THE PHENOMENON OF RESILIENCE AS DESCRIBED BY PEOPLE WHO HAVE EXPERIENCED MENTAL ILLNESS

By:
Karen-leigh Edward

A thesis submitted in fulfilment of the requirements
for the degree of

Doctor of Philosophy (Health Science)

DEPARTMENT OF NURSING AND MIDWIFERY

RMIT UNIVERSITY

2007

Senior Supervisor: Associate Professor. Anthony Welch

Supervisor: Dr. Keri Chater
DECLARATION

This thesis contains no material which has been accepted for the award of any other degree or diploma in any University and to the best of the candidate’s knowledge, it contains no material previously published or written by any other person except where due reference is made in the text of the thesis.

Karen-leigh Edward
2007

Copyright Statement

All rights reserved. No part of this work may be reproduced or transmitted in any form or by any means now known or invented, electronic or mechanical, including photocopying and recording, or by any information storage or retrieval system, without permission in writing from the author. An exception is made for brief quotations in a review.
ACKNOWLEDGEMENTS

Throughout the writing of this thesis I began to understand my own resilience in the face of adversity; my childhood adversity. Although I have not had a mental illness I came to understand that being resilient is an option for all.

Firstly, I would like to extend my gratitude to the participants of this study - your generosity in sharing your experience of how you transcended mental illness using resilient factors made this thesis possible. Thank you.

To my husband of over 20 years, my partner, and my friend - Michael; thank you for all your understanding, encouragement and support throughout all of my studies. Without your words of encouragement and your strong belief in me I could never have undertaken such a journey. You help me believe in the magic of life. I love you and thank you.

To my three sons, Benjamin, Adam, and Samuel. Thank you for allowing me to be with my own thoughts while I undertook this research. I know it must have been hard at times having a mum who was always on the computer. I love you all.

To Associate Professor Anthony Welch, my senior supervisor – a special thank you for your words of wisdom, your humour and generous spirit, the debates, and your belief in me and my ability to undertake this study. You were able to inspire me to seek my own answers, to challenge the world and my own paradigm and to seek deeper meanings in the lived experience of others. You are exceptionally generous of spirit and deed and for this quality of yours I am always awe struck. Thank you dear.

To my second supervisor Dr. Keri Chater, thank you for being encouraging and having those moments of clarity using the whiteboard. That moment we were all discussing the results really helped pull this thesis together.
A special thanks to my dear friend Helen Kohrsen - Fernandez, for your literature searching abilities and listening to my draft chapters. You are a great friend and an amazing woman.

A final note - as I read the thesis of my senior supervisor, Associate Professor Anthony Welch, I noted a poem in the first few pages. This poem acknowledges the joy of life, the awareness of the self and the power within. I think the following poem captures the essence of resilience (O’Donahue, 1998, p. 99):

May you awaken to the mystery of being here and enter the quiet immensity of your own presence.
May you have joy and peace in the temple of your senses.
May you receive great encouragement when new frontiers beckon.
May you respond to the call of your gift and find the courage to follow its path.
May you take time to celebrate the quiet miracles that seek no attention.
May you experience each day as a sacred gift woven around the heart of wonder.
CONTENTS

ACKNOWLEDGEMENTS........................................................................................................... 3

LIST OF TABLES..................................................................................................................... 10

ART WORK IN THESIS......................................................................................................... 11

ABSTRACT............................................................................................................................. 12

CHAPTER 1 –BACKGROUND TO THE STUDY.................................................................... 13

1.1 Introduction................................................................................................................... 13

1.2 How My Research Interest Began .............................................................................. 13

1.3 Literature Review......................................................................................................... 15

1.4 The Origins And Use Of The Word Resilience.............................................................. 15

1.5 Working With Strengths And Resilience: The Pioneering Works Of Norman Garmezy (1991) ................................................................................................................................. 16

1.5 Resilience Defined........................................................................................................ 17

1.6 Mental Illness............................................................................................................... 18

1.6.1 Non-psychotic mental illnesses- Depression and anxiety..................................... 19

1.6.2 Psychotic mental illness- Schizophrenia and Bipolar Affective Disorder............... 21

1.7 Mental Illness And The Australian Context................................................................. 24

1.7.1 Models Of Care In Mental Health In Australia...................................................... 25

1.8 Mental illness- Stress, Coping, and Recovery............................................................ 27

1.8.1 Stress....................................................................................................................... 27

1.8.2 Coping....................................................................................................................... 27

1.8.3 Recovery.................................................................................................................... 28

1.9 Resilience And Mental Illness..................................................................................... 29

1.9.1 Resilience and non psychotic mental illness......................................................... 31

1.9.2 Resilience and psychotic mental illness................................................................. 32

1.10 Qualitative Research On Resilience......................................................................... 32
1.11 Significance of the Study ................................................................. 34
1.12 Summary .................................................................................. 35

CHAPTER 2- PHILOSOPHICAL FRAMEWORK .......................................... 37

2.1 Introduction ............................................................................ 37
2.2 Philosophical Foundations Of Phenomenology ....................... 37
2.3 The Beginnings Of Phenomenology - German Phenomenology ... 38
2.3.1 Edmund Husserl ................................................................. 38
2.3.2 Martin Heidegger ............................................................... 39
2.4 French Phenomenology .......................................................... 40
2.4.1 Jean Paul Sartre ................................................................. 40
2.4.2 Maurice Merleau-Ponty ..................................................... 41
2.5 North American Phenomenology .......................................... 41
2.5.1 Amedeo Giorgi ................................................................. 41
2.5.2 Paul Colaizzi ................................................................. 42
2.6 The Use Of Self In Phenomenological Inquiry ....................... 43
2.7 Phenomenology And It’s Relevance To This Study ............... 46
2.8 Summary .............................................................................. 47

CHAPTER 3- METHOD ............................................................................ 48

3.1 Introduction ............................................................................ 48
3.2 Focus Of The Study ................................................................. 48
3.3 Participant Selection .............................................................. 48
3.3.1 Number of participants .................................................... 49
3.4 Accessing The Participants .................................................... 50
3.5 Information Gathering .......................................................... 50
3.6 Information Analysis .............................................................. 51
3.7 Informed Consent ................................................................. 56
3.7.1 Anonymity .......................................................................... 56
3.7.2 Confidentiality .................................................................... 57
3.7.3 Storage of information .......................................................... 57
3.7.4 Level of risk ........................................................................ 57
Table 1. Potential Risks and Protection and Minimisation Strategies ........... 58
3.8 Rigour Of The Study ............................................................... 61
3.8.1 Credibility .......................................................................... 63
3.8.2 Transferability ..................................................................... 64
3.8.3 Dependability ...................................................................... 64
3.8.4 Confirmability ..................................................................... 64
3.9 Summary .................................................................................. 64

CHAPTER 4- RESULTS OF THE STUDY ...................................................... 66
4.1 Introduction .............................................................................. 66
4.2 Participant Context ................................................................. 66
4.3 Significant Statements ............................................................ 66
4.4 Summary Of The Essence Of The Intended Meaning For Each Participant As Interpreted By The Researcher – Additional Step to Colaizzi’s (1978a) Original Seven Step Process .................................................. 82
4.5 Images Of Resilience As Articulated By Participants – Additional Step added to Colaizzi’s (1978a) Original Seven Step Process ................................................................. 84
4.6 Creating Formulated Meanings From The Significant Statements.......... 87
4.7 Theme Clusters Aggregated From The Formulated Meanings................ 87
Table 2. Theme Clusters, Formulated Meanings and Relative Significant Statement Reference .................................................................................. 87
4.8 The Exhaustive Descriptions Of The Phenomenon Of Resilience As Described By People Who Have Experienced Mental Illness ................................................. 92
Plate 2: *Gather ye Rosebuds while ye may* by John William Waterhouse (1909) ............................................................... 121

Plate 3: *Rushing Water* Photographer Unknown (N.D) .................................................. 122

Plate 4: *Landscape With Butterflies* by Salvador Dali (1956) ........................................ 125

6.6 Mapping The Journey Through Reflection................................................................. 126

6.7 In The Final Stages Of The Research ..................................................................... 126

6.8 Summary ................................................................................................................. 127

CHAPTER 7-SUMMARY, IMPLICATIONS AND INSIGHTS OF THE STUDY ..... 128

7.1 Introduction ............................................................................................................. 128

7.2 Implications Of The Study ...................................................................................... 128

7.3 Clinical Practice ..................................................................................................... 128

7.4 Recommendations For Clinical Practice ............................................................... 130

7.4.1 Recommendation one ....................................................................................... 131

7.4.2 Recommendation two ....................................................................................... 131

7.4.3 Recommendation three ...................................................................................... 132

7.5 Future Research .................................................................................................... 132

7.6 Summary ............................................................................................................... 133

REFERENCES ............................................................................................................... 135

APPENDIX A - Advertisement .................................................................................. 144

APPENDIX B - Invitation to Participate in a Research Project .................................. 145

APPENDIX C – Consent Form .................................................................................. 151

APPENDIX D – Psychologist Letter .......................................................................... 153
LIST OF TABLES

Table 1. Potential Risks and Protection and Minimisation Strategies ............... 58

Table 2. Theme Clusters, Formulated Meanings and Relative Significant
Statement Reference .......................................................................................... 87
ART WORK IN THESIS

Plate 1: *Landscape* by Conley Ebatarinja Hermansberg (circa 1970) .................. 113

Plate 2: *Gather ye Rosebuds while ye may* by John William Waterhouse (1909)
........................................................................................................................................ 121

Plate 3: *Rushing Water* Photographer Unknown (N.D).............................................. 122

Plate 4: *Landscape With Butterflies* by Salvador Dali (1956)................................. 125
The purpose of this research was to explore the phenomenon of resilience as described by consumers of mental health services in Victoria, Australia who have experienced mental illness. In keeping with Colaizzi’s (1978) approach to inquiry, information in this study was gathered through in-depth, semi-structured individual interviews. Information analysis was undertaken using Colaizzi’s (1978) seven-step approach, with the inclusion of two additional steps- making this study’s analysis a nine step process. Emergent themes were explicated from the findings of this study as follows: Universality; Acceptance; Naming and knowing; Faith, hope and being the fool; Striking a balance; Having meaning and meaningful relationships; and ‘Just doing it’. The emergent concept which encapsulated the themes was ‘viewing life from the ridge with eyes wide open’. In respect of this concept, participants described resilience was achieved by choosing to walk through the darkness all the while knowing the risks and dangers ahead; Making a decision for life through the hardships. That is, following a moment of enlightenment through ‘naming and knowing’, participants said they were able to start making decisions and to process what was happening to them by having faith, hope, acceptance, and by ‘just getting on with life’. It is suggested that resilient behaviours can be learned and interwoven with life experiences. In this context, there is the potential to guide therapeutic interventions in various clinical and educational settings.
CHAPTER 1 –BACKGROUND TO THE STUDY

1.1 Introduction
The purpose of this research was to explore the phenomenon of resilience as described by consumers of mental health services in Melbourne Australia, who have experienced mental illness. This chapter begins with an overview of my interest in the phenomenon. The chapter describes the origins of the word resilience and explores the notion of resilience in the context of health care from the viewpoint of the pioneering works of Norman Garmezy (1991) who examined working with individual strengths in the context of resilient behaviours. From this point the chapter puts forward a definition of resilience for the purpose of this study. The chapter continues in terms of relating the notion of working with strengths by examining models of care in mental health available in Australia. The chapter provides a framework for working in this manner by presenting an Australian context for conceptualising mental illness and critically examining mental illness in terms of - Stress, Recovery, and Coping. Further, the chapter describes resilience in terms of mental illness by examining qualitative research concerning the phenomenon. The chapter concludes with an explication of the significance of the study.

1.2 How My Research Interest Began
My own personal experience of *rolling with the punches* occurred during childhood. As an infant through to adolescence, my family was disjointed and unstable. Throughout this period I witnessed the coming and going of father figures, witnessed violence and substance abuse and moved residences frequently. I was the fourth of five children, the first and third brothers dying at, and just following birth. My sister, the fifth child, had a different father to my brother and me. My mother and primary carer, was unpredictable, angry, aggressive, resentful and often threatened to abandon us children. I was not physically abused but endured constant psychological abuse throughout this time. Despite these events, I continued to have hope that life would improve for us all. In spite of being constantly anxious and often terrified, I attempted to contribute to improvements in our quality of life by offering small childish gestures such as being well-behaved, trying to be
helpful and caring, trying to please those around me, being optimistic often in dire situations, and by trying to understand the reality of what was happening to me and mine. I looked to my spirit to comfort me and to my God to protect me. I turned to my own strengths to cope and survive. Upon reflection on these events, I believe that I was resilient; emotionally, physically, and spiritually.

In my professional life working as a mental health nurse, I have observed many of my clients (who experienced mental illness) struggle with the understanding that their lives were complicated with episodes of disability as a result of mental illness, since mental illness is often episodic in nature. In many of these incidences, individuals managed their reaction to this realisation differently. Some people, who lived with disability associated with mental illness, did not manage their symptoms well overall. However, surprisingly and inspiringly I witnessed many individuals and their families cope effectively with the disabling effects of mental illness. I considered these individuals and their families as courageous, a hero in their own lives, strong, and resilient. I would question what they did to transform the negative impact of mental illness (such as, stigma, distracting and debilitating symptoms of disorders, and biopsychosocial disturbances) into a positive, self-enhancing situation. I wondered how they found the inner strength given that at times all hope may have eluded them. I speculated about supports they had in place to sustain them individually, and whether the strength and courage I saw coming from these people came from some innate ability of the individual to transcend the difficulties associated with mental illness.

In my professional experience in mental health service provision, (a career that spans over two decades), some client’s who have experienced mental illness were perceived by me and some colleagues to have ‘given over to the illness’. What this researcher means by ‘given over to the illness’ is that the person appeared overwhelmed by the degree of disability associated with the symptoms of their mental illness. In similar clinical situations, other individuals were observed by this researcher (regardless of the psychopathology of the condition) to have successfully adapted to their situation and resiled from the experience. A deeper understanding of the course of illness towards
recovery becomes important in terms of understanding the nuances of different individuals in relation to stress, recovery and coping. The questions became for this researcher: ‘Why did some individuals thrive, while others did not?’ ‘Is different courses of illness related to perceived stress and different coping styles?’ This researcher looked to the literature for further enlightenment.

1.3 Literature Review
Literature was reviewed in pre-CINAHL, CINAHL, Clinical Reference Systems, MEDLINE, Psychology and Behavioural Sciences Collection, PsycINFO, PsycARTICLES, PsycEXTRA, and Sociological Collection examining resilience and mental illness. The key words used in this review were: Mental Health; Research, Mental Health; Mental Health Framework; Health Policy; Mental Disorders; Models-Theoretical; Mental Health Services; Health Services Accessibility; Recovery and Resilience and Australia. Additional review of the literature was manually undertaken through university library textbooks. From the literature I became aware of the different colloquial uses for the term resilience and found the definition of the word ‘resilience’ held different meanings in different contexts.

1.4 The Origins And Use Of The Word Resilience
The word resilience originates from the Latin *resilere* meaning, *to jump back* (Kumpfer, 1999). The contemporary meaning of resilience is defined as; [of substance] *springing back; resuming it’s original shape after bending or compression;* [of person] *readily recovering from shock, depression etc.* (*The Oxford Modern English Dictionary*, 1996 , p.864). From the above definition it becomes evident the word resilience holds meaning for many situations, whether those situations involve people, substances, or groups. In everyday language, resilience is used to explain the ability of people to *roll with the punches and cope* with life events, both negative and positive (Dryden, 2005).
Globally the term resilience as an adjective has been used frequently since the terrorist events in America, September 11, 2001 and the Asian Tsunami, December 26, 2004. Throughout the media reports of these events, children, families, and communities, were often described as resilient, or having the ability to function well despite experiencing highly stressful losses (Dryden, 2005; Rutgers, 2005). Importantly, at the core of this understanding of resilience is the opinion of supporting people's strengths to successful adaptation and competence and not focusing on their weaknesses or losses. The notion of resilience in the context of health and psychological competence began with the pioneering works of Norman Garmezy (1985; 1991). Resilience as a notion of competence has become increasingly of interest to researchers and drove the inception of this thesis.

1.5 Working With Strengths And Resilience: The Pioneering Works Of Norman Garmezy (1991)

The pioneer in the study of competence and resilience is Dr. Norman Garmezy (1985). Garmezy’s (1991) ground-breaking research on adaptive and maladaptive performance of adults with schizophrenia led him and his colleagues to study children of parents with schizophrenia to determine their risk for also developing the illness. Garmezy (1985; 1991; 1993) and his colleagues went on to investigate what ‘protected’ these children from succumbing to the same problems experienced by the family members, and thus the field of resilience research was born.

Resilience research has greatly expanded the current focus of social and behavioural sciences to include not just risk, deficit and illness, but also what resilience researchers Drs. Emmy Werner and Ruth Smith (Werner & Smith, 1982) described as self-righting capacities. These significant capacities are the strengths that individuals, families, schools and communities call upon to promote health, well-being, healing and recovery. Research data from the 1990s suggest that resilience is actually an interactive and logical phenomenon (Benard, 1997; Wang, Haertel, & Walberg, 1997; Werner, 1993). Resilience was understood to be the product of a complex relationship of specific psychological
inner strengths and environmental social supports throughout a person’s life that determined their response to adversity (Werner, 1993; Werner & Smith, 1982). From the work undertaken by these aforementioned researchers a definition of resilience to inform this thesis was developed.

1.5 Resilience Defined

Konrad and Bronson (1997) suggest the building of resilient behaviours is a long-term process of healthy human development based on nurturing, and participatory relationships that are grounded in trust and respect and reach toward valuable goals. As previously mentioned, many studies have examined the concept of resilience, and these studies have often examined resilience in child or adolescent groups (Anthony & Cohler, 1987; Criss, Pettit, Bates, Dodge, & Lapp, 2002; Garmezy, 1993; Maybery, Szakacs, Baker, & Ling, 2002; Radke-Yarrow & Brown, 1993; Saleebey, 1997; Todis, Bullis, Waintrup, Schultz, & D’Ambrosio, 2001; Wolchik & Sandler, 1997). These studies have given rise to a description of resilience which is expressed as the capacity to spring back, rebound, successfully adapt in the face of adversity, and develop social competence despite exposure to severe stress. The concept of resilience can be captured by the following (Deveson, 2003. p.66);

*Having a sense of belonging and meaning in life is important to the development of resilience...but this connectedness and meaning in life can come in many different ways. We can draw resilience simply from a profound wonder at the beauty of life, and from the way in which everything is connected to everything else.*

When considering this statement I reflected on the disconnectedness of those who experience an episode of mental illness, and speculated how this statement could relate to these individuals. The question for this researcher became; how can resilient behaviours relate to everyone and any situation? The following statement in Anne Deveson’s (2003, p.38) book called *Resilience* captures the accessibility of resilient behaviours, as follows;
What begins as a quest to understand the extraordinary has revealed the power of the ordinary. Resilience does not come from rare and special qualities, but from the everyday magic of ordinary, normative human resources in the minds, brains, and bodies of children and their families...

In contemplation of the various definitions of resilience articulated in this chapter, and for the purpose of this study, the term resilience is defined as, springing back, rebounding, readily recovering, [and] buoyant, [and], the ability to transcend difficult psychological situations (Edward, 2005a, 2005b; Edward & Warelow, 2005).

Mental illness encompasses a broad and varied array of different conditions of psychological distress. The types of mental illness are broadly classified in terms of psychotic and non-psychotic conditions according to diagnostic classification (American Psychiatric Association. & American Psychiatric Association. Task Force on DSM-IV., 2000). In terms of contextualising the considerable impact of mental illness, knowledge of the global impact of mental illness and then the Australian impact is central to building the significance of this thesis.

1.6 Mental Illness

According to the World Health Organisation 450 million people worldwide are affected by mental, neurological or behavioural problems at any time and one in four patients visiting a health service has at least one mental, neurological or behavioural disorder. However, most of these disorders are neither diagnosed nor treated (World Health Organisation, WHO, 2006a). In Australia, one in five will experience a mental illness in their lifetime (Australian Bureau of Statistics, ABS, 2002). Since mental illness is episodic in nature, the occurrence of mental illness can come and go throughout a person's life. Some people will experience mental illness once and fully recover, while other individuals will continue to battle with mental illness relapses throughout their
lives. The meaning of the term ‘mental illness’ is defined by the following quoted in Sadock and Sadock (2003, p. 293);

\[\textit{Mental illness is conceptualised as a clinically significant behavioural or psychological syndrome or pattern that occurs in an individual and that is associated with present distress or disability or with a significantly increased risk of suffering death, pain, disability, or important loss of freedom.}\]

1.6.1 Non-psychotic mental illnesses- Depression and anxiety

Non-psychotic mental illnesses are conditions in which a person experiences a range of psychiatric symptoms that remain based in reality. Such symptoms include feelings of depression, sadness, and tension or fear that are so disturbing as to affect the person's ability to cope with day-to-day living. Conditions, which can cause these feelings, include anxiety disorders, eating disorders and depression. Approximately 16 percent of adults worldwide are affected by depression at some point in their life (Sadock & Sadock, 2003). Approximately twenty percent of Australian adults are affected by mental illness each year (ABS, 2002). The most common forms of mental illness in Australia as reported by the Department of Human Services in Victoria (2004) are Depression, and Anxiety disorders (DHS, 2004).

The incidence of depression has been increasing over the last 50 years in Australia, where depression ranks among the top 10 causes of disability (WHO, 2006a). Additionally, Australian well-being statistics suggest that by the year 2020, depression will be the 2nd highest rate of incidence of disability in the country, second to heart disease (ABS, 2002; Mathers, Vos, & Stevenson, 1999). The literature also posits that in terms of prevalence, women are twice as likely to develop depression as are men (Badal, 2003; Edward, 2005b; Richards et al., 2004). Interestingly, the prevalence of depression varies across cultures due to differences in social support structures and differing conceptualizations of
the symptoms of depression (Boyd, 1995; Edward, 2005b; Ryden, Karlsson, Sullivan, Torgerson, & Taft, 2003).

Fundamentally, depression is an emotional state marked by; sadness, feelings of helplessness, worthlessness, guilt, a withdrawal from others, and disturbances in appetite, sexual desire, and sleep. There are a number of theoretical positions taken in respect to the development and the course of depression, which informs our current knowledge of the condition – psychoanalytic, cognitive, interpersonal, biological and psychosocial theories.

The psychoanalytic theory of depression views grief over object loss as the basis for depression. The cognitive view of depression suggests that the way depressed people think is biased towards negative interpretations and learned helplessness or an external locus of control, that is, depressed people are passive because they have been unable in the past to control traumatic events (Beck, Rush, & Shaw, 1979; Sadock & Sadock, 2003). The interpersonal theory of depression relates to interpersonal relations that are altered in a depressive state, and include the following; depressed people have limited social support networks; depressed people elicit rejection from others; depressed people are low in social skills across a wide variety of situations; depressed people seek reassurance from others, however, this reassurance is temporary. The biological theories of depression which underpin pharmaceutical production of antidepressants include genetic factors and neurochemistry studies which link serotonin (5-HT) to depression (Antai-Otong, 2003; Sadock & Sadock, 2003). The psychosocial theory of depression includes factors such as learned helplessness, poor social networks and poor social skills [eliciting negative reactions from people]. Each theory suggests the presence of anxiety in the manifestation of depression, where the presence of anxiety compounds the disabling effects of depression for individuals.

In relation to Anxiety Disorders, approximately 10 percent of adults worldwide are affected by such disorders at some point in their life (Antai-Otong, 2003; Sadock & Sadock, 2003). Additionally, in Australia approximately one in five people have an
anxiety condition that is severe enough to affect their lives (Mathers et al., 1999). Although there are numerous kinds of anxiety disorders, many of the symptoms are similar. Anxious people are often irritable and uneasy, find it hard to relax, concentrate or sleep. Anxious people may also have physical symptoms such as heart palpitations, sweating, dizziness, nausea, feeling faint, indigestion, bowel problems, or even loss of libido (Badal, 2003). It is an axiom of modern psychiatry that anxiety and depression are two distinct conditions. However, evidence is amassing that they are really two manifestations of one disorder (Judd et al., 2003; Richards et al., 2004; Ryden et al., 2003).

1.6.2 Psychotic mental illness- Schizophrenia and Bipolar Affective Disorder
Mental illness can also consist of psychotic types. More specifically, psychotic mental illness consists of Schizophrenia and sub types of Schizophrenia [this disorder affects approximately one per cent of Australians at some point in their life], Bipolar Affective Disorder [this condition affects up to two per cent of Australians at some time during their life], and, some forms of depression (ABS, 2002; Sadock & Sadock, 2003).

Schizophrenia is a chronic, severe, and disabling brain disease. Approximately one percent of all people develop schizophrenia during their lifetime. In the vast majority of cases, onset of the illness occurs between the ages of 15 and 25, making schizophrenia the single biggest cause of permanent disability starting in youth. Ten percent of people with schizophrenia usually suicide before the age of 30 (Antai-Otong, 2003; Geanellos, 2005; Sadock & Sadock, 2003). People with schizophrenia often suffer terrifying symptoms such as hearing internal voices not heard by others, or believing that other people are reading their minds, controlling their thoughts, or plotting to harm them. These symptoms may leave them fearful and withdrawn. Their speech and behaviour can be so disorganised that they may be incomprehensible, bizarre or frightening to others.

The first signs of schizophrenia in a family member appear confusing or even shocking to relatives. Parents often assume that the early signs of schizophrenia are symptoms of adolescent growth (Warner, 2003). After diagnosis, coping with the continuing symptoms
of schizophrenia can be especially difficult for both the individual and their family members, who remember how involved or full of life a person was before they became ill. Since schizophrenia may not be a single condition - its causes continue to remain unknown - current treatment methods are eclectic based on differing theoretical positions about aetiology (Geanellos, 2005; Sadock & Sadock, 2003). These approaches are chosen on the basis of their ability to reduce the symptoms of schizophrenia, support the individual in living with the presence of this chronic mental illness and to lessen the chances that symptoms will return.

During the 1990s there were dramatic advances in the treatment of schizophrenia (Sadock & Sadock, 2003). Just as the serotonin re-uptake inhibitor (SRI) class of antidepressants has largely replaced the older and more problematic tricyclic antidepressants, a shift in the treatment of schizophrenia is now taking place. The first of the new (post-clozapine) atypical antipsychotic medications, risperidone, was introduced in 1994, followed by olanzapine, sertindole and ziprasidone. These medications known as the new generation of antipsychotics are better tolerated than the old generation of antipsychotics and provide a greater choice of treatment options for clients. However, medication is only one ingredient on the road to recovery from mental illness since mental illness is diverse in aetiology and treatment. Additionally, it is supported in the literature that of equal importance is addressing the psychological adjustment to psychotic mental illness in terms of conceptualising recovery (Singh, Sharan, & Kulhara, 2003; Tait, Birchwood, & Trower, 2003). The road to recovery is captured by this personal reflection from a person living with schizophrenia (Wagner, 2004, p. 1), as follows;
Schizophrenia is, for most people, an uncharted and terrifying shadow-land that they seek to avoid along with the sufferer whose torments, pain and oddnesses so scare them. In the past, such people were put behind the locked doors of asylums. Today they are simply consigned to the anonymity and powerlessness of poverty, and are forgotten. We can’t find our way alone, not without the help and understanding so often denied us. In spite of the closets imprisoning us, we still live among you, hundreds of thousands of us. Only with support and encouragement will we ever be able to break open the doors.

The type, severity and duration of mental illness experienced can vary. Various forms of the course of mental illness is evidenced in other forms of psychotic mental illness, such as Bipolar Affective Disorder. In this condition the mood episodes can last for a few days to as long as several months, particularly when left untreated or not treated effectively. Once called ‘manic depression’, bipolar affective disorder is a mental illness that involves abnormalities in both the brain's anatomy (particularly the hippocampus) and the brain's physiology (neuro-chemical composition) (Antai-Otong, 2003). People who have this illness experience mood swings that go outside the normal range of moods –‘too low’ moods (depression), ‘too high’ moods (mania) or both. When moods are seriously imbalanced, decisions can become impaired and the individual is unable to function within normal demands. The diagnosis of bipolar affective disorder requires the presence of a manic episode of at least one week's duration that leads to hospitalization or other significant impairment in occupational or social functioning. The episode of mania cannot be caused by another medical illness or by substance abuse. These criteria are based on the specifications of the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision* (American Psychiatric Association. & American Psychiatric Association. Task Force on DSM-IV., 2000). Bipolar affective disorder has a number of contributing factors, including genetic, biochemical, psychodynamic, and environmental elements.
1.7 Mental Illness And The Australian Context

Within the Australian context, people who experience mental illness have been exposed to many health reforms in terms of mental health service provision. Deinstitutionalisation of mental health services has occurred over recent decades in many industrialised nations, including Australia, where the national framework for this reform was provided by the National Mental Health Policy and the National Mental Health Strategy (National Mental Health Strategy, Australia, NMHS, 2000). This reform led to the gradual closure of stand-alone psychiatric hospitals as part of the move toward increased provision of integrated community-based services. The process of deinstitutionalization led to the mainstreaming of mental health services, including the establishment of psychiatric units within existing general hospitals. The effects of this reform has been a reduction in available hospital beds for people with mental illness, a shorter average duration of inpatient treatment and more responsive community-oriented services (NMHS, 2000). More recently, the Council of Australian Governments through the Departments of Human Services across Australia has dedicated more resources to mental health initiatives that enhance community based care in terms of access and affordability for people experiencing mental illness (Department of Human Services, Better Access to Mental Health Services, DHS, 2006). The Better Outcomes in Mental Health Care (BOIMHC) program improves community access to quality primary mental health care and provides clients with mental disorders with better access to psychiatrists, psychologists, general practitioners and other allied mental health workers by introducing a range of new Medicare Benefits Schedule (MBS) items. A person is eligible to claim Medicare rebates for these services where they are referred by a medical practitioner.

The introduction of health reforms in mental health (such as, deinstitutionalization and mainstreaming of mental health services) undertaken in Australia over the previous decade (1990-2000) have seen the emergence of a greater emphasis on the building of mental health consumer’s strengths and family members involvement in an intensified carer role. A study undertaken by Marsh (1996), related to the experience of family members when one of their relatives becomes mentally ill. One example put forward in this study was a description by the mother of her mentally ill son, as follows; …it is
gratifying to witness our son's courage as he deals with his [mental] illness (Marsh et al., 1996, p. 9, as cited in Marsh & Johnson, 1997). This study highlights the personal strengths and alludes to resilient behaviours used by mental health consumers to meet the challenges of the disabling effects of mental illness.

For individuals who have experienced mental illness the challenges that they face may appear at times insurmountable. Such a major life event, that the experience of mental illness presents, often generates major shifts in the social, economic, familial, psychological, and physical areas of a person’s life. The unpredictable nature of mental illness and related relapses impacts significantly on the individual’s lifestyle, often leading to an ongoing state of uncertainty in terms of workplace commitments, social networks and sense of self (Sadock & Sadock, 2003). There have been attempts by the Australian government to demonstrate a shift in paradigm in mental health care delivery, from a preventative framework to a working with strengths paradigm of clinical care, where the focus of care delivery is on the strengths or resilient qualities of the individual towards recovery (Australia. Dept. of Health and Aged Care., 2000).

1.7.1 Models Of Care In Mental Health In Australia
Mental health services in Australia comprise two main frameworks for conceptualising treatment; the medical model and the psychosocial model (Braddock et al., 2004; Department of Human Services, Victoria - DHS, 2004). The medical model is made up of causal chains, of primary, secondary, and tertiary, where the primary cause is often seen as the original source (Antai-Otong, 2003). Causes of ill health in this model are often depicted as a problem at the biological level. As examples, germs cause influenza, or brain damage from accidents or strokes cause communication disabilities. The medical model tends to define recovery in negative terms, where symptoms and complaints need to be eliminated. That is, illnesses need to be cured or removed. In this context, patients need to be relieved of their conditions and returned to their pre-morbid, healthy, or more accurately, not-ill state. Similarly within this framework, clients who experience mental illness are often waiting for their illnesses to subside in order to get on with their lives, and many become angry at professionals for not helping them, since their symptoms
persist or recur episodically. The medical model has provided for health providers and users well in offering an understanding of what is going on at the biological level. However, it is important to consider the challenges of other models as compared to the medical approach in mental health recovery.

There are several notions of recovery. Fitzpatrick (2002, as cited in Andresen, Oades, & Caputi, 2003) describes the meaning of recovery with three identifiable models: the medical model, the rehabilitative model and the empowerment model (p.588). The empowerment model suggests that mental illness is a sign of severe emotional distress and how the person responds is crucial to their ongoing development (Ahern & Fisher, 2001, as cited in Andresen et al., 2003). The rehabilitative model acknowledges the biological foundation of mental illness and suggest the person can learn to live well within the limitations of the persistent symptoms of mental illness (Liberman, 1992, as cited in Andresen et al., 2003). The psychosocial model of recovery refers to hopefulness, having meaning in life, self determination, and positive sense of self. In other words, the person recovers from the adverse psychological and social effects of the condition. Andresen et al. suggest the psychosocial model falls between the rehabilitative and empowerment models of recovery, however more importantly, is most consistent with consumer beliefs (2003).

The psychosocial approach acknowledges the complexity of mental illness with an inherent understanding of recovery, which can be defined as the ability to live well in the presence or absence of symptoms (Sadock & Sadock, 2003). This understanding forces a conceptual shift where 'living with' and managing symptoms becomes central as opposed to symptom elimination. This shift in thinking is evident in mental health clinical work, which focuses on one’s strengths and initiatives in terms of recovery. Such initiatives, in Victoria, Australia, can be evidenced by the widely used care provision tool, the Individual Service Plan (DHS, 2004). This care plan is developed through client enabling and the therapeutic alliance - working with the client’s strengths towards attainment of their own identified goals. Contemporary literature supports the belief that most people with mental illness are not permanently incapacitated, irrational, helpless beings whom
mental health care clinicians need to protect (Antai-Otong, 2003; Elder, Evans, & Nizette, 2005; Kneisl, Wilson, & Trigoboff, 2004). While consumers of mental health may occasionally need protection, they also have dreams, hopes, plans and choices, take risks and are responsible for the consequences of their actions. Accessing or facilitating development of resilient behaviours in people who experience mental illness may provide an opportunity for change, growth, self-confidence and, ultimately, recovery itself.

1.8 Mental illness- Stress, Coping, and Recovery

1.8.1 Stress
Stress is common to everyone. Our bodies are designed to feel stress and react to it. It is not always possible to avoid or change events that may cause stress, which can make people feel trapped and unable to cope (Yeager & Roberts, 2003). Coping with stress involves identifying stressors in one’s life and learning ways to direct and reduce the perceived stressor. The human body has innate defence systems in place to manage stressful situations. One of these defensive systems is the Flight or Fight Response, otherwise known as, the Stress Mechanism (Davison & Neale, 2001; Gray, 1999). Stress is a biological and psychological response to any situation or factor that creates a negative emotional or physical change. While stress is an unavoidable aspect of life, some stress is helpful since it provides motivation.

Previous experience, education, and support enable most people to respond appropriately and to change, as circumstances require. Response to stress is considered both learned and natural and may be appropriate and healthy, or inappropriate and unhealthy (Ryden et al., 2003). All people have natural responses to stress (such as increased vigilance, aggressiveness, or blocking out issues/pain) that allow them to survive while the body recognizes, responds to and recovers from stresses. These responses are considered a part of human adaptation; - that is, coping (Edward & Warelow, 2005; Ryden et al., 2003).

1.8.2 Coping
Coping is a fundamental psychological process, and people's skills usually consist of a sophisticated repertoire. In terms of recovery from a major life event, such as mental
illness, the individual’s coping skills range is put through its paces. Building on people's strengths and emphasizing their role as positive adapters is considered an important element to the clinical practices’ of clinicians working in mental health services (Department of Human Services, Victoria, DHS, 2004). Coping generally occurs when people living with mental illness discover, or rediscover, their strengths and abilities for pursuing personal goals and develop a sense of self that allows them to grow beyond the symptoms or disability of their mental illness (Perkins & Repper, 2003; Warner, 2003).

Coping can be achieved by using personal reflective review to subjectively communicate common experiences relating to crisis and then through objectifying one’s own reaction to an event, problem solving, and devise strategies to help alleviate stress and anxiety related to adverse events. The literature supports that analyzing one’s own reactions during an adverse situation, such as a health crisis, can help individuals objectify their own emotions from the event paving the way for effective problem-solving (Edward & Warelow, 2005; Ihlenfeld, 2004; Lazarus & Folkman, 1984; Mermier, 1993; Urquhart, 2002).

Lazurus and Folkman (1984) identified two broad dimensions of coping, that is, problem-focused coping and emotion-focused coping. Problem-focused coping involves seeking information that is relevant to the situation and taking direct action to solve the issue, while emotion-focused coping refers to efforts to reduce negative emotions in reaction to the adverse event (Edward & Warelow, 2005; Jamiolkowski, 1993; Lazarus & Folkman, 1984; Ryden et al., 2003). These adaptive and functional skills are embedded in resilient and emotionally intelligent behaviours (Edward & Warelow, 2005). Each of these styles of coping entail the individual to utilize social supports, hope, a belief self and what is possible, and humour to adapt to their situation and work towards recovery.

1.8.3 Recovery
Mental health consumers and clinicians work together in a therapeutic alliance to assist the person in the process of recovery from mental illness by identifying the abilities
acquired through the experience of the episode or relapse. This therapeutic alliance works towards offering alternatives beyond symptoms and deficits for individuals and their carers, challenging the realities of social exclusion that relates to stigma attached to mental illness, and work collaboratively in the direction of changing the balance of power (Murphy & Dillon, 2003). For individuals who experience mental illness, recovery is often a difficult journey.

The recovery journey for consumers of mental health services, with the help of intervening mental health clinicians and significant others, is directed at promoting successful adaptation and adjustment, creating hope and promoting relationships, facilitating the consumers’ personal adaptation towards understanding and acceptance, and promotion of self efficacy [assisting the consumer towards taking back control over their own life beyond associated disabilities] (Elder et al., 2005; Forchuk, Jewell, Tweedell, & Steinnagel, 2003; WHO, 2006b). These characteristics can be divided into intrapersonal and environmental factors and broadly encompass cognitive features such as optimism, intelligence, creativity and humour. These are often contained within a belief system that provides some existential meaning, a cohesive life story and an overriding appreciation of the uniqueness of oneself. Recovery generally occurs when people with mental illness develop their strengths and abilities for pursuing personal goals, and develop a sense of self that allows them to grow beyond the symptoms or disability of their mental illness (Mueser et al., 2002a). The ability to move beyond the stressors of the moment is implicit in resilient behaviours (Edward & Warelow, 2005).

1.9 Resilience And Mental Illness

Contemporary research on the effects of severe psychological stress and coping towards recovery has focused on stress-related psychopathology (Badal, 2003; Cassano & Fava, 2002; Charney, 2004). Charney (2004) developed a psychobiological model of resilience to counteract extreme stress. He proposed an integrative model which included the notions of resilience and vulnerability that encompassed the neuro-chemical response patterns to acute stress and the neural mechanisms mediating reward, fear conditioning, extinction, and social behaviour. The neural mechanisms of reward and motivation
(hedonic, hopefulness, and learned helpfulness), fear responsiveness (effective behaviours despite intense emotion), and adaptive social behaviour were found by Charney to be relevant to resilient character traits. He concluded through his analysis that an opportunity now exists to advance our understanding of resilience and the neurobiological basis of behaviour to facilitate the discoveries needed to predict, prevent, and treat stress-related psychopathology.

Bachay and Cingel (1999) undertook an analysis of the subjective voice of marginal women in which the individuals revealed three constitutional factors that enhanced their feeling of resilience. These factors were found to be robust measures of self-efficacy, well-defined faith lives, and the ability to reframe perceived obstacles to daily living. Bachay and Cingel (1999) suggest that in conjunction with these emotional and cognitive factors, relational/psychosocial factors also play a significant role in enhancing the experience of resilience for individuals. Bachay and Cingel (1999) suggest further that an important psychosocial factor that mediated resilience was close and positive relationships and, such relationships served as sources of support within and outside the family at various developmental moments.

Additional knowledge of resilient coping processes are of interest to researchers since the outcomes have implications in psychological and physical terms for individuals. Supporting people who experience mental illness toward enhancement of resilience qualities can be achieved through counselling and psychosocial education that is provided through existing clinical practice (Tusaie & Dyer, 2004a). Tusaie and Dyer (2004) suggest that social-psychological strategies (such as self-efficacy, well-defined faith, and the ability to reframe negative experiences into positive, self-enhancing life events) can counterbalance the adversity experienced by people who have mental illness, such as depression and anxiety.

Studies related to resilience and depression support that personality type and resilient behaviours provide protection from the experience of depression and anxiety, and that resilience increased the risk of not being depressed or stressed (Edward, 2005b;
Frydenberg, 1997; Fuller, 2002; Hafen, 1996; Haggerty, 1994; Hammen, 1991; Smith, 2000). Smith (2000) suggests that vulnerability to depression and anxiety may be attributed to the inability of the individual to develop positive self-perceptions. In his study Smith demonstrated that a personality type characterized by self-perceptions tinged with a positive preconception and high levels of optimism, assisted the individual to be resilient from the experience of mental illness.

1.9.1 Resilience and non psychotic mental illness

Resilience inquiry to date has focused on identifying personality characteristics associated with adaptive coping (Bauman, Harrison Adams, & Waldo, 2001; Benard, 1997; Flach, 1988; Garmezy, 1993; Kaplan, 1999; Konrad & Bronson, 1997; Kupst, 2004; Polk, 1997; Rew, Taylor-Sehafer, Thomas, & Yockey, 2001; Schoon, Parsons, & Sacker, 2004; Ungar, 2003, 2004; Werner, 1993). Garmezy (1993) states [resilience is] the ability to recover readily from illness, depression and adversity. A resilient individual can bend, yet subsequently recover (p.129).

Antoni and Goodkin (1988); and Rabkin, Remien, Katoff, and Williams (1993) examined the notion of resilience in the context of chronic illness, which describes illnesses such as cancer, AIDS and mental illness. The results of these studies identify personal characteristics associated with resilience and comprise optimism, an active or adaptable coping style, and the ability to elicit social support (Antoni & Goodkin, 1988; Rabkin, Remien, Katoff, & Williams, 1993). In addition, Rabkin et al. (1993) suggest higher levels of intelligence and education, wide-ranging interests, and an ability to articulate future goals as attributes of resilient individuals. The optimistic and active problem-solving style, goal orientation, and flexible coping identified in these studies correspond to Polk’s (1997) situational patterns, which are conceptualized as resilient coping patterns. Polk (1997) provided a model of resilience that relates to a person’s overall pattern of health and is viewed as the ability of the person to return to their original or near original position after being under duress. Some of the literature relates to non-psychotic mental illness and resilience identify strategies that enhance resilient factors
In particular, these strategies include: early intervention; positive social and familial climate; self-esteem and support building; social and life skills/vocational education; peer involvement and extracurricular activities. These findings covering resilience are important for forms of mental illness and recovery, including mental illness that has psychotic features.

1.9.2 Resilience and psychotic mental illness

There is a dearth of literature related to resilient practices and behaviours in individuals who experience psychotic mental disorders. Of the literature examined, studies focused on children of parents with psychotic mental illness (Maybery et al., 2002). Maybery et al., (2002) examined and compared the needs of these children from the perspective of both parent and child. Need was examined in parallel adult and child focus groups where adults identified core themes such as support, issues to do with the child's coping mechanisms, concerns for children surrounding major mental health episodes, and the need for increased professional supports for their children. Some of the children's needs were corresponded to the adult responses and included coping with their parents' mental health episodes. The findings of the Maybery et al.(2002), study were discussed in relation to resilience, support and coping. Overall, the study supported the idea that assisting people toward successful adaptation and negotiation of difficult life events has the potential to enhance resilience qualities, however further examination of qualitative research on the topic can offer significant insights to improve consumer outcomes.

1.10 Qualitative Research On Resilience

Given that this is a descriptive phenomenological study only qualitative studies will be reviewed. Resilience has increasingly become the focus of study in many countries, often related to traumatic events that have shaped the world context such as terrorism, natural disasters and war (Everly & Lating, 2002; Sung-Joo, 2003; Ursano, McCaughey, & Fullerton, 1994). The majority of qualitative research on resilient behaviours has focused on child and adolescent groups who demonstrated resilient behaviours in the face of adversity (Benard, 1993, 1997; Christiansen, Christiansen, & Howard, 1997; Garmezy,
There appears to be fewer studies that have explored resilience from a qualitative perspective within the Australian context (Maybery et al., 2002). One Australian study undertaken by Edward (2005a) examined the experience of resilience as described by mental health crisis clinicians. The findings of her study suggest that resilience was experienced as a result of the caring environment of the team in addition to having a sense of self; faith and hope; having insight; and self care. This study was the first such study to examine this phenomenon in crisis care mental health clinicians in Victoria, Australia. Examples of mental health crisis situations include; life-threatening events including attempted/successful suicide, exacerbation of acute psychotic symptoms resulting in potential harm to the person or others, and domestic violence as a result of a psychiatric illness such as a person experiencing symptoms of paranoid schizophrenia (Davison & Neale, 2001). Edward (2005a) considered the nature of complex and often unpredictable situations accompanied by the ever-present potential risk of harm as an added stressor on the mental health clinician in intervening in such crises. Given the level of stress of such a work environment, the potential risk for burnout is considered by Edward and other researchers as extremely high (Armstrong, 2002; Lilly, 2002). Edward (2005a) found participants described using resilience factors to transcend the unrelenting, demanding nature of working as a clinician in crisis work in mental health. Other authors have also found despite the demanding nature of psychiatric nursing, many had not succumbed to the pressure of the work but rather, continued to remain enthusiastic, empathic, and skilled in their clinical approach to care (Happell, Martin, & Pinikahana, 2003).

The belief that resilience is a strategy (such as, skills in problem-solving) that can be modelled, and mastered through education was the key point from a number of studies (Benard, 1993, 1997; Christiansen et al., 1997; Edward, 2005a, 2005b; Edward & Warelow, 2005; Garmezy, 1993; Margalit, 2003; McDonald & Hayes, 2001; Pryjmachuk, 2000; Radke-Yarrow & Brown, 1993; Todis et al., 2001; Tusaie & Dyer, 1993; McDonald & Hayes, 2001; Pryjmachuk, 2000; Radke-Yarrow & Brown, 1993; Todis et al., 2001; Westfall & Pisapia, 1994).
One such study undertaken by Benard (1997) described how educators and schools could foster resiliency in youth. Benard suggested the starting point for building on students' capacities is the belief by all adults in the student’s lives that the youth has innate resilience (Benard, 1997). This study advocated that all individuals have the power to adjust, and mentors have the power to transform lives through education and support. The aspects identified as key contributors to fostering resilience involved caring relationships, positive and high expectations, education, goals, and providing opportunities to participate and contribute (Benard, 1993, 1997). The belief that resilience may be a blend of nature and nurture was posited by Westfall and Pisapia (1994). This inquiry investigated students considered at risk, and what emerged was a portrait of resilience in a group of individuals that were considered at-risk. The findings demonstrated that in spite of the presence of several risk factors, there were some students who developed effective coping skills that helped them thrive in the face of adversity (Westfall & Pisapia, 1994). These individuals were considered resilient because they were able to recover from life's stressors. The study by Westfall and Pisapia (1994) produced successful educational and supportive programs that could assist at-risk students to adapt to their stressful life events. The philosophical underpinnings of this program by Westfall and Pisapia (1994) advocated that resilience can be developed as a strategy by the inclusion of key resilience building concepts — such as, early intervention; positive climate; effective personnel; small group/class size; carer involvement; self-esteem and support building; social and life skills/vocational education - into educational programmes.

1.11 Significance of the Study

Literature supports the belief resilient behaviours can be learned and interwoven with contextual life experiences. In this context, there is the potential to guide practical interventions in various clinical, occupational, and educational settings. This research has minimal risks to participants and has the potential to contribute to the general body of knowledge about the experience of resilience as a pathway to recovery from mental illness. It is anticipated that the findings of this research will have the following benefits:
1. This study has the potential to inform mental health consumers of resilience in the context of recovery from mental illness.

2. This study has the potential to inform mental health clinicians of resilience for the purpose of facilitating improved clinical outcomes for mental health consumers by the following:
   - Possible inclusion in psychosocial educational information and training for clients.
   - Insight into the experience of resilience from the perspective of the mental health consumer to facilitate enhanced understanding in mental health practitioner’s clinical practice.

3. The findings of this research have the potential to add to extant knowledge of resilience.

4. The findings of this study may provide a basis for further inquiry into resilience as a strategy for enhancing recovery potential from mental illness.

1.12 Summary

This chapter commenced with an overview of this researcher’s interest in the phenomenon. The chapter described the origins of the word resilience and explored the notion of resilience in the context of health care from the viewpoint of the pioneering works of Garmezy (1991). The chapter continues by providing a definition of resilience for the purpose of this study, outlining a framework for working in mental health by presenting an Australian context for conceptualising mental illness, and critically examining mental illness in terms of Stress, Coping and Recovery. Further, the chapter described resilience in terms of mental illness by examining qualitative research concerning the phenomenon. The chapter concluded with an explication of the significance of the study. Chapter two provides a discussion of the theoretical framework underpinning this research. Chapter three provides a comprehensive explanation of the method of inquiry used in this study, followed by the presentation of the findings in Chapter four. Chapter five presents a discussion of the emergent themes of the study with reference to contemporary literature. Chapter six explicates my reflections of the research.
journey throughout the PhD process. Chapter seven concludes the thesis with a discussion of the implications of the findings of this study followed by recommendations for contemporary and future practice and research.
CHAPTER 2- PHILOSOPHICAL FRAMEWORK

2.1 Introduction
This chapter examines the theoretical framework of phenomenological research as applied to this study. The chapter initially discusses the philosophical foundations of phenomenological thought around the world, followed by an explication of descriptive empirical phenomenology as articulated by Colaizzi (1978a) – the process of analysis employed for this study.

2.2 Philosophical Foundations Of Phenomenology
In the quest for knowledge, health sciences have relied heavily on the positivist approach to scientific inquiry (Bilsker & Goldner, 2004; Mills, Montori, & Guyatt, 2004). Positivists may well perceive qualitative approaches as unscientific, soft scholarship, exploratory, overly subjective and biased. Whilst the positivist approach undoubtedly contributes towards the knowledge base in clinical practice, in some ways it fails to provide a holistic view of the complexity of human behaviour, human experience, or the health-illness continuum, let alone acknowledging the relationships between them. Phenomenological inquiry identifies the essence of a phenomenon and accurately describes it through the lens of lived experience (Giorgi, 1985; Husserl, 1965; Merleau-Ponty, 1956). Through consistency in the use of the methodology, academic rigour can be maintained. It is advocated by qualitative researchers that the phenomenological method is congruent with the ideals in health sciences, where humanistic understanding is valued and sought (Husserl, 1965; Kim & Kollak, 2005; Merleau-Ponty, 1956; Solomon, 2001). Phenomenologists use skills in observation, interviewing, interaction and interpersonal relationships in the appreciation of the individual’s perception of an experience. Literature also suggests that, given appropriate attention to rigour, phenomenological methodology could become the basic instrument in the reform of research from the positivist to the humanist paradigm (Dick, 1999; Sandelowski, 1993). Phenomenology is a 20th-century philosophical movement dedicated to describing the construction of experience as they present themselves to consciousness, without recourse to theory, deduction, or
assumptions from other disciplines such as the natural sciences (Paley, 2005; Solomon, 2001).

2.3 The Beginnings Of Phenomenology - German Phenomenology

2.3.1 Edmund Husserl

Edmund Husserl (1859-1938) was born on April 8, 1859, in Prostejov, a small town in Tsjechoslovakia between Prague and Vienna. His favourite subject was mathematics but he also studied literature, theology, law, philosophy and astronomy. In 1911 he published his article *Philosophy as Rigorous Science*, in which he criticizes forms of naturalism, historicism and psychologism (as cited, Sokolowski, 1988). In his subsequent publications Husserl announces the birth of the new science of phenomenology and elaborates on the distinction between phenomenological psychology as the foundational science for all psychological disciplines, and transcendental phenomenology as first philosophy (Zahavi, 2003). The founder of phenomenology Husserl, introduced the term *phenomenology* in his book - *Ideas: A General Introduction to Pure Phenomenology* (1913; trans. 1931). Early followers of Husserl claimed that the task of phenomenology is to study essences, such as the essence of emotions (Heidegger, 1962a; Merleau-Ponty, 1956). Although Husserl himself never gave up his early interest in essences, he later held that only the essences of certain special conscious structures are the proper object of phenomenology. As formulated by Husserl after 1910, phenomenology is the study of the structures of consciousness that enable consciousness to refer to objects outside itself (Husserl, 1965). He purports the study of phenomena requires reflection on the content of the mind to the exclusion of everything else. Husserl called this type of reflection the phenomenological reduction. Because the mind can be directed toward nonexistent as well as real objects, Husserl noted that phenomenological reflection does not presuppose that anything exists, but rather amounts to a bracketing of existence, that is, setting aside the question of the real existence of the contemplated object (Zahavi, 2003).

What Husserl discovered when he contemplated the content of his mind were such acts as remembering, desiring, and perceiving and the abstract content of these acts, which he
called meanings (Husserl, 1965). He claimed these meanings enabled an act to be directed toward an object and such directedness, called intentionality, which he held to be the essence of consciousness. Transcendental phenomenology, according to Husserl, was the study of the basic components of the semantics/meanings that make intentionality possible. Later, in *Cartesian Meditations* (1931; trans. 1960), he introduced genetic phenomenology, which he defined as the study of how these meanings are built up in the course of experience. As previously mentioned, Edmund Husserl became the founder of the modern phenomenological movement that inspired many influential scholars such as Heidegger (1962a; 1962b), Sartre (1956; 1964), Merleau-Ponty (1956; 1962), Giorgi (1970; 1983; 1985; 1986; 1989; 1992) and Colaizzi (1973; 1978a; 1978b).

2.3.2 Martin Heidegger

Phenomenologists coming from different schools such as Heidegger, Sartre, Merleau-Ponty, Giorgi and Colaizzi adhere to Husserl’s philosophy in attempting to use pure description (Colaizzi, 1978a; Giorgi, 1992; Heidegger, 1962b; Merleau-Ponty, 1956; Sartre, 1956). Thus, they all subscribe to Husserl’s saying *To the things themselves* (Husserl, 1999). However, they differ among themselves, as to whether the phenomenological reduction can be performed, and as to what is manifest to the philosopher giving a pure description of experience (Giorgi, 1992). The German philosopher Martin Heidegger, Husserl's colleague and skilful critic, claimed that phenomenology should make apparent what is hidden in ordinary, everyday experience. He consequently attempted in *Being and Time* (1927; trans. 1962) to describe what he called the structure of everydayness, or *being-in-the-world*, which he found to be an interconnected system of equipment, social roles, and purposes (Heidegger, 1962b).

For Heidegger, a person is what one does in the world, and a phenomenological reduction to one's own private experience is impossible; he suggests that human action consists of a direct grasp of objects, so it is not necessary to posit a special mental entity called a *meaning*, to account for intentionality. Heidegger suggests further, being thrown into the world among things in the act of realizing is a more fundamental kind of intentionality.
than that revealed in merely staring at or thinking about objects, and it is this more fundamental intentionality that makes possible the directness previously analysed by Husserl (Heidegger, 1962b).

2.4 French Phenomenology

2.4.1 Jean Paul Sartre

The French existentialist Jean Paul Sartre attempted to adapt Heidegger's phenomenology to the philosophy of consciousness, thereby in effect returning to Husserl. Sartre (1956) agreed with Husserl that consciousness is always directed at objects, however he criticized Husserl’s claim that such directedness is possible only by means of special mental entities called meanings (Sartre, 1956). The ongoing debate of phenomenology was continued by the French when the philosopher Maurice Merleau-Ponty rejected Sartre's view that phenomenological description reveals human beings to be pure, isolated, and free consciousnesses (Merleau-Ponty, 1956). Like Husserl and Heidegger, Sartre distinguished ontology (reality) from metaphysics and favored the former. In Sartre’s case, ontology was primarily descriptive and classificatory, whereas metaphysics purported to be causally explanatory, offering accounts about the ultimate origins and ends of individuals (1956; 1964). Unlike Heidegger, however, Sartre does not try to combat metaphysics as a harmful undertaking. He simply notes that it raises questions we cannot answer. On the other hand, he subtitles Being and Nothingness a ‘Phenomenological Ontology’. Its descriptive method moves from the most abstract to the highly concrete. It begins by analyzing two distinct and irreducible categories or kinds of being: the in-itself and the for-itself, roughly the non-conscious and consciousness respectively, adding a third, the for-others, later in the book, and concludes with a sketch of the practice of existential psychoanalysis that interprets actions to uncover the fundamental project that unifies our lives (Sartre, 1956). Like Heidegger and Sartre, Merleau-Ponty is an existential phenomenologist, in that he denies the possibility of bracketing existence (Heidegger, 1962b; Merleau-Ponty, 1956; Sartre, 1956).
2.4.2 Maurice Merleau-Ponty

Maurice Merleau-Ponty was born in France in the early 20th century. Merleau-Ponty developed his existential phenomenology by drawing heavily upon the works of Edmund Husserl, although he interprets Husserl’s transcendental phenomenology in an existential direction. In almost all Merleau-Ponty’s work his writing style is closely interrelated with his phenomenological reflections. His texts often have a hesitant quality emphasising that phenomenological knowledge is always incomplete and provisional (1956; 1962). Merleau-Ponty is especially known for his phenomenology of the lived body. While most of his work is written in the 1950s and 60s when there was very little literature on embodiment and essence available, his texts are still extremely original, inspiring and insightful for the phenomenologist of today. Phenomenology continued to have a pervasive influence on 20th-century thought, where phenomenological versions of theology, sociology, psychology, and psychiatry criticism were developed, with the result that phenomenology remains one of the most important schools of contemporary philosophy around the world.

2.5 North American Phenomenology

2.5.1 Amedeo Giorgi

Giorgi argued that a phenomenologically-oriented human science was an alternative paradigm to the current tradition of natural science psychology seen in the late 1960’s. Giorgi took up the banner of phenomenological psychology as a competing paradigm for this period in the history of psychology (1970; 1983; 1985; 1986; 1989; 1992). This paradigm was based in the interpretive paradigm. Over the last half century, this new research paradigm emerged in the social sciences breaking out of the constraints imposed by positivism, with its emphasis on socially engendered concept formation. Containing such qualitative methodological approaches as phenomenology, ethnography, and hermeneutics, phenomenology is characterised by a belief in a socially constructed, subjectively-based reality, one that is influenced by culture and history, while still retaining the ideals of researcher objectivity, and the researcher as passive collector and expert interpreter of data. What emerged was an existential empirical phenomenological
branch, which focused on the analysis of self report data in response to a question posed by the researcher. Van Kaam (1966) was the initiator of existential empirical phenomenological inquiry, which had contributors such as Giorgi, and later Paul Colaizzi. Paul Colaizzi (1973) extended Van Kaam’s (1966) concept of fundamental structures of phenomenon in his book entitled *Beyond Reflection and Research in Psychology: A Phenomenological Study of Learning.*

### 2.5.2 Paul Colaizzi

Colaizzi (1973) developed his method under the supervision of Amedeo Giorgi (1970), who has produced a body of literature in the form of articles and books devoted to the ongoing articulation and demonstration of empirically based phenomenological research in psychology. Colaizzi criticized the pioneer work of Van Kaam (1966) for not making any noticeable use of the fundamental reflection in the survey of meaning. Rather, Van Kaam’s method resembled a linguistic analysis, though his way of using the subject’s subjective experience as empirical ground was noted by Colaizzi. Colaizzi (1978a) had observed the shortcomings of Van Kaam's method, and developed a technique much more in line with Husserl's suggestion for a thorough reduction to the transcendental essence of the phenomenon.

Colaizzi (1973; 1978a; 1978b) reduced his raw-data by transforming the original utterances into basic meaning components. Colaizzi’s empirical existential phenomenological studies focused on the analysis of self report data provided by participants in response to a question posed by the researcher (1973; 1978a; 1978b). There are clear progressions in this type of research. First, the problem and question formulation, where the researcher focuses the investigation. In this phase the researcher names the phenomenon to be investigated, that is by formulating a hypothesis. In the empirical existential phenomenological approach, the researcher starts with narratives combining description and elaborative dialogue to explicate the individuals’ experience. Once narrative data is collected, the emphasis is on the study of the configurations of the meaning of the experiences, involving structure of the meaning and how it was created.
(Saunders, 2003). This process brings about the implicit meanings by means of systematic reflections.

Wertz (1984) suggests the important points in empirical existential phenomenological research include: an empathetic presence to the descriptions, dwelling on details of narratives, magnification and amplification of details, turning from objects to immanent meanings, reflection on judgment of relevance, grasping implicit meanings and relating elements. Finally, the process of empirical existential phenomenology culminates in a formulation of the structure of the phenomenon. This is a presentation of the essential components of the phenomenon, articulating what the phenomenon is as a human meaning (Wertz, 1984). According to Colaizzi, the fundamental structure of the phenomenon under investigation is the articulation of the moment in the researcher’s mental picture and understanding based on accepted presuppositions and situational circumstances (1978a). In this context, the researcher is using the self in the inquiry. This is consistent with phenomenological thought where insight and reflexivity are essential to achieving an understanding of the phenomenon.

2.6 The Use Of Self In Phenomenological Inquiry

Human self-reflection is the basis of philosophy and philosophic inquiry. Humanity has always taken great interest in itself, and through the human faculty of introspection, the urge of an individual to discover more about its essence, invariably leads to inquiry about the human condition and the essence of humankind as a whole (Husserl, 1965; Soloman, 1993). It is therefore important to explore the issues related to the use of self as a researcher in the description and presentation of qualitative data into a thesis. The term Philosophy, as a practice, aims at some kind of understanding, knowledge or wisdom about fundamental matters such as reality, knowledge, meaning, value, being and truth. In philosophy, a being is anything that can be said to be (Bem & de Jong, 2001; Heidegger, 1962b).

The Latin phrase cogito, ergo sum ("I think, therefore I am") is possibly the single best-known philosophical statement and is attributed to René Descartes (Descartes, 1637). The
term *I am* has no meaning by itself; it must have an action or relation attached to it. This in turn led to the thought that *being* and *nothingness* are closely related, a concept developed in existential philosophy (Heidegger, 1962b). Existentialism is a unilateral philosophical movement that emphasizes the individual, the self, the individual's experience, and the uniqueness therein as the only reality. Existentialists are interested in subjectivity, and view general existence as mysterious -that they are isolated entities in an indifferent and often ambiguous universe (Heidegger, 1962a, 1962b; Sartre, 1956, 1964). Philosophers Sartre and Heidegger have written extensively on the concept of being, distinguishing between the being of objects (being in itself) and the being of people (Heidegger, 1962a, 1962b; Sartre, 1956, 1964).

The purpose of phenomenological inquiry is to discover the true essences of phenomena through the experiential narratives of individuals. It utilises human knowledge as a source of data, through which the knowledge of the experience can be extracted. Human knowledge is the sum total of all thoughts, creations, and inventions of the human mind. It includes the small details of each individual's life, such as the memory of what one did yesterday (Gray, 1999; Mruck & Breuer, 2003; Valle, 1998). Viewed in this way, human knowledge is the mental expression of all human experience, and phenomenology assumes that experience is somehow accessible through descriptions (Husserl, 1965; Merleau-Ponty, 1962; Sartre, 1956; Sokolowski, 1988). This notion is congruent to the health sciences in terms of the exploration of meaning from the perception of the health care consumer, and in particular in mental health.

Jackson and Stevenson (2000, as cited, Sahttell & Hogan, 2005) suggest a nurse who has not experienced mental illness themselves cannot know what it truly feels like; furthermore, even when the nurse has experienced mental health problems, they still cannot know what it feels like for that particular client. In other words, the knowledge of an individual’s lived world is only accessible through the person’s narrative about their experience, for example, their health and illness experience. Jackson and Stevenson (2000, as cited, Sahttell & Hogan, 2005) also suggest nurses need to be guided by the client’s own definitions to achieve a clear understanding of the client’s unique lived
world. Elderkin-Thompson, Silver, and Waitzkinc (2001, as cited, Sahttell & Hogan, 2005) support this notion, where they found successful understanding by health practitioners was enhanced by the practitioners being aware of key communication blocks during intimate dialogue with client – that is, taken-for-granted meanings, using active listening skills, asking for clarification about meanings and being guided by the client’s own definitions.

Clients/patients welcome greater understanding within the context of the therapeutic nurse-client relationship and experience greater fulfillment with nursing care when they are truly understood (Sahttell & Hogan, 2005). A study undertaken by Chelf, Deshler, Hillman, and Durazo-Arvizu (2000) explored attitudes and beliefs of patients/clients about storytelling as a strategy for coping with chronic/terminal illness. The response rate was 70% (n = 94) where the findings demonstrated that 97% of the respondents agreed that storytelling was a helpful means of coping with their illness experience. Similarly, Clarke, Hanson, and Ross (2003) described the findings of a developmental study conducted over a 6-month period to investigate the introduction of a biographical approach to care. The findings revealed that life stories facilitated practitioners to see clients/patients as people, to understand individuals more fully and to form closer relationships with their families. The process of using the client/patients own language and definitions to reflect meanings in their narrative facilitates the fundamental standards of nursing practice - establishing a partnership as a basis for therapeutic relationships and promoting the individual health and wellness of clients and their families (Australian & New Zealand College of Mental Health Nurses Inc., ANZCMHN, 2003).

The processes of exploring the uniqueness of the individual is the cornerstone of phenomenological inquiry, where researchers attempt to describe the lived experience of individuals through narrative often using the individuals own words. Since phenomenological researchers attempt to describe and interpret human phenomenon, frequently in the words of selected individuals (the participants), it is important to be clear about their biases, presuppositions, and interpretations so that others can decide what they think about it all. Accusations of bias are not uncommon in the social sciences;
however, the term 'bias' is by no means straightforward in meaning. Sometimes, it is used to refer to the adoption of a particular perspective from which some things become salient and others merge into the background (Mruck & Breuer, 2003). Bias also refers to systematic error: deviation from a true score, the latter referring to the valid measurement of some phenomenon or to the accurate estimation of a population parameter (The Oxford Modern English Dictionary, 1996).

In phenomenological inquiry, it is necessary to talk about researcher presuppositions, choices, experiences, and actions during the research process in a sufficiently precise way so that it allows others to follow what was meant and the way in which it was done (Saunders, 2003). Without such reflection the outcomes of the research process may be regarded as characteristics of objects, despite their constructed nature that originates in the various decisions researchers undertake during the process of researching.

2.7 Phenomenology And It’s Relevance To This Study

The philosophical underpinnings of phenomenological thought are consistent with the values of nursing practice, and specifically mental health nursing - the uniqueness of the person, the importance of personal discovery, acceptance of life situations, the need for exploration of meaning of experience, constructed reality, interpersonal relating, and potential for personal growth. In essence, holistic care and the avoidance of reductionism is at the centre of professional [mental health] practice (Streubert & Carpenter, 1995, p34).

Phenomenological methodology utilises the person’s language to reflect meanings embedded in their own experience. It is a process that accepts the validity of the person’s descriptions and understandings, incorporates the perspective of the experience of the researcher, and produces an interpretative narrative of the experience (Giorgi, 1985; Solomon, 2001). In this context, phenomenology as a philosophical framework and methodology can provide knowledge about aspects of care that cannot be accessed by observation alone and has implications for understanding health. Since phenomenologists analyse social reality and how the usage of certain forms of knowledge contributes
existing knowledge, the phenomenological approach to inquiry suggests that we need to continually examine and re-examine our biases and presuppositions. From the sharing of experiences through dialogue is the connectedness we are looking for in phenomenological inquiry (Heidegger, 1962a). Phenomenology is based on the fact that the experience of individuals is somehow accessible, which we can come into through a personal interview. Colaizzi’s (1978) process is the only method that explicitly identifies para-linguistics as central to achieving clarity in eliciting a person's verbal descriptions of a phenomenon. In this context the method captures the nuances of what participants want to convey in their own words providing the researcher with a holistic view of the participant's responses. Colaizzi’s (1978) approach to inquiry is consistent with my own philosophical disposition and theoretical framework of clinical practice in which a holistic approach to communication is valued as foundational to understanding the lived world of clients. It is for this reason that Colaizzi's approach to phenomenological research was utilized for this study.

2.8 Summary
This chapter examined the theoretical framework of phenomenological research as applied to this study. The chapter initially discussed the philosophical foundations of phenomenological thought followed by an explication of empirical existential phenomenology as articulated by Colaizzi (1978a) – the process of analysis employed for this study. The next chapter provides a discussion of the methodology employed for this study.
CHAPTER 3- METHOD

3.1 Introduction
This chapter provides a discussion of the method employed for this study. The chapter begins with a description of the processes involved in participant selection, accessing the participants, method of information gathering, and information analysis. The chapter concludes with a discussion of ethical considerations for this study and how a rigorous approach to inquiry was achieved.

3.2 Focus Of The Study
For the purpose of this study, resilience was defined as; springing back, rebounding, readily recovering, [and] buoyant (The Oxford Modern English Dictionary, 1996, p 864) and the contextual understanding that resilient behaviours include faith, hope, humour and is supported by functional social networks (Edward, 2005a).

The objective of the research was to explicate the phenomenon of resilience as described by people who have experienced mental illness, using the over-reaching question as stated above, that is: What is the experience of resilience after experiencing mental illness?

3.3 Participant Selection
Those invited to participate in this research were people who have had an experience of mental illness (as diagnosed using the DSM-IV, 2000), and who had been symptom free for a period of six (6) months. Ten (10) - to fifteen (15) participants (accounting for attrition, or data saturation) were expected to form the cohort for this study.

The specific inclusion and exclusion criteria for participating in this research are listed below:
Inclusion criteria

- Between the ages of 18-64 years (that is, an adult demographic)
- An experience of mental illness as classified in the DSM-IV (2000)\(^1\).
- A period of remission\(^2\) for at least 6 months\(^3\)
- Be articulate in English
- Be available for three (3) separate meetings

Exclusion criteria

Participants who are under 18 years of age, unable to comprehend and read English or those demonstrating pronounced psychological distress will not be recruited. Participants will also be excluded if they have cognitive impairment that would influence their ability to understand the consent process.

3.3.1 Number of participants

Qualitative research usually involves smaller numbers of participants than quantitative research. Decisions are made around sampling in qualitative research for the explicit purpose of obtaining the richest possible source of information to answer the research question(s). Sampling in qualitative research is flexible and often continues until no new themes emerge from the data, a point called data saturation (Marshall, 1996; Ploeg, 1999; Tuckett, 2004, 2005). Put into practice, the number of required subjects (sic) usually becomes obvious as the study progresses, as new categories, themes or explanations stop emerging from the data (data saturation) (Marshall, 1996, p. 523). In this study data saturation occurred at 8 participants, that is, themes and explanations stopped emerging from the participant descriptions of the phenomenon under investigation.

---


\(^2\) Remission is defined as the…partial or complete disappearance of the clinical or subjective characteristics of a disease (Anderson, Keith, & Novak, 2002).

\(^3\) Most diagnoses of mental illness require symptoms to be present for a period of 6 months (Kneisl et al., 2004).
3.4 Accessing The Participants

Interested participants from the general community were invited to participate in this study by posting an advertisement in community newspapers/newsletters (see Appendix A). Initially the North East and Northern suburbs of Melbourne were the areas for potential recruitment due to accessibility for both the potential participants and the researcher for interviews related to the study. The recruitment strategy of snowballing was also employed. One participant was recruited by the advertisement process and the remaining participants were recruited using the snowballing method.

3.5 Information Gathering

In keeping with Colaizzi’s (1978a) approach to inquiry, information was gathered through in-depth, semi-structured individual interviews lasting between 30-60 minutes. The following is an outline of the process of engaging participants and information gathering:

1. An initial contact either by phone or in person was arranged with potential participants for the purpose of providing an explanation of the study using the plain language statement (PLS – Appendix B) to ascertain if participants wished to proceed and obtaining signed consent to participate in the study.

2. A second contact time was for undertaking the interview for narrative audio taping. The interview took place at an agreed time and venue between the researcher and the participant. Prior to commencing the interviews, this researcher spent time in quiet general conversation with each of the participants as a means of creating a comfortable environment in which the participants would feel at ease talking about their experiences. Participants were encouraged to speak freely about their experience of resilience in the context of recovery from mental illness.
3. The focus question in this study was:

What is your experience of resilience following mental illness?

*Prompting questions used to encourage the participants to elaborate on their experiences were:*

Tell me about your thoughts and feelings related to these experiences?

Can you give an example of the strategies of resilience you used, such as springing back, readily recovering and remaining buoyant?

4. A final meeting was scheduled with participants. The purpose of this meeting was to validate the transcriptions of participant’s individual narratives. Participants also had an opportunity to include any information that they wished to add to clarify their intended meaning. This meeting took place at an agreed time and place between each participant and the researcher.

3.6 Information Analysis

Information analysis was undertaken using Colaizzi’s (1978a) seven-step phenomenological approach as a basis. Additional steps were included in this study and were steps three(3) and four (4) - a summary of the essence of each participant’s intended meaning as interpreted by the researcher and a written presentation of images of resilience as articulated by participants, respectively. These additional steps created a nine-step process and have been included for the following rationale:

Providing a summary of the ‘essence of the intended meaning of individual participants’ offers a synopsis of the unique experience of the participant, thus providing a deeper understanding often sought through phenomenological inquiry. Additionally, obtaining a description of the image of resilience from individual participants offers an insight into
the mental picture of the intended meaning of participants, and hence better insight for
the researcher of what the experience is for that person. Searching for a deeper
understanding of a person’s unique experience is the cornerstone of phenomenological
research, since phenomenological inquiry identifies the essence of a phenomenon and
accurately describes it through the person’s lived experience (Giorgi, 1985; Husserl,
1965; Merleau-Ponty, 1956). The additional steps to Colaizzi’s (1978a) analysis process,
as presented in this study facilitates humanistic understanding, congruent with the ideals
in health sciences (Husserl, 1965; Kim & Kollak, 2005; Merleau-Ponty, 1956; Solomon,
2001).

The following provides an outline of the nine-step approach to analysis in this study:

1. Transcribing all the subjects’ descriptions.

In this step of the analysis the narratives of participants are transcribed from the
audio-taped interviews held with each individual. According to Colaizzi’s (1978a)
process, the narratives do not need to be transcribed verbatim, as long as the essence
of what the participant was communicating is caught in the transcription. Individual
transcriptions were then validated by the each participant [for their own narratives].
This process of validating the transcription ensures that the essence of what each
participant has expressed is captured. Any discrepancies or omissions identified by
participants in the transcriptions were corrected and/or included by the researcher.

2. Extracting significant statements [statements that directly relate to resilience].

Any statement in the participants narratives that related directly to resilience are
considered significant. Significant statements were extracted from each of the
narratives and numbered. The significant statements are numerically entered into a
list (i.e.: 1, 2, 3, 4…) that is, an assemblage of all significant statements.
3. Summary of the essence of the intended meaning of the participant as interpreted by the researcher – *This step is an additional step I have inserted into Colaizzi’s (1978a) original seven-step process.*

A summary is offered by the researcher related to the essence of the intended meaning of each participant. The summary is created from the significant statements of the participant and is intended to capture the essence of what that particular participant intended to say. This understanding can offer depth of understanding for about the experience for individual participants further to what would have already been obtained by using Colaizzi’s seven step analysis. The researcher’s summary of the essence of intended meaning for each participant also provides a context for the researcher when interpreting the narrative data throughout the analysis process.

This additional step to Colaizzi’s (1978a) approach also provides an opportunity for the researcher to create a definition/fundamental structure of the essence of intended meaning of the notion of resilience as described by people who have experienced mental illness. At the end of the analysis two definitions were generated (one from the significant statements and subsequent steps in Colaizzi’s (1978a) seven step analysis, and the other definition from the summary of the essence of intended meanings) – these definitions are compared to each other to see if there is consistency between the definitions in terms of the description of the experience of resilience. This further and additional step contributes to the rigour of the analysis process undertaken in this research, specifically confirmability (Guba & Lincoln, 1985; Holloway & Wheeler, 1997). To enhance confirmability through this step this researcher is able to demonstrate that information, interpretations and outcomes are rooted in contexts and persons apart from the researcher and are not simply figments of the researcher’s imagination.

4. Images of resilience as articulated by participants – *This step is an additional step I have inserted into Colaizzi’s (1978a) original seven-step process.*
The images of resilience offer a further depth of understanding of the unique experience of resilience from the perspective of the participants. Jackson and Stevenson (2000, as cited, Sahttell & Hogan, 2005) suggest the notion where understanding is guided by participants own definitions to achieve a clear understanding of the person’s perception. The philosophical underpinnings of phenomenological thought are consistent with the values of exploring the uniqueness of the person and the need for exploration of meaning of experience (Edward, 2006; Merleau-Ponty, 1962; Solomon, 2001). These understandings are enhanced by the introduction of what the image is of resilience for the person in their ‘mind’s eye’.

This additional step also enhances the rigour of the study specifically, credibility (Guba & Lincoln, 1985). In the process of ensuring credibility, the process of triangulation can be undertaken in a bid to elicit the various and divergent constructions of reality that exist within the context of a study. This additional step offers a point to collect information about different points of view by asking different questions.

5. Creating formulated meanings.

In this step of analysis, Colaizzi (1978a) recommends that the researcher attempts to formulate more general re-statements or meanings for each significant statement condensed from the participant’s narratives. This process is undertaken in this research by examining and formulating meanings of the significant statements of individual participants (Step 2 of this analysis) and by acknowledging my own presuppositions (articulated in chapter 6 of this thesis). Ashworth and Hagan (1993) highlight the need to recognise any presuppositions, as this will help avoid misinterpretation of the participants’ intended meanings. A critical and initial aspect of data analysis is phenomenological reduction or “bracketing”. According to Husserl (1965) and Heidegger (1962a), bracketing is essential, since it is only when this has been accomplished that more specific investigations can begin. For the
purpose of this study bracketing was achieved by keeping a reflective journal (included in this thesis as chapter 6) to enable me to explore my own suppositions and biases, in order to set them aside rather than concealing them, enabling me to focus the direction of my thinking. This was particularly important since intuition, and reflexivity are central to achieving a common understanding of the phenomenon under investigation (Colaizzi, 1978a).

6. Aggregating formulated meanings into theme clusters.

Colaizzi (1978a) suggests that the researcher group formulated meanings into groups of similar type. In other words, the formulated meanings are grouped into theme clusters. That is, some statements may relate to, for example, faith while other statements relate to self-awareness and so on. In this step the formulated meanings were grouped according to themes.

7. Writing exhaustive descriptions [that is, comprehensive descriptions of the experience of resilience as articulated by participants from aggregating formulated meanings and themes].

Colaizzi (1978a) advocates that the researcher should integrate all the resulting ideas into an exhaustive description of the phenomenon under study. In relation to this research, the exhaustive description is presented, and contains all the dimensions of the lived experience of resilience from the personal perspective of the participants interviewed. Each exhaustive description was created by incorporating the emergent themes, theme clusters and formulated meanings to create its overall structure.

8. Identifying the fundamental structure of the phenomenon.

A fundamental structure/definition of the phenomenon of resilience as experienced by people who have had mental illness is constructed. This fundamental
structure/definition is a compilation of all the exhaustive descriptions created through Colaizzi’s (1978a) method.

In addition, the summary of the essence of the intended meaning of each participant as interpreted by the researcher (step 3 in this analysis) provided an opportunity for the development of a second fundamental structure/definition of the phenomenon of resilience as described by people who have experienced mental illness. Therefore, two fundamental structures/definitions related to resilience were generated.

9. Returning to subjects for validation.

A follow-up contact was made between the researcher and participants for the purpose of validating the fundamental structure that emerged. Any required alterations were made according to participant feedback to ensure inclusion of their intended meaning was conveyed in the fundamental structure of the phenomenon. This follow-up contact for validation purposes allows the participants to ensure the essence of their intended meaning has been captured (Colaizzi, 1978a).

3.7 Informed Consent

Each participant received a full explanation both verbally and in writing [using a Plain Language Statement (PLS)] about the study’s purpose, the information gathering process, time commitment of participants, assurances of anonymity and confidentiality, their right to withdraw at any-time without prejudice and, that the findings of this study will be published at the completion of the inquiry (Appendix B). Written informed consent was obtained prior to commencement of the interview (Appendix C).

3.7.1 Anonymity

Total anonymity was not possible in this study since the researcher knew the identity of the participants. However, in an effort to provide a level of anonymity participants were
not known to anyone else except the researcher, participants were recruited from the general community and did not have a relationship to each other, the researcher or the supervisors of this study. Participants preferred to have a P1, P2 etc; type of pseudonym allocated (note: the order of participants was only known to this researcher). Pseudonyms were used in all transcriptions.

3.7.2 Confidentiality
Participants were assured that I would be the only person who would have knowledge of their identity (the principle investigator). Participants were also informed that coded tape-recorded material would be accessed by this researcher’s two supervisors, for the purpose of recording experiences and analysis of the narrative data. The participants were further informed that on completion of the analysis process the coded tape-recorded narratives will be returned to RMIT University for storage. The researcher informed participants that any names or places would not be used in the final transcriptions and would thus be withheld in the final presentation of the thesis.

3.7.3 Storage of information
Throughout this study all information shared by participants was stored in a locked filing cabinet within a locked office of the researcher. As previously mentioned, in accordance with the policy and procedure of RMIT University Human Research Ethics Committee, on completion of this study all information obtained from the participants in the form of audio-transcriptions would be returned to RMIT University for storage for a period of five years. After this period of time, and in accordance with RMIT University policy for destruction of confidential information, the information will be destroyed.

3.7.4 Level of risk
Participants were asked through this study to share health, sensitive and personal information in relation to their experience of resilience following mental illness. Given the personal nature of what was being asked of the participants, I believed that the
potential existed for participants to experience some discomfort while reflecting on their experiences. In consideration of such a situation occurring, a number of strategies were set in place as contingencies, as follows:

- All participants were informed prior to interview that they can withdraw from the study at any time without prejudice, and that any information they have provided would not be used for the study unless their explicit permission is obtained.
- Debriefing would be offered if requested or otherwise indicated by the researcher in the first instance. The researcher is a registered psychiatric nurse of 21 years experience, and holds an undergraduate degree in Psychology. In this context, the researcher is experienced in offering support and debriefing for people who experience psychological and/or emotional discomfort.
- If ongoing debriefing or counselling was required by participants, the researcher would broker and link the individual to a qualified psychologist local to the Northern and North East Areas of Melbourne metropolitan (Appendix D), or a therapist of their choice. This was not required by participants in this study.
- At the close of the interview this researcher spent time with each participant to ensure that they felt safe and were comfortable with the information they had shared.

The following table (Table 1) outlines all of the potential risks and contingencies considered throughout this study.

<table>
<thead>
<tr>
<th>POTENTIAL RISK</th>
<th>STRATEGY FOR PROTECTION FROM RISK OR MINIMIZATION OF RISK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Disclosure of sensitive, personal, social and health information</td>
<td>➢ This researcher is a sensitive and skilled registered psychiatric nurse and</td>
</tr>
</tbody>
</table>
holds an undergraduate psychology degree, with over 21 years experience working with individuals who have experienced mental illness of both psychotic and non-psychotic types.

- Participation in this study was entirely voluntary. Participants were only participating because of their own choice and interest.
- Participants were assured that confidentiality and anonymity would be maintained (see below).
- The reason for the study, collection, storage and use of data was discussed with each participant, and also explained to participants in the Plain Language Statement (PLS).
- Participants were advised that they did not have to discuss anything they felt uncomfortable about, or any issue they did not want to talk about.
- If participants requested the tape turned off during the interview process for any reason (such as, to gather their thoughts), the researcher would turn off the tape.
- The researcher would refer participants to a Psychologist, or a therapist of their choice, for ongoing support and counselling services if this is
Confidentiality and anonymity

- Anonymity was assured by removing all identifying details. Participants had the opportunity to choose their own pseudonyms, however participants elected the researcher allocate a pseudonym – P1, P2 etc was allocated to participants.
- The reason for the study, collection, storage and use of the data was discussed with each participant, and also explained in the PLS.
- Participants were assured that confidentiality would be maintained. Participants were advised that their information would only be disclosed if the following occurs: In the event as a health professional where I was concerned for their well-being. I would discuss this with them and assist them to obtain appropriate professional support.

Participants may change their mind about participating in the study

- During the process of obtaining informed consent, participants were advised that they may withdraw at any stage and that any data collected from them would not be included in the study results, without their explicit consent.

Participants may come to rely on the researcher as a ‘listening ear’ and wish

- During the process of obtaining informed consent participants were
| to continue the relationship after the third interview has been completed. | advised that the researcher would be available to discuss any concerns related to the study.  
- Participants were advised that the researcher could broker and link them into an ongoing support service should they require such a service as a consequence of participating in this study.  
- The participants were advised that the researcher was not in the role of an ongoing support person. |
| Making an audio-tape recording of the interview with participants may make some participants feel anxious about the use of the tapes and access to the tapes by others not agreed to in the written form. | ➢ The reason for the study, collection and storage of the data was discussed with each participant and also explained to participants in the PLS.  
- The researcher strictly adhered to stringent guidelines for research practice. |
| Participants excluded from the study after the researcher considers the inclusion and exclusion criteria may fell left out and disappointed. | ➢ Potential participants were advised in the instance of not meeting the inclusion criteria, that they were excluded according to the exclusion criteria in order to prevent potential harm to them. |

### 3.8 Rigour Of The Study

The place of validity and reliability in phenomenological research has been the source of considerable debate in the scientific community (Brink, 1991; Sandelowski, 1993; Van Manen, 1990). This debate is generated in terms of paradigm differences, where
quantitative and qualitative researchers use different methods, concepts, theories, techniques, social processes and institutional structures that determine what are legitimate problems and solutions in a field of scientific inquiry.

The process of empirically based phenomenological inquiry proceeds through three stages, as follows; the formulation of the research problem, the collection and analysis of data, and the communication of one’s findings. Literature that relates to phenomenological methodology largely focuses on the essential moments of interpretation (Hayes, 1997; Heidegger, 1962a; Husserl, 1965). The results that emerge are described as a description of a lived experience. The form and content of phenomenological findings, the actual steps of an existential-phenomenological process is of less focus in literature, but has been described by authors such as Cohen, Colaizzi, Giorgi and Husserl (Cohen, 2001; Colaizzi, 1978a; Giorgi, 1992; Husserl, 1999). The description of the phenomenon is, in these authors context, an interpretation of the individual’s lived experience. The interpretation is the working out of possible meanings that have been projected in advance by the researcher’s understanding of the lived experience. In other words, the researcher is not a tabula rosa receiving impressions from the data, but guided by anticipation from their own presuppositions, which are articulated throughout the research process to enhance rigour.

Arie Cohen (2001) describes the steps in empirical existential phenomenology as follows:

1. Emphasising the commonality that is present in the many diverse appearances of the phenomenon.
2. Reliance on the actual words of the participants
3. Explicitness about the design and the steps taken to obtain the findings.
4. These characteristics leads to verifiability and ability to be replicable.
5. Stressing more on rigour of the approach than on its creative aspects.
6. Acceptance that hermeneutic activity (interpretation) is intrinsic process of research

Rigour in qualitative inquiry according to Van Manen (1990) suggests phenomenon is best described through the art of writing and re-writing. In this context, the rigour in
qualitative research is achieved when phenomenological description is collected by the researcher which recollects the experience. In contrast, Sandelowski (1993) argues that reliability of the individual’s descriptions and reviewing are threats to validity in qualitative inquiry. According to Sandelowski (1993) descriptions are memories of past events that are told in the present moment and participants often change their descriptions from one account to the next, however in reality it is the same experience retold as if a new experience. Rigour in qualitative research is purported by Sandelowski (1993) to be more about fidelity or trustworthiness of the essence of a phenomenon.

In earlier works conducted by Guba and Lincoln (1985), the rigour of qualitative analysis was the focus of inquiry. Guba and Lincoln (1985) also posit that trustworthiness of the information allows for greater rigour in qualitative research, and offered a general framework for assessing trustworthiness of qualitative information, which consists of four dimensions: credibility, transferability, dependability and confirmability. Congruent to the methodology used in this research Guba and Lincoln’s (1985) framework for enhancing rigour was applied to this study.

### 3.8.1 Credibility

The focus of credibility is on establishing the match between the constructed realities of participants and those realities as represented by the researcher. Credibility can be established by prolonged engagement; persistent observation; peer debriefing; negative case analysis; and participant checks. Adhering to the theoretical guidelines required for the methodology chosen for the study also enhances credibility (Holloway & Wheeler, 1997). Vigilant attention was given to the seven steps in information analysis as developed by Colaizzi (1978a), including to the additional steps built-in by this researcher.
3.8.2 Transferability

Transferability depends on the degree to which salient conditions overlap or match. This is mostly verified through ‘thick’ description. The researcher does not provide the confidence limits of the study, but instead provides a database in order to facilitate transferability judgements on the part of others. This was achieved by the researcher providing a clear and comprehensive decision trail throughout the study (Guba & Lincoln, 1985).

3.8.3 Dependability

Dependability is concerned with the stability of the information over time with a need to be able to demonstrate any changes or shifts in the way in which the inquiry was conducted. Koch (1994) suggests that dependability of a study (as opposed to consistency) is for the study’s process to be audited. The supervisors to this study scrutinized each stage of the research process to ensure that a clear audit trail was maintained.

3.8.4 Confirmability

To achieve confirmability the researcher needs to show that data, interpretations and outcomes are rooted in contexts and persons apart from the researcher and are not simply figments of the researcher’s imagination. All data needs to be tracked to its source and that the logic used to assemble the interpretations into structurally coherent and corroborating wholes is both explicit and implicit in the narrative of the experience. All aspects relating to methodology has been clearly outlined in this study to demonstrate confirmability (Sandelowski, 1993).

3.9 Summary

This chapter provided a discussion of the method employed for this study. The chapter began with a description of the processes involved in participant selection, accessing the
participants, method of information gathering, ethical considerations and information analysis. The chapter concluded with a discussion of ethical considerations and rigour for this study. The next chapter provides the findings of the study and includes significant statements relating to resilience from the interviews, theme clusters aggregated from the formulated meanings, an exhaustive description of the phenomenon of resilience and the fundamental structure of the phenomenon as described by participants who have experienced mental illness.
CHAPTER 4- RESULTS OF THE STUDY

4.1 Introduction
This chapter presents the results of the study. The chapter begins with an overview of the context of participants in this study followed by the significant statements relating directly to resilience from the participant interviews. The chapter continues with a presentation of articulated theme clusters aggregated from the formulated meanings, and exhaustive descriptions of the phenomenon of resilience. The chapter concludes with a presentation of two fundamental structures of the phenomenon of resilience – one fundamental structure developed from Colaizzi’s method for analysis and the other fundamental structure developed from the additional steps included by this researcher.

4.2 Participant Context
There were eight participants involved in this study. Of the participant cohort 3 were male and 5 were female. The age range of the participant group was between 18 and 57 years. Each of the eight participants had experienced at least one of the following mental disorders; Depression, Bipolar Affective Disorder, Anxiety States with Panic, Post Natal Depression, Sexual Identity Crisis and Personality Disorder. Four of the eight participants had co-morbid conditions associated with their mental illness. Participants represented a mixture of those currently employed, unemployed and on disability support pensions.

4.3 Significant Statements
Any statement in the participants narratives that related explicitly or implicitly to resilience are considered significant. Significant statements were extracted from each of the narratives and numbered.
Participant 1 - Significant statements

1. [To start bouncing back] it was important for me to know what led me to that point.
2. The psychiatrist telling me that the problem first of all wasn’t mine, that it was a very dramatic environmental problem, helped me to be resilient.
3. There were a couple of people that I confided in and I think that was one key element [to being resilient].
4. Being able to confide in people and say ‘look this is where I’m at’ [helped me to cope].
5. You [I] were[was] on less of an island [when I had the support of others].
6. People who you can initially confide in who are going to understand [helped me to adapt].
7. [Being resilient is] just a case of having to be active
8. [To adapt to having a mental illness you can] not sit around and just do nothing.
9. I gained the ability to step back and look and see what has happened [which gave me strength].
10. It wasn’t until I had broken that cycle that I was able to reflect on what had happened.
11. Taking the focus away [helped me to be resilient], and benchmarking somewhere that you don’t want to get to again.
12. It [being resilient ] was that period of enlightenment which was brought about by the psychiatrist, psychologist, and my realisation based on things that they told me. It really made me be resilient. And it made me want to resist returning to a situation like that.
13. So I guess once I was back controlling the work I was doing that was a critical step, because now I was back in control.
14. [Being resilient is having] a way of proving to yourself that you’re not out of the game, that you are able to contribute and participate, that you still have something to offer. Getting back in the saddle again.
15. [Resilience is] a belief in yourself… is an emotional thing.
16. I think it’s [resilience] optimism, hopefulness and naivety all rolled into one. A lot of it is imaginative too. I don’t know; maybe it’s not paying attention to all the details.

17. It [resilience] probably does have something to do with the ability to learn.

18. I think that being intelligent and able to grasp concepts is helpful to being resilient, but not essential.

**Participant 2- Significant statements**

1. I had to be in charge of myself [to survive, to be] responsible. I can remember it clearly, going out to the car park after I had seen the specialist and just crying the grief out. In [feeling a sense of] relief that there wasn’t a cancer. It was cathartic [for me].

2. Acknowledging what it [the mental illness] was. Giving it a name and knowing why I was going through that … Then seeing it for what it was and why it was. You know, I was just blinded to it…acknowledging the grief, that I could grieve.

3. It [knowing what I had] was such a relief, a catharsis. Such a catharsis. It was like a bolt of lightning.

4. To be able to intellectually see it for what it was made it very clear. I suppose for other people they are unable to make that connection. That is when it [mental illness] becomes chronic or more severe over time.

5. I don’t think I allowed enough time for the grief or the loss of the relationship.

6. It was the sleep [that helped me cope], having it out through the catharsis and allowing me to grieve.

7. Being with friends, being of the world, and having my quite reflective time. Being able to lose myself in my interest, my study, it was personal development stuff and self knowledge. It [being resilient] was personal development at that time. Self knowledge.

8. [In recovery] I became strong, I felt very strong. It came from my mind and emotionally I had that cathartic sorting out; a little bit of a tantrum and got it out.

9. I could see that there was something beyond, that this was a new chapter.
10. It [feeling resilient] was as if other things weren’t intruding, it wasn’t la-la land by any stretch, but I felt that I could deal with the disappointments and having the forward planning kept me moving forward. Having full knowledge that it was going to work out.

11. I had lots of people around me, some people get divorced and find themselves alone, but this wasn’t the case for me. It [having people around] helped me restore the balance. It was a good recipe; it ended up being the best of times.

12. It [resilience] was about working through the negativity and healing.

13. I can honestly say I have never looked back and I grew through it.

**Participant 3 - Significant statements**

1. I have to say that I have undertaken cognitive behavioural therapy for about 15 years. I think this is a really significant fact, because it [being resilient] really has to do with the way you think about things.

2. Broadly, I absolutely refuse to be a victim.

3. I have had more severe situations than most people have had. But I don’t see that as “what’s happened to me, why has this happened to me?” I see it as an opportunity to develop a broader experience of the world.

4. I just feel that people can sometimes define themselves by their problems instead of that wholeness of themselves. And I think that your [my] problems enrich you [me] rather than damage you [me].

5. Another thing about being resilient is at the same time as not being a victim is recognizing your vulnerabilities and working around them.

6. I think that the first thing that you have to do [to be resilient] is acknowledge that you have a mental illness... Then, once you have acknowledged it, educate yourself thoroughly about it.

7. I’ve done that adapting [to be resilient] and I’ve done the adapting with no money. Money makes a big difference, poverty is absolutely the pits.

8. I realized with great pride what I had gone through. On a scale of one to ten of being in a position to cope with life, I would say that I’m down at about 3, but I’m functioning emotionally as if I’m about 8.
9. When the depression hits …what I do is, I say [to myself] ‘there is all of this to do, and one day I will do it’. I get through life by basically doing things in very small components.

10. I get through life by basically by doing things in very small components. I look at every little thing and think ‘does it matter?’ for example, there is nothing decent to eat, ‘does it matter?’ there are Weetbixs [trade name for cereal] and there’s milk, that is ok for today.

11. The sad aspect of coping is the self sufficiency, because that’s just been the result of learning to be disappointed in people. But I don’t go, ‘boohoo, people are horrible’. I just think, ‘Oh shit, I took a long time learning that lesson didn’t I?’

12. …self reliance is really huge [in being resilient].

13. The other thing that helps me enormously [to cope] is being organized. Because if you’re organized you don’t have the stress of trying to disentangle something so you can do what has got to be done.

14. You don’t try to organize anything that you can’t control [to keep a balance in life].

15. Every time I’d find myself tensing up and thinking ‘what’s happening?... This has got to happen’, I just say to my self, ‘ok, I can’t do anything about it’.

16. I try and make sure that I engage with the world every day [to remain resilient]. I think that’s vital, hence going for coffees. People would say, ‘you could have a coffee at home’. It’s not the coffee, it’s the going out.

17. I get support from them [support groups] - I feel courageous in those sort of environments …It’s [being resilient] is being amongst people.

18. [I think I am resilient because] I was just as ‘mad as a snake’ but I was still working; I was doing my job ok.

19. One of the things you need to be resilient is the general public, your friends.

20. I had to adapt to those situations [when I was in a manic state].
Participant 4 - Significant statements

1. Before I knew the word depressed I had no word. I thought that it was just who I am, that I would be this person and I thought ‘well that’s fine’.

2. I found music and I thought that music might be a really good way of expressing myself. For some reason music was good for me.

3. To this day I still don’t know how I am still here. What method kept me alive? Then I started thinking, maybe the music…it definitely helped [me to bounce back].

4. I met friends that were in the same situation as me and that kind of made the situation a bit better [for me].

5. I find songs that relate to how I am feeling. I play [music] with all my heart and it does help a lot.

6. I needed music to express myself.

7. I thought that I would be really sad and not talkative. But for some reason I bounced back today and [I am] talkative and stuff. I don’t know how to describe it.

8. I [knew I ] should just accept it, and that you know how to deal with it and you deal with it that way.

9. I just accepted it. You either take it [being depressed] or not. You know? It’s like I am aware that you can’t change some things. That the path is set before you and you need to take it regardless.

10. I worked so hard to change it [depression] and there was no result that I was happy with. So I thought maybe I should let life take me where I am supposed to be. I spent all my life fighting and I just don’t understand so I think, ‘just take it as it comes’.

11. I take each blow by blow; cope with it. Learn from it hopefully.

12. It [acceptance] is when the situation is happening and you can’t change it and there is no use changing it because it won’t work. That is my theory.
13. Talking with friends helps [with coping] a bit, but this is your [own] life - no person in the world can change it for you. That is one thing I have to accept. I can’t let anyone run my life for me.

14. For my whole life I have been fighting it [depression], taking big steps, so I started thinking maybe I should start taking it slowly, very slowly. Another thing I have learned is to consider the responsibility and the consequences of my own actions.

15. I realised the word depression and I thought ‘oh, that’s something different’. And then things started to change afterwards. Knowledge is power. It gave me the ability to know, ‘oh, I am having this, I can do something about it’.

16. [I realised] there are people to relate to who have had the same problem [as me]. It [being resilient] was accepting that I wasn’t alone.

17. I can actually describe myself as having two personalities. Like, the balance of life, ying-yang, yes-no kind of thing. What my friends would usually see is this fake me. I would smile and be who they liked me for. But they don’t see my other side which is the sad person, who I have been for most of my life.

18. My true side. The person who is sad, non talkative. I can’t be happy [with] that side so I have to use the other side so I can be happy.

19. I don’t hide it [my sadness] from myself I only hide it in the presence of others -. But it’s my way of resisting more stuff. I do it so I can hold on to hope.

20. I think that I have knowledge to understand myself. I think this is what is keeping me here; otherwise I would have killed myself ages ago.

21. [I think sometimes] maybe I have a third side, like the really stupid one. The one that has hopes in the world. The fool in a way.

22. Being the fool means that you do not think at all; you just do not think of the consequences. You know, go straight through it.

23. Through the darkness of depression I had a very tiny piece of hope. I had to access my hope. I found I could get hope from my fool [personality] side.

24. I only access my hopeful side if I am depressed. I like positive thinking.

25. I think to myself, ‘you have to stop being sad, there is someone out there for you ok’, you know, [I use] self talk.
26. Sometimes I use self talk [to comfort me], like I question myself. For example, What happens if I wasn’t who I am? What would happen if I didn’t realise the word depression? What happens if I stop playing music?

27. I can’t have my friends there 24/7, I can’t have my parents there 24/7. I can only have myself there 24/7 and I think that acceptance helped make this new hopeful person talking to me [through self talk].

28. I talk to myself. It’s like, the only person who accepts you is yourself; The only person who agrees with you is yourself.

29. If I don’t have music then I have nothing to comfort me so I would probably start using self talk [to comfort me when I am depressed].

30. I realised taking baby steps may not be helpful for me.

31. Self talk for me gives me a feeling of comfort, I have my own issues and I have to deal with them myself. It gives me a feeling of being able to bounce back, and I think that I have been able to do this innately.

32. I generally get over the small things really easy. I feel more able to deal with things as I get older.

33. As I get older I have more knowledge. I think also I have all this time to myself, and you tend to think a lot when you are on your own [which helps me to be resilient].

34. I have found that there is no such thing as a free lunch- you know what I mean? Like there is no such thing as free help so you have to do it on your own. I tend to be self reliant emotionally and mentally.

35. I have to deal with it on my own. I am capable of dealing with situations but it takes a lot of effort.

36. It [the Tarot] gives me answers; it gives me a spiritual opening. Like, for some reason the cards describe me. If I pulled out a card I could designate bits of myself with a card. The tarot is about lessons and descriptions of something and some form.

37. [Resilience is] Spirituality, knowledge, of course knowledge. It [the tarot] then provides me with answers and a bit of hope again.
38. [I think of the] consequences, there are possibilities … either way they will be good or bad for me.
39. [I bounce back by thinking of] the hope of being happy even if I don’t have someone. I thought that one day I would be happy, that I would be happy regardless.
40. You are better off having different forms of being resilient. People think it is one thing but I don’t think it is.

Participant 5 - Significant statements
1. I must have started getting [on a] better track because I was able to make the decision of ‘no this isn’t working, I need to do something’… I was able to make the decision
2. I knew that I needed some help
3. It’s [being resilient] like a tiny little spark …. It’s not big enough to change your whole everyday but it just leads you… like a star…. You know you follow the star… it’s like this little thing that says alright you need to do something. It was [my] resilience saying ‘come on get out of this’.
4. Every step that you take every day it’s just like let’s just get another day over with do what you have got to do to get through it …
5. [Being resilient with a mental illness] is like saying ‘hang on, my life’s gone… so first deal with what’s going to happen’.
6. Going back to the resilient thing … you don’t want your child to miss out on anything. You want them to have everything possible and you want to do the right thing by them… [I knew] my child was really going to end up with nothing if I don’t fix this situation.
7. [Being resilient comes from] knowing that you have to do something to change the situation
8. I just took control because I had to… it was like there was no other option
9. I knew there’s something better for me even though I couldn’t see it properly and everything [appeared] wrong
10. I think you know when your ready to be yourself again.
11. Resilience comes from meeting with people in similar situations and them telling their stories
12. [I found strength by meeting with others]…we were all in the same situation and it is about the support
13. [Being with others who had a similar experience] made me feel normal… made me feel like ‘whoa’ I can share this stuff,
14. [I felt hope because] I just knew that this wasn’t where I was meant to be
15. But you can’t go on what they [the doctors] tell you either they will say 2 years or 3 years … but you have to really get to know yourself…
16. You need to have medication and counselling [to recover] you generally cannot do it on your own …it helped me to come out of it [the symptoms of mental illness].
17. I know a lot more about myself… I would know how to stop it and how to fix it
18. Some really good friends who I’m really close with and so that obviously helps. [Being resilient] is having bonds with other people… it’s about living the normal life …
19. It [being resilient] is like you have all these separate lives you need all those different areas or life cannot improve.
20. Self knowledge…absolutely [can help you be resilient].
21. It [resilience] must be your strength inside yourself… maybe it’s a spiritual thing or a heart thing or like a love for something
22. [Being resilient] is courage
23. It [being resilient] is like [seeing] the light… there’s a light at the end of the tunnel and I just have to get through all this rubbish to get there
24. I’m so much stronger and I don’t care what others do to me because I’m going to get through this…I have had worse
25. [resilience] is like an inner strength
26. I am in a relationship now…I’m not relying solely on me anymore - there are two of us. I’m balancing it out, but I know if he [my partner] goes tomorrow, I’ll be okay.
27. It [being resilient] is that you just have to deal with it
28. Its like in my case, getting better, you just have to. It’s like there’s no option … like I’m not failing… so you just have to.

29. I was really close to my Nan and she passed away. All through that time I just knew she was there and maybe guiding me a little … maybe even thinking about her watching me through this state made me come out of it …

30. I think it is the people in your life though that make you head for something or change or make you see there’s another way around something

31. [My spirituality] lets me know that life is going to be ok… It’s going to be alright no matter what.

32. I’m more courageous than I was before. I don’t know the proper meaning of courage. Maybe it is a strength thing.

Participant 6 - Significant statements

1. What I used to bounce back was the thought that things might get better in the end. That my life isn’t a waste…

2. I actually sat down and was ready to commit suicide and I thought ‘What would happen if I did?’ ‘What would happen in the future if I did?’

3. I thought I may be in the dumps right now but I could move onto bigger and better things.

4. I thought hang on am I acceptable to myself? To be acceptable to myself is the most important thing to me, so I can’t be anything but myself.

5. I’ve learned to grow… I’ve learned to take punches… I’ve learned to bounce back as a result of hard times

6. Being more mature gave me the ability to think beyond the immediate time, to think hang on things can change people can change

7. Once you learn to appreciate yourself other people really don’t matter, they’re just there for company

8. I learned at a young age to respect myself… no one respected me so I only had myself to comfort
9. There are different ways of dealing with it [stress]… Like listening to music that actually means something to me, and listening to other peoples stories. It helps me feel more positive [resilient].

10. If you see someone’s vulnerability it helps you to move on because you can share your story with others and [I have found] people do understand

11. [when] I am listening to music by myself and the words are relevant to me and I am alone, no one can tell me that I am wrong [or do not belong] … I am just myself. I am alone and perfectly myself.

12. To me friends are extremely important ingredient to get over your depression

13. I have a really strong relationship with my mum… we can really talk.

14. It’s extremely important to have a good family … my immediate family is awesome and I thank God for that.

15. I’ve learned to be more myself

16. I accept myself.

17. It’s an awful feeling not being accepted. I need someone to talk to, someone to understand me and I think I am getting that now.

18. I think I’ve sort of learned to roll with the punches a bit more now

19. You have to be accepting of people and I think that if you can give a bit of lee-way and let people make mistakes and say oh well, you made a mistake you’ll be a better person

20. I got depressed and had bad thoughts… awful thoughts… I do not accept them now… I’ve learned to say life’s full of mistakes.

21. It is important to be real to yourself. Others might not like it but you have to be real you have to accept yourself. Then you can adapt to life better

22. Other people are going to make mistakes and you might not like it…

When I realised this it my mind set changed and I evolved.

23. I completely believe that the hard times teach you how to be better in the future

24. My sense of hope comes from inside myself

25. As soon as you get something in your mind anything is possible. You have just got to work at it just so it happens because anything can be achieved
26. People have told me I’m very accepting and easy to talk to because I’ve been through hard times
27. [Helping others gives me a sense of hope] … if I’ve done nothing and I haven’t changed the world and I die tomorrow having done nothing… I could have changed someone’s life and made it better. Because people make my life better
28. [when I make] a difference to one person makes life worth it…gives me meaning
29. [talking with friends] makes me feel I belong in that group
30. I think hope is resilience because the hope that you have will guide you through life through all the hard times
31. You might have a bad day, you might feel like absolute rubbish, you might feel like killing yourself, jumping off a cliff but it’s the thought that tomorrow might be different that gets you through it
32. [being resilient] is constant learning
33. I think every day is a new adventure and every day is a new one and thoughts change all the time.
34. I think if you appreciate yourself it is the key to moving beyond…
35. I’ve learnt through being alone that really you can only really depend on yourself. People may like you today and then not like you tomorrow.
36. It’s all about being at peace with yourself and bouncing back
37. You’ve got to look forward and forget about the bad
38. If you keep your problems inside its going to churn your mind and churn your guts and you will not have the relief. I talked to my mum… she’s a lot like me we’re …I always feel like I belong with her.

Participant 7 - Significant statements
1. I had come to the realization that I did not want to die, that I needed to do something about it - to get my emotions back in check.
2. What I did was I quit my job, tried to look at the positive things that would give me back my confidence again so I got another job
3. [Resilience is] coming to terms why you felt that way and then accepting that’s in the past and moving on
4. A thing that a lot of people struggle with, not everyone is a perfect speller, not everyone is a perfect reader, so be it. So that [knowledge] in itself empowered me.

5. It [resilience] was a realization that I’m not outstanding academically does not mean I cannot be a great success in the world or in my personal life.

6. [my resilience is] the ability to communicate, it is my greatest strength.

7. It [being resilient] is about recognizing not everyone is perfect. It is about being ok with the fact that you’re not perfect and working not only your strengths but also your weaknesses.

8. As soon as I realized I was going to be responsible for another human being it was no longer about me no longer about my needs and my desires. It was about being a strong role model and a strong person for my child.

9. You have to have a balance, you have to respect other peoples opinion, you have to respect your own, and you have to be open to other people’s opinion but you have to also be true to yourself.

10. It [being resilient] is about finding the balance that you can listen to other people, you do not have to agree with them but you have to truly believe in your own convictions and that was … it was like harmony.

11. I started bringing in, going back over my old notes getting back some of my notes taken with my psychologist and slowly integrating the skills that he taught me.

12. I have always been the type of person that falls on my feet so I may go through a little tantrum but deep down I know, that I’m always going to be ok, that I’m a strong person and I’ll get through it.

13. Some people are very fortunate, some people are lucky, some people make their own luck…believing this can help you remain resilient.

14. It [resilience] is a product of karma, I believe that if I treat other people well and I treat people nice then good things will happen to me, its got to be a balance so however cosmic as that may seem I believe that.

15. I had to build my self-discipline back up again and to this day I really don’t think my self-discipline is as strong as it should be.

16. Self-discipline is about stop making excuses. You have just got to do it. If you say you’re going to do it, you’ve just got to do it.
17. I have struck an inner balance
18. I try to stop thinking snap out of it, just move on. Is it important in the scheme of things? Put life into perspective
19. I have started to believe, strongly believe, the truth can be hurtful, but it's better to speak the truth than to avoid it
20. I think I have an obligation to be honest with myself to avoid any accumulation of negativity in my life
21. Being a clear communicator has really empowered me… I feel like my communication cannot be disputed, it cannot be confused, its clear, its concise, its consistent
22. I believe in being honest with myself and others around me, so that there is no mistake of where I'm at and where I stand and how I feel
23. It [being resilient] can’t always be an intellectual way … sometimes you just need to have a cry, and you’ve got to be ok with that as well
24. You’ve got to take it on board, process it, dump whatever you don’t need, get rid of the negativity, get rid of the build up and be comfortable with dumping it, and let it out. You cannot hold everything inside, you cannot be in control all the time
25. [To remain resilient] I believe in the greater good, even though I am not necessarily a religious person
26. It [being resilient] is having a little bit of hope, … self belief… belief in your family and friends and that they’ll be there to support you and help you when you need it and they always are. You can be going through the roughest situation in your life, but if you don’t let anyone in they can’t help you
27. Be prepared to put your hand up and ask for help. Stop trying to be the super person that is expected of us in today’s society
28. You have to be responsible for your decisions
29. [To be resilient in life] do not blame other people for the choices you have made, don’t make excuses for them, just say at that time I thought that was the best choice
30. Resilience is maintained when you give yourself half an hour every day. Allow that time for your body to just stop, rejuvenate, and then move on, but you have to say that’s ok to take that half an hour and be selfish.

31. It [recovery and resilience] is a choice. I think that is a choice and yes the cure is as simple as balancing your body back. Get that balance. Get that balance in mind, chemically balance, naturally instead of artificially [if possible]. Get that health, get moving, and get walking.

**Participant 8 - Significant statements**

1. I pleaded with the doctors there [the hospital at which I was admitted] to let me go, let me go home its my son’s birthday, I have to be there… from that day on I did not look back.

2. I’m a single mum, on my own, and I needed the work and once I got the job I never looked back.

3. What happened to me was I couldn’t see anything clearly; everything was a blank. I thought, what’s going on? … I felt completely out of my body.

4. They (the nurses from the crisis team) said to me ‘if you need us at any time, we will help you’. That was a great support.

5. I was still feeling out of it, and I was taking medication … I couldn’t understand what was going on] … for harmony I would sit in the garden … I feel very peaceful in the garden.

6. To do something in the garden. I feel like I’m in a beautiful place and nobody can hurt me there [I felt safe].

7. I really felt that I [was lost] until my sister said to me, ‘we really love you and come and stay with me and I’ll look after you’, because I felt that nobody else wanted me.

8. I have learned that people are generally all alone like me… they are all individuals and if they want to be there for you they will be there for you.

9. I will always be a giver – it gives me meaning, and I will continue to do that until the day I close my eyes.
10. She [my puppy] is the best thing in my life because she gives me unconditional love and everywhere I go I take her with me.

11. [I won’t decide on anything] until I saw it with my own eyes and that is how I look at life, that I have to see and experience it for myself and not listen to other people …be self sufficient.

12. Being resilient comes when you forgive people and you move on

13. [Being resilient is] To walk away with a sense of dignity

14. [It is important to have] somebody [who] loves you, they love you for the person you are, not for what you wear and the way you look on the outside

15. I love walking along the beach. Each time I go there it’s like heaven [it gives me comfort and strength]

16. When I broke down my sister was my rock

17. I was [and am] responsible for myself

18. Sometimes I get lonely, but I’m happy being on my own

19. [Being resilient is] accepting yourself, accepting me for the way I am and not trying to change because I know people are going to try to change

20. [Being resilient is taking it] day by day

4.4 Summary Of The Essence Of The Intended Meaning For Each Participant

As Interpreted By The Researcher – Additional Step to Colaizzi’s (1978a)

Original Seven Step Process

The following are summaries of the essence of the intended meaning offered by the researcher related to each participant. This step is an additional step to Colaizzi’s (1978) seven step analysis.

Summary of the essence of the intended meaning of participant 1

Resilience is being active, objective and reflective. Being resilient begins with a moment of realisation and proceeds with optimism, hopefulness and naïvity towards ‘getting back in the saddle’ and being in charge again.
Summary of the essence of the intended meaning of participant 2
Being resilient starts with a crisis…a cathartic moment and continues through knowing about, then naming, your situation or condition, working towards healing in a reflective, thoughtful manner, and growing from the experience.

Summary of the essence of the intended meaning of participant 3
Resilience begins with acknowledgment of your situation…a moment of realisation. Resilient qualities include self-sufficiency, taking things day-by-day, adapting to life’s situations and refusing to be the victim.

Summary of the essence of the intended meaning of participant 4
Naming the condition and learning about it is empowering. Being resilient includes being responsible, talking to others, accepting what is, living in hope, engaging in self discovery, self talk to comfort the self in moments of distress, discovering your own spirituality, positive thinking and finding comfort in activities such as listening to music. Being resilient involves striking a balance.

Summary of the essence of the intended meaning of participant 5
Resilience is dealing with the situation and taking responsibility…taking control again. Being resilient includes courage, self knowledge, self reliance, connecting with your own spirituality, having a role model, hope for the future and having an ability to share your story with, and gain support from, another.

Summary of the essence of the intended meaning of participant 6
Resilience is having a crisis, seeing it all, and then choosing to endure it. It includes having hope for the future, adapting to life, evolving in self, talking to others, respecting yourself, accepting yourself and others, being self reliant and believing, belonging and knowing where you fit in the world. Resilience, and ultimately recovery, comes from having a future focus.
Summary of the essence of the intended meaning of participant 7
Being resilient is knowing you do not want to die and choosing life. Realising you are like other people and accepting yourself and others for not being perfect. Resilience involves adapting to situations, using your skills and knowledge to cope and adjust to each circumstance, forgiveness of others and self, and knowing when to ask for help - being able to communicate with others. It is about balance.

Summary of the essence of the intended meaning of participant 8
Resilience is looking forward yet still taking things day-by-day. Resilient qualities involve being responsible for yourself and perhaps others…being needed. Remaining resilient includes having a safe place to reflect, accepting yourself and others for whom they are, giving and receiving unconditional love and having access to support when you need it.

4.5 Images Of Resilience As Articulated By Participants – Additional Step
added to Colaizzi’s (1978a) Original Seven Step Process
The following are images of resilience offered by each participant in this study. Below the articulated image, the researcher offers an interpretation of intended meaning. This step is additional to Colaizzi’s (1978) seven step analysis.

Image of resilience – participant 1
[My image of resilience is]…life’s like a ladder it is about doing what you are doing, where the ladder sits on a foundation which is your beliefs and standards. The rungs are the steps that you take to achieve what ever you have to achieve and the sides of the ladder are your values. If you stand on the ladder and put your legs outside the ladder you are stepping outside of your values and could fall off. So if you compromise your values you can do damage to yourself.

Researcher interpretation of the image - participant 1
Resilience is upward movement…progress. Progress is made in the context of one’s own beliefs, values and standards.
Image of resilience – participant 2
My image of resilience starts with a flower growing and being to blossom in a garden. I was in a house with a wonderful garden, look you couldn’t go to the clothes line without kicking over a bulb; it was like a magic garden. The garden was always in bloom and growing. I was also growing both intellectually and emotionally. And I felt like a better hybrid than I had been.

Researcher interpretation of the image – participant 2
Resilience is growth through evolving change.

Image of resilience – participant 3
Resilience is acceptance leading to action for change (and not despair), being flexible and getting rid of any sense of being "owed" or fairness. Don't let the ‘bastards’ get you down! A sense of humour can be learnt and goes a long way in life.

Researcher interpretation of the image – participant 3
Resilience is being flexible, accepting and seeing the funny side of life.

Image of resilience – participant 4
Resilience is water...
Water is always flowing and moving and when trapped, it will find its way to make a path and keep flowing. If water is trapped by rocks, it will slowly but eventually wear the rock away. Water can evaporate to become rain and hopefully fall to where it can flow freely again.

Researcher interpretation of the image – participant 4
Being resilient is finding a way through.
**Image of resilience – participant 5**
My image of resilience is a rainbow (hope in the black clouds) and a butterfly (being light and free).

**Researcher interpretation of the image – participant 5**
Being resilient is having freedom to hope.

**Image of resilience – participant 6**
Resilience is a colony of ants. Ants make mounds in which to live and then someone may come along and step on it and destroys the mound. So what do the ants do? They repair it, they don’t move on to another place. They stick with it they have and build on it and make it better.

**Researcher interpretation of the image – participant 6**
Being resilient is knowing there is hard work ahead but still undertaking it and surviving.

**Image of resilience – participant 7**
Resilience is Nelson Mandela. Someone who had been in prison and came out with no grudges. He was inspiring, he was a leader… he was human that can have great influence not only on himself but others, you know make the world a better place.

**Researcher interpretation of the image – participant 7**
Resilience is forgiveness.

**Image of resilience – participant 8**
Resilience is my beach. Walking along the beach - sand, very sunny and beautiful. The water calm, sometimes it’s a bit rough but that’s to be expected, because that’s all about life, it gets really rough sometimes, it’s the howling of the wind and the waves you can hear it. I’ve learned to take every day as it comes –the good and the bad, like when I am on the beach

**Researcher interpretation of the image – participant 8**
Being resilient is taking things day-by-day.
4.6 Creating Formulated Meanings From The Significant Statements

This step was to develop themes or meanings for each significant statement. Colaizzi (1978a; 1978b) cautions that this step requires insight and creativity on the part of the researcher. Formulated meanings were assigned to each significant statement (with numerical reference to the significant statement from which they originated) (Table 1). In regards to maintaining rigour in this step of the analysis, both the formulated meanings and the significant statements were validated with my senior supervisor who had read the significant statements and who is experienced in phenomenological analysis (Hycner, 1985).

Creating clusters of themes that were common to all formulated meanings was the next step in the analysis, where formulated meanings were grouped into representative themes (Table 2). The formulated meanings were sorted into groups that represented specific themes. The aggregated clusters then were referred back to the original significant statement to validate them.

4.7 Theme Clusters Aggregated From The Formulated Meanings

Table 2. Theme Clusters, Formulated Meanings and Relative Significant Statement Reference

<table>
<thead>
<tr>
<th>THEME CLUSTERS</th>
<th>FORMULATED MEANINGS</th>
<th>PARTICIPANT NUMBER (P) AND SIGNIFICANT STATEMENT REFERENCE</th>
</tr>
</thead>
</table>
| Resilience is experienced through sharing the experience with others and realizing you are not alone. | Universality- I am not alone in my experience of mental illness. Others in the world have similar experiences | P4–16  
P6–10, 22  
P7–4, 7 |
|                | Resilience comes from the support provided to you from others.                     | P1-3,4,5,6  
P3-16,17,19  
P4-4,7,13  
P5-11,12,13,18 |
| Resilience is expressing yourself, being self aware, self reliant and responsible, accepting yourself as well as others is part of being resilient. | I experience resilience as having an awareness of the duality of self – having 2 faces – one happy, one sad | P4– 18, 19  
P5– 19 |
| --- | --- | --- |
| Being resilient is to be self reliant. |  | P3- 11,12  
P4-34,35  
P5-24,26  
P6-11,35  
P7-28,29  
P8-17 |
| Resilience comes from the acceptance of others and an acceptance of life. |  | P4-8,9,12  
P6-18,19,26  
P7-19  
P8-12 |
| Being resilient is about accepting yourself. |  | P3-5,15  
P6-4,7,8,16,21,34,36  
P7-3,23  
P8-18,19 |
| Being resilient comes from knowing yourself, accepting your own limits and evolving through the experience. |  | P3-8  
P4-20,32,33  
P5-10,15,17,20  
P6-15  
P7-5,6,12,15,16,20,22,24,27  
P8-8 |
<table>
<thead>
<tr>
<th>Description</th>
<th>Pages</th>
</tr>
</thead>
<tbody>
<tr>
<td>Resilience results from a belief in yourself and self respect.</td>
<td>P1-15, P7-13,26, P8-13</td>
</tr>
<tr>
<td>Resilience is being responsible for others. Doing this pushes you forward.</td>
<td>P5-6,7, P6-2, P7-8, P8-1,2</td>
</tr>
<tr>
<td>Expressing yourself promotes resilience.</td>
<td>P4-2,3,5,6, P6-9</td>
</tr>
<tr>
<td>Resilience begins with knowing what is going on, naming it and working within your own knowledge and limits within the situation. This is a moment of enlightenment.</td>
<td>P3-9,10,13,18, P4-14,30, P5-4, P8-20</td>
</tr>
<tr>
<td>To begin being resilient you have to know what you are dealing with, name it and acknowledge the mental illness.</td>
<td>P1-1,2, P2-2,3, P3-6, P4-1,15, P8-3</td>
</tr>
<tr>
<td>It is important to learn from each experience so you can better manage the next.</td>
<td>P1-17,18, P2-13, P4-10,11, P6-5,20,23,32</td>
</tr>
<tr>
<td>Resilience develops after reflecting on what has happened so that you can move forward. Resilience follows a moment</td>
<td>P1-9,10,11,12, P2-1,4,7, P3-2, P4-38, P7-21</td>
</tr>
<tr>
<td>Resilience description</td>
<td>Reference</td>
</tr>
<tr>
<td>---------------------------------------------------------------------------------------</td>
<td>-----------------</td>
</tr>
<tr>
<td>Resilience is having hope, faith, spirituality, courage and optimism...at times being naïve.</td>
<td>P8-3,11</td>
</tr>
<tr>
<td>Resilience is having hope, being naïve and knowing there is a light at the end of the tunnel.</td>
<td>P4-21,23, 39</td>
</tr>
<tr>
<td>Resilience is having hope, being naïve and knowing there is a light at the end of the tunnel.</td>
<td>P5-3,9,23</td>
</tr>
<tr>
<td>Resilience is having hope, being naïve and knowing there is a light at the end of the tunnel.</td>
<td>P6-1,3,33</td>
</tr>
<tr>
<td>Resilience, comfort having hope and courage comes from my spirituality.</td>
<td>P4-36,37</td>
</tr>
<tr>
<td>Resilience, comfort having hope and courage comes from my spirituality.</td>
<td>P5-21,31</td>
</tr>
<tr>
<td>Resilience, comfort having hope and courage comes from my spirituality.</td>
<td>P7-25</td>
</tr>
<tr>
<td>Resilience includes hope, seeing beyond the immediate situation, optimism and a desire to move forward with a sense of optimism.</td>
<td>P1-16</td>
</tr>
<tr>
<td>Resilience includes hope, seeing beyond the immediate situation, optimism and a desire to move forward with a sense of optimism.</td>
<td>P2-9,10</td>
</tr>
<tr>
<td>Resilience includes hope, seeing beyond the immediate situation, optimism and a desire to move forward with a sense of optimism.</td>
<td>P3-4</td>
</tr>
<tr>
<td>Resilience includes hope, seeing beyond the immediate situation, optimism and a desire to move forward with a sense of optimism.</td>
<td>P4-24</td>
</tr>
<tr>
<td>Resilience includes hope, seeing beyond the immediate situation, optimism and a desire to move forward with a sense of optimism.</td>
<td>P5-14</td>
</tr>
<tr>
<td>Resilience includes hope, seeing beyond the immediate situation, optimism and a desire to move forward with a sense of optimism.</td>
<td>P6-24,25,30,31,37</td>
</tr>
<tr>
<td>Resilience includes hope, seeing beyond the immediate situation, optimism and a desire to move forward with a sense of optimism.</td>
<td>P7-2</td>
</tr>
<tr>
<td>Resilience is having strength and courage.</td>
<td>P5-25</td>
</tr>
<tr>
<td>Resilience is having strength and courage.</td>
<td>P5-22,32</td>
</tr>
<tr>
<td>Being resilient is caring for yourself, allowing time to heal, grieve, rest and manage your day.</td>
<td>P1-7,8</td>
</tr>
<tr>
<td>Being resilient is caring for yourself, allowing time to heal, grieve, rest and manage your day.</td>
<td>P2-11</td>
</tr>
<tr>
<td>Resilience is being active and distracting yourself so you don’t sit a stare at the wall.</td>
<td>P1-7,8</td>
</tr>
<tr>
<td>Resilience is about striking a balance.</td>
<td>P3-14</td>
</tr>
<tr>
<td>Resilience is about striking a balance.</td>
<td>P4-17</td>
</tr>
<tr>
<td>Resilience is about striking a balance.</td>
<td>P7-9,10,14,17</td>
</tr>
<tr>
<td>Taking time for yourself to care for yourself helps you remain resilient.</td>
<td>P2-5,6</td>
</tr>
<tr>
<td>Taking time for yourself to care for yourself helps you remain resilient.</td>
<td>P7-18,30</td>
</tr>
<tr>
<td>Taking time for yourself to care for yourself helps you remain resilient.</td>
<td>P8-5,6,15</td>
</tr>
<tr>
<td>Resilience is seeing the Being resilient includes how</td>
<td>P2-8,12</td>
</tr>
<tr>
<td>Resilience related statement</td>
<td>Description</td>
</tr>
<tr>
<td>--------------------------------------------------------------------------------------------</td>
<td>------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>positives, learning from the experience and planning.</td>
<td>you look at the world. Being able to reframing situations and look for other options. Refusing to be the victim and instead adapt to the situation, work through it towards healing.</td>
</tr>
<tr>
<td>Resilience is being able to use diverse coping styles. Using your knowledge and skills to adapt.</td>
<td></td>
</tr>
<tr>
<td>Resilience is having meaning and meaningful relationships where you can belong and feel unconditional regards and care fosters resilience.</td>
<td>Having a key person in your life and experiencing love and unconditional regard and a sense of belonging can help you to be resilient.</td>
</tr>
<tr>
<td>Being resilient is choosing life, being back in charge, moving forward and just ‘doing it’</td>
<td>Being resilient is choosing to walk through the darkness; Making a decision for life</td>
</tr>
<tr>
<td>Resilience is about taking back control of your life and daily activities, and telling yourself</td>
<td></td>
</tr>
</tbody>
</table>
Resilience is encouraging yourself through self talk

| 4.8 The Exhaustive Descriptions Of The Phenomenon Of Resilience As Described By People Who Have Experienced Mental Illness |
|---|---|
| As previously mentioned (in Chapter 3, p 53), Colaiazzi (1978a) advocates that the researcher should integrate all the resulting ideas into an exhaustive description of the phenomenon under study – that is, provide a comprehensive description of the phenomenon under investigation. In relation to this research, the exhaustive descriptions will be presented as a narrative account, containing all the dimensions of the lived experience of resilience from the personal perspective of the participants interviewed. This was achieved by incorporating the emergent themes and formulated meanings into the description, as follows: |
| 1. Being resilient is experienced through sharing the understanding with others and realizing you are not alone. Support gained from being with and talking to others. |
| 2. Resilience includes the ability to express yourself, being self aware, self reliant and responsible in the world. Resilience comes from accepting self, others and life. |
| 3. Being resilient follows a moment of enlightenment and discovering what is going on give you an opportunity to name/identify the mental illness. From there it is possible to expand your knowledge of the mental illness through education and work within your knowledge and limitations within the situation. |
| 4. Resilience involves having hope, faith, being spiritual, courage and optimism…at times being naïve or being the fool. |
| 5. Being resilient means caring for yourself by allowing time to heal, grieve, rest and manage your day. Resilience is about striking a balance. |
6. Being resilient is having meaning in your life - making a difference to another - and having meaningful relationships. This offers you the potential to feel like you belong, to feel unconditional regard and to be cared about and care for another.

7. Being resilient is choosing life, being back in charge, moving forward and just ‘doing it’. Being resilient is choosing to walk through the darkness all the while knowing the risks and dangers; Making a decision for life through the hardships.

4.9 The Fundamental Structure Of The Phenomenon Of Resilience As Described By People Who Have Experienced Mental Illness

A fundamental structure of the concept of the phenomenon of resilience as experienced by people who have had a mental illness is constructed in this step of the analysis. The fundamental structure is a compilation of all the exhaustive descriptions created in Colaizzi’s (1978a) analysis, and in this study located in steps two (2), five (5), six (6), and seven (7) (as previously described in Chapter 3). Since there are additional steps to the analysis in this study, a second fundamental structure of the phenomenon is created. This fundamental structure is constructed utilising the summary of the essence of the intended meaning of each participant as interpreted by the researcher (located in this chapter, section 4.3). The purpose of having two fundamental structures generated relates to providing another perspective of the phenomenon under investigation. Having two fundamental structures constructed also offers the researcher a means to examine the credibility and confirmability of the research process.

The first of the two fundamental structures for the phenomenon of resilience as described by people who have experienced mental illness follows. This fundamental structure was generated by examining the essence of the intended meaning as interpreted by the researcher (step 3 of this study).
1. **Fundamental structure of the essence of the intended meaning of the phenomenon of resilience as described by people who have experienced mental illness (as interpreted by the researcher)**

Resilience is being active, objective and reflective, beginning with a moment of realisation and proceeds with optimism, hopefulness and, at times, naîvity. Resilient qualities begin with a moment of clarity and proceeds towards discovery - knowing about, then naming, your situation or condition, working towards healing in a reflective, thoughtful manner, and then growing from the experience. Being resilient also includes being self-sufficient, taking things day-by-day, adapting, refusing to be the victim, being responsible, talking to others, accepting self and others, having hope for the future, self discovery, self talk to comfort the self in moments of distress, discovering your own spirituality, engaging in positive thinking and finding comfort in activities such as listening to music and sharing your story with, and gaining support from, others who have been in similar situations. Resilient qualities involve adjusting to life, using your skills and knowledge to cope, forgiving, and knowing when to ask for help - being able to communicate with others. Additionally, being resilient involves looking after yourself such as having a safe place to reflect, allowing time to heal, giving and receiving unconditional regard, and having access to resources when you need them. Resilience is about striking a balance.

The second of the two fundamental structures for the phenomenon of resilience as described by people who have experienced mental illness follows. This fundamental structure was generated by adhering to Colaizzi’s (1978) method of phenomenological analysis.
2. Fundamental structure of the phenomenon of resilience as described by people who have experienced mental illness [explicated from all the exhaustive descriptions created in Colaizzi’s (1978a) analysis, and in this study located in steps two (2), five (5), six (6), and seven (7)]

Following a moment of enlightenment and discovering what is going on give you an opportunity to name/identify the mental illness. From there it is possible to expand your knowledge of the mental illness through education and work within your knowledge and limitations within the situation. Resilience is experienced through sharing the experience with others and realizing you are not alone. It includes the ability to express yourself, being self aware, self reliant and responsible in the world. Resilience comes from the acceptance of self, others and life. Resilience qualities involve having hope, faith, having a sense of spirit, courage and optimism…at times being the fool. Being resilient means caring for yourself by allowing time to heal, rest and manage your day. Resilience is about balance. Being resilient is supported by having meaning in your life-making a difference to another - and having meaningful relationships. This offers you the potential to feel like you belong, to feel unconditional love, to be cared about and care for another. Resilience is choosing life, being back in charge, moving forward and just ‘doing it’. Being resilient is choosing to walk through the darkness all the while knowing the risks and dangers; Making a decision for life through the hardships.

4.10 Returning To The Participants For Validation

The final validating step was to return to the participants of the study with the results of the analysis. Participants were asked whether they thought the fundamental structure of the phenomenon contained the meaning conveyed through their original experiences. All participants agreed that the fundamental structure included the aspects that they had experienced.

4.11 Summary

This chapter provided the results of the study. The chapter began with presenting a context for participants involved in this study. The chapter presented the significant
statements relating directly to resilience from the participant interviews. The chapter continued with two additional steps - a summary of the essence of the intended meaning of each participant and included images articulated by the participants of the phenomenon under investigation. These two steps additional to Colaizzi’s (1978a) seven step process makes the method undertaken in this study a nine step process. The inclusion of these additions to Colaizzi’s (1978a) seven step process of analysis offered greater depth of understanding of what participants meant when they described their unique sense of being resilient in the context of experiencing mental illness. In keeping with Colaizzi’s (1978a) analysis, there was an articulation of theme clusters aggregated from the formulated meanings, from which provided the basis of a presentation of exhaustive descriptions of the phenomenon of resilience. The chapter then presented two fundamental structures of the phenomenon under investigation. The next chapter will provide a discussion of the findings of this research with reference to available literature on the topic.
CHAPTER 5 – DISCUSSION

5.1 Introduction
This chapter provides a discussion of the findings of this research. Emergent themes from the findings of the study are discussed through the conceptual lens of available research, literature and the arts related to resilience. The chapter concludes with a presentation of an overarching emergent concept in the context of the explicated themes.

5.2 Discussion
As previously mentioned, initially the North East and Northern suburbs of Melbourne were the areas for recruitment due to accessibility for both the potential participants and the researcher for interviews related to the study. However, some potential participants were recruited by the ‘snowballing’ sampling method. The snowballing approach ensured access to a wider and varied number of potential participants. This resulted in some participants from regional areas of Victoria being involved in the research cohort. There were seven emergent themes relating to the phenomenon of resilience that were explicated. The following is a discussion of the emergent themes in the context of existing literature that relates to resilience. The emergent themes were: Universality and support; Acceptance; Naming and knowing; Faith, hope and being the fool; Striking a balance; Meaning and meaningful relationships; and Just doing it. An overarching emergent concept – Viewing life from the ridge with eyes wide open – is presented as a presentation of how participants utilised the factors identified in the emergent themes in a bid to transcend the often crippling effects of mental illness.

5.2.1 First emergent theme – Universality and support
Participants in this study identified that being resilient was experienced through sharing the experience with others and realizing you were not alone. Participants emphasised they gained support from being with, and talking to, others. This support and sense of being with others was an important factor in being resilient through times when there was the
distressing and often debilitating experience of mental illness. This is described through
the following significant statement from the previous chapter;

Participant 4, significant statement 16
[I realised] there are people to relate to who have had the same problem [as me]. It
[being resilient] was accepting that I wasn’t alone.

The notion of universality was described by the participants of this study as not being
alone in the world, and having awareness that others may have similar experiences as
them. This description is consistent with the second and eleventh of Yalom’s eleven
curative factors of which are respectively: Universality (see that I’m not alone or have
unique problems) and Existential factors (Yalom, 2005). Additionally, there was
recognition by participants that the world, which includes the participant themselves, is
not a perfect place and knowledge of this helped the participant to feel connected to the
world, even at their most disconnected time. This is captured in the following significant
statement, as follows:

Participant 7, significant statement 7
It [being resilient] is about recognizing not everyone’s perfect and it’s about being ok
with the fact that you’re not perfect and working not only your strengths but your
weaknesses and saying that’s ok I’m comfortable with that.

Merleau-Ponty (1962, p. 408) captures the idea of universality as a phenomenological
description in the following quote:

Insofar as, when I reflect on the essence of subjectivity, I find it bound up with that of the body
and that of the world, this is because my existence as subjectivity [= consciousness] is merely one with
my existence as a body and with the existence of the world, and because the subject that I am, when
taken concretely, is inseparable from this body and this world.
Merleau-Ponty (1962) points to the notion of how people as part of a group in terms of their own subjective experiences are then essentially not alone in their experience. In other words, they share the experience at some level with others in the world. The concept of support from others to enhance inner strength has been articulated in literature pertaining to resilience and overcoming adversity. Werner and Smith (1982) maintain that resilience was understood to be the product of a complex blend of specific psychological inner strengths and environmental social supports throughout a person’s life that determined their response to adversity. Social supports were identified by Bachay and Cingel (1999) as an important psychosocial factor that mediated resilience, and further to this, that such relationships served as sources of support within and outside the family for the individual at various points throughout their life, such as during illness. Some studies that examined the experience of resilience in the context of chronic illness, identified personal characteristics associated with resilience included the ability to elicit social support (Antoni & Goodkin, 1988; Rabkin et al., 1993). The importance of support through the experience of mental illness is well articulated by Wagner, a consumer of mental health services who said, *Only with support and encouragement will we ever be able to break open the doors* (Wagner, 2004, p. 1).

Previous experience, education, and importantly, support, enable most people to respond appropriately and to change as circumstances require, assisting individuals successfully to adapt (Ryden et al., 2003). In support of the findings of this study, key aspects have been identified as contributors to fostering resilience which involve having caring relationships and opportunities to participate with, and contribute to, others - where this support and sense of belonging may be experienced through support structures such as family, friends or groups of people who have had a similar experience (Benard, 1993, 1997).
5.2.2 Second emergent theme- Acceptance

All participants in this study identified that acceptance of the situation, self and others were integral to being resilient. Participants specifically identified resilience as the ability to express themselves, being self aware, self reliant and responsible in the world. Participants agreed that resilience comes from accepting self, others and life. Literature supports the recovery journey for consumer’s of mental health services is directed at promoting personal adaptation and adjustment, and facilitating the consumers personal adaptation towards understanding and acceptance (Mullen, Murray, & Happell, 2002; Perkins & Repper, 2003; Spaulding, Sullivan, & Poland, 2003; Stein-Parbury, 2005). Smith (2000) undertook a study in the United States examining the idea of recovery in people who experienced serious mental illness. The findings of Smith’s study suggest recovery begins only when one accepts one's disability and develops a desire to change. Bachay and Cingel (1999) support this notion of acceptance and self reliance when they revealed factors enhancing the feeling of resilience included self-efficacy and self reliance.

Participants in this research suggested that acceptance of the situation, themselves and others created an opportunity for them to view their situation from a different perspective – a different frame, as articulated by the following significant statements of participants:

Participant 4, significant statement 20

*I think that I have knowledge so that I can understand myself. I say that this is what is keeping me here, otherwise I would have killed myself ages ago.*

Participant 6, significant statement 4

*I thought hang on am I acceptable to myself? To be acceptable to myself is the most important thing to me, so I can’t be anything but myself.*
Tusaie and Dyer (2004) suggest that social-psychological strategies (such as self-efficacy and the ability to reframe negative experiences into positive, self-enhancing life events) can counterbalance the adversity experienced by people who live with mental illness. The point relating to positive self perceptions and enhancement of self efficacy was raised earlier by Smith (2000). Smith (2000) suggested that vulnerability to mental illness may be attributed to the inability of the individual to develop positive self-perceptions inferring the possibility of non acceptance of self and/or others. In his study Smith demonstrated that a personality type characterized by self-perceptions tinged with a positive preconception and high levels of optimism, assisted the individual to be resilient.

This notion of self acceptance and positive self perception as elements of resiliency can be demonstrated in the following significant statements:

Participant 7, significant statement 5

*It was a realization to me that because I’m not outstanding academically does not mean I can’t be a great success in the business world or in my personal life because everything that I was reading about in emotional intelligence were my strengths*

Participant 7, significant statement 5

*It [being resilient] is about recognizing not everyone’s perfect and it’s about being ok with the fact that you’re not perfect and working not only your strengths but your weaknesses and saying that’s ok I’m comfortable with that.*

5.2.3 Third emergent theme – Naming and knowing

In this study the participants described that following a moment of enlightenment and discovering *what was going on* gave them an opportunity to name and identify the situation they found themselves in. Yalom (2000) cited Heidegger’s work and spoke of two modes of being. First, an everyday mode in which we wonder at the way things are in the world. Yalom (2000) suggests this mode is understood as a state of forgetfulness of being, of being tranquilized by the objects surrounding us. The second mode of being is
an ontological (reality) mode, which is experienced as a state of mindfulness of being. Yalom suggests in this mode we live authentically and marvel that things are and at the very reality of things and in this state the individual is primed for life-change. This moment of enlightenment - awareness of reality - can be shown from some of the significant statements extracted from chapter 4 of this thesis pertaining to resilience following a moment of enlightenment, as follows:

Participant 1, significant statement 1

*It [being resilient] was important for me to know what led me to that point.*

Participant 1, significant statement 12

*It [being resilient] was that period of enlightenment which was brought about by the psychiatrist, psychologist, and the realisation based on things that they told me. It really made me, I guess; be resilient probably. Or it made me want to resist the return to a situation like that.*

Participant 2, significant statement 2

*Acknowledging what it [the mental illness] was. Giving it a name and knowing why I was going through that ... Then seeing it for what it was and why it was...acknowledging the grief - that I could grieve.*

Participant 2, significant statement 3

*It [knowing what I had] was such a relief... such a catharsis. It was like a bolt of lightening*
Participant 2, significant statement 4

*To be able to intellectually see [recognise] it for what it was made it very clear. I suppose for other people they are unable to make that connection and that’s when it [mental illness] becomes chronic or more severe over time.*

Participants explained from the point of awareness, participants said that it was possible to expand their own knowledge of their mental illness through education in an effort to assist them to individually transcend the negative impact of their experience. This can be demonstrated from some of the significant statements extracted from chapter 4 of this thesis pertaining to knowing, as follows:

Participant 6 significant statement 5

*I’ve learned to grow… I’ve learned to take the punches… I’ve learned to bounce back as a result of hard times*

Participant 6, significant statement 32

*[Being resilient] is constant learning*

Participants suggested that naming and knowing was a period of discovery and then work within their own knowledge and limitations in the prevailing situation. The literature supports that analysing one’s own reactions during an adverse situation, such as a health crisis, can help individuals separate their own emotions from the event (Edward & Warelow, 2005; Ihlenfeld, 2004; Lazarus & Folkman, 1984; Mermier, 1993; Urquhart, 2002). Being able to objectify one’s own emotions from the event can facilitate problem-solving for the individual, enhanced by acquiring knowledge about what is happening to and how one might manage the situation. Polk (1997) supports active problem-solving and flexible learning styles are conceptualised as resilient coping patterns. This is also supported by Ryden et al., (2003) who posit that previous experience or knowledge and education enhances existing information, enabling most people to respond appropriately
to change as their circumstances require – in other words, enhancing one’s ability to adapt and learn from the current situation.

Tait, Birchwood, and Trower (2003) found facilitation of psychological adjustment to mental illness (such as knowing and naming) as well as knowing illness status was important when investigating treatment engagement in people with mental illness. Edward (2005a) in her study in Australia focusing on the phenomenon of resilience as experienced by mental health crisis clinicians, found having insight and knowledge of what was happening were consistent with the descriptions of being resilient. Her study suggests the experience of resilience emanated from gaining insight which provided a sense of personal control through acquiring greater understanding of oneself and others. Kelly (1973, cited in Vaughan & Hogg, 1998) posits that it is a natural human tendency to seek explanations through personal reflection on events – such as physical happenings, social processes and human behaviours. Such explanations provide individuals with a degree of stability and expectedness enabling more logical and adaptive interactions with the world.

Kelly (1973, as cited in Vaughan & Hogg, 1998) suggests further that the process of assigning explanations [attributions] to situations may offer a clearer outlook of the world for individuals. Attributing explanations to events has its basis in Heider’s (1958) theory that pertains to how individuals determine causality of life events. The consequences of these attributions are significant in terms of enhancement of individuals adapting to, and remaining resilient through, untoward life events.

5.2.4 Fourth emergent theme – Having faith, hope and being the fool
For the participants in this study resilience involved having hope and faith, being spiritual, having courage and being optimistic…and at times being naïve or being ‘the fool’. The notion of being the fool or naïve surfaced in participant interviews a number of times, and was evident when participants were referring to their own hopes for the future or when describing a positive potential outcome for themselves in any given situation. Participants described having hope was experienced through their own naïvity and was an
important part of being resilient. This naïve hopefulness or ‘being the fool’ enabled participants to keep hopeful that things could work out for them in the longer term. This concept is described in the following statements-

Participant 4, significant statement 21

[I think sometimes] I have a third side, like the really stupid one. The one that has hopes in the world. The fool in a way.

Participant 4, significant statement 22

Being the fool means that you don’t think of the consequences, no risks what-so-ever. You know, go straight through it [life].

Participant 4, significant statement 23

Through the darkness of depression I hold a very tiny piece of hope. I have to access the hope. I get the hope from my fool side.

These descriptions expressed by the participants of this study are shared by the participants in Willman (1999, p. 140), sometimes [having] hope without knowing what you are hoping for. Yalom’s curative factors also cites the installation of hope - faith that treatment or action will be successful - as important to feelings of self efficacy and empowerment (Yalom, 2005). Participants in this study described how hoping often without knowing what to hope for helped them individually to adapt and cope within the major life event that mental illness presented to them.

Lazurus and Folkman (1984) identified two broad dimensions of coping and adaptation, that is, problem-focused coping and emotion-focused coping. Each of these styles of coping entails the individual to utilize supports available to them- such as, hope and a belief in what is possible for them in order to adapt to their situation and work towards recovery. Merleau-Ponty (1989) states, ambiguity is of the essence of human existence
Faith and hope as a coping mechanism have been observed to be a powerful resource in providing individuals experiencing illness or mental disorders with a sense of relief, calm, and peace (Kelly, 2004). While the notion of being spiritual in adaptation and adjustment to illness is mysterious, the benefits in terms of assisting individuals to transcend the adversity of their situation have been demonstrated in literature (Attig, 1996; Kelly, 2004). Mueser et al. (2002b) points out that recovery generally occurs when people with mental illness discover, or rediscover, their own strengths and abilities for pursuing personal goals and hopes allowing the individual to move beyond the illness experience.

5.2.5 Fifth emergent theme – Striking a balance

For the participants in this study, being resilient involved caring for themselves, allowing time to heal, grieve, and taking time to rest and manage their day in smaller components. Participants described being resilient was about striking a balance. These attributes were demonstrated in some of the significant statements from the previous chapter as follows:

Participant 2, significant statement 11

I had lots of people around me, some people get divorced and find themselves alone, but this wasn’t the case for me. It [having people around] helped me restore the balance. It was a good recipe; it ended up being the best of times.

Participant 4, significant statement 17

I can actually describe myself as having two personalities. Like, the balance of life, ying-yang, yes-no kind of thing.
Participant 7, significant statement 9
You have to have a balance, you have to respect other people’s opinion, you have to respect your own, and you have to be open to other people’s opinion but you have to also be true to yourself.

Participant 7, significant statement 31
It [being resilient] is a choice. I think that is a choice and yes the cure is as simple as balancing your body back. Get that balance. Get that balance in mind, chemically balance, naturally instead of artificially. Get that health, get moving, and get walking.

Striking a balance as described by the participants of this study can be understood in terms of self regulation, self determination and working within one’s competence (Ryan & Deci, 2000). Ryan and Deci (2000) suggest in the context of self determination theory, self regulation is situated in the background of the individuals circumstances. This notion is supported by earlier works by Sheldon, Reis, and Ryan (1996, as cited in Ryan & Deci, 2000) who demonstrated there exists daily fluctuations in the satisfaction of autonomy and competence in the context of self determination with regard to situational factors such as mood, physical state and self-esteem. However, when individuals achieve a balance in their own set of circumstances, and in this case mental illness, successful adaptation can result.

Henderson (1998) states, The goal is to build in enough protective factors to offset the impact of stressful life events. When the balance is favourable [in terms of] successful adaptation, resiliency is the outcome (p. 17). According to Lang, Rieckmann and Baltes (2002, as cited in Nygren et al., 2005) selecting to reduce the number of daily activities in the context of major life changes, actively or passively is suggested to be a successful adaptive strategy in facilitating self transcendence through self determination.

5.2.6 Sixth emergent theme – Meaning and meaningful relationships
Having meaning in life and meaningful relationships were described by participants in this study as important to being resilient. Participants described how their sense of
transcending mental illness - resilience - was supported by having meaning in their life. Participants added that having a sense of making a difference to another and having meaningful relationships were also important to their sense of being resilient in the context of mental illness. Participants described how having meaning offered an opportunity to feel a sense of belonging somewhere, to someone or group, to feel love and to be cared about and/or to care for another. This was demonstrated in the explicated significant statements as follows:

Participant 6, significant statement 27
[Helping others gives hope] … if I’ve done nothing and I haven’t changed the world and I die tomorrow having done nothing... I could have changed someone’s life and made it better. Because people make my life better.

Participant 1, significant statement 14
[Being resilient is having] a way of proving to yourself that you’re not out of the game, that you are able to contribute and participate, that you still have something to offer.

The notion of having meaning in life originates from humanistic psychology and is based on Frankl’s concept of meaning (1963, as cited in Nygren et al., 2005). Frankl describes meaning as a motivational force understood in an existential context. Frankl (2000) suggests meaning in life is individual and contextual, this notion is best captured by the following quote: 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 (p.171). Having meaning or purpose in life has been associated with optimism and enhanced motivation, and is supported by Rappaport, Fossler, Bross and Gilden (1993, as cited in Nygren et al., 2005) who found a positive correlation between purpose in life and optimism.

5.2.7 Seventh emergent theme – ‘Just doing it’ -
Participants described being resilient is about choosing life, being back in charge, moving forward and just ‘doing it’. These sentiments are captured in the following significant statements, where the essence of the theme is about ‘just doing it’- as follows:
Participant 1, significant statement 13

So I guess once I was back controlling the work I was doing, that was a critical step, because now I was back in control.

Participant 5, significant statement 4

Every step that you take every day it’s just like let’s just get another day over with [and] do what you gotta [sic] do to get through it …

Participant 5, significant statement 8

I just took control because I had to… it was like there was no other option

Participant 5, significant statement 27

It [being resilient] is that you just have to deal with it

Participant 5, significant statement 28

It’s like in my case, getting better, you just have to. It’s like there’s no option … like I’m not failing… so you just have to.

The description from participants in this study pertaining to the theme ‘just doing it’ related to the notion of managing life in the best way possible at that time. Participants also indicated that they experienced a feeling of responsibility over their own direction in life, even in the face of the adverse effects of mental illness. There are different ideas that exist which denote driving forces and strengths that contribute to a person's ability to manage adversities, and keep or recover health. Luthar (1993) suggests when individuals think they are incapable of controlling what happens in a situation - an external locus of control- their adaptive skills become restrictive and often ineffective. Alternatively, when individuals believe that life events and outcomes are controllable, learned helplessness is avoided and, active attempts are made by the individual to overcome aversive situations opening the possibility of resilience.
Yehuda, Flory, Southwick and Charney (2006) outline important psychological resilience factors including positive affectivity, cognitive flexibility, coping, emotion regulation, and mastery through to resultant adaptation to the circumstances. Yehuda et al., identified normative responses related to stress adaptation such as extinction and fear conditioning, where the individual reconstructs memory and cognitions under the influence of a stressor. In this study the process of reconstruction of memory and thoughts was demonstrated when participants spoke of using self talk to encourage themselves towards ‘just getting on with what they needed to get on with’ or reframing negative experiences into positive, self enhancing ones. Self-talk refers to the dialogue that goes on inside your mind when faced with conflict or life challenges or even simple day-to-day concerns (Gray, 1999; Kendall & Hollon, 1989). The process of self talk can encapsulate the individual accessing other elements that promote resilience – such as having hope and faith and accepting life’s situations.

5.3 The Overarching Emergent Concept
The following provides an overarching concept explicated by the emergent themes in this study – that is, an essential concept under which emergent themes operated. The overarching concept is captured in the term ‘viewing life from the ridge with eyes wide open’.

5.3.1 ‘Viewing life from the ridge with eyes wide open’
In this study participants described their experience of resilience as choosing to walk through the darkness all the while knowing the risks and dangers ahead; Making a decision for life through the hardships. Participants described the experience of confronting their life challenges in the context of mental illness akin to viewing life from the ridge - viewing life from the ridge requires balance and perseverance to successfully traverse the journey which lay ahead. While engaging with the challenge of viewing life from this precarious position – the ridge – there is an awareness of the realities of the current situation. In other words, the individual’s eyes were wide open to what they were experiencing. Viewing life from the ridge and seeing the ‘what is’ and the ‘what could be’, creates a sense of uncertainty about what could come up, and some certainty about how to cope with the now. From this vantage point all is seen in terms of potential
barriers and obstacles. It is at this point where there is an acknowledgement of fears, feelings of distress, ambiguity, hopefulness of the future, helplessness at some points in the journey and determination to attempt to reach the goal that has been placed in the future somewhere. This determination is a consequence of the belief and faith in self and the balance of life. It is following this moment of enlightenment and through ‘naming and knowing’, that decisions can be made on behalf of oneself.

Naming and knowing enables a conscious mental processing of what is happening. Importantly, making decisions as a consequence of this awareness promotes a sense of control and self efficacy. By naming and knowing each person can begin accepting self, others and life, hoping for better outcomes and possibilities and seeking support when required. Using these processes leads to adaptation to the situation in the context of where one was in their health-illness journey. For example, some managed their day in smaller components and did what they felt they could at that point in time. Others engaged coping mechanisms to use in an effort to transcend the disabling effects of mental illness. Such factors at this point included striking a balance in the daily living responsibilities that suits were the person is in the ‘now’. Through this conscious awareness of the realities of one’s own situation begins the process of accepting the ‘what is’ in their circumstances. That is, mental illness will come in and out of life in episodes or at stressful times, and daily activities such as looking after one’s self or having energy for life will be a personal challenge especially at those points in time. A realisation of aloneness and the need for being self-sufficient in life is coupled with the comforting awareness of not being totally alone in the experience - that others in the world have experienced similar situations such as this.

Some people actively seek to validate the idea they are not the only one going through this situation by joining support groups dedicated to their particular issue. Others seek clarification and validation of their experience through other means, such as increasing their own knowledge related to their situation through education or professional counsel. Through the process of increasing one’s own knowledge of mental illness, and discovering coping strategies others may have used successfully, an ability grows in
terms of being able to reframe one’s own negative thoughts or feelings. The use of self talk to provide personal comfort or encouragement through the adverse situation assists in enduring the worst of times in the present– and those adverse times anticipated ahead - moving toward a moment of balance and perhaps recovery itself. Motivation to transcend stressful situations is supported through keeping faith and hope for positive and successful outcomes - described in some instances as naïvity. Resilience in the context of mental illness is an interplay of cognitive, emotional and spiritual aspects. That is, thinking about, feeling for and believing in the self and life.

When considering the literature on resilient behaviours, Flach (1988) posits resilience is at the centre of what we know as mental health and successful adaptation. Luthar (1993) and Werner (1993) both suggest individuals who have weathered several setbacks are quicker to adapt, recover and move toward new challenging life events. Successful adaptation to life events provides an opportunity for emotional and psychological balance with a subsequent sense of well-being for the individual. It became apparent to this researcher from descriptions and emergent themes that there was determination and courage being demonstrated by participants when they were describing their own experience of being resilient in the context of experiencing mental illness. Participants in this study emphasised when they were aware of their situation and discovered through that problem solving and ‘just doing it’ allowed them to get through life. As mentioned, Yehuda et al., (2006) defined resilience as the process of adapting well in the face of adversity or trauma and includes important psychological resilience-related factors and points out exposure to adversity or trauma does not necessarily lead to impairment and the development of psychopathology in all people. Understanding resilience factors in this way could even prevent adverse outcomes for people. I have included the following Indigenous Australian Painting to depict how I imagined ‘viewing life from the ridge with eyes wide open’.
Plate 1: *Landscape* by Conley Ebatarinja Hermansberg (circa 1970)

This image depicts a possible journey from a ridge - initially over rocks (obstacles) in the foreground, followed by smoother travels over a plain. But further ahead, in the foreseeable distance, there are more obstacles for the traveller to negotiate. The images in this painting show a journey which lay ahead, but hidden under the landscape are unknown obstacles and dangers. The painting represents being in the tension of vigilance and uncertainty while also presenting the known.
5.4 Summary

This chapter provided a review of the findings with reference to contemporary literature, relevant research and the arts. There were seven emergent themes related to the notion of resilience as described by people who have experienced mental illness – Universality and Support, Acceptance, Naming and Knowing, Faith, hope and Being the Fool, Striking a Balance, Meaning and Meaningful Relationships and ‘Just Doing it’. The overarching emergent concept – Viewing life from the ridge with eyes wide open - is a description of a central concept under which emergent themes operated for participants in this study. The next chapter provides the researchers’ own reflections throughout the research process.
CHAPTER 6-THE RESEARCHERS’ REFLECTIVE JOURNEY THROUGH THE STUDY

6.1 Introduction
This chapter presents this researcher’s personal journey through the process of this study. It examines these reflections throughout the information gathering process and reflects on the images presented by participants in this study - additionally viewing the images conveyed through the conceptual lens of the arts.

6.2 In The Beginning
My desire to undertake a PhD started for me while I was undertaking my masters study. My master’s inquiry explored the phenomenon of resilience from the perspective of mental health clinicians in the context of their clinical work. I began to wonder about this notion from the perspective of the client- the mental health consumer- and from that point I had a clear idea for undertaking a PhD program and, in fact, the question I might ask.

I began this PhD journey with the expectation that the process of recruitment would be time consuming and difficult because of the nature of the study. I felt this would be related to the ever-present stigma attached to mental illness in the community and at times by those who have experienced mental illness. Difficulties associated with the experience of mental illness, such as social disruption, family and relationship alterations and often disruption at the workplace, can leave individuals feeling frayed and a little reticent to speak about or re-live their experience. In this research, participants were asked to be open and honest about their experience of mental illness including exploring factors they used to transcend the disabling impact of mental illness. I believed this could potentially cause difficulty in the recruitment of potential participants- however, once the recruitment strategy of snowballing was used, recruitment became easier.

6.3 The PhD Journey
Undertaking a PhD is a significant life changing decision, since the time commitment alone is enough to take you away from any social life you thought you could have! I was
not quite sure about how to proceed with undertaking the PhD…in fact, selection of supervisors for the process was also daunting. My supervisors were both very different from each other, and as a consequence, I experienced them both differently throughout my PhD journey. I had known Associate Professor Anthony Welch since I was a young woman in my undergraduate years, and he was also my supervisor during my masters research. This was the first time I had met with Dr Keri Chater. We were all eager to start this journey together, knowing at some level that each of us would grow in some way from the experience.

The aim of this study, as it is with any other, is to uncover new knowledge. The generation of new information involves critical reflection and critical debate. Critical discussion and sometimes debates are also important to the development of ideas related to your topic. I found I was able to develop ideas from some of these discussions and as a result my explorations, went into areas in which I could not have envisaged at the beginning. As an example, my supervisors and I met as a group just weeks before the Christmas break and discussed the transcript of one of my participants. The conversation soon developed around including a description of participants in order to contextualise who the participants were without compromising their anonymity. Through the insightful words of Associate Professor Welch, who thought this would facilitate a greater understanding for the reader in terms of the reader ‘making sense’ of the participants intended meaning relative to the participant’s context, I included an over-view of participant context information (in chapter 4 of this thesis).

Further discussions within my PhD team lead to the development of additional steps to Colaizzi’s research methodology. As an addition, a summary is offered by this researcher related to the essence of the intended meaning of each participant from my own reflections about their intended meaning. The summary is consistent with Colaizzi’s (1978a) emphasis on including researcher reflections in phenomenological inquiry. The additional step of exploring images of resilience from the participants of this study offer a further depth of understanding of the unique experience providing an opportunity for me to achieve a perception of the mental picture for participants when they were talking
about resilience. Jackson and Stevenson (2000, as cited in Edward, 2006 &; Sahttell & Hogan, 2005) suggest the notion where understanding is guided by individuals own definitions to achieve a clear perspective of the person’s observation. Jackson and Stevenson (2000, as cited in Edward, 2006 &; Sahttell & Hogan, 2005) suggest further a person who has not experienced a particular illness themselves cannot know what it truly feels like for another; furthermore, even when the person has experienced similar health problems to another, they still cannot know what it feels like for that particular person in their own unique experience. The inclusion of the images of resilience as described by participants in this study provided an opening for greater insight for me into participants lived experience of being resilient in the context of mental illness. All in all, these were vigorous philosophical debates which challenged me and my thinking about my study.

6.4 Throughout The Information Collection
I felt honoured to be a part of the reliving of a time that was described as quite difficult, upsetting and disconnecting; that is, the story of participants experience of mental illness. I began interviews by defining what I regarded as resilience for participants saying: resilient behaviours include faith, hope, and humour, supported by functional social networks (chapter 4 of this thesis). I then asked participants the focus question: What is your experience of resilience following mental illness? I found that each participant needed to start their story at the beginning, even though the focus question ask for events that occurred after healing had begun. Participants began by identifying the trigger to their mental illness. At these times the participants became reflective and sad when telling their story - some participants cried. These emotions did not appear to cause the participants to stop telling their story, but instead seemed to encourage them to add further clarification around the issues that related to the onset of their illness. A number of participants told stories related to their health-illness experience that they have not previously shared with another, which demonstrated to me a level of comfort with me. I also perceived this as an indicator of engagement and that the participant trusted and did not feel judged by me.
Once the participants’ description was made clear regarding the triggers to their illness, the participants generally explored their recovery phase with me. I saw individuals sit up straighter in their chairs and they would give me more direct eye contact. As they told their stories, there was a sense of determination, pride, strength, courage and hope for their own future in their voice and body language. A number of participants were able to put words to these feelings; the feelings that I had witnessed from their affect. Throughout most interviews, participants re-lived a moment of anger or determination and relayed this story to me while they were laughing. I initially thought this incongruent, however I began to understand this as a demonstration of seeing the funny side in the worst of situations…perhaps a demonstration of black humour. I wondered further if this could be the typical self depreciating Australian way, or maybe something else I had not anticipated. The way the participants used laughter in the context of their conversation was, as it turned out, a way to demonstrate a sense of the ridiculous and a sense of relief. For me, the experience of hearing the participant’s stories of resilience, strength, courage and determination left me feeling inspired. I also felt a sense of appreciation for the difficultly people face at their most difficult moment - in a fight for their own thoughts and feelings.

An exciting development occurred in the context of participants telling their stories as part of the research process. Participants shared with me, either during or after the interview, they felt better for telling their story. I thought this was interesting, as did Associate Professor Anthony Welch and Dr Keri Chater, since the research interview is not designed to be therapeutic. It appears that while the process of asking participants to describe their experience was clearly within the boundaries of research, participants experienced a secondary therapeutic gain from talking about their lived world. This experience reminded me of my previous research on resilience where I explored the phenomenon of resilience in crisis care workers (Edward, 2005a). The participants in that study echoed similar notions of secondary therapeutic gain through telling their story. Nearly all participants of that study (who were mental health professionals) said that they felt totally debriefed after their interview. I wondered if there was a secondary therapeutic
gain occurring for the participants of this current research – perhaps a similar experience of feeling debriefed.

I also recalled a study that examined how individuals responded to being in a position of telling their story about their experience of the health-illness journey. This study undertaken by Chelf, Deshler, Hillman, and Durazo-Arvizu (2000) explored attitudes and beliefs of patients about storytelling as a strategy for coping with chronic/terminal illness. In that study storytelling was described as a supportive way to cope with experience. The study suggested there was considerable therapeutic benefits from re-telling a story of meaning to another.

6.5 The Images Of Resilience

As previously mentioned images were included as an additional aspect of narrative description in this study. The images that participants offered added not only depth to the essence of what each intended to convey, but also allowed me to develop an image of what was in their mind’s eye. The following is an account of the images and my reflections related to them.

One participant reflected on an image that kept him going throughout his recovery from mental illness. He said that this image related to the concept of a ladder image. In this image the ladder rested on what he identified as a foundation of his beliefs – represented by the earth. Either side of the ladder represented his values. The participant said that the ladder represented an upward and moving on feeling that he held onto throughout his recovery period from mental illness. The participant said that to step outside of his values (the sides of the ladder) was to threaten the progress he was making in terms of transcending the negative impact of mental illness. The foundation on which the ladder was supported represented the participant’s beliefs – perhaps in himself and in the support around him when he needed it. From my reflections on this image, the ladder and the feeling of upward movement represents progress albeit coupled with effort of climbing. The framework of the ladder – the values and beliefs of the participant – guides and supports the journey.
Another participant recounted an image of resilience as a flower coming to bloom. The participant had lived in a house which was described to me in the interview as *a wonderful, alive and magical garden*. This participant described the image of resilience of growth of a new bloom in the context of her actual lived experience with her home and the magic garden. The participant indicated that being resilient was not only about growth but also change in terms of evolving as a human being. This participant’s description seemed to refer to more than learning from experience, but also to a spiritual even magical evolutionary moment in time. My reflection of this image evoked in my imagination a garden lush and alive, with parts of the garden having many flowers while in other areas the flowers had not yet began to bloom (Plate 2). The garden represents the cycles of life. I have included the following painting as a depiction of the mental image I created from the image description offered by the participant.
One participant said that her image of resilience was related to *having a go* and *just doing it*. Her image was not relayed in a visual way, such as a description of a picture or a symbol, but rather a verbal image. Her image related to having a high level of personal responsibility and accountability. The participant explained that the image of resilience started with a moment of acceptance which led to change in terms of finding her own balance in dealing with the day-to-day in a realistic and conscious way. She highlighted the importance of laughing (at herself and the world) and being flexible in different situations. From my reflection of this image I understood for this participant resilience was being flexible, accepting self and others and seeing the funny side of life.
One participant articulated water as the image for resilience. The participant explained that water is soft yet powerful, always flowing and moving as opposed to static or stuck. Water evaporates and reforms as rain and may end up in another place in order to move freely again. This image for me was referring to being resilient as finding a way through the obstacles of a particular situation. I also believe the participant was intending to convey that, like water, being resilient is about evolving, changing and at times reinventing yourself. The following image (Plate 3) depicts the mobility of water, alluding to the flexibility of water –self- in the face of obstacles.

**Plate 3: Rushing Water Photographer Unknown (N.D)**
A participant said that their images of resilience consisted of a rainbow and a butterfly. For the participant the rainbow was a symbol of hope in darkness (hope in the black of the rain clouds). I reflected on this image and concluded that the participant was saying hope was important to hang onto, even when you are in your darkest moment. When I reflected on the image of the butterfly, the butterfly is beautiful and free from its confinement…the cocoon. However, the butterfly still struggles to break free, a point that is important to its very survival [that is, the butterfly when breaking out of the cocoon pushes blood into its wings strengthening the wings so it can then fly. If this process doesn’t happen the butterfly cannot fly and will die]. This image upon reflection meant a few things to me. In the first instance being resilient is having the freedom to hope. Also, being resilient is about going through the hardships and the struggles.

For another participant, resilience was represented by the image of a colony of ants. For this participant, ants work hard through life in order to survive – such as making a mound to live in. Even for ants major adverse life events occur, and in this image the participant described the ant mound being destroyed. So what do the ants do? They repair it, they don’t move on to another place. They stick with what they have and build on it. My interpretation of this image was being resilient is about knowing there is hard work ahead but still undertaking it and surviving…perhaps thriving as a consequence. Ants also work together, so I considered the participant was acknowledging through this imagery that they were not alone in the world when hardships occur. Often and without warning, being resilient was related to undertaking the hard work. Resilience is not about shying away from the situation, but knowing it and somehow embracing acceptance of it as a point of moving though the situation toward transcending it.

One participant said the image of Nelson Mandela was for her an image of resilience. The participant went on to describe how Nelson Mandela held no grudges even though he had been imprisoned for many years for political reasons. The participant explained that as a human being, Nelson Mandela had a great impact on others and the world by this demonstration of care and his desire to encourage others towards helping the world become a better place. For this researcher I was struck by the point being made where
resilience is for this participant forgiveness, having meaning and being a part of a bigger world…that is, not only helping yourself and your own family, but also others in the world. There was a notion of Universality about what this participant was describing.

A participant described the image of the beach as one that represented resilience to her. For this participant, walking along the beach, the sand, the sun and the calmness of this location were all key ingredients for her remaining resilience – a place to think, slow down and feel safe. The participant described how the ocean can sometimes get rough but that it is to be expected because that also occurs in life. It is about taking time with major life events that occur by using the image of the beach (or on some other occasions, the beach literally). The participant said, *I’ve learned to take every day as it comes and it was scary before when there’s no money and you can’t pay the bills, there is always someway it will come.* The participant developed a sense of faith things would turn out for the best in the long term and the knowledge taking each day as it comes helped her to transcend difficult times.

The following painting (Plate 4) depicts a beach scene where the scene appears calm and serene; however the sky suggests a storm may have recently passed. In the foreground of the painting are two butterflies, flying freely from their cocoon in the sunlight. This researcher believes the following painting conveys a similar message as that from the participant describing the beach as an image of resilience. That is, there is a sense of freedom and safety experienced at the beach which promotes a sense that life will work out in the long term.
When these images were described to me I felt that the participants had invited me into their experience through imagery. It was a powerful and wonderful experience to be able to walk with individuals when they are relaying the very intimate details of what was, at times, described as the fight for their very thoughts. I decided after discussions with my supervisors, to include the images in the findings and researcher reflections of this thesis. I believed that the richness the images offered to the explication of the notion of resilience was a significant addition to this study’s results. I understood the process of phenomenological inquiry as being consistent with the values of nursing practice - the uniqueness of the person, the importance of personal discovery and acceptance of life situations, and the need for exploration of meaning of that experience. In essence, holistic care ... at the centre of professional practice (Streubert & Carpenter, 1995, p34 ). Since phenomenological methodology utilises the person’s own language to reflect meanings
embedded in their own experience it is a process that accepts the validity of the person’s descriptions and understandings, incorporates the perspective of the experience of the researcher, and finally produces an interpretative narrative of the experience (Edward, 2006; Giorgi, 1985; Solomon, 2001). This understanding helped me to identify the importance of the inclusion of the images of resilience for participants from their minds eye.

6.6 Mapping The Journey Through Reflection
The inclusion of personal reflections of the researcher’s experience of undertaking research in phenomenological inquiry adds to the methodological rigour of this research process. The inclusion of reflection is in keeping with Colaizzi’s (1978a) emphasis on researcher reflections and overting researcher presuppositions towards the provision of methodological clarity and rigour. The documentation of a reflective chapter provided opportunity for this researcher to interpret and explore one’s own understanding of the lived experience being described. Colaizzi (1978a) and other phenomenologists suggest the researcher is not a blank slate for information in this type of inquiry, but guided by anticipation which is articulated through this process (Cohen, 2001; Giorgi, 1983). The inclusion of a reflective chapter also offers other phenomenologists’ insight into the experience of research as a part of the PhD process, which is valuable in terms of guiding others through the marathon journey that is the PhD journey.

6.7 In The Final Stages Of The Research
The final stages of this research were both exciting and daunting for me. A paradox of sorts. Working through the findings of the research was more difficult than I had originally imagined where I became stuck in terms of my progress at various points in analysis. Once I had completed the findings chapter I began to understand the hard work would continue on into the discussion chapter that followed. Dedicating as much time as possible to this was imperative for me so as not to lose the momentum I had developed. I could suddenly see the conclusion of this epic journey in sight and began to worry about whether I had included all the points I needed to make in this thesis. I worried about life beyond my PhD, since I realised as I undertook this dissertation how this would mark the
beginning of another journey and not necessarily the end of my academic pursuits. The final stage of any large undertaking is often fraught with emotions such as frustration, anxiety, anticipation, excitement, fear and relief. I felt these emotions all at different times and at other times all together. Webster and Kruglanski (1994) suggest the process that occurs for individuals at times such as this is called cognitive closure. Cognitive closure is identified as a dispositional construct, such as a desire for predictability and a personal preference for order and structure (Taris, 2000; Webster & Kruglanski, 1994). With this in mind, cognitive closure presented this researcher with a sense of discomfort/comfort, that is, uncertainty/certainty, in terms of my undertakings following the completion of this dissertation and beyond.

6.8 Summary
This chapter presented the reflections of the researcher throughout the research process. Researcher considerations are consistent with Colaizzi’s (1978a) emphasis on inclusion of reflections as part of the rigour in phenomenological inquiry. The chapter provided a consideration of the images conveyed by participants related to resilience, also using the conceptual lens of the arts. The inclusion of this chapter also offers other phenomenologists insight into another researchers’ journey through the PhD experience.
CHAPTER 7-SUMMARY, IMPLICATIONS AND INSIGHTS OF THE STUDY

7.1 Introduction
This chapter offers a discussion about the implications of this study’s findings in terms of clinical practice and research in the area of resilience. The chapter also provides recommendations related to resilience in the clinical setting for mental health consumers and clinicians.

7.2 Implications Of The Study
The findings of this study have many important implications for clinical practice, positive consumer outcomes and future research. Some of these implications are explicitly stated and some are implicit in the following text.

7.3 Clinical Practice
Yehuda, Flory, Southwick and Charney (2006) point out that exposure to adversity does not automatically lead to impairment and the development or the manifestation of behaviours and experiences which may be indicative of mental illness or psychological impairment. Yehuda et al., (2006) and Charney (2004) suggest that exploration of resilience, and why some people are resilient and others are not, could offer a basis for clinical interventions that have a potential to prevent poor or adverse outcomes for clients. From the literature, resiliency means being able to bounce back from life developments that may feel totally overwhelming at first (Charney, 2004; Edward, 2005b; Siebert, 2005; Tusaie & Dyer, 2004a; Yehuda et al., 2006). Resilient people allow themselves to feel grief, anger, loss, and confusion when hurt and distressed, but they do not let it become a permanent feeling state. This study’s findings suggest by allowing healing in the initial stages of mental illness (that is, time to feel grief, loss and confusion), then naming, knowing, and active problem-solving using existing knowledge and skills and developing new skills in the situation, are considered important ingredients to being resilient in the context of experiencing mental illness.
In this study, participants identified that giving in to negative emotions such as fear, anger, anxiety, distress, helplessness, and hopelessness impeded their own ability to solve their problems, thus weakening their resiliency. This is supported by contemporary literature and research which identifies that experiencing these negative emotions in a protracted way is unhelpful to adaptation of events and weakens resiliency (Siebert, 2005; Tusaie & Dyer, 2004a; Yehuda et al., 2006).

Dr Al Siebert is internationally recognized for his research into the inner nature of highly resilient survivors suggests highly resilient people are flexible, adapt to new circumstances quickly, and thrive in constant change (Siebert, 2005). Most importantly, he posits they expect to bounce back and feel confident in the hope that they will. In this study participants described they had a sense of hope and faith that things would turn out for them in the long term. Participants described this experience as though being naïve or feeling foolish however, emphasised that it was important to have this hope to remain resilient in the context of having their life disturbed by the experience of mental illness. As an unexpected outcome by participants, they found that they did not look back on the experience or dwell on it, that they felt able to work through the negativity, learning from the experience and evolving as a human being in the process. Participants demonstrated a self motivation and commitment for adapting to their situation and managing their own day-to-day lives in the context of mental illness. This is remarkable since the experience of mental illness often left them feeling disconnected and at times alone.

As previously mentioned, the unpredictable nature of mental illness and related relapses impacts significantly on the individual’s lifestyle, often leading to an ongoing state of uncertainty in terms of workplace commitments, social networks and sense of self. Therefore, the impact of mental illness has implications for not only the individual who has the experience, but also their family, friends, workplace and productivity in the workplace, and the healthcare system in terms of re-hospitalisations and other associated treatments. Successful adaptation to the difficulties that one experiences from having mental illness is important in terms of potential savings and reductions—more specifically, saving the potential of a person and reducing the burden of disease on
individuals, family members, carers and the community—by using resilience factors to successfully adapt to the difficulties of mental illness.

When some people in the community hear that resilience can be learned they may look for a technique or a self help guide them towards being resilient, however from this study, being resilient is unique and is driven by the desire of the individual to master a particular situation. Being resilient cannot be achieved through a detached process of going through self help steps (Siebert, 2005). However, the literature supports that resilience factors can be learned and added to already existing skills the person has already. In this context, supporting the learning of resilience in clinical practice has implications for the development of therapeutic interventions for people who experience mental illness (Edward, 2005b; Edward & Warelow, 2005; Siebert, 2005; Tusaie & Dyer, 2004a; Yehuda et al., 2006). McGowan (2006) suggests there exists a potential for building resilience and as a subsequence promote mental health. McGowan focused on young people however this information can translate to the adult demographic, and his findings suggests key actions in the facilitation of building resilience may include the following concepts: Welcome packs, clear relationship roles and responsibilities, skills development and accessible sources of help.

7.4 Recommendations For Clinical Practice
Since the statistics for people affected by mental illness, neurological or behavioural problems is currently at approximately 450 million people worldwide, and one in four patients visiting any health service has at least one mental, neurological or behavioural disorder where most of these disorders are neither diagnosed nor treated - there remains a significant need for the development of clinical mental health practice (World Health Organisation, WHO, 2006a). As previously stated in chapter one of this thesis, in Australia one in five will experience a mental illness in their lifetime (Australian Bureau of Statistics, ABS, 2002). In response to this startling statistic, in April 1992 Australian Health Ministers endorsed the National Mental Health Strategy as a framework to guide mental health reform over the period 1993 to 1998. Affirmed in 1998 with the Second National Mental Health Plan and more recently in 2003 of the National Mental Health
Plan 2003-2008 (National Mental Health Strategy, NMHS, 2003; Whiteford, Buckingham, & Manderscheid, 2002). The aims of the National Mental Health Strategy are the following; Promote the mental health of the Australian community; Prevent the development of mental disorder; Reduce the impact of mental disorders on individuals, families and the community; and assure the rights of people with mental illness. Inclusion and facilitation of resilience factors in the development of therapeutic interventions can offer the potential for reducing the impact of mental disorders on consumers of mental health services, their carers/family and the community.

7.4.1 Recommendation one
As mentioned, the participants of this study described through naming and knowing they were better able to accept their situation and initiated problem-solving strategies within their own limitations to transcend the negative effects of their experience. This process can be facilitated by clinicians in mental health for people who experience mental illness with a greater emphasis on developing skills in clinical practice related to the assessment of existing resilient factors of mental health consumers—demonstrated problem solving, demonstrated ability to positively restructure cognitions, and demonstrated goal setting and planning abilities. It is from this assessment that planning for interventions for individual and unique needs of each mental health consumer can occur.

7.4.2 Recommendation two
Since the introduction of health reforms in mental health (such as, deinstitutionalization and mainstreaming of mental health services) undertaken in Australia over the previous decade, family members involvement in an intensified carer role has resulted. Building of resilient factors for the carers of people who are experiencing mental illness can enhance successful adaptation of the changes carers undertake in the intensified carer role. This process begins with an assessment of existing resilient factors the carer has and interventions/support in directed at further enhancement of resilient factors or the development of new resilient factors.
7.4.3 Recommendation three

Emphasis on resilience factors in mental health clinician education is required in order for the development of knowledge of resilience and the consequential development of therapeutic interventions to facilitate enhancement of these factors for mental health consumers and their carers. As mentioned in this chapter, the literature supports that resilience factors can be learned and added to already existing skills; therefore mental health clinicians are well positioned to facilitate the development of these factors for mental health consumers and their carers. Inclusion of, or greater emphasis on, cognitive behavioural strategies and their use in day-to-day clinical practice (such as in-patient and community settings) for clinicians in mental health could facilitate this shift in routine clinical practice— in particular, inclusion of cognitive re-structuring, education related to the enhancement of self talk to address automatic negative perceptions, and working with ambivalence, motivations and beliefs towards transcending the negative impact of mental illness- in educational forums for mental health clinicians.

7.5 Future Research

The purpose of engaging in research to explore the phenomenon of resilience as described by people who have experienced mental illness is to enhance awareness of the phenomenon under inquiry and to advance knowledge of the phenomenon. The exploration of the phenomenon points to new pathways of discovery about the phenomenon and invites reflection on therapeutic interventions for consumers experiencing mental illness with the potential for preventing adverse outcomes for clients and/or their carers. Exploration of the phenomenon also offers information for consumers and/or their carers to contemplate when considering their own personal journey through the illness-health continuum in the context of mental illness.

Since this is the only study thus far to explore the phenomenon of resilience as described by people who have experienced mental illness in Australia, further inquiry into this experience could offer greater depth of understanding in terms of the factors individuals have utilised to successfully adapt to life in the context of such an experience. Future research examining the phenomenon through another conceptual lens could offer further
richness of knowledge to the phenomenon of resilience in this context. Additionally, examining the notion of resilience in the context of mental illness cross-culturally would extend the findings of this study in terms of cross cultural relevance and significance.

7.6 Summary
The completion of a phenomenological study such as this does not mean the end of inquiry about the phenomenon under investigation. This text will continue to offer opportunities from which insights can be taken. The moment of completing a thesis in the uncertainty-certainty of the moment offers a little anxiety as I offer my work up for critical review and comment from academic peers. I remain enthusiastic and hopeful about the possible implications of this study exploring resilience for mental health consumers and the development of therapeutic interventions. I remain confident that the road of researcher ahead for me is open and full of opportunity. I will leave you with this poem called Winter’s Road that for me tells the story of different roads, different choices and different opportunities and how we ultimately choose what is right for ourselves:
Winter's Roads

I cannot speak for all who stem
'Long roads less traveled as their way,
Nor question choices made by them
In days long past or nights long dim
By words they spoke and did not say.

Each road is long, though short it seems,
And credence gives each road a name
Of fantasies sun-drenched in beams
Or choices turned to darkened dreams,
To where each road wends just the same.

From North to South, then back again,
I followed birds like all the rest
Escaping nature's snowy den
On roads I've seen and places been,
Forsaking roads that traveled West.

This journey grows now to its end,
As road reflections lined in chrome
Give way to roads with greater bend
And empty signs that still pretend
They point the way to home sweet home.

But all roads lead to where we go
And where we go is where we've been,
So home is just a word we know,
That space in time most apropos
For where we want to be again.

For even home, it seems to me,
Is still a choice we all must face
From day to day and endlessly,
To choose if home is going to be
Another road - or just a place.

(Carnell, 2006)
REFERENCES


Copy of the advertisement for community newspapers/newsletters

Research Project

‘Exploring the experience of resilience as described by people who have experienced mental illness’

Are you?

- Between the ages of 18-64 years
- Have had an experience of mental illness (i.e.: depression, anxiety, schizophrenia etc), and have been symptom free for a period of 6 months
- Have English as a first language
- Available for three (3) separate interviews

Please ring for more information

Karen-leigh Edward, RPN,BN,GDipPsych,MHSc and PhD candidate at RMIT University

Tel: 0438 316 074

B/w 9am-9pm, Mon-Sat
APPENDIX B - Invitation to Participate in a Research Project

Plain Information Statement

Project Title:

‘The phenomenon of resilience as described by people who have experienced mental illness’

Dear …

My name is Karen-leigh Edward. I am undertaking a Doctor of Philosophy degree at RMIT University. You are invited to participate in a research project being conducted by RMIT University. This information sheet describes the project in straightforward language, or ‘plain English’. Please read this sheet carefully and be confident that you understand its contents before deciding whether to participate.

Who is involved in this research project? Why is it being conducted?

You are invited to participate in this study if you are:

✓ Over 18 years of age.
✓ Under the age of 64 years.
✓ A lived experience of mental illness.
✓ A period of remission for at least 6 months
✓ Articulate in English
✓ Available for three (3) separate interviews, the first is an initial contact to arrange for an interview time and a follow-up interview to ensure that I have captured the essence of what you intended to say.
**What is the project about? What are the questions being addressed?**

The aim of this study is to explore the understanding of resilience of people who have experienced and recovered from mental illness.

For the purpose of obtaining full knowledge of the experience under investigation the definition of ‘Resilience’, that is; *springing back, rebounding, readily recovering, [and] buoyant* will underpin the focus of the study.

The focus question in this study will be:

*What has been your experience of resilience after experiencing mental illness?*

**If I agree to participate, what will I be required to do?**

Your participation is voluntary and I will need your consent. The interviews can be held at your private home, or somewhere else that suits you. Information will be gathered through in-depth, semi-structured individual interviews lasting between 30-60 minutes. The interviews will be tape-recorded, (as a means of capturing your full narrative).

You will be encouraged to speak freely about your personal experience of resilience in the context of recovery from your experience of mental illness. There is an initial contact to allow you to gather a full understanding of the project, provide consent if you wish to participate and organize a time for the interview. The interview will be audio-taped and last approximately 30-60 minutes. A follow-up interview will be arranged with you to validate that I have captured you intended meaning. This final interview will not be audio-taped. At this ‘validation’ interview, you will be able to add or clarify your interview information to ensure that it conveys what you meant to say.

You will be required to be available for the three (3) separate interviews in total.
What are the risks or disadvantages associated with participation?

There are no perceived risks outside your normal day-to-day activities. However, in the interview questions pertaining to clinical conditions (such as mental illness) will be discussed and there is the possibility, however slight, that you may be concerned or upset about your responses.

If you are unduly concerned about your responses to any part of the interview or if you find participation in the project distressing, you should contact me (Karen-leigh Edward) as soon as convenient. I will discuss your concerns with you confidentially and suggest appropriate follow-up, if necessary.

What are the benefits associated with participation?

While there is no direct benefit to you associated with participation in this study, this project will contribute to the general body of knowledge about the experience of recovery from mental illness. Resilient behaviours can be learnt and interwoven with life experiences. In this context, there is the potential to guide practical interventions in various clinical, occupational, and educational settings. It is anticipated that the findings of this research will have the following benefits:

- This study has the potential to inform mental health consumers of resilience in the context of recovery from mental illness.
- Possible inclusion in psychosocial educational information and training for mental health consumers.
- Insight into the experience of resilience, from the perspective of the mental health consumer, to facilitate greater understanding in mental health practitioner’s clinical practice.
**What will happen to the information I provide?**

**Anonymity**
You will be able to choose your own pseudonym for the purposes of maintaining anonymity. The uncoded data will only be accessed by the principal investigator (Karen-leigh Edward). Coded data (in which you are not identifiable) will be accessed by me (principal investigator) and my supervisors for the purpose of data analysis.

**Confidentiality / Storage**
Tape-recorded material would be only accessed by me, (the principal investigator), for the purpose of recording experiences and analysis of the data. On completion of the analysis process the tape-recorded narratives will be returned to RMIT University for storage. Any names or places will not be used in the final transcriptions and will thus be withheld in the final presentation of the thesis. Throughout this study all information shared by you will be stored in a locked filing cabinet within my locked home office. In accordance with the policy and procedure of RMIT University Human Research Ethics Committee, on completion of this study all information obtained in the form of audio-transcriptions will be returned to RMIT University for storage for a period of five years. After this period of time, and in accordance with RMIT University policy for destruction of confidential information, the information will be destroyed.

Any information that you provide can be disclosed only if (1) it is to protect you or others from harm, (2) a court order is produced, or (3) you provide the researchers with written permission.

The findings of this study will be shared with health professionals and the community. This may include presentations at conferences, publications in professional journals and books. At no time will any information that would
contravene anonymity be included. You will be provided with a copy of this form and your signed consent form for your own records.

**What are my rights as a participant?**

You have:

- The right to withdraw their participation at any time, without prejudice.
- The right to have any unprocessed data withdrawn and destroyed, provided it can be reliably identified, and provided that so doing does not increase the risk for the participant.
- The right to have any questions answered at any time.
- The right to a copy of your respective transcript and if requested a copy of the final report.

**Whom should I contact if I have any questions?**

Karen-leigh Edward ph: 0438316074

**Would you like to take part?**

Please contact me, Karen-leigh Edward, if you have any questions or require further information about this research on **ph: 0438316074**.

If you wish to take part in this study please contact me to arrange a suitable time and place to obtain your informed consent prior to being interviewed as part of the study.

If you wish to speak to my supervisors for this research they can be contacted as follows:

- Dr Anthony Welch (Senior Supervisor, Senior Lecturer RMIT University, Bundoora West Campus, ph: 99257389)
- Dr Keri Chater (Supervisor, Senior Lecturer RMIT University, Bundoora West Campus)
Yours Sincerely

Karen-leigh Edward, PsychN, BN, GDipPsych,MHSc

Associate Professor Anthony Welch, PhD

Dr Keri Chater, PhD

Any complaints about your participation in this project may be directed to the Secretary, RMIT Human Research Ethics Committee, University Secretariat, RMIT, GPO Box 2476V, Melbourne, 3001. The telephone number is (03) 9925 1745.

Details of the complaints procedure are available from the above address.
APPENDIX C – Consent Form

HREC Form No 2b

RMIT HUMAN RESEARCH ETHICS COMMITTEE

Prescribed Consent Form For Persons Participating In Research Projects Involving Interviews, Questionnaires or Disclosure of Personal Information

FACULTY OF
Health & Behavioural Sciences

DEPARTMENT OF
Nursing & Midwifery

Name of participant: ____________________

Project Title: The phenomenon of resilience of people who have experienced mental illness

Name(s) of investigators: (1) Karen-leigh Edward Phone: 0438316074

(2) ____________________ Phone: ____________________

1. I have received a statement explaining the interview/questionnaire involved in this project.

2. I consent to participate in the above project, the particulars of which - including details of the interviews or questionnaires - have been explained to me.

3. I authorise the investigator or his or her assistant to interview me or administer a questionnaire.

4. I acknowledge that:

(a) Having read Plain Language Statement, I agree to the general purpose, methods and demands of the study.

(b) I have been informed that I am free to withdraw from the project at any time and to withdraw any unprocessed data previously supplied.

(c) The project is for the purpose of research and/or teaching. It may not be of direct benefit to me.

(d) The privacy of the information I provide will be safeguarded. However should information of a private nature need to be disclosed for moral, clinical or legal reasons, I will be given an opportunity to negotiate the terms of this disclosure.
The security of the research data is assured during and after completion of the study. The data collected during the study may be published, and a report of the project outcomes will be provided to RMIT University. Any information, which will identify me, will not be used.

Participant’s Consent

Name: ___________________________ Date: ___________________________

(Participant)

Name: ___________________________ Date: ___________________________

(Witness to signature)

Participants should be given a photocopy of this consent form after it has been signed.

Any complaints about your participation in this project may be directed to the Secretary, RMIT Human Research Ethics Committee, University Secretariat, RMIT, GPO Box 2476V, Melbourne, 3001. The telephone number is (03) 9925 1745.

Details of the complaints procedure are available from the above address.
To whom it may concern,

I have been asked by Ms Karen Leigh-Edward who is undertaking a phenomenological study concerned with the notion of resilience to act as counsellor and support person for participants if the need arises. The participant cohort are people who have experienced mental illness and have recovered. I have agreed to provide such services for ongoing support and counselling if required by the participants. I am an experienced psychologist, registered with the Australian Psychologists Board.

Yours sincerely

Ms. Kana Intherarasa