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## Life at a rural psychiatric hostel : The experience of a group of male residents

Rosalie R. Van Aken  
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**LIFE AT A RURAL PSYCHIATRIC HOSTEL:  
THE EXPERIENCE OF A GROUP OF MALE RESIDENTS**

**BY**

**ROSALIE VAN AKEN**

**A thesis submitted as partial fulfilment for the degree of**

**MASTER OF NURSING**

**at the School of Nursing, Edith Cowan University,  
Western Australia.**

**DATE OF SUBMISSION: 31st January, 1995**



## USE OF THESIS

The Use of Thesis statement is not included in this version of the thesis.

## **ABSTRACT**

The study reported in this thesis describes and analyses the experience of 15 men with long term mental illness, living and/or working at a rural farm and hostel complex. The research was set in the context of recent studies and literature focussing on the transfer of care of people with mental illness from large psychiatric hospitals to community based care and the consequent quality of life issues.

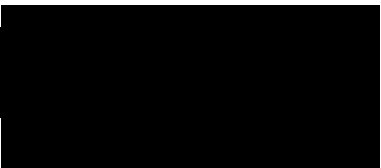
A phenomenological approach was chosen as the most appropriate for the study, in order to understand the meaning of the residents' experience. Data was obtained from three sources: in-depth interviews with 2 key informants, 50 hours participant observation involving 15 residents and 8 staff and focussed or semi-structured interviews with 10 participants. The Ethnograph computer program was utilised to facilitate and expedite analysis of the resulting large volume of data.

The four themes that emerged from the data analysis reflected the major meaning of life, for the men, at the hostel. They were a sense of belonging, valued relationships, enabling activities and a spirit of hope. After sharing these themes with the participants, the researcher returned to the literature with a view to critically analysing the themes and disclosing any relationship to existing theory. The study extends ideas from previous literature by proposing a model outlining aspects of recovery/rehabilitation for people with long term mental illness. Implications for psychiatric/mental health nursing knowledge were examined with emphasis on empowerment issues for people with long term mental illness. Finally, recommendations were made for further nursing research which would extend this work.

# DECLARATION

I certify that this thesis does not incorporate without acknowledgment any material previously submitted for any degree or diploma in any institution of higher education; and that, to the best of my knowledge and belief, it does not contain any material previously published or written by another person except where due reference is made in the text.

SIGNATURE:



DATE:

31. 1. 1995

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# **CHAPTER ONE**

## **INTRODUCTION**

This thesis describes a study of the experience of 15 residents, with a long term mental illness, living and/or working at a rural psychiatric hostel. The study is based on the assumption that accurate information on the meaning of the experience of people with long term mental illness would be gained from those experiencing the phenomenon.

The study seeks to make a contribution to knowledge in the following ways. Firstly, it extends prior research. The majority of previous studies, within supervised settings, have sought to describe single aspects of experience without examining the total experience. The prior research has, however, given no decisive indication as to how people with long term mental illness experience differing settings and what it means to them. Secondly, each setting has distinctive social characteristics. These range from almost totally unsupervised, boarding house type accommodation to highly structured, fully supervised settings. The hostel milieu, in this study, differs considerably and is also based in a rural setting. The third contribution to knowledge lies in the development of a model of recovery/rehabilitation generated from the data. With further research, nurses could utilise the model to assist the person with a long term mental illness, in the recovery process.

### **Background to the study**

This study is based on increasing concern for people with mental illness and their quality of life, within the changing structure of the mental health system. During the past two decades there has been a trend in English speaking countries for movement of mental health care away from large state hospitals. This is

acknowledged to be the most significant change in mental health care since the era of large mental hospitals began in the early 19th century, when it was argued that people with mental illness required care and asylum (Moffatt, 1988).

In the 1960's, the initial impetus for implementation of large scale movement from the hospital system, was in response to studies that highlighted the adverse and dehumanising effects of hospitalisation (Barton, 1959; Goffman, 1961). The traditional hospital system for people with a mental illness was viewed as stigmatising and responsible for many aspects of chronicity (Smith & Harris, 1991). The other major influences in the move away from hospitals were the spiralling costs of care and the advent of effective psychotropic medications (Leibrich, 1988).

By reducing the severity of symptoms, the use of psychotropic medications, made it feasible for people with mental illness to be discharged from hospital. However, Flaskerud (1986) argues that although these medications have reduced hospitalisation, individuals with long term mental illness continue to have a range of functional and health deficits, that compromise their ability to function in the community setting.

Goldman, Gattozzi and Taube (1981) contend that a person is seen to have a long term psychiatric disorder on the basis of psychiatric diagnosis, duration of disorder and functional disability. A diagnosis of long term mental illness or chronic psychiatric disorder usually applies after several episodes of a psychiatric illness over an extended period. Horsfall (1986) asserts that studies demonstrate that at least 57% of people with a long term mental illness have a primary diagnosis of schizophrenia and a further 12% have a bi-polar disorder. O'Connor (1994) maintains that schizophrenia is a heterogenous disorder with no proven cause

although present evidence implicates genetic inheritance patterns, viral or toxic exposure and susceptibility to stress. However, Malone (1990) contends that knowledge about schizophrenia is only in the beginning stages. Bi-polar disorder is a mood disorder characterised by alternate cycles of overactivity and depression (Rawlins & Heacock, 1988). Functional disability resulting from the effects of long term mental illness is more abstract and less easily defined.

Munjas (1986) describes people with long term mental illness in two ways: firstly as those whose psychiatric disorders erode their capacity for managing aspects of daily life and secondly, as being socially isolated resulting in exaggerated dependency needs. Erstoff (1989) argues that the process of developing long term mental illness is essentially social and interpersonal and not an inevitable consequence of primary symptoms or neurochemical abnormality. Bridges, Huxley and Oliver (1994) assert that the personal costs of long term mental illness include the burden of psychopathology, social disabilities, increased physical disorders, reduced material resources, reduced opportunities for personal development, poor quality of life, dissatisfaction with services and increased burden on primary support systems.

Richmond (1983) reports that Australian studies indicate that approximately 1.5% of the population have a serious, long term mental illness. Over 5,000 thousand adults have been diagnosed with long term mental illness in South Australia (Zadolinnj & Zadolinnj, 1991). In Western Australia, The Report of the Psychiatric Rehabilitation Advisory Group (PRAG) (1991) estimates that there are between 1,700 and 1,900 adults with long term mental illness. This is a much lower estimate than Richmond (1983) made which, with the adult population of Western Australian being approximately 1,000,000 (Cassells, 1992), would furnish

a figure of 10,000 people with a long term mental illness. The reason for the discrepancy is unknown.

Regardless of which estimate of the number of people with long term mental illness in Western Australia is correct, the trend to reducing hospitalisation continues. A system of subsidised, licensed, privately owned hostel accommodation has been implemented throughout the Perth metropolitan area. Residential places are provided for 660 people, most of whom have a long term mental illness (Health Department of Western Australia, 1991). The majority of hostels do not employ health professionals, though several have group workers who visit and a small number offer rehabilitation programs. This is in direct contrast to the site of the present study which provides 24 hour psychiatric nursing services and a comprehensive rehabilitation program.

While the Health Systems Task Force (1988) document claims that existing moves to community based care are successful, other authors dispute this assertion (PRAG, 1991). On a global basis, Anthony (1993) maintains that the movement away from large hospitals is about 'bricks and mortar' and not people. He suggests that attitudes toward and expectations of persons with long term mental illness have not changed within this era (Anthony, 1993). Brown (1985) adds that the transfer of care often involves a shift of location yet retains traditional forms of control.

The Australian Health Ministers (1992), in the National Mental Health Policy, recognised that priority should be given to people with serious, long term mental illness. This assertion is supported by Burdekin, Guilfoyle and Hall (1993b), from the National Inquiry into the Human Rights of People with Mental Illness, who claim that many people with mental illness, in all states of Australia, confront major



problems. These problems include living in 'appalling' conditions with inadequate numbers of trained staff and lack of services caused by savings not being redirected from large state hospitals to the community. Accommodation is seen as one of the major problems with Government housing programs routinely excluding people with long term mental illness. The major difficulties encountered by these people include housing being expensive, substandard or inappropriate with boarding houses becoming the new 'institutions' (Burdekin, Guilfoyle & Hall, 1993a)

A number of authors document the physical and social needs of people with long term mental illness. For example, Harries, Jayasuriya, Werne and Dickinson (1991) in their study on the social needs of people with schizophrenia in Western Australia, found that suitable accommodation remains a major issue. Satisfactory housing is only part of the larger picture of the unmet needs of people with long term mental illness within the community. Other areas of concern include day care, social skills training and vocational support (Burdekin et al. 1993a, 1993b ; Lavender & Holloway, 1988). Bridges et al. (1994) contend that the needs of people with long term mental illness include material aspects, role performance skills, reduction of symptoms, social skills, self esteem and awareness. In the National Strategies Issues Paper No 5 (1993), living skills, vocational skills, accommodation, support and family education are highlighted. Although skill development has been identified as a vital need, the majority of people with long term mental illness are not afforded any opportunity to do so (Anthony, 1993). The site chosen for this study offers accommodation, social and vocational skills programs, therefore addressing the issue of suitable accommodation highlighted in the literature.

### **Significance of the study for nursing**

In investigating the experience of residents of a rural psychiatric hostel, this study will add to the knowledge base of how people experience a hostel environment. Knowledge of how individuals cope with mental illness outside the hospital setting remains limited (Malone, 1989). While studies on hospital services and clinical symptoms abound, information from residential settings, both urban and rural, is rare. The Australian Health Ministers (1992) concede that research in the area of mental health care needs to be given a higher priority, particularly in the area of long term mental illness.

Clinton (1994) asserts that a major criticism of mental health nursing research has been that the perspective of the consumer has been largely ignored. This study has addressed that criticism in seeking to understand the meaning residents attribute to their experience at the hostel. In fact, Munhall (1992) advises that “nursing knowledge must include human experience” (p. 262) and concludes that “meaning will enlighten and give direction to nursing practice” (p. 262).

Another major criticism of psychiatric research is that there is a continuing focus on causes of disorders and the vital issue of care for people with long term mental illness has been neglected (Crosby, 1987). By investigating the experience of this population this study will provide a base from which to begin focusing on nursing care. Psychiatric/mental health nurses have extensive contact with people with long term mental illness. They are often primary caregivers and therefore have the potential to improve care for this vulnerable population (Flaskerud, 1986; Worley & Albanese 1989).

Although some of the needs of people with long term mental illness have been identified, to date, care has been dictated by the needs of the service, not the needs

of the person with mental illness (Jasper, 1994). An understanding of the experience of this population will enable nurses to respond more effectively to their needs and will provide a basis from which to begin developing realistic, specific support networks.

Nurses will have an increased sensitivity to the experience of the person and offer care in response to the way in which people with long term mental illness experience their world (Polkinghorne, 1989). This response to the person's experience could well result in the recipient of care placing more value on that care. The quality of nursing care will be increased by basing it on the experience of the person rather than professional value judgements, historical impositions or false assumptions (Robertson, 1994). The potential exists for nurses to become therapeutic agents by negotiating to support the person during his/her experience (Taylor, 1993).

### **Purpose of the study**

The purpose of this study is to describe and analyse the experience of residents with long term mental illness in a rural psychiatric hostel. This analysis will provide knowledge of the meaning residents attribute to their experience within the hostel environment..

### **Research questions**

1. What is the experience of the residents, with long term mental illness, of a rural psychiatric hostel?
2. What meaning do the residents assign to the experience?
3. In what way does this information contribute to the knowledge base for psychiatric/mental health nursing?

## **Theoretical framework**

This section of the introduction presents the theoretical basis used for this study. It was decided that Person Environment (PE) fit theory would provide the most useful theoretical background for the study.

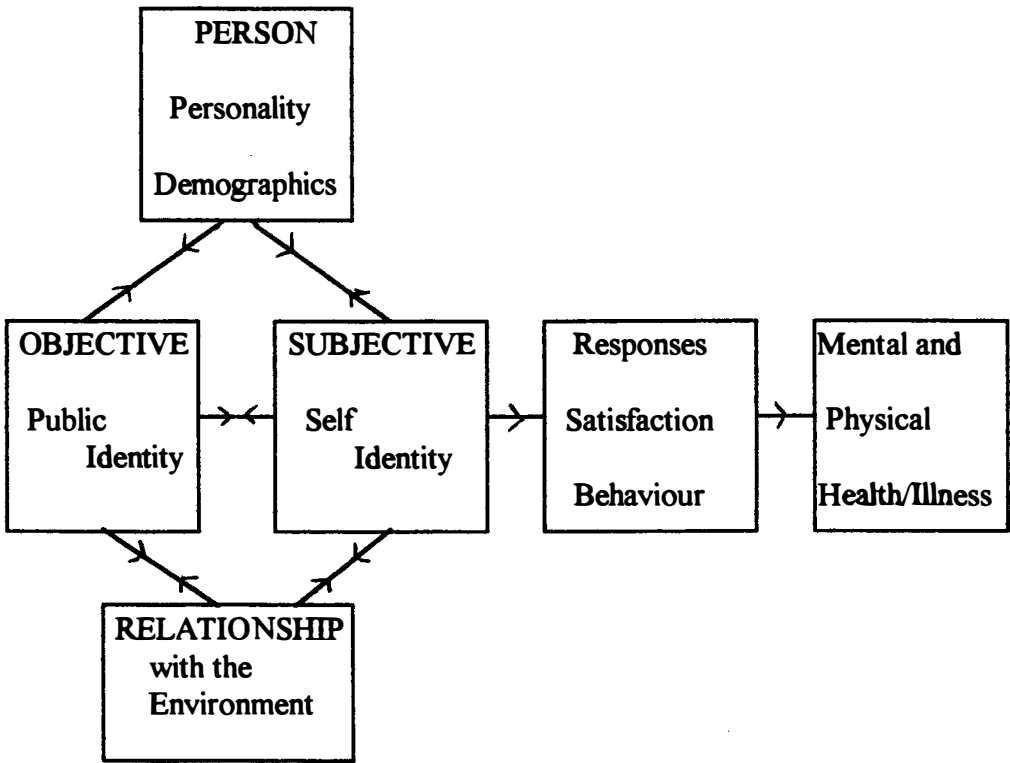
The need for provision of a therapeutic environment for people with mental illness was first recognised in 1792 by Philippe Pinel who removed the chains from violent patients. It was noted that patients were calmer when they had space to move about (Radant, 1992). The York Retreat established in 1806 in England was the first to base care on a kind atmosphere and was the beginning of a trend to 'moral' treatment of people with mental illness (Moos, 1974). Since that time, interest has waxed and waned between emphasis on physical treatments and sociological environmental aspects of treatment.

The terms milieu therapy, therapeutic milieu and therapeutic community have been used interchangeably to describe the use of the environment as an instrument of treatment. Negative effects of the treatment environment have been well documented (Goffman, 1961; Stanton & Schwartz, 1954) as well as some of the potential positive effects (Jones, 1953). Socioenvironmental programs, using varying techniques but with a common thread of peer support and reduced external control, have been seen to affect behaviour (Radant, 1992). Moos (1974, 1976) has been studying the effects of treatment environments on people with mental illness and commented on person environment congruence affecting the development of skills.

Out of this same movement came PE fit theory. John French made significant contributions to the development of PE fit theory during nearly thirty years since 1963 (Caplan & Van Harrison, 1993). The basic premise underpinning PE fit

theory is that behaviour is a function of the person and the environment which consequently effects the mental and physical health of the person. The studies performed led French to define adjustment as the fit between the properties of the person's perception of self and his/her environment, thereby separating objective or public identity from subjective or self identity (Caplan & Van Harrison, 1993).

Figure 1 provides a diagrammatical representation of PE fit theory.



**Figure 1.** Person Environment (PE) fit model shows the effects of social environment and individual characteristics on mental and physical health (Adapted from Caplan & Van Harrison, 1992, p. 258).

PE fit theory has been applied to the mental health area in a variety of ways. For example, Fellin (1992) discussed the application of PE theory to guide the development of individual treatment goals for people with mental illness. Perkins and Baker (1991) performed a study of residential and program placement for people with long term mental illness using PE fit theory as a basis. It is concluded

that it is vital to understand which aspects of the environment have negative effects and which have positive effects on the person. This theoretical framework will provide an appropriate basis for analysing the experience of residents who have mental illness in the hostel context.

### **Structure of the thesis**

In this introductory chapter, the background to the study has been delineated. An overview of the rationale for the study and the potential contribution to nursing were presented, followed by the purpose of the study, the research questions, and the theoretical basis,

Chapter Two provides a review of the research literature to identify what is known about the experience of people with long term mental illness. This chapter will trace the move from hospital based care, highlighting the impact on quality of life associated with accommodation issues. Several interpretive studies relating to the experience of people in supervised settings are also reviewed.

A number of theoretical perspective's have significance for the study and these are discussed in Chapter Three. This chapter also contains the argument for placing the investigation within an interpretive rather than positivistic paradigm based on the fact that the research intent is to describe human meaning. The environmental context of the study is also summarised in this chapter with an outline of the history of the hostel being included in addition to the physical and social setting. The research procedures are detailed and include a discussion of credibility and trustworthiness issues.

Chapter Four describes the findings of the study presented in answer to the research questions. Firstly, the experience of the participants is outlined. Secondly the interpretation of the meaning of that experience is presented as themes. Finally the contribution of the findings to nursing knowledge is discussed.

The discussion that follows in the final chapter critically analyses the themes within the context of relevant literature. Some conclusions are then drawn from the themes gained by returning to the literature with all the themes in mind. Responses of participants and colleagues are discussed in the second section of this chapter which is followed by an outline of the limitations of the study. Finally, the implications of the model of recovery/rehabilitation for nursing knowledge , implication for research methods and recommendations for further research, are presented.

## **CHAPTER TWO**

### **LITERATURE REVIEW**

This chapter reviews the literature relevant to the care of people with long term mental illness within the changing structure of mental health services, with an emphasis on accommodation. The material is discussed under three main headings. The first section focuses on the transfer of care from a hospital based model to one that is community based and how these changes have impacted on the experience of people with long term mental illness. The second section analyses studies of quality of life of people with long term mental illness, including research comparing hospital and community based accommodation. Finally, in the third section, interpretive studies of the experience of people with long term mental illness living in staffed residential hostels, are examined.

#### **A history of the transfer of care**

In the first half of the 20th century, psychiatric research concentrated mainly on studying the causes of mental disorders and assessing the effects of the increasing number of physical treatment modalities (Garton, 1988). For example, a laboratory was opened in Sydney, in 1900, to advance scientific knowledge of the causes of mental illness and research was based on the assumption that mental disorders had a physical origin (Garton, 1988). During this time, most people with mental illness were housed in large institutions or asylums built to protect the outside community and often remained in these institutions for life.

This era of institutionalisation continued until the 1950s when literature containing critical analysis of the effects of long term hospitalisation emerged. Authors such as Gorman (1956), Stanton and Schwartz (1954) and Barton (1959), observed a common pattern of the dehumanising effects of hospitalisation which



included development of behaviours unique to people living in that type of setting. The term institutional neurosis was coined to apply a diagnosis to these behaviours.

A major ethnographic study of the effects of hospitalisation by Erving Goffman (1961), entitled *Asylums*, provided a clear insight into the experiences of people with mental illness and provided a major impact on society's views of institutional life. One year of participant observation was undertaken by the researcher with the aim of learning about the social world of the inmates. Data were obtained by being with the patients, being confined without keys and avoiding social contact with the staff. These measures increased the researcher's ability to understand the inmates' situation. The resulting essays provided a portrait of life in a mental hospital and considered specific aspects of the experience such as loss of identity, sense of betrayal and custodial attitudes (Goffman, 1961).

Over the past two decades, Western countries have signalled the end of the asylum era by embarking on the reduction of psychiatric hospital beds with a varied pace and timing in each country (Benson, 1994). The direction of psychiatric research has paralleled this development by adopting a focus on evaluation of services and development of policies.

As a result of the shift from a hospital to a community based service, a number of inquiries into existing services were undertaken. Benson (1994) asserts that the process of hospital closures in Australia began in earnest after the 1983 Richmond Inquiry in NSW. The purposes of the Inquiry included reviewing existing services, identifying priority areas for development of new services, assessing resources required and identifying broad strategies to implement recommendations. Data were collected from a wide range of sources, by reviewing previous studies and

inquiries, as well as consulting with professionals, clients and community groups. The common thread was the finding that many people with long term mental illness in the community occupied substandard accommodation and had a high rate of readmission (Richmond, 1983).

These findings were in contrast to those of one of the first controlled studies of community treatment in Australia performed by Hoult et al. (1983). The study compared traditional hospital based care with community treatment by allocating 120 subjects to either the control or project group when they presented for hospital admission. Evaluations of the participants' psychiatric condition and perceptions, relative burden and satisfaction as well as costs of both programs were included in the study brief. The findings led Hoult et al. (1983) to conclude that community treatment was significantly more satisfactory to patients, clinically superior and responsible for reduced readmission rates. However, it was of interest to note that the one group found to not respond positively to the community program was those people diagnosed with a long term mental illness.

One explanation for the apparent discrepancy between the Hoult et al. (1983) study and the Richmond Inquiry (1983) is that in the Hoult research, the members of the project group were offered comprehensive community services including provision of suitable housing, whereas Richmond (1983) studied randomly selected individuals with mental illness in the community. This highlights one of the recommendations stemming from the Richmond Report, that top priority be given to community support programs for people with long term mental illness, with an emphasis on accommodation.

The Richmond Inquiry (1983) also focused on the poor quality of life of some people with long term mental illness in the community. This assertion is supported

by Tantum (1988) Fabian (1990) and Simmons (1994) who agree that in many instances the move from hospitals only altered the residence of the individual with much reduced living conditions, little support and limited social contacts.

### **Studies of quality of life**

Fabian (1990) contends that there has been a move to using multifaceted methods to measure outcomes and thereby obtain knowledge of the experience of a particular population. Studying quality of life is one approach available to evaluate existing community facilities and programs, in contrast to studies that employ readmission rates and psychiatric assessment. The advantage of approaches that focus on quality of life, is that they are considered to offer a global perspective, capture the reality of the experience, are easily understood and have universal appeal (Oliver & Mohamad, 1992; Simmons, 1994). One of the major disadvantages is the potential complexity and ambiguity of the field of inquiry (Fabian, 1990).

Lehman, Ward and Lawrence (1982) developed a quality of life scale specifically for use with people who have a long term mental illness, examining both subjective and objective components of quality of life. The instrument consists of a structured interview in which subjective data are obtained on living situation, family, social relations, leisure, work, finances, religion, personal safety and health by rating satisfaction on a seven point scale from terrible to delightful. Measures of general well being are obtained on a similar scale and also by using several responses to the statement "my life is.....," with responses such as 'boring-interesting' or 'miserable-enjoyable'. Objective data is gathered by asking direct questions requesting personal information. Cronbach's alpha was employed to assess internal consistency with test-retest correlations which revealed a significant

level ( $p < .0001$ ) of stability (Lehman, 1988). The scale has subsequently been employed in several studies in the United States (Lehman, et al., 1982; Lehman, Possidente & Hawker, 1986 ; Simpson, Hyde & Faragher, 1989).

The first study using the quality of life scale evaluated the quality of life of 270 people with long term mental illness residing in 30 unsupervised, unstaffed board and lodging homes (Lehman et al., 1982). More than half of the subjects were dissatisfied in three areas of their lives; finances, employment and personal safety. In fact, 34% percent of the subjects had been recent victims of crime, including rape and assault.

This finding was in contrast to two studies which compared supervised residential and hospital settings using the quality of life scale (Lehman et al., 1986; Simpson et al., 1989). Lehman et al. (1986) found that 99 residents in staffed community housing had more financial resources, perceived their conditions more favourably and were less likely to have been assaulted than 99 residing in the mental hospital. Claims of assault within the hospital setting, regardless of staffing levels, was 27% compared to 5% of community residents.

Simpson et al. (1989), using the Lehman quality of life instrument, compared the quality of life of the 13 residents living in unstaffed group homes, 10 residents in a staffed hostel ward and 10 patients on an acute hospital ward. The findings in this study were that the hostel ward provided comfortable, socially active conditions, although the highest overall satisfaction was expressed by those in the group home. However, the authors did note that the quality of life instrument did not lend itself to assessing the quality of life in the supervised group homes. Supervised hostel living conditions were found to improve the quality of life and

safety of people with long term mental illness in contrast to the limiting hospital setting (Simpson et al., 1989).

Gibbons and Butler (1987) performed a descriptive qualitative study of 15 patients with long term mental illness, residing in a staffed hostel ward one year after discharge from a psychiatric hospital. The research aimed to describe the impact of the different environments on residents and obtain their views. Non participant observation was employed, using the Behaviour Observation Instrument, to study sample patients on the hospital ward and after they had lived in the hostel ward for 11 to 18 months. At the completion of the observation section, 14 of the subjects completed a semi-structured interview, in order to obtain their perceptions of their quality of life. It was found that community participation and social interaction of residents in the hostel ward had increased and all but one resident expressed satisfaction with his/her living arrangements.

These studies of quality of life have found increased satisfaction, safety and higher levels of functioning for people with long term mental illness living in a supervised hostel and provide recommendations on services. As Lehman (1988) noted, the research to date provides evidence of people with long term mental illness being capable of expressing their views in spite of their disabilities.

Concerns regarding studies of quality of life include susceptibility to response bias with some disabled individuals responding positively because of either social expectations (Fabian, 1990), or fear of being returned to hospital if they express dissatisfaction. In addition, studies of quality of life do not generally provide detailed examination of the experience of people with long term mental illness in residential settings. Researchers such as Norman and Parker (1990) criticise the

use of studies of quality of life, when examining experience, stating they lack depth, validity and ignore residents' views.

### **Interpretive studies of experience**

Single aspects of the experience of residents with long term mental illness living in supervised community settings have been studied by Wilson (1982) and Malone (1989). Both researchers utilised a qualitative method with a grounded theory design.

Wilson (1982) uncovered the core variable of limiting intrusion from outsiders in a community residential treatment facility when studying the effects of outside influences. The study was performed in response to intense public interest in the facility, coupled with the readiness of outside agents to attempt to intervene and take control. These factors had the potential to compromise group cohesiveness, effective functioning of the treatment facility and autonomy of residents.

The study data base consisted of 200 hours of participant observation, in-depth interviews with staff members and reviewing documents related to the setting. The constant comparison method of data analysis was employed to generate categories in order to build a theory grounded in the data. This study provided insight into the sociological processes within the residents as they related to limiting intrusion. It was found that informal and formal strategies were used to limit intrusion with resulting greater autonomy for the residents (Wilson, 1982)..

Malone (1989), also employing the grounded theory method, studied rehabilitation issues in a supervised living skills setting. The focus of the study was the nature of the interactions between the staff and the residents, specifically in the area of meeting needs. Participant observation and interview were utilised to obtain data from 43 residents and 6 staff members of a Community Bound hostel in

Texas. The interviews were semi-structured and involved all the staff and half of the residents. A common pattern observed was related to staff assisting the residents to acquire survival skills, which was named as the core variable. Malone (1989) noted that the identified aspects of survival skills; co-operation, hanging out, checking up and support are congruent with problem solving processes used within nursing.

Norman and Parker (1990) employed in-depth, unstructured interviews to study the views of residents before and after moving to a staffed community hostel although a specific methodological approach was not nominated. The research was aimed at generating subjective accounts of the perceptions and experiences in addition to establishing the feasibility of using unstructured interviews with people who have long term mental illness. The sample consisted of 10 residents, aged between 20 and 54 years, who had been inpatients at the psychiatric hospital for between 14 months and 25 years.

The in-depth interviews were conducted two weeks prior to moving and again six weeks after the move. Issues discussed included best/worst aspects of hospital life, privacy, comfort and relationships. The transcripts were analysed qualitatively and seven recurrent themes emerged around staff and resident relationships. Freedom, comfort, activity and dignity were viewed as much improved in the hostel situation. The themes were then related to previous studies, particularly to the work of Goffman (1961), on the effects of hospitalisation on people with long term mental illness. The findings supported the assertion that unstructured interview is a useful method when researching with people with long term mental illness, in that the disorder does not interfere with the person's ability to provide important and useful information.

Norman and Parker (1990) noted that the major limitation of their study was the short time span of six weeks between the first and second interview. As the residents had been in the hostel for such a limited time, this could have affected results. With any move to a new environment, it may be some time before problems surface. The results may have been further influenced by the diversity of age of the residents (20-54 years), in addition to the wide variance in length of their latest hospitalisation. Due to the small size of the sample, the researchers were unable to control for age or length of hospitalisation.

In summary, the published literature review has shown that the study of experience of the people with long term mental illness in diverse settings has been approached by using a variety of methods. The majority of studies reviewed in this chapter have compared experience from one setting to another. None of the reviewed studies were performed in Australia and it is important that systematic exploration to understand perspective's in this country be undertaken (Lawler, 1991).

By concentrating on one setting, the study reported in this thesis has aimed to provide a detailed account of the experience of people with long term mental illness in a rural supervised hostel setting. In qualitative studies, the question is raised when using more than one site for a study whether sites can be compared and the dependence of the study on context (Morse, 1991). In addition, participants who have been at the hostel for more than six months were invited to participate in the study to overcome the potential limitation of the short time span between admission and interview noted by Norman and Parker (1990).

The qualitative studies utilising participant observation and/or interview have provided the most thorough description and interpretation of the experience of



people with long term mental illness. As a consequence, this study has employed both interview and participant observation to achieve both breadth and depth of data. The literature reviewed has also supported the contention that people with long term mental illness are capable of expressing their views, therefore justifying the use of interview and participant observation in this study.

Studies of the experience of long term mental illness from the person's perspective are not abundant although they are seen as a rich source of information (Vellenga & Christenson, 1994). This study has been undertaken to provide a beginning knowledge base regarding the experience of people with long term mental illness in a hostel setting.

## **CHAPTER THREE**

### **METHOD**

This chapter contains a description of the method used to study the experience of residents of the psychiatric hostel and is divided into three sections. Firstly, the theoretical context or philosophical approach underpinning the researcher's approach to this study is presented. An overview will be given of the phenomenological method including issues relating to validity. The study setting is described in the second section of the chapter. Finally, the research procedures are detailed.

#### **Method of inquiry**

A phenomenological approach was considered to be the most appropriate to study the experience of people with long term mental illness in a residential hostel setting for three reasons. Firstly, the experience of the long term mentally ill depends largely on the value and meaning they attribute to the events and circumstances of their lives. The phenomenological approach aims to understand what it means to have a particular experience then describe and interpret that meaning (Anderson, 1991a; Manen, 1990; Taylor, 1993).

Secondly, the nature of long term mental illness affords sufferers reduced opportunities for choice. Phenomenological approaches generate forms of explanation that offer understanding and choice for the participant rather than control (Benner, 1985). By utilising in-depth interview with little structure, the participant is not confined to responding in a specific manner and may provide as little or as much information as he/she chooses. It is that attention to the meaning of the experience and the opportunity for choice that decided the selection of

phenomenology for this study. Finally, and most importantly, phenomenological studies examine experiences and meaning in context. This ensures that participants' perceptions of their experience are sought within the person's environment and therefore remain true to the reality of that experience.

### **Philosophical background of the method**

During the second half of the nineteenth century positivism became widely adopted in the Western world as a philosophical basis for knowledge and scientific inquiry (Chung & Nolan, 1994). It replaced demonology and superstition as a means of explanation. This was particularly evident in the area of the evolving science of medicine.

Munhall (1989) asserts that nursing, following the lead of medicine, has been built on positivist or mechanistic assumptions with natural science as a driving force. It is asserted that nurse scholars have begun to question and debate these assumptions, calling for the tenets of human sciences to be used in all facets of nursing theory development, research and practice (Munhall, 1989). Natural science aims to explain causes and to predict reactions and events, whereas human sciences pursue understanding and interpretation.

One such human science and philosophy, phenomenology, has been widely adopted in nursing and permeates the writing of nurse scholars such as Parse, Benner, Watson, Paterson and Zderad (Smith, 1991). Nursing is described as a humanistic endeavour and phenomenology provides tenets to underpin such an enterprise (Munhall, 1992).

Phenomenology views human beings as subjects, not objects and holds that understanding people as they are in everyday life is of prime value (Reed, 1994; Thorne, 1991). The focus is on people's relationship with their environment and

what that means for them. A further fundamental belief within phenomenology is that people are free in situations to choose or even create the meaning an experience holds for them (Munhall, 1989).

During the period of development, phenomenology was viewed not only as a philosophy but also as a basis for inquiry. One of the acknowledged founders of phenomenology, Franz Brentano (1836-1917), wished to develop a philosophy, based on human service, that could provide answers to dilemmas that organised religion was unable to supply (Cohen, 1987). Edmund Husserl (1859-1938) studied with Brentano and believed that science needed a philosophy that had more contact with human concerns (Cohen, 1987). Other contributions were made to phenomenology by Martin Heidegger (1889-1976), Gabriel Marcel (1890-1973), Maurice Merleau Ponty (1908-1961) and Jean Paul Sartre (1905-1980).

In 1963, Sartre criticised positivistic approaches to research as not valuing the human properties of human beings. His major goal was to understand human experiences because he believed that to understand others brings changes in oneself (Sartre, 1963). This notion could be likened to those expressed by nurse theorists such as Peplau and Benner as well as Paterson and Zderad. In fact Paterson and Zderad (1988) contend that to understand the patient's perspective and experience affords nurses the opportunity to ensure nursing care provides for patient needs. For example Harvey (1993) claims her phenomenological approach to nursing practice has helped her work with clients to develop care plans, based on the experience of the person. This involves the person in the development of the care plan and gives him/her the opportunity to review the experience and the meaning of the experience. Munhall (1992) asserts that phenomenology offers a humanistic and useful philosophic basis for nursing practice and research.

Another major criticism of positivism is that it lacks context, that reality is perceived as single and tangible and can be divided into independent variables to be studied in isolation (Lincoln & Guba, 1985). When this is related to the study of human experience, it would follow that human beings would be viewed as being separate from their environment.

In contrast, phenomenology focuses on the meaning that is found in the communication between the person and the situation so that the person both constructs and is constructed by that situation (Munhall, 1989). The investigator seeks knowledge from the authentic source within the context or natural setting and does not attempt to manipulate the study setting (Patton, 1990). Manen (1990) sums it up by maintaining that phenomenology studies the life world as it is experienced, rather than through conceptualisation or categorisation.

### **Research method**

Phenomenology as a research approach has created debate within authors' ranks. For example Morris (1977) and Swartz and Jacobs (1979) discourage the use of a specific structure and suggest that the experience of the researcher dictates the direction of the research while other authors, such as Oiler (1986), argue that to achieve acceptance a definite method is required (Wilkes, 1991). For this study it was decided to adopt a specific method.

The study design is a field study within which data are collected by interview, observation and the researcher's response to the situation and events. The method of analysis developed by Colaizzi (1978) has been chosen as the most applicable to provide the information required to answer the research questions. Seven steps are utilised in analysis: reading all data, extracting significant statements or events, formulating meanings, gathering meanings into clusters of themes, integrating

themes into a description, interpreting the description and returning to informants to verify findings (Colaizzi, 1978).

In phenomenology, as in other qualitative research approaches, ensuring validity requires different criteria than quantitative methods. Sandelowski (1986) suggests using the criteria of credibility instead of internal validity; fittingness rather than external validity; auditability in place of reliability, all of which help to establish a claim for confirmability. A study is credible when the study participants are able to provide verification of the themes and interpretation in addition to recognition of the experience by other researchers and people reading the findings. Researcher credibility is enhanced by the use of the bracketing of preconceived ideas and biases to prevent intruding personal biases on the data collection and analysis. Bracketing involves acknowledging and examining one's own prejudices, beliefs and commitments about a phenomenon and then purposely suspending them in order to understand the experience of the participants (Anderson, 1991a; Jasper, 1994; Lipson, 1989).

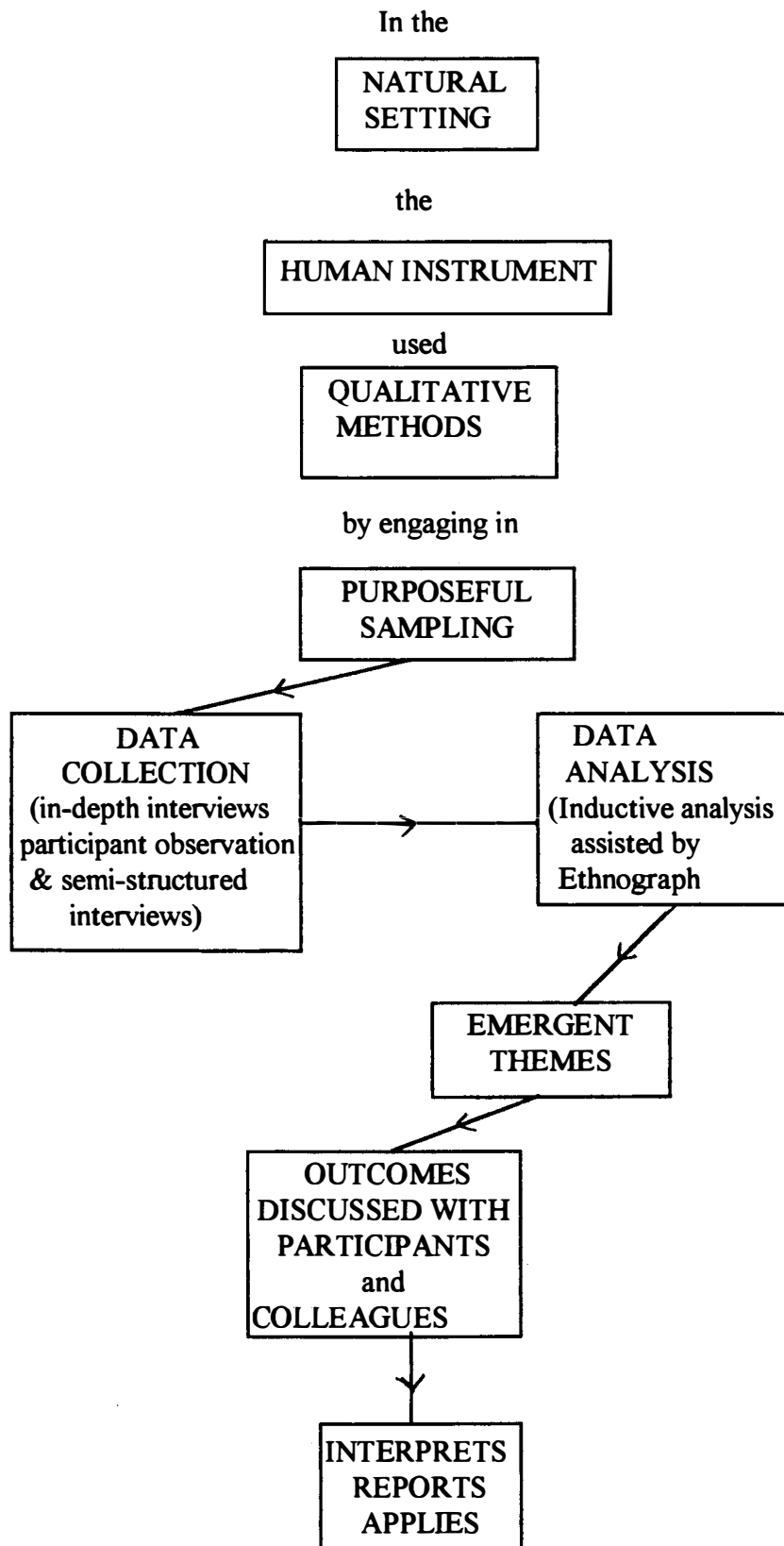
The criteria of fittingness of the study is met by judging if the findings can be compared to settings outside the study context, if they can be recognised by the audience and can fit the original data from which they were derived (Lincoln & Guba, 1985). Sandelowski (1986) states that fittingness is achieved when "the findings are well-grounded in the life experience studied and reflect their typical and atypical elements" (p. 32).

Auditability can be achieved when a clear description of the procedures used is provided by the researcher which may be easily followed by another investigator (Sandelowski, 1986). Following the steps for analysis as outlined by Colaizzi (1978) is one way of promoting auditability. Patton (1990) asserts that a credible

study will address the rigorous data collection and analytic techniques, credibility of the researcher as well as the paradigm orientation of the study. It is also important, particularly in a study of this type to attempt to ensure that the participants are representative of the group being studied. Because sample sizes are typically small in qualitative studies, to have the participants who are the most articulate or members of the group with the highest status could fail to achieve a truly representative perspective. The use of two distinct methods of data collection, in addition to two types of interview format, provides consistency and allows for cross checking categorisations during the analysis (Rosenbaum, 1988). Triangulation of data sources, that is the use of interview and participant observation, promotes credibility (Lincoln & Guba, 1985). Burns and Grove (1987) suggest that the researcher should also actively search for negative cases and evidence.

In summary, the philosophic tenets of phenomenology were chosen as the most appropriate to provide a method for this study. The importance of viewing the experience of the human being within their natural situation or in environmental context is also highlighted in this approach. Studying the social world in the natural state enables the researcher to capture the essence of the phenomena being studied (Porter, 1993). When discussing the relationship between phenomenology and nursing Taylor (1993), asserts that the experiences of people are meaningful in terms of the situations in which they occur so therefore the context of events is vital to the perception of the experience.

Figure 2 provides a diagram of the flow of the study.



**Figure 2.** The flow of the study with the activities of the researcher highlighted. (Adapted from Lincoln & Guba, 1985, p. 188)



### **Study setting**

In this section of the chapter, a detailed description of the study setting is provided. The most pertinent aspects of the environment are outlined, such as physical surroundings, other persons within the setting and programmed activities. All these components of the environment affect the experience of the residents (Miles & Huberman, 1984). Several photographs of aspects of the setting have been included as a tool to add visual aspects to understanding the every day life of the residents (Hagedorn, 1994). Relevant historical background will be incorporated in the portrayal in addition to some of the future plans for the hostel, particularly in the work related area.

### **Physical environment**

The hostel is a 60 bed unit situated on 900 acres of land 16 kilometres from a major metropolitan centre. The drive leading to the hostel is lined with pine trees and slopes up a slight incline. One large building, completed in 1958, accommodates the residents and a small recently built administrative block stands nearby. At the entrance to the hostel, there is an aviary built by the residents which combats the 'bricks and mortar' look of such an extensive structure.

The kitchen and dining room command a large section of the west end of the building. There are several lounge areas for the residents with the largest containing a pool table and television, one on the east end of the building for non smokers and some rooms for listening to music or reading. These are many large open areas in keeping with hospital architecture of the 1950's, with one smaller room set aside specifically for activities. Figure 3 shows a photograph of the front of the hostel, demonstrating the typical 1950's structure.



**Figure 3.** Main accommodation building depicting the typical 1950's architecture.

Sleeping accommodations are divided into three types. Firstly, there is an area that houses 12 residents, which has been partitioned into individual bays, allowing some privacy and scope to spread out personal belongings. Secondly, a room with two beds in each partitioned bay provides some privacy. The third type of sleeping arrangement consists of a large room with glass partitions with four residents allocated to each bay which permits little space to personalise the area. This last area reflects the dormitory building style used for hospitals in the 1950's, although there have been renovations and improvements such as the glass partitions.

There is a large communal bathroom with toilet facilities being situated throughout the building. The main staff office, treatment room, several other smaller offices and storerooms are also housed in the main complex. The verandah

is a major focal point within the hostel, where many residents may be found at times of relaxation. It is a long structure with chairs, in a range of conditions, arranged along the length. Morning and afternoon tea are often served on the verandah. It is an area where socialisation can take place or alternatively a person can sit alone. Figure 4 provides a photographic aspect of the view, looking from near the east end of the verandah.

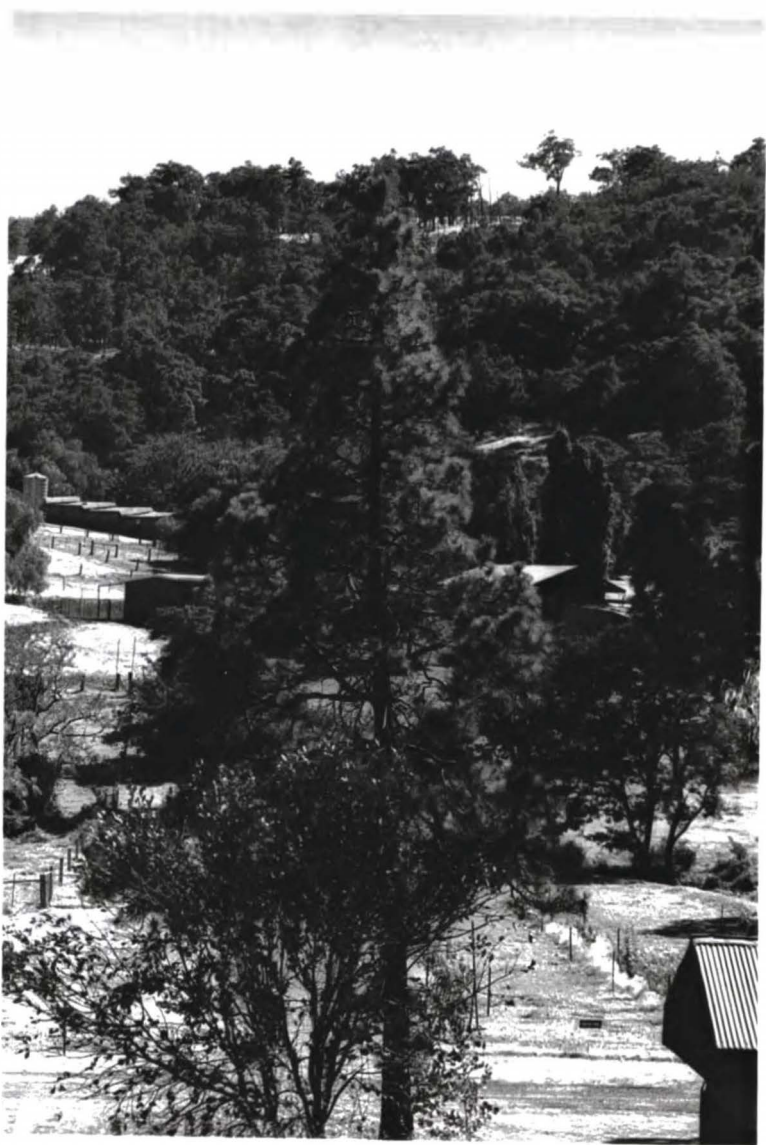


Figure 4. Outlook from the east end of the verandah showing some of the older buildings in the background.

Taking the main path to the right from the front of the hostel leads one past the egg storage shed, then through the main gates leading to the paddocks where the animals are situated. This path leads to the milking shed, hay shed, hen housing and up the hill to the pig sty which is still under construction. Many of the buildings in this area are those built late last century although they are becoming dilapidated and derelict. The views throughout the farm, have been used to benefit the residents by marking walking trails with bench seats situated at specific points. Figure 5 provides a photograph of the views over the hostel complex..

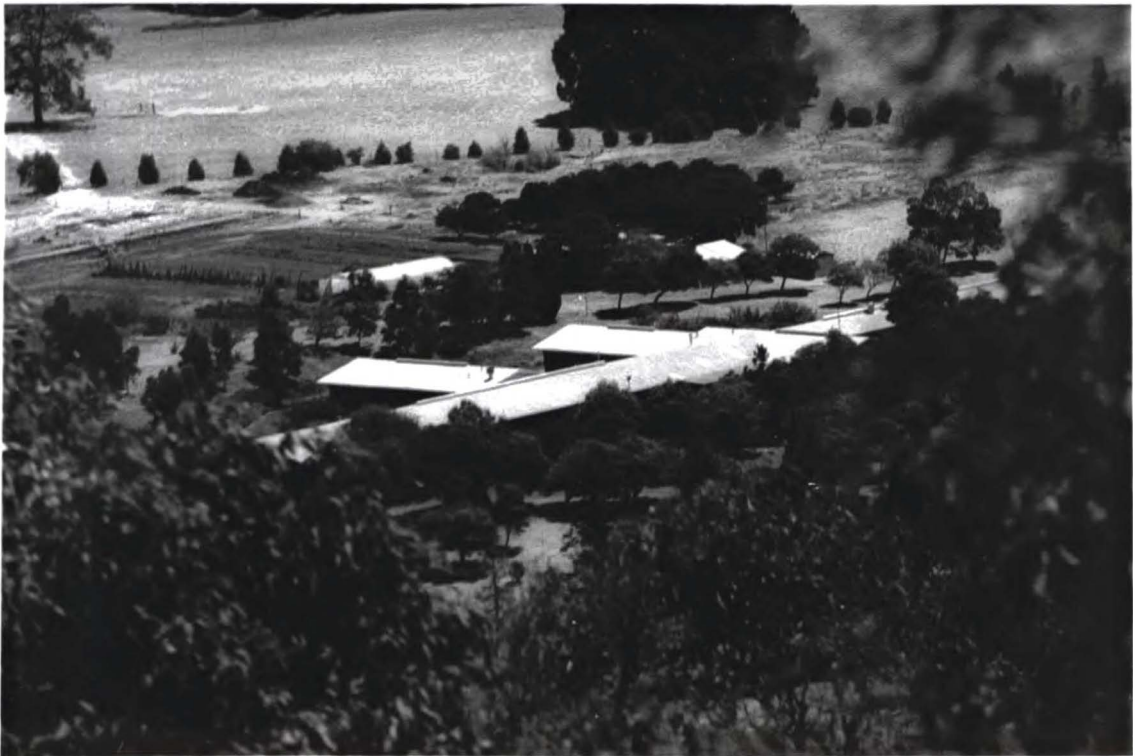


Figure 5. View over the hostel complex from one of the walking trails.



The horticultural activity areas are located immediately to the south of the hostel. There is a large shed which is used for storage, potting plants and tea breaks, a transportable building and two shadehouses. The garden is planted with a variety of vegetables and some fruits, with the orchard nearby. Trees and shrubs are propagated in the shadehouses for planting around the property. Shearing is carried out in a large, purpose built shed to the east of the garden while to the west of the front of the hostel is the barbecue area, constructed by the residents as portrayed in figure 6.



Figure 6. Barbecue area which was constructed by the residents.

There are three staff residences within the grounds of the hostel, one for the farm manager and his family. The farm manager owns several working dogs and he also has a pet kangaroo that wanders the property. The presence of the kangaroo is particularly enjoyed by several residents. The two other houses are occupied by nursing staff.

### **Historical background and present policies**

The site was purchased by the government of the colony, in 1897, as the site for a new 'asylum' which was urgently required because of gross overcrowding in the building used to house the 'insane' (Ellis, 1984 ). The land was not utilised for the new 'asylum' because the 'asylum committee' decided that the site was too far from the town. The existing farm house was modified to accommodate 50 'quiet and chronic' men, with the first 24 moving there in September of 1897 (Virtue, 1977). This establishment was seen as an advance in the care of the 'insane', representing a break from the penal character of the asylum and providing everyday living and working experiences for the patients (Virtue, 1977).

The number and diagnoses of residents housed at the hostel has varied greatly over the 95 year history of the farm, according to the demands of the major psychiatric hospital. For example, during the years of the first world war patient numbers at the hostel fell to only seven, but due to overcrowding at the asylum, the number rose dramatically in 1918 (Inspector General for the Insane, 1929). Following the introduction of the 1912 Inebriates Act, the hostel was used to house 'inebriates' and for the 'mentally deficient' during the 1950's (Ellis, 1984; Inspector General for the Insane, 1929 & 1942).

At present, there are between 56 and 58 men residing in the hostel at any one time. Residents are aged between 24 and 71 years and time living at the hostel

ranges between 6 months and 40 years. The diagnoses of residents include intellectual disability, brain injury and long term mental illness. Some of the older residents have reached retirement age and the possibility of admission to nursing homes is being considered. There are several frail men who now require assistance with activities of daily living.

Changes in policy initiated by reports such as PRAG (1991) have meant that the focus has changed to admission of younger men with serious mental illness. Referrals are usually instituted by a psychiatrist or medical officer and are accepted from any agency within the state. Upon receipt of the referral, an appointment is made for an interview with the Clinical Nurse Specialist and the interview panel to assess suitability for admission to the hostel.

The prospective resident and carers/relatives are invited to attend the monthly barbecue, after which interviews are held. Interested prospective residents may also attend the weekly guided tour of the hostel. The final choice of admission, after acceptance by the panel, is left with the individual. Some residents remain within the bounds of the Mental Health Act and they may return to an approved psychiatric facility by choice or necessity.

The hostel is administered and funded by the Western Australian State Health Department and a fee equal to 66.66% of the invalid pension is charged for board and lodgings. Early in the documented history of the hostel, there were comments on the increased cost of keeping a patient at the hostel compared to the asylum. In 1903, the cost for each 'inmate' at the asylum was 14 shillings and 2 pence a week whereas at the hostel it was 1 pound 2 shillings and 6 pence (Inspector General for the Insane, 1929). This was explained as being due to the relatively higher number

of staff required for a smaller patient population which increased the staff wage bill.

The farm did begin to make considerable profits from the sale of produce with 450 pounds, 19 shillings and 11 pence being recorded for 1906 increasing to over 2,000 pounds in 1946 (Inspector General for the Insane 1929, 1947). The sale of produce continued until the 1960's when the fresh food was then sent to the hospital as their own farm had been closed. A current resident remembers when 60 dozen eggs per week would be transported to the major psychiatric hospital. There is a long tradition of animals being shown at the Royal Agricultural Show with great success over many years. This tradition continues with some of the residents being involved in the preparation for the annual event.

### **Activities**

The focus of activities at the hostel has changed with a major rehabilitation component being established over the past decade. The work related activities include horticultural, agricultural and individual programmes. Milking, collecting eggs and caring for the hens, propagating vegetables and building rockeries are but a few of the current activities. The majority of these tasks are performed in groups of 5-10 residents, although there are some residents who work alone.

The working week for most residents is from Monday to Thursday. However, several residents are required to work on weekends for the milking and collecting eggs and have days off during the week. Two men live in a nearby country town and attend the farm on a daily basis. Currently, there are plans for more residents to live independently while continuing to work on the farm. Some of the residents have lived in rural settings, therefore have experience of farm life. Many come from an urban background and are gaining knowledge and a variety of new skills. There



are plans for some residents to begin working outside the confines of the farm. For example, two men were commencing employment at the nearest urban centre at the time this research was being completed.

The social and recreational activities have always been an important part of hostel life. Visiting picture shows, wood working, rabbit trapping, nature studies and regular trips were recorded in the Annual Report in 1957 (Inspector General of Mental Health Services, 1958). Regular social outings, bus trips, holiday camps are all incorporated into the present day programme. Social events include dining out at restaurants and going to the movies with staff usually accompanying a small group of four to six residents. There is a yearly holiday camp, which most residents attend and there are also smaller groups away for a week at a time. Transport is supplied for residents wishing to visit the local hotel on Saturdays.

A well attended and popular weekly art group is led by a visiting art teacher. The volunteers hold activities every Thursday morning and will often take residents out on Mondays. Volunteers have been involved in the hostel activities for many years. For example votes of thanks were made to the volunteers in many of the annual reports dating back to the 1940's (Inspector of Mental Hospitals Report, 1947). Establishment of a bush walking programme is a recent innovation with walkers receiving recognition for the distances covered.

### **Staff**

There are 18 nursing staff employed at the hostel, covering three shifts, consisting of 11 registered mental health nurses, 5 enrolled nurses and 2 nursing assistants. Among the registered nurses, there is a Clinical Nurse Specialist, Nurse Manager, Clinical Nurses, an Activities Co-ordinator and Registered Nurses. There

is a farm manager, a farm manager assistant and two 'tutor' gardeners. The domestic staff and cooks are also involved in the experience of the residents.

A psychiatrist and psychiatric registrar visit each Thursday when residents are reviewed. There are regular occupational therapy, physiotherapy, podiatry and welfare services available to the residents. A hairdresser attends the hostel regularly. Other facilities offered to the residents include a daily canteen on the hostel premises, where residents can buy cool drinks, sweets and cigarettes. Regular bus services run to the nearest large shopping centre, where residents are able to obtain other items they may require. Local church groups offer transport to church services within the area. Residents usually attend a local dentist and may use the GP within the region over the weekends for medical treatment. Emergency medical treatment is obtained from the local hospital.

In summary, the experience of the residents in this rural hostel is influenced by many factors. The historical perspective, including the attitudes of Mental Health Department officials, has affected the pace of change. For example, the Annual Reports between 1971-1986 only included financial costs with no mention of the activities at the hostel. It was when there was increased concern for the situation of people with long term mental illness, that any documented questions regarding the hostel occurred.

With the heightened concern around rehabilitation of people with long term mental illness between 1986 and 1988, the hostel has been the subject of much discussion. In a review carried out in 1989, it was recommended that the focus at the hostel change from offering long term residential care to programs orientated to rehabilitation of younger men with serious mental illness (PRAG, 1991). Virtue (1977) states that in 1897 the hostel was seen as "an advance. By providing outdoor employment in an extensive rural setting for a group of selected patients"

(p. 41). The same may well still apply in 1994.

It has also been expressed that the financial cost of the hostel is excessive for a relatively small number of residents, particularly since the farm produce is no longer sold (Hoult, Burchmore & Schizophrenia Australia Foundation, 1994). There has been a recent move for vegetables and eggs produced at the hostel to be utilised at the local regional hospital with a possibility of meat also being supplied (Healthview, 1994). This could result in a considerable cost savings for the Health Department.

The uniqueness of the setting and the activities provided for the residents make studies such as this one vital, particularly as a common theme in the literature is the resistance of people with long term mental illness to traditional modes of psychiatric treatment (Malone, 1989). There is no typical hostel environment for people with long term mental illness just as there is no typical person with long term mental illness. As stated, in the introduction, many of the urban hostels have no activities for the residents and the only other hostel in a rural area is within a country town. The unique and isolated nature of the setting provides benefits as well as inconveniences for the residents.

Residents are known by people in the small local community and this promotes understanding. On the other hand the location, so far from the city, means transport to outside employment may create problems for the resident. In addition, friends and family, who live elsewhere, may find the hostel inaccessible and confront difficulties with transport.

### **Research procedures**

An account of the field work including entry to the setting, data collection and exiting the setting is provided in this section of the chapter. Data analysis procedures are also addressed together with methodological issues such as ensuring credibility and ethical considerations being incorporated within the main body of this section..

A germane description of qualitative approaches is given by Garratt (1989, p. 19), who states that “the researcher focuses on the everyday life, world experiences of the informants, their satisfactions, disappointments, surprises and astonishments.” Obtaining information from the residents’ perspective was considered vital to the purpose of the study, therefore a field study approach to data collection was used. Field studies are performed in natural settings, such as hospitals and clinics, and are often intensive rather than extensive (Polit & Hungler, 1991).

### **Fieldwork**

Fieldwork is recognised as a central task in any qualitative study (Patton, 1990). The period of fieldwork extends from the first approaches to the gatekeepers for entry to the setting, through to the conclusion of the relationships with the participants of the study. Figure 6 outlines stages of the fieldwork in the study, highlighting the three stages of fieldwork: stage one - entry to the setting, stage two - acceptance in the setting, stage three- exiting the setting.

STAGES OF FIELDWORK	I ENTRY	II ACCEPTANCE	III EXITING
ACTIVITIES	ESTABLISHING RELATIONSHIPS	IN DEPTH INTERVIEWS	PARTICIPANT OBSERVATION
AND	GAINING INFORMED CONSENT	16TH OCT - 22ND NOV '92	16TH OCT - 22ND DEC '92
	SELECTING PARTICIPANTS	PILOTING SEMI- STRUCTURED INTERVIEWS	SEMI- STRUCTURED INTERVIEWS
TIMEFRAME	15TH AUG - 15TH OCT '92	5TH JAN- 12TH JAN '93	15TH JAN 15TH APR '93
			DISCUSSING FINDINGS
			15TH MAR-15TH OCT '93

**Figure 7.** The three stages of fieldwork provides a clear outline of the activities and timeframe for the field work section of the study,

(Adapted from Field & Morse, 1990, p. 92)

**Stage one of the fieldwork includes gaining entry to the setting, developing relationships with the prospective participants and obtaining informed consent.** Gaining entry to the setting is the first stage of fieldwork.

Hammersley and Atkinson (1983) assert that strategies should be devised to approach gatekeepers in order to gain entry to the prospective study setting. In this study, approaches were initially made to the Director of Nursing of the region, who knew the researcher. The response to these approaches was positive, with permission given to begin when ethics clearance had been received from the Committee for the Conduct of Ethical Research at Edith Cowan University.

Field and Morse (1990) contend that acceptance of the study by potential participants and establishing credibility and trust relationships is vital. To this end, the researcher initially visited the hostel for several hours on three occasions in order to meet the staff and residents and generally 'hanging around' to initiate contact. The researcher was known to several staff and residents of the hostel and informal discussions elicited a favourable response to the prospect of the research project.

Once ethical clearance had been received from the Committee for the Conduct of Ethical Research to proceed with the research study, a description was posted on the main notice board and a meeting was arranged with nursing staff. The researcher continued to establish contact with residents and staff in the research setting and spent 12 hours over a period of several weeks to encourage familiarity with and acceptance of her presence (Evaneshko, 1988)..

There are potential difficulties for a nurse researcher performing studies within a health care setting which are highlighted by Field and Morse (1990), Evaneshko (1988) and Chenitz and Swanson (1986). Firstly, participants may view the nurse

as a part of the hierarchy and may be hesitant to be totally frank. For example, several of the residents in this study, demonstrated open suspicion toward the researcher and the project. The very nature of long term mental illness can elicit this response and repeated explanations of the purpose and aims of the study were required to overcome this problem. The residents and staff who were acquainted with the researcher were able to allay many of the fears.

A second potential problem is the possibility of the nurse researcher being viewed as an “expert” thereby alienating the participants (Evaneshko, 1988). In this study, the researcher was not employed in any mental health facility which provided reassurance to the participants. This also allowed the researcher freedom to request general information about life at the hostel, thereby dispelling any ideas that she could be seen as an expert in this setting.

Thirdly, the researcher may be tempted to become involved in clinical interventions and issues (Chenitz & Swanson, 1986; Field, 1991). For example, the residents may have attempted to engage the researcher in a therapeutic relationship. Although there was no desire to negate that component of the total relationship within hostel life, it was suggested that specific clinical concerns be discussed with the hostel nursing staff (Germain, 1986). Therefore, during the time spent with residents, the researcher spoke openly about the research and made it clear that the research study was the reason for the frequent visits to the hostel. The other activity this researcher performed during this familiarisation process was to begin selecting prospective participants.

The method used to select an appropriate sample was purposeful, as described by Patton (1990), with participants being chosen according to the needs of the study. Participants who had specific knowledge of the experience were selected

using this nonprobability sampling technique thereby enhancing the researcher understanding of the setting (Thomas, 1990).

To obtain relevant information about the experience of people with long term mental illness living in a hostel, it was vital to select participants who met the criteria of possessing detailed knowledge. As previously stated, the residents of the hostel have a variety of diagnoses and range in age from 24 and 71 years. Many of the older residents suffer an intellectual disability or brain injury therefore the older residents experiences may vary greatly from that of younger residents. Polit and Hungler (1991) claim that purposive sampling is more effective when employed with a homogenous group. Accordingly, it was decided to control for age and diagnosis by inviting residents under the age of 45 years with long term mental illness to participate in the study.

The same sampling procedure was utilised to select staff participants. A minimum of 8 of the 22 staff members, including nursing, farm and gardening staff, was adjudged to be representative. This was to ensure that the most appropriate informants participated in the study (Field & Morse, 1990). Staff who had extensive contact with the residents were invited to join the project.

Using the purposeful sampling design, 15 residents, 5 nurses, the assistant farm manager and both tutor gardeners were invited to participate in the study. Taking into account the control for age and diagnosis the number of potential resident participants was 16. One resident was excluded from the study because he had lived at the hostel for less than six months. This was to control for the honeymoon period described by Norman and Parker (1990). A honeymoon period is a time when a person may perceive only the positive aspects of a situation. In



total, 15 residents were subsequently approached and invited to participate in the study.

Once participants had been selected and approached, the next task was the important process of obtaining informed consent. Obtaining informed consent from the participants was particularly significant in this study as the participants were mentally ill. In fact, Watson (1982) contends that any vulnerable population should not be involved in research if another population can be found, highlighting the need for increased vigilance to protect the people who have difficulty in protecting himself/herself.

In order to safeguard the potential resident participants, the Psychiatrist Superintendent was requested to verify that the prospective participants were capable of giving informed consent. Relatives of resident participants were also provided with a description of the study and given the opportunity to discuss the project with the researcher or her supervisor. This provided families with a sense of involvement and kept them informed. Two family members contacted the Nurse Manager of the hostel and three telephoned the researcher requesting information. None objected to their family member being involved in the study.

The residents were then approached individually and given a verbal and written description of the study and requested to sign a consent form (Appendix A). Some residents wished to add items to the consent form. For example, one requested that the researcher would not attempt to read his mind, two others refused interviews but consented to the observation section of the study and all participants refused the use of tape recorders. Once these questions were settled to the satisfaction of the resident, both they and the researcher signed the consent form.

Potential staff participants were also given a verbal and written description of the study and requested to sign a consent form. All the participants, staff and residents, were invited to participate on a strictly voluntary basis and given the unconditional option to withdraw from the study at any time. To ensure confidentiality, the participants were assigned codes, for example the participant residents were coded PR1-15 and staff participants were coded PS 1-8, thus protecting informants' anonymity. The original coding sheet was kept in a locked drawer with the key being held by the researcher.

**Stage two is the acceptance stage of the research during which data are collected.** Once informed consent had been obtained, the data collection stage was commenced. Three distinct methods were used to collect the data. Firstly, in-depth, unstructured interviews with two resident participants, followed by participant observation and concluding with semi-structured interviews. The mixture of data collection methods was chosen to provide depth of data and give credibility to the study. The inherent strengths of informant interview and participant observation are reinforced when the two methods, interview and observation, are combined, thus triangulating the sources of data (Patton, 1990; Smith, 1975).

Prior to commencing data collection, the issue of potential researcher bias was addressed. Having specialised in the area of mental health nursing for many years, preconceived ideas and beliefs relating to the experiences of people with long term mental illness were held by the researcher. Without the putting aside or bracketing of personal biases and values the study would be a reflection of the researcher's beliefs without the realities of the field (Anderson, 1991b).

To achieve an awareness of biases, the researcher kept a personal daily journal during the fieldwork, reviewed the entries and made notes to put aside any values

observed. Discussion with a colleague, with similar clinical nursing experiences, enabled the researcher to gain insight into ideas developed over her career. The aim of this exercise was to allow the researcher to record biases, review them frequently and purposely suspend them in order to understand the participants' perceptions (Anderson, 1991a). This process of bracketing biases was ongoing throughout the data collection and analysis. The first data collection method was in-depth interviews.

Two resident participants identified as key informants, in consultation with nursing staff, agreed to be involved in the in-depth interviews. The key informants were chosen with consideration of their knowledge and understanding within the hostel setting and because of their ability to articulate their feelings and give a broad view of hostel life (Field & Morse, 1990).

Five interviews were held with one informant and four with the other over a period of five weeks. The reason for the relatively high number of interviews was threefold: firstly, shorter interviews were required as both informants had refused the use of a tape recorder, secondly, to increase rapport with the informant and finally, to add credibility to the data. Credibility is present when the informant gives essentially the same information over a period of time even with allowances for changing moods (Brink, 1991).

In-depth interviews or conversations are usually defined as having little or no organisation (Bergum, 1991; Polit & Hungler, 1991). However this definition is challenged by Hammersley and Atkinson (1983) and Oppenheim (1992) who assert that interviewers would have some area of interest in mind when beginning the interview process, thus disputing the existence of a truly unstructured interview. To make allowance for this possibility, the first interview with each informant

began with the statement “Tell me about your experience at the hostel”. Several questions relating to broad inquiry were prepared as an aide memoir, as suggested by Leinenger (1985), to be used if prompting was required.

For example “What is a typical day like here?”

“What are your thoughts about the daily routine?”

“I would like to learn more about your work”

“Could you give me an example?”

Each interview lasted 40 to 60 minutes, in a place of the informant’s choosing. There were two reasons for the interviews being short, firstly the data would be fresh in the investigators mind for transcription and secondly, the informants would not be tired before the completion of the first conversation. Notes were made throughout the conversation, with verbatim quotes, to remind the interviewer of the general trend and provide an outline for the transcription. A day and time was set for the next session and the interviewer immediately found a quiet place to begin recording the conversation in detail.

The time taken to transcribe the conversation was an ideal opportunity to review interview technique, look for problem areas, and to decide on topics or statements which required more detailed study (Field & Morse, 1990). Preparation of material for further examination was developed to reflect the language of the informants. For example both the key informants called their fellow residents “blokes”, schizophrenia a “sickness” and medication the “drugs”. Any reference made to these areas used the informants’ language which is said to add credibility to the data (Leininger, 1985 ).

Before the commencement of each subsequent interview, the informant was requested to peruse the transcript from the previous conversation to verify

accuracy. At this time the interviewer asked for clarification of any areas of doubt so as to avoid placing her own interpretation on the information, by asking “Is this what you meant by.....”, as suggested by Oiler (1986).

The in-depth interviews were performed between 16th of October and the 22nd of November with participant observation commencing at the same time. Using both data collection methods at once allowed the researcher to gain in-depth information about the observations made. For example, a difference was noted between one work group and another and one of the key informants was able to explain this anomaly with ease.

Participant observation consists of observing what is happening in the setting, taking the opportunity to ask questions about activities, behaviours and perceptions as events occur, while personal participation promotes understanding of the participants’ view of reality (Boyle, 1991; Patton, 1990). The use of observation provides access to the “here and now” experience, in contrast to the interview which allows movement from the past, through the present to the future. In this study, this was achieved by using participant observation techniques where the researcher is directly involved in the activities of the informants. Observation increased the researcher’s ability to understand how the participants’ experience and view their world, by using oneself as a data source (Lincoln & Guba, 1985).

The objective of the participant observation in this study, was to achieve a degree of participation that would give the most useful data while causing as little change as possible (Germain, 1991). There were limitations to performing participant observation in the hostel setting. One limitation was that of gender, the researcher being a female in a male dominated area. This required the researcher to be particularly sensitive to the issue of privacy. For example, observations were not

extended to bathing activities or to entering sleeping areas after 6pm. A second potential limitation is that of the researcher being accepted to work alongside the residents, as the residents were not accustomed to having 'outsiders' involved in working activities. This was approached by holding informal discussions with residents on the day prior to the field activity.

A total of 15 residents and 8 staff members agreed to participate in this stage of the study. A total of 50 hours participant observation was performed within work, therapy and social activities areas to provide the broadest possible picture of the residents experience. This wide range of activities was chosen to reduce the possibility of bias reported to occur with inappropriate use of observation (Polit & Hungler, 1991). (Appendix B provides a detailed outline of activities observed and time involved).

Initially, the researcher did not fully participate in some tasks such as milking. This allowed time for the participants to become accustomed to her presence as well as allowing the researcher to seek guidance on how best participation could be achieved. The routines were well developed in some activities. For example, there was reluctance by the residents for the researcher to apply the milking apparatus to the cows. However, she was allowed to assist in moving them to the milking area, to ensure the feed boxes were replenished and to assist with cleaning the milking shed.

To obtain resident participants' views on an event or situation, the researcher would ask how an observed experience affected them or how they felt about a particular activity. Also the opportunity was taken during these times to obtain resident participant feedback and verification of observations (Field & Morse, 1990; Patton, 1990; Wilson, 1989). The researcher would couch questions in

general terms, usually in a social situation such as morning tea breaks, then add these perceptions to the field notes.

Field notes were written every 30 minutes in private when possible by the researcher excusing herself from an activity for a short time as necessary. This assured that the researcher was not relying on memory of events as this has previously been a major criticism of participant observation as a data collection method (Polit & Hungler, 1991). All field notes included the number of the observation, date, time, activity and the participants present with other staff and residents being acknowledged as being present without observation or identification. Descriptions of activities, behaviours, relationships, how tasks are performed and allotted were detailed (Patton, 1990, Polit & Hungler, 1991).

Resident participant perceptions, using direct quotes were differentiated from the descriptions of events for ease of transcription. Transcriptions were typed on the same day with a large margin on the right hand side to allow for comments and for ease of preparation for programming into Ethnograph. (Appendix C contains an example of the field notes).

Interest in the field notes was shown by several of the participant residents. For example, one resident requested to know what was written after he had instructed the researcher on a particular activity. He was shown the field notes for that activity which he verified as being accurate and added some comments of his own. This informant continued to show a keen interest in the research and expressed pleasure that he had a skill worth 'teaching' others. Another resident was interested in how the bus trip, one of the social activities observed, was recorded and was also shown the notes pertaining to that activity. He was amused

by some of the researcher's descriptions and shared his opinions with some of the other hostel residents.

Patton (1990) asserts that the researcher's reactions and reflections are an important aspect of the data, so these were recorded on a daily basis in a personal journal. (Appendix D provides an excerpt from the diary). This also provided the opportunity to examine comments for any evidence of bias or over involvement in the lives of the residents or "going native" as highlighted by Hammersley and Atkinson (1983).

The data collected during the participant observation and in-depth interviews provided the information required for development of the semi-structured interview questions. The advantage of semi-structured interviews is that the same information is requested from all informants while allowing flexibility by encouraging individual, detailed information. Therefore, the researcher is assured that differences in answers are due to differences between informants rather than in the questions asked (Barriball & White, 1994; Hutchinson & Wilson, 1992). A semi-structured interview format was suited to elicit information from people with long term mental illness who may confront problems with a totally unstructured format but have the detailed information required for the study purpose.

Authors such as Oppenheim (1992) assert that a combination of open and closed questions will offset the weaknesses in each type of question. Where closed questions are difficult to construct, easy to administer and analyse, open ones allow fuller, richer information although they are time consuming to analyse (Polit & Hungler, 1991).

The clarity of the questions was of paramount importance not only to increase trustworthiness of results but to present questions that the residents could answer



with ease. People with long term mental illness may misinterpret an unclear question. Oppenheim (1992) suggests several strategies that will assist researchers to ensure clarity in the development of questionnaires. These include the use of short sentences of no more than 20 words, which was vital with informants who have a short attention span. Avoiding double barrelled and leading questions and using language that is easily understood by the participants also promotes clarity (Oppenheim, 1992).

In this study, the questions for the semi-structured interviews were developed from in-depth interviews and participant observation using the language of the residents. An item pool of statements from transcripts of interviews and participant observations was arranged into categories. The categories included work, social activities, finances, relationships and spirituality. Within each category the decision was made on what aspects would be evaluated. For example, one of the key informants was most specific in enumerating what he did and did not like about his work, so two questions were included asking for resident perceptions and preferences.

The questionnaire was to begin with questions that were the least threatening to allow participants time to relax. The questions were developed in a sequence that would be logical to the informant while also moving from the general to the specific (Polit & Hungler, 1991). As asserted by Oppenheim (1992) the most effective method of ensuring adequacy of a questionnaire is to pilot it. The pilot study was undertaken with three colleagues and two residents of the hostel who were not included in the study but who proved vital in ensuring clarity of the questions. One of the residents indicated which questions were difficult to

understand and which provoked interest. The researcher's colleagues were able to detect leading questions which were then reworded.

Development of the questionnaire was completed in January, 1993 and is shown in Appendix E. In all, 11 participants were approached for interviews. One person, who participated in the observation section of the study, gave consent but found he was unable to answer the questions. The remaining 10 participants were interviewed between January and April, 1993.

The timing of interviews was arranged for a period of 15 to 60 minutes to allow for establishing rapport and taking extra time if required. For example, two participants voiced delusional material and the researcher required extra time to get the interview back on track. It was also important to take the time to get the whole story as two residents wished to say more just as the interview ended.

Setting informants at ease was achieved by encouraging them to choose the venue for the interview. One resident decided that the local hotel was an ideal place and the interview was conducted in the hotel bar on a Saturday afternoon. Another resident requested the interview be carried out in the music room of the hostel with the volume of the stereo increased to prevent the conversation being overheard.

**Stage three, exiting from the setting, is the time the researcher takes to attend to the closure of relationships with the participants.** Taylor (1991) contends that concluding a study can often be problematic for researchers and the question of timing is rarely addressed in the literature. In this study it was decided to conclude the study after completion of the semi-structured interviews because an understanding of the setting and the experiences of the residents had been achieved.

Wilson (1989) advises that the wise researcher attends to closure and withdraws from relationships with participants. This was particularly important in this study when researching with people who have a long term mental illness. Time was taken to gradually terminate relationships that had been established over 12 months. The researcher did not withdraw suddenly from the setting as it may have left some of the participants bewildered.

The participants were advised at each stage of the research process and were informed when the data collection phase was near completion. A letter was posted on the notice board expressing appreciation for the assistance received from all staff and residents within the hostel. The notice also stated that the researcher would return and share the results of the study.

Discussion of the results of the study was arranged on an individual basis with key informants and on a meeting basis with staff and participant residents. Many of the participants expressed a keen interest in the results, particularly on a one to one basis with the researcher, and their comments will be incorporated in the discussion chapter. Trustworthiness of the results of the data was ensured by taking emerging codes and categories back to the participants to ensure findings were recognised to be true by those who lived the experience (Field & Morse, 1990; Oiler, 1986).

### **Data Analysis**

The Ethnograph software computer package was used to facilitate management of the data by expediting organisation and preparation for interpretation (Tesch 1991). The programme does not eliminate the need for the rigour required in the qualitative research process although it does reduce the possibility of researcher bias affecting the results and allows more time for interpretive activities (Boyle, 1991; Burns & Grove, 1987; Irurita, 1990).

The first step was to transcribe the files onto lines that held 40 characters and instruct the computer to number each line. This step in the analysis elicited 85 pages of data with a total of over 5,000 lines. Then according to the steps of Colaizzi (1978), the data were read several times to obtain a 'feel' for the content. The data were then ready for extraction of significant statements or events. Significant statements and events were those which directly pertained to the experience of living at the hostel. For example, PR 14 made the following statements in one in-depth interview that were considered to be significant:

1. "In some ways it is good having the staff to talk to, they can help you sort things out".
2. "Working in the garden with the other blokes, having something in common to talk about and do together".
3. "The bus outing and visits to the pub are great".
4. "Feeling comfortable and at home, knowing you are accepted sickness and all".
5. "Some of the staff, particularly the ones in the garden, always have faith in you and help you to be as well as possible".

The third step of formulating meanings from significant statements and events involved translating what participants said and did to what they meant (Vellenga & Christenson, 1994). For example one key informant stated that "I am much better that I have ever been but still when it comes to the crunch there is nowhere else where I can go and be me". The meaning gleaned from this statement was that regardless of psychiatric condition, this person believes he would not truly be accepted in any other environment. To ensure that the formulated meanings did not

move beyond what the participant intended, they were asked to validate the descriptions.

The data were then hand coded with the code being entered on the right hand side of the page. (Appendix F contains an example of the data with the code on the right hand page). The codes were then entered into the Ethnograph programme and the computer was directed to sort through each piece of data for each given code. For example, each time the code acceptance appeared the segment was retrieved and printed out. The computer was then instructed to list the number of times each code word appeared for each type of data collected. For example, in participant observation and interviews, the code acceptance appeared 30 times.

The relationship between codes was then sought to begin the task of gathering meanings into clusters of themes. This process necessitated viewing each code within context. For example, it was found when seeking a relationship between the codes 'acceptance' and 'belonging', that each was an aspect of a sense of belonging. This process was continued until the four major themes were identified.

Anderson (1991a) proposed that the description of lived experience in phenomenology should always be true to the lives of the participants. In this study, as interpretive themes developed and were identified, they were viewed within the context of all the data to avoid fragmentation. This involved returning to the original data with the themes in mind to ensure accuracy (Polit & Hungler, 1991). Each theme was compared with the original data and was considered to be valid if it appeared in most interviews as well as a significant portion of the participant observation data.

A description of all findings from the study was developed as the fifth step in the data analysis. Bartjes (1991) contends that an exhaustive description

integrating all the findings should also shed new light on the phenomenon under investigation. The description may be found in the findings section of the study.

Manen (1990) asserts that themes are useful focal points of the common experience of the informants around which interpretation occurs. In this study interpretation was accomplished by exploring the literature pertaining to the themes and seeking the common thread that would best express the meaning that the residents in this hostel setting, attribute to their experience. This interpretation was put to the participants for their comments which are outlined in detail within the discussion chapter.

## CHAPTER FOUR

### FINDINGS

This chapter provides a description of the findings of the research. To answer the research questions the chapter has been divided into four sections. Firstly, a brief description of the participants is given. Secondly, an outline the life of the residents at the hostel is provided. Thirdly the themes that emerged from the interpretation of the data are discussed to provide the essence of the meaning of the experience. Finally the contribution of the findings to nursing knowledge is addressed. The majority of the data are presented as a description of what was observed and communicated within the context. Some of the observations and statements drawn from the data are enumerated as frequency counts as a way of substantiating their strength. Direct statements are used to illustrate the common experiences and themes, with verbatim quotes from the data with the following referencing format being used :

Resident participant	PR1-15	Participant observation	PO
Staff participant	PS1-8	Semi-structured interview	SSIV
The researcher	RVA	In-depth interview	IDIV

#### **Participants**

The resident participants in the study were aged between 24 and 45 years with an average age of 33 years. The length of time at the hostel ranged from 6 months to 11 years with an average of 4 years. Co- incidentally it was found that all had a primary diagnosis of schizophrenia, although several had a secondary diagnosis of mild brain injury or obsessive features. Many had spent several years in large psychiatric hospitals while several had received treatment from private psychiatrists or in small psychiatric units in the metropolitan area.

The nursing staff who participated included the Clinical Nurse Specialist, two nurse clinicians and two registered nurses. Of these participants, four were male and one female which reflected the male to female ratio within the nursing staff structure. Both tutor gardeners and a member of the farm staff were invited to participate because of the high percentage of time spent by the residents in working activities. The staff participants had been employed at the hostel for an average of four years and were aged between 35 and 60 years.

### **Life at the hostel**

Life at the hostel provides safety, basic necessities but also some challenges to people with long term mental illness. An environment of acceptance, tolerance and hope is provided where new skills can be gained. The activities at the hostel also provide a feeling of being useful and give a sense of accomplishment. Residents feel able to move onto more challenging activities. Lack of female companionship is one aspect of hostel life that is of concern to participants. Relationships with peers and staff assist residents to reach beyond the effects of long term mental illness and find new meaning.

The safety offered by the hostel environment was discussed several times by residents. One participant, when asked how he would describe the hostel to a new resident, replied:

“It’s an OK place where you can work, feel safe but still get some responsibility.”

and from another respondent

“Being here you have the chance to try new things in safety and you will find new friends.”



The differences between psychiatric hostels was highlighted by one resident when he commented that at another hostel, where he had lived for some time, there was an air of more freedom but that was an excuse for neglect. When requested to elaborate he described how he was “allowed to do anything he wanted at the other hostel, but that was only because the owners didn’t care”. Being able to work makes a contribution to the individual and the group. When asked how work affected feelings, one respondent stated:

“My mind is much clearer and I feel more calm.”

while another resident replied:

“Stops the pressure in my head from the thoughts.”

On a group basis it was observed on at least three occasions that participants showed pride in their work and found a sense of achievement. On one occasion, when a major activity of clearing a large number of rocks, particular pride in working as a group was observed. There was much enthusiasm for this task possibly because many hands made light work. PR6 commented that it was really good that everyone joined in cleaning up the ‘mess’.

A flexibility between working as a group and on an individual basis was evident. During preparation for the monthly barbecue, one resident was responsible for organising transportation of furniture and other items. Even though he liked to primarily work alone, a small group was allocated to work alongside him. Even though little was said, the group had a sense of purpose and seemed relaxed with each other. The work went smoothly and efficiently.

The support and concern for fellow residents was evident throughout the data collection. For example, it was observed on one occasion that the gardening group were very subdued and there was an air of sadness, because of an attempted

suicide by one of the residents. Several of the other residents were planning to visit him in Fremantle Hospital as soon as possible.

Developing the ability to look beyond the present was observed and/or discussed on a number of occasions. For example, a key informant stated on one occasion that:

“I would like to be able to contribute something to the outside world, but I don’t know what yet.”

Six weeks later the same resident stated:

“I can now see myself with a job on the outside.  
The things I have learned here will help me  
make a go of it.....I might even get a girlfriend.”

A final comment from a resident who, when replying to a question regarding how he feels when by himself on the farm, stated:

“Well.....it’s like I’m really able to be part of the world and feel close to the earth and God and also inside. One of the worst things for me is feeling as if I don’t belong in me either. But at those times, everything fits. It’s as though everything is right, at last and all the pain has been worth it”.

### **Themes**

The experience of the residents can be understood when presented as themes. The following themes represent the interpretation of the findings of the study. The four themes emerging from interpretation of the description were a sense of belonging, valued relationships, enabling activities and a spirit of hope.

## **Sense of belonging**

Anant (1966) describes belongingness as a feeling of 'being a part' of a social environment but in no way involving an element of dependency. Hagerty, Lynch-Sauer, Patusky, Bouwsema and Collier, (1992) define a sense of belonging as "the experience of personal involvement in a system or environment so that persons feel themselves to be an integral part of that system or environment" (p. 173). Even though there is no suggestion of dependence, a consequence of this sense of belonging may be the wish to not move from the hostel. For example, PR 1 stated that he never wished to leave the hostel in an early interview. He explained this as being because he had never previously felt as though he belonged in any place. At a later time, when the researcher raised the topic, he said that he could now 'see himself' living elsewhere but would like to still work at the farm complex.

Feeling accepted and 'fitting in' surfaced frequently throughout the data. Participants used the term 'belong' particularly in response to questions about the best thing about living or working at the hostel. The term 'acceptance', in various forms, occurred in interviews 10 times and was observed in practice on 20 occasions. For example in IDIV with a key informant, close to discharge, the following occurred:

RVA: "What impressions of your life here will remain with you when you leave the hostel?"

PR14: "Working in the garden with the other blokes, having something in common to talk about and do together.

The bus outings and visits to the pub. Feeling comfortable and at home, knowing that you are accepted, sickness and all."

On another occasion the same resident when talking of his fellow residents stated:

“They made me feel at home, as though I am really accepted. They didn’t laugh when the spirits interfered in what I was doing”.

- (Appendix G provides further examples of the use of the term acceptance in interviews.)

In the participant observation data ‘acceptance’ of residents by staff, particularly the garden and farm staff, was evident and appreciated by them. For example, during the working day, several residents, remained in close physical proximity to one of the staff members, listening closely to instructions. When the researcher inquired as to the reason for PS4’s popularity several informants cited his supportiveness and acceptance.

Acceptance of the participants on a broader community level is not as clear cut as within the hostel itself. Residents were more likely to describe the people in the local towns as ‘tolerant’. However, PR 2 stated that the people in town are ‘very friendly and accepting’. One possible explanation for this discrepancy is that the isolation of the hostel prevented frequent resident visits to the nearby towns. Lack of familiarity may hinder the development of any relationship with the locals, whereas the two participants living in another nearby town had more opportunity to establish relationships with the local people.

Participant observation data indicated that the contact of hostel residents with local people was limited. For example, when joining the resident group that visited the local hotel on Saturday afternoon, the researcher noted that although the other patrons were friendly, there was little communication. The residents sat well away

from the other patrons but fairly close to each other in the lounge section. PR6 was playing the TAB and returned frequently to share news of his fortunes with the group. When RVA asked why they sat apart, it was stated they usually sat there and when there was more activity in the lounge like a televised football match, the locals joined them. As PR6 stated 'We feel accepted by people at the pub'

Feeling safe is a further aspect of a sense of belonging. A resident said that he felt safe even though 'the spirits' told him he would be bashed, he was confident that it would not happen at the hostel. PR4, during the bus trip, commented that living in the hostel provided a place of refuge, protection from the outside world.

Another aspect of belonging, that of feeling 'at home' was highlighted by one of the key informants when he stated:

"I feel at home, as though I was meant to live in the country and this is what will help me to stay out of trouble".

and another resident suggested that he felt 'at home' in the hostel as much as in his family home when he said:

"Sometimes when I go home for weekend leave, I feel very sad.

Don't get me wrong, I love going home, but I feel sad for the others and sometimes I miss them because I have been used to talking to them. My family get shirty with me sometimes".

A sense of belonging depends largely on the relationships with others within the environment which is the topic of the next theme. Not only the relationships but the value given to those relationships.

### **Valued relationships**

The key informants focused on the value they placed on support they received in the relationships with staff members and other residents. For example, in an interview with one key informant, prior to discharge, the following occurred:

RVA: "What do you think made you feel better?"

PR14: "A few of the blokes really helped me and made me feel at home here, they showed me what to do. .... I will miss them, they are good friends"

at a later time:

"Some of the staff here, particularly the ones in the garden always have faith in you and help you be as well as possible.....They make it easy to believe in yourself."

The effect of one resident assisting another had an influence on each of them which was observed on several occasions. For example, when PR13 led the bush walk, he was observed to be considerate and showing concern for each walker, while still maintaining an even pace. When asked how he viewed the afternoons events, he stated that it really helps him to be able to help others.

There is a follow on effect of residents feeling positive about themselves and in return, helping others. As stated by:

PR 14: "We need the support that we can get from each other ..... it makes me feel good to see to see ..... and ..... how they are doing well outside".

This understanding and support is offered to each other by residents of the hostel. For example, in an interview:

RVA: "What do you like about the other residents?"

PR15: "Everyone looks after each other."

Tolerance was cited as an important aspect of the relationships with fellow residents. For example when asked what differentiates fellow residents from family, the following statement was made:

PR 10: "They know what you are thinking and why you act a little strange sometimes. They are much more tolerant than people in the outside world."

Eckartsberg (1989) defines valued relationships as those relationships that matter to us, are socially structured and carry mutual obligations. In the private sphere, the qualities of friendship, mentorship and fellowship are attributed to valued relationships, whereas in the public sphere, these situations are more socially prescribed. Both of these domains apply within the hostel situation where the residents are living and working together in both a private and public manner within the supervised setting.

Shared work provides a sense of connectedness that may not be experienced at any other time or in any other context. Staff work alongside the residents in whatever tasks are being carried out, providing more than a supervisory or advisory role.

In contrast, residents described some of the nursing staff members as 'bossy' in interviews. This was discussed in conjunction with a lack of involvement and desire to assist. One informant observed that the 'bossy' nursing staff, although a minority, behaved very similarly to many hospital based staff. "as if they needed to control everything that happens." The 'bossiness' described was not observed in the participant observation. There are three possible explanations for this

discrepancy. Firstly, the staff may have avoided the described behaviour in the presence of the researcher. Secondly, the nursing staff who participated in the study were not those thought of as 'bossy'. Thirdly, the researcher may have a different perception of 'bossiness' than the resident participants, although they were requested to point out any examples of 'bossiness' that occurred

The major negative aspect of relationships, described by residents, is the lack of female companionship at the hostel. As stated in response to the question concerning the worst aspect of life at the hostel:

PR10: "You feel like you are in a monastery..  
it's not natural you know, all these men together.  
You could understand if we were on a cattle  
station miles from the night life."

and

PR5: "Maybe we couldn't handle talking  
to girls, but it would be nice to try".

### **Enabling activities**

Activities were described by participants as helping them to feel more able in many aspects of their lives. One resident made the following statement:

PR13 "Just to know I can drive a tractor gives me  
confidence that I can do lots of other things".

and from another resident:

"When I first came here, I couldn't do anything,  
I was dangerous with the lawnmower. Now  
I can milk cows".



Work related activities were described by many of the resident participants as giving them a feeling of usefulness. The term 'useful' was used on 20 occasions during interviews and a further 6 times during observations. For example in an interview:

PR1: "Work is mostly fun and it makes me feel useful".

and on another occasion:

".....keeping busy and doing something useful,  
like I told you before. There is something special about  
seeing a real result for your work and not just something  
useless like a paper mache thing".

A sense of accomplishment was evident on many occasions, in the data, even when the term 'useful' was not used directly. For example, when a group was mixing concrete. A resident stated that he finds this activity helps to keep him fit and finds it satisfying to see the completed slabs. On another occasion in the vegetable garden PR14 commented that planting vegetables gives him a strong sense of achievement. Knowing that something will grow from his work is important.

Accepting limitations was a major issue highlighted by this informant:

"It's easy to not face what you can't do  
when you are not trying to do anything.  
Does that make sense? Now that I'm actually  
working, I've had to face the truth about what I  
can and cannot do. I have had a few pleasant  
surprises and am much stronger than I  
thought."

Social activities were also found to be enabling by resident participants. In the participant observation section of the data, there are many examples of the value placed on the social activities. For example, PR9 commented that the social aspects of the program were most enjoyable and enabled him to go out without feeling uncomfortable. A further example occurred at the monthly barbecue when the researcher sat with PR5 for a short time, who said he was enjoying himself. He stated that the past few weekends away from the hostel had not been successful and this sort of social gathering was an opportunity to mix with others without feeling threatened or uncomfortable.

The art classes provided a further avenue for social contact as well as a challenge to attempt something that differed from the everyday activities. In the PO on the 17/11/92, both PR6 and 7 stated that they enjoyed the art classes, as much for the contact with the instructor as the drawing. PR 7 had no formal drawing background and found the prospect of being 'artistic' most enjoyable. He said " it makes me reach past the sickness into another place."

Gaining confidence is one of the major challenges to the person with a long term mental illness. In the present study, a resident described participating in the camping trips as one of the main reasons he feels more confident. Enabling activities, whether social, work or therapy related can assist a person to look to the future and have increased hope which is discussed in the following theme.

### **Spirit of Hope**

The future and the importance of hope was highlighted by PR14 on several occasions in the IDIV. For example

"The biggest problem for anyone with a sickness  
like mine is having hope and being able to make

plans for the future”

When asked what hope meant to him he gave an account of feeling lost, describing himself as “stumbling like a zombie through timelessness.” When this informant was able to describe what hope is, he did so using a spiritual context. For him God and hope were related. For example, he stated that hope meant he would be able to sort things out with the help of God and “God means for people to prove that they can turn bad things into good things.”

For the person with a long term mental illness to reach out beyond the boundaries of his/her illness is a major step and demonstrates a beginning mastery of their illness and the environment. When responding to the question of how they feel in a spiritual sense, some residents used hope in their reply.

RVA: “How do you feel in a spiritual sense?”

PR4: “Hope is very important to me.”

RVA: “Does that feeling relate to personal meaning for you?”

PR5: “Yes, because I need to have hope after being sick for so long.”

Participants found elements of hope in a variety of activities. Work, in particular, contributed to a heightened sense of self value which increases a person’s feelings of hopefulness. For example when asked if work affects ideas and feeling one resident replied:

“Yes, it helps me think about the future, gives me hope of one day getting a job and a girlfriend.

You see, if you can do a full days work here, it means you can get a job on the outside.

We learn lots of things here which will help us  
in the future.”

and another resident replied

“Work helps me to keep my thoughts on track  
and helps me to think about the future”.

Seeing success being achieved by self and fellow residents had the effect of promoting hope in the current study. For example it was observed that PR8 lifted some very heavy items and was exhilarated. He yelled “Did you see what I just did?. Can you believe it”? Several residents standing nearby took time to congratulate him and PR2 stated “You never know what we can do, if we have hope and believe in ourselves. The importance of hope was captured by PR1 who stated “Without the spirit of hope being with us, we might as well be dead”

### **Contribution to nursing knowledge**

The findings, although not generalisable, make a contribution to the knowledge base of psychiatric/mental health nursing with people who have a long term mental illness. Nurses could utilise aspects of the findings that have been identified as important to the residents. One example would be for nurses to assess if the person possesses specific feelings such as a sense of belonging. Hagerty et al. (1992) assert that assessing relatedness to the environment could provide a unique approach to client care. Questions in the assessment could include “Does this person feel as though they “fit in” anywhere?” “Who do they believe accepts them as they are?”.

Secondly nurses can develop healing relationships with the clients to assist in helping the person to maintain a feeling of hopefulness. A person is only able to have hope if others have hope for him or her. Focussing on the persons strengths is one way nurses can demonstrate that hope (Munjas, 1986). Anonymous (1989), when writing of his/her experiences with mental illness,

advises that all people with mental illness should be encouraged to think of themselves as capable of change.

Kretlow (1990) states that nurses should be advocates of the persons' right to hope and to not feel alienated. Describing a person as an illness, for example a "schizophrenic", infers an unchangeable nature, affords little opportunity for hope and increases alienation. Erstoff (1981) argues that with this labelling procedure a person is given a career as a "schizophrenic" and little else is expected. By using labels, mental health professionals are imposing psychiatric language on the person to describe his/her experiences (Armstrong, 1994). Such a description may make it difficult for the individual to uncover the meaning of the experience.

Lovejoy (1984) describes how she objected to being introduced as a "schizophrenic" when she was a guest on a television program by stating to the presenter that "I am not a practising schizophrenic" (p. 812). One way nurses can help reduce the alienation of the person with a long term mental illness is by discouraging the use of terms such as "schizophrenic". The term mental health consumer is now used extensively in the literature to describe people with a diagnosed mental/ psychiatric illness (Gyulay, Mound & Flanagan, 1994)

Assisting the person to become involved in activities that he or she finds to be enabling is a further way nurses can aid people with long term mental illness.

Anthony (1993) advises structuring settings that foster a feeling of usefulness can be achieved by creative programming. One example of creative programming is highlighted in the study, by Gyulay et al., (1994), of mental health consumers as educators. Teaching sessions, conducted by professionals and consumers, were organised on a long term basis at the local high school. The findings indicated that the consumers felt a sense of purpose, empowered and gained the respect and acceptance of the students (Gyulay et al., 1994).

The description of life at the hostel, the four interpretive themes and the contribution to nursing knowledge outlined in this chapter represent the findings of the study. The discussion of the themes is presented in the following chapter in conjunction with relevant literature.

## **CHAPTER FIVE**

### **DISCUSSION**

This last chapter has been divided into four sections. Firstly, relevant literature discussing personal experiences of long term mental illness will be highlighted in relation to each of the themes. A discussion of the findings follows, including some conclusions that were drawn by returning to the literature with all the themes in mind. Reactions of participants and colleagues to the findings have been included in the third section. The limitations of this study will then be considered. Lastly, the implications of the study for nursing knowledge and further research will be discussed.

#### **Discussion of themes**

The four themes were reviewed individually and collectively in the context of all the data, to uncover any common concepts. This was done with the purpose of preventing fragmentation (Anderson, 1991b). The most pertinent aspect resulting from this review was that the themes identified are internal processes, that occur within the person. Although outside factors influence the processes, they are primarily internal.

The researcher then returned to the psychiatric literature with the internal process concept in mind to disclose any relationship to existing theory. The recent work of Anthony (1993) provided the most relevant focus to begin the discussion. Anthony has been working in the area of psychiatric rehabilitation for over twenty years (Anthony, 1982 & 1993; Anthony, Cohen & Farkas, 1990; Anthony & Leiberian, 1986). He now asserts that the concept of recovery should guide mental health services, to people with long term mental illness, in the 1990s rather than a strictly rehabilitation approach (Anthony, 1993).

In this context, recovery does not indicate that the person with a long term mental illness is entirely symptom free. Rather, that they are able to live a satisfying life with meaning and purpose, challenging limitations imposed by psychiatric illness (Anthony, 1993). The focus of the person's attention moves away from disabilities and onto living a life with purpose. Deegan (1993), when writing of recovering a sense of value, advised "The task is not to become normal. The task is to take up your journey of recovery" (p. 11).

The four interpretive themes from this study are cited within the literature as contributing to, or as components of, recovery (Anthony, 1993; Deegan, 1988 & 1993). Establishing and maintaining connection with the environment, including others and self, are vital human concerns and a sense of belonging is one component of that concept (Hagerty et al., 1992). Indeed, Maslow (1954) identified belonging as a basic human need, ranking it third in his hierarchy after the requirements of shelter, safety and sustenance. Anant (1966) proposed that the need to belong, as a mental health concept, is the missing link in the identified factors that constitute effective emotional growth and the ability to form interpersonal relationships .

Clark, Goering & Tomlinson (1991) noted in their study, on the experience of people with long term mental illness white water canoeing, that a feeling of belonging surfaced frequently in the data. Acceptance of each other and the ability to feel "a part of the team" were described by participants (Clark et al., 1991).

The presence of clearly delineated roles is linked with belongingness and an individual without that defined role relationship, will be lacking a sense of belonging. It is posited that persons with a mental illness such as schizophrenia will feel more isolated and less able to have a part to play in their environment (Anant, 1966). Erstoff (1989) asserts that a person with schizophrenia



experiences progressive role reduction. Individuals lose social roles, cease to attend school, become unemployed and lose contact with friends as the symptoms of the disorder become chronic (Erstoff, 1989). For a person with a long term mental illness, the feeling of isolation is heightened because of the chronic nature of the disorder and the communication disabilities likely to be present.

Hagerty et al. (1992) identify two major factors that are present with a sense of belonging: firstly that the person feels valued and accepted and secondly that the person feels as though he or she 'fits in' to the environment. In the findings of this study, feeling accepted and 'fitting in' surfaced frequently throughout the data. The importance of a sense of belonging and feeling accepted was highlighted by a person with schizophrenia when writing an account of managing mental illness (Anonymous, 1989). The author related a real sense of achievement when describing how he/she re-created the sense of living and belonging within a community. When recounting this experience he/she claims that no one should underestimate the importance of a sense of 'belongingness' for people with a long term mental illness (Anonymous, 1989).

Taking an active role in life is cited as one major component of recovery from long term mental illness which may include white water canoeing (Clark et al., 1991), working in clubhouse activities (Vorspan, 1992), subsistence gillnet salmon fishing (Stauber, 1993) or describing their experiences to high school students (Gyulay et al., 1994). Vorspan (1992) provides some clues to the reason for the importance of work related activities when writing of his own experiences in clubhouse activities. He explains that people, with mental illness people lose their sense of connectedness and that being engaged in meaningful shared work provides a starting point for making conversations. Work gives a stable focus, makes a

future imaginable, brings one in touch with strengths and engenders a sense of being valued (Vorspan, 1992). In the present study, work emerged as a major positive factor in the lives of the participants.

Stauber (1993) described the responses of a group of people with long term mental illness people involved in subsistence gillnet salmon fishing and asserted that vocationally related skills were demonstrated by clients who were not competitively employed. In addition, all participants demonstrated an increased self confidence in exercising strengths while accepting limitations (Stauber, 1993). Vorspan (1992) captures the essence of this point when he states that work provides an “invaluable handle back into reality, into relationships and into the experience of satisfaction, self esteem and appreciation” (p. 54). The activities need to be rewarding and enabling, thereby adding a sense of purpose for the person.

Hope is another component of recovery discussed by several authors (Anthony, 1993; Deegan, 1988 & 1993, Lovejoy 1984; Plum, 1987). Hope is described as a multi-dimensional changing force in life that is goal and time oriented and is seen to point to the ability of the person to cope with challenging situations (Farran, Wilken & Popovich, 1992; Haase, Britt, Coward, Leidy & Penn, 1992 : Dufault & Martocchio, 1985). Hope is defined by Holdcraft & Williamson (1991) as a healing force which allows humans to rise above difficulties.

Interestingly, Sister Madeleine Vaillot (1970) begins her description of hope by stating what it is not. Sister Madeleine (1970) asserts that hope is not optimism or desire and is directly opposed to despair and that any situation where hope is required is not responsive to ordinary means. There are no ready made answers that can provide the hoped for, and most importantly, people who hope, reach beyond their own boundaries (Vaillot, 1970).

Patricia Deegan (1988), when writing of her own experience with mental illness, identifies feelings of hope as a major turning point in her journey, stating that “one day something changed in us. A tiny fragile spark of hope appeared and promised that there could be something more than all of this darkness” (p. 14). Deegan (1993), in a later article, emphasised the importance of hope in the development of a sense of self value.

Lovejoy (1984), when describing her experience in the treatment world of chronic mental illness, declared that she wanted to have hope. She maintained that hope gives one courage to change (Lovejoy, 1984). Having the courage to change engenders even more hope (Anonymous, 1989).

Plum (1987), performed a study researching autobiographical accounts to identify factors that proved helpful or harmful to the recovery process from major mental illness. Hope and anticipating the future were among the key themes at the active, risk taking end of the recovery continuum (Plum, 1987). Hope emerged in the present study as most important to residents gaining a focus on the future.

Supportive relationships that are valued also surfaced in the study by Plum (1987). Albrecht, Burleson and Sarason (1992) contend that reliable social support systems enhance recovery from mental and physical illness and increases the sense of self control, stating it is the “cornerstone of human life” (p. 149). Tardy (1992) found, when studying the characteristics of supportive messages, that ability to perform important tasks, achieve positive emotional states and maintain physiological equilibrium may be affected by people who are not family members. In the hostel situation residents live more closely with each other than with their families.

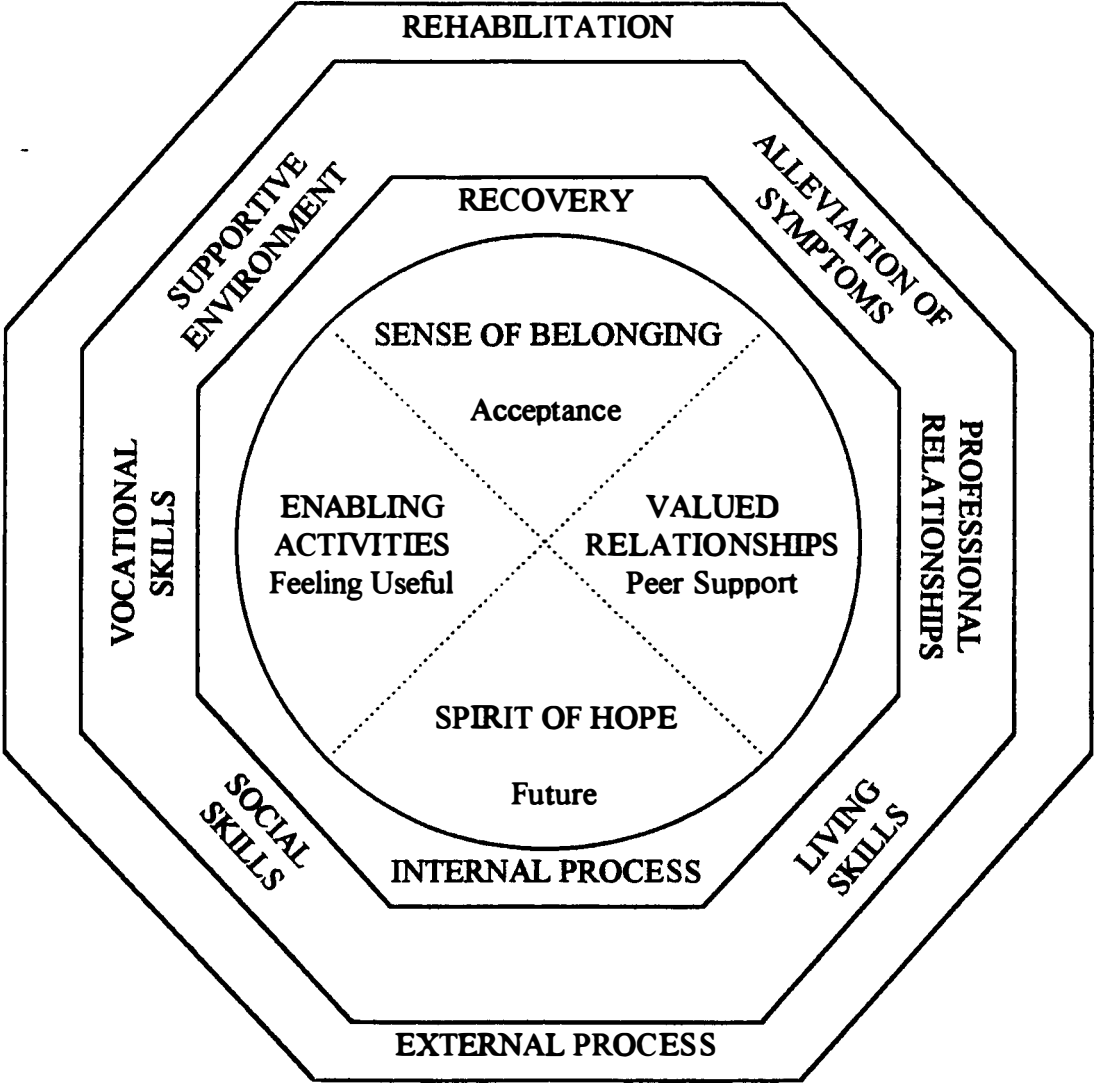
Peay (1980) contends that being “reachable” is a further contributing factor in

valued relationships. This indicates that the person is not only readily available but truly understands how the individual feels and his/her experiences. This tenet is supported by Leete (1989) who, when writing of her perception of living with schizophrenia, asserted that reliable support from a peer run group was vital in her management process.

The concept of the value of social support applies equally to the provision of support to others. Kelly, Sauter, Tugrul and Weaver (1990), when reporting on a coping group, developed on a psychiatric unit, maintain that 'playing the well role' influences the patient as much as those he/she is attempting to help. The most valued relationships are not necessarily those with professionals, with peer support being described as vital (Anthony, 1993; Lovejoy 1984). Anthony (1993) argued that a common denominator of recovery is the presence of people in the environment who support and have faith in the recovering person. Deegan (1988) highlighted what she calls the 'gift' that disabled people can give each other in sharing their hope and experiences. Participants in this study placed a great deal of value on the supportiveness of the relationships with fellow residents at the hostel.

There is a clear distinction made in the literature between recovery and rehabilitation. Deegan (1988) contends that rehabilitation is the services that are made available for the disabled person to assist in their adjustment to the world. Recovery refers to the person overcoming the challenge of the disability (Deegan, 1988). Rehabilitation is an external process, a tool offered to the recovering person. Anthony (1993) asserts that "Recovery is what people with disabilities do. ... and rehabilitation is what helpers do to facilitate recovery" (p. 15). Figure 8 provides a diagrammatical model of the internal process of recovery using the

themes from the present study in addition to the external process and components of rehabilitation.



**Figure 8.** The recovery/rehabilitation model developed by the researcher, incorporating the themes from the study and the components of rehabilitation identified by Anthony et al (1990)

The components of psychiatric rehabilitation, identified in the model (figure 8), cover the main aspects of rehabilitation as proposed by Anthony et al. (1990). It is reported that the aim in psychiatric rehabilitation is to increase the functioning of people with long term mental illness, so that they can lead successful lives and are satisfied in their environment. This is achieved by helping the person develop the specific skills and providing the supports within the environment (Anthony et al., 1990). The competence of the person in the areas of vocation, social and living skills is a major focus and often an improvement in the behaviour of the person is one clue that functioning is increased.

Alleviation of symptoms is not necessarily a major focus in psychiatric rehabilitation but can be a secondary effect. It may be difficult for the person to learn or practice the required skills if he/she is preoccupied with symptoms or has problems concentrating. Long term drug treatment with supervision and monitoring of blood serum levels and side effects is one part of the rehabilitation process. Professional relationships are necessary for all aspects of drug treatment.

Contact with professionals throughout the structured rehabilitation model is vital because living, vocational and social skills groups are usually conducted by professional occupational therapists, psychologists, social workers and nurses. Some vocation skills centers are consumer managed (Vorspan, 1992), although it is only one aspect of rehabilitation.

As previously stated, rehabilitation can be viewed as an external process where the services are offered to the person with a psychiatric disability. Whereas, recovery is an internal process affecting the person's belief about themselves. To achieve the best possible outcome, for individuals with a long term mental illness, both rehabilitation and recovery need to be considered.

### **PE fit theory**

The effects of the combination of environment and the individual traits of the person on the responses and functioning of the participants of this study can be related to PE fit theory. The rehabilitation component of the findings can be related to the objective aspects of public identity and the recovery component to the subjective or self identity identified in PE fit theory.

The relationship of the person to the environment played an integral part in the recovery/rehabilitation process and impacted positively on the participant's self esteem. To accomplish the identified components of recovery; a sense of belonging, valued relationships, enabling activities and a spirit of hope, a 'fit' with the environment was vital. Many of the residents experienced a "goodness of fit" within the hostel environment and found it useful in the recovery process. This is supported by the use of the term 'belonging' where residents, often for the first time, felt that they 'belonged'.

The characteristics of the environment that assisted the 'goodness of fit' were the relationships and support from peers and staff, having satisfying activities as well as a component of safety with all basic needs supplied. The feeling of 'fitting in' would have contributed to the hope for the future expressed by participants. If they are able to fit into one environment, the possibility exists that they may fit in to others.

To promote empowerment for people with long term mental illness, an environment that is conducive to recovery is vital. Connelly, Keele, Kleinbeck, Schneider and Cobb (1993) contend that empowerment occurs on four levels, participating, choosing, supporting and negotiating. The majority of participants of this study were able to achieve the first three levels, with several functioning at the

fourth level. For example residents were participating in activities designed to assist in their recovery process, often choosing different activities in consultation with the Activities Co-ordinator or Clinical Nurse Specialist, in addition to choosing whether to participate and offered support to each other. Two of the informants were able to negotiate some aspects of the discharge process that they believed would be beneficial to their recovery.

### **Responses to findings**

Responses to the findings of this study were sought from resident and staff participants and hostel staff who were not participants. Colleagues and delegates to a nursing research conference were invited to comment on the findings which were presented in a poster format. During the data analysis, emerging codes and themes were discussed with key informants and two other resident participants. PR14, a key informant, maintained an active interest in how the codes and themes were developed and which data contributed the information. This questioning was of great assistance to the researcher because it ensured in-depth understanding so as to explain data analysis and actions. The other participants approached did not make any comments although they demonstrated an interest in the findings.

Meetings were scheduled with resident participants and staff, once themes were established and the interpretation around recovery was made, to share findings and obtain comments. The resident participants, at the meeting, offered some pertinent comments on the themes. One agreed that hope was very important and that the environment at the hostel generally was hopeful. Two expressed an interest in the “sense of belonging” theme and said they had not viewed the hostel that way before. One resident approached the researcher after the meeting and said he thought the findings were a “lot of hogwash” and the hostel was a “terrible



place”. The resident declined to elaborate although he was requested to do so. He was the only resident who verbalised a negative response to the findings.

During the meeting with 15 staff members, there were very few comments about the findings. One staff member, not a participant of the study, expressed surprise at the amount of insight shown by the residents.

Several residents, who were not at the hostel on the day of the meeting or requested discussions, were approached individually. PR1, a key informant, commented that the researcher had “hit the nail on the head” about the difference between recovery and rehabilitation. He agreed about the sense of belonging and said that it certainly applied to him and his mates. PR13 said that the enabling activities theme struck a chord with him and said that he felt useful and needed at the hostel. PR14 was most excited to hear of the findings of the study and said that now he was away from the hostel he could relate to the themes more readily. He commented that he found the diagrammatical model “a little complicated” but agreed with the concept once an explanation was made. Overall, the findings were recognised to be true by the participants who lived the experience.

The researcher approached six colleagues, working with people who have a long term mental illness, to gauge responses to the findings. Relating findings to specialists in the field is seen as an important step in the qualitative research process (Brink, 1991, Polit and Hungler, 1991; Stern, 1991). Five of the colleagues approached expressed recognition of the findings with one commenting “I knew that already, but I had not really considered it.” The sixth person approached denied any recognition of the findings as true to her experience and commented that she found the recovery/rehabilitation discussion to be “subjective”.

The study was also presented as a poster at a nursing research conference and delegates were asked for their responses. Most commented that they found the research very interesting but only three delegates made comments on the findings. Two commented that although they did not work in the psychiatric area, they could see application for the recovery/rehabilitation model in many areas relating to chronic disorders. One person, working in the mental health area, agreed that it was useful to have the resident perspective and he could clearly recognise the sense of belonging theme.

### **Limitations**

Bergum (1989) comments that major limitations of a phenomenological study can only be fully comprehended through in-depth discussions with participants, their family, practitioners, colleagues and scholars. This provides the opportunity to explore the data by clarifying and expanding the phenomenon researched (Bergum, 1989). Several potential limitations of the present study surfaced during discussions with colleagues and participants.

People with long term mental illness, by virtue of their diagnosis are reported to be poor historians (Tantum, 1988). Therefore, the use of interview with this population may be viewed as a limitation. However, this assertion is disputed by several authors (Pinkney, Gerber & Lafave, 1991; MacGilp, 1991; Norman & Parker, 1990). In fact, Norman and Parker (1990) assert that their study demonstrated that “interviews are capable of eliciting rich narrative from people who have severe and chronic mental health problems” (p. 1042).

In the present study, three of the fifteen resident participants were not responsive to interview, although all participated in the participant observation. Two of the three residents declined to be interviewed while the third agreed to

interview but was unable to respond to questions. Some people with a long term mental illness may require a longer time than that available in the present study to develop the necessary trust in a researcher.

A further limitation suggested by a staff participant was that of the researcher being a female in an almost totally male environment resulting in residents being less open than they would have been with a male researcher. The key informants, when requested to comment on that suggestion, said that, once they became familiar with the researcher's presence, they were honest in all interviews. The researcher did note during the early stages of the participant observation that there was very little use of swear words among the residents, although there had been warning of some colourful language. This changed as familiarity with the researcher increased and she was accepted as "one of the blokes".

The size of the sample, 15 residents and 8 staff, was also highlighted as a possible limitation by a colleague of the researcher. Munhall (1994) advises, that sample size, generalisability or probability should not be listed as limitations when utilising a qualitative method of inquiry, because the same meaning for those aspects does not apply as for quantitative research methods.

Other limitations may surface as the research findings are discussed on a broader level. For example, there was no discussion undertaken with relatives of the residents, which may be a fruitful future activity.

### **Implications**

The implications of the study are summarised in this final section which is addressed under three headings. In the first, the implications of the concept of recovery for nursing knowledge are presented. Secondly, the implications for future research studies are discussed. This will include some recommendations for research methods to utilise when investigating with people with a long term mental

illness. Finally, recommendations for future research are made.

### **Implications for nursing knowledge**

With further research, the potential exists for nurses to utilise the recovery/rehabilitation model. Munjas (1986), asserts that “nurses help patients through healing relationships to maximise their participation in and control over their own recovery” (p. 211). Encouraging the person with a mental illness to participate in the recovery process is a vital role for nurses. Consumers participating in and assuming control of recovery is receiving increasing attention in the psychiatric literature (Connelly et al., 1993; Fisher, 1994; Nikkel, Smith & Edwards, 1992;). This applies equally to all spheres of nursing where the movement has been toward participation of the patient/client in the healing process.

Programs developed jointly by professionals and consumers or those developed and conducted by consumers alone can contribute to health promotion and empowerment (Connelly et al., 1993). Fisher (1994) argues that the present mental health care system is based on an illness model where symptoms are reduced but the person is prevented from taking an active role in his/her recovery. A system is promoted where individuals define their own needs and collaborates with a variety of people in the recovery process (Fisher, 1994). The path to recovery is not always smooth. People in recovery can experience strong emotions in reaction to overwhelming stimuli and can feel stressed and overloaded with added responsibility (Anthony, 1993; Connelly et al., 1993). It is vital that these reactions are not seen as “relapses” but as a part of the recovery process.

Nurses are in the ideal position to act as advocates in any changing system and to assist people to monitor their own recovery. The recovery journey for each individual is unique and a wide variety of services is required. Deegan (1988)

suggests that a recovery environment that is 'fail proof' and has multiple entry and exit points is essential.

For nurses to contribute to the recovery of people, with long term mental illness, they must first become involved in mental health care reform debates. Aiken (1989) proposes that nurses are not assuming a visible leadership in the debate about providing care for this population. This is explained to some degree by the fact that nurses are so engaged in the day to day management of care they are either not aware or not consulted about proposed changes (Krauss 1989). As suggested by Krauss (1989) "We cannot afford to be absent or silent in the midst of social reform: psychiatric mental health nursing is capable of building a new culture for mental health" (p. 286).

### **Implications for research**

Nurses can promote a recovery/rehabilitation model of care by continuing to research from the clients' perspective. Connelly et al. (1993) contend that nurses cannot act as advocates for people with long term mental illness unless it is known what is required and how empowerment is viewed. The phenomenological approach focuses on the subjective every day experience of the person therefore, is a most beneficial research tool. Nursing and phenomenology both view people as whole beings, creating a common goal (Walters, 1994).

The research process itself has the potential to contribute to the recovery of the participant. In the present study, one resident requested copies of all transcripts of interviews as he was nearing discharge and wished to review his time at the hostel. He had originally believed that he had been 'marking time' and was surprised at the benefits he had gained from work. The decision to place work as a top priority was reinforced by this discovery. Lather (1986) advises that in

research, learning and action should be combined to assist participants gain the most benefit from the process. As stated by Anderson (1991a) “ The dialogue between the researcher and informant should be recognised as a resource available to informants and as a way of empowering the disadvantaged and oppressed” (p. 115).

Lather (1986) proposes that the researcher and participant should be the ‘changer’ as well as the ‘changed’. The researcher was certainly changed by the research process, as evidenced by the diary kept throughout the study. The entries in the diary promoted self awareness for the researcher particularly in relation to belief systems and the temptation to move from the role of researcher to a more traditional therapeutic role. (Appendix D provides an excerpt from the diary). Several of the participants reported that they felt changed, with one stating “I didn’t know research could be fun”. Both Anderson (1991a) and Bergum (1991) maintained that the respondents in their studies were able to use the research experience to begin change.

The research process can be utilised as a tool in the recovery process and extended to participants assisting to design studies, collecting data and distributing findings among their peers. Pratt and Gill (1990) contend that by sharing research knowledge with clients and encouraging their involvement in education, empowerment can be increased and disability decreased.

### **Recommendations for future research**

The concept of recovery, for the person with a long term mental illness, has only been featured with any frequency in the literature in the past three years and extensive research is required. Nurses are in a position to take a leading role in this research. Kiikkala and Munnukka (1994) assert that the role of nursing research is the promotion of health whereas the focus in the medical sphere is on seeking cures

for disease.

Development of research data from a Western Australian perspective is vital, as each community differs. For example the experience of the participants in this study may be completely different from residents of an urban hostel that has no vocational program in place. Hunter and Riger (1986) state that transferring models wholesale from one community to another will “doom efforts to failure” (p. 68), which again highlights the importance of environmental factors.

Services in Western Australia, for people with long term mental illness, have increased markedly in the past 12 months. Rehabilitation programs have been developed which include accommodation facilities, vocational and living skills components. Staff have been employed and all areas have the services in place or near completion. The effectiveness of these services needs to be evaluated.

### **Conclusion**

This study has provided a beginning to the body of knowledge of the experience of the people, Wilson (1994) describes as Australia’s most needy. The conditions at the hostel afford the residents an opportunity for recovery, although the lack of female companionship is seen as a disadvantage by the participants of this study. The respondents were able to provide rich narrative to give depth to the data.

The future function of this particular hostel remains in the balance and it is vital that the views of residents and other consumers be taken into account before final decisions are made. Hoult et al. (1994) declare that Western Australia scored very poorly in the area of accommodation for people with long term mental illness. There are still a large group of people described a “falling through the net”

on a television program on the 23rd of November, 1994. It was claimed that one half of all the homeless people in Perth have a long term mental illness and many others live in substandard conditions (Carpenter, 1994). This highlights the situation that although there is accommodation available, many people with long term mental illness find it substandard, unacceptable or does not meet their needs.

Accommodation, with the necessary support services, remains a major issue for people with long term mental illness. Variety in types of accommodation is required to allow for the individual requirements of this population. Wilson (1994) asserts that the recommendations of the Burdekin Report have been given only lip service by the Federal Government and substantial new funding is required for this most needy population. Benson (1994) states that, "If we judge society by the way in which it treats its most vulnerable members, then we should remember that the mentally ill are also our beloved children and surely deserve the best of care."

(p. 34)



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## APPENDIX A

This appendix contains the consent form as presented to the residents.

**STUDY TITLE:** The experience of residents of a rural psychiatric hostel.

**INVESTIGATOR:** Rosalie Van Aken  
Master of Health Science (Nursing)  
Edith Cowan University

**POSTAL ADDRESS:** 151 Wellington St  
Perth 6000

The purpose of this research is to increase understanding of the experience of residents of the hostel. The investigator will gather information from observation and interview. Observation will be performed at various times throughout the day and evening and field notes will be recorded.

Interviews will be tape recorded. After the research is completed, tapes will be erased and codes will be used to identify participants, eg resident 1. All research materials will be kept in a locked cabinet and only accessed by the researcher. Research data may be published and anonymous quotes may be used in publication.

You are free to withdraw from this project at any time. There are no apparent risks involved in the research or direct benefits to the participant. The project could provide valuable data in an area where there may be positive contributions to care and the quality of life of residents.

Any questions can be directed to Rosalie Van Aken, hours on the unit are..... or telephone [REDACTED] or if necessary Gill Richardson by telephoning [REDACTED] during working hours.

Thank you for your participation

Please sign the attached consent form

**APPENDIX A (CONT)**

This is to certify that I .....  
(print name)

herby agree to participate as a volunteer in the project described above, realising that I may withdraw at any time. The research has been explained and questions have been answered to my satisfaction. I give permission to be observed and interviewed

**Participant** .....

date .....

**Researcher** .....

date .....

## APPENDIX B

The following table provides a list of all activities observed in participant observation with the time involved in each activity

WORK RELATED	HRS	SOCIAL	HRS	THERAPY	HRS
Milking	4	Breakfast	1	Medication	
Moving cows	1	Morning tea x 4	1	administration x 2	1
Egg collection	3	After work		Bush walks x 2	2
Vegetable planting	1	relaxation x 4	5	Art classes x 2	2
Weed removal	2	Bus trip	6		
Grass slashing	1	Hotel visit	2		
Reticulation installation	1	Barbecue	3		
Feeding pigs	1	Lunch	1		
Clearing shed	1	Christmas party	6		
Rock removal	1				
Concrete mixing	1				
Potting	2				
Picking vegetables	1				
<b>TOTAL</b>	<b>20</b>		<b>25</b>		<b>5</b>

## APPENDIX C

The following is an example of the field notes, typed in preparation for use with the Ethnograph computer program.

PO (7) 10/11/92 breakfast 7.30 a.m.

1 hr PR 2,3,4,5,6,7,8,9,10,&14

PS1, 2, 4, & 7. Many other residents  
& two other staff. RVA sat with PR8,  
11 & PS2.

RVA arrived immediately before breakfast with much activity in the unit. Blokes finishing showers, others looking for cigarettes. People beginning to queue for breakfast, there is a air of tension.

This may be because some residents do not have cigarettes or possibly because of the high activity level. PR14 commented that although getting up for breakfast is a hassle, it is enjoyable. Once the residents have received their breakfast, the air of tension disappears. The atmosphere is jovial with plenty of jokes, laughter, toast and tea. PR11 said he enjoyed having someone different around at breakfast. PS4 seems very popular and residents join him.

When RVA inquired why, it was stated that he is very supportive and accepting. There was discussion about plans for the day and a reminder about the art class.

## APPENDIX D

An excerpt from the researcher's diary is presented in this appendix

5th November, 1992

It has been a long and eventful day and time is definitely required to sift through all that happened and how I was affected. The organisation for the bus trip went smoothly and there was only a momentary hesitation in PS4's voice when he told the group that I would be coming along. One resident asked me why I wanted to come on his bus trip and not on the other groups.

Once on the road I began to examine my attitude to the idea of the 'bus trip' which holds many negative connotations in the mental health arena. The thought of piling people onto a bus and then ignoring them for the next few hours until you pile them off the bus again when returning them to their wards was strong. I decided it was important that this attitude be suspended and to treat this as a new adventure.

We stopped about 1 hour from the hostel for coffee and found the cups had been forgotten. This led to great hilarity and teasing when deciding who might be responsible. It also led to one of the most moving experiences I can remember.

Once we had arrived at our destination, a small delegation, including myself, ventured to the local supermarket to buy some disposable cups. There were three residents in the group, one very quiet aboriginal man, one rather talkative fellow (PR6) and a third man who is very withdrawn (PR8). The lady at the supermarket looked very uncomfortable from the time we walked in. The talkative fellow and I went looking for the cups, the aboriginal man walked up and down the aisles and the PR8 was looking through the sweets and chewing gum at the counter. On returning with the our goods, the woman was standing behind the till, looking decidedly agitated. We had completed our purchase and I was preparing to leave

## APPENDIX D (CONT)

when she yelled at PR8 “What do you want?”. He looked startled, touched my arm and said “You tell her”. This man had not spoken to me before. I found the whole episode very funny but also very touching.

Later in the day after a most enjoyable lunch at the hotel, where we ate our own sandwiches, there was a stop taken on the road back to the hostel. The area was made up of low rocky outcrops with some scrubby bush and a few hardy wildflowers. The sun was shining for the first time for the day and it was very pleasant just sitting watching. I spotted PS4 and PR8 walking below the rock on which I was perched and I could sense the camaraderie between these two men. I realised that the response of PR8 to the environment is often very subtle and my assumption about him being a ‘withdrawn man’ was based on clinical instead of research observation.

The days experience for me has been most enlightening, bus trips are not always as my prejudices led me to believe.

## APPENDIX E

This appendix contains the prompts used for semi-structured interviews.

RESIDENT

DATE

LOCATION

TIME

1. How long have you lived here?
2. What work do you do?
3. What is the best thing about your work?
4. What is the worst thing about your work?
5. Does your work affect your ideas and feelings?
6. If yes, how?
7. What do you do in your spare time?
8. What do you think about that/those leisure activities?
9. Is there anything that you would prefer to do?
10. Describe how you get on with the people around you.

Residents

Staff

11. What do you like about them?
12. Is there anything you do not like about them?
13. Are you content with your money situation?
14. Do you have enough money to pay for things in your everyday life?



## APPENDIX E (CONT)

15. How do you feel in a spiritual sense?
16. Does that feeling relate to personal meaning?
17. Does being here affect those feelings?
18. What is the best thing about being here?
19. What is the worst thing about being here?
20. How would you describe living here to a new resident?
21. Is there anything you would like to add?

## APPENDIX F

This appendix provides an example of a participant observation field note with each line numbered and code written on the right hand side of the page.

PR11 says he enjoys having	993
someone different around at	994
breakfast. PS4 seems very	995 )
popular and residents join	996 )
join him at the table. When	997 )
RVA inquired why, it was	998 )
stated that he is very supportive	999 )ACCEPTANCE
and accepting. There was	1000 )
discussion about plans for	1001
for the day and a reminder	1002
about the art class.	1003

## APPENDIX G

The following are examples of the term 'acceptance' used by participants to support this word as part of the sense of belonging theme.

PR14: "Its especially good when PS4 goes with us, there is lots of laughter and he accepts us...."

PR1: "I don't feel so bad about myself when the other people here accept me."

PR8: ".....well it's like a community here, where you are accepted. I can work here, get my medications and learn new things."

PR1: "I'm feeling comfortable and accepted for the first time I can remember and I want it to stay that way for now."

PR10: "My problems don't make a difference to the way I'm treated. People accept that I find it hard to socialise."

PR6: "Feeling accepted and the friendliness, I can express myself and people understand."

PR2: "You can't know what it means to know that I am accepted by the people that I work with. I have had plenty of experiences where people thought I was lazy because my sickness prevented me from finishing a job."