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Ariel Schneider
Finding Personal Meaning:
Vocational Horticulture Therapy for
Individuals with Severe and
Persistent Mental Illness

ABSTRACT

As the medical treatments available for mental illness continue to progress in the context of an ever-growing medical model with the roll-out of the Affordable Care Act, individuals living with severe and persistent mental illness (SPMI) continue to experience barriers to receiving treatment. Furthermore, the treatment modalities largely based in pharmacological interventions and insight-based talk therapies fail to facilitate recovery, or to help individuals reach a place of sustained functionality. This theoretical study investigates vocational horticulture therapy as a way to facilitate recovery for individuals living with SPMI. I use Viktor Frankl's theory of Logotherapy in which he argues for the innate human drive towards meaning to understand the usefulness of vocational training opportunities and horticulture activities. I also provide an analysis of current mental health policy and argue for the collaboration between the well-resourced, mainstream medical model with the poorly funded long-term treatment-oriented recovery movement.

**FINDING PERSONAL MEANING: VOCATIONAL HORTICULTURE THERAPY FOR
INDIVIDUALS WITH SEVERE AND PERSISTENT MENTAL ILLNESS**

A project based upon an independent investigation,
submitted in partial fulfillment of the requirements
for the degree of Master of Social Work.

Ariel Schneider

Smith College School for Social Work
Northampton, Massachusetts 01063

2014

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TABLE OF CONTENTS

ACKNOWLEDGEMENTS	ii
TABLE OF CONTENTS.....	iii
CHAPTER	
I INTRODUCTION AND METHODOLOGY	1
II VOCATIONAL HORTICULTURE THERAPY IN THE UNITED STATES AND ABROAD	24
III LOGOTHERAPY: FINDING MEANING IN THE FACE OF HARDSHIP.....	35
IV ROOM FOR COLLABORATION: MEDICAL AND RECOVERY MODELS FOR MENTAL HEALTH POLICY AND SERVICES.....	47
V DISCUSSION.....	63
REFERENCES	72

CHAPTER I

Introduction and Methodology

The Story of D

I met D, a 19-year-old Caucasian male, when he came to the emergency room with his father for worsening psychotic symptoms. These included intense feelings of paranoia, responding to internal stimuli, and catatonia whereby he could not move his body or take care of himself. He attended a series of music festivals where he allegedly used illicit drugs and returned in a psychotic state. For a number of months he was missing, and then in and out of hospitals before landing in the care of his father and our hospital. After a 60-day inpatient stay, he was given the diagnosis of Schizophrenia and discharged to his father's home with heavily sedating anti-psychotic medications and a follow-up appointment with an outpatient psychiatrist who was to monitor his response to the meds. Though he was not in a state that the psychiatrist or his father felt was "well", he was no longer improving in the hospital. Other aftercare options such as a group home and intensive outpatient group therapy for psychosis were offered but D ultimately did not see how those options might help him and decided not to go. Whether or not they might have, the fact that he did not want to participate and that the format did not speak to him was reason enough not to force him to go, as he likely would not have benefited.

While his hospital stay certainly offered him and his family crisis stabilization and his outpatient doctor is a helpful provider in relation to his medications, D is not thriving. Before becoming ill, D was a first year undergraduate student at a prestigious 4-year university studying

anthropology and was achieving good grades. With the sudden onset of his symptoms, he had to un-enroll from school and in effect lost his sense of greater purpose with nothing to work towards. He is almost completely isolated at home where he watches television and his only regular interactions are with his father and older brother, who are now his caretakers. As such, he has lost a sense of independence and hope for the future to be better. He has been able to engage in some previously enjoyed activities like practicing yoga and playing guitar, but not to an extent that he would describe as fulfilling. While his symptoms are better controlled and not as intrusive to his thinking as they were before, it is still unclear to D and his family what he is capable of doing and they currently do not have support for exploring the possibilities.

D's story is one example of the struggle experienced by millions of adults living with mental illness in the United States. In losing a meaning to his life, becoming isolated and without direction after the onset of his symptoms, D's illness has become his identity and dictates an endless loop of unsatisfying and meaning-less days. His care has objectified him as a set of symptoms that can only be managed with medicine and lacks a dimension of seeing him as a unique individual with a set of interests, strengths, and dreams.

Therapeutic and Vocational Horticulture

One out of four U.S. American¹ families experience mental illness. Unlike other ailments, mental illness does not discriminate across race, age, income, religion or education (NAMI, 2013). For the nearly 57.7 million adults living with a mental illness in this country (NAMI, 2013), the hopes for recovery are largely dependant on an individual's access to both pharmacological and psychosocial interventions, an opportunity that may be hard to come by for those without good insurance or access to treatment (NAMI, 2013). For acute crises, psychiatric

¹ I choose to use the term "U.S. American" as opposed to "American" throughout this study to acknowledge that "Americans" not only live in U.S., but in Central and South America as well. To assume otherwise can highlight and reinforce U.S. imperialism in those countries.

hospitals serve as places for stabilization and connection to longer term options which often include partial hospitalization programs, board and care facilities, or residential treatment centers, depending on an individual's diagnosis.

These modalities can be helpful for teaching coping skills and facilitating connections to others with similar struggles. However, at the same time, for those who are even able to access these services, treatment can be isolative and prevent an individual from engaging in “real-world” pursuits. Less than 15% of people receiving public mental health treatment hold competitive jobs despite the sixty to seventy percent of people who would like to do so. This is in part due to a lack of vocationally focused rehabilitative services (SAMHSA, 2009). In the United States only 2% of people with serious mental illness receive any form of supported employment (Marshall et al., 2013).

There are however a number of community based programs and research addressing the growing desire among individuals with psychiatric disability or mental illness to acquire vocational skills that target helping people find meaning in their lives. In fact, “Supported Employment” is now considered an evidence-based practice with widely researched outcomes and models for implementing programs in mental health agencies (Becker & Drake, 2003; SAMHSA, 2009). Yet there is an underutilization in mental health treatment in part due to different perspectives between practitioners and consumers about the importance of the consumers' desire to work (Casper & Carloni, 2007). Vocational Horticulture (VH) is one such modality that comes out of the larger field of Horticulture Therapy (HT). VH focuses on training individuals to work in the horticulture industry professionally, either independently or semi-independently (Messer Diehl, 2007) as a way to provide rehabilitation for individuals who historically would have been institutionalized for treatment.

In this study, I offer an exploration into the effectiveness of VH for the adults with major mental illness in their recovery process. I hope to illuminate the many benefits of giving people the skills to interact as a functioning member of society, including helping the individual reach his/her own goals (Slade, 2007). A striking and pertinent aspect of VH and HT in general is its ability to get a person in motion: doing something different from attending only to internal stimuli regardless of its delusional/hallucinatory nature. Unlike traditional forms of individual and group therapy, which rely on self-reflective and cognitive approaches to conversation and tasks, VH offers an action-oriented experience. For example an individual in VH who reports psychotic symptoms may finally participate in experiences outside of his delusional and disorganized thoughts, which has been shown to increase the likelihood of recovery and future employment (Baksheev et al, 2012).

While certainly successful at offering individuals medication to address their psychiatric symptoms, mainstream psychiatric treatment is limited in its ability to offer treatments that address the whole person or an individual's psychosocial needs as mentioned previously. In the context of a hospital, for example, patients² frequently receive care from a team of doctors and nurses in order to stabilize their physical health, including medication to address physiological distress. What is much less common in a hospital are skills-based opportunities such as occupational therapy. Short-term treatment models, which limit the ability for a patient to engage in therapy, are another important limiting factor of hospitals.

Re-connecting people with the outdoors and their food source is gaining popularity after a long time of mainstream cultural disconnection. From the White House initiative to end obesity through fresh food education to a free substance abuse treatment center in Italy that utilizes farm-

² The term "patient" is used similarly to "client" in this study, and is used when referring to a medical setting.

based work (Pianigiani, 2013), the healing effects of the outdoors are increasingly recognized across disciplines. The new local food movement phenomena popularized by such authors as Michael Pollan, Barbara Kingsolver, and Eric Scholsser, urges us to support sustainable agriculture by eating fresh foods produced by near-by farms (Alkon & Agyeman, 2011). Yet the idea that people with mental illness might benefit from working outside in a farm-like environment is not new.

Care Farms, a tradition started and maintained in the UK, are a regularly used modality for treating mental illness across Europe (Elings, 2011). Citing their foundation to 1350 in Gheel, Flanders, where people in need could come to live and work alongside village families, the tradition spread most notably in the 1940s taking the form of therapeutic communities whereby members worked and cared for all farm responsibilities (Elings, 2011). Programs such as these have been successful in providing a social outlet for individuals with mental illness and providing them with a meaningful way to spend their days (Elings & Hassink, 2008). With the rise of the Industrial and Technological Revolution, it became increasingly difficult to spend regular and sustained time outdoors, let alone interact meaningfully with nature. Perhaps the time has come to think about how the movement to interact more with our natural world can apply to vulnerable populations such as those with major mental illness. Given the current cultural focus on “going green” and a rich European history in Care Farms to draw upon, it seems as though the U.S. is poised to take advantage of such modalities.

About 200 years ago America’s first Surgeon General, Benjamin Rush, MD wrote prolifically about the use of farms for the treatment of the mentally ill (Lewis, 1987) and started the first hospital-based garden program at Friends Hospital in Philadelphia, PA in 1817 (Taylor, 2009). Years later this approach evolved into a more institutionally based treatment modality

routinely implemented by state psychiatric hospitals. In 1936 the Camarillo State Hospital in Southern California (which is now the California State Channel Islands University campus) was founded as one of many state hospitals designed to treat patients for months to years to entire lifetimes (Noxon, 1997). They housed 100 “working patients” to maintain farming operations on its 1200 acres, including 304 acres of alfalfa, 227 acres for vegetables, 178 acres for grain crops, and 80 acres of orchards. Hospitals around the country operated similar programs within the context of “moral treatment,” a period of U.S. American psychiatry during much of the nineteenth-century whereby patients were treated humanely. Under this model providers developed close personal relationships with their clients, rewarded positive behavior from patients, and created daily opportunities for purposeful activity (Dunkel, 1983). Some cite this as a hugely successful treatment model because it facilitated recovery from mental illness and is thought of as the first practical effort to provide systematic and responsible care for the mentally ill in the United States and abroad (Bockoven, 1963). Camarillo’s program was drastically reduced in 1969 when new legislation eliminated indefinite commitments of persons defined as “mentally disabled” (Camarillo State Hospital, 1993) though it continued to house patients into the early 90s. This time in history marked a significant shift in attitudes and public policies in the treatment of mental illness.

In the 1960s and 1970s legislation discontinued state hospital-based psychiatric care following President John F. Kennedy’s call for a reduction in hospital patients (Davis, Fulginiti, Kriegel, & Brekke, 2012) and President Jimmy Carter’s concepts of freedom, self-determination, autonomy, and dignity while receiving mental health treatment (Torrey, 1997). What came to be known as “deinstitutionalization” unfortunately led to what many called the “mental health crisis” because after patients left the hospitals, rehabilitative and other follow-up services were

not implemented at the level or in the manner as planned (Torrey, 1997). A movement to address the long-term rehabilitative needs of the severe and persistent mental illness (SPMI) population since deinstitutionalization includes programs that aim to offer vocational opportunities.

Historically, vocational rehabilitation (VR) and psychiatric services have been largely disconnected (Weinstock & Barker, 1995). With the passage of the Rehabilitation Act of 1973, this country's policy prioritized VR for the "most severely handicapped" including those with severe mental illness. In 1986 new amendments more clearly defined the importance of VR services for the mentally ill population including new funding sources and resources for implementation. (Weinstock & Barker, 1995). In practice however, this collaboration is in still in process and often only succeeds on small-scale, local levels because of the initiative of committed individuals in leadership rather than policy-led funding or mandate (Weinstock & Barker, 1995).

One such example is the Grow Native Nursery in Westwood, Los Angeles, CA that partners with the VA Greater Los Angeles Healthcare System to "maximize veteran's opportunities in the sustainable horticulture industry" (Rancho Santa Ana Botanic Garden, 2012). Located within the Veteran's Garden, capable VA patients are invited to spend a few hours per week at the nursery, engaging in all aspects of nursery business and building skills that they can apply in a job once discharged from hospital care. This one example of a successful local partnership and similar programs can be found at VA hospitals around the country (Taylor, 2009) but unfortunately is neither representative of national VA policy, nor psychiatric hospital policy in general.

Mental health-gearred vocational rehabilitation models take numerous forms. Psychosocial Rehabilitation is one of the most practical and aimed at re-integrating individuals

into the community. Its catalyst occurred in Helsinki at the 1971 International Committee Against Mental Illness conference (Gittelman, 1997). Broadly defined, “psychosocial rehabilitation” denotes efforts and interventions designed to reduce mental and social impairment, disability, and handicap in persons with mental illness and improve functional competence, improve quality of life and reduce risk of acute relapse (Gittelman, 1997). Some psychosocial rehabilitation programs work in conjunction with traditional psychiatric care including medication, while others are implemented strictly as an alternative to pharmacotherapy. Leading guidelines, however, including those for the treatment of major mental illnesses like schizophrenia, advocate for a combination of these two approaches, i.e. medication and rehabilitation because many programs have shown them to work compatibly and successfully (Lieberman & Kopelowicz, 2004).

Another similar modality relevant to horticulture therapy is the clubhouse model, originally developed in 1948 for patients discharged from the New York psychiatric hospital. Similar to the goals of psychosocial rehabilitation, the clubhouse model embraces their “members” as individuals contributing to the community by sharing responsibilities inside and outside of the living space. “Each individual is welcomed, wanted, needed, and expected each day and is considered a critical part of a community engaged in important work” and thus provides structure and meaning for each engaged individual (Corcoran & McKay, 2013). Given the importance of these types of treatment options for individuals in addition to their well-researched success, there is space for their expansion and accessibility to the severely mentally ill in the United States today.

Research Gaps

The literature on the efficacy of VHT interventions for individuals living with SPMI is scarce, fragmented and anecdotal. In a review of the current literature on horticulture therapy as an intervention for mental illness, investigators found only ten studies published since 2003 and disappointingly did not use randomized-controlled trial design which indicates a need for higher quality studies in this area (Clatworthy, Hinds, & Camic, 2013). Overall there is a dearth of scientific evidence to support VHT despite the extensive research conducted on its major components such as human-plant interactions, horticulture therapy for other populations, and supported employment.

The current literature relating to people and plant interactions largely supports the healing effects of nature for compromised or vulnerable populations. It has been effectively used across presenting problems that range from clinical depression (Gonzalez, Hartig, Patil, Martinsen, & Kirkevold, 2010), dementia and Alzheimer's (Jarrott, Kwack, & Relf, 2002), cognitive delays (Berman, Jonides, & Kaplan, 2008), post-traumatic stress disorder (Lorber, 2011) major mental illness (Simpson & Straus, 1998), sensory integration issues (Wagenfeld, 2009), individuals involved with the criminal justice system (Hale, Marlowe, Mattson, Nicholson, & Dempsey, 2005) to those who build community in low-income neighborhoods (Hale, Knapp, Bardwell, Buchenau, Marshall, Sancar, & Litt, 2011).

Furthermore, considering that activity is an important component for psychiatric rehabilitation, there is clear and consistent evidence for using supported employment in mental health rehabilitation. Such research demonstrates that individuals placed in jobs early on in their recovery improve employment outcomes (Becker & Drake, 2003). Supported employment, of which vocational horticulture is one specific type, is defined by the federal government as:

competitive work in integrated work settings...consistent with the strengths, resources, priorities, concerns, abilities, capabilities, interests, and informed choice of the individuals for individuals with the most significant disabilities for whom competitive employment has not traditionally occurred; or for whom competitive employment has been interrupted or intermittent as a result of a significant disability (Rehabilitation Act, 1998).

While horticulture settings were formerly central to earlier models of psychiatric care, only in the last few decades have designers and policy makers returned to that model. U.S. American models can learn a lot from British ones, which prioritized gardens and farmland in the building of psychiatric hospitals as part of long-standing tradition (Hickman, 2009). Building sites for hospitals were chosen based on their ability to offer ample outdoor land and were increasingly ruralized through the 19th century (Hickman, 2009). This set-up not only provides recreation activities but also a general environment connected with nature that promotes healing (Hickman, 2009). Furthermore, gardens are enjoyed not only by patients, but also by all people accessing healthcare settings (Barnes & Cooper Marcus, 1995). There are a number of leading healthcare facilities across the world that have prioritized gardens including Legacy Health System in Canada. Gardens are an integral part of their rehabilitation efforts for patients across illness and diagnosis and have proven to be a healing component of their care (Horowitz, 2005).

Despite the resounding research to support the healing effects of outdoor experience and supported employment programs, barriers to connecting people with such opportunities include limited access to supported employment, poor resources to implement programs, and inefficient government policy (SAMHSA, 2009). There continues to be a need for more specific research

that correlates VHT with positive mental health rehabilitation outcomes so that policy and funding can be informed by such findings.

Horticulture Therapy and Clinical Social Work

As clinicians we need to have the widest breadth of treatment options available for working with patients and for helping their families in the struggle with mental illness. Given our ethical standard to “promote well being” and to make “client’s interests primary” (NASW, 2008) social workers are a key link to rehabilitative services. We are able not only to provide a therapeutic experience while interacting with our clients, but also to offer options about where to receive treatment and where the most healing might occur. The intentional and attuned relationships social workers build with their clients, similar to the mentorship model employed in VHT, is core in how social workers are instructed to approach treatment.

A fundamental tool for the practice of clinical social work includes eco-mapping, or a deep understanding of an individual’s relationships, which exist within a web of social systems including family, institutions, and care providers (McCormick, Stricklin, Nowak, & Rous, 2008). Social Work’s whole person approach to care implies that we must look at complementary and alternative treatment options as we work to connect people with the services they need. Similarly implied is the idea that the actual environment (i.e. the natural world) is to be considered when conceptualizing an individual existing within a system and that it is part of a social worker’s role to facilitate this relationship given its function in identity formation, meaning-making, and the negative effects we see of environmental destruction (Norton, 2009).

The advancement of horticulture therapy is embedded in social work’s history in part due to the work of psychiatric social worker, Alice Wessels Burlingame, whose research and practice in the 1950’s hugely expanded the scope of HT and helped bring more publicity to the field (Ann

Arbor Farm & Garden, 2013). Alice is part of a long tradition of social workers involved in psychiatric care dating back to the early 1900s when Dr. Richard Cabot of Massachusetts General Hospital invited the first social workers into hospital work as collaborators in patient care (Gehlert & Browne, 2006). Since then, clinically trained social workers have become the U.S.'s number one mental health care professional compared to psychologists, psychiatrists, and nurses (Social work speaks: NASW policy statements, 2000) and thus have a lot of power in numbers when it comes to providing care.

I invite clinicians and mental health care professionals to consider a more expansive view of “treatment” and be open to considering the value of complementary and alternative approaches that augment and support conventional interventions. When involved in an individual’s treatment and recovery plan, clinicians are working with people and their families at a particularly poignant and vulnerable time and thus are poised to offer a variety of care while considering important patient-centered factors such as cost, accessibility, and likelihood of success.

Theoretical Orientation and Methodology

This study uses a theoretical approach to examine the uses of vocational horticulture for individuals suffering from major mental illness. My central hypothesis is based on ideas developed by Viktor Frankl through Logotherapy and an analysis of current mental health policy (elaborated below). These lenses offer a framework to understand why vocational horticulture is a helpful modality to consider as part of an individual’s recovery.

Definition of Terms

To orient the reader to what is meant by some of the vocabulary used in this study, below I offer a discussion of the central terms. Each term has its own set of complex uses, applications,

and critiques I distilled down for the reader in order to create a common starting place from which to begin a conversation.

Mental illness. This study focuses on the experiences of **mentally ill** individuals, which is a general term that can apply to a wide range of people. The National Institute of Health defines mental illness as “a health condition that changes a person’s thinking, feeling, or behavior (or all three) and that causes the person distress and difficulty in functioning” (“Information about Mental Illness and the Brain, n.d.). The Diagnostic and Statistical Manual of Mental Disorders (DSM) is the tool clinicians of psychiatry, psychology, and social work most often use to make diagnostic decisions about the definition of their clients’ illness. For the remainder of this paper I will refer to the mental illnesses that appear in the fourth edition (DSM-IV). Mental disorders are listed by category with description diagnostic features, associated disorders, prevalence, course, family patterns and symptoms. The reductionistic nature of the DSM descriptions as well as a lack of consideration for sociocultural factors (i.e. culture, gender, race, etc.) is widely debated. Because of its potential to harm, the relevance of diagnoses in treatment planning is debated within the community as well. These critiques include the tendency of diagnoses to oversimplify, to be pejorative, to pathologize non-problematic behavior, and to limit the client’s access to services.

For individuals facing chronic and severe mental illness, the negative effect of diagnoses can be pervasive and can impact willingness to engage in treatment. In addition to a number of environmental and illness-related factors, the therapeutic alliance between clinician and client is an important indicator as to a person’s engagement and potential for benefit from treatment (Mitchell, 2007). Modern psychiatry is greatly influenced by a so-called “medicalization” of mental illness: ‘when a specific aspect of the body becomes the focus of medical attention, there

is a process by which it is claimed, controlled, and brought into medical ideology' (Mason & Mercer, 1999, p. 57). These individuals commonly feel defined by their diagnosis and symptoms because treatment providers may objectify rather than treat the client as a complex and dynamic person. Szasz (2007) posits that the medicalization of mental illness can be a form of social control when what follows a diagnosis primarily benefits the dominant group (i.e. care providers) and justifies the interventions in the name of medicine or society rather than the patient. For example, prescribing a medication reifies the identified pathology as something that needs fixing. The treatment specifically exists within the paradigm for "normal" and "pathological" set forth by psychiatry and places the illness within the individual. Having treatments performed "on" as opposed to in collaboration "with" the patient leads to an even greater disengagement from treatment.

In many ways, the conversation about individuals living with mental illness is synonymous to individuals living with disability. Abberley (1987) identified some of the effects of the societal oppression upon disabled individuals namely in 1) discouraging disabled people from engaging with their "privileges" (social supports, government benefits, etc.) and thus excluding them from the work world; 2) assigning negative stereotypes which decrease the likelihood for a disabled identity or association with disabled others. Both forms of oppression lead to isolation and distance from the services, providers, and activities that may be helpful.

However, diagnostic labels can sometimes fulfill an important purpose in treatment. McWilliams (2011) points to their utility in treatment planning, prognosis, facilitating empathy, and creating a basis from which to have a conversation about mental health policy. In addition, many individuals report feeling relief upon knowing that what they are experiencing is within understood phenomena that others experience as well. It can similarly be a relief to know about

course of treatment. By suggesting a time commitment from a client, clinicians are able to communicate empathy by way of recognizing the complexity and depth of an individual's struggle. I would also add that quite simply, diagnoses attempt to create a language for the very personal and subjective experiences of people. With a set of vocabulary, people across differences can enter into a conversation about the phenomena they and their clients may be experiencing.

Recovery. The ideas of psychiatric rehabilitation or “recovery” are also addressed in this study in the context of individuals suffering from mental illness. It is important to note that recovery exists on a spectrum and that functioning will manifest differently for each individual engaged in treatment. The term is often heard in the substance use field and has been widely applied to an individual overcoming an addiction. More recently, the term has been re-applied to mental illness and is in many ways is more difficult to define as there is a wide variance in what recovery might look like for an individual. This could include symptom reduction, reduced necessity for medication, living independently, holding a job, etc. In her foundational article for the modern understanding of recovery, Patricia Deegan (1988) distinguishes recovery from rehabilitation as “the lived or real experiences of persons as they accept and overcome the challenge of the disability”. Rather than a repair, the goal in recovery is instead to establish “a new sense of self and of purpose within and beyond the limits of the disability” (Deegan, 1998). William Anthony, the director of the Boston University Center for Psychiatric Rehabilitation, develops the idea further and offers that:

Recovery is a deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills, and/or roles. It is a way of living a satisfying, hopeful, and contributing life even with limitations caused by illness. Recovery involves the

development of new meaning and purpose in one's life as one grows beyond the catastrophic effects of mental illness (1993).

He radically proposes a set of basic assumptions implicit in a recovery process: 1) a person can recover without the use of outside interventions. Mental health providers can be helpful, but only individuals themselves hold the key to their recovery; 2) one needs a set of people dedicated to consistently support them throughout the process; 3) recovery does not in any way rely upon the etiology of an illness; 4) symptoms will reoccur; 5) symptoms will decrease over time and reach a state in which they do not interfere with a person's functioning; 6) the recovery process is not linear; 7) recovering from the consequences of the illness can be more complicated than the illness itself; and 8) experiencing recovery does not take away from the previous experience of being ill (Anthony, 1993). As he explains, recovery is a personal and complex process that cannot be simply prescribed. Furthermore, recovery aims to do more than manage symptoms but instead to help people reach a place of sustained functionality.

Some governing bodies in the U.S. integrate recovery-oriented language and services. The Substance Abuse and Mental Health Services Administration published a document in 2010 outlining their working definition of recovery. Included were four main components to their generalized definition: “a process of change through which individuals improve their health and wellness, live a self-directed life and strive to reach their full potential” (SAMHSA, 2012). They also highlight the importance of having purpose: “meaningful daily activities, such as a job, school, volunteerism, family caretaking, or creative endeavors, and the independence, income, and resources to participate in society” (SAMHSA, 2012). There are a number of evidence-based interventions practitioners can utilize to help individuals develop their own goals for recovery. For example, Illness Management and Recovery (IMR), encourages clients to work

collaboratively with their providers on psycho-education, to understand their medication and the mental health system, to build social supports, and to reduce stress (McGuire, 2007).

Horticulture therapy (HT). As previously discussed, horticulture therapy is a broad and generalized term. Davis defines horticulture therapy as “a process through which plants and gardening activities are used as vehicles in professionally conducted programs of therapy and rehabilitation” (as cited in Simson & Strauss, 1998, p. 3). Only in the last forty years has horticulture therapy become an established and organized field of practice in the U.S. and gained membership organizations such as the American Horticulture Therapy Association (AHTA). In fact, HT has been used across many disciplines and in the treatment of an array of illness, disability, and age groups. A study of the AHTA’s membership revealed that the majority of people engaged with this organization identify as horticulture therapists or educators. Less than 5% of respondents identified themselves as people engaging in mental health work (Larson, Greenesid, & Meyer, 2010). Thus there is an opportunity to increase the breadth of HT work with new professionals and populations. One of HT’s greatest strengths is in its versatility and as I will explore further, its power in helping people move towards recovery across a wide array of presenting concerns.

The Theoretical Lens

Logotherapy. Developed by Austrian neurologist and psychiatrist, Viktor E. Frankl, Logotherapy offers a psychological framework from which to understand how humans can persist through extreme hardship. Frankl is considered one of the founders of the Third Viennese School of Psychotherapy following Freud who proposed a “will to pleasure” and Adler who proposed a “will to power” (Frankl, 1969). Instead, Frankl offers a “will to meaning” based

partly in his experiences as a survivor of a concentration camp during the European Holocaust in World War II (Ameli & Dattilio, 2013).

His concepts are based on three major tenets including freedom of will, the will to meaning, and the meaning of life—all of which rest on the core assumption that humans are capable of surviving even the most horrific of experiences if they have an attitude and belief towards a higher meaning (Frankl, 1969). Similar to the phenomena around vocational horticulture, these three major concepts focus on an individual's future and the meanings to be fulfilled (Frankl, 1959). Following diagnosis of a mental illness, individuals have been reported to feel a loss of self, power, meaning, and hope for the future (Slade, 2009) or what Frankl would call the “existential vacuum” and explains why rehabilitation efforts not addressing these feelings fail (Julom & de Guzmán, 2013). Furthermore, as described above, individuals can experience a sense of isolation, rejection, and objectification following a diagnosis. I will argue how horticulture activities provide individuals with meaning via responsibility to plants and animals, to other community members, and a newfound sense of purpose. I will use Frankl's concepts of tri-dimensional ontology, the existential vacuum, and his three core assumptions: freedom of will, the will to meaning, and the meaning of life to look at how horticulture therapy is a useful and meaning-making intervention for individuals with mental illness.

Mental Health Policy. Programs for rehabilitation from mental illness are largely dependent on the ways in which state and federal policies allocate money and resources. As the United States government currently functions on a federal, state, and local level, money and resources are allocated based on the political priorities set forth by policy and law. The Disability Act and Mental Health Parity Law prioritize mental health treatment in the same way as physical health care and has attempted to equalize access and treatment availability, though current

research points to a continued problem for the SPMI population to access mental health services (“The Numbers Count”, 2014). By way of mandates put forth by health insurance companies, limited access to coverage, and Federal funding allocation priorities, the current mental health care system is still failing to adequately meet the needs of individuals living with SPMI. There is however a movement of community-based programs providing recovery-oriented services that hold much promise for individuals reaching the long-term goals of living independently, earning money via a job, and learning to live with their illness. In an analysis of the current barriers to treatment imposed by the medical model of treatment I offer a collaborative model for future policy that advocates for the integration of recovery-oriented services such as VHT into a mainstreamed system of care for individuals living with SPMI.

Methodology

This theoretical thesis consists of five chapters. In the first chapter I introduce the field of vocational horticulture therapy and briefly lay out the argument for why there is a need for different kinds of treatments for the severely mentally ill in the United States. I also define important concepts and lay out the structure of the study. The second chapter offers an in depth exploration of the therapeutic benefits of nature and horticulture therapy as well as an overview of the individuals living with mental illness in the United States so as to ground the study in a set of researched phenomena. Chapter three offers the reader an understanding of Logotherapy as developed by Viktor Frankl and those who have come after him. Chapter four describes past and current policies related to the treatment and rehabilitation of mental illness in the U.S. and offers an analysis of the medical and recovery models. Finally, chapter five aims to synthesize the ideas from Logotherapy and the limitations in current policy by way of a case study to make recommendations to clinicians and future researchers.

Study Biases and Limitations

As I explore major mental illness and the uses of horticulture therapy, I encourage the reader to maintain a critical standpoint. As is true for any theoretical study, my personal biases will color every aspect of this investigation. This project is influenced by my life experiences, educational background, and social predispositions. Specifically my positive experiences working on farms lead me to approach this study with the personal belief that horticulture work in community settings is deeply healing.

A few years ago I had the opportunity to live and work on a rural farm in South America called “Mama Roja” (Red Earth) where I learned about earthen building, organic farming, and natural medicine. I sought out this opportunity after three years of living in New York City. I felt fatigued and had become aware of my own limitations from participating in the competitive, fast-paced lifestyle that dominates and defines the educated class with which I identify. While Mama Roja is not designed specifically for a mentally ill population, it shared many of the programmatic aspects of the farms mentioned in this study including communal living, skill building, living and working directly in nature, and accountability to the farm tasks. After a couple weeks of being fully immersed in nature, using my physical strength to complete tasks throughout the day, and being held accountable by the other individuals living there, I noticed positive changes in my physical and mental health. My body felt stronger and my mind clearer. It satisfied me to sustain others and myself with the fruits of my labor. I was experiencing a deeper connection to myself: my feelings, my hopes and dreams, my body. Living in close community and being asked to participate in communal meetings accelerated my process of introspection and provided me opportunities to grow personally by working through personal and relational conflicts. These reflections led me to wonder about a broader healing power of connecting with

nature. Why had society seemingly disconnected from the very things that were making me feel so happy? Did I really have to come all the way to rural Argentina to learn of this? Is this lifestyle really not available and under-appreciated? And if I'm feeling so content, how might this work affect people who are experiencing illness? It is from these musings that I decided to research HT and write about how it might be helpful for people who live with mental illness.

Another important methodological bias involves my experience as an intern in a psychiatric hospital. While this experience certainly enriches my understanding of the topic, it also skews my perspective on what I perceive are viable options for individuals and their families living with mental illness. I worked as an intern for eight months with inpatient adults and their families to create appropriate and supportive discharge plans when they were presumed "ready" to leave the hospital by their psychiatrists after achieving crisis stabilization. Some of these individuals were for the first time experiencing severe mental illness including first episode psychosis or suicide attempts. Others had been in and out of the hospital for many years and struggled to live with their illness (i.e. medication adherence, outside social supports, or connecting with helpful outpatient treatment).

Despite an individual's history of mental illness the goal always became, how could we help keep this person out of the hospital? Our toolbox of interventions that could address this question was limited and frequently dictated by insurance policies. I often felt a sense of dissatisfaction upon discharging a patient who I believed might come back to the hospital because their plan failed to include recovery-oriented services. My patients were at minimum scheduled for a psychiatry follow-up appointment to address medication management. Any additional services they accessed were a "bonus" and included opportunities like a partial hospitalization program whereby patients participated for approximately five hours a day in

group talk therapy, or outpatient insight-based psychotherapy. Certainly these options provided some support to the individuals who were able to meaningfully participate, but this was not the majority of people for whom symptoms or social situation were barriers to participation or follow-through. I often found myself wondering, what alternatives exist for people following discharge to work towards recovery? More often than not, there was not a concrete answer.

The main limitation of this study is that it is being completed solely based in literature and not in direct connection with the practice of horticulture therapy. Unfortunately this places my findings at a distance from the actual experiences of individuals with mental illness. A qualitative study that gathered interview information from horticulture therapy participants would be an ideal way to understand the effects of such a program. This format instead offers a deeper theoretical and policy consideration of rehabilitation from mental illness. It also avoids difficulties with confidentiality while suggesting an application of theory and future directions in policy. My hope is that this study complements empirical research by presenting a theoretical grounding for why horticulture therapy is an effective intervention with this population.

Research Goals

This study aims to contribute to the limited research on vocational horticulture and horticulture therapy in application to mentally ill populations. I will demonstrate the real potential in the healing power of nature, a historical context for harnessing that energy, and the utility of finding meaning through activity. I believe that we can help people recover through the use of alternative and complementary therapies such as horticulture therapy and address the limits of medical models that attend to symptom reduction and stabilization, but fail to address the needs of the whole person over their lifespan. In reconnecting people to a sense of self-worth and building upon the work of the recovery movement in acknowledging the personal and

subjective experience that defines recovery, we can help move people towards more function and fulfillment. Furthermore, incorporating Frankl's philosophies on the nature and importance of personal meaning provides an opportunity to assess our current policies and their future potential.

CHAPTER II

Vocational Horticulture Therapy in the United States and Abroad

This chapter will review the literature and history related to the Vocational Horticulture Therapy field and explores the implications of that therapy for the treatment of the chronically mentally ill population. In the following sections I take a deeper look into the issues facing this group as well as into an understanding of this modality to begin to build the argument for the importance of access to complementary and alternative therapies such as VHT. In the course of my review, three primary areas of inquiry will emerge as relevant to this study:

(1) Who are the mentally ill in the United States? (2) What is therapeutic about horticulture practices? (3) How is vocational horticulture therapy a useful intervention for psychiatric rehabilitation?

Living with Mental Illness in the United States

As previously mentioned, The National Institute of Mental Health (NIMH) reports that approximately 26.2 percent of U.S. Americans over 18 years old suffer from mental illness, meaning about 1 in 4 adults in any given year. An additional subsection of individuals with mental illness include those whose symptoms are more acute, commonly referred to as the severe and persistent mentally ill (SPMI) population. Kessler et al (2003) offer a definition for SPMI as either meeting criteria for 12-month NAP (nonaffective psychosis) / mania or having a 12-month anxiety or mood disorder that required hospitalization or treatment with antipsychotic medications. The researchers distinguish this from a lower level of severity defined as “severe

mental illness,” which includes either criteria for SPMI or a 12-month anxiety or mood disorder that was associated with at least one indicator of serious role impairment (suicidality, mental health-related work disability, marital violence, or extreme social isolation). SPMI and severely mentally ill individuals make up about 6 percent of the U.S. adult population, or about 1 in 17 (“The Numbers Count”, 2014).

There are many manifestations of mental illness with a broad range of severity and functional impairments. The DSM gives us a language to describe the symptoms we see across individuals and is useful for the purposes of descriptive statistics. About 18% of adults live with anxiety disorders such as panic disorder or post-traumatic stress disorder; 1% of adults or about 2.6 million people live with schizophrenia; 2% or 6 million people live with bipolar disorder; 6.7% or 14.8 million people live with depression (“The Numbers Count”, 2014); and nearly 45% of whom experience a comorbid disorder, meeting criteria for more than one DSM diagnosis (Kessler et al, 2005). The number of non-elderly adults who report mental health disability in the U.S. rose from 2% (in 1997-1999) to 2.7% (from 2007-2009), which corresponds to 2 million individuals (Mojtabi, 2011).

When thinking about the severely and persistently mentally ill population, there exist a number of varying stages of illness that identify different subgroups. Depending on whether or not an individual has been living with mental illness for the duration of their adult life, has become homeless as a result of illness or is experiencing illness for the first time as a young adult, for example, will present a different set of needs. D, discussed in the introduction, is like many other young adults experiencing their first episode of psychosis and whose life trajectory is in a particularly vulnerable place. Whether or not he can work towards recovery, or lead a life

that he finds meaningful and fulfilling with his illness, is a question of the recovery-oriented services to which he can be linked.

Mental Health Stigma. Unfortunately, social stigma about receiving mental health services influence whether or not someone chooses to engage with those services (Corrigan, 2004). Even if an individual does initially engage with mental health treatment, perceived stigma impacts their compliance with treatment such as medication (Sirey et al., 2001) or likelihood of returning to individual or group therapy (Wade et al., 2011).

Stigma associated with individuals who suffer from mental illness can be understood under two major themes. *Social stigma* refers to knowledge (ignorance), attitudes (prejudice), and behavior (discrimination) directed towards the ill by other people, whether that be people we know or strangers (Thornicroft, 2007). This manifests in a number of places, for example the prison system where mentally ill individuals are disproportionately represented. In our health system, those with mental illness are less likely to benefit from treatments for physical illness; this often causes people to “hide” their mental health identity and deny themselves services (Corrigan, 2004).

Self-stigma refers to the reduction in a person’s self-esteem or sense of self-worth due to the perception held by the individual that he or she is socially unacceptable (Vogel, Wade, & Hackler, 2007). Self-stigma, or one’s negative attitudes about mental health, is one of the primary predictors of an individual’s willingness to seek help (Vogel, Wade, & Hackler, 2007). Many individuals ultimately experience both types because public stigma directly spurs self-stigma. As a result they do not seek out the services that might be beneficial (Vogel, Bitman, Hammer & Wade, 2013). Both types of stigma diminish self-esteem and eliminate social

opportunities in addition to negatively impacting suicide risk, coping, vocational functioning, and symptom severity (Yanos, Roe, & Lysaker, 2010).

There is some debate in the literature about the varying levels of stigma that exist in response to different diagnoses. On the one hand, researchers found that despite the specific diagnosis, the fact that an individual is deemed “mentally ill” implies a more severe stigmatization than individuals diagnosed with a physical illness (Corrigan et al., 2000; Weiner, Magnusson, & Perry, 1988). Other research suggests that there is more stigma associated with people who have psychotic disorders than people with a mood disorder (Pescosolido, Monahan, Link, Stueve, & Kikuzawa, 1999). The perceptions and beliefs driving this stigma are that people are unpredictable, dangerous (JianLi & Daniel, 2008), hard to talk to, and that they have themselves to blame (Crisp, Gelder, Rix, Meltzer, & Rowlands, 2000). Trying to cope under these conditions makes life difficult for individuals who want to find community, work, or to have a positive sense of self.

Implications for mental health stigma are further complicated by social factors including cultural background and socio-economic status. Rates of stigma and shame around a diagnosis are often higher in communities of color as opposed to their White counterparts (Jimenez, Bartels, Cardenas & Alegría, 2013). A diverse range of cultural connections further compounds racial identification. For example, when asked about the barriers to mental health treatment, a group of first generation immigrants cited as major impediments, 1) stigma associated with services being perceived as non-normative in their country of origin and 2) competing cultural practices (Saechao et al., 2012). Furthermore poverty associated with racial and ethnic minority groups puts an individual at a higher risk for experiencing stigmatizing beliefs about mental health treatment and therefore not engaging with services (Nadeem et al., 2007; Thoits, 2005). By contrast, upper class and White individuals generally exist within a culture of acceptance and

curiosity about mental illness (Menke & Flynn, 2009), placing them in a position to more easily access services.

As I have explored, the experience of an individual living with mental illness in the U.S. is varied based on the presenting problems or diagnosis, stage of life and living situation, as well as the impact of stigma. These considerations are important when conceptualizing the ways in which mental health providers deliver services. The variability in experience points to a need for more individualized interventions to help people and communities move towards rehabilitation and recovery.

Therapy in Nature

Research supports the notion that the opportunity to connect to and immerse oneself in the natural world is beneficial. As E. O. Wilson's "biophilia" hypothesis states, "to explore and affiliate with life is a deep and complicated process in mental development" (Wilson, 1984). Biophilia suggests that an innate attraction to other living organisms is a basic human quality. Wilson further argues, the continued expression of this tendency is essential for individuals' ongoing psychological and spiritual well-being (1984).

In support of the evolutionary argument that humans are wired to connect with our natural surroundings, many researchers have found that connecting with or being surrounded by the natural world has numerous positive effects. It produces an increase in the subjective experience of vitality (Ryan, Weinstein, Bernstein, Brown, Mistretta, & Gagné, 2010), and a restoration to mental clarity and a physical healing to the body (Clay, 2001). For example, perhaps you have noticed a positive change when you step outside for "fresh air" after a long day inside or when you visit a rural area after extended periods in an urban setting. These examples relate to the healing quality of nature that has been shown to improve functioning for vulnerable

populations including people with depression (Gonzalez, Hartig, Patil, Martinsen, & Kirkevold, 2010), dementia & Alzheimer's (Jarrott, Kwack, & Relf, 2002), cognitive delays (Berman, Jonides, & Kaplan, 2008), post-traumatic stress disorder (Lorber, 2011) major mental illness (Simpson & Straus, 1998), sensory integration issues (Wagenfeld, 2009), individuals involved with the criminal justice system (Hale, Marlowe, Mattson, Nicholson, & Dempsey, 2005) and for individuals in low-income neighborhoods (Hale, Knapp, Bardwell, Buchenau, Marshall, Sancar, & Litt, 2011).

The idea that people thrive surrounded by a natural environment has been adapted to numerous fields. In the healthcare setting, for example, we may consider the use of Optimal Healing Environments (OHE). OHEs advocate for comprehensive consideration of the person in need of healing whether his needs be physical or mental. In order to facilitate this healing, professionals look at a person's relationships, lifestyle, and treatments, in order to create specific "healing spaces" which include nature, color, light...etc." (Horowitz, 2008). These features and specifically introducing nature at a particularly vulnerable time, have been shown to reduce stress and promote healing (Zborowsky & Kreitzer, 2008).

Biophilia, the human desire to connect with nature, is reflected throughout the research conducted on horticulture programs. Chen and Tu (2013) investigated the biophilia hypothesis in application specifically to horticulture activities. Their findings—increased positive mood and improved social relationships—bolster support for engaging horticulture in the clinical setting. Horticulture initiatives such as plant tending, watering, weeding vegetable beds, planting seeds, building planters or raised beds, and carrying soil and compost to the growing area facilitate an interactive and hands-on environment. Veterans receiving hospital care for psychiatric issues and pain management report needing to use less of their pain medication when given the

opportunity to spend time in the hospital's gardens (Martha, 2011). Frumkin (2001) suggests that animals, plants, landscape, and wilderness are four aspects of the natural world that both contribute to biophilia and are typically implemented into horticulture activities.

Research shows marked benefits for people engaging with horticulture therapy activities. Among these are cognitive benefits such as improved concentration (Wells, 2000 & Taylor et al 2001), and improved goal achievement (Willets & Sperling, 1983); as well as psychological benefits such as increased self-esteem (Moore, 1989; Blair et al., 1991; Smith & Aldous, 1994; Feenstra et al., 1999), reduced stress levels (Ulrich & Parsons, 1992; Whitehouse et al., 2001; Pfeffer, Deyton, & Fly, 2009), improved mood (Wichrowski, Whiteson, Haas, Mola & Rey, 2005; Whitehouse et al., 2001), and an increased feeling of personal satisfaction, pride and accomplishment (Hill & Relf, 1982; Blair et al., 1991; Matsuo, 1995; Feenstra et al., 1999). Further studies have demonstrated that horticulture therapy positively benefits social integration and interaction (Moore, 1989; Kweon, Sullivan & Wiley, 1998; Perrins-Margalis, Rugletic, Schepis, Stepanski, & Walsh 2000) and promotes healthier patterns of social functioning (Langer & Rodin, 1976; Moore, 1989).

Horticulture therapy can especially benefit individuals suffering from mental illness. A study of horticulture therapy designed for mental health outpatient participants in the United Kingdom found physical exercise, being close to nature, plus the social benefits of working in a team are the three main benefits of HT for people in mental health treatment (Parkinson, Lowe, & Vecsey, 2011). Participants reported thinking, "It's the exercise that does me good. I feel a bit better afterwards" and "There's always more to do but it isn't stressful" (Parkinson, Lowe, & Vecsey, 2011). This study is substantiated by many others including one with mentally ill individuals in the United States who engaged in horticulture therapy in a group setting.

Researchers found that the activities had an immediate and positive affect on life satisfaction, well-being, and self-concept (Perrins-Margalis, Rugletic, Schepis, Stepanski, & Walsh, 2000).

These reports highlight the interplay of healing factors present for people when engaging with horticulture: being outside, moving their body, and being in the company of others. Exercise is known to reduce the risk for a number of illnesses including cancer, diabetes, and cardiovascular disease (CDC, 2011). Exercise has also been shown to strengthen bones and muscles, improve mood, and improve ability to perform activities of daily living (CDC, 2011). Engaging in gross motor movements helps the human limbic system find equilibrium and recalibrate when emotionally triggered (Hartman, & Zimberoff, 2006) meaning that moving and breathing evenly better enables us to calm and redirect negative emotional experience. This explains why many psychotherapists have been conducting therapy sessions with clients while outside, taking a walk outdoors or conducting intensive retreats in rural areas, for example (DeAngelis, 2013).

Being around other people is another important healing factor that further contributes to the positive impact of HT. Groups give people a sense of identity, and the positive effects of close relationships are long-lasting (NOVA/WBGH Science Unit & Vulcan Productions Inc., 2009). Essentially, we feel happier when around other people. Participants of a gardening program at San Quentin prison facility reportedly found the garden to be “neutral territory” in which hope was created and thus increased collaboration, trust, and respect among those incarcerated there (Leah, 2012). Research demonstrates that HT positively impacts people on a number of levels including interacting with nature, physical body movement and being in community.

Vocational Horticulture Therapy and Supported Education

Vocational Horticulture, a sub-specialty of horticulture therapy, focuses on training individuals to work professionally in the horticulture industry, either independently or semi-independently with on-going support from employers or clinicians (Messer Diehl, 2007). While it is difficult to estimate how many people and organizations provide vocational horticulture therapy, the American Horticulture Therapy Association described a “recent surge” in the “past decade” of interest in horticulture-related therapies (Messer Diehl, 2007). Vocational Horticulture can trace its roots to a movement of vocational rehabilitation programs, also known as supported education or employment. These programs operate from the premise that individuals with psychiatric diagnoses will benefit the most from ongoing support and therefore are trained before they receive assistance with (re)entering the workforce (Vaccaro, Cousino, Vatcher, 1992).

There are a number of reported benefits from participating in a supported employment program. For one, people are able to work more consistently over time and stay in jobs for several years (Becker, Whitlet et al., 2007 and Kinoshita, Furukawa et al., 2013). Specific to supported employment that was focused on horticulture, participants in a UK-based study at a Care Farm describe an increase in the following: physical improvement, appetite, confidence in skills for being productive, self-esteem, social interactions, and overall engagement (Haubenhofner, Elings, Hassink, et al, 2009). Practical and basic works skills are taught in VHT programs, from how to properly use tools to time management to social skills such as identifying interpersonal problems and learning to resolve them. All of these skills are also fundamental for successful employment in the horticulture industry and thus can lead individuals towards gainful employment and recovery.

An example that illustrates this description is Grow Native Nursery, a program for U.S. Veterans with psychiatric diagnoses at the VA Hospital in West Los Angeles. The five components into which the Grow Native Nursery program is divided all take place on the hospital's garden land: work skills/stamina assessment, work skills training, social skills for work environments, didactic horticulture training, and job support/coaching (Vaccaro, Cousino, Vatcher, 1992). The Care Farm and the Grow Native Nursery program illustrate the many benefits of VHT outlined thus far, which range from benefits associated with being in nature to those associated with supported employment practices.

Robert Drake and Deborah Becker of the Dartmouth Institute for Health Policy and Clinical Practice research the idea that *tailored support* is the key to help someone move from illness to joining the workforce. Drake and Becker have shown that the Individual Placement and Support (IPS) model is one of the most effective for addressing long-term rehabilitative objectives. Their research suggests that the following six elements consistently contribute to positive outcomes, that is, the ability of an individual to meaningfully work in a given job: (1) client determined eligibility (2) full integration with other mental health treatment (3) a goal of competitive employment (4) job-searching begins almost immediately (5) the job fits the individual (6) follow-along supports are not time-limited (Drake, Bond, & Becker, 2012). Furthermore, the IPS model results in higher levels of employment activities than traditional vocational and education services (Cook & Mueser, 2012). Success is largely based in the idea that individuals thrive when given the opportunity to perform. If individuals present with an initial desire to work, they often have realistic goals and will overcome barriers such as substance use (Becker & Drake, 2003). What is particularly unique about the IPS model is the close mentorship and person-specific tailoring of this support. Across disciplines and

populations, research has shown that having someone who closely monitors and takes interest in an individual's progress positively impacts their ability to succeed (Drake, Bond, & Becker, 2012).

In an interview with Durgin (2010) for the Dartmouth Medicine magazine, Drake counters the argument that individuals with mental illness might find work to be a stressor or somehow impede their recovery:

What we keep finding again and again and again is that people have a much greater capacity to work than we expected and when they start working, they tend to be successful. And rather than stressing them, it seems to help them get their lives organized and to do much better in every area.

Drake's ideas are intrinsic to a vocational horticulture therapy program whereby a person is asked to participate in skill-building activities aimed towards employment. The prospect of combining the IPS model with vocational horticulture programs across the country holds much promise for even better outcomes. In the research on supported education the sense of community in which an individual is engaged as well as the attuned and supportive mentorship from program staff are key to impactful intervention.

Although the HT research outlined above highlights the healing effects of outdoor experiences, connection to nature, and community, there continues to be a disconnect in its implementation. This occurs especially in psychiatric treatment for the chronically mentally ill, a population that receives a significant amount of services in the U.S. and worldwide each year. The current HT literature offers heartening results in support of VH as a staple in psychiatric care as well as room to explore this connection as it may emerge in the coming years in the field.

CHAPTER III

Logotherapy: Finding Meaning in the Face of Hardship

“For the meaning of life differs from man to man, from day to day, from hour to hour. What matters, therefore, is not the meaning of life in general but rather the specific meaning of a person’s life at a given moment” (Frankl, 1959, p. 108).

Logotherapy is a theory and psychotherapy practice developed by Austrian neurologist and psychiatrist, Viktor E. Frankl. “Logo” is the Greek word for meaning or spirit, and as the name implies, Logotherapy offers a theoretical framework from which one can understand how humans find meaning in their life in particular when faced with hardship. His work spans from 1921, his first lecture on life’s meaning, to 1997, the publication of his final book, *Man’s Search for Ultimate Meaning* (Frankl Institut, 2014). Frankl’s most popularized book, *Man’s Search for Meaning*, was written over the course of nine days after his release from a Nazi concentration camp. It chronicles his experiences as a prisoner and lays out the foundations for Logotherapy (Frankl, 1959). The book has been translated into over 30 languages and was listed as one of the top ten books to make a difference in the lives of U.S. American readers (Library of Congress, 1991). Frankl was quoted in the 1992 edition of this book as understanding its best-seller status as “an expression of the misery of our time [because] if people reach out for a book whose very title promises to deal with the meaning to life, it must be a question that burns under their fingernail” (Frankl, 1992, p. xiii). The quick embrace of his work by the international community highlights the power of his ideas for both those living with mental illness as well as more broadly.

This chapter describes the basic concepts of Logotherapy with a specific focus on finding meaning. These ideas create an argument for the use of horticulture therapy with individuals struggling with mental illness. I will first delve into the historical context from which this framework emerged, including Frankl's lived experiences. Next I will move into a discussion of the major tenants, followed by a look at how Logotherapy has been applied in the rehabilitation literature.

Historical Context

Born and raised in Vienna, Frankl was trained in neurology and psychiatry among some of the best-known contributors to psychological thinking including Sigmund Freud and Alfred Adler. At this time there was a marked shift in the popular attitude towards mental health. Mental illness was emerging as something that could be understood and treated as opposed to a degenerative disease such as dementia (McCranie, 1999). Furthermore, people began to believe that psychiatric pathology did not necessarily have physiological causes alone (Grob, 1972).

Despite this new outlook, mental illness and human behavior were still thought to be derived from a set of universal deficiencies that stem from early childhood experiences. That is to say, the major psychological theories did not differentiate what type of deficiency a person might have based on the individual. Rather they were believed to apply to all people. For example, in Adler's view, all people are lacking in self-esteem. He believed that we are driven by a desire to be noticed and feel significant as a way of compensating for a self-perceived inferiority to others (Adler Graduate School, 2014). Inferiority, he explains, comes from a number of different childhood experiences such as birth order, parental relationships, and social influences. Freud similarly understood human drive in the context of inadequacies and talked

about unmet sexual (libidinal) and aggressive wishes being a person's main motivating forces (Mitchell & Black, 1995).

Frankl's ideas were, however, different from his contemporaries. His basic assumption about a person's "will to meaning" stood in contrast to Freud's ideas about the human "aggression and pleasure principle" and to Adler's "will to power" in that there is no universal deficiency. Instead, Logotherapy highlights the abundance of meaning that is available for each person to find and that each person's version of meaning can be actualized in the context of their personal values (Frankl, 1961). Logotherapy therefore offers an element of self-transcendence or direction towards something outside of the individual in a way that previous thinkers did not acknowledge. It "is a method less retrospective and less introspective ...[it] focuses rather on the future, that is to say, on the meanings to be fulfilled by the patient in his future" (Frankl, 1959, p. 98). By de-emphasizing a person's past and childhood experiences, Frankl's ideas yet again depart from the mainstreamed psychological thinking of the time that asks individuals to look back and interpret previous life experience.

Frankl also counters Freud's idea that people seek pleasure in that the "pursuit of happiness" and similarly Adler's notion that people who seek to attain "status" are actually self-defeating. He explains instead that, "...pleasure is the side-effect of attaining a goal...if there is a reason for happiness, happiness ensues automatically and spontaneously..." (Frankl, 1969, p. 34). Similarly, "striving [for status] also proves to be self-defeating, insofar as a person who displays and exhibits his status drive will sooner or later be dismissed as a status seeker" (Frankl, 1969, p.34). Overall, Frankl posits that happiness and status are positive side effects of a pursuit of meaning. Here is where Frankl's ideas build upon Freud and Adler's: human life is not

without pleasure, status, or the interest in reaching these goals but rather than driving our behavior, they are parts of our overall drive to find meaning.

Frankl wrote and presented on the intersection of psychology and philosophy from a very young age. One such talk that he gave at the age of 14 was titled, “The Meaning of Life” (Frankl Institut, 2014) in which he discussed his major ideas: 1) we are obligated to be responsible for our own existence and 2) that there exists an “ultimate meaning” about life that will remain beyond our comprehension that we must hold onto (Frankl, 1997). In this talk he flips the age-old question, “what is the meaning of life?” on its head and instead encourages people to think of life as posing that very question to them. He urges individuals to ask themselves, “what meaning can I find for myself?”. In placing responsibility within the individual he empowers people with the belief that such a meaning is attainable. This stands in contrast to the idea of an “ultimate meaning” which is something he believes individuals will never be able to know. Holding these two in tension, he explains, is yet the key to being able to reach a place of knowing and of fulfillment. “What [man] actually needs is not a tensionless state but rather the striving and struggling for a worthwhile goal, a freely chosen task” (Frankl, 1959, p.105).

The 1940s, after years of enduring persecution from the Nazi regime in Austria during World War II, mark the temporary hiatus in Frankl’s freedoms to publish and practice psychiatry. Over the course of three years, Frankl lost his wife and parents (for whom he gave up a visa to the United States to stay in Austria) to the Nazi agenda of eradicating Jews from Europe (Frankl Institut, 2014). This was a time of great loss for Frankl and his family and is not unlike the experience of many other Jewish and persecuted groups in Europe at the time. While this time was a break in his public career, Frankl’s experiences with loss were a catalyst for his future works.

Frankl cites the concern he had for keeping track of his manuscript pages (later to be published into his first of many books) to be one of the driving forces that kept him alive during his imprisonment. His desire to share his beliefs with the world served as his “meaning” and functioned as the first case study in Logotherapy. Frankl (1986) reflects on this process in the introduction to his book *The Doctor and the Soul*, which he wrote from manuscripts that he carried with him and protected during the war:

... Suddenly I saw myself standing on the platform of a well-lit, warm and pleasant lecture room. In front of me sat an attentive audience on comfortable upholstered seats. I was giving a lecture on the psychology of the concentration camp! All that oppressed me at that moment became objective, seen and described from a remote viewpoint of science. By this method I succeeded somehow in rising above the situation, above the sufferings of the moment, and I observed them as if they were already of the past. (p. xi)

Frankl’s first-hand experience with such hardship continued to inform his work when he returned to Vienna after being liberated on April 27, 1945 (Frankl Institut, 2014). He continued to write and lecture around the world sending a message of a universal experience of overcoming suffering through meaning-making.

Major Tenants

Frankl dedicated most of his life to creating hundreds of books, lectures, and papers presenting his ideas which describe what he called Logotherapy. To give his work full justice is not within the scope of this study. Therefore in the following section, I will highlight three of what I believe to be the core tenants of his theory that are relevant in application to horticulture therapy for individuals with mental illness: tri-dimensional ontology, the existential vacuum, and

the three core assumptions (the freedom of will, the will to meaning, and the meaning of life). I will also discuss what Frankl means by “meaning”.

The Spirit as Uniquely Human. According to Frankl, people are made up of three overlapping dimensions: the physical (somatic), the psychological (mental), and the spiritual. These three he calls the tri-dimensional ontology. He objected to the idea that people can be understood solely in terms of one of these separate spheres: “Conceiving of man in terms of bodily, mental and spiritual strata or layers means dealing with him as if his somatic, psychic, and noetic [spiritual] modes of being [as if they] could be separated from each other” (Frankl, 1969, p. 22). Using only one dimension he believes is too limiting when exploring the complexity that is a person.

The “spiritual” dimension is translated from the German word “geist” which differs from English in that it does not have a primary religious connotation. It instead refers to “the core or nucleus of the personality” (Frankl, 1986, p. 8) and to what Frankl proposes is specific to humans alone. Functioning in the spiritual dimension distinguishes humans from other animals because it requires a shift away from learned responses and socially-based expectations such as peer group expectancies or mass advertising (Schulenberg, Hutzell, Nassif, & Rogina, 2008). It is instead a space in which a person operates based on their drive towards personal fulfillment. Fabry (1994) explains the human spirit as the “medicine chest” (p.18) of Logotherapy; it contains love, the will to meaning, purpose, creativity, conscience, the capacity for choice, responsibility, and sense of humor.

In discussing the three parts of a person, Frankl encourages individuals to consider all three dimensions when wondering about the cause of a piece of suffering, or pathology:

Pathology is ambiguous in that, in a given case, we still have to search for the logos of the pathos, for the meaning of the suffering. And the meaning of the suffering need not dwell in the same dimension as the symptomatology but may well hide in another dimension (Frankl, 1969, p. 28).

Take for example an adolescent for whom I provided psychotherapy over the course of an academic year. She came to see me for worsening anger management issues and failing grades. These presenting concerns could be understood in the psychological dimension given their etiology related to parental neglect. The intervention that was most effective for her though, was not insight-based therapy or a teen CBT-based workbook for anger. Instead, it was through a leadership role in the school where she could acquaint new students with the softball team that she was able to focus successfully on her schoolwork and more easily control her anger. A change that affected her spirit proved more efficacious than one aimed at her psychology.

According to Logotherapy, offering treatment to an individual requires an in-depth understanding and analysis of what is at the core of a person's suffering. This complexity, he highlights, is important because "we are not merely treating diseases [or mental illness], but dealing with human beings" (Frankl, 1969, p. 28). Along this line of reasoning, he critiques the psychotherapy of his time as not giving enough attention to the spiritual dimension of the people it aims to treat. Instead, psychotherapy stops with the physical and psychological dimensions because entering into the spiritual requires an evaluation of values, hopes and dreams, something that is largely avoided by the medical community (Frankl, 1986, p. 11). This, he describes, leads to an objectification of a person which in effect overlooks their subjective experience (Frankl, 1953).

The Collective Neurosis. The existential vacuum is a term Frankl gave to the feeling described by many of his patients as an “inner void” or a sense of meaninglessness and emptiness (Frankl, 1969). This, he believes comes from a lack of insight about what they wish to do. Humans, unlike animals, do not have an inner instinct that mandates what must be done, nor does our modern society have strict rules or traditions pointing to what should be done. We are therefore left doing what other people have done or what others wish us to do (Frankl, 1969). He writes about the vacuum manifesting in a state of boredom, or the “Sunday neurosis” whereby a person feels depressed after becoming aware of the lack of content in their lives when the rush of the busy week is over and the void within themselves becomes noticeable (Frankl, 1959, p. 107). It is to this point that Frankl brings in the word “collective” as he believes this to be the ailment of the 20th century.

Frankl ultimately believes that pathology stems from the existential vacuum. On an individual level this is called noögenic neurosis from the Greek “noös” meaning “mind”. He draws a parallel in many of his works to Maslow’s hierarchy of needs in that reaching what Maslow calls “self-actualization” or the ability to be creative, spontaneous, accepting, and problem-solving, is in fact the similar goal of Logotherapy. “Happiness cannot be pursued,” he writes, “it must ensue...as a by-product of living out the self-transcendence of existence” (Frankl, 1972).

The Will to Meaning. Finally, Frankl outlines three underlying assumptions about human nature that he believes can be accessed in order to achieve meaning. First, people have a freedom of will to experience life under all circumstances. This is implying that humans are able, should they choose, to persist through any kind of hardship and that the individual’s power exists

within an ability to choose their response. In a television interview with a media representative in South Africa Frankl explains,

A human is never fully free from circumstances; our freedom is finite. But the ultimate freedom is always reserved to us: the freedom to take a stand to whatever conditions might confront us and it is how we react to the unchangeable conditions that is up to us (Viktor Frankl Institut, 1985).

Second, people have a *will to meaning*. This follows much of his basic teachings and holds that humans long to experience their own sense of personal life meaning, which will look differently for each person. People have an innate and unconscious drive to find their version of meaning. Frankl explains, “At the moment that someone can find meaning in their situation, it can be molded and they can change their tragedies into an accomplishment” (Viktor Frankl Institut, 1985). Third, he believes, there is a *meaning of life*. This does not refer to an absolute or universal truth for humanity. It instead refers to the idea that all human life has meaning to find. Whether that is a career path, a project, a community, a belief system, etc. it will be specific to each person separately. Related to this idea of life having meaning, when asked about the feeling of hopelessness Frankl explains, “perhaps it’s useful to think instead that life expects something from you versus trying to get something out of life” (Viktor Frankl Institut, 1985).

What is meant by meaning? A complex and philosophical pursuit, meaning is defined in the Miriam Webster dictionary as: “significant quality; especially: implication of a hidden or special significance; as in a glance full of meaning” (Meaning, n.d.). Meaning has a distinctly subjective connotation and implies a layered understanding. Joseph Fabry (1988) who founded the Institute of Logotherapy in California writes about the two kinds of meanings that Frankl conceptualized:

Meaning occurs on two levels: ultimate meaning and the meaning of the moment. ... the meaning of life—the ultimate meaning—is like a horizon, which you never will reach. If you think you could attain it, you would be spiritually dead.... but, to lead a fulfilled existence you have to try to reach the meaning of the moment.

Here again is the tension Frankl uses between the ultimate meaning versus the subjective and timely meaning. In Logotherapy, meaning is unique and individual. There are no universal meanings, however there are meanings that are shared by people across societies and history, or values. Frankl warns against searching for values (as opposed to meaning) because they can easily and accidentally fill in where someone's meaning might be. It can be helpful to think about this in the context of inter-generational immigrant families. A value often imposed on first generation U.S. American children is the idea that “taking care of one's parents as they grow old” must trump any other focus in adult life. A person who has struggled to find his or her own personal meaning could easily lose sight of his/her own meaning in fulfilling such a value.

Frankl also warns against values because they may not be able to accurately answer a question of meaning for someone: they may overlap or contradict with each other (Frankl, 1969). For example, one may value modern medicine for its advancement and ability to extend life while also place value in a high quality of life. In the situation where a medicine might be able to decrease symptoms but in doing so lower quality of life by introducing side effects, there is no clear answer as to next steps. In the context of mental illness, one could argue that the medicalized system operates from a set of values that are in effect forced onto the patient as opposed to based in helping an individual find their own sense of meaning and fulfillment.

Logotherapy and Rehabilitation Literature

Striking in Frankl's work and relevant to recovery from mental illness is the way in which he operationalizes the meaning-finding process. He proposes that one can only find meaning in the process of existing outside of oneself:

...the true meaning of life is to be discovered in the world rather than within man or his own psyche, as though it were a closed system... The more one forgets himself—by giving himself to a cause to serve or another person to love—the more human he is and the more he actualizes himself (Frankl, 1959, p. 111).

For those who are asked to focus inward on a regular basis through the process of modern mental health treatment, Frankl's mandate has a powerful implication for the process by which someone suffering from mental illness can move towards happiness and fulfillment. He argues against using insight-based therapy alone and instead to engage people in the world around them.

There exists an established relationship between Logotherapy and rehabilitation work as evidenced in the empirical research. A number of studies point to the efficacious integration of Logotherapeutic techniques to help rehabilitate individuals with chronic illness and injury (Julom, & de Guzmán, 2013; Starck, 1981; Thompson, Coker, Krause, & Henry, 2003; Lazar, 1984) drug and alcohol abuse (Wadsworth, 1992; Armstrong, 1992; Walters, 1993; Walters, 1995; Olive, 1990; Haines, 1997) incarceration (Eisenberg, 1989; Whiddon, 1983), post traumatic stress disorder (PTSD) (Southwick, Gilmartin, McDonough, & Morrissey, 2006; Gilmartin, & Southwick, 2004), and stress and burnout (Miller, & Adwell, 1984). The wide breadth of literature is indicative of the power and universality of this set of ideas. More specifically, Logotherapy and other resources that help people to consider their personal meanings are

important tools for moving beyond hardship. This, I will argue, is at the core of why horticulture therapy and specifically vocational horticulture training are such useful interventions.

Furthermore, there is much research to support the concept that recovery from mental illness includes aspects such as finding hope and having meaning in life (Davidson et al., 2005b; Linhorst & Eckert, 2003; Markowitz, 2001; Noordsy et al, 2002; Spaniol et al., 2005). In particular, Noordsy et al (2002) propose three criteria for recovery from mental illness that fit in nicely with Frankl's ideas. Hope, taking personal responsibility, and "getting on with life" are the three main components to a recovery program that will help individuals in the face of mental illness. Similarly, researchers have found that the search for meaning has a stronger implication for wellness than being forced into a treatment. In her research on individuals with major mental illness, Strack (2009) looked at how Logotherapeutic interventions and coercive treatment affected a person's experience of empowerment. While she points out that overall the degree to which someone's psychiatric symptoms are present will affect all treatment outcomes, when those can be well-managed helping someone find their personal meaning has more impact than forcing them into any kind of treatment regime.

Building upon the contributions of his teachers and integrating his own life experience, Frankl offers a clear and simple standpoint from which to engage people in healing. By redirecting the question of meaning in life to the individual and thus empowering one to discover what that means for oneself, Frankl places the recovery process in the hands of his clients. His conceptualization of human needs fundamentally connects to the goals set forth by recovery and rehabilitation providers in their pursuit of helping people find their personal meaning.

CHAPTER IV

Room for Collaboration:

Medical and Recovery Models for Mental Health Policy and Services

The current implementation of our mental health care system fails to adequately address the needs of one of this country's most vulnerable populations: people living with severe and persistent mental illness (SPMI). Some writers believe that instead, the system largely benefits middle class people with less severe disorders and that individuals living with SPMI often fare the worst (Davis, Fulginiti, Kriegel & Brekke, 2012). In fact I believe it to be a more nuanced and complicated picture, one in which it is difficult to say who is benefiting more. Rather than an issue of class, though this may well contribute, adequate mental health care is a question of access. In 2013, 60 percent of adults and almost half of children ages 8-15 with a diagnosed mental illness did not access care in the United States ("The Numbers Count", 2014). With \$120 per capita spent on mental health services in 2010 (Kaiser Family Foundation, 2014) and mental health care costs being called the third costliest in the U.S. behind heart conditions and trauma (Soni, 2009) how is it that so many individuals are without treatment?

Certainly there are a number of factors that may contribute to a person's course of illness, access to treatment, and recovery. Many of these are factors are not within the scope of this study due in part to biological and pharmacological implications, which greatly influence how an individual might experience symptoms of their mental illness. Equally relevant are some of the

sociopolitical forces that influence the way in which the government allocates money towards services and therefore what is available for individuals to access.

Two such nationally funded and somewhat opposing models in the U.S. include what some have called the medical-industrial complex (Mirowski & Sent, 2002; Mahar, 2006) and the recovery movement. The medical industrial complex, a somewhat controversial idea, refers to the collaboration of the pharmaceutical, agricultural, and chemical companies together with hospital and insurance corporations to create the profit-taking model for acute care (Mirowski & Sent, 2002). This system exists within the medical model whereby treatment is conceptualized as a process of identifying a cause of a problem and the prescribing a treatment to eradicate that problem (Kihlstrom, 2002). This stands in contrast to the recovery movement, which exists in the community under the non-profit model and conceptualizes mental health treatment as a long-term process whereby the goal is to lead individuals with SPMI towards rehabilitation. Recovery emphasizes helping the individual shift their perceptions of illness and work on living with it, as opposed to getting rid of it. Within the realities of poor access to treatment and inefficient systems, there is a way in which strengths from both models can be used to reach the ultimate shared goal of helping people to feel better.

How can government officials write meaningful policy that promotes long-term recovery and stability for the mentally ill in the U.S.? The answer is ever-evolving, complex, and is greatly influenced by popular opinion. As one can see throughout history in the U.S., perceptions about mental illness have evolved from being a temporary ailment, to a cure-less disease worthy of lifetime hospital stays, to a condition treatable in the community (Jimenez, 2010). Currently it is troubling that state Medicaid directors, the Social Security commissioner, the administrator of the Centers for Medicare and Medicaid Services (CMS), and human resource directors in U.S.

corporations are the voices with the greatest influence on the direction of mental health policy; many of them have little direct connection with the mental health sector (Frank & Glied, 2006). And yet the U.S. spending on mental health has drastically increased in the last five years because of many lower side-effect prescriptions drugs and the insurance coverage for such drugs (Frank, Goldman, & McGuire, 2009). Thus, there is a substantial amount of money being directed at mental health care by leaders who are not particularly trained in how to best meet the needs of this population.

I pose many questions to the reader—some of which have no straightforward answers—in order to engage clinicians in a conversation about how to most effectively provide care. I will first explore the historical context for our current mental health policies including attitudes towards mental health and a progression of policy in the U.S. Next, I present a brief discussion of where our policies are today and offer some answers to the question: why is it that so many people are without mental health care? Finally, I will take a closer look at the recovery movement and present some of the strengths and weaknesses. I choose to elaborate further on recovery work (mentioned in Chapter I) as I think it offers policy makers and clinicians a useful way of conceptualizing care and can be directly applied to VHT and HT. Individual states in the U.S. have a great deal of power when it comes to how federal money will be allocated and as such, policy varies widely among them. In the discussion that follows, I aim to offer the reader a generalized understanding of the federal priorities as well as some ways in which these are not implemented at the state level.

Historical and Social Context

Evolving Attitudes Toward Mental Health. During the 17th and 18th centuries in the U.S., mental health was generally not treated, as there were few known effective interventions.

Individuals who were considered “lunatics” or “distracted persons” –to use the terminology of the time-- were rarely confined unless dangerous to others and instead people were cared for by family members in their homes (Grob, 1972). It was largely believed that a mental illness was a temporary condition as opposed to a chronic or permanent ailment (Jimenez, 2010). Policy addressing a community’s responsibility to provide relief for such individuals emerged around the 1640s and emphasized the social and economic aspects of mental illness such as guardianship and rights to land ownership, as opposed to the medical treatment or confinement (Grob, 1972).

By the end of the 18th century, there was a shift towards institutionalization for people with mental illness. Popular attitudes changed such that abnormal behavior was believed to be deliberately adopted by the individual, similar to criminal activity, (Kihlstrom, 2002) and therefore there was a social responsibility to care for or punish such individuals (Grob, 1972). This, coupled with a newly established medical model whereby physicians could offer treatments, led to individuals with mental illness being confined to hospitals (Jimenez, 2010). The process by which people were admitted was lax and as simple as a family member dropping a loved one off and deeming them ill. Many were never released, denied treatment, and subjected to invasive exams.

When outpatient mental health treatment became available to those who could afford it and there was a growing vocabulary to describe different types of mental illness in the 1920s and 30s, hospitalized individuals were largely forgotten and left to languish (Grob, 1994). By the end of World War II, mental health care in the U.S. existed in a two-class (public and private) system, similar to how it exists today. However treatments such as shock therapy, ice baths, sterilization, and lobotomy were regularly implemented (Jimenez, 2010). Mental illness had moved into the realm of medical treatment whereby psychiatrists held the power when it

came to their care and for the most part this is where psychiatrists have remained (Scull, 1989). Large state hospitals around the country housed hundreds of patients at a time and became the long-term solution for many individuals living with mental illness, as well as a place to practice and research new medical techniques (Camarillo State Hospital Collection, n.d.).

A Major Shift: Deinstitutionalization. As mentioned in Chapter 1, the 1960s and 1970s mark a substantial change in attitudes and practices towards individuals with mental illness in the U.S. and implicated policy for the following decades. Post WWII, there were three major shifts that gave rise to a movement to move patients from the state psychiatric hospitals to the community: 1) state hospitals were lacking in funds and sufficient staffing in the wake of the Great Depression and war; 2) the newly recognized “combat neurosis” (or what we would now call PTSD) necessitated more mental health professionals than ever before; and 3) the creation of the National Institute of Mental Health in 1949 led to much more government-funded research into etiology and treatment options (Davis, Fulginiti, Kriegel & Brekke, 2012). Coupled with an emerging concern for the civil rights of SPMI individuals, the shift towards community-based care was set in motion (Accordino, Porter & Morse, 2001).

Following the signing of the Mental Retardation and Community Mental Health Centers Construction Act in 1963 whereby President John F. Kennedy called for a “bold new approach” to mental health care, federal grants for the construction of public or nonprofit community mental health centers were made available (National Council for Behavioral Health, 2013). Soon after in 1965, President Lyndon B. Johnson signed amendments to the Social Security Act, creating Medicaid and Medicare funding streams for low-income, disabled, and elderly citizens (Kaiser Family Foundation, 2014). A number of subsequent Supreme Court cases furthered the rights of individuals with mental illness including Wyatt vs. Stickney in 1971 whereby a person

confined in an institution must receive treatment and O'Connor vs. Donaldson in 1975 whereby criteria for being able to hold someone in a hospital against their will were established (Jimenez, 2010). Hospitals underwent a transformation such that instead of housing individuals for lifetimes, they were largely emptied and re-purposed for acute stabilization and were only allowed to hold people should they be a danger to themselves or others.

An Era of New Policy: SAMHSA and Mental Health Parity. The 1980s and hence forward mark a continued involvement by the Federal and State governments in mental health care. With the continued introduction of policy advocating for the rights of citizens to utilize mental health, the U.S. has made large strides towards recognizing mental health treatment. Included in this is the establishment of Substance Abuse and Mental Health Services Administration (SAMHSA) within the Department of Health and Human Services in 1992, which was to distribute block grants to community mental health and substance abuse community centers so that they could follow-through with the federal plan to provide comprehensive MH treatment. An additional milestone includes the passage of the Mental Health Parity and Addiction Equity Act in 1996 mandating that employers with 50 employees or more are required to offer mental health coverage that is comparable to physical health benefits (Centers for Medicare and Medicaid Services, 2014). We have come a long way from long-term hospital stays and inhumane treatments. Mental health continues to be re-evaluated as a legitimate concern worthy of national attention and focus.

The Aftermath of Deinstitutionalization. There however has been a significant amount of criticism for the federal move towards community-based care in the mental health literature (Accordino, Porter & Morse, 2001; Frank & Glied, 2006; Davis, Fulginiti, Kriegel & Brekke, 2012; Kennedy, Greden & Riba, 2013) that points to an insufficient amount of federal money put

towards these efforts that have in effect left people in prisons (Raphael & Stoll, 2013), nursing homes, and homeless (Zlotnick, Zerger & Wolfe, 2013). The goal set forth by the policy makers of the time was to build a mental health center for every 200,000 people. But by 1980, only 750 centers were built and typically they required payment from clients, which presented a barrier to access for the uninsured (Davis, Fulginiti, Kriegel, & Brekke, 2012). The unfortunate reality is that federal funding stopped at a point before many of the ex-hospital patients it intended to reach had been treated or housed. Moving mental health care into the mainstreamed healthcare system dispersed responsibility such that no single agency within each state is responsible for mental health treatment. This is particularly problematic for the SPMI population who as a result rely on a wide range of uncoordinated programs (Frank & Glied, 2006). The question of whether or not individuals with mental illness are better off than they were previous to deinstitutionalization is a complex and nuanced question for which there have been entire books written (Frank & Glied, 2006; Moniz & Gorin, 2014). The question of how to most effectively offer care to this population continues to puzzle policy makers and has unfortunately resulted in an inefficient system.

Room for Collaboration: The Whole is Greater Than the Sum of the Parts

Research points to a widespread unmet need for mental health services in the U.S. particularly among the uninsured (Roll, Kennedy, Tran & Howell, 2013; Jones, Lebrun-Harris, Sripipatana & Ngo-Metzger, 2014). What I propose in the following sections is that much of the unmet need is in part due to two opposing policy forces within the mental health care services industry. Within the medical and recovery model paradigms there exist strengths and weaknesses, and ultimately ways in which they can complement and enhance each other. The medical system has the infrastructure, resources and science-informed treatments to stabilize

people with medication while the recovery movement offers an evolving array of evidenced-based long-term rehabilitative interventions in the community. The medical model has in fact made movement towards a recovery-based model for physical illness by implementing techniques such as shared decision making and person-centered care (Barber, 2012) and thus is a starting point from which to integrate such ideas for mental health care.

Medical Model. Dissimilar to earlier models of healthcare, the current system in the United States is most commonly mediated by insurance companies. Individuals and families sign onto plans through which they receive benefits and services paid for in some amount, as opposed to paying out of pocket for their care. There exist many variations on this general model including integrative care where the insurance and clinical providers work together (such as Kaiser Permanente on the West Coast), the non-integrative or HMO model where individuals can take their coverage to different providers in the community (such as Aetna or Blue Cross), or public entitlement coverage paid for by government programs (such as Medicare or Medi-CAL).

Mental or behavioral health services fall under insurance reimbursement as long as they meet the (often strict) diagnostic and medical necessity criteria put forth by one's insurance provider. This calls into question the ability for mental illness and its treatment to easily fit into such demands, especially as many of the non-medical interventions such as psychotherapy are not quantifiable under the same measures. Insurance companies have long viewed mental health treatment as having a poor cost-benefit analysis and therefore enforce stringent controls on services such as caps on lifetime hospital days and frequent doctor-to-doctor reviews (Hudson, 2008). Thus, even those individuals with accesses to care struggle to maintain it and get reimbursement.

U.S. healthcare policy is evolving with the implementation of the Affordable Care Act (ACA) since 2010. The government boasts “one of the largest expansions of mental health and substance use disorder coverage in a generation” by requiring that insurance plans offered through the national marketplace cover such services, including preventative care (U.S. Department of Health and Human Services, 2014). Furthermore, the ACA necessitates coverage regardless of whether or not an individual already has a mental health diagnosis (U.S. Department of Health and Human Services, 2014). There is a sense, however, that the question of improved access is widely variable among states, dependent on whether or not that state has opted into Medicaid expansion, aimed at reaching the previously ineligible poor adults, (Kaiser Family Foundation, 2014) or the quality of the marketplace used in that state. Some have estimated that there will be significant gains in healthcare access and use for adults with chronic and mental health conditions for states that choose the expansion (Clemans-Cope, Long, Coughlin, Yemane & Resnick, 2013) though as of June 2014, there are still 24 states that are not moving forward with expansion at this time or are still engaging in open debate (Kaiser Family Foundation, 2014). While the issue of whether or not an individual will have insurance is becoming less prevalent with the implementation of the ACA, some accounts estimate that there are still a staggering 40 million people without it (Caman & Eibner, 2014). Without insurance then individuals experience an added barrier to accessing any mental health care.

Often, insurance is acquired via employers or public entitlements. In 2011, 55.1% of all U.S. Americans received employment-based health insurance, which encompassed 34.7% of individuals who do not work but receive benefits from someone else’s employment based benefits (Janicki, 2013). This left 44.9% of individuals without either an entrance into the healthcare system or monetary protection from incurring expensive bills. For others public

entitlement programs such as Medicare and Medicaid are vital access points. However, these federally funded programs require that an individual meet specific criteria including age, income level, disability status, etc. Stringent application processes, frequent renewals, and long waiting periods to receive services make public insurance less than ideal for many people. Furthermore, researchers have suggested that utilizing such entitlements and asking consumers to continually prove their illness in order to receive vital resources traps people in a cycle of poverty. Here, people have little incentive or viable avenues to explore feeling better, finding work, and thus not needing to depend on public funds (Hansen, Bourgois, & Druker, 2014).

Among those who do have serious mental health needs, there are a number of added challenges to acquiring insurance. For one, people in the U.S. diagnosed with mental illness are less likely to have health insurance than the general population (Rowan, McAlpine, & Blewett, 2013). In fact, approximately one in nine uninsured adults has a mental health condition or a substance abuse disorder or both (Clemans-Cope, Long, Coughlin, Yemane, & Resnick, 2013). This puts them at a higher risk for going untreated than it would be with insurance and points to a more systemic issue whereby this population is uninsured at a higher rate.

Explanations for this disparity are found in the barriers that individuals suffering from SPMI experience in finding gainful employment, particularly access to education. Individuals suffering from major mental illness are often not able to attain higher education and having a diagnosis is associated with reduced educational attainment (Cook & Mueser, 2012). This is in part due to that fact that many people with chronic mental illness are diagnosed very early in life: one half by age 14, and three-quarters by age 24 (NAMI, 2013). Thus, they are not as able to engage in mainstream education from a young age.

Other barriers to employment relate to the individual and their treatment. Many individuals are not motivated to pursue work (Mueser, Salyers, & Mueser, 2001); some have found other meaningful activities outside of employment; or others choose not to engage with work for fear of losing government benefits (MacDonald-Wilson, Rogers, Ellison & Lyass, 2003). Some are not privy to the encouragement and scaffolded support that some mental health providers can offer (because they do not have any providers or because providers are not trained in such a way). Many do not have the opportunity to join programs aimed at vocational rehabilitation and even for those who are resourced enough to apply, only about two-thirds will find a competitive job (Bond, 2004). A further key issue relevant to psychiatric populations attempting to find employment is symptom management. Many struggle with medication non-compliance, cognitive deficits or co-occurring medical issues that inhibit overall functioning.

The demands of the insurance-driven system on mental healthcare providers pose another challenge for individuals with mental illness. As it exists now, providers are reimbursed for very specific services such as inpatient hospitalization, medication management, and intensive outpatient programs (group therapy and case management). These treatment interventions can be helpful for some individuals, especially those experiencing acute symptoms. However, the system often falls short in delivering preventative and long-term interventions such as psychotherapy and case management. The unfortunate reality is that these services are highly limited. In California for example, approximately 15% of the population live in what is referred to as a “shortage area,” which denotes a lack of mental health professionals within two hours driving due to excessive distance, over-utilization, or other access barriers (Healthcare Atlas, 2010). Furthermore, quite unfortunately, there is an inverse relationship in California between counties with high rates of mental illness and practicing psychiatrists (California Healthcare

Foundation, 2013). Even if an individual lives in an area deemed sufficiently filled with outpatient providers, finding a clinician with an opening or with an affordable or reimbursable fee can be difficult. These impacted programs are not able to provide new intake services or follow-up regularly enough with already established patients. Fragmented services across numerous providers and agencies and unfeasible time commitments often required by treatment programs create even more barriers to accessing care (Becker & Drake, 2003).

Many of the aforementioned challenges that clients face in managed care arise in part because of the paradigm in which most medical systems in the United States now exist. This paradigm (unlike Eastern medicine, for example) prioritizes symptom management and treats conditions as isolated manifestations—that is, a medication to address each symptom (Kirmayer, 2004). This system directly contrasts with other more holistic traditions including some Eastern medical perspectives such as Ayurveda or Traditional Chinese Medicine, which instead look at the body as a complete system—that is, connected and intertwined (Pritzker, Katz, & Hui, 2013). In addition to treating the symptoms, the patient would be asked about the stressors in his life. Upon learning information about, for example, his sleep cycle and exposure to trauma he would be helped to alter his lifestyle, given some homeopathic remedies, and offered access to regular support and care. One such model for integrating both systems exists in the United States at the UCLA Center for East-West Medicine where practitioners lean towards preventive, patient-centered interventions (Pritzker, Katz, & Hui, 2013) though this is by no means a standard of care yet.

Eastern medical ideologies are foundational for what is referred to in the West as “complementary and alternative treatments”, therapeutic practices that fall outside of the established tradition of medical, psychiatric, and psychological practice (Lumadue, Munk, & Wooten, 2005). Some of the alternative treatments include acupuncture, massage, reflexology,

hypnosis, and horticulture therapy. The treatments are alleged to reduce healthcare costs in the U.S. and improve quality of life (Abbott, 2011). While still not mainstream practice, complementary and alternative treatments are a growing trend in the U.S. as more than half of a random sample across the states report having used at least one before the age of 30 (Kessler et al., 2001).

Recovery Movement. As I elaborated on in Chapter I, recovery is largely based in the idea that individuals are able to accept and overcome the challenges of their illness (Deegan, 1988). The goal is to reach a state of living that is satisfying, hopeful, and meaningful even with limitations caused by illness (Anthony, 1993). Based largely in the outpatient mental health community, recovery-oriented services for mental illness are fragmented, largely based in urban centers, and difficult to fund.

It is notable that a number of governing bodies in the U.S. have adopted recovery-oriented models. Organizations such as the U.S. Psychiatric Rehabilitation Association as well as policies like the California Mental Health Services Act attempt to enact the values and assumptions discussed above in working with SPMI populations. SAMHSA also regularly publishes literature and research to support recovery-oriented work by way of disseminating this information to agencies practicing in the community.

Recovery-oriented programs however are difficult to fund and thus the implementation of such models does not occur in any systemized or consistent way. One of the main funding streams is through federally allocated block grants via SAMHSA. Grants are awarded to “programs for the prevention, treatment, recovery support, and other services to supplement Medicaid, Medicare, and private insurance services” (SAMHSA, 2014). The amount of money available is trending upward from \$420 million in 2010 to its current level of \$484 million for

fiscal year 2014 which, as the National Alliance on Mental Illness (NAMI) points out, has been important for filling in gaps where state funding has been cut by more than \$4 billion since the recession in 2008 (Giliberti, 2014). Despite the seemingly large sum of money available for disbursement, there are a number of factors that contribute to whether or not a program, despite its efficacy, may have access to such funds. For example, becoming a recipient of a SAMHSA mental health block grant requires a substantial amount of paperwork including a grant proposal and follow-up updates that report on the success of the program. Such a process privileges the organizations that can afford to have a staff person dedicated to concentrating on grant management or the resources to hire someone off-site. What happens to the smaller-scale and/or rural programs that are not able to apply for such grants? Overhead expenses are cut leaving facilities in disarray, staff members are over-extended and asked to do work outside of their job description and organizations are caught in what some have called the “nonprofit starvation cycle” (Gregory & Howard, 2009). A further complication to such a grant-making model is the time-limited nature of the funding. Each year, organizations are asked to reapply for block grant money, which places programs at risk for losing the ability to continue providing services. Without a reliable and long-term funding source, many of these programs are not sustainable.

What’s Next in Mental Health Policy?

There is a significant need for services in order to address such a numerous and diverse SPMI population. In addition to services that address individual symptoms, which can vary widely from person to person, people who are suffering from a significant decline in functioning need recovery services as well. As I have explored above, there is room for collaboration between the two policy forces in the U.S. to move towards an integrated model for mental health care: medical and recovery services. People like D, whose return to normalcy was paused upon

discharge from the hospital, need a place to continue to develop a relationship to their illness and to find ways to meaningfully engage during the day.

Service agencies like The Village in Long Beach, CA, have the potential to be the standard of care for SPMI. A leader in providing recovery services to individuals in their community, The Village provides “quality of life” services as opposed to “illness services” by offering collaborative psychiatry, supportive employment, substance abuse recovery, housing assistance, financial services, and opportunities for community involvement (Mental Health America of Los Angeles, 2008). By training staff to prioritize human commonality, personhood, relationship, and trust, the individuals who come for services are not seen as their diagnosis or medications but instead as full and dynamic people (Erickson & Straceski, 2004). The long-term and positive impact made on the lives of their members is nationally recognized as the hopeful future of recovery services. With mainstreamed funding and acceptance in medical models, organizations replicated after The Village’s structure hold promise for the future of mental health rehabilitation.

It is easy to fall into the trap of blaming poor mental health care on insurance companies or the medical model. While the insurance issues explored above reveal how it inhibits access (and thus outcomes) for consumers, the issue of treatment modality also greatly impacts the mental health outcomes. Is regular outpatient psychotherapy and psychiatry the most effective intervention to treat mental illness? The medical model endorses this point of view, however the literature about rehabilitative care is careful to point out that interventions should depend upon the unique individual, his diagnosis, and his goals for treating it. Moreover, the potential of an individual’s response (and pursuant life changes) to psychotherapy often depends upon the content of that therapy. For example, some might benefit more from insight oriented talk

therapy, in which a client reflects about his experiences, while others would prosper more from experiential therapy, in which he works through a set of goal-directed activities such as gardening or hiking. The importance lies in the flexibility of care providers to meet their clients' needs and access the effectiveness of various treatment modalities. With a wider breadth of recovery-focused options built into the medical model delivery, mental health care professionals can move towards a long-term paradigm for treatment with the resources to do so sustainably.

CHAPTER V

Discussion

“we are not merely treating diseases [or mental illness], but dealing with human beings”
(Frankl, 196, p. 28).

As clinicians, policy-makers, and community-members, must we accept that our neighbors living with severe and persistent mental illness (SPMI) will spend their day with nothing to do? That a SPMI diagnosis necessarily leads to lifetime dependence on caregivers, disability benefits, and without meaningful activity? How can policy makers be encouraged to examine the limitations of the current treatment models? How can vocational horticulture activities intervene in the process whereby thousands of U.S. Americans suffering from major mental illness are without comprehensive and long-term treatment? And furthermore, offer meaningful activity to the less than 15% of people receiving public mental health treatment that desire it (SAMHSA, 2009)? In this chapter I will address the practice wisdom from VHT that can make change on a clinical and policy level. By looking at the case of D through a Logotherapy and Policy level lens I will argue for the integration of VHT and recovery-oriented interventions into the routine treatment for individuals living with SPMI.

Logotherapy and Policy Interpretations

As I explored in chapter three, Viktor Frankl offered the psychological community a new way of conceptualizing human drive. Departing from Freud and Adler’s assumptions about a fundamental sexual/aggressive or superiority drive, Frankl instead understood people to have a drive towards meaning that focused on an individual’s future. Frankl fundamentally assumes that

each person is capable of discovering his or her own personal sense of meaning. This stands in contrast to the idea that there is a universal meaning to life and opposes the modern medical conceptualization that another person such as a clinician holds such an answer. Furthermore, individuals are necessarily free and able to live through any hardship by way of choosing to transcend the experience by finding meaning. In doing so, Frankl offers suffering individuals, such as those experiencing mental illness, an empowering lens through which to recognize their personal agency in the process of healing.

Frankl teaches that psychotherapy and the medical community in general focus on the first two dimensions in their treatment within his “tri-dimensional ontology,” i.e. the physical and psychological dimensions. He believes this is because entering into the spiritual requires an evaluation of values, hopes, and dreams (Frankl, 1986, p. 11) and thus argues that this is the fundamental flaw in modern treatment because the spiritual realm is often where many people are experiencing their pain. It is this sense of inner void or meaninglessness felt on the spiritual level, that Frankl calls the existential vacuum or the collective neurosis, and it is here that pathology begins. With an intervention that hones in on the “core or nucleus of the personality” (Frankl, 1986, p. 8) such as HT, clinicians are better equipped to help individuals make meaningful change in their relationship to their illness and subsequently in the way they spend their time.

Conceptualizing the plight of individuals living with SPMI within a Logotherapy framework highlights the ways in which our society views mental illness and the real gaps in its treatment. Firstly, the fact that so many U.S. Americans, approximately one in four (NAMI, 2013), suffer from mental illness points to the importance of such a discussion. Of the 57.7 million adults living with mental illness previously noted, there are a large number of barriers to

accessing treatment as well as critiques of the mainstreamed treatment modalities. The barriers explored in this study, including age of onset of illness, mental health stigma, industrialized society distanced from the natural world, impeded access to education and employment, and the complexities of insurance coverage that characterize the mainstreamed medical model of treatment, contribute to an environmental “existential vacuum” whereby people are less able to spend the energy and time needed to focus outside of oneself and one’s illness. The daily reality for individuals living with mental illness in a vicious cycle of symptoms, acute treatment, and isolation requires an illness-focused lifestyle that does not leave room for consideration of higher purpose. HT and Logotherapy further support the critiques of the routine treatment modalities that require an individual to use insight-based, reflective therapies (in addition to psychotropic medications). Again, there is a focus on staying within the individual, his or her problems, and without connection to community or physical movement. Logotherapy and HT research instead imply that clinicians facilitate a process by which their client can explore their spiritual dimension, their hopes and dreams, and be connected to something that takes them outside of their individual experience.

Individuals in general, and especially those living with SPMI, can be understood to make decisions regarding how to spend their time based on what others instruct them to do. This is based on Frankl’s analysis of modern human experience and his belief that society has moved away from traditional mandates or roles (Frankl, 1969), and thus we turn to other people to understand what we “should” be doing. This understanding of society highlights the complacency embedded in individual decision-making as it creates an environment for people to do as they are told as opposed to discovering what it is that they would find most meaningful or healing. Power is in turn given to the institutions considered expert in treating mental illness: our

medical system and other clinical treatment providers. Their recommendations for treatment and subsequent follow-up interventions are paramount in the trajectory of their patients.

The “existential vacuum” frame can additionally help providers conceptualize problems with how mental health treatment is disseminated. Using D as an example, one can understand his current state as existing in such a vacuum:

Before becoming ill, D was a first year undergraduate student at a prestigious 4-year university studying anthropology and was achieving good grades. With the sudden onset of his symptoms, he had to un-enroll from school and in effect lost his sense of greater purpose with nothing to work towards. He is almost completely isolated at home where he watches television and his only regular interactions are with his father and older brother who are now his caretakers. As such, he has lost a sense of independence and hope for the future to be better. He has been able to engage in some previously enjoyed activities like practicing yoga and playing guitar, but not to an extent that he would describe as fulfilling.

While D’s physical and psychological dimensions have been addressed via anti-psychotic drugs and the opportunity to attend insight and skills based talk therapy groups, his spiritual dimension is neglected. The part of D that longs for an experience outside of himself and directed towards a greater good is left unfulfilled by sitting at home and receiving care from others. To address only some of the tri-dimensional ontology is not to address the whole person. Research findings in the realm of supportive employment and mental health rehabilitation support Frankl’s ideas about finding meaning and point to the importance of activity in the daily life of individuals living with mental illness (Becker & Drake, 2003). According to Frankl’s conceptualization of human will,

in the face of illness (suffering) D has the power to choose meaning and yet does not have access to opportunities to do so.

As previously explored, researchers have identified some of the negative impacts that social and self-stigma have on individuals living with mental illness. These include diminished self-esteem & vocational functioning, increased symptom severity, and a decreased engagement and compliance with treatments (Sirey et al., 2001; Yanos, Roe, & Ysaker, 2010). Furthermore, individuals have reported feeling a loss of self, power, meaning, and hope for the future following a mental health diagnosis (Slade, 2009). Through this lens, the connection between the Frankl's idea of "suffering" and the experiences of SPMI is strengthened. Given the significant impact that stigma has on individuals with mental illness, treatment considerations moving forward have an imperative to work towards reducing stigma. The more mental health is talked about and people are exposed to treatment options, the less it will be perceived as taboo or counter-cultural. In addition, there is an imperative for mental health policy to incorporate an understanding of stigma. While the stigma discussion certainly informs why the U.S. has a long and nuanced mental health policy history, it is important to consider reasons why an individual may or may not access services that a certain policy may make available.

The U.S. has certainly come a long way in terms of recognizing mental illness as a concern worthy of national-level policy and resources and yet continues to be unable to reach many individuals in need, including those living with SPMI. In shifting patient care away from long-term hospital stays, deinstitutionalization prioritized community-based treatment for the SPMI population from a conceptual standpoint. However, in practice individuals who would have formerly been housed in state psychiatric hospitals are now in prisons (Raphael & Stoll, 2013), nursing homes, or are homeless (Zlotnick, Zerger & Wole, 2013). The medical model

poses challenges for traditional mental health treatments, as they do not easily fall under “billable” interventions by insurance companies. Despite the implementation of the Affordable Care Act (ACA) that significantly expands the accessibility of mental health treatment, an estimated 40 million people are still without insurance due to variance in ACA implementation between states. Additional barriers to acquiring insurance or reimbursement for services include ability to find employment, complicated public entitlement programs, or lacking motivation and access to the resources that could intervene. Furthermore, insurance may fall short in reimbursing for mental health treatments that do not fit into a Western Medicine paradigm or not provide clinicians in their area.

The recovery movement for long-term rehabilitation aimed at moving clients through a process of learning to live with and accept their illness offers an answer to the fragmented and insufficient treatment models currently in place. The implementation of such services are at a significant risk for insufficient or unsustained funding because the grant-making model SAMHSA requires includes complicated applications and annual approvals. For these reasons I argue for a collaboration between these two opposing policy-driven priorities. The resources and mainstreamed implementation of the U.S. acute stabilization medical model in combination with the meaning-supportive under funded recovery models would create a Logotherapeutic model of care necessitated by the current disenfranchised state of individuals living with SPMI.

The importance of reaching a wide breadth of individuals living with SPMI lies within the flexibility of care providers to meet their client’s needs and access to effective treatment modalities. This flexibility can be understood within a Logotherapy frame whereby individual meaning-making is made priority. How could D move through a mental health system that supported his acute stabilization and his recovery? Firstly, an intervention to address acute

symptom stabilization within the medical model of care is indicated given the severity of his symptoms and level of impaired functioning. Upon discharge from a psychiatric hospital and when his symptoms are further stabilized, D could be referred to a community-based VHT program wherein he would work and learn in a natural setting among peers and facilitators. The aim of such a program would be to help D gain the skills necessary for finding employment, or at the very least, to be an integral part of a horticulture program in the future. In giving him the opportunity to learn such skills, benefit from being in nature, and work in community, D is empowered with a context from which to find his own version of meaning and to move towards living a life with independence, confidence, acceptance of his diagnosis, and perhaps reengage with his academic pursuits.

Strengths and Weaknesses of this Study

The theoretical nature of this project has afforded me the opportunity to take a step back from the intensity of engaging in clinical work and consider the larger context for the frustrations and failures in treatment that I encountered in a psychiatric hospital. I have been able to look deeply at the structural mechanisms by which the SPMI population is disenfranchised in treatment via insurance companies and priorities placed on medical and insight-based interventions. Because this theoretical project addresses a wide population, my arguments can be applied broadly and can be used critically to understand treatment modalities being used across the United States with adults living with SPMI.

As is true of any study, there are ways in which this fails to present all the information that is relevant to the topic area. One weakness particular to this design is its departure from actual horticulture therapy programs and thus its removal of the discussion away from the lived experiences of individuals living with mental illness. My research primarily focused on the

programs and studies that support horticulture and recovery-oriented intervention and therefore did not fully explore the literature that may exist in counter argument to the ones that I present. The literature reported reflects my beliefs that horticulture activities are healing and that there are real gaps in the ability for our current health system to deliver long-term recovery interventions rooted in my personal experience with farming communities as well as with psychiatric inpatients. This study could be strengthened by an exploration of other populations and recovery-oriented interventions that exist other than SPMI and VHT.

Implications for Social Work Practice, Policy, and Research

My findings offer a way in which the mental health field can conceptualize a healing process with mental illness that does not necessarily imply isolation and functional decline. With a re-framing of the way that social workers and other mental health providers think of long-term care for the individuals they work with, there is room for growth in terms of available treatment options. This re-conceptualization also affords clinicians a new way to view their clients. This study proposes that social workers conceptualize the people receiving their services as individuals yearning to find their own personal sense of meaning in the world and thus implies interventions aimed at such a purpose. In adding this existential framing, social workers can bring a unique and powerful perspective both in their independent work and as part of interdisciplinary teams in healthcare settings. I encourage social workers and others to expand their thinking about the treatment modalities they regularly offer to clients and to examine their assumptions about where a person's course of illness may lead.

The dearth of research that investigates HT for the SPMI population speaks to the need for more studies to be conducted in this field. As my research points out, the implications for working with individuals towards finding their own personal meaning holds promise for helping

individuals through a recovery process. With more empirical studies conducted, systemic changes might well be more attainable and substantiated.

The current healthcare system is poised to contribute to a shift towards recovery-based interventions via monetary resources, regular access to the public, and strengthening the recent shift in the medical community towards recovery-oriented practices (Barber, 2012). People look to their doctors and mental health care providers as experts and therefore they have a lot of power when it comes to shaping their patients' perceptions via education. Reaching people within their chosen communities and offering interventions to meet people at the level of engagement in which they are open will further reduce the barriers to receiving care and ultimately help people feel better and live more meaningful lives.

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