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ISSN: (Print) (Online) Journal homepage: https://www.tandfonline.com/loi/wsmh20

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To cite this article: Dyann Ross, Mary Couche, John Connolly & Bindi Bennett (2023) Emotional wellbeing as a matter of relationships and love: insights for social work from mental health peer mentor trainees, carers and practitioners, Social Work in Mental Health, 21:6, 634-655, DOI: 10.1080/15332985.2023.2195521

To link to this article: https://doi.org/10.1080/15332985.2023.2195521

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Published online: 12 Apr 2023.

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SOCIAL WORK IN MENTAL HEALTH
2023, VOL. 21, NO. 6, 634–655
https://doi.org/10.1080/15332985.2023.2195521

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Emotional wellbeing as a matter of relationships and love: insights for social work from mental health peer mentor trainees, carers and practitioners

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ABSTRACT

The research gathered lived experience accounts of emotional wellbeing as a counter to the over-focus on illness and deficit language and approaches in mental health practice. The exploratory research study involved semi-interviews with mental health peer mentor trainees, carers and practitioners to explore their ideas about emotional wellbeing, what enabled it and what challenged their wellbeing. Emotional wellbeing was understood as a fluctuating continuum of capacities to engage in everyday activities, to self-care and to foster relationships with others. The absence of emotional wellbeing was linked to a reduced quality of relationships and ability to love.

KEYWORDS

Emotional wellbeing; love; mental health carers; mental health peer mentor trainees; mental health practitioners; relationships

Introduction

Wellbeing is an under-appreciated concept even though it is the main goal of many professions involved in the social, health and mental health sectors. For example, according to the Australian social work's *Code of ethics*, wellbeing is to be achieved by recognizing the uniqueness and intrinsic worth of people and their right to experience wellbeing (Australian Association of Social Workers, 2020). Boulet argued (1992) that social work's mission centers on matters to do with justice, peace and social wellbeing. His article in the journal *Australian Social Work* remains, after 30 years, one of only a few that mention the idea of social wellbeing as being important in social work (see also Mensingaa & Pylesb, 2021, in relation to social workers' wellbeing). Another article in the journal by Day, Nakata, and Miller (2016) discusses the need for programs to improve the social and emotional wellbeing (SEWB) of Australian First Nations communities. Day et al. link wellbeing with First Nations Peoples' mental health in a broad way in recognition of the low levels

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of wellbeing due to the adverse impacts of racial discrimination and socio-political disadvantage.

The term SEWB is established in the field of First Nations health care (Australian Indigenous HealthInfoNet, 2018; Gee, Dudgeon, Schultz, Hart, & Kelly, 2014) and provides the conceptual emphasis on the social and emotional dimensions of wellbeing in the current article. This is important due to the relevance of socio-cultural connection and support for First Nation people with a lived experience of mental illness (Dudgeon, et al., 2014). Dudgeon et al. explain that a holistic, non-medicalized and culturally-responsive understanding of wellbeing helps avoid blaming the individual (Baum, 2018) and gives scope for considering all the factors which can impact health and life chances. It enables a sociological perspective drawing on social and other determinants of health, which is not always evident in mainstream mental health services (Zubric et al., 2014) and related medicalized approaches (Thompson, 2018). Further, SEWB is congruent with the idea of mental health and wellbeing as a human right which is more than the absence of disease and illness and encompasses the personal and societal resources needed for human flourishing (Parker & Milroy, 2014; Nind & Lewthwaite, 2018).

Veenhoven (2008) suggests that there has been a lack of research on the related concept of subjective wellbeing in sociology due to sociologists' interest in explaining social phenomenon where wellbeing is regarded as an individual experience. Perhaps this reason holds for the related field of social work, when Veenhoven argues that sociologists are interested in measurable indicators of wellbeing such as social equality where how people actually feel in these situations is not relevant, or could be unwelcome, if it led to suggestions that people can experience wellbeing in unequal social contexts. Social work practitioners focus on the "person-in-environment" (Weiss-Gal, 2008, p. 65) and as such presumably have at least a theoretical interest in social wellbeing as well as peoples' emotional wellbeing. The language of SEWB can bridge the social and individual levels of experience of wellbeing which has emotional, mental and physiological dimensions, within social, cultural and political influences (Keyes, 2002).

There is perhaps a more convincing reason for the lack of research about wellbeing in social work. It can be found in the bias in the research literature due to the medicalization of inequality broadly, and of mental illness specifically (Thompson, 2018). A key understanding of the limits of a medicalized response to mental illness is how it individualizes and can blame the person for their own situation (Baum, 2018; Germov, 2018). Social workers and other writers have made a significant contribution to knowledge through the critique of neoliberalism and managerialism in mental health practice (Baum et al., 2016; Sawyer & Savy, 2018) and the intersection of these dominant discourses with the dominant medicalized approach to mental health (Morley,

2003; Sawyer, 2008, 2011). Wellbeing language may open the space for recognizing the social and relational nature of emotional wellbeing for people with a lived experience and significant others, such as mental health carers and practitioners.

Literature review

The World Health Organization (WHO, 2018) defines health in holistic terms as the absence of disease and a positive state of wellbeing where the individual can realize their own potential, are coping with everyday life stressors, working effectively and productively, and are making a meaningful input into their community (WHO, 2004). Mental health can be understood as a complex interaction between biological, psychological, social, environmental and economic factors (Australian Government, 2016). Mental illness can involve varying levels of psychological distress which can impact on peoples' ability to maintain social connection and meaning in their lives (Australian Government, 2016). The terms mental health and mental illness are socially constructed and contested and can be used interchangeably such that their meaning is often unclear. Dominant medical constructions of mental health are critiqued because they tend to refer to the absence of disease and focus on the treatment of symptoms of mental illness (Morley, 2003; Sawyer & Savy, 2018; Sawyer, 2008, 2011) with less regard given to the range of factors that can impact on peoples' mental health (Germov, 2018; Thompson, 2018).

Mental health legislation is premised on similar medical and psychological understandings of mental illness and in a legal context it is mental health clinical staff, typically psychiatrists, who decide if a person has a mental illness (QHealth, 2022). Mental illness is usually classified through the *Diagnostic and Statistical Manual of Mental Disorders* (American Psychiatric Association, 2018) or the *International Classification of Diseases*, ICD, (1992/2016). This method of classifying complex human experiences as the basis for mental health systems of care is strongly contested by people with a lived experience as well as activist groups and advocates. It is criticized for its lack of consideration of the broader range of factors that can impact peoples' mental health (Frances, 2010). Slade (2010) argues that there has been considerable success in the science of illness, with taxonomies which identify types of illnesses and empirically evidenced interventions supported by a system of policies, procedures and clinical guidelines. However, he claims there has not been a corresponding advancement in the science of wellbeing and research into what this means for mental health service delivery. This matters because research shows that people with mental illness can experience wellbeing (Slade, 2010; Slade, Adams, & O'hagan, 2012). Further, a focus on wellbeing is both more consistent with mental health service user definitions of recovery

(Coleman, 2004/2014) and more beneficial for people (Slade & Wallace, 2017), especially people who experience severe and enduring mental illness.

The term wellbeing is difficult to define due to the divergent ways in which individuals comprehend wellbeing within their differing contexts (White, 2010). According to Ryan and Deci (2001), wellbeing is a multifaceted concept that comprises optimal living and functioning. They describe the two main approaches within the research on wellbeing, namely: hedonic thinking which focuses on happiness and fulfillment through pleasure as well as averting displeasure or pain; and eudaimonic thinking, focussing on deeper meaning and self-fulfillment in life. Wellbeing is a term that can encompass psychological, eudaimonic, emotional, economic and spiritual elements (Keyes, 2002). Keyes proposes a mental health continuum model where the emotional, social and psychological wellbeing are all components of mental health. According to Seligman's (2011) wellbeing theory, when mental health is discussed, what is actually being referred to is mental illness, as opposed to a more holistic interpretation that mental health also includes wellbeing. Wellbeing then could be thought of as an umbrella term to describe a life of fulfillment, optimistic affect, thriving and resilience (Diener & Chan, 2011) and flourishing as a complete state of mental health (Keyes, 2007).

Typically, the literature focuses on the mental health or mental ill health of people with a lived experience of mental illness. The focus is warranted and at the same time it can belie the role and involvement of significant others in the person's life. It can also hide the experience of mental ill health or lack of emotional wellbeing in close relationships, namely, for current purposes, carers and practitioners. There has been some relevant research relating to the mental health or wellbeing of carers (Broady & Stone, 2015; Happell, Wilson, Platania-Phung, & Stanton, 2017; Lawn & McMahon, 2014; Quinlan, Deane, & Crowe, 2018) and mental health practitioners (Dransart, Treven, Grad, & Andriessen, 2017; Moore & Cooper, 1996; Rabin, Feldman, & Kaplan, 2011). Research shows, for example, that hospitalization rates increase for people with a lived experience of mental illness when their carer experiences compassion fatigue (Cocker & Joss, 2016). Further, research also shows that mental health practitioners experience high levels of vicarious trauma (Finklestein, Stein, Greene, Bronstein, & Solomon, 2015), which can seriously impact their wellbeing and ability to help people with a lived experience. However, it is unclear how all three groups, people with a lived experience, mental health carers and mental health practitioners experience wellbeing and how the interrelationships between them might impact their own ability to sustain emotional wellbeing. The research begins to explore these concerns and focuses on how people with a lived experience of mental illness in peer mentor trainee roles, carers and practitioners understand emotional wellbeing.

Method

An exploratory research project (Stebbins, 2001) was undertaken to develop an understanding of emotional wellbeing from different perspectives of people involved in the mental health sector. The impetus for the current research was an earlier Delphi research (Ross & McAllister, 2010) with people with a lived experience, carers and practitioners, which proactively recruited Australian First Nation People in a separate focus group. It was their contribution to that research that led to the outcome that emotional wellbeing needed to be researched. By adopting the SEWB ideas of First Nation writers in the current research, it was hoped that due credence would be given to First Nation Peoples' contribution in the earlier Delphi research.

Participants

The research engaged three cohorts of participants, namely; people with a lived experience of mental illness who are peer mentor trainees; people in informal carer roles, and; people in professional mental health roles. The main characteristic of the sample group was their identification with one of these roles. The participants were not recruited on the basis of having a known relationship with each other.

Recruitment procedure

Participants were recruited through an educational program, a community-based organization and a professional practice group in three separate processes. The people with a lived experience of mental illness were recruited through an educational program for adult students studying to be mental health peer mentor trainees. The people in a carer role of a family member who was experiencing mental illness were recruited through a carer support agency in the locality where the research was undertaken. The mental health practitioners were recruited by an invitation to members of a social work professional group and by snowballing through existing professional relationships with people who worked in the public mental health system.

The inclusion criteria were membership to the relevant education program, community-based organization or professional practice group and self-selecting after receiving the research invitation. Also, participants needed to be over 18 years of age, able to speak English, and not currently receiving in-patient care for a mental health condition. There were no other exclusion criteria relating to the mental health status of people who were recruited through the educational facility. Participants were offered a small reimbursement of $50 where they had to travel to participate in the research.

Sampling and size

Prior to recruitment, ethics approval was obtained from XXXXX. Sampling was based on people who expressed interest in participating across the three cohorts at the selected sites and recruitment was concluded when there was no new data being gathered. The saturation of data was related less to the number of participants but rather to the lack of new information in the data set (Guest, Namey, Chen, & Soundy, 2020). The attempt to be inclusive of diversity, including age, non-dominant forms of gender, sexual identity, diverse abilities, race and ethnicity, was limited by the field of potential participants in the recruitment sites.

The purposive sampling technique (Etikan, Musa, & Alkassim, 2016) resulted in a total of twenty-one participants being recruited and Table 1 shows the characteristics of the three cohorts.

The eight people with a lived experience of mental illness, including five cisgender women and three men, were all students in a mental health peer mentoring program of study. The second cohort was comprised of recruits from a carers' non-government organization who had family members with a lived experience of mental health and who additionally gave support to their carer peers. Attempts were made to recruit male and female carers but only eight female cisgender carers joined the research, where their care relationship was with one of their adult children. Five mental health practitioners, all of whom were women and cisgender, were recruited with two mental health nurses from the researchers' professional networks, and three mental health social workers, accessed through a social work practice group. The carers' and practitioners' cohorts were all female, with carers' tending to be older than 61 years of age. Almost all the participants were borne in Australia, were non-Aboriginal and were predominantly of Anglo-Saxon and European heritage. One participant was born in South Africa.

Table 1. Participants' characteristics.

Recruitment cohort	Number	Roles	Gender	Age	Community-based site
Peer mentor trainees	8	Peer mentor trainee	*M* = 3 F = 5	18–40 = 5 41–60 = 3 61+ = 0	Diploma in peer mentoring provider
Carers of persons with a lived experience of mental health	8	Family member and support to other carers	*M* = 0 F = 8	18–40 = 1 41–60 = 2 61+ = 5	Carers organization
Mental health practitioners	5	Social workers Mental health nurses	*M* = 0 F = 5	18–40 = 1 41–60 = 3 61+ = 1	Social work practice group & researchers' mental health network
	Total = 21		*M* = 3 F = 18 Total = 21		

The cohorts' experiences and roles were not mutually exclusive with 2 practitioners describing their mental health challenges and two were also a carer of a person with a lived experience. For current purposes, the participants were asked to identify and speak to one role and this resulted in one practitioner being interviewed twice and the other participant not being interviewed about their carer role.

Data collection

The participants were invited to a face-to-face, semi-structured interview (Jamshed, 2014) with one of the researchers. Jamshed explains that semi-structured interviews allow flexibility for people to tell their stories, while being guided by questions related to the research aims. The interviews were audio-taped, with participants' permission, and informed consent was obtained prior to the commencement of the interview. The interviews were conducted in a place chosen by the interviewees and took approximately one hour. Participants were asked what emotional wellbeing meant to them from their respective roles and identities. A working definition was provided to participants as a starting point to the interviews – "emotional wellbeing refers to a person feeling positive and hopeful about their mental health, with personal resilience in their life situation."

The data was distilled from the responses received to the questions: How would you describe emotional wellbeing? What challenges your emotional wellbeing? What enables your emotional wellbeing?

Data analysis

The themes were developed manually using Braun and Clarke's (2012) six phase guide of becoming familiar with the data including, searching for themes, reviewing themes, defining themes and writing up (Maguire & Delahunt, 2017). The data analysis was done by two of the researchers, working independently and then reaching a consensus on the range of responses to the research questions. This is part of building trustworthiness in the analysis of research data and is an example of criterion related aspect using an inter-rater technique (Roberts, Dowell, & Nie, 2019). Member checking with participants (Birt, Scott, Cavers, Campbell, & Walter, 2016) took the form of providing draft copies of the manuscript that showed the researchers' interpretations of the data and the de-identification of participants. Feedback from participants was not about matters of substance or accuracy. Researcher reflexivity which refers to the awareness of power relationships in the research (Fook, 2002) was important as two of the researchers had been mental health practitioners and some of the respondents in the carer and practitioner

cohorts were known to them. Participants were given a choice to meet with a researcher not known to them. The peer mentor trainees' educator was known to the researchers and participants' confidentiality was carefully protected, both from their educator and other trainees.

Results

The results are presented as a summary of the terms and phrases used to describe emotional wellbeing that support the main themes. The theme of understandings of emotional wellbeing is reflected in phrases involving beliefs, relationship capacities and life skills. The theme of challenges to emotional wellbeing centered on the absence of emotional wellbeing and is reflected in phrases indicating loss, challenge and threat to quality of life and surviving. The theme of self-care and love of others reflects the language the participants used to report what they do to support their emotional wellbeing. Examples of the terms and phrases are presented in Tables 2, 3 and 4 for each participant cohort, and are elaborated upon in the section following each table.

Table 2. Mental health peer mentor trainees' understanding of emotional wellbeing.

Understandings of emotional wellbeing: Personal capacities and skills	Challenges to emotional wellbeing: Absence of emotional wellbeing	Enabling of emotional wellbeing: Self-care and love of others
• how you react or how you are capable • freedom when recognise our emotions are not us • enjoying life each day • ability to delight in the present • can move a little outside my comfort zone • can learn new skills • got motivation to get up and be happy. • having a happy environment • have a strong faith • it's the middle when things are just going even, equal and normal • being free to be who we are • gaining from self-inquiry and self-awareness • ability to create a place of freedom to come back to • feel connected to your whole self • making progress in quest for discovery and understanding • a series of balances between observation, introspection, perspective and context • play to learn, to take risks, to explore the world • doing practical things • ensuring I have safety valves and safety nets • allowing the person to hold responsibility for their life	• emotionally unwell • isolation is the most insidious form of torture known to humankind • not enough money to live on • alienated from my child • spiralling down with depression • feeling suicidal • feeling worthless, useless – I just want to die, I don't care • too many stigmas • when there's no safety net • absence of basic human needs – shelter, income, healthy relationships • no connection with people • unable to receive kindness and help • unable to find help that • love – I don't know what that is like • disempowerment • environments of eggshells and tripwire • claustrophobia and complete worthlessness • made to feel shame and embarrassment • being told that I was wrong	Self-care: • safe in yourself • being fully accepted for who you are • when I feel loved • attending Alcoholics Anonymous (AA) • attending Dialectical Behaviour Therapy (DBT) • attending Overeaters Anonymous (OA) • seeking counseling • having people in my life who are helpful • I've learned to love myself, not reject myselfLove of others: • I want to help support people • we all cry the same tears • love is the most important thing to me • creating a recovery program for others • learning about my mental illness • gaining empathy for others who are struggling

Table 3. Mental health carers' understanding of emotional wellbeing.

Understandings of emotional wellbeing: Personal capacities and skills	Challenges to emotional wellbeing: Absence of emotional wellbeing	Enabling of emotional wellbeing: Self-care and love of others
• not having too many stressors • when life is generally manageable • a comfortable feeling • doing things I believe are worthwhile • just to be heard • respected • included in loved one's care • gratefulness makes me happy • keeping a positive mind • seeing loved one achieve things • being proactive, making a difference • belief in something bigger than me • good sense of knowing who I am and my purpose • when you accept your life it gives you peacefulness • no negativity • loving the people around you • a happy environment without conflict • important that people understand you	• carers often neglect ourselves • you are only thinking about the other person • I'm always in survival mode • I've lost my confidence • I've lost the ability to cope • sadness in yourself all the time • you're living on tender hooks all the time • not being heard but left responsible • witnessing loved one being misunderstood and mis-diagnosed • financial and housing worry for my son • when overwhelmed I withdraw from things • not eating and sleeping properly • concern for future • tiredness, sadness and trauma when they come home in crisis • expected to be able to care for yourself • constant fear she will go too far • I've tried to step back but he has nobody	Self-care: • it's relative to what your loved one is going through • supportive people • carer support groups • have little breaks away • try to cope with the roller coaster • being able to do what I want when I want • I walk a lot • I've established a mental health organizationLove of others: • we really want him settled and managing on his own • loving people around you • friends I've known for years • having a connection with people who care about you • grateful to other carers very empathic caring of me

Participants who were recruited due to their peer mentor trainee roles all readily spoke of how important emotional wellbeing was and many could articulate the skills and capacities needed to experience emotional wellbeing. These ranged from the day-to-day ability to get out of bed and do every day routine tasks – "doing practical things," being able to "delight in the moment" and learning by "moving a little outside my comfort zone." One participant spoke in eloquent terms about emotional wellbeing consisting of "a series of balances between observation, introspection, perspective and context." He had a very detailed philosophy of life borne of decades of struggle trying to understand his mental illness and getting the help he needed. He believes that the main components of emotional wellbeing are the "quest for discovery, comprehension and individualized understanding." This was echoed by other participants who spoke of the importance of self-inquiry and self-awareness, for example – "I've learned to love myself, not reject myself."

Another participant commented on being their own advocate by "ensuring I have safety valves and safety nets." One participant had worked hard for a long time to understand their experiences after childhood abuse and years of alcohol and drug abuse and seeking out many counselors. She found guidance in eastern ideas and meditation and finding "freedom when

Table 4. Mental health practitioners' understanding of emotional wellbeing.

Understandings of emotional wellbeing: Personal capacities and skills	Challenges to emotional wellbeing: Absence of emotional wellbeing	Enabling of emotional wellbeing: Self-care and love of others
• a flexibility and choice around reaction • a general 'got it together' feeling • access to a sense of calm when required • resilient • safe at work • balance, homeostasis • having some perspective • learning from past experiences • belief in humanity • good supervision • talking with colleagues re client issues • getting enough breaks including in my head • boundaries that help keep work at work • held (supported) well in the workplace • vulnerable and able to express my weaknesses • loved • confidence • validated • balanced enough mentally and physically to support clients • able to manage parallel trauma at home and work	• nobody listened to me • trauma can affect us all • when unsafe can't check own emotions and boundaries • emotional rollercoaster • fear of being held responsible for client suicide • getting overwhelmed with everything • global chaos and corruption depletes my wellbeing • witnessing negative assumptions about clients • harbouring hatred towards people • low confidence and self-esteem from witnessing bullying and intimidation of colleagues • questioning my ability • extreme performance pressure • scapegoated at work due to my mental illness	Self-care: • alert to any negative self-talk • don't accept blame from others • recognized and seen • swimming helps with horrendous stressors • reach out and talk to someone if isolated • caring for myself when overwhelmed • validating own feelings of traumaLove of others: • everyone deserves to be loved • hearing peoples' stories • advocating for people • spending a moment with a colleague in need • helping systems learn how to care for staff • worry about my performance at work, want to be there for clients

[she] recognize[d that] our emotions are not us." Participants in this cohort explained that their emotional wellbeing was a fluctuating experience of moving in and out of feeling in control of their lives. However, sometimes it was a long-term absence of wellbeing where several said they did not know what emotional wellbeing felt like. One participant described his struggle with mental illness and years of alienation from his child as feeling "completely isolated and no connection with people." He concluded that "isolation is the most insidious form of torture known to humankind." There were recurring experiences of feeling overwhelmed, depressed, suicidal and misunderstood. One person said "love – I don't know what that is like." Many actively sought out help but found they were "unable to receive kindness and help" because they felt disconnected or were "made to feel shame and embarrassment." Others were "unable to find help that helped" them because they were so immersed in persisting feelings of "claustrophobia and complete worthlessness." One participant spoke of living in an "environment of eggshells and tripwire" where anxiety and depression weighed them down.

This cohort of mental health peer mental trainees is possibly a particularly highly motivated group within the diversity of experiences documented for people with mental health experiences (Russo & Sweeney, 2016). What is common between the participants was a desire to help others and to pay forward their own learning and understandings of what can help. Helping others was a goal of the study they were undertaking. Nevertheless, this capacity to negotiate the challenges of mental illness and to commit to study that includes considerable introspection reflected a dedication to self-care linked with a commitment to care for others. One participant said that "allowing the person to hold responsibility for their life" was really important for emotional wellbeing. They were all demonstrating responsibility where many were receiving help in a self-help support group or counseling. All had decided to be interviewed for the research as part of giving to others.

The participants in the carer cohort were recruited through a non-government carers' organization and thus were highly motivated to help other carers and to do so as well by participating in the research. They all had an adult child with a mental health condition and the carers' responses strongly reflect the impact of this relationship on their emotional wellbeing. For example, they explained it was related to the need "just to be heard" and "respected" by mental health professionals by being "included in [their] loved one's care." Another carer said they felt emotional wellbeing when "seeing [their] loved one achieve things." The feeling of life being "manageable" with not "too many stressors" as well as "keeping a positive mind" and being "grateful" were important to several of the carers. A carer shared that her emotional wellbeing related to her "good sense of knowing who I am and my purpose" in life. This same carer has a "belief in something bigger than me" which translates into "being proactive and making a difference" in the world.

The carers spoke of the tendency to neglect themselves and their own self-care because "you are only thinking about the other person" and "always in survival mode." Carers conveyed an absence of emotional wellbeing with comments such as "I've lost my confidence" and "I've lost the ability to cope." Another carer says she has a "sadness in ... [her]self all the time" because of the struggle of her adult daughter over a long period of time. The depth of feeling challenged often related to witnessing how their family member was treated in the mental health system. As one participant explained it was very hard "witnessing [her] loved one being misunderstood and mis-diagnosed." Some carers grapple with physical health issues which detracts from their emotional wellbeing with one carer saying she found it difficult to reconcile that she needed help with her broken leg because you are "expected to be able to care for yourself." The role reversal was shocking to them and impacted their confidence.

Several participants said there was a common saying among carers that being able to self-care is "relative to what your loved one is going through."

By virtue of the involvement with a carers' support group, they all appreciated their relationships with other carers but sometimes found it hard to go out to the meetings - "it's too much effort even getting dressed" - because of the lack of confidence or being on a "rollercoaster" of exhausting experiences due to "living on tender hooks all the time." One carer explained that "you think things are going OK and the next minute BOOM!," when her adult child is admitted to a mental hospital again. Another carer lives with a "constant fear that ... [her daughter] will go too far" in her self-harming behavior. Several carers expressed concern and "worry" for their family members' future due to insecure housing and inadequate finances. One carer spoke of her "tiredness, sadness and trauma when they come home in crisis." Another participant has friends telling them to be less involved but she says "I've tried to step back but he has nobody."

The mental health practitioner cohort of three social workers and two mental health nurses shared their ideas on emotional wellbeing by drawing on its meaning professionally while its absence impacted personally as well as professionally. A participant explained they think emotional wellbeing is when they are "balanced enough mentally and physically to support clients" which for another person involved "boundaries that help keep work at work." This balance was not always achieved as one practitioner explained it is about being "able to manage parallel trauma at home and work." Others described emotional wellbeing as "a general got it together feeling," the ability to "access a sense of calm when needed" and "getting enough breaks including in my head." Several shared about needing to be "held [supported] in the workplace" and feeling "safe at work" because they weren't feeling these things. Access to "good supervision" was valued as was being "vulnerable and able to express my weaknesses" and "learning from past experiences."

A number of practitioners explained how the absence of emotional wellbeing related to "low confidence and self-esteem from witnessing bullying and intimidation of colleagues," as well as "being scapegoated due to my own mental illness." There was a recognition that "trauma can affect us all" and "when [I am] unsafe [I] can't check [my] own emotions and boundaries." One practitioner used the phrase "emotional rollercoaster" and an example was another participant's "fear of being held responsible for a client suicide." The demands of mental health workplaces were expressed as "extreme performance pressure," "questioning [of] my ability," "getting overwhelmed with everything" and "witnessing negative assumptions about clients." One participant explained that they "worry about my performance at work, [I] want to be there for clients."

Self-care was highly valued where a number of participants shared that they needed "validating [of their] own feeling of trauma" and to "reach out

and talk to someone if isolated," so they feel "recognized and seen." The practitioners expressed motivations based on ideas such as "everyone deserves to be loved," the importance of "hearing peoples stories" and "advocating for people." Several participants expressed the importance of "spending time with a colleague in need" and of "helping systems learn how to care for staff."

Discussion: emotional wellbeing impacts the quality relationships and love

Some points arising from the research

The three cohorts of participants have different vantage points to understanding emotional wellbeing through their respective experiences, roles and relationships. The aim of the research was to explore how emotional wellbeing is understood and experienced in the area of mental health. The three main themes which resonated for all the research participants were identified as: emotional wellbeing as its absence; emotional wellbeing as capacity and skills; and the closely related; emotional wellbeing as self-care and love of others. The themes are consistent with accounts by people with lived experience, carers and mental health practitioners (Bland, Drake, & Drayton, 2021). At the same time the researchers recognize that the recruitment of participants for the three cohorts was not representative of the diversity of people who might identify with the roles. The peer mentor trainees' views, in particular, do not represent the diversity of experiences for people with severe and enduring mental illness. Mental health service user priorities are heterogeneous being influenced by a range of factors including family context, personal experiences and relationships, the dominant socio-cultural norms, their employment and financial circumstances, and the support resources available to them. The three roles for the research cohorts are also not mutually exclusive, enduring or non-problematic for the people. The research focus on the idea of emotional wellbeing is located in a western context and is therefore a culturally bound construct as well as being a contested idea in the literature.

Members of all three groups highly value emotional wellbeing, many have experienced an absence of emotional wellbeing at times and all were dedicated to some degree of self-care with an explicit regard for caring for people in their personal and, where appropriate, volunteer or professional lives. The social nature of wellbeing (Baum, 2018) was evident as was the willingness to identify with life experiences as being understood as a continuum of emotional wellbeing (Keyes, 2002). Some of the participants could not provide a description of emotional wellbeing and spoke of not knowing what it feels like. Others described times when they had experienced it and when it was absent and how they worked to regain their emotional wellbeing. For some peer mentor

trainees it was not necessarily a priority to be thinking about their emotional wellbeing and this may have been why some preferred to focus on their immediate experiences and challenges in the interviews.

The results for the peer mentor trainee and carer cohorts need to be viewed with the caution that the context of their relationships with family members is not included in any depth in the research. For example, peer mentor trainees' experiences of childhood abuse in their families points to complex relationships that can include violence and not only care. Research on adverse childhood experiences show that the higher people are on scores such as childhood abuse, sexual assault, domestic violence, parents' with mental illness, the more likely the person is to experience mental illness as an adult (Merrick et al., 2017). Additionally, there are documented cases in the literature that report carers' fear of, or experience of, violence from their loved one who has mental illness (Onwumere et al., 2014). Several mental health practitioners mentioned issues of violence and lack of support in the workplace as part of explaining their challenges with maintaining emotional wellbeing. Workplace violence is a recognized issue and is known to have adverse consequences for service users if the organization is trauma-organized instead of trauma informed (Bloom, 2017). Bloom explains that a trauma-organized workplace occurs when employees are not given debriefing and support when there are adverse service user outcomes and where there is authoritarian and punitive management. The mental health practitioners were identifying trauma-organized work environments with two of the participants directly experiencing bullying as they grappled with their own mental health issues. Further, it was explained that practitioners could perpetrate inadequate care of mental health service users which is similar to research showing stigma and discrimination against mental health service users (Mental Health Council of Australia, MHCA, 2011).

Additionally, a caution is needed about how emotional wellbeing is fostered or depleted by social relationships may be a complex mix of care, absence of care and neglect or abuse. The research suggests the role or identity of the person is linked to an ability to foster their own or others' emotional wellbeing. Peer mentor trainees were actively learning how to foster their own emotional wellbeing as integral to helping others. The link between self-care, resilience in the face of life challenges and the ability to maintain social relationships is complex and crucial to mental health and living a meaningful life (Auttama, Seangpraw, Ong-Artborirak, & Tonchoy, 2021). The research literature recognizes that carers' dedication toward a family member with a mental illness can co-exist with it being depleting of carers' wellbeing (Bland, Drake, & Drayton, 2021). There is a close and complex relationship between carers' emotional wellbeing and their loved ones' emotional wellbeing (Savage & Bailey, 2004). The research participants explained that this can create situations of serious lack of support for both the carers and people with a lived experience of mental

illness. Carer self-help groups recognize this relationship dynamic is a major challenge in their out-reach to carers (My Mental Health, 2022). It was also the case that a mental health practitioner spoke of the importance of love for others in their work in contexts which were not always supportive of them. The use of the term love in professional situations is fraught because it is equated with intimate partner relationships (eros) and of love within families (storge). hooks (2001) explains that love can also be understood as actions based on compassion and critical understanding which seek to effect change where there is harm and injustice. In the current research participants initiated the use of the idea of love but were not asked how they understood love. For carers and trainee cohorts it was more in line with the conventional understanding love as storge between family and between friends, love as philia (LaPierre, 2022). For practitioners love coincided with agape, the unconditional acceptance and regard for others, which is consistent with professional codes of ethics (eg. Australian Association of Social Workers, 2020).

There is an indication in the research that emotional wellbeing impacts the quality of relationships and ability to give and receive love. Where a participant does not know emotional wellbeing, their relationships were limited in number and quality and their ability to love themselves and others is also limited. This interrelationship is recognized in the literature, in particular, as shown by the Australian First Nations' idea of social and emotional wellbeing being impacted by adverse social and economic contexts (Zubric et al., 2014). What the current research provides is a spotlight on the importance of emotional wellbeing for the give and take interactions of safe and loving relationships. However, emotional wellbeing is not sufficient for addressing the structural factors which cause inequality such as systemic racism (Bennett, 2021), carer gender bias (Pease, Vreugdenhil, & Stanford, 2018) and mental health stigma (Markowitz, 1998). Thus, social wellbeing needs to be factored in with the idea of emotional wellbeing to gain a more contextually responsive understanding of impacts on peoples' wellbeing.

Re-visioning recovery as a non-medicalized fostering of relational and emotional wellbeing

A refined visioning of recovery is needed that accommodates a stronger emphasis on emotional and social wellbeing. The mental health service user movement has struggled against medicalized understandings of mental illness (Epstein, 2013; Pinches, 2004; Waterhouse, 2014) and worked to have the concept of recovery embedded in national policy statements, standards and state legislation (Australian Government, 2016). However, recovery has tended to assume the focus is solely on the person with a lived experience of mental illness and is described subsequently as a deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills and/or roles

(Anthony, 1993). The language of recovery has the potential to challenge beliefs that mental illness is a life sentence from which people cannot recover. It still, though, uses language consistent with the disease and illness paradigm of mental health care and locates the experience of mental illness as an individual phenomenon devoid of the person's social relationships, context and capacities for self-care.

Slade, Oades, and Jarden (2017) note that there is an intersection between the term recovery and its older working definition of living symptom free and the term wellbeing or, as it is generally understood in practice, living well. The recovery approach, then, recognizes that people with severe mental health experiences can attain a positive life and live with their challenges, whilst identifying potential processes and strategies to support beneficial changes (Slade & Wallace, 2017). Kidd, Kenny, and McKinstry's (2015) research with service users, carers and clinicians explored their respective understandings of recovery for people with a lived experience and their journey for a meaningful life. They identified five key areas, namely: finding meaning; possessing an invisible disability; empowerment and agency; connection, and; the passage of time. Research on the mental health experiences of carers and practitioners is often left out of the considerations of recovery and in so doing creates what is possibly a false dichotomy between who has a mental illness and who does not. The First Nations' idea of social and emotional wellbeing (Australian Indigenous HealthInfoNet, 2018) turns this medicalized and dichotomous approach upside down. It does this by locating wellbeing as a shared human experience that is intricately impacted by many factors including the relational and cultural contexts (Day, Nakata, & Miller, 2016).

Limitations of the research

The research had the aim of exploring what participants who identified with one of the three cohorts thought about emotional wellbeing. Recruitment was influenced by the community-based organizations and groups accessed which limited the scope to recruit according to cultural identity and other characteristics. This may have limited the value of the research as it was not possible to locate participants' understandings in their cultural and socio-economic context. It can be expected that culture, sense of social connectedness and financial security would be very influential in shaping lived experience and meaning-making in relation to emotional wellbeing. For example, a First Nations Peoples' view is that mental health is about spiritual health, it is where "you don't have a mental illness, it's your spirit that is sick" and this means for First Nations People being on country and engaging in "deep cultural practice" (Williams & Pallas, 2021, p. 151). It was beyond the scope of the research to explore the cultural and spiritual dimensions of emotional wellbeing and to more substantially acknowledge and be influenced by First

Nations ways of knowing, being and doing (Bennett, McMinn, Millgate, & Morse, 2021).

Implications for further research and social service practice

Further research is recommended to explicitly explore these initial ideas that emerged as participants sought to describe what emotional wellbeing meant to them. A research methodology focusing on social as well as emotional wellbeing using narrative methods would elicit a stronger appreciation of the social and contextual influences on participants' wellbeing. Strategies and material support to enable the presence and quality of loving and supportive relationships may be a productive area of future research as a crucial factor in fostering and sustaining experiences of emotional wellbeing. Further, research is needed to consider the nature of the interrelationships between people with a lived experience of mental illness, carers and practitioners, where this could also involve people known to each other.

The explicit dual focus on recruiting for cultural diversity and on understanding the quality of these relationships and the place of love as a motivating factor in care of self and care for others is likely to be productive. Further, deeper consideration needs to be given in the research aims, methods and processes to ensure culturally appropriate and culturally safe considerations are placed centrally (Bennett, 2021) and guidance is sought from First Nations People about their inclusion and respect to them for their ideas (Bennett, 2020) about social and emotional wellbeing. Finally, given the stigmatizing nature of mental illness (Corrigan, Druss, & Perlick, 2014; Markowitz, 1998) it is recommended that future research explores how people from these three cohorts resist the impact of stigma.

The research suggests that social workers can make a contribution by embedding emotional wellbeing into a recovery-oriented mental health knowledge base and practice. It also suggests that canvasing what is important to peoples' emotional wellbeing may be productive as it is less medicalized and stigmatized language and all the participants found it useful language with which they readily identified. It appears that participants from all three cohorts were acknowledging in different ways the importance of emotional wellbeing for themselves and for the people they love or care for in their work.

Conclusion

Historical research which used the Delphi method by one of the authors and several of her colleagues found that people with a lived experience of mental illness, carers and practitioners all separately voted that emotional wellbeing was the most important topic that needed research. The current research built on this earlier finding and found that participants readily identified with and

valued the idea of emotional wellbeing. Three themes emerged from the interviews namely, emotional wellbeing as its absence; emotional wellbeing as capacity and skills; and; emotional wellbeing as self-care and love of others. Emotional wellbeing was described by participants as revolving around the quality or absence of key relationships and loving care in those relationships, including with themselves in the form of self-care.

The research results were obtained from small samples across the three cohorts of participants. As such there is a need for further research with each of the cohorts to build more knowledge in this area. We therefore, with the limitations of the research in mind, wish to acknowledge and stand with social work and mental health practitioners who affirm the agency and experiences of people with a lived experience and the people in personal and professional relationships with them. In so doing we are recognizing peoples' interrelated dedications to supporting their own and others' emotional wellbeing. Further research might contribute to the re-visioning of recovery as being about enabling skills and resources in fostering emotional wellbeing, relationships, and caring. As such this would provide a counter to individualized, medicalized understandings of mental illness.

Disclosure statement

No potential conflict of interest was reported by the authors.

Funding

This work was supported by the University of the Sunshine Coast under a faculty internal research grant to collaborate with industry partners

References

American Psychiatric Association. (2018). *Diagnostic and statistical manual of mental disorders – (fifth edition (DSM-5).* ed.). APA Publishing.

Anthony, W. (1993). Recovery from mental illness: The guiding vision of the mental health service system in the 1990s. *Psychosocial Rehabilitation Journal*, *16*(4), 11. doi:10.1037/h0095655

Australian Association of Social Workers. (2020). *Code of ethics*. Barton, Australia: AASW.

Australian Government (2016). *Social determinants of health*. https://www.aihw.gov.au/getmedia/11ada76c-0572-4d01-93f4-d96ac6008a95/ah16-4-1-social-determinants-health.pdf.aspx

Australian Indigenous Health*Info*Net (2018). *Australian Indigenous HealthInfoNet*. https://healthinfonet.ecu.edu.au/

Auttama, N., Seangpraw, K., Ong-Artborirak, P., & Tonchoy, P. (2021). Factors associated with self-esteem, resilience, mental health, and psychological self-care among university students in Northern Thailand. *Journal of Multidisciplinary Healthcare*, *14*, 1213–1221. doi:10.2147/JMDH.S308076

Baum, F. (2018). *The new public health* (5th ed.). Oxford University Press.

Baum, F., Freeman, T., Sanders, D., Labonté, R., Lawless, A., & Javanparast, S. (2016). Comprehensive primary health care under neoliberalism in Australia. *Social Science & Medicine*, *168*, 43–52. doi:10.1016/j.socscimed.2016.09.005

Bennett, B. (2020). What to bring when you are told not to bring a thing: The need for protocols in acknowledging Indigenous knowledges and participants in Australian research. *Journal of Sociology*, *56*(2), 167–183. doi:10.1177/1440783319876988

Bennett, B. (Ed.). (2021). *Aboriginal fields of practice*. Red Globe Press.

Bennett, B., McMinn, S., Millgate, N., & Morse, C. (2021). Mistakes and misunderstandings: Why are social workers still not getting it right? In B. Bennett (Ed.), *Aboriginal fields of practice* (pp. 304–322). London, United Kingdom: Red Globe Press.

Birt, L., Scott, S., Cavers, D., Campbell, C., & Walter, F. (2016). Member checking: A tool to enhance trustworthiness or merely a nod to validation? *Qualitative Health Research*, *26*(13), 1802–1811. doi:10.1177/1049732316654870

Bland, R., Drake, G., & Drayton, J. (2021). *Social work practice in mental health* (3rd edn ed.). Taylor & Francis.

Bloom, S. (2017). *Organizational stress as a barrier to trauma-sensitive change and system transformation*. Drexel University.

Boulet, J. (1992). Justice, peace and social well-being: Fundamentals for social work practice. *Australian Social Work*, *45*(1), 3–15. doi:10.1080/03124079208550180

Braun, V., & Clarke, V. (2012). Thematic analysis. In H. Cooper, P. M. Camic, D. L. Long, A. Panter, D. Rindskopf, & K. J. Sher(Eds.), *APA handbook of research methods in psychology*APA handbook of research methods in psychology (Vol. 2, pp. 57–71). American Psychological Association doi:10.1037/13620-004

Broady, T., & Stone, K. (2015). "How can I take a break?" Coping strategies and support needs of mental health carers. *Social Work in Mental Health*, *13*(4), 318–335. doi:10.1080/15332985.2014.955941

Cocker, F., & Joss, N. (2016). Compassion fatigue among healthcare, emergency and community service workers: A systematic review. *International Journal of Environmental Research and Public Health*, *13*(6), 618. doi:10.3390/ijerph13060618

Coleman, R. (2004/2014). *Recovery: An alien concept*. P & P Press.

Corrigan, P., Druss, B., & Perlick, D. (2014). The impact of mental illness stigma on seeking and participating in mental health care. *Psychological Science in the Public Interest*, *15*(2), 37–70. *Supplement*. doi:10.1177/1529100614531398

Day, A., Nakata, M., & Miller, K. (2016). Programs to improve the social and emotional wellbeing of Aboriginal and Torres Strait Islander communities. *Australian Social Work*, *69*(3), 373–380. doi:10.1080/0312407X.2015.1069866

Diener, E., & Chan, M. (2011). Happy people live longer: Subjective wellbeing contributes to health and longevity. *Applied Psychology: Health and Well-being*, *3*(1), 1–43. doi:10.1111/j.1758-0854.2010.01045.x

Dransart, D., Treven, M., Grad, O., & Andriessen, K. (2017). Impact of client suicide on health and mental health professionals. In K. Andriessen, K. Krysinska, & O. Grads (Eds.), *Postvention in action: The international handbook of suicide bereavement support* (pp. 245–254). Göttingen, Germany: Hogefe Publishing.

Dudgeon, P., Milroy, H., & Walker, R. (Eds.). (2014). *Working together: Aboriginal and Torres Strait Islander mental health and wellbeing principles and practices*. Barton, Australia: Commonwealth of Australia.

Epstein, M. (2013). *The consumer movement in Australia: A memoir of an old campaigner*. https://www.ourcommunity.com.au/files/OCP/HistoryOfConsumerMovement.pdf

Etikan, I., Musa, S., & Alkassim, R. (2016). Comparison of convenience sampling and purposive sampling. *American Journal of Theoretical and Applied Statistics*, *5*(1), 1–4. doi:10.11648/j.ajtas.20160501.11

Finklestein, M., Stein, E., Greene, T., Bronstein, I., & Solomon, Z. (2015). Posttraumatic stress disorder and vicarious trauma in mental health professionals. *Health & Social Work*, *40*(2), e25–31. doi:10.1093/hsw/hlv026

Fook, J. (2002). Theorizing from practice: Towards an inclusive approach for social work research. *Qualitative Social Work*, *1*(1), 79–95. doi:10.1177/147332500200100106

Frances, A. (2010). Opening Pandora's box: The nineteen worst suggestions for DSM-V. *The Psychiatric Times*, *11*, 1–10.

Gee, G., Dudgeon, P., Schultz, C., Hart, A., & Kelly, K. (2014). Social and emotional wellbeing and mental health: An Aboriginal perspective. In P. Dudgeon, H. Milroy, & R. Walker (Eds.), *Working together: Aboriginal and Torres Strait Islander mental health and wellbeing principles and practice* (2nd ed., pp. 55–68). Barton, Australia: Commonwealth of Australia.

Germov, J. (2018). Imagining health problems as social issues. In J. Germov (Ed.), *Second opinion: An introduction to health sociology* (6th ed., pp. 5–22). Melbourne, Australia: Oxford University Press.

Guest, G., Namey, L., Chen, M., & Soundy, A. (2020). A simple method to assess and report thematic saturation in qualitative research. *Plos One*, *15*(5), e0232076. doi:10.1371/journal.pone.0232076

Happell, B., Wilson, K., Platania-Phung, C., & Stanton, R. (2017). Physical health and mental illness: Listening to the voice of carers. *Journal of Mental Health*, *20*(2), 127–133. doi:10.3109/09638237.2016.1167854

Hooks, B. (2001). *All about love: New visions*. New York, United States of America: William Morrow.

Jamshed, S. (2014). Qualitative research method-interviewing and observation. *Journal of Basic Clinical Pharmacology*, *5*(4), 87–88. doi:10.4103/0976-0105.141942

Keyes, C. (2002). The mental health continuum: From languishing to flourishing in life. *Journal of Health and Social Behavior*, *43*(2), 207–222. doi:10.2307/3090197

Keyes, C. (2007). Promoting and protecting mental health as flourishing: A complementary strategy for improving national mental health. *The American Psychologist*, *62*(2), 95–108. doi:10.1037/0003-066X.62.2.95

Kidd, S., Kenny, A., & McKinstry, C. (2015). The meaning of recovery in a regional mental health service: An action research study. *Journal of Advanced Nursing*, *71*(1), 181–192. doi:10.1111/jan.12472

LaPierre, S. (2022). *What is agape, phileo, storage and eros love?* https://www.scottlapierre.org/agape-phileo-storge-eros-love/

Lawn, S., & McMahon, J. (2014). The importance of relationship in understanding the experiences of spouse mental health carers. *Qualitative Health Research*, *24*(2), 254–266. doi:10.1177/1049732313520078

Maguire, M., & Delahunt, B. (2017). Doing a thematic analysis: A practical, step by step guide for learning and teaching scholars. *All Ireland Journal of Higher Education*, *3*, 3351–33514.

Markowitz, F. (1998). The effects of stigma on the psychological wellbeing and life satisfaction of persons with mental illness. *Journal of Health and Social Behaviour*, *39*(4), 335–347. doi:10.2307/2676342

Mensingaa, J., & Pylesb, L. (2021). Embodiment: A key to social workers' wellbeing and attainment of social justice. *Australian Social Work*, *74*(2), 131–133. doi:10.1080/0312407X.2021.1858472

Mental Health Council of Australia, MHCA. (2011). *Consumer and carer experiences of stigma from mental health and other health professionals*. MHCA.

Merrick, M., Ports, K., Ford, D., Afifi, T., Gershoff, E., & Grogan-Kaylor, A. (2017). Unpacking the impact of adverse childhood experiences on adult mental health. *Child Abuse & Neglect*, *69*, 10–19. doi:10.1016/j.chiabu.2017.03.016

Moore, K., & Cooper, C. (1996). Stress in mental health professionals: A theoretical overview. *The International Journal of Social Psychiatry*, *42*(2), 82–89. doi:10.1177/002076409604200202

Morley, C. (2003). Toward critical social work practice in mental health. *Journal of Progressive Human Services*, *14*(1), 61–84. doi:10.1300/J059v14n01_05

My Mental Health (2022). *Carer and family support*. https://mymentalhealth.org.au/carer-and-family-support

Nind, M., & Lewthwaite, S. (2018). Hard to teach: Inclusive pedagogy in social science research methods education. *International Journal of Inclusive Education*, *22*(1), 74–88. doi:10.1080/13603116.2017.1355413

Onwumere, J., Grice, S., Garety, P., Bebbington, P., Dunn, G., Freeman, D. … Kuipers, E. (2014). Caregiver reports of patient-initiated violence in psychosis. *Canadian Journal of Psychiatry Revue Canadienne de Psychiatrie*, *59*(7), 376–384. doi:10.1177/070674371405900705

Parker, R., & Milroy, H. (2014). Aboriginal and Torres Strait Islander mental health: An overview. In P. Dudgeon, H. Milroy, & R. Walker (Eds.), *Working together: Aboriginal and Torres Strait Islander mental health and wellbeing principles and practice* (pp. 25–38). Barton, Australia: Commonwealth of Australia.

Pease, B., Vreugdenhil, A., & Stanford, S. (Eds.). (2018). *Critical ethics of care in social work: Transforming the politics and practices of caring*. Routledge.

Pinches, A. (2004). *What the consumer movement says about recovery*. http://ourcommunity.com.au/files/OCPPinchesRecovery.pdf

QHealth. (2022). *Mental health*. https://www.health.qld.gov.au/clinical-practice/guidelines-procedures/clinical-staff/mental-health

Quinlan, E., Deane, F., & Crowe, T. (2018). Pilot of an acceptance and commitment therapy and schema group intervention for mental health carer's interpersonal problems. *Journal of Contextual Behavioural Science*, *9*, 53–62. doi:10.1016/j.jcbs.2018.06.006

Rabin, S., Feldman, D., & Kaplan, Z. (2011). Stress and intervention strategies in mental health professionals. *The British Journal of Medical Psychology*, *72*(Pt 2), 159–169. doi:10.1348/000711299159916

Roberts, K., Dowell, A., & Nie, J. (2019). Attempting rigour and replicability in thematic analysis of qualitative research data; a case study of codebook development. *BMC Medical Research Methodology*, *19*(1). doi:10.1186/s12874-019-0707-y

Ross, D., & McAllister, M. in collaboration with Munday, J., Clarke, K., Dunn, P., Taikato, M., & Waterhouse, B. (2010). *Research into the mental health research priorities of the mental health service (SCHSD): Final report*. University of the Sunshine Coast.

Russo, J., & Sweeney, A. (Eds.). (2016). *Searching for a rose garden: Challenging psychiatry, fostering mad studies*. PCCS Books Ltd.

Ryan, R., & Deci, E. (2001). On happiness and human potentials: A review of research on hedonic and eudaimonic wellbeing. *Annual Review of Psychology*, *52*(1), 141–166. doi:10.1146/annurev.psych.52.1.141

Savage, S., & Bailey, S. (2004). The impact of caring on caregivers' mental health: A review of the literature. *Australian Health Review*, *27*(1), 103–109. doi:10.1071/AH042710111

Sawyer, A. (2008). Risk and new exclusions in community mental health practice. *Australian Social Work*, *61*(4), 327–341. doi:10.1080/03124070802428183

Sawyer, A. (2011). Translating mental health policy into practice: Ongoing challenges and frustrations. *Health Sociology Review*, *20*(2), 114–119. doi:10.1080/14421242.2011.11003075

Sawyer, A., & Savy, P. (2018). Mental illness: Understandings, experience and service provision. In J. Germov (Ed.), *Second opinion: Introduction to health sociology* (6th ed., pp. 270–287). Melbourne, Australia: Oxford University Press.

Seligman, M. (2011). *Flourish: A visionary new understanding of happiness and wellbeing*. Atria.

Slade, M. (2010). Mental illness and wellbeing: The central importance of positive psychology and recovery approaches. *BMC Health Services Research*, *10*(26), 1–14. doi:10.1186/1472-6963-10-26

Slade, M., Adams, N., & O'hagan, M. (2012). Recovery: Past progress and future challenges. *International Review of Psychiatry*, *24*(1), 1–4. doi:10.3109/09540261.2011.644847

Slade, M., Oades, L., & Jarden, A. (2017). Wellbeing, recovery and mental health. In M. Slade, L. Oades, & A. Jarden (Eds.), *Well-being, recovery & mental health* (pp. 324–332). Cambridge, England: Cambridge University Press.

Slade, M., & Wallace, G. (2017). Recovery & mental health. In M. Slade, L. Oades, & A. Jarden (Eds.), *Well-being, recovery & mental health* (pp. 24–34). Cambridge, England: Cambridge University Press.

Stebbins, R. (2001). *Exploratory research in the social sciences: 48*. Sage Publications.

Thompson, N. (2018). *Promoting equality: Working with diversity and difference*. Palgrave Macmillan.

Veenhoven, R. (2008). Sociological theories of subjective well-being. In M. Eid & R. Larsen (Eds.), *The science of subjective well-being: A tribute to Ed Diener* (pp. 44–61). Guilford Publications.

Waterhouse, B. (2014). I'm not mad! *Social Alternatives*, *33*(3), 15–19.

Weiss-Gal, I. (2008). The-person-in-environment approach: Professional ideology and practice of social workers in Israel. *Social Work*, *53*(1), 65–75. doi:10.1093/sw/53.1.65

White, S. (2010). Analysing wellbeing: A framework for development practice. *Development in Practice*, *20*(2), 158–172. doi:10.1080/09614520903564199

Williams, J., & Pallas, P. (2021). Mental health as spiritual health: Toward a new understanding of a healing approach. In B. Bennett (Ed.), *Aboriginal fields of practice* (pp. 148–159). London, Britain: Red Globe Press.

World Health Organisation (WHO). (1992/2016). *The ICD-10 classifications of mental and behavioural disorder: Clinical descriptions and diagnostic guidelines*. https://www.who.int/classifications/icd/en/bluebook.pdf

World Health Organisation (WHO). (2004). *Mental health: A state of wellbeing*. https://www.who.int/mental_health/evidence/en/promoting_mhh.pdf

World Health Organisation (WHO). (2018). *Comprehensive mental health action plan 2013–2020*. http://www.who.int/mental_health/mhgap/consultation_global_mh_action_plan_2013_2020/en/

Zubrick, S., Holland, C., Kelly, K., Calma, T., & Walker, R. (2014). The evolving policy context in mental health and wellbeing. In P. Dudgeon, H. Milroy, & R. Walker (Eds.), *Working together: Aboriginal and Torres Strait Islander mental health and wellbeing principles and practice* (pp. 69–90). Barton, Australia: Commonwealth of Australia.