rooms, farm sheds, the old superintendent's house.

My memories and narrative of being at Ashburn Hall are redolent with the place itself. As I cast my mind back I remember, particularly emotionally and visually, the light, the changing seasons, the gardens, the countryside, the buildings and the many and particular windows that gave me views through to this outside world. I re-visit, in my mind and my heart, parts of the buildings: my bedroom, the psychodrama room, the room where I had individual therapy. Aspects of my narrative relate to where and what the Hall was, this having both literal and figurative aspects. The 'what and where' of it seem obvious: a private psychiatric hospital in a rural setting, close and accessible to a sizable university town; but it wasn't that straight forward. I remember telling my interviewer that I didn't call it a hospital; it was just 'the Hall'.

The other research participants identified a range of places that were healing for them. One person identified a similar hospital: a therapeutic community; two people talked about urban-located forensic units, another a Maori cultural unit in a rurally located old mental health hospital, and two spoke of acute mental health units in the grounds of general hospitals. Several people described community respite facilities, friends' homes and one, her own home; another identified a community-run art studio. Some people chose to talk about more than one environment that had been healing for them; a few also spoke of places,

experienced either in their personal or working lives, that had healing characteristics. Most of us talked about other places we had been, that we had found unhelpful, and sometimes detrimental to our well-being. We also acknowledged that our healing places had positive and negative, helpful and unhelpful aspects.

It is the themes of ‘what’ and ‘where’ these places were, that informs this chapter, but there is artificiality in separating out the elements as I will discuss them; place is more complex. A window is a structural element that can bring light and fresh air in to a building; providing a view that facilitates a sense of connection to the natural world. But it may also be a reflection of ‘what this place is’, meaning intentionally or unintentionally implied by the physical structure. Consider the window that cannot open, conveying a prison-like quality; with blinds that sit between two panes of glass, suggesting a need to contain risk. The location of the Hall, with its grounds and surrounds, gave me access to nature; a place to walk, giving me space to explore internally as well as externally. The collective aspects of the place itself cannot be separated from their meaning and how they were utilised to support the journey of exploration.

What were these places?

I don’t know why I just called it a hospital; I don’t think I ever called it a hospital... it was just the Hall.

and...

The original building was a farmhouse; extended through the years, now it is like an old manor house. The grounds are wonderful, even in winter; they are part of the specialness of the place. Quite magical, and for me a haven, then a place of healing... A haven, god I needed a haven, somewhere to be safe for a while. Safe from my feelings of hopelessness, helplessness and despair.

and...

I had a sense of needing to be somewhere else, with people who might understand what it was like for me, to help me make changes. Being in a place where I had supports around me, and could be held enough so that I could work some things out for myself; without a whole lot of other expectations.

and...

For some, the Hall and its community provided time-out, a rest of sorts. For others, it was a means of helping settle acute crises, so they could carry on at home. But for many people, like me, our time at Ashburn Hall was a major turning point in our lives.

and...

I remember once at the end of a hard day's work in psychodrama we went down the road to the pools; going down the hydroslide we just yahoo-ed like kids. It was that slightly odd thing that here I am in a psychiatric hospital and at the end of my day's work I could go down to the public pools and play silly buggers. It wasn't all deadly serious, all the time; and we learnt how to, and from, having fun.

and...

The Hall is a privately-run psychiatric hospital... the place functions as what is technically known as a Therapeutic Community.

These extracts variously refer to Ashburn as the Hall, a haven, a psychiatric hospital, a therapeutic community, somewhere else, a place to be, a place to be safe, a place to be held, a place to live, a place to learn, and a place for hard work and for fun. One extract, written a year after I left the Hall, also presages my understanding that Ashburn could be different things to different people; a place for time-out, a rest-of-sorts; a place to settle acute crises; or a place for a more transformational change. The Hall was a hospital but not as I knew it; when I initially wrote this I meant it wasn't like any hospital that I knew. I realise that it could also mean that I came to know it, the Hall, as something other than a hospital. It was a hospital but not like the other hospitals I had known, it was somehow different; or perhaps I experienced the place differently.

It's not the other place

In telling our stories we utilised comparison to convey that our healing places were different to other places we had been: 'it's not the other place'. Sometimes it is easier to say what something is not, rather than what it is; and talking about what it isn't can say something about what it is. For me, the Hall was different to the other hospitals I had been admitted to for ECT, the blandness of those environments perhaps exacerbated by the memory loss associated with the treatment.

The sun had gone and the mist rolled in as I skied the slopes of Coronet Peak. Half-way down the mountain I stopped. The white cloud so dense I couldn't see my outstretched hand. There was no sound, just a heavy white silence, and a panic stirring within me.

Where did that panic come from? I realised as I stood on the snow that this was my white room; that half-remembered place of nothingness, as I woke from ECT; that few moments of time as I awoke, when I had no memory, my mind blank, not knowing where I was, or indeed who I was. This was my white room, a place of nothingness where I ceased to exist.

Ashburn Hall wasn't that place, it re-introduced richness into my life. And the Hall wasn't home, where nothing seemed to change.

Several people, when asked where they would like to start, began their stories overtly with comparison, 'I suppose it's hard to start without sort of comparing, you naturally kind of compare.' And, 'well I suppose there's a contrast for me... and I kind of have to put the two together to make a comparison. The first time I was admitted to an acute psych unit in '94 was really not a healing place'. For others the comparison was implied as they began their stories talking about the other places, 'I'd had previous admissions in and out of hospital for four years...' and 'Alright, so my anti-healing experience'. Beginning his story, David's 'other place' was his internal world with a sense of being in a place, emotionally as much as physically, where nothing was changing.

I think the place to start would be when I was rock bottom, rock bottom. I was talking to a wall, talking to my cigarettes, listening to my voices... I was with my family and nothing was changing.

Prison was a frequent place of comparison, sometimes from personal experience, but also by likening 'other places' and even their healing place to a prison:

The whole appearance of the place; the way the floors were booming when people walked over them and the doors slamming and the keys rattling and it felt like a concentration camp. Worse than a prison you know; mental hospital in every sense of the word.

and...

I remember that click-click, and that made me feel even worse, just the click-click, click-click. Felt like a jail and I've never been to jail but it was the closest I've ever been to jail.

and...

You're put into like a big cage outside, there's a huge fence. You see all these trees and all the traffic going past; it's a prison really.

These extracts referred to different aspects of the environment that felt prison-like: the echoing corridors, the click-click of keys, being enclosed behind locked doors and caged within fences. My sense too is our experience of these places mirrored an internal sense of being imprisoned by our illness, life going past us with no hope for escape; no place for healing.

The need to compare was evident in everyone's narratives, with the 'other places' being acute mental health units, psychiatric institutions, particular respite facilities, and prison. While this may have been due to my initial scene setting for the interviews, my sense is that comparing places served several purposes. Comparison can be a way of demonstrating difference, particularly when it is hard to define the thing you are trying to describe, the ineffable nature of healing. Reference to the other place also implied being or going somewhere new, with potential for something different, offering hope for change. Barb captured this sense of hope in being admitted somewhere different.

There's that sense of newness. You know with something new there's a different potential; new life, new start.

Comparison may also be a way of framing the story by 'setting the scene'. I am aware that when I talk about my experience at the Hall I often begin with what has gone before, in effect telling a story of transformation.

A hospital but not as I knew it

Although, when I made the decision to go to the Hall I did not know what to expect, I did have expectations; I expected them to help me get better. I am sure my decision to go to the Hall was partly because it was a hospital; I knew that things were seriously wrong and my experience, both professionally and personally, was that hospitals were places I/we go when unwell to get treated, 'to get fixed'. Assessment, diagnosis and treatment were the tasks of hospital (medical, surgical, psychiatric); as a patient, apart from engaging in the assessment process, my role was to cooperate with the treatment: a somewhat passive role, to be a patient. Perhaps this was why I went to the Hall prepared to stay two weeks: I expected them to fix me, or simply tell me what I needed, for me to then go away and 'do'. That isn't what happened; instead I had to give myself, and them, time. There was no quick fix and I was very much part of the process.

My role as a patient at Ashburn was not just to be compliant, to be adherent, or even to be unwell. I might have been in a hospital, but life went on, and I was alive in it. This was what our visit to the pools said to me: I was in hospital, but one in which I worked, and at the end

of the day we ‘could go... down to the public pools and play silly buggers.’ This was a hospital but not a hospital as I had known them.

Sally also described a hospital, but not what she was expecting. Her expectations were different to mine, her influences being what she had seen on television and heard in family stories.

I had been expecting the worst I think, thinking oh my gosh, I'm crazy, and the thought of the [old psychiatric hospital] where I imagined it was like I had seen on TV.

I remember one of the first things that really surprised me was that the staff dressed in normal clothes. I was expecting to be put in a room where it was lines of beds and people were in hospital pyjamas; and people to be shuffling about and looking very, very unwell. I was scared that I might be hit or they might swear at me or expected that staff would be very authoritarian and have little to do with me, and that kind of thing. And it was just the complete opposite... it was just incredibly relaxing.

Sally arrived at this hospital with a preconceived notion of what it meant to be ‘crazy’; already struggling to ‘keep it together’, and informed in part by what she had seen on television, she expected hospital to be ‘the worst’ experience. Instead, aspects of the physical place, the interpersonal relationships and what happened there suggested this hospital was different, changing her relationship with the place, and potentially herself: she relaxed.

Like me, for some people their place’s identity as a hospital was important. Alice spoke of her relief at being transferred from prison to a hospital: a locked mental health unit. For her, a hospital was a place where she was recognised as being unwell and would be cared for, but being a hospital also brought challenges.

I came through the prison system for one night, so [the hospital] was a relief in a way because they knew how to deal with me as I was: very unwell. I thought finally I'm in a place where they understand that I'm not a bad person.

But day after day, month after month, year after year, you know it's really, really challenging, because also you're surrounded by people in stages of wellness and unwellness... It is an intensely charged place.

Although Alice initially appreciated that this was a hospital, this identity also meant she was in the company of others who were unwell. This was an intensely emotional environment;

reference to her lengthy stay perhaps implied that this became more problematic as time went on. Alice's hospital was very different to mine; while I experienced freedom from my anticipated patient role, Alice experienced incarceration:

But still it was a locked unit... we didn't want to be there, you were forced to be there. It would have been hard for everybody really, not just me. You have to learn ways of coping with being so institutionalised.

Alice did find ways to cope, being offered and creating opportunities to transform her hospital stay and her experience of illness.

In contrast Barb's perception and experience of early admissions to hospital in old-style institutions did not transform; these were not healing places. Whereas I experienced my hospital as a place to live, to be alive, Barb's experience was opposite; the institutions engendered a sense of hopelessness: nothing was going to change.

When I went into the institution I didn't expect to be fixed. I felt very fearful because I thought I'm not going to get out of here; basically this is where you come to live out your life. And of course I'd seen that; you didn't have to go too far to see people who had come in when they were quite young and were now quite elderly.

When people were acutely unwell, they were taken away, they'd go somewhere else: I presume they went to another villa or something. You just disappeared; I suppose it's one of the things that I learnt: there were places where you just kind of vanish. People did in the institution, they just kind of vanished.

Barb arrived in this hospital not expecting to be fixed: this would be where she lived out her life. Unlike Sally, her experience of the place did not alter this expectation. As discussed in later chapters, her beliefs about the institution were reinforced by the physical environment, her relationships with others, and what did or didn't happen there. Barb talked about people vanishing in these institutions, and I was reminded of how, in our illnesses we lost our sense of ourselves; the self we knew disappeared. Barb's institution gave her a sense of actual disappearance. Later, Barb was admitted to another type of hospital, an acute mental health unit.

When I went to the acute unit I can remember being really anxious and fearful, but also feeling quite elated because I thought they're going to fix me, they're finally going to fix me.

Her move from institutional care to the acute mental health unit was associated with hope; but hope was not enough: as Barb told me later, her journey of healing was not about someone ‘fixing her’. Simply going somewhere else (‘it’s not the other place’) was not enough; there were other aspects of place that were necessary to begin the journey of healing.

Helen’s experience of an old style institution contrasted significantly with Barb’s.

I thought the place was quite spiritual really, and where it was situated was quite a [pause] I don’t know how to explain it; it just seemed quite spiritual in the way that there were people that had lived in those places for years before you. They had a cemetery out at the hospital, people that their family’s just left them there; they didn’t have the medications to get better so they just all lived there together and died there.

Helen conveyed a sense of comfort in her connection with the place, its history and the people who had gone before, and as she talked I had a sense of being grounded and of belonging. I was reminded of my response to the old dry-stone walls at the Hall, giving me a sense of history, of being part of something. There was however a tension, and perhaps sadness; Barb experienced these institutions as places where people simply vanished, to live out their lives, suggesting that we derive meaning in varied ways. Somehow, for Helen, this place, the people, and their histories invoked a sense of spiritual connection; being ‘difficult to explain’ suggested intangibility, but perhaps was an accumulation of pre-existing experiences and new understandings. When I was driven past the dry-stone walls of Ashburn for the first time, I suspect I was too terrified to give them much notice, let alone meaning. In themselves they may have had little significance, but as time passed and I began to understand this place, they became integrated into a landscape that mattered to me.

The notion of a psychiatric hospital meant different things to different people. Our expectations may have been informed by stories we had heard, books we had read, films we had seen, or from family or personal experiences. It is unlikely that any of us were admitted to hospital, or respite, without some preconception of what it would be like; sometimes our expectations were confirmed, sometimes not. Some people identified hospital environments as detrimental to their recovery, and sought out other places that gave them a sense of healing. Others, like me, understood hospital as a place to go when unwell. Alice ‘made do’ with aspects of the ‘hospital’ identity, but wished for something different; Sally and I appreciated that our hospital was not a hospital as we knew it.

It's not home but it is

Although for me being away from home was important in my journey, there are aspects of the Hall that were very home-like; I remember the blue duvet on my bed, and the daily routines. This was a place to live, rather than a place to be unwell: it became home for a while. I could suggest that this was because of the length of time that I was there, but a number of others made reference to their healing place being home-like, whether their stay was short or long.

David said of a respite facility:

It felt like I was walking into a home, you know. Like, she had the sleeping quarters in one area and the office in one area, but it was, how can you call it, home office. You know I never seen that before. So when she walked out and then she just showed me herself and said would you like a cup of tea, and I was like – wow. I think respite was just a little ticking flame, you know those pilot lights that always light the flame.

This was a profound experience for David, an important moment in his journey. The home-like quality of the place was important but so was the person, offering a cup of tea: 'she just showed me herself'. The coherence between the physical environment and the woman who welcomed him, told David something about what this place was. Like our places that were hospitals but not as we knew them, David recognised that this respite place could be both home with all that implied, and a place to be helped. This place gave David hope; it was a 'ticking flame' that sparked something, with the potential to sustain him as a pilot light does.

Barb's healing place was not just home-like, it was home or 'a home'.

It feels like a home. She's got pictures of her family everywhere; family is everything for her. And that very much is reflected in her house. She is reflected in her home.'

This place felt like home; Barb indicated the interplay between the person, her friend, and the physical environment – the house – that created and added richness to her experience of home. In stark contrast to her descriptions of institutional places, as Barb described her friend's home I felt myself exhale: physically and mentally relaxing, I was coming home. This was a familiar, welcoming place; not simply a place to stay, 'home' suggested Barb belonged like family. Being somewhere familiar perhaps reminded her that she was not in those 'other places', both physically as in the institutions and metaphorically, where she felt hopeless and stuck.

Several people noted the home-like environment of their healing places, suggesting that it conveyed a sense of normality.

It was more like a home than a hospital and I had been expecting the worst I think... There was this space downstairs where there was a pool table and a CD player; I'd go there when my friends came... we'd listen to music, to try and kind of keep it normal.

and...

It's just like a house, like a family home... It's a pretty nice area and it's just a normal house next to a whole lot of other normal houses. There's no big blaring, flashing sign that says anything bad.

I was struck by the desire to 'try and keep it kind of normal' and reflected on our experiences of being unwell: my sense of being lost and the chaos that others described. Perhaps a place that was 'kind of normal' or 'familiar' had the potential to anchor us a little, while supporting the notion that these were places to live, not just places to be unwell.

For most of us our healing place wasn't home, but it was home-like. We talked about our need to be somewhere other than home, away from the responsibilities of the place that defined us. Home was the place where I felt desperate and unsafe; while I wanted space from that place, I still appreciated being somewhere that felt like home. I am reminded of the expression 'home is where the heart is' and if I think of my journey, and that of others as 'getting to heart of me' then it makes sense that a place that helped me feel 'at home' would assist this journey; that is where I might find my heart. Or is it that, in 'getting to the heart of me' the place became home? Home is a place that welcomes us when we feel lost, giving us a sense of familiarity when our world is confused; a place to belong when we feel disconnected, anchoring us when we feel battered by the storms of our illness.

A safe place

I variously referred to the Hall as a haven, a safe place, and a place to be held enough; while these are related themes it has been useful to tease them apart. Safety was a recurring theme in most of our stories. Sometimes we identified a need for physical safety, to be kept safe from thoughts of suicide or harm from others. Before I had arrived at the Hall I had been besieged by thoughts of wanting to die. Others identified similar thoughts:

I think the reality also is that possibly if we hadn't been well supervised most of us, or lots of us would have killed ourselves.

For Sally, hospital was a place that physically contained her, keeping her safe from her suicidal thoughts when she was unwell.

I needed to be in a place that was going to at least put some stops in place, to keep me safe; at times they locked the doors... It just allows you time to not have to fight that constant fight of trying to get better against something which is trying to cause your destruction.

Describing her illness as something that threatened to destroy her, Sally experienced locked doors as protective, giving her a rest from having to keep herself safe. These doors, however, had the potential to create other tensions.

During another admission it was doors locked, I couldn't go outside and then my room was locked as well. So I was trying to find space where I could just be; there was nowhere to go really, and that was just hideous.

There is a sense that this place still didn't feel safe for Sally, suggesting that it was not simply the physicality of locked doors that made a place safe. For some people the locked doors of a mental health unit had different, more distressing, meaning. Margaret found locked doors intolerable; originating in her past experiences of hospital, this fear now encouraged her to avoid mental health services.

If I had someone saying look, you really need to get help and I'll go with you and I'll make sure they're not going to put you in a place that is locked down, I'd go tomorrow.

David likened his experience of locked doors in a mental health unit to the trauma that was locked inside him.

You can't walk out unless you [pause]; you have to go through a process [a locked door]. And that process is like you have trauma inside you that you haven't been able to open; you still feel bottled up... When you have a spiritual door that you never open that's holding that, it's scarier than having a physical door that'll hold you.

I understood David to mean that he experienced the mental health unit doors as locking him in both physically and emotionally, likening them to the metaphorical door that kept him closed off from himself. He didn't comment on whether these doors added to his physical safety, but they added another layer of meaning to his experience of hospital. I was reminded of the lack of locked doors at the Hall; there were times when my suicidal thoughts re-

surfaced but I was kept safe in other ways: as will be discussed shortly, I had a sense of 'being held'.

Sometimes a 'safe place' provided protection from anticipated harm by others. Having come from prison, Alice recognised the mental health unit as a physically safe place to be.

They didn't do things to me aggressively, violently, so I was feeling safe.

But more than this Alice expanded on her sense of what constituted a safe place.

As soon as I got there, I felt: I don't know what this place is about but I know it's safe. They're treating me with respect and they're treating me with care... There's trust, there's a sense of purpose for good, for your good; that moving through, moving forward; that dealing and healing thing; that you're making positive progress and that you're receiving the right treatment for what you need.

Alice suggested a more complex understanding of what helped her feel safe. As well as appreciating physical safety, she implicated aspects of the interpersonal relationship such as respect, care and trust. This was perhaps not surprising given the sense of threat and distrust she experienced when unwell. She also suggested that safety was associated with a sense of having hope: being part of something that had purpose and moved her forward.

Barb described a sense of safety in the familiarity of home.

Home is where I feel safest... I can't tolerate change very well when I'm not well. I suppose safe means [pause], it's about being familiar. There's nothing like being in your own bed; it's got your creases in it; it's your body shape; the smell is familiar.

And it was the idea that I knew where the kettle was; if I wanted to get up and make a cup of tea I would be able to do that automatically. If I wanted to I could make popcorn or put something in the microwave which made me feel like I was still functioning.

Barb had previously described her sense of disconnection and displacement when unwell and in hospital; she now found safety in her connection to familiar places. The practical tasks of making popcorn or a cup of tea perhaps reminded Barb that she was still functioning and hadn't gone away.

There were many aspects of our illnesses that engendered a lack of safety: experiences we couldn't make sense of, our feelings of despair, and the threat that was our sense of being lost. It is beyond the scope of this thesis to fully tease out the phenomenon of 'feeling safe',

but each of us expressed the need for a safe place. Safety meant different things to different people but was fundamental to our experiences of places that were healing. As a psychiatrist I tend to think of safety in terms of physical risk to or from self and others. While there were elements of this in each person's experience, a 'safe place' was much more than one that physically protected us. Sometimes we experienced safety, or were simply kept safe, by the physicality of the environment e.g. the locked door, but most people described a broader sense of safety, experienced in interpersonal relationships, a sense of connection to the familiar, or finding hope in a sense of purpose.

A haven, a time-out-of-sorts

Connected with the notion of a safe place is that of a haven. In my early descriptions of the Hall I suggested that it was a haven; for some people this provided a 'time-out of sorts,' to settle an acute crisis so they could carry on at home. For me, embarking on a longer journey, I initially and recurrently needed a haven, a place where I could rest away from the storm that was my distress, my illness. Others used similar terms connoting notions of retreat or sanctuary. It could be the place itself that was the haven, or a space, physical or psychological, within the place. A haven, as well as providing safety, evoked a sense of being cared for, with permission to 'just be'.

Hospital and respite to a degree is the physical space and time to get to that point of, yep I can jump back on the bandwagon of life and do what I need to do. [It's] just not having any of the stresses of normal life, having no responsibilities I guess. And probably the biggest freedom is not needing to have complete responsibility for my own stuff, what I'm doing or what I'm not doing.

and...

It gave me permission to just be for a while... It doesn't matter if you're in a not okay place, you can still be there. I don't feel like I have to put on the mask that sometimes in various situations in the world you have to do and to kind of get on with things.

Most of us talked of needing a place where we could forgo the responsibilities of everyday life, the need to manage our illness and keeping ourselves safe. These were places where we didn't have to pretend, where we could be looked after for a while. Recognising and having this need met, meant that for some of us admission to hospital no longer felt like a failure, it had a purpose.

In a locked and sometimes overwhelming mental health unit Alice needed to create her own haven; she found this within herself. This prison-like environment still became her healing place; she learnt ways of coping. A friend suggested that she had a choice.

You can choose whether to cope with this; this either has to be your prison or your monastery. A prison is not only a physical thing, it's also a spiritual, emotional, mental thing. Monks aren't actually physically locked up, and they don't hear those great big keys clanging [but] you still stay within the same space. They can walk in the grounds of the monastery and that's a sanctuary, and they can focus on their relationship with themselves and with God and with the world. That became a bit of a mantra for me at times when I was finding it [hard]. I'd have to try to think, okay how can I look at this in a different kind of way just to get through today?

Rather than being a prison, her hospital became her monastery. The physical place hadn't changed but Alice chose to view it differently. Altering her relationship with the hospital, and the meaning it had for her, she created a psychological space that was her sanctuary within which she could explore her relationship with herself, her God and her world. By exercising this choice, Alice raised the possibility that the same place can mean different things, in effect be a different place, depending on how we come to know and experience it.

When Margaret was unwell, she sought places that helped her find stillness. She found this in the garden of a respite facility, in a friend's house or walking on an isolated beach. Invoking a similar sense of spirituality as Alice, Margaret described her experience of a particular beach as 'it was just like I'm in one of the sanctities of creation'. She told me about being unwell:

I get very scattered with so many thoughts and creative impulses, that I do need some kind of containment. But the containment I really need is just a space, much like what you write about in Ashburn Hall really; places that help you to reach that point of stillness within yourself.

Margaret talked of needing containment, but this was not a physical containment achieved by the locked doors that she found intolerable. The next section discusses her sense of metaphorically being held, countering the scattering and fragmentation of psychosis.

Two people talked about physically hiding and I wondered if this served a similar purpose to a safe haven. One was supported in her desire to hide, the other was not.

Sometimes on the first day I hide somewhere, squeeze in between spaces. I quite like to hide.

and...

I have a vivid memory of being told off for hiding under the bed; really kind of berated for what felt like a natural response to a frightening situation.

Hiding could be understood as a retreat from a frightening and overwhelming world, and I was reminded of bed-rest (discussed in more detail in chapter twelve).

The times for me that I was put on to bed-rest was when I was having a tough time, when I was emotionally really struggling with something. It would be suggested that I go to bed for a few days; tucked in to bed, my meals delivered on a tray.

On bed-rest I was given time out for a few days from the ward program, hiding or retreating from the world but not my feelings. Bed-rest was for me haven within a haven, a place that I could come and go from as I needed it, creating space to be with myself and with my distress. This was a safe haven that perhaps obviated the need to run away into my dark hole. Various referred to as respite, sanctuary, and more problematically asylum, I used the term 'haven' to describe our need for a place or space where we had permission, and were supported, to be as we were: suffering; able to put aside our day-to-day responsibilities, to take time-out for a while with permission to be cared for and metaphorically to be held.

A place where I felt held

Describing the Hall as a safe place and a haven, I also said it was 'a place where I could be held enough so that I could work some things about for myself'. This was not a physical holding or, as some people experienced in their 'other places': the 'chemical hold of medication', or the mental health unit described as like a 'holding pen; just medicate you and keep you in there for a while until they think you're safe to go out'. Ashburn did not have locked doors, or seclusion rooms, yet I felt 'held' while I did the hard work of exploring. Much like Sally's warm bandage, somehow this place gave me a sense of reassurance that, even if I became distressed or unwell, I would be held enough to remain on my journey. In trying to understand what I and we meant by this sense of being held, I was reminded of the fragmentation at the core of our illness experiences; the threat that I, and my world, would fall apart.

Margaret evocatively captured this sense of being held.

I don't know why people don't get the fact that when you're psychotic what you need is gentility, what you need is maybe being held. What you need is a cloak around you, not a straight-jacket kind of cloak. I have an awful lot of shawls and I, kind of, cloak myself in shawls because it's a way of containing my sense of self and being; of trying to integrate experience and the breath.

Margaret used the gentle physicality of a shawl to metaphorically hold her fragmented, scattered self. She also talked of sometimes needing a 'gentle kind of holding place' likening this to how we would hold a child in distress. She talked of being at a friend's house and her sense of being held.

That was a holding; but as you would a sick daughter and they're lying on the couch. You might tuck them in, you might put a wrap over them, you might give them a cup of tea.

She suggested that this sense of holding might arise in a number of ways, in acts of care. Barb had a similar sense of being held by her friends.

You're just held, it feels like being held... they fill the house with love. I can feel that love which is like being embraced; it's almost a physical sensation as well and that's what they bring.

Her friends created an environment in the house that Barb experienced almost as a physical holding; she was embraced by their love.

Sometimes, for me, holding was not just a protection against fragmentation, or the comfort of metaphorically being embraced; it was a holding me in place. When I was unwell I would 'go away', run away into the darkness, disconnecting from myself and from others, and in that dark and lonely place I despaired. In this sense of holding, I was held in place by being tucked into bed, by a gentle touch on my shoulder that reminded me I was still there and that someone cared, and eventually by my sense of belonging to this place, and to myself. The Hall was for me a place to be safe for a while; a place that was able to hold me in my despair, allowing me to be vulnerable. Initially and recurrently it was a place to retreat to or within, without the need to 'go away'; safe to be and, when the time was right, safe enough to explore.

A place to learn and to explore; and it might not be an easy place to be!

Twenty years ago I wrote that the Hall was 'a haven, then a place of healing' suggesting an awareness that these were different things, albeit connected. Our healing places were not just

hospitals or homes, not just a safe place or a haven; they are all these things, and they were places to learn and explore and could be ‘a very hard place to be’.

I earlier identified exploration as a necessary part of our journeys to healing, and it is in this aspect that our collective stories and experiences significantly diverge. I set few parameters at the beginning of this study on what I meant by a healing place; that was for the research participants to decide. My experience was of going to a place where I embarked on a lengthy journey of exploration, lengthy both in time and (metaphorical) distance travelled. Others described similar lengthy associations, months or years, with their place of healing in which they had opportunities for exploration and practice, developing skills, understanding and eventually wisdom; these became places to heal.

Some people, however, told me of places and experiences that were qualitatively different in that they provided the haven aspect: a place to be for a while, ‘a time-out of sorts’, but with minimal opportunity for exploration. Their associations with these places tended to be much shorter, measured in days or weeks. These were considered to be healing places, providing temporary relief from suffering, and for one person, a ‘turning point’ moment that changed his relationship with his illness. Perhaps, though, these were not places to heal, lacking the time and opportunities for transformational change.

The difference between a haven and a place to heal was evident in several people’s stories. Sally was admitted into hospital when she was no longer able to ‘keep it together’.

It gives me rest and recuperation to be able to pick my life back up again. Certain aspects of healing I think the hospital environment does, but it doesn’t 100% give the spiritual or emotional healing. It does half the job, and not the other half that matters more, probably.

While hospital provided Sally with a haven, an environment to recover enough to be able to continue at home, she acknowledged that it didn’t support the multidimensional aspects of healing, particularly emotional and spiritual.

Emily problematized the notion of a haven as being a place of healing.

It’s quite strange, because when you say what makes a place a place of healing you think that it should be tranquil and an easy place to be. But that’s not actually a place of healing, an easy place to be... I think a lot of people come in thinking it’s kind of like a respite or maybe because it’s a private hospital they think it’s going to be easier, but it’s not. It’s a very hard place to be.

She recognised that healing, as a journey of exploration, was emotionally and psychologically difficult; it was hard work and took time. For some people a haven was all they needed, it being evident that the journey of exploration was on-going in their daily lives at home. For most of us, our places supported our healing more actively and overtly, providing or creating sufficient time and opportunities for the processes of healing. The conceptualisation of a healing place as one that supported exploration and learning will become more apparent in the next three chapters. We found or created opportunities for healing in our interactions and relationship with the physical environment, the people we met and the formal and informal doings and beings of these places.

Where were our healing places?

I remember one day just deciding that I needed to go; I needed to go somewhere and get myself sorted out. I'm not sure I knew what I meant by that, but I knew that if something didn't change then I wouldn't survive. I would like to say that it was a well thought out decision. It wasn't, it was born out of desperation, and based on very little knowledge of where I was going.

I needed time away from home; it was only being away from home that allowed me to let my defences down enough to actually come to understand. Home was the place that had the expectations on me, all the things that I was responsible for; where people expected me to be a certain person. And whatever that was, it wasn't working; it had come unstuck in a big way.

When I have talked about my Ashburn experience, I always said that I needed to get away; I needed to be at the other end of the country to get the help, and to do the work that I needed to recover. This wasn't simply because the Hall happened to be in Dunedin, 1400 kilometres from home; my assumption as I began this research process was that I needed to be geographically distant from home, to be away from the responsibilities of my everyday life, away from the things that defined me, for things to change. The rural setting of the Hall also seemed important: an integral aspect of the place that facilitated my recovery. I have wondered if we needed a return to the countryside, reflecting on the now-historic rural asylums; but the others I spoke to identified a range of places that were healing for them, many of which were urban, and not necessarily far from their homes.

Some found distance problematic. David spent time in a respite facility in a rural situation many miles from his home. He did not identify this as a healing place; it imposed a,

culturally understood, burden on his family, which admittedly was perceived by David as a 'wake-up call'.

We don't usually do long travels and going out there to respite was a long travel. For our custom, for the big responsibility, we don't give it back to the elders. So yeah, when they started to come and see me it was a wake-up call because my mum was taking the terrible trip amongst the custom just to see her son.

So how might I understand the diversity of people's experiences and how they related to mine? Going to the other end of the country, I was symbolically as well as physically putting distance between myself and the life in which I lived with extreme distress. Creating this distance was not simply about running away; connection was an important part of the healing process. In effect I was creating space. Physically this might be space between or from those places that defined me, but metaphorically I also found space within, creating room to explore with potential for new meaning. This was not empty or disconnected space, replicating the dark places of my illness; space perhaps only contributed to healing if accompanied by the opportunity to explore and connect.

Finding and creating space

There was one particular bedroom that was right down the end of the corridor; that is the room I resonate with most. It was really important that it was my space and wasn't a place that nursing staff walked past all the time.

and...

I got into the habit of getting up early in the morning and I would go for a walk out along the county roads. There was one particular road that ran along the ridge and from there you got a view across Dunedin, up the harbour but also down to the beach at St Clair. At 6.30 in the morning it was really quiet; it was a really special time when I just got to... I don't know, I could just think about things.

I created geographical space by going to the other end of the country, and found interpersonal space in my bedroom at the end of the corridor, and on my long walks in the countryside. Like a haven, these physical places allowed me to briefly retreat from the often distressing everyday life of home and hospital; more than a sense of time out though, these spaces gave me room to roam in my thoughts and feelings.

Like me, Emily thought it was important she was admitted to a hospital a long way from home.

I had been in and out of facilities; within a couple of weeks I would always go back into this frantic lifestyle... I think I needed to get out of all of that to get some perspective I suppose, eventually.

I do think for me, it was important to be removed from my home; to be far away, so I couldn't go home on the weekends [and] to get away from all those responsibilities, and other influences. But at the same time that (being away) does end up making you a bit vulnerable – when you go back into the community it takes some transition time, and I think that's quite a vulnerable time.

Emily identified the need for physical distance between herself and her life at home, with all its responsibilities, to stop the cycle of returning to her frantic lifestyle with nothing changed. Distance helped her get some perspective, and I was reminded of the expression 'taking a step back, to see the bigger picture'. Like me, Emily's experience could be understood as creating space, having both a physical aspect (geographic distance), and psychological (giving her space from her sense of responsibility and, as she says below, the pressure of everyday life), with the potential for change. Her use of the word 'eventually' alluded to the time required to develop new understandings.

Emily suggested, however, that there was also vulnerability associated with the transition back into the community, particularly when we have been distant from home. I remember the uncertainty and anxiety as I left hospital.

When I left, I made the decision that I would stay in Dunedin so I could continue my therapy. Even after leaving the Hall it wasn't magically all okay; it was still hard work. I had to take everything I had learnt about myself and try it out in the big wide world. Not going home had some positives; if I had come straight back it might have been a bit harder in terms of what people expected of me, like going back to work. And eventually I did go home.

The journey wasn't over when I left hospital; I still needed time and the space to practice what I had learnt. There were positives in being away from home but also, as described by others, an associated tension: the risk of space without connection, recreating the disconnected isolated places of illness. With geographic distance, we risked becoming relatively disconnected from our usual lives.

Emily went on to describe her admission as removing her from the noise of life. I had asked her if the hospital could have been in the middle of town.

Probably not; I think there's kind of a lot of noise in life generally and one of the things that this place does is remove you from that noise.

I always find it particularly hard coming out of there, [like] going to the supermarket – [it] is one of the noisiest places in life. There are all those trolleys, and that ding, ding, ding, and music overhead; and then the noise of all those appliances and all the people you've got in there. It's actually quite overwhelming when you're not well; and everything's like that really.

Emily suggested that when unwell 'noise' was harder to tolerate. I wondered if the supermarket was an analogy for the 'frantic lifestyle' within which she 'ran on empty', never able to recover. In this particular hospital, Emily found space away from distractions: the busyness and noise of life, providing her with an opportunity for stillness.

Unlike Emily and me, Barb experienced a sense of displacement when she was moved, from a hospital she knew to one several hundred miles from where she lived.

They decided to move me [from one hospital to another]... I went there and I felt quite displaced; I think that's when I really started to deteriorate. That's the kind of thing that used to go on there; there was never any explanation, it was just "pack up, we'll put your stuff together, you're going somewhere else".

Barb's experience of going to a hospital far away was qualitatively different to mine. Sent away with no explanation or framework for understanding this place, she felt 'displaced', experiencing this move as a disconnection. She seemed to suggest an association between this sense of displacement and her mental illness deteriorating. Barb explained to me that now remaining at home when unwell 'aligns you with your current life instead of your past life in some ways', suggesting that how we experience place can be affected by past influences.

Barb had years of admissions to hospitals that she did not find helpful; now when she was unwell she chose to stay with friends or have them join her in her own home. While desiring the presence of others she also appreciated space.

I must admit having my own space is important. A private space is important too... [My friends] are quite happy just to flit around the house or lie down with me; they know just to be in the house, because even though they're not doing anything, just their presence is sufficient. So I can be in the bedroom and they can be out in the lounge knitting or watching telly.

Rather than going away, Barb remained in a home environment, but created a sense of space in the way she and her friends interacted. She had space and privacy while still knowing that people were present; maintaining connection, she could be with herself, not by herself.

Fran's description of a local art studio, her place of healing, captured a sense of space, both physical and psychological.

... a big open studio space with very high ceiling.

... having space that I could make art and write in an environment that was conducive to that.

Fran suggested that not only did her studio provide a spacious physical place to make art, the architecture and environment gave her an inner sense of space that enabled her creativity. It was important to Fran that this was a place that was away from home, but the distance/space was achieved in a different way to me.

When I came back home [after discharge from hospital] I felt like I was continually being watched; I felt like a little child again... If I had to stay at home, I would very easily have found myself isolated and quite inward looking and the art studio provided that impetus to get outside of that.

Being at home, Fran experienced herself being treated as a child; she risked becoming isolated and introspective. Going to the studio was associated with a sense of expansiveness, shifting her view from inward to outward, as if the physical movement became a metaphor, or provided a prompt for personal movement. She had distance from a place that defined her in a particular way, in a place that gave her space to explore.

Sally told me about making the decision, to be admitted to a mental health unit in a town distant to her home. Compared with admission to a unit in her home town, this was a relatively positive experience but, like David, she worried about the burden for her family.

It's not a help [being further away]... My family find it really hard because they can't visit; and I think sometimes if I don't have that connection with them right there, then it encourages the isolation.

It's much, much harder when you've got children to allow yourself to go and have time away because you know that means it's going to put stress on everybody else; which tends to mean that it's much later in the piece when I need to go to hospital.

Sally suggested that being away from home risked disconnection, but her use of the word 'allow' and 'permission' suggested tension, perhaps an awareness that it could also be helpful. Although she struggled with the geographical distance of this hospital, Sally appreciated more localised space: having space to 'escape' if she needed to. As did Emily, she wanted to escape 'the noise' but this time it was not the noise of life, but the noise of an acute mental health unit. Comparing two experiences:

[One unit] is just so noisy and constantly people in your face, there was no space to escape anybody. Whereas [the other], I think there were only 10 or 11 beds or whatever it is... and there's enough space to kind of escape, if you need to escape.

Sally described a need to be away from the noise and activity of others; much as I appreciated the space I found on my early morning walks, physical space gave her a sense of relief or respite from the demands of interpersonal contact.

Several people had no choice about where they were admitted, and yet these places became their healing places. Alice and Colin were compulsorily admitted for lengthy periods to mental health units; the geographic sense of where these places were did not seem particularly relevant. They were both locked in, with consequences for their access to the outside world: 'but still it was a locked unit... we didn't want to be there, you were forced to be there'; and 'I was made a special patient; I got taken from the courts... and I found myself in there'. Both described noisy, challenging places but each found or created a sense of space. Alice talked about the challenge of being in the first of two locked units, a place within which she felt suffocated.

Being locked up, it's a massive challenge. There were times when I just could hardly breathe I was so overwhelmed by it.

She was subsequently transferred to another ward; despite still being locked it felt different.

You walk into the lounge, and there's this big tall ceiling and you feel like you've got some space around you, you're not rammed into this little tiny space.

This experience of space around her, created by the physical architecture, had a significant impact on Alice and as she described this I had a sense of there being room to breathe. Colin's bedroom was the place he escaped to; this gave him a physical place to be, but there was also a sense of freedom in this personal space. Rather than being stuck in this locked environment, it was as if his bedroom released him, giving him space to wander.

We all made the best of our rooms; we could make ourselves comfortable... that was a release in my room, to escape.

I was reminded of my bedroom, with my art therapy paintings on the wall, and of bed-rest. I earlier described bed-rest as ‘a time-out of sorts’ but I wonder if it could also be conceptualised as a way of creating space to be able to stay with my feelings and my thoughts; and to be looked after while I did that.

The theme of finding and creating space recurs throughout this thesis, becoming important as we consider the nature of healing: if exploration is fundamental to healing then so is space, for it is space that we explore, space becoming place as it is known. Creating space in and around our illness experiences offered potential for new connections and understanding; developing meaning to transform our suffering. Space in this context is conceptualised as space within or between, this being physical space (both distant and local), and interpersonal space; and space within, experienced as space to think and to feel.

Creating spaces for healing

With little consideration of the perspective of service-users, the ‘what’ and the ‘where’ of mental health facilities continue to be debated in the psychiatric literature. A major focus of reform in the development of services, it is in these aspects that historians have identified recurrent cycles of care (Fagin, 2007). The ‘where’ or location shifted from inner city general hospital based (1700s), to the edges of town or isolated rural settings (1800-1950s); deinstitutionalisation prompted a return to the inner city, facilities often co-located with the general hospital (1950s-current). In England at least there has been a recent move to build stand-alone units in the local communities; another turn of the wheel perhaps. The ‘what’ or type of facility has evolved from institutions or asylums with thousands of inmates, to acute mental health units or wards (my local mental health unit has beds for 70 patients); more recent developments include respite facilities: community based residential ‘alternatives to admission’ for a handful of clients.

I benefitted from being in a rurally located facility hundreds of miles from home; with many physical similarities to the asylums of old, I wondered if everyone needed a similar opportunity. However, another way of understanding my experience emerged in consideration of the stories of other participants. Rather than the physicality of where this hospital was, there was meaning and purpose for me in the spaces that this created. We each found and created the space we needed in different ways, this being physical space both

distant and local, interpersonal and intrapersonal space. In space we found relief from our distress, with room to roam and explore. When we were overwhelmed by our experiences we needed space to perhaps 'take a step back to see the bigger picture'.

We found space in physical aspects of an environment: a bedroom, a high ceiling, the openness of countryside; sometimes space was created in temporarily letting go the responsibilities of home, stepping away from the busyness and noise of a hospital ward, a supermarket, or life in general. Creating distance from what we had known, space held the possibility for something new. If healing is conceptualised as a journey of exploration, then it was in space that we explored; it was in the unknown-ness of space that we found new understanding. Space is dynamic allowing movement; but also allows us to find places to pause, captured in those moments of stillness beside a reflective pond. When we were unwell we felt stuck, hopeless; although the unknown-ness of space could be scary, it was in space that we had the opportunity to re-define ourselves, finding new meaning.

Our stories suggested that our healing places were something more than was implied by our traditional expectations of a hospital as a place to be unwell. While acknowledging the need and desire for care, these were also places to live, creating opportunities for active engagement with our illness experiences and how these affected our lives. We entered our healing places when we were suffering: disconnected and fragmented, often distrustful of ourselves and our world. We needed a haven, a place to ride out the threat of our illness; somewhere to feel safe and protected. These were places where we felt held, metaphorically not physically; this holding provided a counterpoint to our sense of fragmentation. Sometimes a haven was enough, allowing us to continue our journey at home in our everyday life. But my experience, and that of others, suggested that these places could be something more. These were also places to learn and explore; and at times they might not be easy places to be. To serve the purpose of healing, these needed to be places to live (perhaps this is the necessity for 'home'); providing safety in its broader sense, these were places where we continued to feel held enough while we did the hard work of exploring ourselves in relation to others and our environment.

The 'what' or type of facility tells us something about we can expect of a place, providing a context or purpose for being there. It also tells us something of who we are or are considered to be; when our self-definition is fragile or lost, we can come to be defined by place. We variously referred to our healing places as somewhere different from before, a hospital but not as we knew it, and not home but home-like. These places were often not what we

expected, or had experienced before; we were not in that other place, both physically and metaphorically, and perhaps by extension we weren't who we thought we were or expected to be: sick, helpless, hopeless and lost. These were places of healing and therefore we were on a journey to healing; this is the interplay between place and self.

Chapter ten: The physical environment

When Gesler (1992) first developed the concept of therapeutic landscapes he identified four aspects of place that promote healing: the natural, the built, the social and the symbolic. As the concept evolved the built and natural have come to be clustered within ‘the physical’ while still maintaining some distinction. I have found it useful to separate the two; when I reflect on my experience at the Hall I tend to think of the built environment as distinct from the natural, they provided me with different opportunities. The grounds and surrounding countryside became an important part of my journey, as well as the telling of my story of that journey; this was where I found space to roam, literally and figuratively. The buildings served different functions; these were more social spaces, both formal and informal. The buildings also ‘held me’, they provided me with protection, a haven; although as I write this I realise that my walks in the countryside were also a haven, an opportunity to be by myself, a moment of respite from the busy(i)ness of being in relationship with others in the hospital environment. This is the artificiality of separation: aspects of the building gave access to the natural; equally the natural enhanced the experience of the built. It is also difficult to separate the physical spaces from what happened there and the people who populated the rooms. The lounge, with its heaters and a hot cup of tea, gave me comfort on a cold winter’s day. The windows made me aware of the snowfall outside and, when I was ready, opening the door let me enter this outside world. Although presented as potentially disparate elements of place, it is in our stories that the interplay can be found, creating places with meaning.

The Built Environment

The Hall was divided into three wards; Pinel ward, my ward, had two floors: the ground floor with our lounge, kitchen, dining room, nurses’ office and two bedrooms; and then upstairs a long corridor with bedrooms off each side. The bedrooms at the end of the corridor were the best rooms, because they had wonderful views through the windows to the gardens and the sun poured in. But you didn’t get those rooms until you had been there for a while.

... and the psychodrama room and group therapy room – my memories of those spaces are so vivid, always populated with people, little stories along the way. Wednesday afternoon was always psychodrama. We would make our way up to what had been the old hospital laundry, the sinks and coppers long gone; the room now furnished with carpet and comfy old armchairs. I remember the

anxiety, the anticipation. Would I be picked this week? Would it be my turn to recreate my world in drama or would I play a part in someone else's life?

... and the lounge: armchairs and couches lining the walls; coffee tables in the middle and a piano at one end. This was the venue for our daily ward meetings, for music therapy groups, ward activities and in the evenings a place to sit and talk, or a place to curl up and read. Also for our farewell afternoon teas or suppers, and I remember a music evening – the piano, my violin, a guitar and voices.

Consistent with the therapeutic landscape concept I have taken the built environment to mean man-made structures: the buildings and their design. There were many ways I could have analysed our stories for aspects of the built environment. As discussed in the earlier literature, repeated studies have generated lists of disparate architectural and interior design features that are thought common to healing environments. The stories that people told me did not lend themselves to such analysis; in some ways these elements were also not important. As Golembiewski (2015) suggested, the silver bullet won't arise in a particular colour or texture, rather it is likely to be a complex interaction of people and place that create a particular narrative of healing.

Some aspects of the built environment can be deduced from the major themes of the previous chapter: creating space, and what these places were, and won't be discussed again in any depth. Our healing places were often home-like, the architecture and furnishings contributing to this sense: 'like an old manor house', 'a farmhouse', 'a pool table and CD player' keeping it 'kind of normal'. These were places where we could have a bath when we wanted to; knowing where the kettle was added to the familiarity of 'home'. The high ceiling of a ward and art studio created a sense of space, as did the privacy of our bedrooms. The physicality of some environments contributed to a sense of imprisonment: the click-click of the key in a locked door, the booming corridors and the fences that caged us in.

In this chapter I tease out other aspects of the physical place; in keeping with other sections of the analysis, I was drawn to themes with emotional intensity or resonance, either for me or as I sensed for others. Many of our descriptions of the physical environment were enriched with accounts of the way the places were used for social and other activities. My mind goes to particular rooms: my bedrooms, the lounge, the dining room, the psychodrama room, the gym; variously private and social spaces, each was the setting for a story that I tell that says something about my experience of place and healing.

Cared for and cared about

I am not sure how much I knew about it before I went there, but this was a place that felt good. The buildings were old; they're not grand and they are not really fancy but they were really nicely looked after. Like my bedroom – I had an old spring bed with a blue floral duvet on it; and old wooden sash windows, but it's all well looked after.

Being cared for and cared about was a recurring theme in this project, being expressed in the concept of a haven, and later in our interpersonal relationships. When I arrived at the Hall, and at times during my stay, I was distressed and suffering; at least initially I needed to be cared for. Although old, the buildings and the grounds at the Hall appeared to be well maintained and comfortable, suggesting to me that they were cared for and valued; this care perhaps meant that I too would be looked after, cared about and comfortable. Particular aspects of the buildings and their design suggested this care: my blue flowery duvet, the comfy armchairs in the psychodrama room where we re-created our distress; the lounge with its armchairs and couches was a place to curl up with others around, and the venue for our farewells. I didn't know at the beginning what these spaces would come to mean to me but I would have been reassured by their familiarity. As I continued to engage both privately and socially with these spaces, their meaning would grow, taking on symbolic value in the story that I tell.

Caring for the physical space was an expectation of all the users of Fran's art studio.

It's their space so they should care that somebody does the dishes. And looking after each other and the space, and making sure areas are cleaned up after; it's about being considerate to who's coming in after you.

Fran suggested a link between physical and interpersonal aspects of care, and the meaning this conveyed: doing the dishes was not just about keeping the physical space clean, it was an expression of care towards others. Being considerate suggested they were valued, and that they belonged: 'it's their space'.

Barb made a similar link between taking care of the physical space, and how she might be treated. I was reminded of how she felt welcomed, arriving at friend's house in the middle of the night.

[Although] she struggles to make ends meet and none of her furniture matches, it's spotlessly clean. She takes huge pride, and she does things like take flowers out of the garden and make little chains. She's very similar in nature – very caring, very nurturing.

Like the Hall, this environment wasn't expensively furnished but Barb sensed her friend's pride and care for her home. She suggested that the house reflected her friend's personality, telling her something about how she would be treated: she too would be nurtured. This home, a haven for Barb, was in stark contrast to the institutional environment where she had previously spent time.

The institutions were [pause] not grubby, but they were always neglected, even when they weren't. I remember they used to paint the bathrooms and that relatively regularly; maybe it was the colour scheme but they always looked old, they never looked fresh. I think in some ways it reflected the kind of neglect that went on with people.

Where I experienced 'old' as having substance, Barb experienced it as neglect; while this may have been due to furnishings (Barb questioned the impact of the colour scheme, and I commented on my blue duvet), Barb suggested a more complex interplay. She perceived the institution as both neglected and neglectful; while recognising that practically the buildings may not actually be neglected, the place imparted a sense of physical neglect. Barb suggested that this perception was connected with the way she felt treated, she was neglected; her view of the physical environment was perhaps interpreted in part through the lens of interpersonal neglect. In a written communication sent to me after our first interview Barb expanded this interplay.

I realised that the institutions permeated an environment of pre-ordained obsolescence which infiltrated into my soul. It was a place to give up.

This was a place that had been given up on, a place that had no purpose; it was no longer valued. While this might be considered a consequence of the last years of asylum care, the experience of others e.g. Janet Frame (1984) suggests this neglect was more longstanding. 'This was a place to give up' suggested that not only was the place obsolescent, Barb would be given up on, and she should give up on herself. In contrast to her friend's home, Barb did not feel cared for and valued; and it is likely this arose not only in response to the physical environment but in the interplay between the physical and the social and the meanings these conveyed. This place infiltrated Barb's soul, pointing to how our perception of the physical and broader environment becomes absorbed or integrated into our sense of self.

Sally's experience of hospital also suggested that the physical environment alone did not convey a sense of care; like my experience of the Hall, newer and brighter was not necessarily better. Talking of her healing place she said:

It's an old building: not flash by anyone's standards and it certainly doesn't have top star facilities.

She compared this to another hospital:

I went to [the other place] where they're completely new: en-suites blah, blah, blah. The environment was supposedly better but you still had all this old school behaviour happening.

A 'supposedly' improved environment was not reflected in changes to Sally's experience of either the interpersonal relationships or things that happened there, so wasn't experienced as an improvement. There remained a dissonance between the physical and other aspects of the environment, and I was reminded of my optimism when we moved, professionally, to a new mental health unit. I remember our hope for improved care, and my subsequent doubts and concerns. Our perception of the physical environment can tell us something about how we will be cared for and cared about, but perhaps this interpretation is dependent on other factors forming a coherent whole.

Bedrooms

I had three different bedrooms in my time there. When I first arrived I was given the bedroom beside the nurses' office; across from the dining room and close to the lounge. I just remember it as a space to sleep; it felt different to the others. But it was comfy enough, and it was my own room. It was in the middle of things and you knew there were people around. I also remember it as a place to come back to when things were not going so well.

There was one particular bedroom that I had for maybe 3 or 4 months; this is the room that I think of as my bedroom, the room with the blue floral duvet and the sash windows. I had a lot of my art therapy drawings on the walls and a desk where I could write and do things. It felt private; up the stairs and at the end of the corridor, you didn't get there unless you were going there, people weren't going past your door all the time.

I had several different bedrooms during my time at the Hall, each serving different purposes and becoming more or less mine. I sometimes needed a room that was 'in the middle of things', but the bedroom that is most vivid in my memory was 'at the end of the corridor'. This was, and always will be, my room; a comfortable and private space, that was decorated with my personal things. The furnishings served a purpose beyond being functional. My bed was a haven, as well as a place to sleep; my blue duvet spoke to me of home. The desk was a place where I could work, that being the personal work of exploration and discovery: usually

writing and drawing. The walls were a place to hang things important to me, in plain view to me but away from others' eyes. This was my safe place, a place to be, sometimes to hide, and a place to think, to write, to read, without scrutiny.

Bedrooms were a prominent feature of most people's descriptions of their healing place: the way this room was used and what it meant to them. Our bedrooms were not simply places to sleep; these were spaces in which we created our own place within place.

Having my own space

Our bedrooms were spaces that we often made our own. Colin's bedroom was where in a locked, often noisy environment, he found personal space.

It had a single bed and I had all my clothes. We had all our decked out stuff; a lot of us had televisions; I bought a guitar and amplifier – self-expression which I feel is important... Actually it didn't look too dissimilar to the way my room looks now.

In contrast with the sterile hospital that it was part of, Colin decked his room with personal belongings. Being able to express himself in this way, perhaps facilitated the process of finding himself. It is interesting that he described his home now, looking like that bedroom suggesting that he carried it with him; its meaning was such that he recreated it in what has now become his home.

David had begun his story telling me about sitting in his bedroom at home, talking to the wall, listening to his voices. He associated admission to hospital as a new start, an opportunity for things to change. The way he used his hospital bedroom supported this change.

In my section of the [bed]room there were little cubby holes where I could put my papers, and the other side I put pens in. I started to organise myself there really. I started to feel okay this is a place where I'm starting off new... learning how to organise myself again.

Although this was a shared bedroom, David had his own section which he used to begin the process of 'organising' himself. I was reminded of the way he described his experience of 'the blocks that were... scattered', his bedroom's shelves providing a physical resource to begin his personal coming together or integration.

Alice talked about several hospital bedrooms. As she progressed through these spaces, and on her journey, she appreciated the increasing privacy and sense of this being her own space, to manage as she chose.

In the first unit you have to stay out of your rooms during the day. You're being medicated up to the hilt, so you just want to lie down and go to sleep [but] there's nowhere to go. You can't even turn your own light on in your room, and you've got no privacy.

Physically that [next] unit made a difference; you can turn the lights on and off in your own bedroom and things like that... [So did you have any privacy?] Not really, you had your room, but the rooms have a big window in it and you're being checked every half hour.

Finally [in the last unit] you had your own room, and that was a fantastic feeling, just to think I can shut my own door. They were very small, but you had your own space, and you could sit and read your book.

Like others, Alice's bedroom was the place she went to retreat, to 'curl up' when she was distressed, or to read a book. Early on she described a sense of minimal control over her environment; as her journey continued she moved into a room where she experienced greater autonomy. This was her own space, her own room where she had privacy. Alice commented that she would have liked the earlier environment to be different, but also that the later freedom came at a time when she was already part way along her journey. She went on to acknowledge that, particularly early on, 'possibly if we hadn't been well supervised [we] would have killed ourselves'; this reflected a similar awareness to my need for different bedrooms at different times.

Helen also emphasised the privacy aspects of her bedroom. When she first arrived in the ward she had a bed in the female dormitory which she described as open, with no privacy. Later she moved into her own space, a 'little cubicle'.

We had little cubicles, a glass thing and a door; the staff could look in and see you in your room, but there was a lot more privacy. And I was right at the end of the dormitory so there weren't many people walking past my room. I didn't really like the open dormitory thing; when I was in my own cubicle it felt like it was just my own little space.

It surprised me that Helen spoke with such fondness of a little cubicle with glass that staff could look through. I imagined her room as relatively stark compared to my bedroom at the Hall, but it seemed critical that it was her 'own little space'. I wondered if she grew into the room, it became her own, partly as a function of the length of time she was there. It was her own space, becoming her familiar place as she came to know it, being incorporated into her

story of a transformational time. As with other stories, the room and her experience of it perhaps cannot be separated from the larger story.

Each of these excerpts described a bedroom that was 'my own space'. Inherent in the word 'my' is that our bedrooms were, or became, personalised. For some we made the room our own, for others it was done to an extent for them, such as Lauren's bedroom in respite (page 179), 'furnished quite differently to hospital' or the bedroom that is hers when Barb stays with friends (page 183). We used our bedrooms in different ways: sometimes just to be, or to escape; or to find the space for self-expression facilitating the process of piecing ourselves back together. Our bedrooms were places that gave us privacy (more or less), although sometimes that privacy was tempered by a need to be around people.

Social spaces

There were times when I was struggling, and rather than the privacy of my upstairs bedroom, I needed to know that people were around.

I remember times when I just needed to be and wanted to be with people, like when I moved back downstairs for a while, into the bedroom by the nurses' office. This was a room where I could hear the activity of the ward: the nurses in their office through the wall; people heading for the dining room across the hallway. That was really important for me. I was going through a pretty tough time and feeling quite distressed, and it meant the nursing staff could pop in on me regularly through the day, have a chat, check out how I was doing. And I could also hear people were around and that was really important.

When I was particularly distressed and struggling, trying not to go away into that deep dark hole and feeling lost and alone, I needed to hear the activity of the ward. After a few days, as my distress settled, I moved back to my bedroom upstairs, which recognised my need for different spaces at different times. I discussed earlier the various bedrooms that Alice lived in during her extended stay in hospital; although she would have liked more control over those first bedrooms she also acknowledged her need for supervision to keep her safe--or perhaps it was connection she needed. Barb felt safe just knowing that her friends were around.

So I can be in the bedroom and they can be out in the lounge... I can sense their presence, and that is sufficient.

The ways we used our bedrooms pointed to a need for both private and social spaces. This flexibility was also identified by Fran, talking of her art studio.

There's a big, open studio space... and it has a big group of tables where people that are doing whatever, whether it's mosaics or print making, are clustered. We also have a small room for the writing group. And there's a bit of a place out the back where some people who are making art but not in classes have their own space, where they can get on with whatever they're doing at the time. So it allows for a little bit more versatility.

The studio provided open spaces where people could cluster, smaller spaces for more intimate disclosure, and a place out the back to get on with one's own work. As will be discussed, later, these differing spaces provided Fran with opportunities to connect with herself, and with others.

Connection was a fundamental part of our journeys of healing, both connecting with ourselves in our own space, and connecting with others in more social spaces. While this section has focussed on our experience and use of our bedrooms, the need for social spaces was apparent in the many other rooms that I remember at the Hall: the lounge, the dining room, the gym, the psychodrama room. These served varied functions supporting both formal and informal interactions with people. The lounge was a place to sit and talk, or to read while the activity went on around me. The group and psychotherapy rooms had more specific functions, supporting the formal work of our recovery; these functions will become more apparent in chapters eleven and twelve.

The other places

Some of the more evocative extracts of our stories related to physical environments that we considered unhelpful, leaving me with powerful images of places we didn't want to be. This was in keeping with other research reporting that the physical environment was only commented on when negatively experienced (Gilburt et al., 2008), perhaps being most noticed when there was a lack of coherence with our perceived needs.

Lauren told me about two contrasting physical environments; both bedrooms, the first was in a community respite facility. She was only there for a short time so had little opportunity to make it her own, but like others it too was home-like, in part created by the furnishings.

There are four rooms and they're furnished quite differently to hospital. They all have their specific duvet pattern, they're nice ones with nice sheet... and the room sizes vary slightly, so what they have

in their rooms varies slightly as well. They all have normal stuff: lamps and clocks and bedside tables and drawers to put your clothes, and really awesome rugs.

Each room had its own character, Lauren commenting on the awesome rugs and the duvets, which evoked in me a sense of care. It seemed important that the rooms varied in size, in contrast to the regimentation of the usual hospital environment. Perhaps like Colin and me, these qualities told Lauren that this was ‘her’ room, that she was not just one of many. She had earlier described a bedroom in the inpatient unit: a very different experience.

There was a small bed up against the wall and it didn’t look very comfortable. And a slab of wood that I guess was supposed to be a desk and some drawers and they were all attached to the wall. I can’t remember the colour of the walls, it was blank.

I remember having a powerful emotional response to the contrasting images of these rooms. The latter seemed stark, colourless and perhaps soulless: it was ‘blank’, lacking the richness of the other room. I was reminded of the dark places some of us went when unwell, where we felt disconnected from others, ourselves and our physical environment. Lauren went on to say:

If I stayed in that room long enough I can’t ever imagine coming to any kind of place of healing. You know nice people could talk to me in that room or whatever and it would still be impossible.

Lauren suggested that the aesthetic of the physical environment, albeit only one aspect of her care, was a necessary part of healing. Invoking the word ‘place’ to refer to her personal experience of healing, Lauren alluded to the interplay between the external physicality of place and its internal representation. Contrasting with the richness of the bedroom in respite, residing in this colourless room was not a healing place to be.

Fran similarly described a stark hospital ‘bedroom’. This was a room which allowed no escape from her distress, neither literally nor figuratively.

What always got me was being locked in a room the size of an elevator with a mattress on the floor and I was supposed to calm down in that sort of a space. It just didn’t make sense to me.

This was how Fran began telling me her story; it had been a lasting and vivid memory, an experience that didn’t make sense to her. I heard the hurt and anger in her voice, her description seeming to sum up her experience of this hospital that conveyed little sense of being cared for, or cared about. For Fran, this room was not a haven.

Another room in a mental health unit was described in similar terms; this was also an unhelpful experience.

It was all the same colours, pale green, the carpet was yuck and, for a building that was a year old, it looked decrapitated. It all kind of looked the same; the beds weren't beds, cabinets weren't cabinets; bookcases, the chairs and couches and stuff were very industrial.

There was a harshness to this description, with no sense of comfort or welcome, perhaps confirming a perception of the world as uncaring and unreliable. When I talked of my 'other places' I described them as 'bland'; although I attributed this to the memory effects of ECT, several of the comments above are similar: 'it's all the same colours', 'it all kind of looked the same', 'it was blank'. In contrast with the richness of the bedrooms in our healing places, these rooms were uninviting, with little to tempt us to stay. These were powerful evocative images, the external perceptions perhaps mirroring our internal sense of places we didn't want to be. These environments confirmed our place in the world, with little hope for anything different.

Quiet, warm, airy and light

When I think about the Hall, I remember it being warm and light. It had lots of windows with views to the gardens. My bedroom had old sash windows that I could open in summer to let in the breeze; and the sunshine that poured in.

I don't remember noise, but I also know that I wrote back then, 'I remember sitting in the lounge inwardly screaming at the noise, the voices, the activity. LEAVE ME ALONE.'

And I remember the blackness of my despair, and the times it felt like the sun came out.

Ambient aspects of the physical environment were commonly identified as important features of our healing places; my memory of the Hall was that it was warm and light, with fresh air when I wanted it. I don't remember the Hall being a noisy place; I do remember my intolerance of noise, and at times wanting everyone to go away. Other people also referred to temperature, air, light and noise to describe aspects of their healing place, these sometimes being a metaphor for their emotional experience of the place or themselves.

A number of us struggled with the noise of our (usually) hospital environments; in contrast, Emily told me (page 165) of her appreciation for hospital which removed her from the noise of life. Echoing her description of supermarkets, Colin described hospital as:

... a very noisy place, that's one thing I found annoying. It's like a din, just general people noises, vacuum cleaners, stereos; it takes it out of you.

Noise had the potential to make us feel unsafe, one person suggesting that it was not simply the level of noise that was important; the type of noise and its associated meaning could alter our response.

I never felt particularly safe there because it was so noisy. I suppose if it had been nice noise then it wouldn't have bothered me, but there was a lot of yelling and calling out and things going on. It was the type of noise rather than the noise itself; I found that distressing and disturbing.

Noise, or its absence, was sometimes referred to in a metaphorical sense; a haven removed us from the noise or busyness of life. Although Barb had 'really come to appreciate quietness and solitude', she identified an earlier and different sort of quietness in an old-style institution.

All the villas I was in were always so bloody quiet. But that was because everybody was so medicated; all the action happened outside. I suppose it's that institutional thing of: this is how things are done, so there are no disturbances. Our role here is to keep you as quiet as possible. No one is really interested in what you have to say; the important thing is to stay quiet.

This was an imposed quietness, without an associated sense of peacefulness; a quietness where she wouldn't be heard. This was quiet associated with stillness of a different kind: the stillness of nothing changing and of no hope. I remember the times when I needed to be around people, to hear the activity of the ward, to be reminded that I was not alone and perhaps that I still existed. As I reflect now on the 'noise' I encountered sitting in the lounge during my early days at the Hall, I am sure the decibel count was not significant. I was so overwhelmed by my distress that the activity of others' lives was an intrusion; I needed space from the demands of life. And yet I am reminded of being in a place where 'I couldn't be heard and I couldn't hear myself, a lot of noise and no noise'; perhaps needing sounds of caring to fill that void, quiet but not silent.

Warmth was also a repeated association with our healing environments. Colin linked the sensory experience of warmth with how he felt in himself and his ability to connect with others.

Warmth, warm colours, warm carpet made me feel nice and warm and comfortable and able to relate better.

Extending the interpersonal link, Barb said of her friend's place,

There's a room downstairs which is my room when I stay. It's always warm... and it's warm from her and it's warm because it's nice and sunny and stuff like that.

The warmth she experienced was not just a matter of temperature; it was felt within the relationship with her friend. Helen also conflated this sense of warmth.

I just found it a warm place, both in temperature and also how they looked after you.

I also said that the Hall was a warm place; yet the buildings were old, I am sure there was no double glazing and in winter the snow could sit on the ground for days. Our use of the term warm had both physical and metaphorical meanings. The latter referred to qualities of our interpersonal relationships and emotional responses to the environment, reflecting a deepening of connections. A hot cup of tea might warm my hands and my heart, so might the conversation that went with it, with perhaps one enhancing or informing the experience of the other.

Air, light and sunshine, although possibly considered an aspect of the natural environment, were often accessed via the built. I vividly remember the sunshine pouring into my bedroom through windows that I could open to let in the breeze, and the favourite couches by the windows in the lounge. Alice also appreciated the ambience of her environment.

One of the first things you notice when you go there is suddenly everything's lighter and brighter... I remember walking into that room and thinking, wow this is so different. You want a physical environment that's good to be in; things like light, space, airiness, comfort, food are really important.

She equated a 'good' environment with one that was light and airy, having talked of previous locked environments 'rammed into this tiny little space' where she struggled to breathe. There was a sense that with light came hope, and I was reminded of my experience of depression as a cold, dark place where I could hardly breathe.

Fran's eyes lit up with enthusiasm when she described the art studio that was her healing place.

The actual studio has very high ceilings and there's a big, open studio space which is very light.

Compare this to her description of two mental health units:

The psych ward was on the sixth floor, and there were no open-able windows and sometimes if you were there for a long while you didn't get any fresh air for weeks.

and...

It was noisy; quite closed in, quite dark, quite confined. It was horrid.

I was aware in myself of an emotional and almost physical response to Fran's description of the two environments. Fran's means of finding herself was creativity and I wondered where I was more likely to be creative: in her art studio or these hospital rooms?

Sally's description of an early experience of hospital admission emphasized the importance, for her, of the ambient aspects of place.

It was just incredibly relaxing. When I think about it I just see light and warmth and the sun; and out the back, there were decks to sit on. It seemed like people would just hang out; even the staff would go out there, so you'd go and join them to sit in the sun. And there wasn't this division between inside and outside. In other places you didn't go outside unless you smoked really; there was this purposelessness to going outside.

When Sally reflected on a place that she considered healing for her, she remembered light, warmth and sunshine associating these with a sense of relaxation, in stark contrast to her sense of desperation when depressed. The outside decks in the sunshine were an invitation to move beyond the internal environment, also creating the potential for social interaction. She compared this experience with being in a locked ward.

There wasn't a courtyard, there wasn't anything. So if the door was locked you just didn't have fresh air, you didn't have the sun, you didn't have anything like that. There were no places to sit that the sun would just stream in. And that was hideous, hideous and for the first while it didn't matter; but yeah it becomes punitive.

The lack of fresh air, light and sunshine in this environment became associated, for Sally, with a sense of being punished. As people described these varying environments: light-dark, quiet-noisy, warm-cold, airy or not, I noticed my emotional and sometimes visceral

responses. There is a sense in each of these extracts that the physical ambience of a place evoked emotional responses that told us more about the place and its people than the simple presence and absence of sensory experiences.

Windows

I have lovely memories when I think about my bedroom at the Hall. The sunshine poured in through the old sash windows; and it wasn't just the sunshine, I remember the frosts on the lawn and misty mornings with my views across the garden and through the trees. Sometimes when things were really bad, I would be tucked into bed for a few days; I could curl up with my distress and just through the window the world was still there.

Windows were mentioned as part of the built environment in most people's stories. My bedroom window let me see the outside, to watch the changing seasons, while providing protection if I needed it. If I opened the window a little, I could hear the casual conversations of tea drinkers in the sunshine, reminding me that the world was just there. The window of my therapist's office provided somewhere to gaze, when I was struggling to make sense of my feelings; the window of the nurses' office let me see who was there, providing reassurance or a barrier of sorts, depending on my needs of the day.

Barb liked to be able to see the world through a window so that she didn't feel too cut off.

Being able to see it [the world] through the window, it doesn't cut me out too much from the outside... I'm not removed. So yeah the idea that the outside is just out there, actually makes me feel better; being in front of it but there's a barrier, so people can't get in.

Being able to see the outside is a motivator for me, to be out there. I don't have to go far; but it sort of chips it away. The desire to go out there becomes greater than the anxiety to be inside.

She described windows as providing connection, protection and motivation. Being able to see outside helped Barb feel less removed, discouraging disconnection and perhaps reminding her she hadn't gone away, or that the world hadn't left her. The window also gave a sense of protection from those things she feared, whilst also offering her motivation; rather than feeling helpless in her illness, being able to see the view chipped away at her anxiety, replacing it with the desire to step outside.

For others, windows were the means to access sunshine and light. Windows ledges and seats added another dimension to this experience.

[The place] had a lot of windows and you could sit on ledges in the windows and stuff. In other places you don't have that. You take it for granted when you have it, but when you don't...

Sally's window ledges perhaps invited her to sit, a place to rest from 'fighting the fight'; much like the window seats at my home, the most popular spot in the house on a wet or cold winter's day.

In contrast, the window David described provoked a sense of disconnection. When first admitted to hospital he went into a high care unit.

It felt like I was in prison, the windows being blurred. And it's just facing the carpark, now that I've visited. I didn't know that there was a carpark on the other side, that's how set back I felt. All I saw was a hazy window, and light, and then no light, and that was when it was night-time. All I could see was just black or white, but it was hazy, so I wasn't really connected with myself, not knowing which direction I wanted to head in my recovery.

David described windows that were blurred or hazy, presumably designed for privacy from the carpark just outside. As if imprisoned, unable to see out, David experienced these windows as disconnecting him, setting him back, not just from the outside world but also from himself. His inability to see the outside world also had metaphorical meaning for David: he couldn't see in which direction to go in his recovery.

Other windows served different functions, with a reversal of gaze.

My bedroom door had a little window in it. You'd be doing something and the cover would open and then shut again. So you'd think okay someone's going to come in; and then I'd realise nope, they're not coming in. And that was how they'd do their checks.

and...

It was a relatively new building and the bedrooms all had windows but the biggest windows looked into the lounge, towards the nurses' station I think, so it was kind of weird.

These were windows to be seen through, to be observed: 'this was how they'd do their checks'. There were also windows that provided protection but not in the sense suggested by Barb.

There were bars on the window. It had the look of a concentration camp and that's the way I thought of it.

and...

... windows with blinds between two panes of glass.

These functional elements of windows allude to the physical threat attributed to mental illness, and carry with them an implication of distrust. Windows are an integral part of most built environments, framing a view both inside-out and outside-in. Windows can connect us to a greater world: windows with ledges to sit on, bathed in sunshine, with views to the hills, to the garden or sea; a window that opens to let in fresh air, to feel the breeze, hear the birds or people talking; connecting us to nature or simply a reminder of life; letting light in, or maybe when we need it keeping the world at bay. Windows can serve many functions, and have many meanings; open or closed, opening up or closing down, locked or unlocked, connecting or disconnecting, creating privacy or exposure. A window can tell us something about the place we are in, showing us where we are and where we are going, expanding our horizons; or windows with blinds between two panes of glass; windows with locks, and occasionally bars, made out of glass that no-one can smash. Windows can be for looking in or looking out: who is the viewer and what do they see? Windows of possibility? Perhaps it depends on your point of view.

Much like the journey of healing, working on my thesis involved hours, days, weeks and months of sitting at my desk reading, thinking and writing; immersing myself in my story and the stories of others; engaging emotionally and intellectually, seeking a deepening understanding of our experiences, sometimes my head so overwhelmed I couldn't see my way through. Sometimes I needed to walk, but often I found myself just getting up from my desk, to gaze for a few moments through the window. The view out to sea from the front of the house was my particular favourite: ever changing; sunshine, rain, the wind whipping up waves, or a gentle breeze with barely a ripple. A few moments of time and I felt released; something shifted and I returned to my desk refreshed, my head a little clearer, ready to engage again with my work.

What is it that the window and its view gave me? Did it, as a mindfulness practitioner suggested, bring me back to the present moment? But, then I am reminded of the past; the day the dolphins came into the bay and I wonder, with a frisson of excitement if I will see them again today. Perhaps gazing through the window gave me a sense of connection, being re-connected with the wider world. Maybe it was the horizon, widening my vision, metaphorically expanding the horizons of my mind, opening up the possibility of new viewpoints. Or was it simply a distraction, a moment of respite, creating space for reflection

during which new connections may be made? Perhaps it was simply knowing that I could: not stuck with my computer, nor the thoughts in my head.

Finding meaning in bricks and mortar

The built environment provided the settings for many of the encounters that occurred on our journeys of exploration in which we found healing. We arrived in these healing places lost, usually suffering, uncertain and distrustful of our surroundings and ourselves; facilitating healing, we needed to be able to explore, developing connections and making sense of our environments and ourselves. The uses to which we put the spaces created within these buildings supported this journey, sometimes unexpectedly. A set of shelves became the tool for David to organise his life, the writing room was where Fran found her voice, the dining room and a pot of tea was the venue for testing out my relationships; sometimes it was finding a space to ‘hide’ for a while. These were private places and social spaces, supporting the formal and informal doings and beings of our recovery.

We described buildings and rooms that were cared for and cared about; these didn’t need to be new or expensively furnished, rather they were comfortable and home-like. These were places that ‘felt good’, perhaps having a greater congruence with our need for care. We talked a lot about our bedrooms, private spaces that we could make our own, as we began the task of re-establishing our identity. Sometimes, the desire for privacy was tempered by a need to know that others were around. Sometimes this meant being in social spaces, sometimes it was sufficient to know that the world carried on outside our door or window.

We appreciated places that gave access to light, sunshine and fresh air; perhaps because so much of our lives seemed out of our control, in some places we struggled with the inability to control these and other aspects of our environment. Quietness, while sought by some, had potential for mixed meanings variously experienced as providing space from the busyness of life, and as disconnection; the type of sound and what it meant to us became important. Meaning was integral to our experience of most aspects of the built environment: a uniquely decorated bedroom meant that Lauren was not just one of many; a ranch-slider to the outside imparted a sense of freedom; my blue duvet didn’t just keep me warm, it meant I was at home; a bed was a place to sleep and it was a haven. We found meaning in the warmth of a room or a patch of sunshine, and in the care expressed by a bunch of flowers from the garden.

Meaning was perhaps most evocatively evident in our stories of windows. Windows could be understood as providing a view of a garden or a snowfall, being the vehicle to allow air into a room, or giving us some light; but for Barb a window meant she was connected and protected, reminding her and us that the world, and we, still existed. Antithetically a hazy window shut us off from the world, unsure in which direction to go, a window perhaps the difference between a prison and a monastery. Connecting us to a bigger world, windows invited us to sit and watch for a while and when ready to step outside.

The Natural Environment

Bounded by old, low, moss-covered dry-stone walls (a year later I would ‘unwittingly’ replicate these walls for raised garden beds at the herb farm where I re-entered the workforce), the grounds were amazing, beautiful. There were big old trees and lots of rhododendrons that for me will always signify Dunedin. And daffodils; I remember the daffodils in spring under the oak tree up in the back field, or peeking through the late snowfall on the lawn where we built our snowman. Behind the buildings, the property continued up through fields, a track leading through the pine plantation to the top road, and on up to Mt Cargill.

My descriptions of the Hall and the stories I tell, are filled with aspects of the gardens and surrounding countryside, and those experiences continued to enrich my life. The natural world around the Hall became very important, whether viewed through a window, as a place to closely connect with others (I well remember the profoundly personal conversations I had with a friend as we sat in the private space that was the ‘bus shelter’ beneath the garden’s trees), or the countryside where I regularly walked. I have a now long-standing, but then new, delight in walking in nature, and in gardening. I remember the home-picked flowers that nurses would bring me when I was struggling; and later joining the town’s gardening club, learning to make my own tussy-mussies to brighten someone else’s day, and passing on the things I had learnt. Rhododendrons and daffodils have taken on almost symbolic meaning, the daffodil bulb representing the ever-repeating cycles of life, and each spring’s yellow sea under the fruit trees at home reminding me of Dunedin, and times of growth. I am sure my choice of a local herb farm as the place to begin my return to the workforce was a response to my association with the grounds and surrounding countryside at the Hall.

Most of us talked about being out in, or being connected to, nature and identified this as an integral aspect of our healing landscapes. For some access to nature provided a sense of space, but there was also importance in the nature itself and in the meaning it had. Margaret

talked at some length about the place of the natural environment in her sense of well-being, from the view out a friend's window to walking along a wild coastline.

I was the only person on the beach. I did the walk between the tides to the cathedral caves and it was just like I'm in one of the sanctities of creation; a place that was so special and viewed with such wairua [spirituality] from the local people, and it was like [pause], these are my places of healing.

There was a sense of awe and perhaps transcendence in Margaret's description, this landscape connecting her with her spirituality; she suggested that it was in this quality that she found healing. Margaret had been telling me about navigating the storms of her illness when everything was extraordinarily heightened.

I tend to screen anything to do with human interactions when I'm fairly alert and psychotic because it's too busy for me.

Describing a respite facility she spent time in, Margaret told me:

It had a garden and a lot of native bush with a stream down the road. There was this beautiful, beautiful reflective pool with lily ponds in it; it was exquisite. So, you know, those places that help you to reach that point of stillness within yourself, it really is what the brain and the mind and the being is questing; reflective stillness from nature.

It was in this garden with its reflective pool that Margaret was able to screen out the busyness of human interaction, finding the stillness she needed to settle her internal storm. She seemed to suggest that the external environment became reflected or transposed into an internal state of being. Perhaps, also, like the reflections seen in a quiet pond of water, she was able to again see her herself, with the capacity to be self-reflective.

Helen also appreciated being able to go outside.

It was an old institutional building in the country, so there were no high fences. You could just walk outside and you'd see cows and sheep in the next paddock. That helped my progress because [after months in acutes] I felt like a bad person with the fences.... After a bit of time I was allowed to walk around the place.

Rather than high fences, the sight of farm animals and paddocks represented a sense of freedom, influencing how Helen saw herself as a person: no longer a bad person deserving of imprisonment behind high fences. This resonated with Sally's sense of being punished when

unable to access sunshine and fresh air. Having access to the natural environment had the potential for Sally to ameliorate more difficult aspects of an environment: a locked ward.

The outside area was still accessible and there were trees and a veggie garden. It's something about normality and a more homely kind of feeling I guess.

I wondered if seeing the trees and vegetable garden reminded Sally that the rest of her world still existed. When I asked Colin about being able to walk outside his hospital ward, he reflected on a short stay in prison, suggesting a similar association between lack of access to nature and feeling imprisoned.

You need places to walk; I missed the grass. People who are locked in [in prison] are totally surrounded by concrete: a cave. They don't even get to see the sky, to feel the breeze, to feel the rain, to smell the fresh air, to smell the roses. You can get really closed off you know.

Colin suggested a connection between the physicality of being in a prison-like environment, and his internal experience; he felt closed off, disconnected, when he lacked access to nature. This was more than a sensory disconnection of being unable to feel the breeze or smell the air; I understood Colin to mean that he felt closed off from his awareness of himself and others.

The natural environment was sometimes the vehicle for the necessary exploration of healing. Colin took the opportunity to actively engage in a new way when he transitioned to a supervised hostel.

There was a good piece of ground and it was offered to me along with some of the seeds, so I took it up and just went for it. I even got a trough sitting on the veranda outside on the patio, and I put chillies and coriander in there because I'm a great curry man. I got some fresh coriander and that was great, to actually harvest these things and put them in your food. It connects you to the earth and a lot of people tell me how therapeutic it is to garden, to watch things grow, and it was satisfying.

Offered a piece of ground to garden, Colin grew spices that he would later use in his own food. He went on to tell me about the small garden he now had at home; Colin had taken this experience of engaging with nature, and integrated it into his life moving forward. He also indicated the importance of others in how he came to learn for himself: people told him about watching things grow, and experienced it for himself. As I will discuss in chapter twelve, Colin told me of his sense of satisfaction in cooking a curry meal for his hospital

ward; these experiences became part of how he defined or understood himself: he was a 'curry man'.

Later I asked Colin what he would wish for if he became unwell again.

I imagine my perfect place of respite would be in bushland, lots of trees and I think if they actually could, native forests; surrounded by bush robins and fantails and animals and creatures and natural surroundings. That makes me feel grounded and at peace.

I was struck by the richness of this imagined environment that would ground him, bringing him peace and very different from the darkness of the illness experience in which he had previously been embroiled. Although he didn't make this connection, I was aware that some of the wards of his hospital were named after trees, perhaps becoming part of the story of a place that helped Colin place his feet on the ground.

Alice reflected critically on the lack of access to nature in her healing place, referring to the rural institutions of the past.

I think they made a mistake when they got rid of all the grounds. When you're vulnerable and hurting you need loveliness. I know now even if I have a bad day I just have to go to the sea. Just even being by the sea, and looking out over the water, something helps me feel better.

Alice identified experiences that I have had: that somehow having access to nature could alter the way we felt. She suggested that the 'loveliness' of the grounds was a counterpoint to the 'hurt' she experienced when unwell. Being in the grounds of the Hall, or sitting in the sunshine might lift my spirits; equally, so might being wrapped up warmly and playing in the falling snow, or quietly contemplating a view. And sometimes I was revived by feeling the cold, walking in the bracing wind.

But it was not the same for everyone. At times, Barb liked to be a little removed from the outside world, this being associated with a sense of threat. She appreciated being able to see it through a window, at the same time feeling safe and protected inside. More significantly, Emily talked very little about the physical environment of her hospital, either built or natural. When I questioned her about this she said:

I mean it's a beautiful environment... [but] I'm not really a big kind of environment person.

Emily placed more importance on other aspects of the healing environment, particularly relationships and therapeutic opportunities, suggesting that we develop our connections in different ways and to different aspects of our environment.

Walking

I quite quickly got into the habit of getting up early in the morning and I would walk out along the county roads. There was one particular road that ran along the ridge and from there I had a view right across Dunedin, up the harbour and down to the beach at St Clair. At 6.30 in the morning it was really quiet. I would walk most mornings, sometimes with my head phones on and sometimes without. It was a really special time when I just got to be on my own, and I could think about stuff before we got into the busyness of the day. I remember the snow, the elements, and the southerly wind blowing across the ridge from the Taieri plains; the misty mornings hiding the town from view, and the mornings when I watched the sun rise over the sea.

At the Hall, I developed a new-for-me routine of walking most mornings, out along the ridge road with its scattered houses and fields, with a view across the city to the sea literally and figuratively expanding my horizon. I remember the shift of the seasons observed in the changing landscapes and the physical experience of weather, in particular the stark contrast of a warm still day, and the biting cold southerly blowing off the snow. I have described the countryside as giving me space to roam, literally and figuratively; just being able wander in my thoughts, processing things in my own way, in my own time. Walking connected me with the natural environment, with my senses and my self.

Others referred to their experiences of walking: Margaret along the wild coastline beach; Helen, as soon as she was allowed to, walked every day over the hill of the farmland with no fences; Colin missed the grass, he needed to walk. Sally expressed a need to roam as a means to re-establish trust in herself.

You have to learn to trust yourself again, so having the ability to roam a bit is trying to get to a place where, for yourself, [pause] there's that testing to see: is it okay? Because without that, you're going from a ward environment out into the real world and who knows?

Being able to roam was an opportunity for Sally to test if it was okay for her to be in the 'real world' rather than the artificiality of the protective hospital environment. She implied

that walking was also a way of getting to a (metaphorical) place where maybe she trusted herself and felt safe.

Alice, reflecting on the limited opportunities available in a locked hospital environment, told me about her usual practice of walking.

... and long walks really help processing. When I'd do retreats, that's what you would do. You wouldn't speak to anybody for 8 days, but you'd walk, and it's amazing how it brings up stuff that you need to either work with, or come to peace with, or whatever.

I identified with Alice's experience that walking helped her process personal 'stuff'; walking down the country lanes with their extensive views, gave me time in the morning to be by myself. It was a break from the activity of the ward, and somehow created space within from my inner turmoil. The countryside gave me space to roam, physically and psychologically. It was often on those walks that I had a 'light bulb moment': that spark of insight that connected emotion and thought, or past and present. During the latter parts of writing my thesis, walking on the treadmill at the gym might be enough to generate new thoughts, make new intellectual connections, but our experiences of walking suggested the potential for connection to something more. Alice contrasted her retreat experience of walking with being in the mental health unit:

I use to walk around and around and around a million times a day; just this little exercise yard basically with these fences, and lots of other people did too. You're like a caged animal really; you have a level of anxiety that's through the roof, you are often restless; you've got to get out, you've got to walk. You know, you need something to heal your soul really because you're so anguished.

Alice identified a need to walk, the physicality of walking perhaps relieving her restlessness; but, walking in the fenced space of the exercise yard, she still felt like a caged animal. There was no freedom in this walking, neither physical nor metaphorical; as with her illness she remained stuck, imprisoned behind a fence in a place she didn't want to be. Walking in more open spaces helped Alice connect with something more profound: her soul; and I was reminded of Margaret's 'being in one of the sanctities of creation' and Helen's walking across 'a spiritual sort of land'.

Walking is recognised as being beneficial to general and mental health and well-being (J. N. Morris & Hardman, 1997); when discussed in the psychiatry literature this is usually attributed to walking as exercise, improving fitness and altering neurotransmitters

(Callaghan, 2004). My morning walks did improve my fitness after months of the amotivation of severe depression, and I am sure they benefitted me psychologically imparting a sense of accomplishment and agency. When viewed through the lens of exploration and healing these walks served purposes, beyond the physical, that I would argue were even more profound. There was a sense in our descriptions that walking facilitated an internal journey: Sally might get to another place in herself, ‘stuff’ emerged for Alice to work with, and I could wander in my thoughts. These walks were not undertaken with the intention of physically getting from here to there, although they might serve that purpose; these walks created space: space for experience, and for connection with ourselves and with the world around us. Both Alice and I described a sense of thoughts and feelings emerging as we walked, thus supporting the journey of exploration. Capturing this potential for internal movement within the physical rhythm of walking, Edensor (2010) suggested that “the rhythms of walking allow for a particular experiential flow of successive moments of detachment and attachment, physical immersion and mental wandering, memory, recognition and strangeness” (p.70).

Walking has been associated with spiritual journeys for millennia: pilgrims walked to Santiago de Compostela seeking salvation, and to Kumano¹⁵ practicing rites of worship and purification along the way; walking the labyrinth of Chartres Cathedral¹⁶ is considered a tool for personal, psychological and spiritual transformation, and walking meditation is a traditional Buddhist practice. In each of these practices, while the destination may be important, walking is a necessary and some might say the most important part of the journey. Perhaps it is a stretch but it could be argued that each of us identified a spiritual quality to our walking; Alice identified this most evocatively when she inferred the potential for walking to heal her soul.

The healing influence of nature was one of the corner stones of moral treatment, but along with the move to an urban landscape, and the reviling of the rural asylum, consideration of the benefits of nature have been predominantly limited to physical health improvements, and access to the ambient aspects of place: light, sound, fresh air. While much is written about the importance of nature and green spaces for health (e.g. De Vries, Verheij, Groenewegen, & Spreeuwenberg, 2003), very little is written in relation to serious mental illness, except in relation to exercise. There is recognition that access to outside and garden spaces, sunshine

¹⁵ <http://www.tb-kumano.jp/en/kumano-kodo/>

¹⁶ <https://labyrinthociety.org/about-labyrinths>

and fresh air are associated with improvements in mood and distress, but this too is often explained in objective terms: changes in neurotransmitter responses and immune cascades (e.g. E. M. Sternberg, 2009). While our descriptions of the natural environment allude to improved mood, an explanation for nature's healing potential was also to be found in how we experienced nature, and what this told us about ourselves and our world. Nature had the potential to open us up to new possibilities. We developed a relationship with our natural environments, that added to our identities: I became a 'walker', Colin a 'curry man'; Helen experienced herself as 'free', others as spiritual beings. The natural environment provided another opportunity to add richness to our experience.

Building coherence

The buildings and their furnishings, and the surrounding grounds and countryside were the physical manifestation of, and gave structure to, my sense of 'what this place was'. The buildings and the way we used them created spaces with meaning; providing physical spaces that supported the activities, the opportunities, that facilitated healing. The physical and the natural environments became the 'stage sets' for the stories of our journeys. First impressions counted for something, giving us an indication of what we might expect: arriving in these places overwhelmed by sensations we did not understand, often lost and fragmented, a soaring ceiling with plenty of light implied room to breathe; a place that was cared for and comfortable suggested we would be looked after and valued; a window to the garden was a reminder of life. But that was not the end of the story; meaning developed over time.

The physical environment provided the setting for many of the encounters that occurred on our journeys of exploration in which we found healing. The psychiatric literature has looked towards architecture and neurobiology to inform hospital design, further informed by history and socio-political influences such as management of risk, with very limited interest in what could be learnt from the service-user experience. Research connecting the physical environment to well-being is replete with concrete but disparate elements that are reported to be beneficial. Studies have suggested the benefits of home-like environments with both social and private spaces, proximity to windows and access to outside, with natural light and sunshine. Although some of these elements were apparent in our descriptions, for example colour, noise and privacy, interpreting these aspects of place in the context of a journey to healing has the potential to provide coherence to a disparate collection of findings.

When I re-visited the Hall recently I spent some time sitting in their new ‘sanctuary’ a small structure built in the old orchard; a space for quiet reflection, it was peaceful and warmed by the dappled sun¹⁷. It was a lovely structure, and I understand it is well used, but I was aware that I didn’t feel connected to it in the heartfelt way that I was with other aspects of the buildings and grounds. This was not a structure that would linger in my memory other than as something interesting; it had no history for me and we had no relationship other than that moment, suggesting the importance of the way we come to know places. The physical aspects of these environments had meaning that evolved in our experience of and relationship with the place, developing coherence as our journeys progressed, and becoming incorporated into the stories of our healing. As we came to know these internal and external spaces, they were incorporated, integrated into our sense of knowing, for us to take away.

¹⁷ See photo in ‘Moon, G., Kearns, R. A., & Joseph, A. E. (2006). Selling the private asylum: Therapeutic landscapes and the (re)valorization of confinement in the era of community care. *Transactions of the Institute of British Geographers*, 31(2), 131-149.’

Chapter eleven: Sharing the journey with others

I was going to give them two weeks – enough time to sort me out and I'd be fine; that's how out of touch with myself I was. Somehow in the process of arriving and being at the Hall in those early days I must have trusted them, and trusted the place enough to want to stay there, and begin to take down my defences. I don't know how it happened, but I think had a sense that I got to leave my white coat at the gate.

I remember my psychiatrist – I sensed that this man cared about me and cared about what was happening for me. It was about me; it was about me in my heart, not me out there. He/they wanted to understand what was going on for me and wanted to help me with that. When I think about other places I had been, it all felt impersonal; no one was actually getting to know me. It comes down to people who actually bother to [pause]. It's not just bothering, they wanted to know about me, know who I was; what is it that makes you tick?

The other patients were the people I spent most of my time with, and some of them I got to know really well. Hmmm, yes I did call them patients. There were about 60 of us, the population changing all the time as people left and others arrived; all from different parts of the country, different walks of life, different life stories, different psychiatric histories. The mix of people there – it was the same as I'd meet anywhere. There were people that I got on really well with, I made some really good friends; and there were people who pushed my buttons really strongly, like anywhere really.

I arrived at the Hall; not quite as depressed as I had been, ECT had seen to that, but still desperate. I was stuck, disconnected from myself and my world, with my sense of identity in tatters. My relationships were breaking down: 'I didn't have a relationship with myself, how could I expect to relate to anyone else'. I felt lost, alone and intensely lonely and others have talked of similar experiences of disengaging from their world, becoming isolated, losing everyone. Although healing is a deeply personal journey and experience, this was not a journey we undertook alone; this was a journey that we shared with others.

This chapter discusses relationships; specifically the interpersonal relationships that existed within and informed our experience of places that were healing. These were the people who accompanied and supported us on our journeys, and became the characters in our stories. At the Hall, people fitted neatly into one of two groups: staff or patients; we were our own

community. Apart from two brief visits, my family were not a significant part of my experience; they were supportive and we maintained contact, but I had little sense that they were part of my world at the Hall. I also had little contact with surrounding neighbourhoods except on irregular visits to town, and with ex-patients who lived in the region. Although in explicating these relationships there are some similar themes, my relationships with staff and patients were different, they served different roles and responsibilities on my journey.

While for most of us there were similar groupings of relationships, for some the divisions were not so clear. For example, when Barb was unwell she chose to have friends, all with lived experience, to support her in her home, or she spent time in their homes. David identified a key person on his journey being a peer support worker (staff-member), but it was his meeting with her as service user that was his turning point; she was both staff and service user. I was left uncertain about the necessity and criteria for differentiating the varied relationships, also aware that in creating these groupings I risked replicating the traditional and hegemonic structures of my workplace: patients and staff.

In the first layers of analysis, consistent with my experience, I separated relationships into the two groups, staff and patients/service users, arbitrarily assigning Barb's friends and David's peer support worker to 'staff'. The tensions involved in these blurring of roles is one familiar to current mental health services, with its growing workforce of people with lived experience of mental illness. It is also a tension inherent in my experiences: I am staff and I was a patient. When I was admitted to the Hall, it seemed important to me that I could metaphorically leave my white coat at the hospital gate, putting aside my identity as doctor. When I re-entered the medical workforce, despite my best intentions I put aside my identity as patient; one outcome of this thesis has been recognising the tension between or within these identities, and this will be discussed in Part IV. In the meantime, holding the tension, the separation is maintained; 'staff' being taken to mean those people whose identified role was to provide us with care, however that might be defined, as distinct from those who were with us as fellow sufferers.

There are many ways to think about these relationships, many ways in which this material could be analysed. When I remember the people from that time, I know their names, can see their faces and have stories that I tell; I do not remember the words that were spoken, but I remember or experience them emotionally. As with earlier sections of analysis, I was drawn to phrases or excerpts with emotional intensity, moments when my hand went to my heart; most of the themes explicate the subjective experience of relationship, and its influence on

healing. These relationships told us something about the place we were in, ameliorating or transforming the effects of the places we had been: our places of suffering.

These relationships were complex. Although I arrived with my defences strong I was, as were others, extremely vulnerable. Previously I had repeatedly fled from illness back into my life and my work, perhaps to escape myself. This time I was going to give them two weeks and then I was going skiing; instead I stayed for a year. 'Somehow' this time it was different; 'somehow' they managed to get inside my defences, or perhaps I felt safe enough to lower them. 'Somehow' suggests intangibility; there will be aspects of these relationships that are beyond interpretation in this study. I cannot know what the staff and other patients really felt, or what thoughts and emotions guided their responses to me: I can only speculate. I can know how I felt, how I experienced them. Likewise I only have access to the other research participants' interpretation of relationships they experienced, but in deepening my understanding of our experiences there are aspects of these relationships that seem common to all, that supported the journey of healing, and helped create our sense of place.

I begin this chapter discussing our relationships with staff; although we each talked about service users we met, we talked more about the staff (or equivalent) in our healing places.

Cared for and cared about

Being cared for and cared about is a recurring theme in this thesis. Our healing places were at times a haven, a place to be cared for, when we felt unable to do that for ourselves; the cared for and cared about quality of the physical environment suggested to us that we would be treated the same. Care can be defined as the provision of practical and emotional support (Milligan & Wiles, 2010), thus while it could be considered as an activity, care occurs within and can say something about a relationship: the emotional and cognitive aspects inherent in 'caring about'. When I arrived at the Hall and again at times during my stay I felt desperate, I needed a haven. While I had reasonable expectations that, this being a hospital, I would be cared for, I experienced something more: I also felt cared about. I experienced this in the acts of kindness that went beyond the practicalities of day to day care: the posies of flowers from a nurse's garden, the gentle touch on my shoulder, the people who sat beside and with me as I cried in my grief. But more so, this sense of being cared about arose in the relationship: I seemed to matter to them. Aspects of our relationship that conveyed this caring: their desire to know me, and their willingness to be 'real', will be discussed in the next two sections.

Other people talked about their experiences of being 'cared for' and 'cared about' in the same context, suggesting that they were related but not necessarily interdependent. Alice had

similar expectations of care as I did, describing her relief at being transferred from prison to hospital; reassured by the presence of staff and trusting their abilities, she knew she could relax she would be looked after. Not only did she feel cared for, Alice also felt ‘cared about’, linking this experience to compassion.

You can pick the vibes – whether they actually care about you. Later on I actually experienced things like love, people being loving and kind and helpful. There were people who were very compassionate; you can feel that, but they also display that compassion.

Alice’s experience of being cared about arose both through the actions of others, and in their emotional responses to her: she experienced them as loving, kind and compassionate. Compassion was not a word I had used to describe my experiences, but Lauren also expressed aspects of her care in this way.

Healing comes through people because I guess I haven’t been able to have a healing relationship with myself. So I have to rely on other people to foster that in me by kind of role modelling caring, compassion, empathy. And that happens as a relationship is built; it’s very hard to get that from a respite nurse you’ve met a few hours ago.

Lauren identified the interpersonal relationship as fundamental to healing; it was through others that she learnt to have a healing relationship with herself. Rather than being physically cared for, looked after, she implied that care was a quality of the relationship: an emotional connection. This connection took time to develop and was unlikely to happen with ever-changing staff, reminding me that relationships weren’t static, developing for better or worse over time. In connecting with the emotions of others, Lauren suggested that by role-modelling she developed compassion and care for herself. Perhaps she was learning to value herself.

Sometimes it was the practical aspects of care that were important. When Fran was unwell, and not taking care of herself, respite gave her three meals a day along with other support which prevented the downward spiral.

When I’m really unwell I stop eating or I stop taking care of myself, and respite provides a way that you can gently have that provided. It just staved off that real spiral I might have been getting into.

Fran’s use of the word ‘gently’ suggested that it was not just the practical aspects of care that were important, also the way it was delivered. Barb’s description of her arrival at a friend’s

when unwell suggested she was cared for, but what I experienced in listening to her was also a sense of being cared about.

You could knock on her door at 4 o'clock in the morning and there would be no questions asked; she'd go and put the electric blanket on and make a cup of tea.

Arriving at an 'unsocial hour', Barb didn't have to explain herself; putting on the electric blanket was not simply an act of care, it was an expression of 'caring about'. David's experience of his care by staff illustrated the sometimes unanticipated meanings that could arise from the provision of care. When he was admitted to hospital, staff gave him the towels and soap he needed for a shower.

They were really kind, you know... I needed to get my spirituality cleansed by practical way, and they were there to help. I was feeling really sick with the emotional negatives in my life; the physical side of clean helped me clean my emotions. That's why I would shower 5–6 times a day.

Providing him with the necessities to have a shower, this aspect of physical care and caring had particular meaning for David. I could not know what understanding the staff had of David's need to shower, but he perceived them as supporting and caring for him in a way that addressed his emotional and spiritual needs as well as physical. David was distressed, at rock-bottom with an out of control fire within him; the staff not only looked after him, but their care helped diminish his suffering: his emotions, and spirituality, were cleansed.

Fran talked of another aspect of care, using the word nurture in relation to her developing artistic skills.

Some of the print making tutors have been really nurturing of something that I already had, and allowed me to find the confidence that this was something that I was actually good at.

She experienced her tutors as 'nurturing' her artistic ability, helping her find her confidence. To nurture is defined as 'to care for and encourage the growth or development of; to foster, cultivate' (Stevenson & Waite, 2011); thus far, being cared for had connotations of being looked after when we could not do this for ourselves, but Fran experienced care as helping her grow, to develop self-belief.

We have used a number of terms to convey our sense of being cared for and cared about: care, caring, comfort, nurture, compassion and 'even love'. While being cared for had

practical expression in the provision of physical and emotional support: a towel for the shower, a cup of tea or someone popping in to check on me, more often these terms said something about the quality of the other's response to our suffering. We recognised an emotional response in the other that meant we were seen, perhaps even that we existed, and we were worthy. These expressions of care in relationship continued to develop the coherence of a place in which we mattered.

They wanted to know me

I said of the staff at the Hall that not only did they 'bother' to know me, they 'wanted' to know me; the corollary of this is that I also let them know me, perhaps a consequence of trust which will be discussed in a later section. The emphases in these assertions were on the 'me' and 'to know'. When I was unwell, I felt as if I disappeared into a deep dark hole; I lost me, 'I' disappeared and became instead my illness. At the Hall I felt met by people who wanted to understand who I was and what 'made me tick'; reflecting the healing process of 'getting to the heart of me'. I experienced their interest in me; asking 'who was I, the person', rather than 'what is this illness'. Not only did I feel valued in their interest, but the 'I' was valued; if it was important that they knew the 'whole' me, the implication was that I needed to know the 'whole' me, not just my illness. In their process of getting to know me, I was encouraged to explore, eventually coming to know myself in my entirety and this set the scene for the integration of me and my illness experience.

Most people described being related to differently by staff, or significant others, in their healing place, as compared to other places they had been; a recurring phrase was 'being related to as a person'. Alice talked of being met 'as a person', rather than 'just a person with an illness'. Talking of a supportive relationship:

She listened to where I was at every time I went there. It wasn't medication focussed, it was about me as a person... You want people treating you as a person, not just as a person with an illness. You need to meet the person to find how they are going to make their way through this awful place that they've found themselves in.

When she was unwell, Alice described being 'broken down, shattered' and 'trying to find [herself] amidst' her illness. Rather than being defined by an illness, 'just a person with an illness', she needed staff to meet her as a whole person. In her illness Alice felt lost; a supportive, healing, relationship was one that wanted to find her, and in the process help her find herself.

Colin talked about previous staff not taking the time to get to know him.

Always before, I slipped through the cracks because no one took the time to study me, to talk with me and find out... Had I had more time with the doctors, they would have understood me instead of putting me in a box with the rest of them. I didn't feel like I was a person really; I wasn't treated like an individual, we were all chucked in the same box.

Being 'chucked in the same box' suggested there was nothing unique about Colin's experiences; nothing unique about him. This has similar connotations to 'just a person with an illness' and my sense that previous treatment had felt impersonal. Colin had described being embroiled in his illness, unable to see past it; he seemed to experience the same from his doctors: not taking the time to see past the illness, they didn't see him. In these unhelpful relationships Colin didn't feel like a person. He contrasted this with the staff in his healing place.

I was able to talk and they'd listen and be non-judgmental. There were only a couple of occasions where they were talking to me just for the sake of making notes; just digging around and trying to write something. A lot of them showed a genuine interest and it made me feel great.

Colin experienced staff as talking with him for reasons that went beyond completing the tasks of their job, writing notes; he experienced their interest in him. When a threat to our identity is at the heart of our experiences of illness, it makes sense that being treated as a unique individual with the complexity that might entail, rather than 'numbers to be put in a box', would be helpful. Helen experienced this personal interest as being valued.

I think in other places you're just another patient. But living there, you know, you just felt valued.

When I arrived at the Hall I didn't know anyone; the staff were meeting me for the first time and I have talked about the experience of their connecting with me, getting to know me. Several people had 'staff' who were known to them, and 'knew' them. Lauren had been to the same respite facility several times; she appreciated the continuity, but also that staff 'knew' her.

I appreciate that it's the same two people there every single time; I don't have to start my story off again, they know what's going on with me. They let me unpack my bags if I want, and then they come back and talk, and find out what's going on for me and what they can

do to help me. They want to hear about what I think about it, rather than just reading the notes; in fact I think they put more credence on what I'm saying rather than what the notes are saying.

It was important to Lauren that her perspective was considered important; these people were interested in and placed value on what she had to say, not what was written in clinical notes. Others made a similar association between clinical note writing and a sense of not being met, these records being viewed as valuing objectivity over subjectivity. Lauren talked later about her sense of being accepted; these people knew her and valued and accepted her in that 'knowing'.

Margaret was supported by a peer worker who knew her, had 'intimate knowledge' of her life, and with this came trust.

The trust in him was because I knew that he knew. He was the person who had sat beside me when I had psychiatrists go through my story; sort of like a very reliable friend who already had intimate knowledge of my life, and, how it was spinning out in a horrific manner.

This person already knew her; Margaret implied that this was a deeper knowing, an 'intimate knowledge'. She 'knew that he knew', sensing a shared understanding of her at that moment. This knowing had the potential to enhance trust in the relationship.

'They wanted to know me' and 'they already knew me' are perhaps stages of a journey. Each of these extracts referred to the importance of having people around us who wanted to know us. This knowing had an intimacy, a depth that went beyond my name, my symptoms or my diagnosis. The desire of others to know us engendered a sense of being valued and accepted, and fostered the development of trust. Our use of the phrases 'it was about me', and 'me as a person' implied a wish to connect with us in our entirety; rather than the fragmentation of illness, these relationships reflected integration and a quest for wholeness. When unwell, we felt disconnected and lost; in these connections we could be found.

Fran extended the association between interpersonal connection and healing, suggesting that 'they wanted to know me' prompted 'I wanted to know me', encouraging her journey of exploration.

Here I had the sense that what you had to say was embraced. When you're within yourself, sometimes you need a prompt from outside in order to begin to write.

Fran used writing as a way of finding her voice and herself; the writing group was a place where what she had to say was embraced, this interpersonal interest being the prompt for her internal exploration. These relationships not only suggested that we were worth getting to know; they implied that our subjective experience, and perspective, was important in the process of healing, encouraging us to undertake the necessary exploration to get to know our selves.

They were real people

I have never been good with names but I remember the staff and their names clearly. Some of that is a function of being there for quite a long time, but these were important times and they were important people to me. They were real people with their own personalities and you got to see that; I got to know them as people, and they were staff. But it's more than that; I have such strong visual and emotional memories of them; it's like I took them with me.

They were genuine people; there was always a strong sense of caring and availability, and perhaps normality really. What was it that told me that? They looked me in the eye. I think, also, you just know; there is genuineness in the interaction. When Mary or Julie or Greg arrived in the morning and they saw me, there would be a really genuine check-in: how are you going? And also the way that they responded when it was obvious that times were tough: the flowers that Mary and Julie would bring me from their gardens when I was on bed-rest. I'm sure there were times too, when staff put their foot down, and said no if I suggested it was time to leave, or I didn't want to go to group; but those are not the lasting memories.

An important aspect of our healing relationships was that of reciprocity. This is reflected in that aspect of connection: not only did they want to know me, but I felt like I got to know them as well; or perhaps they let me know them. I got to know them as people, and they were staff: the 'and' in this statement was an important distinction. I could not tell you, nor did I need to know, the intimate details of their lives; they retained their identity as staff but I and we were describing a quality to the relationships that we hadn't experienced in other places. I referred to staff being 'genuine' and 'they looked me in the eye'. They shared enough of themselves that I experienced them as 'real people' not just staff; with the potential meaning that I too was real, and not just my illness.

David had told me about meeting the woman who ran the respite facility, a place that seemed home-like.

So she walked out and then she just showed me herself and said, would you like a cup of tea; and I was like: wow.

I did not have the opportunity to go back and explore what David meant by ‘she showed me herself’; maybe it was as superficial as he could physically see her, but as I read his transcript I was aware of a deeper emotional response in myself. There seemed to be a connection between how he viewed the physicality of her respite place, and his experience of her. The place was ‘this-and’: an office and a home. In that moment when she offered him a cup of tea, she was not just or only a respite operator, he saw (she showed him) something more of herself. I think she showed him her heart; by this I mean she was open to him emotionally. And he said ‘wow’.

The notion of ‘this-and’ could also be seen when David described his response to a peer support worker that he met when they were both guests¹⁸ in hospital.

It was one of the really important things that happened there. Melanie¹⁹ wore different hats, put it that way. She wore a hat outside as peer support specialist; in hospital she wore a hat as a guest, and she was wearing the same hat as me. When I came out of hospital I thought wow that was a real person in there. And I started to [clicking fingers]...

David didn’t talk about how Melanie related to him, but he experienced her as more than a peer support worker. In meeting her as also a ‘guest’, she became ‘real’ to him; she had greater complexity than the hat or role that might define her. And in becoming ‘real’, she modelled possibilities for his relationship with himself.

Alice also used the word ‘real’ to describe staff who shared something of themselves with her.

... staff who you can have a laugh with, who share something of themselves, who are real human beings, who just meet you as a person.

The staff who helped Alice on her healing journey were ones that were ‘real human beings’, with whom emotions were shared. The last phrase ‘meeting as a person’ could be read and understood two ways: who was ‘the person’ – the staff member or Alice? I think for Alice, and others, it was important it was both: they met her and she met them, both as people.

¹⁸ This is the term used by David

¹⁹ Name changed for anonymity

When Barb was unwell, she sought support from her friends, saying their ‘presence is sufficient’ (page 165). She implied more than a physical presence, this becoming clearer as she continued:

I can go to my friend's place down the line, and I, as soon as I walk in there it's a place of healing for me. It's because of her, she permeates the house. She's a very loving, nurturing, gentle person, and very thoughtful. But very strong, she's not a walk over either. And her place, the minute you walk in I can feel her essence in the whole place. So I love going there.

Barb experienced this woman's essence as permeating the environment of her house, implying an openness beyond simply being physically present. Barb would go on to talk about ‘being embraced, being held’ by that presence, suggesting that the subjectively perceived quality of the relationship was critical. Barb also implied that being present didn't mean just being nice. And I am reminded of my comment that staff could put their foot down too, when needed.

Emily described a different quality to the relationship with her psychiatrist.

When we first arrived we met with my psychiatrist and she scared the shit out of both Mum and me, which was quite relieving to my mother. She knew that this woman wouldn't get embroiled in any of my manipulation I think.

When I came to leave she had a bit of a cry which was quite moving; she and I had a very adversarial relationship the whole way through, until probably our very last session.

Thus far, our stories have framed relationships in terms of emotional connections that were caring, heartfelt, and often compassionate. Emily suggested that these relationships could also be experienced as conflicted, but the ability of her psychiatrist to show her emotions to Emily was a significant connection. When unwell, we often disengaged from relationships; it was not surprising then that the resumption of relationships might be fraught. Emily talked about the psychiatrist not getting embroiled in any of her manipulation; I wonder if what ensued was a ‘real’ relationship, at the end of which Emily saw their shared emotional connection. I have to reflect here on my tendency to ‘forget’ negative or difficult emotion – perhaps the difficulties Emily described was what I meant by ‘genuine’.

We used the word ‘real’ to describe the staff that we met and appreciated; but what did we mean by ‘real’? These people remained staff, with thoughts and emotions we weren't party

to, but they still showed us something of themselves. In these relationships we experienced responses that told us they were present with us, emotionally and physically; we were in this place together. Perhaps, too, this sense of realness was important given my and our own sense of unreality. Bringing their 'real' selves to these relationships suggested I too was a 'real' whole person rather than the fragmented shell that I perceived; enabling between us the complex interplay of human connection. And in this interplay we experienced not only connection with others but also with our selves; taking these people with me when I left, they became incorporated into the landscape of my healing.

Trust goes both ways

They seemed to believe in me; believe that there was something in me, trusting that I could do this. I think that is the fundamentals of the therapy, really: they trusted me. I trusted them but they trusted me too, and somehow they managed to convey that to me. When I had been there for about six weeks [my psychiatrist] suggested I come off my medication. I was terrified; terrified that I would get unwell again. But somehow I decided to trust them – trust what they were suggesting, but also trusting that they would accept the consequences. I needed to know and trust that they would look after me and look after that process, so that we could see what was really going on and make sense of things.

I trusted them but they trusted me too; twenty years later this statement still has emotional intensity, and I almost shake my head at their capacity to trust me. I was recurrently depressed, I was suicidal and I didn't trust myself yet I experienced their trust in me. Loss of trust was an important aspect of our illness experiences, losing trust in ourselves, in others and our wider environment; the restitution of this trust is an important part of healing. As a psychiatrist I am used to asking patients to trust me during periods of intense illness; but reciprocity is more challenging.

When unwell I lost trust in myself. Defined by my illness my emotions weren't to be trusted; I also lost trust in my ability to cope with my illness and my life. In this place of vulnerability I needed to trust that these people would look after me, and that they would help me recover. In many ways this expectation was no different from other places I had been – I tend to be a trusting person; what felt different here was that they trusted me too. This trust developed as they came to know and understand me but, even earlier than this, their desire to know me suggested a belief in me: 'believing that there was something in me, and trusting that I can do this'. They held that hope for me, when I was unable to do that for myself.

This reciprocity in trust was expressed by a number of participants, identifying aspects of trust and the role trusting relationships had in their healing process. Helen had a lengthy stay in an old-style institution; after being there some time she was trusted with a key.

They had this old standard key to all the doors. I wanted a towel because I was very shy, so they gave me the key and I unlocked the cupboard, took the towel and gave them the key back. I mean that wouldn't be done now would it? No way.

I remember those big heavy keys: when the institutions closed, I know of staff who kept the keys as a 'keepsake'. These keys were symbolic, perhaps of the 'us and them' divide, and reflective of control and (dis)trust. As I re-read Helen's transcript, I felt my slight intake of breath: a patient having a key! But this wasn't a patient, this was Helen: she was known; and years later she remembered that moment.

Alice experienced this mutual trust as a respect for and trust of her process, this coming at a time when she had little trust for herself.

There's this mutual trust thing going on. I was respected and seen as a person of value, a person that could be trusted; a person that was recognised as going through a really, really difficult time, rather than a schizophrenic or a this or a that. She trusted my own process, it wasn't imposed on me.

This person recognised that Alice had a process to go through; this was a personal journey, Alice's journey, not that of 'a schizophrenic'. This trust was mutual, perhaps reassuring Alice that she too, could trust her process. And in this trusting relationship she felt recognised and respected.

Barb's friends also trusted that she was able to guide her own recovery.

They trust me, so that they know just to be in the house; they don't force me to talk when I don't want to, they let me direct and guide. We trust each other in terms of when she's ready she'll call out; and then me knowing that when I'm ready there's someone there.

[Sometimes] it's a little bit hit and miss. They might anticipate some of my needs, and sometimes they get it right and sometimes they don't get it right.

These were relationships that had developed over time; Barb suggested to me that the understanding and trust was also informed by the lived experience of her friends: they too had been unwell so knew what it was like. Barb's friends trusted her to direct and guide, and

she trusted them to be there when she needed. Perhaps this mutuality accommodated the ‘sometimes they get it right and sometimes they don’t’. Barb told me of a conversation she had with a friend, when something didn’t go right, suggesting a process of developing understanding and trust.

Unlike Barb’s friends who knew her well, Sally’s admissions to hospital often involved staff who didn’t know her. She had developed an advanced directive, guiding her treatment, to be used at times she didn’t feel able to speak for herself.

I didn’t know them and I think for a while I was quite mistrusting. It took me a while to trust that they actually wanted to do something to help. I had an advanced directive that I’d built up because of all my previous experiences and right from the start they followed it... the fact that they were listening and following it was just like wow.

Loss of agency was a significant part of our illness experiences. Sally’s advanced directive was a means of retaining or re-gaining some control of her environment: this was Sally’s plan for what she wanted to happen when she was unwell. When these people followed her plan, Sally began to trust them; she also felt trusted: they trusted the plan she had developed, and the knowledge she had. This was an important moment, ‘wow’, which encouraged mutual trust to develop. One consequence of increasing trust was Sally’s willingness to be more open. She said of another hospital experience:

And I guess I started trusting them and was quite open about what I was experiencing and how I was feeling.

Developing trust meant that Sally began to let these people know her. She also talked of how this trust decreased her need ‘to play the game’, an expression Margaret also used in describing a conversation she had with a psychiatrist: ‘I knew how to play the game’. As Emily explained, playing the game involves ‘knowing what to say to get out of hospital’. The metaphor of playing a game suggested a lack of ‘realness’ to the relationship, likely arising out of a lack of trust.

Our stories of illness are steeped with distrust. These were confusing experiences, nothing making sense; our emotions, thoughts and perceptions seemed unreal, and were not to be trusted. We lost trust in our environments; these were places in which we suffered. I lost trust in my ability to cope; others told of losing trust in family, friends and professionals, and perhaps more importantly we felt distrusted by them. It was important to each of us that we trusted the people involved in our care; we needed to trust that these people would care for

us and could help us recover. Sometimes that trust was an expected part of their professionalism: when Alice arrived in hospital from prison she trusted that staff would look after her; although, as some participants made clear, these professional relationships did not always generate trust. Trust often developed over time; both Sally and I identified our trust of staff growing as they and we got to know each other.

More pivotal, perhaps, were the moments when we realised that they trusted us, and it is in these moments we developed hope. This wasn't necessarily trusting that we wouldn't hurt ourselves, 'play the game', or leave; this was trust in our process, our understandings, our abilities to cope and to recover. Perhaps this was a trust or belief in our humanity, when we were struggling to believe that for ourselves. Their trust in me suggested I was trustworthy; just as Helen was given the key, and Sally thought 'wow', these were moments when we learnt to trust ourselves. The development of trust in relationships didn't just apply to our relationships with staff; it was a necessary part of our relationships with other service users. This was most apparent in formal therapeutic group processes, but was also experienced in our everyday relationships; this was part of our learning: who and what we could trust. As I began to trust others, and myself, my world became a more trustworthy place.

Being with people who knew what it was like

When you are there for that length of time you get to know people in different ways – there was always a really special bond with the people you did psychodrama with. These groups were the most profound thing that I did, and have done, anywhere in terms of my learning. In psychodrama, I exposed those really vulnerable parts of me, and I was sharing that with the others in the group; we had to trust each other.

When I look back I still find it really hard to attach diagnoses to anyone; mostly the labels didn't matter because what we had in common was that we were all struggling to live positively in our own communities. My relationships with my family and friends were breaking down. Hell, I didn't have a relationship with myself, how could I expect to relate to anyone else! Even now, looking back, it's difficult to remember the blackness of that time, the hopeless view I had of my world. But there was support for me in being with people who knew or had known what it was like.

The people who I spent the most time with in my year at the Hall were fellow patients; we lived, worked and played together. Sometimes connections were developed over the lunch-table and a cup of tea, or on the badminton court at the end of the day; it may have been

those moments of intensity as I exposed my vulnerability in group therapy, and sometimes it was simply sharing the quiet space of the lounge in the evening. Some people became friends, others I knew only superficially, but whatever the intensity of the connection, there was support for me in being with people who knew or had known what it was like to be unwell. I was no longer so alone, nor did I have to pretend quite so much; I was with people who had felt the same, and were also exploring, also on this journey.

When I reflect on this now, it seems counter-intuitive: when I was at my most distressed, how was it helpful to be with others who were also distressed? When we were terrified of 'going mad', was it helpful to be with others who were mad? Again, I am aware of my tendency to sugar-coat memories; other participants reminded me that it wasn't all comfortable; but still, it remains true that at the end of that stage of my journey, I said that it was helpful to be with people who knew what it was like to be unwell. There were some people that I connected with positively and others that pushed my buttons: our connections were sometimes conflicted, but 'it worked'; these connections were part of my healing process.

Margaret agreed but went further, asserting it was imperative to have amongst her carers someone who knew what it is like to be similarly unwell.

The absolute imperative for me is people who have inhabited realms of madness, who know that landscape. It's all about those linkages of people who know, and who could care in a manner that no clinician could ever care, unless they'd had some experiential reality.

She suggested that these experiences enabled a quality of connection (linkage) and care that she couldn't experience with others. She went on to tell me that she didn't relate so well to people who had only had depression, suggesting it was the shared nature of the illness experience that was helpful: they knew what it was like to be mad.

Alice found hope in sharing her journey with others.

There would be times when I'd sit and listen for hours to people, and times when people have done that for me. You get a sense of mutuality; even meeting people on a different point of the journey, and somehow you can support each other. It actually brings a lot of hope.

These were the people Alice spent the most time with; being able to listen or talk with each other not only provided support, it also gave her sense of mutuality: being part of something

together. There was hope to be found in talking with others who were at a different stage of the journey; but Alice, like others, also expressed a tension in being with people who were similarly unwell.

You're in this intensely charged place; it's a huge challenge to be sharing your journey with a whole lot of people that are in a difficult situation. You have to find ways of getting on; you have to access your own compassion and understanding. And yet you also have quite special connections with people, so it's a real mixed bag.

Despite, or perhaps because of, the difficulties of being in this environment Alice experienced special connections with people. She had to find ways of getting on with people, suggesting an element of exploration and connection with self, accessing her own compassion and understanding. I wondered if, in finding ways of getting on with others, she was also re-establishing a compassionate relationship with herself.

Colin thrived in the company of others who had 'been there and done that': been unwell.

It helped me grow, helped me relate; I had stayed to myself for so long I'd become stunted. There was a sense of camaraderie between the clients, almost like a fellowship; like a closeness [pause] not a closeness, a bond if you like. We've all been there and done that, and we all listen and can talk about these kind of things. It's an unsaid thing almost isn't it? We got on.

Colin had described himself as blooming in the hospital environment; 'stunted' by his lengthy illness, living with other people helped him grow. He too had identified difficulties in 'being with a lot of people who had conditions'. His use of the word fellowship suggested that, rather than the closeness of friendship perhaps, these relationships evoked a sense of belonging to something. Their shared experience could be talked about and understood, but more than this, there was a bond that didn't need to be spoken about, arising in the actuality of their shared illness experience.

In keeping with others, Helen appreciated the relationships that she developed with others in hospital. While acknowledging that she didn't have to get on with everyone, like Colin, she experienced a sense of communality.

Whanau members as they called us. Whanau is like a group, all the same family, a collective; being on the same page; we're all in the same boat; someone to share your day with: the ones that you plan to see when you get out, establishing friendships. There are a few from

when I was in there that I still maintain contact with; but not everyone, because obviously you don't get on with everybody.

She explained that in this unit she was considered a member of the whanau; she was part of the 'family' implying this was a place she could belong. These were people with whom she connected: sharing experiences and their day, developing friendships and future plans. But as Helen recovered she was also troubled by those who remained unwell.

Sometimes I used to think, when I'd got well, oh it's not that pleasant being around people that are really acutely unwell. Sometimes if you have a whole room of all unwell it sort of winds you up a bit.

A number of us expressed a discomfort in being with people who were acutely unwell, particularly when we were recovering; as Alice observed, these could be 'highly charged environments'. When I was admitted to the Hall I was depressed, withdrawn and lonely, and I suspect I wasn't easy to be around either. We gained support from those who were on the same journey, gaining hope from those who we could see on the road ahead; but I wondered if there was fear in being reminded of the place (illness) we had been, this being an unsafe place to be.

By virtue of being in hospital, some of us necessarily spent time with other service users; in contrast, Fran made an active choice to be with service users in an art space: her healing place. She too valued the shared experience of mental illness.

People have been there and they're sensitive to when people are perhaps having a bit of a rough time and it's a place where that's not a barrier to being there.

Like Colin's sense of an unspoken bond, Fran suggested that a shared experience of illness facilitated a sensitivity to the emotional state of others; and with this came a sense of safety: being unwell was not a barrier to being there and belonging. The safety in others 'knowing' what it was like, meant that we were accepted as we were; our emotions and experiences didn't have to be hidden, we didn't have to be hidden.

It's being able to say to someone who actually has been there, and gets it, that today I'm having a really crap day and nothing's going right; and having the sense that this is someone who gets it from the inside.

Fran suggested, as did others, there was something particular about the connection made with someone 'who has been there'; they would 'get it', in a way that others perhaps could

not. 'Getting it' carried connotations of being understood and accepted; and with this came trust.

David expressed a similar sense of being understood.

We could speak the same language you know, and there were just connections going left, right and centre. Having that kind of common ground, you latched to it so fast.

I was reminded of my comment that service user-me and psychiatrist-me seemed to speak a different language, and my sense of no longer being alone when I first attended the Service Users in Academia Symposium: we spoke the same language. This was the language of a lived experience of illness, giving a sense of commonality and ground on which to stand: no longer alone, David latched on, he belonged. These connections seemed easier, when we had something in common; perhaps we felt we were more likely to be understood, when we often struggled to understand ourselves, and less likely to be judged.

This ease of connection was alluded to by Barb; she pointed to an apparently instinctive element to the supportive relationship that can develop between those who know what it is like to be unwell.

They are people who have experienced psychosis themselves. Apart from a few bits and pieces we probably experience quite similarly and we do it for each other. We don't really talk about it much to be honest because it does feel at a much more instinctive level.

Perhaps this 'instinctive' quality reflected the multiple ways in which we came to know or understand our environment and the people within it. Barb suggested that conversation wasn't always necessary. Having experiences in common meant her needs would be recognised at an instinctive level rather than needing discussion, the shared experiences contributing to their trust in each other. The complexity of these relationships was apparent in a comment Barb made about being in acute mental health unit:

There wasn't the camaraderie as there was in the institutions. I remember feeling much more vulnerable in the acute unit; that's the time when I felt frightened.

Our experiences of 'the other places' demonstrated that for healing it wasn't enough to simply be with others who shared an illness experience; suggesting there were other influences that affected the quality of our relationships with our peers: an accumulation of experiences that told us we were safe, accepted, trusted and trustworthy. Conversely our

relationships with others could change our relationship to place, these becoming safe or unsafe places to be.

In a way these experiences left me with more questions than answers. The other patients at the Hall were an important element of my experience; it was helpful to be with people who knew what it was like to be unwell. Some research participants talked of an ‘instinctive knowing’ in these relationships; emotions and experiences did not need to be explained and this ‘knowing’ was accompanied by a sense of acceptance. Several suggested the nature of the illness experience was important in this ‘knowing’, Margaret and Barb expressing a need to be with people who had similarly experienced psychosis. Reflecting on my healing place, I have to admit there was little evidence of psychosis, and others have talked of their discomfort at being with those who were actively unwell and/or psychotic. Perhaps it was the nature of the experience that was shared that was important; for some that might be a sharing of symptoms, or a shared journey of exploration, or simply shared laughter. And our needs perhaps changed at different stages of our journey.

I haven’t thus far discussed the importance in this theme of the word ‘being’ with others. As I will discuss in the next chapter, the journey of exploration had aspects of being and of doing. It was helpful to be with people who felt the same, but was that sufficient? In my original writings I went on to say ‘I talked with others who did, or had, felt the same, and as we talked and shared, we gained wisdom; wisdom about ourselves and about those around us’; this was not just ‘being’ with people, this entailed ‘doing’.

We learnt from each other

I had an awareness that everyone, all the other patients and staff, were useful to me because this was where I was going to learn; this was where I was going to learn how to deal with all the crap in my life. There were people who felt like really good friends. Like G and M, we hung out together all the time. At the end of the day we would go up to the rec hall and play badminton or just sit in the middle of the court and natter; dissect the day and dissect who had done what. When they left it felt sad, but again there was a sense that this was a progression and we always intended that we would catch up again, and we did.

There were some people who just used to drive me absolutely potty – they just triggered me. And alongside this I knew that there was some learning in this for me.

As discussed in chapter nine and implied in the journey of exploration, our healing places were ones in which we learnt about ourselves, developing the meanings that underpinned our recovery. I will discuss in the next chapter the other varied opportunities for exploration and learning that these places provided or created, but often these occurred within interpersonal relationships. Formal therapeutic activities provided opportunities for active exploration, but often our learning occurred in our everyday interactions. Sometimes these became relationships of friendship, within which we shared our most vulnerable selves. I remember the many and varied conversations sitting on the badminton court, or the ‘bus shelter’ under the trees, when I cautiously spoke my secrets and fears, testing the reactions of others. As other participants intimated in the previous section, I didn’t get on with everyone and there could be learning in this too. In these varied interactions I gained the wisdom of experience.

This theme, ‘we learnt from each other’, can be applied to both staff and service users; we each brought ourselves and our experiences to bear. These relationships were more than simply supportive; they were opportunities for exploration and growth. Much of this has already been alluded to in the previous themes but was articulated explicitly by several participants: Colin in his recognition of growth as he developed relationships with others, and Lauren’s awareness that in the context of relationship, role-modelling by others fostered change in herself. Emily initially resisted engaging with people she perceived as unwell, but developed an understanding that within these relationships she might move forward.

My psychiatrist used to always talk to me about being in relationship, and I used to argue with her and say well I don’t want to be in relationship with any of the people around here because they’re all sick and mad. And she would say well that’s not the way the world works and unless you start engaging with people here you’re never going to actually be able to engage in the world at large... Yeah, it did change and it was very important.

We later talked about the friendships she and I developed in these places; not always easy relationships, but valued and valuable on our journey. The places that were healing for us were not necessarily easy places to be, nor was the journey of exploration; it was hard work. These people accompanied us on this journey, and with them, and often through them we learnt about ourselves. I didn’t have a relationship with myself, how could I expect to relate to anyone else; in the interplay of these relationships we were learning and testing new or different ways of connecting and being with others, and ultimately ourselves.

Engaging with our shared humanity

I remember my fear, every day: holding my breath, would this be the morning when I would wake up and find I'd been slowed to a crawl, switched off, gone away into that black hole? And what kept me going was a sense of sitting with faith, trust. The trust I had to have, that these people knew me enough, cared enough, to follow me, to hold me if I lost myself, as it seemed I had in the past; they would hold me, soothe me – until I found myself again. Or maybe until I saw and knew that I really was still there; being held with my fear, until I could come back to what was in front of my eyes: myself.

Towards the end of my time there, I remember going down town and buying myself some flowers to celebrate. It was the first of May and the inevitable hadn't happened; I was still here; I was still standing and I wasn't depressed; I was so excited. I bought these beautiful red ranunculi to put in my bedroom. I got halfway back home (to the hall) and I started to cry. I wanted to celebrate and I had to cry. I cried for my pain, for my loneliness, for my anger. I cried for myself and the waste and the hurt of all those years. I cried and I cried and I thought it was never going to stop. I spent most of those three days, day and night, sitting in the lounge; people would join me, taking turns to sit beside me, just be with me.

I arrived at the Hall not knowing anyone and left a year later taking with me, in my heart, the people I had met. My experience of these relationships became integrated not only into my understanding of a place that was healing, but into my sense of myself. Various carer, supporter, teacher, champion, fellow-explorer, and companion, these people were essential to my journey of exploration and transformation; healing was a journey not undertaken alone (Hsu et al., 2008). It is interesting in first writing this that I didn't think to include, doctor, nurse, fellow-patient. I guess these roles are obvious but, much as diagnoses 'mostly didn't matter' amongst patients, the professional labelling of staff seemed irrelevant; It was the nature and quality of the connection in these interpersonal relationships that was important to me.

Writing this chapter of my thesis proved the most difficult. My research diary contained repeated references to my struggles.

My writing lacks depth, I am not engaged with the analysis as I have been with other sections. These people are in my heart and yet I struggle to reduce our experiences to written words on the page. I wonder if it is that these relationships are so precious that I resist analysing and objectifying them. They are in my heart; in taking

them out and looking at them, do I fear losing them? “They just were”. When I talk of them my hand goes to my heart, but what is that in academic writing?

It all just seems too simple: when I was suffering, lost, frightened, hopeless, stuck I needed people who I could trust, who cared for me and about me, who didn't look sideways at me, who treated me with kindness and compassion; people who helped me find myself and helped me get moving again. But none of this is surprising, so why were our places special? What was it about these people that facilitated a better outcome?

Perhaps the answer lay in the struggles of the writing. It was the emotional experience of these relationships that stayed with me over the years; my fear was that in reducing these relationships to explanatory themes and ideas, I risked losing their heartfelt quality. Rather than something to be observed and explicated, these were relationships that were felt and experienced. Maybe this difference was at the heart of the success of these relationships: we needed to be people experienced in all our vulnerability, rather than treated as patients to be observed and explained. I said of the Hall ‘it was about me in my heart, not me out there’; these people seemed interested in my heart, the personally subjective quality of my experience, rather than what could be observed ‘out there’, the objective evidence of my illness. Their interest in me, in my entirety, perhaps countered rather than mirrored the fragmentation I experienced: an illness that I experienced as separate to my self.

Each person's story implied that the relationships we developed in these places were qualitatively different to previous experiences. These were ‘real’ relationships in which we experienced emotional engagement and respect. We have identified feeling cared for and cared about; some identifying this quality as compassion and nurturing. We experienced people who wanted to know us, and in the process let us know them, this being a very different experience from that in other places we had been. Trust was an important aspect of these relationships: we trusted others, but more profoundly we were trusted too, this being a trust or belief in our capacity to heal. We felt supported by our carers, but also experienced support in being with our peers, our fellow service users.

Arriving in these places, broken and suffering, we described first and repeatedly needing a safe haven, a place where we would be cared for and metaphorically held, while we did the hard work of exploring that underpinned our healing. The relationships we experienced supported each of the tasks inherent in this description of place: provision of care, holding and opportunities for exploration. An often quoted definition of caring is Leininger's (1981)

“those assistive, supportive, or facilitative acts toward or for another individual or group with evident or anticipated needs, to ameliorate or improve a human condition or lifeway” (p.9). This definition contains behavioural (action), and cognitive (anticipation) aspects. In the distress of illness, we were often suffering; we needed and wanted to be looked after but that was not necessarily at the heart of our care. Not only were we cared for, we felt cared about, the latter implying an emotional connection that went beyond the practical aspects of care. Weiner and Auster (2007) supported our experience arguing that, more than an action, caring involves a sustained emotional investment in a person’s well-being.

Several people linked care to compassion. In common with other terms used to describe interpersonal emotional connections, definitions vary but a recent review argued that compassion is “the feeling that arises in witnessing another’s suffering and that motivates a subsequent desire to help” (Goetz, Keltner, & Simon-Thomas, 2010, p.2). Youngson (2011), a New Zealand anaesthetist, suggested that compassion and care need to return to healthcare, arguing that medical professionalism currently encourages “rational detachment and objectivity” (p.9). This view is consistent with the surprise, inherent in our stories, when we were met with the antithesis of detachment and objectivity: we experienced in the other an emotional, compassionate, response to our suffering; more than this, it was a sustained response or investment in our well-being. We felt cared about, and with this came hope: the belief in our potential to recover (Schrank, Hayward, Stanghellini, & Davidson, 2011).

Possibly the most profound aspect of my early experience of these developing relationships was my sense that ‘it was about me, they wanted to know me’. Most people expressed in some way their sense of being met as a person rather than an illness; not only did these people care about us, they wanted to know us. This was a knowing that went beyond the asking of questions to construct a story enabling us ‘to be put in a box’; we had a sense of being seen in our entirety, with the subsequent knowing implying both uniqueness and wholeness.

Empathy, from the original German ‘*einfühlung*’ or to ‘feel into’, (Weiner & Auster, 2007) has been described as “the capacity to think and feel oneself into the inner life of another person” (Kohut, 1984, p.82), this being an expansion on an earlier view that empathy was a strictly emotional response (Gerdes, Segal, & Lietz, 2010; Håkansson & Montgomery, 2003). There has been a burgeoning of literature in recent years examining the concept of empathy and its role in healthcare; multiple definitions are offered, all having in common a sense of recognising another’s internal emotional and/or cognitive state, arguing variously

for imagining, knowing and feeling another's thoughts and feelings (Batson, 2009; Neumann et al., 2012). Perhaps empathy was what we experienced in our carers, and this was what an empathic response feels like. They wanted to know us, their desire suggesting not only curiosity but worthiness: we were worthy of being known.

While the concepts of care, compassion and empathy may go some way to explaining our sense of being 'cared for and cared about' and 'they wanted to know me', the mutuality implied in 'they were real people' and 'trust goes both ways' suggested another aspect to these relationships. Care, compassion and empathy in healthcare are usually expressed as qualities of the carer, with little comment on the experience of the other; research also tends to be from the point of view of the health professional, and where the patient is implicated the focus is on clinical outcomes. Halpern (2003, 2014) characterized the medical view of empathy as detached cognition, advocating instead for a shift in approach: from focussing on the internal processes of the empathizer to the dynamic interaction in the relationship. It was a dynamic interaction that we experienced in these relationships.

Barb described her supports as 'being present', I said 'they were staff and they were people', Alice referred to 'real human beings' with whom emotions were shared, Emily's psychiatrist allowing her tears to be seen and felt. These were relationships in which we were seen and we felt met; but this was not a one way process, there was an interpersonal transaction in which we trusted each other enough to allow us both to be seen. This broader view of empathy was articulated by Misch and Pelouquin (2005): "an iterative, mutually interactive and interdependent process in which the behavioural, emotional and cognitive signals of one participant are read and responded to by the other" (p.42). Rather than being a unidirectional quality of the carer, empathy is a mutual relationship requiring both to be present. David captured this beautifully when he said 'she walked out and she just showed me herself', asking if he would like a cup of tea. Perhaps, also, the 'instinctive knowing' that we identified in others with lived experience was a similar mutual transaction between those who knew what it was like, or could be 'bothered' to find out.

So what might this have to do with healing and place? These were relationships within which we were held, when we needed holding, and in which we explored; contributing to our experience and understanding of what these places were and could be. Compassion, care and empathy were what helped hold us; telling us we were seen when we feared we might or had disappeared: the existential threat of our fragmentation; while holding the hope and belief in change when we could not do that for ourselves. We experienced these relationships

as a mutual transaction within which we were able to explore, to learn, and to develop understanding. Entering these places fragmented and disconnected, we learnt by experience; developing relationships with others, we developed new relationship with ourselves and in the process we grew. As we came to know others, we came to know ourselves.

I described the healing journey as 'getting to the heart of me', others talked of finding their 'essence', the implication being that getting to know the 'I' was fundamental to our healing. Healing was a process of gaining wisdom; a 'deeper knowing' that was encouraged by others' interest in me, and deepening in our shared connection. Gallese (2003) suggested that empathy is dependent on "the constitution of a shared meaningful intersubjective space" (p.517): the intersubjective space at the heart of our relationships was a place to meet, to share and to explore what it meant to be human. I wonder if creating this meaningful space requires both a willingness to enter and to allow the other in: a collaborative process that takes time and trust.

Chapter twelve: A place of opportunities

I had known for some time that, for all that I had this illness that they said was manic depression, there was crap in my life. I knew that unless I got my issues sorted out, I would never cope with my illness. I'm not sure how quickly I cottoned on to the therapeutic process at the Hall, but I think relatively early on I realised that this was where I was going to learn; this was where I was going to learn how to deal with my stuff.

As I ran into all the same day-to-day difficulties that existed for me at home, I talked. I talked about – "why the hell should I get out of bed, when all I want to do is curl up and stare at the wall?" Talked about – "I feel like I just want to die – why do I want to die?" or perhaps, "Why do I not want to live?" Talked about – "No-one loves me, I'm all alone." I talked with others who did, or had, felt the same. And as we talked and shared, we gained wisdom; wisdom about ourselves and about those around us.

I have argued that healing necessitated a journey of exploration, through which we developed wisdom and meaning. This journey took time and was hard work. Chapters ten and eleven considered the physical and social aspects of the places that supported our healing, but a reading of these chapters in isolation risks neglecting complex interplays between buildings and people, the environment both external and internal, and objective and subjective, that conflate to form meaning. This chapter considers the various formal and informal, planned and unplanned, doings and beings that occurred as we moved in and around these places. It was in this movement that interactions occurred: between us, the rooms and spaces we inhabited, and the people we shared them with; interactions and relationships within which we experienced places that became safe havens, holding us enough while providing opportunities for the exploration, connection and learning that underpinned our healing.

I arrived at the Hall intending to give them two weeks: I thought they would tell me what I needed to do and then I would go away and do it; but healing was much more than being told what to do. Healing was a journey of exploration, exploring ourselves in relationship to and with our world. Wisdom developed in the opportunities available or created: in our formal work of therapy and/or personal reflection; our experiences of play or connecting with nature, and in the everyday occurrences of daily life. We learnt from each other, and as we

did our connections and understandings deepened, becoming integrated into an experiential knowing: wisdom.

Routines and rules

Our day started with the ward meeting; there was always a round of feelings, a ritual check-in for the day. The rest of the day we were involved in activities: basically a working week, Monday to Friday. We had our individual therapy twice a week, and a structured programme of group therapy, psychodrama, art therapy, music therapy and ward activities. It was a challenge for me (as well as threatening) to learn to use these different ways of expressing myself, of exploring myself; and it was hard work.

We were all involved in doing chores, like setting the tables, clearing the dishes and taking the dinner trays to those people that were on bed-rest. If someone wasn't pulling their weight we had a conversation about it; it was a conversation that was expected to be done in a way that reflected some kindness and understanding, but things did get discussed.

In the evenings and at weekends it was our own time, although you couldn't just go off whenever you felt like it. If I wanted to go into town I would need to tell one of the staff and, if they didn't think I should, we would have a discussion about it. The Hall had a van that we could get permission to drive, when you'd been there for a month or two; we'd use it for trips out to the beach at St Clair. So that is what we were doing at evenings and weekends, that's how you spent your time: being with everyone.

Ashburn Hall had an underpinning philosophy: it was a therapeutic community (Haigh, 2002). We had a structured programme, my 'working week'; these were events that happened regularly: the daily ward meetings, multiple forms of psychotherapy on a daily schedule, and chores to be done. We had less regular community events, and ways of doing things such as being welcomed and farewelled. Outside the formal programme, evenings and weekends, it was our own time to organise as we wished. I don't remember a list of official rules and regulations, but there were unspoken ones perhaps better considered as expectations. I wrote many years ago that the most important part of my and our treatment at the Hall was simply living as a community; while this statement might reflect how well I absorbed the culture of the place, others have described places that had similar structures, though not identified as therapeutic communities. This section considers the doings and

beings that might be considered structural: the routines and rules that were part of our experiences.

When I arrived at the Hall I knew very little about what to expect, what was going to happen there; I just knew that I was stuck, and that something needed to change. Always before I had run away into 'wellness' but that never lasted long; this time it was different, I stayed for a year, and in the process regained my life. Very early on in my admission I began to feel part of the place, trusting that this place and these people could help me, and that if I stuck with it change was possible.

The welcoming committee was a group of patients, with I think one staff member, which met each week and identified who was arriving for admission. Someone would volunteer to be a buddy for the first couple of weeks to show the new person around, introduce them to people, and talk a little about how the place ran.

Arriving at the Hall, I am sure that I was welcomed; although I remember little of that time I know that the structures existed for me to have a buddy, who showed me around and probably told me something of the philosophy of the place. I would have attended my first morning ward meeting the next day, where I heard the programme for the day; I am sure there would have been discussion of any particular issues that either staff or patients wanted to bring to the meeting, and as always participation in 'the round of feelings'. The ward meeting was a means of communication, but also served to introduce me to the idea of sharing something of myself with the community. This was an opportunity to begin to understand what I might experience there; my introduction to the culture of the place had begun.

Others described processes of welcome or introduction to the places they identified as healing, Margaret suggesting that 'how you are admitted really defines what your experience is going to be'. When Colin arrived at his hospital, having been brought from the police cells:

I had a shower, a nice warm shower; then I had an introduction, you know when they introduce you to the basic ideas of the place. The first thing I did was introduce myself and just went on from there.

Colin was introduced and he introduced himself, beginning a process of engagement that was an important aspect of his admission and healing process, countering the isolation of his years of illness. He particularly remembered the warmth of the shower; I wondered if this also reflected his emotional experience of the welcome to this hospital unit.

Fran's introduction to the art studio included meeting with staff to develop a personal plan.

When people come there, they sit down with a staff person, or some people do it themselves, and write an art plan which has some goals: what you want to get out of being a part of the centre... It's not a drop in centre, it's an art centre.

The art studio was a place where Fran felt welcomed and nurtured. Developing an art plan made explicit an understanding that she could be part of this centre, the setting of goals shifting this from being a place to 'drop-in' to a place with a purpose which was shared. These experiences were in stark contrast to that of Sally's admission to an acute mental health unit.

I don't even think they showed me around; it's just basic, I mean I'd never been here before. So it was kind of finding things by accident.

I was reminded of the admission process that David went through: the locked doors through which he entered, replicating his 'bottled up' trauma behind a door that he couldn't open. This place did go on to become an important part of David's healing journey, suggesting that all was not lost! And I remembered the welcome relief that Alice felt when she encountered the soaring ceiling of her new ward; a sense of welcome was not just a product of people or actions.

My daily life at the Hall was marked by routine; my first ward meeting was just the beginning of my working day, our structured programme; with breaks for morning and afternoon tea, and lunch, our day wasn't finished until 5pm. At some point we also completed our chores; these routines rarely varied: Monday to Friday, my working week, the only exception being bed-rest. It is interesting that I referred to this routine as my working week; in a similar analogy, others referred to the 'hard work' that was therapy. Always before as I emerged from my 'black hole' I had run back to my job, perhaps to give me some structure and purpose to my day; this time I engaged in a different type of work.

Routines were an integral part of my stay at the Hall, but was this structure important? Colin compared his experience of two mental health units, one with structure, one without.

There's no structure in [the other unit], it's totally random; you can wander off any old time. The structure, the routines matter – preparing yourself for the day, the events you organise yourself around... that's all healthy, it all adds up.

He too had routines that mattered, describing them as events to ‘organise yourself around’. There was a sense of purpose in Colin’s routines; rather than ‘wandering off’ and perhaps remaining lost, he prepared for his day. In contrast Barb described her experience of an old style institution, comparing it unfavourably with prison.

[In both place] you didn’t have a lot to do and it was quite regimented. But prison was different: the people were always up to some sort of high jinks because they still were alive. In the institutions no one was alive; today it would be similar to going into a rest home where people are just wheeled into the day room, sitting waiting to die.

Barb’s comment that the institution was ‘quite regimented’ suggested that there were routines, but with little else to do. This was structure without purpose and with no hope for change, perhaps confirming the experience of illness as being stuck with no life. Alice, too, referred to extended periods when there was little happening; when she ‘felt like death warmed up, doing nothing constructive, just sitting around’; this was time that lacked purpose or meaning. These extracts suggested that having structure or routines alone didn’t help us live; what happened within that structure was important. Barb and Alice wanted to be doing something constructive, to have a purpose other than sitting waiting to die.

Sometimes routines were self-imposed, rather than externally determined. Fran suggested that her routine of going to the art centre began the process of re-building her life.

Being a part of the centre to some extent gave me a routine; something to begin rebuilding my life, a kind of stepping off point, allowing me to make changes in direction.

Re-establishing a routine was a ‘stepping off point’ for Fran, implying new beginnings with the potential for movement and change. Importantly too, she felt part of the place: she belonged; perhaps adding a reason to engage in the routine. Similarly, David used the cubby holes in his hospital bedroom (page 176) to begin to establish some structure in his life. While not overtly a routine, organising his physical space was a way of organising himself and countering the sense of disorganisation that accompanied his illness: ‘bringing together the blocks that were scattered’. David told me that this organisation meant that when he left hospital he ‘looked normal to the normal eye’. I did not sense that this was just about ‘looking normal’; this was akin to Colin’s ‘events to organise yourself around’, which he considered healthy. We were re-establishing the structure and routines that are part of everyday lives when well.

I remember, when unwell, days of not being able to get out of bed and my sense of being lost, alone and disconnected; now when times are tough I fall back on my routines. When life's inevitable crises threaten to rock my world, I turn my focus to getting the basics right: eating, sleeping, exercise. Routines are what anchor me so that I don't have to run away. When I was feeling so hopeless, and yes useless, I gained a sense of mastery from simply getting up each day. And it wasn't just me, I got out of bed along with everyone else; there was a sense of communality, a sense of being part of something and belonging. Our round of feelings at the morning meeting was a time of acknowledging that yes, I felt awful and I was still here. So why did I get out of bed, when I struggled to at home?

The rules weren't overt – the rules and breaking the rules. The rules were around: Monday to Friday was work; you attended meetings and you were on time for groups, and for ward meetings. That's what I mean by rules; it's not 'you will be in bed by such and such a time'. Rather, you are not late for group and if you are then you are asked why... The rules were about being aware of everyone else and the impact you had on them.

The rules at the Hall were not overt, but I was aware of the expectations. We were expected to attend activities, to be on time and to participate; and if it was hard we were encouraged to explore why. I said that the rules were about being aware of others, and the impact I had on them; they were also about being aware of the impact I had on myself.

Sometimes the rules or expectations were subtle: Barb's friends 'just knew' to give her space, being present was enough; Margaret's friends 'knew' they didn't need to hang around, she would call if she needed them. These were relationships with trust and understanding that had been developed over time; their expectations of each other didn't need to be spoken. For others, particularly in larger, yet to be known groups, the rules were more overt.

Helen said that the rules in her hospital ward were clear.

It's made clear that you have to go to karakia [prayer], and the programmes. Some people obviously dug their toes in, but they were soon moved on if they weren't going to participate.

Yeah, there were definite rules. I remember their main ones were respect yourself, respect others and respect the whare, the house.

Helen described practical rules that included attending the programme even when she didn't want to; a consequence of non-participation was being moved on, obeying the rules

supporting the opportunity to belong. It's interesting that, rather than the practical rules, Helen placed emphasis on an overarching set of 'rules', respecting herself, others and the culture of the place; the provision of and participation in the programme perhaps reflected these fundamentals.

Fran's art space fostered its sense of community and culture with expectations.

[The art centre] tries to foster the feeling within people that it's their space so they should care that somebody does the dishes; it's looking after each other and the space and being considerate to who's coming in after you. You're part of a community that supports one another and there are things that are not tolerated. Recently there's been a discussion about... how do we have those conversations with people to say [what's] not okay.

Evoking a sense of being cared for and cared about, these rules or expectations acknowledged that Fran and others were part of a community that supported each other; they were markers of respect and consideration. Fran alluded to the tensions inherent in establishing rules: who decided, how were they communicated and what were the consequences of rules or expectations not being met?

Emily described her sense of being coerced to participate in community activities, contrasting this to her understanding of the principles of recovery. I sensed her being almost bemused by this tension.

A lot of things that we say about what recovery means are not compatible with what this place did; things like supporting autonomy, giving consent and giving people choice. [Here] you don't really get to choose what to go to. You are coerced a lot, but not in a negative way; you have to attend programme, you have to engage and to talk about things, putting yourself in a position to be challenged. It's very controlling, it's very confronting and it's hard work.

Like other places, there were 'rules' that governed Emily's community. Just as I did, not only did Emily have to attend the programme, she was expected to engage. She experienced this as coercion, though 'not in a negative way', contrasting this with a tenet of recovery: freedom of choice. The tension for Emily was that this programme 'worked' for her. I initially baulked at Emily's use of the word coercion, but as I reflected I was reminded of the many times it felt too hard and I didn't want to get out of bed – but I did. And she was right;

at times I probably was coerced, though I prefer the word encouraged, until I was able to do that for myself. Coercion implies an element of threat so what was the threat?

Emily: They could ask you to leave the programme; people who didn't engage were asked to leave.

I/we did have a choice of sorts. If I didn't want to make use of the programme I could leave; for others leaving was not an option, but we all had a choice to make about engaging. I got out of bed because of hope; instead of being lost, I began to feel part of something that gave me hope for change. Perhaps I needed to feel part of something: rather than being disconnected I wanted to belong; but this programme also made some sense to me: that if I could understand myself, then I had a better chance of making sense of my illness. The rules were a statement that participation was important, and with this change was possible. More than this though, we each described a set of rules or expectations that developed and maintained the culture: with respect for each other, the community and the place.

And rituals

I remember a Saturday morning chat with one of the nurses – she suggested that it was about time I started being nice to myself. I felt lost, I didn't understand, how was I supposed to be 'nice to myself'? Try making a list, she said; so I turned to M: a game of badminton and much hilarity later, I had my list. But I had to practise; I made my list, put it on my wall (where no-one else could see it), and every day I would say, okay, what have I done to be nice to myself. And slowly the pot of tea became a moment for myself; my bath: a treat, a comfort when I need it.

I guess before I went to the Hall I didn't have much of that richness in my life; but I learnt things by talking, and seeing what other people did, and building some of these rituals into my life.

I called the morning round of feelings a 'ritual check-in for the day'; this was one of the ward meeting routines, but my use of the word ritual suggests it took on particular meaning, telling me that I belonged and was cared about, and that my feelings mattered. Routines were things we did regularly, almost without thought; but beyond the simple structuring of my day, as I learnt and developed understanding of myself, many of these routines took on deeper or symbolic meaning, taking on the mantle of rituals that have continued to sustain me. This was a process of adding richness to my life; a cup of tea made with a tea bag provides physical sustenance, the warmed tea pot adds a moment of care and attention, and

often reflection. In the slow accretion of actions and meaning, these routines became part of me; mine to integrate as I grew into my skin.

Some participants had recognised rituals: Alice would 'take some quiet time and pray'; Helen's mihi (greeting) and karakia (prayer) carried specific cultural meaning, connecting her with herself, with others and with 'the man up above'. Sometimes our learning was in challenging a ritual that had no personal meaning:

There were things like religious prayers in meetings where you had to stand. I did for awhile but then I noticed one of the staff members sitting down and I asked her about it; I said look I'm a non-believer why do I have to stand?

For others I recognised routines that perhaps became rituals: Barb's friend who madly cleaned, her signature of caring; or the warm shower that washed David clean; or Margaret leaving the door unlocked, which told her she was free.

The celebrations of welcome and farewell deserve particular mention as rituals.

Whenever someone, patients or staff, was leaving we had a celebration. I remember the afternoon teas that we made in the hospital kitchen, the afghans and the cakes, and also the gifts that usually came out of the art room – gifts with thought, representing something about the person. I still have the cardboard box that was made for me, containing a cutting of wisteria that went into my garden. During the afternoon tea there would be a round of feelings, a chance to say something to the person leaving. There was a lot of thought given to these rituals; it was not just 'well everyone gets a cake'. I learnt a lot about ways of leaving places.

I have already discussed the practicalities of our arriving; our welcomes were not only an introduction to our places, they began the process of letting us know we were valued and that we could belong. For me the farewell was perhaps even more important. We farewelled everyone whether their stay was two weeks, two months or two years. Rather than a formulaic event, these farewells were personalised celebrations symbolic of the significance each of us had within the community.

Helen also told me about leaving her hospital ward after a lengthy admission during which she re-connected with herself and where she was from.

I went up there to the local fish and chip shop and I bought – it must've been about 40 pieces of fish. It's all around food, that's a Maori thing isn't it? It makes you feel you belong too, if you have

some ways of doing things: beliefs, values, all the things you do, how things are done.

This sharing of food had meaning beyond the routine of eating a meal; it was ‘a way of doing things’ that supported Helen’s sense of who she was. Rather than ‘existing, no life’, she had become part of this ward, and the ritual of sharing food was an expression of that belonging. We were learning the heartfelt importance and value inherent in our rituals of arrival and departure.

The routines, rules and rituals of the Hall told me that I was part of something, imparting a sense of belonging to this place. These were the anchors that I learnt to fall back on; that told me this was a place that could hold me as I engaged in the hard work of therapy and living; anchors that held me in place as I threatened to go away, and that I took with me for sustenance when I left. These were the structures that helped bind us as a community, as we travelled along the road towards self-discovery/healing; and sometimes they were simply about getting the basics sorted: eating, sleeping, and looking after our home; giving us a way ahead, when we felt lost.

The formal work of therapy

Wednesday afternoon was always psychodrama... It would start with a simple story, something that happened in my life yesterday, last month, many years ago. The therapist would lead me to develop my story, introducing others into my life, recreating the dialogue, constantly changing roles; we recreated the story and somehow the emotions came with it. Even now I can’t explain it, but I remember like it was yesterday – drama took me to such profound emotional places. I learnt about myself, my relationships, and my place in the world. And I learnt just as much from being in someone else’s drama; we learnt from each other, to make sense of our collective world. And most times I didn’t even know we were learning – it might be some weeks later that there would be the light bulb moment when a piece of insight would fall into place.

I remember my first psychodrama session: curled up on the floor, unable to move, unable to stand on my feet... until I offered myself my hand²⁰. I remember the enormous effort, the time it took, the fear, the seeming inability to lift myself off the floor, to stand there, to hold my hand. This was the most profound experience; I had awful days again, but that was the first moment when I realised I had some power in this. It was realising that my recovery wasn’t all about

²⁰ See page 129

medication; instead it was finding things that let me discover things about myself and psychodrama really worked for me.

I argued earlier in the thesis that our healing places were a place to learn and explore, and not necessarily an easy place to be; exploration could be hard work and took time. This was a journey of discovery; of finding myself, and my place in my world; of making connections, developing understanding and learning. For me, the formal/structured programme of psychotherapy was where much of this exploration occurred. In my individual therapy I exposed some of my most vulnerable thoughts and emotions that were at the heart of my suffering. These were the experiences that I did not understand, that I couldn't make sense of. It was often hard, feeling risky and dangerous; I was getting to the heart of me, and if it was easy I probably wouldn't have been suffering as I was.

Other therapies occurred in groups, offering opportunities to explore and express myself in different ways. In talking about my difficulties with others and sharing their experiences, I made connections both intrapersonal and interpersonal, connecting with myself and connecting with others. Much of this was talking therapy: talking about how I felt, asking why I felt the way I did. I don't now remember the specific content of our group therapy discussions. Sometimes it would be whatever we were working on in individual therapy at the time: testing the response of the wider group, and my response to them; but often we discussed the everyday events and niggles that inevitably occurred when living with others. At the time it all seemed very hard work: emotionally fraught; looking back now I realise I was learning to live with people. We were a vulnerable group of people, and if I could learn to live in this cauldron of emotions, I could probably live anywhere!

But I didn't just learn through talking; 20+ years later I still remember some of the songs I chose for music therapy, and what these said to or about me. And I remember the song that another patient played at her last ward meeting in the lounge: Bette Midler's 'You are the wind beneath my wings' and I am transported back to that moment. When I listen to these songs now, they are no longer background noise or entertainment; they spark an emotional, heartfelt, sometimes painful but meaningful, response; connecting me to that room full of people. I also remember the day, in art therapy, that the colours changed: black became purple; my emotions began to take form. I had always said that I couldn't draw to save myself, but actually I did: I saved myself. I remember finding myself late in the evening down in the art room using the crayons to draw what I felt; drawings that would end up on my bedroom wall where only I could see them, sometimes to take to my next therapy session, but often just for me to look at and be with. In these various forms of therapy I was

finding and testing out, different ways of making sense of things and of expressing myself. I learnt to be self-reflective looking inside and out, to make sense of my inner world and why I reacted in the ways that I did, why some things were difficult and others were easy. These groups were the work of finding, connecting with and making sense of myself; and in the process I made connections with others.

An organised programme was identified as important by several other people on their journey of healing. This took a number of forms including educational groups, individual and group therapy processes, culturally-based programmes and creative processes. Although different modalities, they each provided opportunities for connection: interpersonal, emotional and cognitive; and an environment that recognised and nurtured our need for exploration.

When Colin arrived at his place of healing he was symptom free for the first time in years. Although a turning point, he did not identify this as healing; he experienced healing in subsequent opportunities for learning, much of this occurring in a group settings.

The environment's important as well, but not so much as the education; that's where I actually learned something. We had groups that dealt with action plans, early warning signs, slippery slope. My first experience there on the first day was how medication worked: receptors and neurons and all that kind of thing. I found it all very interesting and I achieved a level of understanding that was all good.

The nature of the groups is that it gives you new perspectives; other people can reflect on what you've said and reflect it back to you with feedback. We're all on the same level.

The access to educational groups on this ward contrasted with Colin's previous experiences in mental health. These groups were offered at a time when Colin had begun to trust the 'system', this perhaps being a confluence of right-timing and the availability of opportunities for learning. Colin vividly remembered the moment when he learnt how medication worked; occurring early in his stay, this group sparked his interest, perhaps setting the tone for the rest of his stay. With access to other perspectives, Colin 'achieved a level of understanding' of himself.

I don't second-nature think action plans in a sterile way. With these groups you take them away for the rest of your life. I'm a changed man.

This wasn't simply a process of learning 'in a sterile way'; these lessons meant something to Colin, suggesting an element of self-exploration. He took these groups and the lessons he learnt away with him: he was a changed man, suggesting both integration and transformation.

Emily's initial engagement with group therapy was more difficult.

I was firmly of the opinion that group therapy was a waste of time. Sitting round and listening to people – I didn't rate that; but looking back on it that probably was the most important; you become part of the whole thing. Essentially if anything gets too hard the first thing I'll do is stop talking; and talking about things actually does make things better. It comes back to being in relationship with yourself and with other people.

Emily was initially dismissive of the value of talking with people. It was not clear to me when this changed for her, but she identified the importance of this therapy in her recovery. When unwell, Emily said that she dealt with life by disengaging from everyone and everything, perhaps explaining her initial reluctance to 'sit round listening to people'. Emily had a way of understanding her recovery which was 'being in relationship': being connected with herself and with others, which she identified as a more 'healthy way' of dealing with her struggles. Engaging in group therapy, she became 'part of the whole thing', suggesting engagement, connection and a sense of belonging not just to the people, but to the group, and perhaps the wider, environment.

Just as I found what I needed in different forms of therapy, some preferred other modalities. Alice emphasised the importance of individual psychotherapy in her journey, recognising the value, to her of talking.

Talking therapy is very important to me; I'm an extravert so I need to talk it out because then I hear it as well. I can talk about these things now because I've done so much work about it; I've worked really, really hard.

Alice had talked about 'facing into', and a desire 'to depth things', to deal with her psychosis, its antecedents and consequences; individual therapy became her way of exploring her self. Like me she referred to her exploration as work, this being a purposeful activity that required effort. Alice talked about the need to practice what she was learning.

You're living your life and practicing what you're learning. You need from week to week to develop that skill a bit more, and it goes down to another level.

In time and with practice, Alice's learning 'goes down to another level'; this deepening perhaps reflected the process of integration in her description of healing as 'actually facing into, and integrating'. As indicated by Alice, practicing in 'life' was important, supporting the notion that for healing these places needed to be for living, not to be unwell.

Helen's programme of therapy was different to the rest of us, in being overtly, culturally informed.

We had programmes; a lot of it was run on a marae [meeting house] concept. They might have a te reo [Maori language] session with one of the kuia [female elder]; one of the older males taught us whakawhanaungatanga [establishing relationships]: [to know] what your name is and where you come from is a big thing there. They did it often, so by the time I left I knew quite a few karakia [prayers], a lot of waiata [songs], and I knew how to get up. I can't speak te reo Maori, but I can get up and say my whakapapa [genealogy] and whanaungatanga [kinship].

Helen understood that the lessons she was learning were important and valued. They were repeated often, suggesting practice was necessary; and by the time she left hospital, Helen had both the ability and confidence to 'get up' and tell people who she was (an important cultural ritual). There was an emphasis in her statement 'I knew how to get up', that suggested more than learning: in this programme Helen was learning about who she was, but more than this, these rituals became integrated into Helen's deepening understanding of herself in her world. In contrast to the disconnection she experienced in illness, Helen was connecting with a larger landscape: her culture and the land.

Mason Durie²¹ thinks that not knowing where you're from is a significant factor in becoming quite disconnected and maybe unwell.

Helen developed an understanding of the relationship between disconnection and becoming unwell, placing this within a cultural framework that made sense to her, becoming part of the story that she told and giving her confidence in her recovery. Helen took these skills and understanding with her; she told me how these skills allowed her 'to live in the real world' where she felt 'accepted' by others.

²¹ (Durie, 2004, 2011)

Thus far participants have identified talking therapies as helpful; Fran utilised another form of communication: writing. Like Emily, when unwell Fran stopped talking; unable to articulate what was going on for her, a writing class helped her find her voice.

I think I was introduced to the art studio by a key worker who knew that I was artistic. One of the first classes I was part of was the writing class. I lost the ability to talk, and writing was really a communication tool for me.

Coming out of a very fragile place, it was a really supportive environment to find myself in; a place that enabled me, with help, to find my voice.

Fran suggested that the art studio was a good fit for her, recognising her artistic talents and offering her another means to ‘find her voice’ when talking was difficult. Fran found herself in this supportive environment; I cannot know whether she meant physically being in that place, or the more existential interpretation of finding herself, but both are implied: in finding her voice, she was also finding herself. Although not a formal therapy situation, this writing class served similar purposes to our groups: a safe and supportive environment that Fran felt part of, where she was able to begin to articulate what was going on for her, a step towards understanding. I knew that Fran was also engaged in individual psychotherapy; we didn’t really talk about this, not being part of her healing place, but she reflected on how creativity in all its forms had helped her psychotherapeutic process.

Through creativity I find my wellness. I find if I’m stuck in a mood or something, even if I don’t feel like it, doing something creative will begin the process of lifting things out of that. For instance I was with my therapist last week; I just picked up a pen and I wasn’t drawing anything that was particularly related to what we were talking about, but through focussing on drawing something I was able to continue the conversation.

Sometimes if I’m at the studio and struggling a bit, just the fact of a small project enables me to be more present, more engaged with the world as opposed to not.

Fran noticed that when she felt stuck, doing something creative facilitated a shift, reconnecting with her world and herself; and perhaps helping her connect with whatever she was struggling to put into words. I was reminded of the way that art therapy, the use of material colours, gave me a different ‘language’ to express myself; expanding my repertoire for exploring and connecting with my emotions and my thoughts.

This section described the varied forms of therapy offered in our places of healing, these being opportunities for exploration of ourselves, our relationships with others, and our interactions with the wider environment. For some this involved facing deeply into oneself in individual therapy; for others, working in a group setting was particularly meaningful. For each of us this therapy had or developed a context that was relevant and meaningful for us: Helen, disconnected from herself and others, developed an understanding of who she was in relation to her culture; Alice, wanting to heal from her personal traumas, looked to individual therapy to face into herself; Emily ‘got into relationship’ in groups; Colin, stunted by his illness, grew into himself in the company of others, learning skills along the way. Lost and alone, I embraced different forms of therapy to make the connections that would get me to the heart of me: who I was in my world. Not only did these therapies provide a structure for exploring, they gave us an explanatory framework that we incorporated into our stories of healing: a platform for our understanding of ourselves, as whole people rather than simply an illness.

These therapy opportunities were social spaces with their own rules and expectations; part of the structure of our lives at that time. I earlier described the room in which we did psychodrama, and I vividly remember my psychiatrist’s office, with its view to the garden, in which we met each week for individual therapy. Inseparable from their physical locations, just as my bedroom could be a haven within a haven, these group and individual therapies became places within places, that held us while we did the particularly hard work of facing ourselves, or as I described it, unpicking and then piecing myself together again.

Becoming self-reflective

Wisdom, as defined by Baltes and Smith (2008), involves an element of deliberate reflection on life matters; while I was still learning to be self-reflective, several people described doing this for themselves. Barb told me about her earlier experience of being in a psychotherapy group.

The inference from the staff was that I must have got that insight from somebody else and it couldn’t have come from me. So it was completely invalidated. I was endeavouring to make sense of what was going on for myself, and was very firmly told you don’t, that’s our job; you leave the analysis to us.

For her, this group lacked the sense of collaboration that I and others experienced; rather than being encouraged in her endeavour to make sense of her experiences, she felt invalidated. Later, Barb reached a point that I have previously described as her turning point,

an ‘intuitive knowing’ that she needed to deal with this on her own. She turned and faced her experiences and in the process she disarmed her madness, reclaiming her ‘own stuff’. Now, Barb did her own therapy; rather than running away she faced herself.

The running away stuff, that’s very ingrained in me; so I have to think that through a lot more. I do my own therapy – ‘so tell me about how running away has helped in the past? And what about when you’ve turned and faced things; haven’t things worked out better?’ Things are different now so I can do that [for myself] okay.

Barb earlier described a similar process in dealing with her psychotic symptoms; knowing her mind ‘plays tricks’, she ‘called’ her thoughts back in (page 118). ‘Things are different now’ suggested that Barb was further along her journey, so able to do this for herself. David drew on tools and skills he had learnt in the past, to deal with his psychosis and effectively doing his own therapy.

One time late at night, when I was hallucinating and hearing voices I saw this big black grid come up. And lying in my bed thinking about it, I would step back a bit and understand what that grid was: every single trauma I had. Understanding that grid made me think – some negatives are more negative than the others. There was the one that was totally pitch black, and I started putting positives into it. Most of my days and nights [I was] just thinking about emotionally putting positivity in the blackest negative. And those tools or skills I had learnt to attack negativity, I used it to attack stigma.

David described metaphorically stepping back from his hallucinations, effectively creating a space, much as we had in our individual and group therapies, where he could reflect on and develop a way of understanding his psychotic experiences. His stepping back was not a disconnection; David engaged with his experiences, ‘attacking them’, and in the process transformed his psychosis turning negative into positive. This helped him ‘take off the tight hat’ that was his illness, using the same skills to counter his sense of self-stigma.

Like David and Barb, Margaret observed that as her journey progressed her needs changed, now drawing on her own resources to process her experiences.

As I’ve got older it’s less about who I interact with, it’s how I process the experience within myself. I’m in a different period of my life.

Margaret was critical of mental health services, suggesting that in the past she wasn’t offered therapies other than medication because she was ‘crazy’; and I remembered, as a young

psychiatrist 20 years ago, being taught that psychotherapy was not appropriate for people who were psychotic as it would make their psychosis worse. Margaret told me about finding healing modalities outside of mental health services.

I found a man who was an extraordinary worker; he worked with so many tools in a fluid manner. I've got a whole wealth of skills and ability from my journey that I've made. But, you know, I'm creating more and more space for that to happen.

Margaret was learning to 'do the rides' that were part of her madness experience; the multiplicity, or wealth, of skills seemed important. She had talked about how these different modalities helped her contextualise her experiences of psychosis, placing this within the journey and story of her life; drawing not only on therapeutic experiences, but also theoretical frameworks that provided different ways of thinking and talking about her illness.

I really like the work of Patti Randal²². I like her framework of talking about these things as spiritual emergencies; creating other languages to convey the experience.

Perhaps Margaret was articulating the aim of our various forms of therapy and self-reflection. As we gained skills and an understanding that made sense to us and was consistent with our evolving world views, we developed the capacity or ability to process the experiences within ourselves; maintaining connection and reducing the risk of fragmentation.

I learnt from having fun too

In discussing the various psychotherapy groups above, there are already intimations of the multiple modalities and experiences through which we reconnected with ourselves, others and the world in which we lived, gaining understanding along the way. I utilised talking, drama, art and music therapies, some forms resonating with me more than others. Alice and Colin also engaged in talking therapies; but with differing emphases. Fran utilised a writing group and Margaret's therapist worked with 'many tools in a fluid manner'; Barb did her own therapy, and David drew on skills previously learnt. Predominantly these experiences occurred within a structure that we likened to work, but we also talked of everyday informal and often unexpected opportunities for exploration: getting to know our environment and, by implication, ourselves. While psychotherapy was the formal means by which I learnt and developed understanding, I learnt in many other ways and in so doing introduced a richness

²² (Randal & Argyle, 2005)

into my life that I perhaps hadn't known before. I am reminded of an artist's palette: 'black became purple', and I began to see the colours of the rainbow. And I am reminded of the 17th century proverb, 'all work and no play makes Jack a dull boy' or perhaps 'makes Jackie a dull girl'.

I learnt from having fun: sliding down the hydroslide, after an intensely emotional afternoon in psychodrama, I re-discovered my capacity for having fun. I experienced the shift in my emotions, from despair to joy, and would later reflect on this in my therapy. While the work of therapy, and sometimes of life, could be painful and difficult, I was learning the potential for balance. I also learnt through the spontaneous conversations we had sitting in the middle of the badminton court or over a cup of tea. I discovered a love of nature through my morning walks, the daffodils in spring, and the flowers that nurses would bring me from home. I also learnt from massages.

We did this exercise one day in a ward activity: if you were given ten thousand dollars what would you spend your money on. We were given three choices: a housekeeper, a chauffeur, or a masseuse. The only one that I couldn't justify spending money on was the masseuse, it felt self-indulgent and unnecessary. It's funny, the other options I could justify on the basis of allowing me to work harder! So I challenged myself and massage became a really important part of my therapy. Once a fortnight I would go and have a massage. And the body work alongside the head and heart work was really, really important because that was me getting in touch with things in different ways.

My massages became an integral part of my process of healing. Like Margaret's 'Chi-Gong exercise' in which she was 'encouraged to feel [her] feet, and the presence of [her] body', I was coming to know myself in a variety of ways, connecting with myself cognitively, emotionally and physically. Although these informal experiences were not explicitly asked for in participant interviews, and most people focussed on the formal elements of their therapy, some did identify other opportunities for exploring, experiencing and learning; these included David's suggestion of rap music.

When I look at it now there's so many things, other tools out there, like rap: rap music, and you can learn from that.

As described in previous chapters, many of us had become disconnected from ourselves and our environment in its broadest sense. Alice acknowledged this when she said:

Your world becomes so shut down... [and staff] have a responsibility to create as many opportunities for people to open their world again, to say there's a big wide world out there and you've got to grow towards it. Was it St Augusta who said, you know the glory of God is a person fully human, fully alive.

She identified the need to provide or create opportunities for growth, 'fully alive' suggesting breadth and richness. Colin exemplified this potential for growth; while he embraced the opportunities that group therapy gave him, it was interesting that his identity as 'a curry man' (page 191) arose in more informal activities. In part, this came from his introduction to gardening growing chillies and coriander, but also meal times on the ward.

On one day a week we'd take turns in cooking for the ward; I did a curry once which went down very well. I had people smacking me on the back saying good feed mate; it was great. And I learnt about how, when you cook for friends or your partner, it can be a powerful tool, getting people to talk over food and get closer.

Colin had told me about his social isolation when unwell: 'I had stayed to myself for so long I'd become stunted.' In activities such as cooking he experienced a sense of achievement, learning about himself in the process. He identified cooking as a means to connect with others, extrapolating this understanding into his future with friends; more than this, these experiences became incorporated into the identity that he was building, no longer defined by his illness. Colin also talked about the importance of humour.

It's great to have a laugh, it's healthy. I'd been so serious over the past twenty odd years I needed to redevelop my sense of humour.

I could identify with Colin's need to redevelop a sense of humour and of fun; particularly when our experiences of illness were lengthy, we were often 'just existing', with little joy in our suffering. We learnt about ourselves and our place in the world within the formal structures of therapy, but it was in the informal activities that we added richness. These were opportunities to explore and learn through experiences in and of our social and physical environment; and it was in these activities that I began to fill the nooks and crannies of emptiness within the shell that was my skin: I/we grew into my/our skin becoming whole.

Doing and Being

Thus far I have written of the varied activities of our healing places, but I also have strong emotional memories of needing to be still; activity has an implication of doing but on this journey, and in these places, we also needed space for being.

When I was emotionally really struggling with something, one of the staff members might come and ask me if I thought it would be good to go onto bed-rest for two or three days. It might be during the week or it might be at a weekend; on reflection, part of that is whether they thought it was useful for me to be out of groups for a while. You were tucked up in bed, your meals on a tray; staff would check on you regularly and you just got to curl up in bed. Generally it was a step back, a time-out-of-sorts; actually you just needed to be with your feelings and be molly-coddled for a while.

Difficult as it was, rather than running away, I needed to stay with my feelings. Bed-rest was a mechanism for removing me from the busyness (and business) of the ward and programme, encouraging me to be with myself. Notably not 'by myself'; bed-rest was not necessarily about being alone, nor was it a place to run away to, a place to hide from my emotions. More than an escape, respite or time-out, bed-rest created a space to 'just be', occurring in an environment of care and support. I don't know if it was explained to me as such, but somehow I absorbed an understanding that bed-rest was an opportunity to be cocooned, to be able to stay with my distress in an environment where I was being cared for, and cared about. I am reminded of the 'indulgence' of going to bed for a few days when I have the flu, and having someone bring me hot lemon and honey drinks, and a good book to read if I feel up to it; with permission to be cared for, permission to be distressed and metaphorically to be held.

When I initially talked of my experience of bed-rest I told my interviewer I 'loved it'; on reflection, I think I came to love the idea of it but early on the reality was much harder. Occurring at times of most distress, staying with and experiencing my emotions was difficult and painful, and it felt necessary. I know that there were times when I railed against bed-rest.

I remember once someone came to me and suggested that it would be useful for me to have a couple of days on bed-rest. I tried to tell them that no, I'm fine and I can carry on and I'm going to go to group, and I'm going to do this and I'm going to do that. But they could be reasonably firm about it: "actually no, you need to go onto bed-rest".

I wanted to keep busy, to keep working (albeit in therapy); what I needed and did learn was balance. There were times for movement, and for stillness; times for activity, and time to just be. In bedrest I had the space, permission and encouragement to be with myself, and a safe place to be. I did not need to be somewhere else, neither in my black hole nor busy at work; I needed to be with myself, getting to know myself, getting to the heart of me.

Alice told a similar story. Although without the formal recognition of bed-rest, she sought a similar place to be when she was struggling after her psychotherapy sessions.

I'd feel dreadful because this was dealing with deep, deep pain. I'd just crash, literally go and lie on my bed, and I would feel the physical pain in my body. They would come and make sure that I was okay, maybe talk to me a little bit more. They showed that they really knew that I was going through a difficult process.

Alice had earlier described healing as a process of 'facing into' her experiences, and this involved dealing with her pain. She described an emotionally laden experience, with no suggestion of turning away, seeming to suggest that being with this pain, both emotionally and physically, was a necessary part of her healing. My description of bed-rest contained a similar assumption: that experiencing our emotions and thoughts was important. Barb implied a similar need: to 'just be'; allowing her to work through her illness experience. She talked of not wanting family with her when she was unwell.

What they want to do is just make me better. What they don't want to do, or aren't capable of doing, is allow me to work through it. And there's a few friends that I would call on to help me out who would just allow me to be; so when I felt like talking they'd talk with me, and if I felt like just lying on the bed they might just lie on the bed with me.

Barb's family wanted to do something, to make her feel better; but she emphasised that recovering from illness was a personal process that she needed to work through. Her friends enabled (allowed) a process in which at times Barb needed 'to be' rather than 'do'. Fran expressed a similar need, her art studio giving her a place to 'just be'.

It gives me a place where I can be myself. I'll find myself there sometimes when I'm not really sure what I'm supposed to be doing there, but sometimes that emerges just by being there, and [pause] I'm finding it hard to kind of grasp [pause] It's a place that gave me permission to just be for a while.

I have written about a haven as a place to be safe for a while, and a time-out-of-sorts; Fran's studio was at times a haven for her, but it was also a place where she could 'just be'. Fran hinted at the intangibility of what we meant by 'just being', having aspects of both 'being herself', and 'being rather than doing'. More than this, she suggested that in the relative stillness of being in her studio with no particular intentions, something might 'emerge',

suggesting 'being' involved a deeper sense of connection. Margaret's quest for a place of stillness when psychotic (page 158) had a similar quality to our 'need to just be'.

My healing places are places where I slow down, where things aren't demanded of me, and I don't have to produce outcomes. I can play my piano; I can sing in the wind, I can walk on the beach.

Finding opportunities to be with herself, such as in music or walking in natural surroundings, countered Margaret's experience of being scattered when unwell. Like Fran, having no external demands or need for outcomes allowed Margaret to re-connect with herself; this was not the stillness of doing nothing, but of being with herself. David told me about his need for sleep and I wondered if this was another form of stillness.

When I look back I needed to have sleep non-stop. [The hospital ward] was top dogs for that, they let me sleep and eat and sleep and eat. There was a day that I actually said: oh okay that's enough sleeping. I think that's an important word that: waking up. I had enough of just sleeping, and waking up....

There was a sense that, before David could wake up, he needed to sleep; 'waking up' meant getting on with his life. David had been unwell for a long time and his need for sleep suggested a need to take care of the basic necessities, in order to recover; but more than this, 'waking up' had connotations of emerging. Several people talked about sleeping 'because I was bored; I was just filling in time'. David's sleeping had a different purpose; it was a necessary part of his recovery, and had a quality similar to other's need for stillness: allowing him to emerge, to wake up.

A lack of activity or stillness didn't always equate with a helpful or healing process, for example Barb's experience of sitting waiting to die.

Basically this is where you come to live out your life; never really having any sort of interventions, nothing really done; just kind of babysat, really. One day just moulded into the next.

This was an imposed stillness, imbued with hopelessness; Barb was to be kept quiet, rather than seeking quiet as a means of connecting with herself. 'Just being' didn't always mean inactivity, or being with painful emotions or thoughts; for me walking was an activity that had some of the qualities of 'just being'. On my early morning walks along the country roads my thoughts would often drift, and I am reminded of the practice of walking meditation. Walking gave me the space to be by myself, and with myself; and somehow in the process of walking, I would have 'ah-ha' moments. Just as things emerged for Fran, these were

moments when connections were made and ideas seemed to take form; and I also sense that it is in these moments of stillness that integration can occur.

Medication

Early on, [my psychiatrist] said that he would like to decrease my medication. When I arrived at the Hall I was on lithium, amitryptilline, carbamazepine, tryptophan, sleeping tablets; and basically everything was stopped over a six-eight week period. The idea was to see what I was like off medication; to get a better sense of what was going on. Such a lot of my treatment before was about increasing or changing medications; this was different and I was terrified, I didn't want to get depressed again, I didn't want my world to fall apart.

That early discussion with my psychiatrist was an important moment in the story of my time at the Hall. The idea of decreasing my medication was terrifying; medication was the only thing that anchored me, kept me well, or so I believed. He was suggesting a different understanding and path. 'Decreasing' became 'stopped', and gradually I realised that 'it wasn't all about drugs'; as I continued on my journey of healing, medication became unnecessary. Decreasing my medication, achieved in an environment of trust, became associated with a sense of self-determination: I controlled my illness, rather than it controlling me.

Medication was, perhaps surprisingly, only briefly mentioned as an aspect of healing by the other participants. Two people identified medication as vital to their recovery while asserting that healing was more than medication-associated relief from symptoms. Colin became symptom free with medication, perhaps sparking his journey of healing, but he suggested that 'the education, the life skills... all of that chunked in almost outweighs the medication.' Helen learnt 'the hard way that medication must be for me' but this understanding took time to develop as she 'woke up' to how unwell she had been.

A number of people expressed ambivalence about taking medication.

The problem when they give me the antipsychotics is I can't think. That's the scariest thing in the world to me, not being able to think clearly. Even if I'm having mystical, magical thoughts, that's preferable to not being able to string thoughts together.

and...

It wasn't all about medication; medication's a tiny bit of it, but it has a huge effect on you.

and...

I can't bear being medicated till you're so zonked you can't lift your head off the table, off the pillow. So, the medication thing... I mean, I've had to come to terms with the fact that I use medication.

Much of this ambivalence related to side effects of medication: a sense of being over-medicated and being unable to think clearly. More striking though was not the presence or absence of medication in our treatment, but that it 'wasn't all about medication'; this notion supported our sense that healing places were interested in us as people, rather than an illness to be treated with medication. Medication was sometimes part of our journeys as an aspect that needed to be incorporated, but was not perceived as the focus of treatment or of people's stories of healing.

I, too, have an ambivalent relationship with medication. While I have little doubt that medication and ECT at times kept me alive, stopping my medication seemed a profoundly important step on my journey to healing. For some people medication remained an integral component of their experience, but what if that had been true for me? I am reasonably confident I would have woven that aspect of care into my story, suggesting that it was not the medication per se that I was pleased to be rid of (although I remember losing my lithium-associated tremor); rather it was what medication had represented: my loss of agency. Treatment, that seemed to be focussed solely on biological modalities and understandings, disconnected me from my illness and from myself. In contrast our healing places offered and created a rich plethora of opportunities, sometimes including medication, within which we could explore our illnesses. Making use of what worked and dealing with what hindered, we reconnected with ourselves and the worlds in which we lived.

The wisdom of experience

Healing was a journey of exploration and learning, facilitating the discovery and testing of the connections that underpinned our recovery. This was exploration of our selves, our relationship to and with others, and with the world in we lived: phenomenal, physical and spiritual. Our healing places supported us on this journey by providing or making possible opportunities for exploration and connection. While these were to be found in the people and the place itself, opportunities were also offered or discovered in the formal and informal, planned and unplanned, doings and beings of the places in which our healing occurred. These were opportunities that took on meaning, becoming the events that gave structure and shape to the stories that we told.

Places within mental health services that we identified as healing tended to have formal structures in the form of routines, rules and programmes of therapy; those outside of services perhaps did not have the same structures but had elements, such as expectations and ‘ways of doing things’, that served similar purposes. Routines are things that we do regularly, in an established way (Stevenson & Waite, 2011), usually with little thought beyond the act of doing (Fiese et al., 2002), their regularity and predictability perhaps implying reliability. Colin described his routines as something to ‘organise yourself around’, Fran’s were an opportunity to begin re-building her life; routines got me out of bed, with an associated sense of accomplishment, and the potential for something new. We each needed to learn the routines of our places, but in many respects these were probably not so different from home, at least when we were well. With so much in our lives being untrustworthy and threatening, I wonder if routines gave us something to rely on, to fall back on and anchor us; to hold us, and reminding me I was still here. This notion is supported in a recent conceptual analysis suggesting that routines are a means for coping with change, creating order from disorganization, and facilitating adjustment when our resources are limited or threatened (Zisberg, Young, Schepp, & Zysberg, 2007).

Routines were not just an individual endeavour, they also served a purpose of community; many of our routines were shared and there was support in being with people who knew the struggle of taking the next step when we felt stuck. Ferreira (2014) suggested that routines “are responsible [for] and guarantee not only individual existence but the coherence and survival of a community” (p.64); routines helped us function not only as individuals but as communities: meetings occurred at particular times, meal times were shared along with conversation and connection. Participating in the routines of her art centre added to Fran’s sense of belonging, Helen’s participation in the programme reflected respect for the culture. Linked to our experience of routines was the notion of rules, perhaps better conceptualised as responsibilities or expectations; some of our places had rules that if broken might mean expulsion, but more importantly we described responsibilities or expectations that helped define the culture of our places. Expressing a sense of common purpose, these expectations of respecting ourselves, each other and the culture of the place enhanced our sense of belonging and with that came hope.

The routines and rules told us something about what was considered important in these places; unfortunately Barb ‘learnt’ that the rules and routines in the institution were about keeping her quiet. In our healing places, we developed an understanding that routines were a means to organise ourselves, preparing us for the work we needed to do, and maintaining our

communities. As I came to understand more of their meaning for me, some routines took on the mantle of rituals. In common with routines, rituals are socially acquired patterns of behaviour (Ferreira, 2014), but with the addition of symbolic or psychological meaning, demanding an element of reflexivity (Zisberg et al., 2007). I developed rituals that I learnt through others, that I took with me and continue to sustain me; integrated into the pattern of my life, they took on deeper meaning. For some these rituals developed into spiritual practices such as prayer and karakia.

If our routines, rules and rituals served the purpose of maintenance, the other doings and beings more directly provided us with opportunities for exploration. These opportunities occurred in formal therapy, in the relative stillness of personal reflection, and in the often more social aspects of our daily lives. While it was not the purpose of this thesis to argue for a particular modality of therapy, nor would I want to, our stories suggest that in the varied therapies we found an explanatory framework that made sense to us and fitted or came to fit our developing world view, being incorporated into the way we made sense of our illnesses and ourselves. In this exploration we were learning about ourselves, discovering ways of understanding and managing our illnesses, and getting on with life: we were gaining wisdom.

Wisdom arises in “some combination of education, practice, apprenticeship, personal experience, and deliberate reflection about life matters” (Baltes & Smith, 2008, p.57), and implies a deeper experiential knowing requiring both time and effort. Each of these elements is to be found in the work we undertook. In a sense, our education occurred in either the therapy we engaged in or developed ourselves, though our stories identified a multiplicity of learning opportunities: massage, cooking, gardening, art. We gained personal experience and practice in the many and varied activities of each day, planned or spontaneous. Our places encouraged deliberate self-reflection, be it within our therapeutic groups, or within the community as we ‘worked through our stuff’; or connecting with our selves in those moments of stillness in which we could ‘just be’.

A necessary aspect of our healing places was that, alongside more active exploration, these needed to be places where we felt safe to just be. These were places of doing and being, not one or the other, but what did we mean by ‘being’? I have said that healing wasn’t as simple as being told what to do, and that ‘getting to the heart of me’ was ‘a very experiential thing’, meaning that this process was a heartfelt experience of body and emotions. Being had elements of identity: being who we really were, which might be our suffering selves, rather

than the pretence that everything was okay or playing the game; it also had elements of being with ourselves, not an easy thing to do when we felt lost and confused. Although having a quality of stillness, being was not a passive ‘sitting and waiting’; being required a deliberate allowing and valuing of the subjective experience, because within this experience we found ourselves.

An opportunity is a set of circumstances that makes it possible to do something (Stevenson & Waite, 2011); the places we have described provided, or created space for us to discover, the varied opportunities that made it possible to heal. Opportunities arose on these journeys of exploration, in the doings and beings within which we interacted: with ourselves, with the people we met and the spaces in which we moved; offering potential for connection, for practice and, with time, integration. Opportunities placed the possibility with the explorer; rather than passive recipients of care, we were active participants in our journeys of healing.

Part IV: Integration



AM, 2010

Chapter thirteen: A place for healing in mental health care

June 1990: that is when I began my journey back to me. Originating in my concern that we do not yet have it right with respect to places of treatment for mental illness, this project set out to examine my experiences of being in and around Ashburn Hall: a place that I came to know simply as the Hall. It describes a journey in and around my self, on a journey to a place that I called healing. The psychiatric literature is replete with accounts of what is wrong with inpatient psychiatry; I wanted to come at it from a different angle, considering what works and why. I wondered if everyone needed an 'Ashburn Hall', but what would that look like?

Endeavouring to answer this question I have explored aspects of the places we identified as healing, considering questions of what and where these places were, the physical environment encompassing the built structures and the natural surrounds, the people we shared our experiences with, and the doings and beings of living in these places. I have contextualised these aspects of place within the journey of healing, which provided a way of understanding the experience of place. Healing places were ones in which we encountered interactions and experiences that indicated that we mattered; and in the process we came to know places that mattered to us. These were neither hospitals as we knew them, nor other places we had known; being somewhere different offered us the possibility to move on from places in which we were stuck. In reading these conclusions the reader is encouraged to envisage these places as both within and with-out: internal and external representations of the places we had been, and others we came to know. In the exploration of external place we transformed the metaphorical places we went to when unwell. Integrated into the stories we told, the landscapes we would come to know in all their richness were the expression of our healing.

In concluding this thesis I will bring together the aspects of place that facilitated healing. Coherence develops in an understanding of the process of healing: an integration of our experience of place and our relationships within; relationships that firstly supported us in our states of suffering, then facilitated the process of transformation that is healing. Attention then turns to the tension I perceived between healing and recovery, the tentative resolution being an indicator of the potential for me to hold hands with myself: a metaphor for the potential disruption of the power dynamics that kept me silent for so long. The third section

of this chapter turns to other tensions exposed by my multivocality. Extrapolating from my experience of autoethnography, I will explore the need for a negotiated space for dialogue within which service users and mental health professionals can engage willingly and respectfully, for the evolution of both without the subjugation of the other. The final section offers a pause for reflection and consideration of future directions.

Section I: Seeking integration

Three months after I left the Hall, I got a job working on a herb farm, a training scheme for people who were unemployed. I am sure that my decision to go there was determined by things that I had found really helpful at the Hall. I remember I built some garden beds using rocks we collected from a local farm. It was ages before I realised I had replicated them from the old stone walls of the Hall.

When I think now about the Hall, it is like I took it with me when I left: all the lessons I learnt, the people I met, the things we did, my bedroom, the lounge, the grounds. I have my memories, but it is more than that; I feel those experiences within me, they helped make me who I am today.

Beginning with the perceived differences between my service user experience and what I could offer as a health professional, and supported by my belief that we could learn from my and our service user experiences, in this thesis I picked apart the aspects of places that we described as healing. While offering the potential to identify elements for intervention, this separation also denies the dynamic interplay of relationships that inform our experience of place and ourselves. This section presents my attempt to weave together the elements thus far discussed: our experiences of what it was like to be unwell, and of healing, and of the places within which we healed; seeking integration. The validity of this interpretation will be judged by those who recognise themselves: be it the person who knows what it is like to be unwell, the professional mental health worker or academic. Seeking integration is a response to the fragmentation experienced in our illnesses; and an attempt to make sense of and integrate the often disparate elements of the researched mental health environment. It was in integration that I ultimately found healing; when viewed through a lens of the experience of illness and healing, the blocks that were scattered are pieced together, developing coherence, and becoming whole.

This interpretation is predicated on the conceptualisations of illness, healing and place, arising out of Parts II and III of this thesis. Defined by our illnesses, both in label and

experience, we experienced these illnesses as an existential disruption. Disconnected, fragmented and lost, we suffered; our life's meaning had collapsed, with little hope for change. Healing, being both process and outcome, is necessary when there has been a disruption of integrity; conceptualised as journey and destination (or perhaps resting place), healing was an intensely personal process of exploration in which we found ourselves. Interacting with our environment we made connections, developing understanding and wisdom. With time and hard work we integrated these experiences into our sense of ourselves, restoring our integrity, becoming whole; and in this process of transformation our suffering was relieved. A place that was healing was one that provided safe haven, holding us enough in a collaborative environment of care, hope and trust; while providing or creating space and opportunities for the hard work of exploration that underpinned our healing.

Place is space that becomes known (Tuan, 1977); more than the physical location and structures within, and more than the cumulative experiences, place is an accretion of interacting experiences, creating meaning that lends coherence to who we are in our worlds. Our experience and understanding of our healing places was contextual: as we told our stories of being in these places we offered rich pictures of what it had been like to be unwell and then of healing, providing a subjective context for the associations between place and healing. Initially informed by the understandings with which we arrived, context was open to change: just as Alice's hospital/prison became her monastery, I expected a hospital where I would be told what to do; instead I stayed for a year and went exploring. As we experienced these places in their complexity and richness, we developed new or more complex understandings; we developed new meaning. Redrawing our internal landscapes, black became purple, then all the colours of the rainbow; and our experience of illness and ourselves transformed. As we grew into our skins, these representations of place came to reside within us, integrated into our sense of ourselves: without conscious intent, I took the Hall's dry stone walls with me as I rebuilt my life.

Disruption, fragmentation and a place that held us enough

Understanding the subjective experience of illness and recovery offers a different way of making sense of what we need from places of care. Healing is necessary when we experience a disruption to our integrity or wholeness; while this is often considered in medicine as a disruption of physical integrity as with a broken limb or skin laceration, in mental illness this is an existential disruption, our illnesses being perceived as a loss of or threat to our sense of self. Our stories were redolent with fear and threat, these intense emotions being expressed in terms such maelstrom, battle, frightened, raw, desperate, excruciating pain, fierce fire and

rock bottom. Embroiled in our illnesses we were lost in places from which we feared we might not come back, loss being a prominent theme in all our stories: material and social loss, and loss of our sense of self.

These were illnesses in which we suffered; often experiencing our illnesses as relentless, we felt stuck with no escape, losing hope that our lives could be different. These were experiences that many of us struggled to make sense of; in the dissonance between our pre-existing sense of reality and the world we perceived through the lens of illness, we lost trust in ourselves and in our world. While loss of trust and hope were a consequence of our illness experiences, it was disconnection and fragmentation that lay at the heart of our loss of sense of self, and hence of healing. Experienced as feeling lost or going away, we described being disconnected from ourselves, from others and from our environment, expressed as the world seeming not quite real. We talked of being shattered, scattered, smashed and broken, these metaphors evoking a sense of fragmentation.

It was these experiences that explain our need for safe haven, providing relief from the storm that was our illnesses. These places also held us, understood metaphorically as a holding together to counter our sense of fragmentation, and a holding in place, a counterpoint to our sense of being lost or gone away. I hesitate to even discuss the notion of holding; psychiatry has such a long history of holding: in chains and jackets, and the restraining boards of tin baths; in physical restraint and the physical isolation of seclusion rooms; and in the legal mechanisms of compulsory admission to hospital and treatment. If we accept Seamon's (2015) assertion that place "remains one of the great stabilizing constituents of human life, in that it automatically holds lived bodies in place" (p.44), then the question becomes how might places hold us?

We described different sorts of holding. Sometimes it was a physical holding such as a hug when we cried our grief, or being gently cloaked in a shawl; only rarely was it the physical containment of a locked hospital ward. More often we described a metaphorical holding arising in an interplay of physical, relational, and structural aspects of these places: we were held by the familiarity of a home-like place, and by the routines, rules and rituals that anchored us in place. We were held in and by interpersonal relationships in which we were met with care and compassion; being embraced by their presence, a gentle kind of holding. And we were held by the reciprocity of trust in relationships within which we felt seen and knew we mattered. Bed rest, as a place where I felt held, told me that I and my distress were seen and valued; it was a retreat to a room and bed that was my haven within a haven; and it

was a structural element of our community, supported by the routine and ritual of meals on a tray delivered with kindness and care. Both held in place, not running away, and held together while I was battered by my illness experiences, this holding enabled me to be with my distress while I worked some things out for myself, developing my capacity for self-reflection. Holding was not a holding tight; an environment of mutual trust created space and opportunities to face the risk of fragmentation, and in the exploration we learnt to hold ourselves.

The need for a safe haven is not new in the mental health literature (Barker & Buchanan-Barker, 2010; Gilbert et al., 2008; Pinfold, 2000; Walsh & Boyle, 2009). Nor is a place that could hold us: at a stretch this could be applied to the acknowledged current purpose of often locked, acute inpatient units: containment for safety (Bowers et al., 2009; Glick et al., 2003). But it was the manner of the holding that differentiated places that were healing from others, and an understanding of holding as a response to the fragmentation of illness. It is interesting that I hesitated to use the term holding, fearing what psychiatry in its biomedical approach might do with this 'evidence' for 'holding'. Ours was a metaphorical holding, and it is perhaps in this shift from metaphor, conveying the complexity and richness of lived experience, to literal application that concepts lose their meaning, and we lose our heart: subjectivity gives way to objectivity, and the complexity of place becomes four walls and a locked door.

Creating space for exploration

I described our experience of illness as a collapse of meaning, this being who, why and how we understood ourselves to be; this was an experience most of us had in common, seemingly irrespective of our symptoms of illness. Places that were healing supported a process in which we found and came to know ourselves, and our place in the worlds in which we lived. It was in this respect that our experiences of place differed. Several people described environments that provided safe haven, but for most of us these places had the additional function of supporting the processes of exploration that were fundamental to healing. This exploration was hard work and took time, requiring a place that both metaphorically held us and provided space. Like others I experienced healing as a journey, moving from fragmentation to wholeness, and suffering to healing; one way of conceptualising this movement is that it occurs in space, whilst place that is known suggests a momentary pause (Massey, 2005; Tuan, 1977). Perhaps we were held by place, but it was in space that we explored: space contained potential and possibility, not yet known.

Creating space might be interpreted as distancing or removal, as in the space reserved for insanity that was the old psychiatric institution (Philo, 2004); but ours were spaces in which we connected, through which we moved physically and metaphorically, exploring as we went. We explored in many ways: having space from places that defined me, and in which I lived in great distress, created the possibility of something new; a safe haven gave us a place and space to be with our selves, providing not only respite from the storms of our illnesses, but also the opportunity to be self-reflective. As we met in the formal and informal doings and beings of our healing places, the intersubjective space was a place within which I explored my relationships with others in an environment of trust and reciprocity; experiencing what worked and what did not, and learning about myself in the process. The built environment gave us spaces that we could make our own, and in so doing helped us define who we were; the natural environment provided us with space to roam, both inside and out.

Mental health tends to think of the exploration of self as occurring in the context of formalised psychotherapeutic interventions and, although a number of us utilised these modalities on our journeys, we also described a variety of other opportunities, including walking, the creative potential of art, cooking, playing badminton, massage or simply sharing a cup of tea. Duff's (2012) concept of enabling resources: social, material and affective, captures this sense of an array of opportunities that aid the work of recovery; but I would argue that it is through exploration, a process that implies movement, that we develop the wisdom and meaning that underpin healing. Places that were healing, valued and fostered an interest in exploration that facilitated movement and change.

In understanding this exploration, I was reminded of Frank's metaphor of himself as a bricoleur who "wanders the byways and beaches of our lives picking up bits of narratives that appear and appeal to us. We do not yet know what we will do with these fragments but their use will come to us... Sometimes we piece together a story to render sensible something that in itself does not make sense" (Frank, 2009, p.186). Our lives in the context of illness often did not make sense, meaning being limited by the discourses available to us (Richardson, 2000). In our healing places, the multifarious and sometimes uniquely unpredictable opportunities for exploration and learning enabled the piecing together of a different story and metaphorical place to be: stories and places that were uniquely ours, that made sense and gave our experiences meaning.

Opportunities for Connection

An opportunity is a set of circumstances that make it possible to do something; in exploring our environments we found or created multiple opportunities to develop and test the connections that underpinned our healing. Exploration is an active process, placing the possibility with the explorer. Interpersonal connection is recognised as a fundamental aspect of the therapeutic environment (Hsu et al., 2008; Thibeault et al., 2010; Wendler, 1996); and a paucity of meaningful connections is often identified in modern mental health units (Hummelvoll & Severinsson, 2001; Mind, 2004; Quirk & Lelliott, 2001). Healing is a journey that is not undertaken alone; I required the company of others – if I could have done this on my own, it is likely I would already have done so. Nor were these journeys that others could undertake for us: not passive recipients of care, we were active participants making use of the opportunities available or created. The quality of the relationships we described as healing were different from those we had experienced elsewhere. Having a sense of reciprocity, these were ‘real’ relationships in which we felt seen and met as ‘real’ people, reflecting an understanding of shared humanity. There was recognition that the ‘I’ mattered on both sides of the interpersonal relationship, reflecting a willingness to share the intersubjective space, requiring a sense of collaboration and mutual trust. These were journeys of collaborative endeavour.

But connection was not just interpersonal, be it staff, fellow service users or family; our connections were multidimensional. Although connection in mental health care is usually considered only in the context of the professional/service user dyad, Mount et al (2007) supported a multidimensional view suggesting four types of healing connections: with oneself and others, with the phenomenal world as experienced through our senses, and with our spirituality. To this I would add connection with the broader physical environment, with which we develop relationships and meaning. Conradson (2005) made this point when he exhorted us to consider other aspects of the environment with which we emotionally engage including the objects, flora and fauna that populate our landscapes. This multidimensional view of connection makes sense when understood in the context of illnesses that provoked distrust in ourselves and our sense of reality: illnesses in which we experienced disconnection and uncertainty with respect to our emotions and thoughts, and our perception and understanding of the world we in which we lived.

Places that were healing were environments in which we found or created opportunities for connection with a larger and richer landscape (Cassel, 1982). We connected to ourselves emotionally, cognitively and physically; and often interconnecting all three: making

connections between thoughts and feelings, sensations and behaviours. We connected with others in various ways, in the formal and informal opportunities we found or created, to do or be with each other; these being relationships in which our humanity was shared, and within which we learnt. We connected with our physical environment: the home-like environment of our bedrooms connecting us to a place where we could belong; and our sometimes profound connections with the natural world that would become integrated into our sense of identity. And we connected with our spirituality in the rituals that sometimes began as routines, but developed meaning that sustained us. In these multidimensional processes of connection I came to fill the nooks and crannies of emptiness within the shell that was my skin.

Time for integrity and wisdom

The journey of healing takes time, this being a prominent feature of our stories: five of us described lengthy stays in our places of healing and we implied that time was necessary. This was not simply time for time's sake; while time-out can provide rest and thus be restorative, the time we took and were given was of different quality: this was time with purpose. As discussed in the introductory chapter, desperate to try and change something I decided to take time out from my job, and travel overseas. It is interesting to reflect that I spent a year travelling overseas, and a year at the Hall, suggesting that it was not just taking time that was critical; it was the purpose to which that time was put. Both could be viewed as journeys of exploration; I had thought that exploring the far reaches of the physical world would cure my ills, but nothing changed. Instead the necessary exploration required constructive, purposeful time, whether it be doing or being, directed at the processes of healing.

Our healing occurred within a journey of exploration which was hard work, a stark contrast to the often commented-on boredom experienced in many mental health units (e.g. Rose, 2001). The difficult labour, captured in the expression 'breaking rocks, cutting tracks', arose in the need to face our distress and the risk of fragmentation; rather than going away, or being lost, we remained in and around place. In our exploration of this and these places, we learnt, developing an understanding of ourselves and our illnesses; but more than this we developed wisdom. Wisdom, inferring the capacity to know what to do or how to respond in a given situation (R. J. Sternberg, 2004), implies a deeper form of knowing, requiring not only education or learning, but also a combination and synthesis of personal experience, practice and apprenticeship (Baltes & Smith, 2008). Being grounded in experience, the evolution of wisdom takes time. Rather than places to move through, these were places in

which we spent time both doing and being, with relationships akin to apprenticeship and the necessary opportunities for learning and practice. As we came to know these places we developed the wisdom that enabled us to continue to negotiate our life journeys.

Integration, the antithesis of fragmentation, is a phenomenon that remains elusive; I and we just knew it happened. We grew into our skins, becoming whole, calling in our thoughts and tying them back in place, the blocks that were scattered came together. Integrity, or the state of being whole, is an outcome of integration; healing being necessary when integrity is disrupted. I have already argued that integration took time and purposeful exploration; perhaps this is not so different from the healing of a physical laceration. Surgeons learn from experience that unless time is taken to explore and ensure the integrity of the underlying structures before closing a wound, there is risk of dysfunction or subsequent breakdown of that wound. Connection may happen in a moment, but the necessary integration in which we found wholeness, like wisdom took time and practice: much like riding a bike, as we experienced and practiced, the skills and understanding became integrated into our sense of who we were. Wisdom demands an element of self-reflection about life matters, and I suggested that it was in those moments of stillness, of being with ourselves, that integration might occur, supporting a link between wisdom and integration. Perhaps wisdom is the expression – in words, actions and emotions – of integration and integrity.

The need for time in our quest for wisdom and integrity raises questions about the function of mental health units, time now being a commodity in short supply in many modern services. In contrast to the endless time that people experienced in the old-style institutions, the time I am arguing for is purposeful time: time for doing and for being, engaged in the necessary exploration of experience within which we develop wisdom. While acknowledging the risk of another turn of the wheel, this tension will be discussed in the final section of this conclusion.

A hopeful place to be

This project investigated place from the point of view of what supported healing, rather than focussing on negative aspects of mental health environments, as recounted in much of the psychiatric literature. This was perhaps the first intimation of the necessity for hope in the journey of healing. The answer to the research question ‘what makes a place a place of healing for the treatment of mental illness?’ is perhaps simply answered as ‘hope’, this being implicated in many of the aspects of place we identified as healing.

Hope is an essential aspect of most explications of mental health recovery (Leamy et al., 2011), but what is hope? Hope is described as primarily a state of mind, or way of thinking about the future (Snyder, 2002; Snyder, Lehman, Kluck, & Monsson, 2006), encapsulating a belief in one's ability to set and achieve reasonable and personally valued goals (Schrank, Stanghellini, & Slade, 2008). Snyder (2002) conceptualizes this as goals, pathways and agency; Brown (2012) describes hope as knowing where we want to go, knowing how to get there, and believing we can. Our experiences of mental illness were imbued with a sense of hopelessness; with little hope for the future, I might have known where I wanted to get to, but I neither knew how to get there nor believed in my ability to do so. I was stuck; I needed to, and did learn hope. At times when I had little hope for myself, I was met by people who believed in and trusted me; this was a belief in my potential to process, understand and transform my illness experiences and my self. Belief in my potential being a necessary ingredient of hope, these people held hope for me when I couldn't do that for myself; and as I explored and gained wisdom, I began to experience hope for myself.

Hopelessness can be both a direct symptomatic consequence of mental illness, and indirectly a result of the associated stigma (Schrank et al., 2008); my experience was that it also developed from an environment of medical pessimism, in part my own. Place, and mental health places of treatment, concretize our assumptions and expectations of what it means to be mentally unwell (Bromley, 2012). In our healing places, sometimes with the right-timing that can manifest a turning point, we were met with an understanding and belief that healing was possible, with the necessary time and opportunities to explore, connect and integrate the wisdom that we developed. These were hopeful places to be: our monasteries not our prisons, where we saw light at the end of tunnel and the world just through our window; and where we met our hearts and grew into our skins. We came to know these places inside and out, re-authoring our life stories. We found meaning in our suffering, and our selves: becoming whole.

Section II: Healing the heart of recovery

When I first wrote about my service user experiences 24 years ago, I described the Hall as a place of healing; recovery was not part of my lexicon. Later, training in psychiatry, my practice was informed by the principles of recovery, yet these failed to capture the heartfelt quality of my experience as service user. This dissonance was the first of the tensions exposed in this project, arising in my positionality as both psychiatrist and service user. As researcher, I decided to set aside the concept of recovery, choosing to foreground my service

user experience of healing; but as I explored the literature the distinction became blurred. I argued in chapter three that the translation of personal recovery into a guiding vision for mental health services came with risk and loss, that being the dilution or, indeed, disappearance of the subjectivity that lies at the heart of our lived experience of mental illness. As a clinician, recovery was steeped in models, competencies and policy but as my research progressed and I read more widely, I ‘discovered’ the literature on personal recovery, Patricia Deegan describing recovery as ‘a journey of the heart’ (Deegan, 1996). Or perhaps I should say re-discovered; I remember reading Deegan as a junior trainee and being inspired, but put her experience-based writing aside as I continued my training, ‘becoming a psychiatrist’.

The capacity to heal is a universal, albeit unique, human experience; discussion in the healthcare literature is largely independent of medical speciality or diagnosis. Recovery, as applied in mental health, is context-specific. In mental health literature there is little mention of the concept of healing but are we in fact talking of the same thing? The early service user descriptions referred to healing as an aspect of recovery: Deegan (2002) described recovery as a process of healing and transformation; and conceptualisations of personal recovery as an active journey involving change, have resonance with healing (Lapsley et al., 2002; Leamy et al., 2011; Onken et al., 2007). Neither recovery nor healing requires absence of disease or cure, and both involve at their core unique and deeply personal processes that emphasise connectedness, meaning and transitions in identity (Egnew, 1994; Hutchinson et al., 2009; Onken et al., 2007). The strategies and processes that underpin both healing and recovery have much in common, for example: learning, emotional growth, and support from others (Lapsley et al., 2002). There is however a hint of difference in some literature, perhaps reflecting the ‘recovery from’ and ‘recovery in’ debate (e.g. L. Davidson & Roe, 2007). Deegan (1996) described recovery as a journey of the heart, but also that “recovery is an attitude, a stance, and a way of approaching the day’s challenges” (p.96). Likewise Anthony (1993) wrote of recovery as a “way of living a satisfying life... even with limitations caused by illness” (p.527). In contrast to the wholehearted endeavour of healing, recovery for me still carries a suspicion of personal deficit to be struggled against.

Both Anthony and Deegan worked in rehabilitation psychiatry and their early work is written within a frame of disability, with Anthony explicitly referring to adjustment to disability being part of recovery. My journey was one of personal recovery, developing a life that is extremely satisfying and hopeful; I am able again to contribute to society. But as I skied down that slope in the fields behind the Hall, and when I walked out their door for the last

time, I also experienced a sense of peace and joy, and of wholeness. There is a qualitative difference to my experience, Colin's blooming, Margaret's being in the sanctities of creation, and Barb's moments of contentment, that is often missing from formulations of recovery. These qualities are perhaps better captured by the concept of healing.

I began this project disconnected from recovery but have come to re-embrace the concept with healing at its heart: I suggest that it is through healing that I achieved recovery. Healing reminds us of the fundamental personal processes at the heart of our journeys, with the added potential of a universal human experience removing a sense of othering. Recovery offers a widened vision incorporating community and societal issues and responsibilities such as stigma, social integration and rights for and of citizenship: important areas of the recovery from mental illness that have not been explored in this thesis (e.g. Hamer, 2012). Deegan's original descriptions of personal recovery invoked healing, suggesting that the concept was not necessarily the problem; rather it was the recovery I had come to know as a clinician. The literature that formed the basis of my training and ongoing education, and the policy documents I was expected to know, placed emphasis on evidence based medicine. Endorsing nomothetic rather than idiographic research perspectives, this was literature within which I was unrecognisable. Recovery's translation from the richness of experience, often expressed as metaphor, into the professional language of principles and policy risks an associated loss of the heartfelt, subjective qualities of personal recovery. A recovery that I recognise and that recognises me is one that embraces, and put at its heart, the lived experience of mental illness.

Section III: Creating space for multivocality

I began the journey of this thesis with a desire to reclaim my service user voice. In the process of becoming a psychiatrist this part of me had become silent, unable to bridge the apparent divide between service user-me and psychiatrist-me; unable find a place to articulate the hard-earned wisdom I had gained, and unable to apply that wisdom to influence service provision or development. I was not alone. With respect to mental illness, silence remains the default position for many health professionals (Hinshaw, 2008c). Setting out on this journey required an assumption that my experiences had value. I never really doubted this, covertly at least, but other forces had been at play, my relative silence reflecting the power relations still so prevalent in our health services. It was as if we spoke different languages, and the language I spoke as service user had no meaning or value beyond the identity of illness.

Challenging the dominant paradigm of evidence-based medicine, a postmodern sensibility in psychiatry is one that values the voice of lived experience, creating space for multiple discourses (Bracken & Thomas, 2001). Service user research, with its origins in the 1980s, aimed to develop an alternative discourse that challenged mainstream psychiatric knowledge (Sweeney, Beresford, Faulkner, Nettle, & Rose, 2009); my problem was that simply embracing a service user perspective risked silencing psychiatrist-me, reversing the roles. Autoethnography provided the means to explore my service user experience, but in my relatively unique positionality of also being a psychiatrist, it also created opportunities to explore this multivocality. Giving representational space for my plural and sometimes contradictory voices (Mizzi, 2010) offered the potential to observe, if only marginally, the dynamics that had kept me apart from myself.

The focus of this enquiry was the facilities in which we provide mental health care, this being the most overt area of dissonance between my personal experience of what worked for me and what I was able to offer as a professional. The methodology of autoethnography suggests that I am well positioned to explore the subjective experience of illness and place, and much of the thesis was investigated and written from my service user perspective. In the reflexive to-and-fro process of analysis, however, I exposed tensions between my medical professionalism, and the hard-earned personal understandings developed as I recovered from illness. These tensions manifested concretely in consideration of medication, diagnosis, and safety, and more abstractly in differing understandings of recovery, as discussed above: my service user experiences conflicted with my professional training. While I reached a resolution in understanding the relationship between healing and recovery, other tensions still do not sit comfortably together. As a result of my journey of healing, I ceased to think about my illness experiences in terms of diagnosis. Although I probably met criteria for both bipolar disorder and severe treatment-resistant depression, these were no longer labels I usefully applied to myself; yet diagnosis remains a cornerstone of my work as a psychiatrist. Similarly I have briefly discussed my personal ambivalence towards medication, yet I continue to prescribe, recognising the contribution medication can make to others' recovery. An understanding of safety and risk remains an evocative tension beyond the bounds of this thesis; the management of risk is fundamental to my work, but as stated firmly by one participant 'your risk is not my risk'.

Consideration of the perspectives of service users, in the context of our journeys from illness to healing, potentially opens up new ways of thinking about the environments in which we provide mental health care, but this project also identified tensions between professional

knowledge and lived experience that I suggest are reflective of wider dissatisfaction with the provision of mental health care. Service user-me and psychiatrist-me spoke different languages: one based in the realm of subjective experience, the other steeped in an objectively weighted biomedical discourse; these subjective and objective voices offer different perspectives and ways of knowing. This is the tension between different forms of knowledge and what counts as evidence, as previously discussed in relation to service user and mainstream research. While at the beginning of this thesis I resisted fragmentation of my multiple voices, for it was in integration I found healing, I have also had to grapple with dissonance, manifesting as the space between my voice of experience and of psychiatrist.

On our journeys of healing, understanding and wisdom developed in the exploration of space. Extrapolating from the multivocality of autoethnography, to a consideration of the multiple perspectives of service users, health professionals, researchers and organisational structures, perhaps it is in the exploration of this space of multivocality that the necessary wisdom for mental health services resides. The 'negotiated space' is a purposeful space of engagement at the interface between different world views and knowledge systems (Hudson, Roberts, Smith, Tiakiwai, & Hemi, 2012; Hudson, Roberts, Smith, Hemi, & Tiakiwai, 2010). First described as a model for engagement between Maori indigenous knowledge and Western science, the concept has been expanded to explore the relationship between other cultural understandings of mental health and illness (Mila-Schaaf & Hudson, 2009). Emphasising the need to recognise the value of different forms of knowledge, respect for each other's process of critique and questioning, and remaining open to one's own potential for transformation and change, engagement in this space has the intent of evolution of all participants rather than either integration or subjugation of the other.

Given the research focus on healing aspects of place, I have been limited in the way these tensions could be explored, offering areas for fruitful future work. It is perhaps in a consideration of wisdom as the combination of experience, knowledge and apprenticeship that mental health can benefit from the service user experience in a quest for a richer, more nuanced, understanding. While autoethnography facilitated the beginnings of a dialogue between my multiple voices and differing perspectives, enabling me to hold hands with myself, there remains the wider issue of competing discourses: service user/health professional/political-economic/societal. Creating space for exploration to occur, the negotiated space for dialogue becomes a place within which service users and mental health professionals can engage willingly and respectfully, for the evolution of both without the subjugation of the other.

Where is my white coat now?

Engaging in the work of this thesis has not left me unchanged: my identity as a doctor and psychiatrist has been shaken and stirred. I said of my experience at the Hall that I was able to 'leave my white coat at the gate'. The metaphor of a white coat referred to my identity as a doctor; leaving this behind conveyed my sense that at the Hall, I was seen in my entirety rather than the façade I presented to the world: the competent white-coated doctor. I wrote in my research diary:

My white coat represented the layers or defences I had developed, that kept me away from others and from myself. Perhaps my white coat was also what held me together (albeit in a not very useful long-term way) when I felt so vulnerable. My white coat allowed me to repeatedly pick myself up and go back to work, but nothing fundamentally changed. To use Alice and Barb's words, I had not yet 'depthed' or 'faced' myself.

My white-coated identity contained layers of assumptions made by me about myself, and by others about me; with associated expectations of what it meant to be 'a competent doctor' (Blumhagen, 1979). This was the identity I showed to the world; perhaps over time it had also 'become me': an identity that was not serving me well. Druss (1998) referred to the doctor's white coat as a 'shield for the soul': my white coat protected me from the emotional demands and responsibilities of my job, of facing into others' distress. With the pretence of protection, it also became a means to shield me from my own distress; in the years leading up to my admission to Ashburn, I had become disconnected from myself. In the act of leaving my white coat at the gate, I was acknowledging my vulnerability: I needed to be cared for rather than caring for others. But more than this the Hall enabled me to drop the façade of the competent doctor, to reconnect with myself, and grow into my skin.

When I left the Hall I had no intention of keeping my experiences secret, so why in the process of my subsequent training to be a psychiatrist did I become silent? It would be easy to claim that I was silenced by others, but my experiences through this project suggest something more. The autoethnographic process has at times not been a comfortable one. While I appreciated the opportunity to re-visit experiences that were personally transformative, the re-visiting was often evocative and demanding. But there was another discomfort; as I engaged more directly with my service user experience, I began to struggle emotionally with my clinical work. From my research diary:

I feel like I have been stripped raw, my emotions laid open for all to see- yes a little melodramatic, but it is how I feel. I have been at work again the last two days; the transition from thesis to clinical work is hard. Do I go into work too open, too exposed? Have I not got my protection in place? As I put myself repeatedly back into my service user's shoes, I find it harder to hold my professional stance. What is this tension... between me and other, between subjectivity and objectivity, between emotion and thought, between me and my self? Does the professional stance protect us from our own vulnerability and anxiety? But it is also what keeps me away from myself.

Church (1995) made a similar observation. As a psychologist researching survivor participation, she said of her relationships with survivors: "they cracked me open as a person" (p.2), also observing that health professionals were often discomforted when confronted with survivor knowledge. She suggested that to engage in survivor research she needed to undergo a process of professional and personal deconstruction. Much as I picked my self apart in the process of healing, perhaps what I experienced as I continued to work clinically through this research was my deconstructed professional self. So did and do I need my white coat, my shield, in place; or can I piece myself together integrating and making use of the wisdom of experience? Like Church, I don't necessarily have the answers yet, but if I trust my explication of the healing process then in the hard work of exploration, and with time for integration, I have the potential to develop a far richer landscape within which to work.

This project began with a desire to reclaim my service user voice (even if subconsciously, I knew that professionally I was missing out on the richness of experience and its attendant wisdom), but at times I threatened to lose my psychiatrist's voice. Autoethnography exposed the tensions in me: between service user and psychiatrist; and for now it has enabled me to hold hands with myself. Perhaps my adopted stance of foregrounding and backgrounding, rather than separation of voices, offers an approach to the holding of these tensions: no longer either/or, I am this – and. Recognising we can speak different languages and have different points of view, an awareness of the tensions allows me to make informed choices. No longer othered, I am valued; and, holding hands with myself, I can draw on the best of both worlds. I am developing a comfort with engaging in discourse that occurs in the space between knowledge and experience, within which resides wisdom. I hope that in these places of healing, I have regained the heart in my work.

Section IV: Reflections and future directions

This thesis has developed ideas in several domains. The first is the potential in exploring subjectivity, and specifically the service user experience, to better understand and inform service development and delivery: valuing the wisdom of experience. The second is the explicit exploration of place as it facilitates healing, indirectly questioning the current organisational structures of acute mental health units and other options for mental health care. The third is a reflection on the concept of recovery, arguing for a consideration of the universal phenomenon of healing as integral to recovery. The fourth area of interest has been, somewhat peripherally, an observation of the intersection of my particular positionality, and what my service user experience means and contributes to my identity and work as a psychiatrist. Each of these four domains offers potential for further development and application, and while I have drawn on mental health and geographic literature and what they offer to enrich understanding, I am aware of the multiple other perspectives that can potentially be brought to bear in consideration of each of these domains.

This project has offered formulations of illness and healing, and of aspects of place that facilitate healing, but the methodology of autoethnography comes with limitations. Although some features of my positionality create opportunities for insight and wisdom, the interpretations that have developed are limited by others: I am white, female, educated and middle class. These attributes potentially influenced both my access to care, and my experience of that care, being implicated in the power dynamics that may contribute to service inequality. Additionally, I was never treated compulsorily, nor did I have a psychotic disorder, though the research recruitment addressed these differences to a limited extent. I accept the potential that interpretations I have generated are inadvertently, and perhaps inevitably, influenced by these attributes and by my psychologically informed education.

Autoethnography is an emergent methodology in the mental health research landscape; although with a now several-decade pedigree in social sciences, the methodology still has little or no uptake by the medical profession. With the intention of offering emancipatory perspectives, and challenging canonical ways of doing research and what counts as evidence, autoethnography may require time and repeated exploration to integrate into 'the way things are done'. Autoethnography seeks validity through verisimilitude, meaning that the experience described seems believable and possible (Ellis, 1999). This will be for the reader to determine, but an early test has been the responses of varied audiences who have heard earlier versions of this work. Including service user, peer worker, geography and psychiatric

audiences, these presentations have often been a prompt for others to tell me their stories, suggesting elements of identification and connection with the stories I have told. Somewhat to my surprise, the feedback has generally been of interest and enthusiasm from both service user and health professional audiences; although I accept I might not have heard from those listeners who dismissed the validity of such approaches to research, and chose to walk away.

My hope is that this research project and thesis will sensitize the reader to ideas that need further development, identifying areas that can be explored and tested by other methods. These include, but not discussed here further: the multifarious opportunities that supported our exploration; and the notion of empathy and trust as reciprocal transactions in the intersubjective space, which would benefit from further exploration within the dynamic. A key component for future work is the richness of multivocality, which can manifest in interdisciplinary approaches to work and research: akin to the multiple perspectives paradigm (Rose et al., 2006).

Just as this thesis began with an acknowledged personal interest in the focus of the research, I have identified areas for future development that have particular interest and relevance to me.

- I described our places of healing as metaphorically holding us while creating space and opportunities for exploration. These are highly subjective experiences, with inherent tensions that deserve further qualitative exploration. It is in a wider understanding of the experiences of holding, and of space for exploration, that we may find alternatives to locked doors and compulsory treatment. This work would benefit from multidisciplinary input including, but not exclusive to, service user, mental health professional and service provider, with the addition of architectural and geographic conceptualisations of space and place. I began this project with no knowledge of the subspecialty of mental health geography: perhaps a consequence of academic silos. In the bringing together of multiple perspectives we create the potential to visualise new and different places for healing.
- This project began with my assumption that people with serious mental illness may benefit from being away from home when unwell: creating space to heal; and that seems to have been supported by some of our experiences. The scope of the study is unable to resolve the issue of what type of place we need and where it should be, offering instead a descriptive formulation; but perhaps the most contentious aspect is the problem of time. We currently provide services, both inpatient and outpatient, that emphasise short-term interventions; the drivers for this approach are both

philosophical and economic. I have argued that healing and recovery take time, but challenging the current focus is difficult. Historical approaches to mental health care have been critiqued for the long-term sequestration of people who were unwell; and there are still unanswered questions of where and how recovery is supported. At an individual level (me), the investment of time and money 25 years ago paid dividends both personally and societally: simplistically considered as a financial transaction, I have subsequently paid considerably more in taxes than the cost of the treatment that helped me return to work. The benefits of the investment are considerably wider: with no further admissions to hospital or other mental health costs, the question remains how we count the non-economic contributions I and we make to society. Extrapolating these long-term cost-benefits to a population level has its challenges, but should be possible, guided by measures of outcomes that have relevance not only for services and society, but also for service users.

- The notion of a negotiated space for dialogue raises interesting options for exploring the multiple perspectives touched on in this thesis. I am fascinated by the emergence of language, with its potential for silencing, as a significant aspect of the divide I experienced between psychiatrist-me and service user-me. Autoethnography has the intention of challenging the dominant discourse thereby making it a useful methodology for investigating and deepening our understandings of the differing discourses of madness/illness. Collaborative autoethnography, involving both those with lived experience and health professionals, offers a space for these discourses to meet.
- The last area of interest is of particular personal importance: the intersection of my perspectives as service user and psychiatrist. This thesis serves the purpose of ‘breaking the silence’ (Hinshaw, 2008c) that shrouds the psychiatrist’s personal encounter with mental illness, with the potential not only to counter stigma but also to provide hope. Rather than viewing mental illness as an impairment (Wilson et al., 2009), I have begun to consider the aspects of my and our experiences, and the resultant understandings, that contribute positively to the provision and development of mental health care. In breaking the silence we create an opportunity to explore what it means to be a psychiatrist with experience of mental illness, with the resulting possibility for associated wisdom.

And so my journey continues. As I spend more of my time as psychiatrist the balance will shift, but this thesis offers hope, and expectation, that service user-me will no longer be silent. The opportunity is there for service user and psychiatrist to continue in conversation,

exploring our often different perspectives, knowledge and experiences, developing understanding and contributing equally to a wiser mental health service.

Appendix one: Participant information sheet

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PARTICIPANT INFORMATION SHEET FOR INDIVIDUAL INTERVIEWS

What makes a place a place of healing for the treatment of mental illness?

My name is Jackie Liggins and I am a student enrolled in a PhD programme in the Faculty of Medical and Health Sciences at the University of Auckland. I also work as a Liaison Psychiatrist at Middlemore Hospital in Auckland, and am a past service-user of mental health services in New Zealand. For my PhD I am undertaking a qualitative research project, supervised by Associate Professor Peter Adams in the School of Population Health and Professor Robin Kearns in the School of Environment, at the University of Auckland.

The study, "What makes a place a place of healing for the treatment of mental illness", aims to identify and describe the factors that make a treatment place, a healing place to be for people with mental illness. In the last thirty years, in New Zealand and overseas, there have been major changes in the environments in which mental health care is provided ('deinstitutionalisation' saw the move from large 'mental hospitals', or asylums, to community based care). Although the philosophy of community-based care is that treatment is provided while people continue to live at home, there are still times when, for various reasons, home is not an option, and people may be admitted to hospital. The first part of this research project has involved me describing my experiences of being admitted to various mental health treatment places in New Zealand, and my experience of working in similar environments as a psychiatrist, and considers healing aspects of place. I am now interested in hearing from other service-users about past or recent experiences of mental health units, or perhaps other types of places that they have gone when mentally unwell, and the experience has been a positive and healing one. My hope is that knowledge gained from this study can influence the ongoing and future development of mental health services in New Zealand.

So, I am seeking participation from service-users who have previously been admitted to a mental health unit for treatment of mental illness, on at least one occasion and for more than a few days. You also need to have had an experience of what you consider to be a **healing** mental health environment that has aided your recovery in an ongoing way. This positive experience may have been the mental health unit admission or another place away from your usual place of residence.

I am asking you to volunteer to meet with me, on two or three occasions. At our first meeting, I wish to have a conversation with you about your experience of mental health environments, particularly with respect to the positive, healing experience. At our second meeting, I will tell you something of my experience so that we can have a discussion about similarities and differences between our experiences, and so that I can better understand your experience of a 'healing place'. These interviews will take place in a setting that is convenient for you, at a time that suits you, and I anticipate taking 1 to 1 ½ hours for each interview. With your permission I will record our interviews using a digital recorder (you can ask for the recorder to be turned off at any stage during the

interview). The recordings will be transcribed, and I will also write a brief narrative that reflects your experience (if needed we could meet again to finalise this). The transcripts and narrative will be given to you to review, enabling you to amend or withdraw any information you have provided. These interviews will require us to have contact over a period of approximately two months.

I will analyse the narratives and the interview transcripts of participants, as well as my story, to identify and describe the features of mental health environments that promote recovery and healing from mental illness. Please note that all personal information will remain strictly confidential and you will not be identified in the thesis or any publications or presentations resulting from this research. Pseudonyms will be used on transcripts and Identifying features will be removed from the material so that anonymity is ensured. The interviews will be transcribed by a professional, who will sign a confidentiality form to confirm that they will not disclose the content of the information that you have given. The transcriber will protect your files using a password and destroy all records once they have forwarded copies to me. All recordings and written material will be stored in a locked cabinet within the University of Auckland premises and will be destroyed six years after completion of the study. My computer files will be password protected for security.

Your ongoing emotional and psychological safety is important to me. I am an experienced interviewer and have worked for many years in mental health services. Participating in this study is an opportunity to talk about your experiences and share ideas about what creates a healing environment in mental health services. However, taking time to reflect on your own personal experiences may evoke difficult memories or emotions. I will be able to identify and minimize any possible psychological stress that may arise in the discussion and if necessary provide guidance for obtaining support for you. To minimize this potential risk, I ask that you consider yourself mentally well before participating in this study.

You can withdraw from the study or withdraw any information you have provided until two weeks after our last interview. If you have any further questions about the research, and/or have decided you would like to be a participant, please contact me at the email/phone number on the letterhead. If you agree to take part in this study you will be asked to sign the consent form attached before the first interview. You will be offered a summary of the findings on completion of the study.

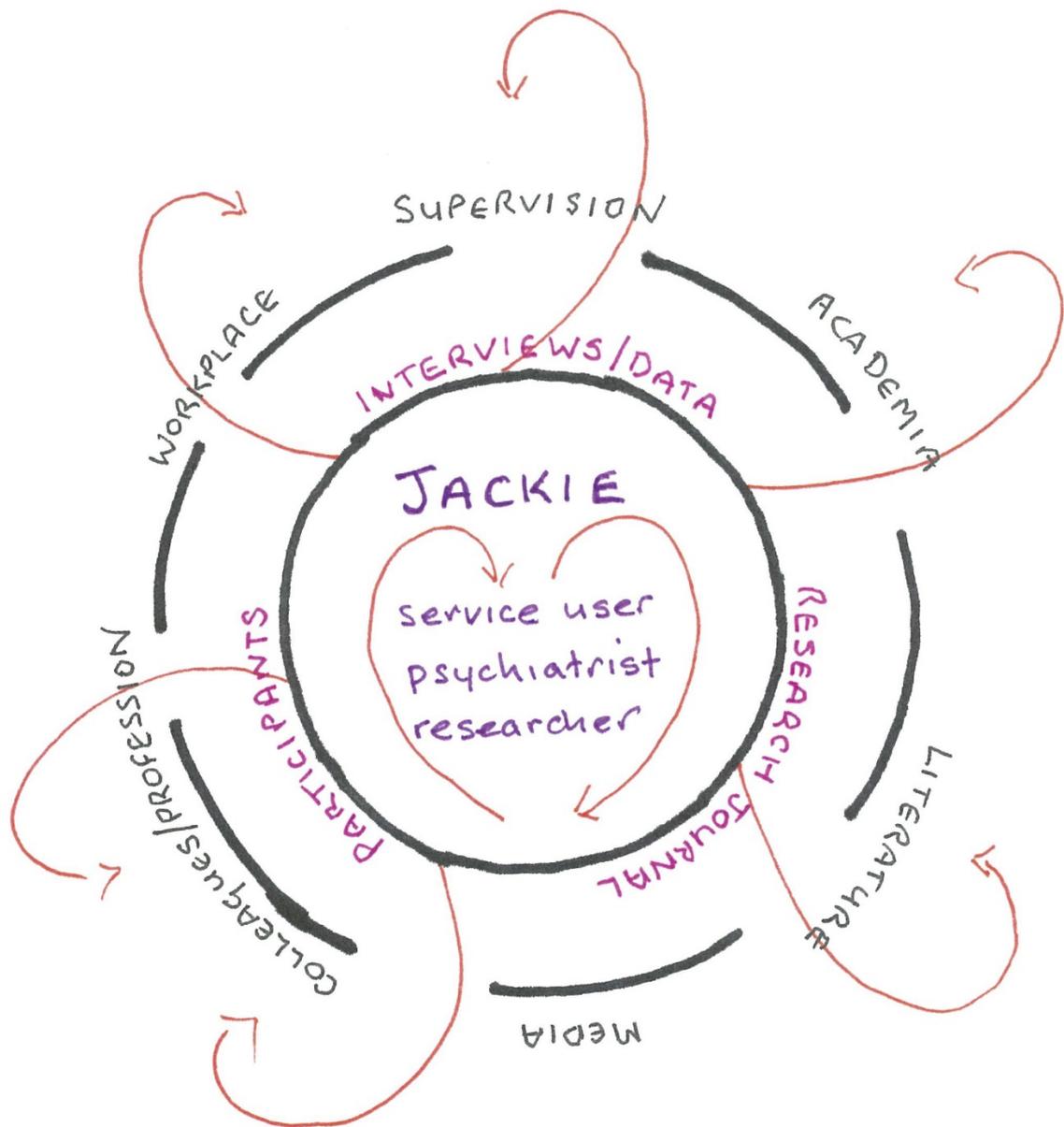
If you have any concerns or queries regarding this study please do not hesitate to contact me (Jackie.liggins@auckland.ac.nz or ph: [REDACTED]), or my supervisor Assoc-Prof Peter Adams (phone (09) 373-7599, ext 86538, email: p.adams@auckland.ac.nz) or Head of Department, Assoc-Prof Elsie Ho (phone (09) 373-7599, ext 86538, email: e.ho@auckland.ac.nz).

If you have any ethical concerns about the study you may contact the Chair, The University of Auckland Human Participants Ethics Committee, The University of Auckland, Office of the Vice Chancellor, Private Bag 92019, Auckland 1142. Telephone 09 373-7599 ext. 83711.

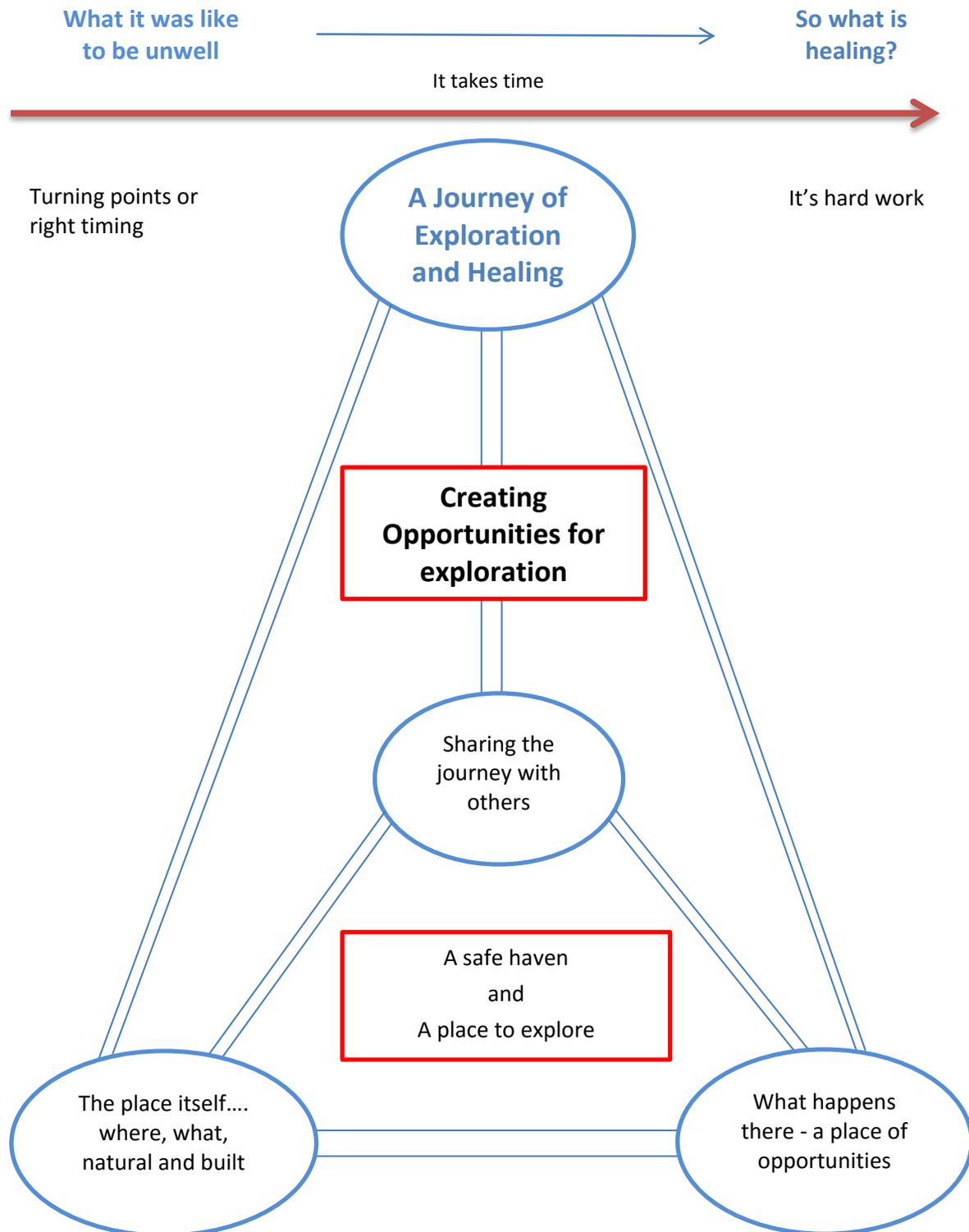
Thank-you for taking the time to read this information sheet.

APPROVED BY THE UNIVERSITY OF AUCKLAND HUMAN PARTICIPANTS ETHICS COMMITTEE ON 24 FEBRAURY 2012 or 3 years. Reference Number 7934.

Appendix two: Visual representation of my autoethnographic process



Appendix three: My conceptual framework for the journey of healing in place



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