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The Haven: A Clinical Ethnography of a Farm-Based Therapeutic Community

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THE HAVEN: A CLINICAL ETHNOGRAPHY OF A FARM-BASED THERAPEUTIC COMMUNITY

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Monica A. Lawson

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ABSTRACT

THE HAVEN: A CLINICAL ETHNOGRAPHY OF A FARM-BASED THERAPEUTIC COMMUNITY

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Dissertation supervised by Daniel Burston, PhD

Therapeutic communities are communal spaces where individuals live for an extended period in hopes of recovering from personal crises, or while coping with severe mental illness. They provide a humanistic alternative to inpatient hospitalization. Although they are seldom studied, even less is known about farm-based therapeutic communities in the United States, where communal work is viewed as central to recovery. This dissertation examines the experience of living and working at the Haven. Originally conceived as a farm-based community where suffering individuals could experience reprieve from the demands of the "working world," and heal by living in community, recent changes in the mental health field require the Haven to provide more clinical services to residents to remain viable. This transition has evoked a collective identity crisis for the Haven.

After four months of ethnographic participant observation and 50 interviews with current and former residents and staff, it became evident that the Haven's work program, formerly its primary treatment modality, was no longer sufficient to meet residents' needs. In fact, residents overwhelmingly requested more clinical services. However, the Haven has embraced a medical model approach to the provision of clinical services, which is at odds with its humanistic history and aims. This fact is likely the cause of many staff members' wariness regarding the growing clinical programming. This approach reduces residents' agency, autonomy, and implicitly reduces the role of non-clinical staff as well. This dissertation explores the evolution of these changes and provides suggestions for how to reorient the Haven towards a restoration of community, revitalization of the work program, and an existential-humanistic orientation consistent with the values of the Haven's original vision.

DEDICATION

Interviewer: Do you identify as having a mental illness?

Resident: I don't believe in the psycho-medical-mental complex. Psycho medical mental health process.... or the psychiatric complex. So yes, I have things wrong. Yes, I am different from most people and some of those things are faults. I think wherever you look [though] you can see that in everybody.

~

Staff Member: I want to thank you and appreciate folks like you, taking the time out of your life and part of your profession to come to a [this] place and offering your time. ***It gives me hope that, you know, my voice doesn't have much of a voice here, but maybe it has a voice out there somewhere."***

This dissertation is dedicated to the all of the individuals who look to, or reach for, the mental health system in times of distress, especially in light of the times the mental health system has failed us. In particular, I want to dedicate this project to the residents of the Haven who participated in my study. Thank you for sharing your time, lives, and thoughts with me. In the spirit of the above participants, every single one of us suffers distress and has unique ways of expressing and responding to that distress. As patients, clients, researchers, and mental health professionals, may we continue to advocate and work for a more humane and person-centered model of care that does not strip individuals of autonomy and humanity.

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grateful for your support and love. WE DID IT. Now let the healing begin.

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To my family, your support during the months I wrote my dissertation was

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"Like I think I mentioned it…earlier…how to explain this place. Even philosophically, it depends on who you ask. You're going to get very different answers." (Fred)

"I think we just need to understand what we are and be very clear about who we are." (Alison)

"That's part of the problem with this place. It's neither. It's neither the hippie farm where the staff get in the hot tub with residents, and it's not like the treatment center where there's locks on all the doors. And so that's a problem. It's like somewhere in the middle. It's not clearly defined." (Annie)

Literature Review

Therapeutic Communities

What is a therapeutic community? Therapeutic communities (TCs) are perhaps best defined by what Kennard (1983) calls a "therapeutic community impulse" (p.11). Kennard (1983) describes this impulse as made up of the values of "egalitarianism, psychological mindedness, liberalism, and a toleration of expression of conflicting ideas" where the focus of treatment is on the relationships and communications between individuals within the community (p. 11). This impulse is contrasted with the impulse to simply manage people by methods of control. Thus, the main aim is to focus on relationships and their manifestation from within a shared community where individuals are treated with respect and dignity, and as equals.

Such communities can be located within a hospital, institutional treatment setting, or a house or farm outside of the traditional treatment setting. However, despite the location itself, the unifying factor of all therapeutic communities is that they are comprised of a space where individuals can "live or come together daily" because their previous environment is untenable or not sufficient to their needs and wellbeing (Kennard, 1983, p. 11). Despite their political and value differences, most therapeutic communities share several similar qualities or views. First,

they value the creation of a communal atmosphere where the institutional or treatment setting is transformed to become more inviting and "home-like" (Kennard, 1983, p. 7). Regular community meetings are a staple of therapeutic communities—although the institutional therapeutic communities (those developed in military hospitals in the 40s and 50s) tended to focus more on psychoanalytic interpretations and processing of interpersonal dynamics in groups, while the "antipsychiatry" therapeutic communities tended to focus less on analytic interpretation and more on building cohesion and addressing interpersonal conflicts. Therapeutic communities emphasize sharing in the daily maintenance of the community (which again looks different based on the community—for some TCs this means engaging in manual labor to contribute to the upkeep of the house or institution, or by paying rent to keep the house running). Finally, the residents or patients are viewed as key players in their treatment—there is a flattening of the power dynamic between staff and residents where residents are also seen as healers, and staff may share their own psychological struggles with residents as well (Kennard, 1983). Common to all TCs is a focus on how difficulties emerge in, and are transformed by, relationships—hence the need for a communal, relational nexus to process and heal. This need for a safe, soothing, communal space in which to heal was first elaborated during the era of moral treatment, the era most often cited as heralding the advent of the therapeutic community movement.

Moral Treatment

Although disputed by some (Hollander, 1981), the development of therapeutic communities is most often traced back to the era of moral treatment. Moral treatment emerged in direct response to the appalling treatment suffered by so-called mentally ill patients in psychiatric asylums during the 17th century. The two men most associated with the advent of

moral treatment were the French doctor Philippe Pinel (1745-1826) and English Quaker William Tuke (1732-1822). Pinel and Tuke approached moral treatment from similar, yet different perspectives (Loue, 2016; Whitaker, 2002). Although Pinel is often credited as the father of moral treatment, Whitaker (2002) notes that it was the Quakers who really championed and defined this approach of the "moral sense" (see also Loue, 2016, p. 3). Tuke advocated a return to kind, humane treatment instead of the callous beating and chaining away of the mad, with an emphasis on religious engagement (Scull, 2015; Whitaker, 2002). The York Retreat, established by Tuke and the Quakers in 1792, was the first of its kind—an asylum inspired by the principles of moral treatment—asylums located in a calm and soothing environment, coupled with the unchaining of the mad, and treating patients with respect and dignity alongside keeping the individuals busy with activities and work (Whitaker, 2002). For Tuke, religion was an important component for a patient's recovery, and religion became especially salient with European asylums adopting a moral treatment approach to healing (Loue, 2016). Moral treatment took off in Europe during this time and the movement would follow some years later in the United States.

In 1817, the first asylum inspired by moral treatment opened in America, developed by Quakers in Philadelphia (Scull, 2015). Whitaker (2002) notes the following "blueprint" for asylums guided by moral treatment principles in the US: the asylum was to be kept quite small with no more than 250 patients; the location of the asylum should ideally be in the country for the combination of soothing peace and quiet, alongside the ability to maintain gardens on the grounds, and to give the patients a spacious natural landscape to tend to [this became a significant part of the "activities" or work also required of moral treatment asylums] (p. 27). Another important tenet of moral treatment asylums was the role a superintendent played. As Whitaker (2002) writes, the superintendent must be of humane character, treating the patients as

equals in terms of their humanity and he should take on the role of "father figure" guiding the patients back to reason (p. 26). Finally, patients were encouraged, or required, to engage in activities or work thought to deliver them (or distract them) from their mental suffering (Whitaker, 2002). Instead of physically restraining patients to induce calm, work and activity were conceptualized to function as self-restraint (Hollander, 1981; Scull, 2015). Thus, gardening and taking care of the land became an important part of the patient's daily life, and among other activities, was thought to encourage self-restraint thereby diminishing the patient's neurotic symptoms.[1] However, Loue (2016) notes that work was emphasized for patients of lower socioeconomic status and that patients from the upper classes were given more recreational opportunities, and were not required to work (p. 7).

For individuals of a lower socioeconomic class, work was thought to develop the "moral values of independence, industry, and self-respect" (Loue, 2016, p. 7). The manual labor required of farm life should function to "counteract any inclination to be lazy, would decrease morbid thoughts, and provide exercise" (Loue, 2016, p. 7). These ideas are still prevalent in the farm-based therapeutic communities functioning in the United States and are of particular import to the community discussed in this dissertation.

What led to the end of moral treatment was largely its inability to maintain its principles as more and more patients were piled into asylums. Soon, many more than the recommended 250 patients populated the institutions, taking away from the ability for superintendents to offer compassionate, individualized attention while managing financial realities that left superintendents poorly paid and the institutions poorly maintained and accommodated (Whitaker, 2002). As Whitaker (2002) notes, the very things needed for asylums to be run in the

[1] Work takes a more central and, arguably, meaningful role in farm-based therapeutic communities, the subject of this dissertation, and is explored more fully in chapters two through four.

way of moral treatment: spacious buildings, educational opportunities, relaxation rooms, and so on, were no longer a part of the asylums which, when matched with the overcrowding of the asylum, led back to the warehousing of patients and the superintendent becoming an instrument of discipline.

According to Hollander's (1981) critique, one cannot consider moral treatment apart from its place in the historical landscape. For example, he notes 19th century asylums were focused on helping patients re-establish a connection with traditional values, which were cultivated from the discipline that working (and a calm environment) provided. However, in the 20th century therapeutic communities largely arose as a social movement opposing the constraints of modern society (Hollander, 1981; Kennard, 1983). Although civilization is seen as exacerbating social disease or malaise from both perspectives (moral treatment and therapeutic communities), their ultimate aims were quite different. For asylums of the moral treatment era, the deterioration of modern society led to disease and a need to re-establish traditional values (authority) and the traditional family, whereas the therapeutic community movement critiqued such traditional social conventions and worked to transform, challenge, and question such conventions (Hollander, 1981).

Therapeutic Communities: A Brief History

The term "therapeutic community" was first used by Tom Main (1911-1990) in 1946 while working at Cassel Hospital in England, a military hospital. He coined the term to describe his "hospital as a whole" approach (Kennard, 1983). Main felt that everyone involved in the treatment wing (staff as well) should be involved in processing what happened in the treatment site. He writes,

> One evening I suddenly realized the whole community, all staff as well as all patients, needed to be viewed as a troubled larger system which needed treatment. Could all people in it move to consideration of other people's plight, and benefit from opportunities to examine the conscious and unconscious uses each was making of others? Could the total institution become therapeutic for all? (cited in Kennard, 1983, p. 46)

In a similar vein, Maxwell Jones (1907-1990), took note of group process while working in 1940 at Mill Hill Hospital treating shell shock and effort syndrome.[2] In 1947, Jones became director of the Industrial Neurosis Unit at Belmont Hospital. This unit came to be known as the Social Rehabilitation Unit, the subject of Robert Rapoport's 1960 book, *Community as Doctor*. Coming from his previous experience at Mill Hill, Jones' interest shifted from physiology to social and interpersonal dynamics. This unit later became Henderson Hospital, and is where the concept of therapeutic community seemed to truly coalesce (Kennard, 1983). Jones identified three core themes for developing his notion of therapeutic community: 1) community meetings (following Main's "hospital-as-a-whole" approach) involving the entire community, 2) staff review meetings to help staff process and acclimate to a treatment environment that appeared very different from typical medical-model treatment (e.g. patients taking a more active role than is typical in hospital settings), and 3) living-learning situations where patients and staff come together to respond to a crisis situation (Kennard, 1983). These elements became core in the definition of "therapeutic community" and Rapoport's (1960) research revealed four principles

[2] Effort syndrome was characterized by the symptoms we now refer to as symptoms of panic attacks: palpitations, racing heart, sweating, shaking, chest pain, sensations of shortness of breath, nausea, feeling dizzy or lightheaded, numbness, etc... (APA, 2020). In the current diagnostic manual of mental disorders, *DSM-V* effort syndrome would be classified as panic disorder.

that are now synonymous with therapeutic communities run along egalitarian lines: 1) democratization, 2) permissiveness, 3) communalism, and 4) reality-confrontation. Democratization refers to the sharing of power between staff and residents in the running of the therapeutic community. Permissiveness refers to the acceptance of what is often conceived of as deviant behavior outside the treatment setting. This principle appears particularly salient in the later development of the "anti-psychiatry" therapeutic communities in the 60s. Communalism focuses, again, on the community as a whole and a sense of living in a community, or shared space, together. Reality-confrontation concerns the interpersonal processing and interpretation of community members' behaviors and actions (Kennard, 1983). These principles explicated by Rapoport (1960) and developments by Jones shaped and influenced the therapeutic community movement.

Kennard (1983) notes that the first wave of therapeutic communities of the Main and Jones era (the 40s and 50s) focused on transforming the practice of psychiatry from within the institution itself. This attempt is summed up well in the following quote from Main:

> This attempt to create an atmosphere of respect for all and the examination of all difficulties would be a long way from the medical model, whereby disease is skillfully treated in anonymous people under blanket medical compassion and served by a clinically aloof and separate administration. (cited in Kennard, 1983, p. 46)

Main and Jones worked exclusively *inside* the hospitals or institutions to make them more conducive to fostering psychological transformation: providers would become more related to their patients and see them as human beings deserving of compassion, and as co-therapists in the healing process. This approach follows the moral treatment model by trying to make the hospital

more humane in order to provide better care for patients. However, the therapeutic communities of the 60s and 70s, being wary of prevailing pressures to conformity, felt treatment must be established *outside* of the institution to create change (Kennard, 1983; Laing, 1985).

After founding the Philadelphia Association in 1964, R.D. Laing (1927-1989) helped to create several therapeutic communities in London which were designed to offer genuine asylum to residents who wished to avoid involuntary hospitalization, but were deeply distressed and disoriented, and to former mental hospital patients (Burston, 1996). Treatment here was always voluntary, and residents were not labeled according to prevailing diagnostic criteria by their therapists. These points are salient, given Laing's (1960) conceptualization of psychosis as a process arising from a disrupted or disturbed relational matrix. In Laing's (1960) most famous work, *The Divided Self,* he described how psychotic experience and behavior unfold when certain relational needs, including the development of self-consciousness through an I-Thou relationship with a primary caregiver, are not met. Laing (1960) theorized that when the human need for recognition (having one's self and experience validated) is thwarted consistently in infancy and childhood, and a false, compliant self evolves to meet others' demands and insure the person's safety, the individual may develop severe psychopathology arising from ontological insecurity (an impending sense of inner annihilation when in contact with others, while still desiring contact with others).

During his psychiatric training, Laing (1985) observed many disturbed patients who were hungry for human contact, which prompted his desire to create a community where they could live together without the dehumanizing and disturbing treatment often provided in psychiatric hospitals. Laing (1985) said the average mental hospital lacked any kind of real communion and meaningful communication between staff and therapists, on the one hand, and patients on the

other, thereby disrupting the natural healing process, and worsening the patient's prospects for recovery. Having discerned that the restoration of a capacity for genuine relatedness could mitigate the suffering and symptoms of madness, Laing and his colleagues David Cooper (1931-1986) and Aaron Esterson (1923-1999) created the Philadelphia Association, which created several networks of therapeutic communities for individuals suffering from psychosis or schizophrenia (Burston, 1996). These, in turn, inspired Soteria House, led by an American existential psychiatrist, Dr. Loren Mosher, which was (by far) the most successful and well documented community of this kind (Mosher, Hendrix, & Fort, 2004).

Thus, therapeutic communities can be defined as residential or communal spaces where individuals live together for an extended period of time in the hope of recovering from personal crises. Many strive to flatten, or, in some cases eliminate, the distinction between staff and residents, doing away with the word "patient "altogether. Residents and staff live and eat together, and ideally maintain connections with one another, after residents have graduated from the program (Mosher, Hendrix, & Fort, 2004). With the notable exception of Soteria House, therapeutic communities are seldom studied, and even less is known about farm-based therapeutic communities in the United States. Founded to create a stigma free, humanizing environment where individuals with mental illness live and work with laypeople, farm-based therapeutic communities treat residents as capable members of the community and as agents in their own recovery and care, and not primarily as "mental patients," or passive recipients of mental health services. Moreover, they regard meaningful work as their primary treatment modality, and the residents' engagement in communal work and play as pivotal in their eventual recovery.

Farm-Based Therapeutic Communities

The history of farm-based therapeutic communities is quite different in Europe than in the United States. According to Loue (2016), therapeutic farms abound and are referred to as "green care farms, care farming, social farming, and green care agriculture," in Europe (p. 11). This movement is widely referred to as care farming and emphasizes inclusivity and the rehabilitation of individuals with mental illness and developmental disabilities, with the provision of therapeutic services (Loue, 2016). Inclusion and rehabilitation are theoretically fostered through the shared physical labor of farm work. Loue's (2016) research documents that the Netherlands and Norway contain the majority of "well established" care farms (p. 12). Similarly, Elings and Hassink (2008) report that care farms have grown from 75 in 1998 to over 800 as of 2008 in the Netherlands.

Loue (2016) describes how Europe's gradual move from an economy based in manufacturing and agriculture to a service-based economy, it's aging population, increased transportation between rural and urban areas, and increased focused on living healthfully has increased the development of care-farming (p. 12). Loue (2016) also describes the two philosophical frameworks used in European care farms: public health and social inclusion. The social inclusion framework seems to overlap the most with the philosophical framework of the farm-based therapeutic communities in the United States. This framework focuses on: "the reintegration of excluded persons into society through activities formulated to increase their knowledge and skills, the reestablishment of their ability to engage in work, and the development of their self-esteem" (Loue, 2016, p. 12).

Only a handful of farm-based therapeutic communities seem to exist in the United States (Loue, 2016), all of which appear focused on the social inclusion framework described above. In

particular, farm-based therapeutic communities differ from other therapeutic communities due to their large emphasis on work as a mechanism of healing and restoration. In order to investigate this seldom studied treatment approach, this dissertation explores the lived experience of people residing at the Haven,[3] a farm-based therapeutic community in the United States by way of ethnographic observation and interviews.

Method: Clinical Ethnography

Ethnography is a qualitative research methodology that aims to understand "what people actually do" and to get as close to their lived experience as possible by way of participant-observation—that is, becoming a participant in a community and observing it from both within (as participant) and outside (LeCompte & Schensul, 1999, p. 1). Traditionally, ethnography involves immersive participant-observation of a particular group of individuals or a particular cultural space in order to better understand such groups or spaces, to get a sense of what it is like to be a part of that space or group. Ethnography, as a method, grew out of cultural anthropology and is applied differently across academic disciplines: (i.e. anthropology, sociology, psychology). Historically, ethnographic work in anthropology involved being immersed in a community (particularly a culture distinct from one's own) for several years (LeCompte & Schensul, 1999). Contemporary ethnography takes place in various settings and for different periods of time with often an emphasis on shorter-term encounters (LeCompte & Schensul, 1999). Clinical ethnography is a particular use of the broader ethnographic method.

Calabrese (2013) defines clinical ethnography as follows: "culturally and clinically informed self-reflective immersion in local worlds of suffering, healing, and well-being to produce data that are of clinical, as well as anthropological value. Empathic skills and self-

[3] The Haven is a pseudonym used to maintain the confidentiality of the site where I completed this research.

awareness are emphasized in this approach because they are understood as indispensable to both clinical understanding and intercultural understanding" (p. 51-52). This definition is similar to what Lester (2011) calls applied psychiatric anthropology, defining it as "a person-centered approach" that "bridges research, policy, and engaged clinical practice concerned with alleviating psychic distress and optimizing meaningful forms of care" (p. 483). This method requires facility with clinical knowledge such as treatments, diagnostic categories, methods of clinical care, and theories on human suffering[4] and flourishing.

My project combines elements of Calabrese's (2013) clinical ethnography and Lester's (2011) applied psychiatric anthropology. I chose ethnography as a method in order to get a vivid sense of what living in a therapeutic community is like. Therefore, I lived alongside residents and observed their daily interactions and experiences at the Haven from June 2018 to October 2018. Prior to my four months on site, I visited the Haven in May 2018 for a week to get a preliminary sense of what living on site for four months would be like. Ethnographic participant-observation allowed me to immerse myself in a "clinical world of suffering and healing" as discussed by Calabrese (2013) and located me in a world of discovery (Shweder, 1997) regarding how this particular site functions and what the site, as a lived cultural space, is and does.

Before describing the methodological steps of ethnography, I begin with a brief description of the field site where I completed my ethnographic research.

[4] I wish to thank to my former teacher Ronald B. Miller at Saint Michael's College for this language of human suffering. His beautiful work *Facing Human Suffering: Psychology and Psychotherapy as Moral Engagement*, asks the field of psychology to return to an understanding of distress as human suffering, rather than seeing our role as clinicians treating "patients with mental disorders." Miller reorients us to the moral and ethical sense of suffering that is lost in conceptualizing distress solely as mental disorder. Since my studies at Saint Michael's College, I have used the language of human suffering to describe and conceptualize psychological distress, a phrase that best highlights the meaningful, difficult, and sacred work of psychotherapy.

The Haven: Brief Field Site Description

The Haven is a self-pay[5] farm-based therapeutic community in the United States known for work-centered therapy, where work is conceptualized as central in helping people get back to themselves, in order to find that they are valuable members of society, and not merely defined by their symptoms and suffering. By sharing work with the staff, residents are ostensibly able to develop a sense of self-efficacy and self-esteem while also building supportive relationships. Moreover, many believe that there is existential value in getting back to basics, connecting to the land, and working in a community where residents and staff are equally responsible for the upkeep and functioning of their community. The philosophy of the Haven[6] is that all members of the community have something important to contribute, and that it is through building community that a resident's contribution can be cultivated and flourish.

The Haven hosts anywhere from 20-30 residents at one time who find themselves unable to maintain employment or acquire the skills considered necessary for daily functioning. Residents come from all over the United States and are often struggling with a dual-diagnosis of mental health concerns and substance abuse. During my stay at the Haven, residents were mainly

[5] One significant barrier to accessing services at the Haven, as well as most farm-based therapeutic communities, is the exorbitant cost of attendance. The monthly tuition for the Haven is $10,000 dollars a month, meaning the majority of residents come from upper class financial backgrounds. The Haven does offer some scholarship support to residents; however, the scholarship often still leaves residents paying around $5,000-6,000 a month for tuition. Such a barrier was cited as a salient concern by many of the staff I interviewed with, as well as residents who appeared particularly mindful of the cost of their stay at the Haven. As Elizabeth, a longtime staff member commented, "it's such a rub that we want to make it affordable for the most people possible understanding that 90% of Americans can't afford to come here."

[6] For the purposes of confidentiality, some details regarding the Haven have been altered. Additionally, some identifying details about participants have been changed to protect their confidentiality. In some cases, single participant names are split into various pseudonyms due to the depth of the interviews, in attempts to protect their confidentiality. I have tried to disguise the identity of the Haven to the best of my ability; however, as discussed in the informed consent forms, given the depth of detail provided in ethnography, there is a chance the identity may be known to some readers. This limit to confidentiality was discussed with all participants prior to their signing the informed consent form.

young adults (early to mid-twenties) who struggled to maintain jobs or complete a college education due in part to both mental health and substance use struggles. However, an increasing number of the residents during my observations appear to be college educated adults who suffer some sort of psychological hardship prior to, or after, completing their education. This particular population marks a change from the Haven's original clientele, who were largely older adults struggling with what many staff termed "chronic mental illness," who stayed at the Haven for several years,[7] or in some cases, for the majority of their lives.

The Haven's staff is composed of work team leaders who oversee the various work-centered therapy options for residents (i.e. farming, gardening, maintenance, carpentry), a number of counselors or therapists, case managers, grounds crew, cooks and kitchen crew, a number of administrative staff, and house advisors. House advisors are arguably the most important staff at the Haven. They live in the onsite housing with residents and are responsible for providing emotional and social support to residents, in addition to serving as second work crew supervisors and in a multiplicity of other roles.[8]

Once admitted to the Haven, a resident becomes part of a work crew, overseen by a work team leader, and performs a variety of tasks, focusing on farming, gardening, carpentry, and maintenance. In addition to work, residents now see a therapist at least once a week for individual therapy,[9] attend weekly team meetings where the resident's house advisor, therapist,

[7] Although older residents were remembered as having stayed at the farm for several years, Ron, a longtime colleague at the Haven, who held several roles throughout his time there, remarked that truly only about 10-15% of residents ended up staying at the Haven long-term, meaning several years of their lives. As Ron stated, "those are the residents you remember the most," because they had invested so much time there, and often became pillars of the community. Such memories may lead to an overestimation of how many residents spent a majority of their lives at the Haven.

[8] As became clear to me through interviews with current house advisors, their role includes much more than just described and oftentimes was felt to be quite confusing to the house advisors themselves.

[9] The addition of individual therapy for residents is a relatively new phenomenon at the Haven as of the last five years. This change will be explored more fully in chapter five of the dissertation.

and residential support staff [10] discuss the resident's experience and progress at the Haven, attend group therapies if desired, and participate in other therapeutic programming, such as yoga and art groups.[11] During the weekends, residents do not participate in work crews; however, there are some activities that take place both off and on-site at the Haven. Residents might travel into town to visit the local farmer's market, church, or other social events.

A typical stay at the Haven for residents is 3-6 months and upon finishing their work at the farm, residents sometimes begin to work with the transitional program. The transitional program allows residents to continue working and spending time at the Haven if desired, while also helping residents integrate into a larger community. Some former residents come back to work at the Haven and become part of the therapeutic community as staff members, and many residents appear to stay connected to the Haven by visiting.

Many residents leave the Haven and return home. Time spent at the Haven is focused on helping residents develop certain skills or learn, what staff call "the soft skills" associated with maintaining a job, such as being on time, taking responsibility, and navigating difficult situations or interpersonal dynamics. The goal for the Haven's current population is to help residents better integrate into the working world: to leave the Haven and maintain a job, or to be able to complete an education. Said another way, the Haven strives to help residents learn various skills to manage their distress, so they can continue to work and pursue their goals in the world beyond the Haven.

My use of clinical ethnography involved the following aspects: reflexivity, immersive

[10] All staff are eligible to be residential support staff, a person who serves on the resident's "team" to provide additional support. This means even non-clinical administrative staff, such as the business manager, or grounds crew manager, may serve as a residential support staff. Such a model appears to retain aspects of the lay-person model historically used in therapeutic communities to downplay reliance on medical and clinical understandings of the resident/patient.

[11] During my time at the Haven, the "other therapeutic programming" offerings were quite limited. Towards the end of my stay, the Haven was working to provide more programming such as art classes, yoga, martial arts, and others.

fieldwork or participant-observation, and person-centered interviewing. This section of the dissertation explores these aspects of ethnography as they relate to my project.

Reflexivity

Historically, ethnographers within anthropology sought to separate strict descriptive fieldnote writings from self-reflexive writing (Emerson, Fretz, & Shaw, 2011). Sociological ethnographers in the 1960s began to integrate both descriptive fieldnotes with personal, reflexive notes (Emerson et al., 2011). Emerson et al. (2011) cite Lofland and Lofland's (1995) reasons for integrating the two forms of ethnographic note-taking: for insight into how the fieldworker's experience may mirror those of the participants, how integrating these notes may offer important analytic insights, and how such an integration allows for the checking of bias and illustrates how views and perspectives change over time. Although I kept a personal reflexive diary specifically for reflecting on my daily experiences at the end of each day, I also integrated reflexive moments and thoughts into my daily fieldnotes as they occurred in the moment. I used my own experiences on site with participants to potentially provide insight into participant experiences, as well as used my writings about said experiences to "check" where my feelings and interpretations were coming from, and how my own subjectivity influenced my approach to the data collection.

Calabrese (2013) discusses two traditions of reflexivity: 1) psychological or clinical reflexivity, and 2) socio-cultural reflexivity. Psychological reflexivity is defined as "self-consciousness of one's personal identity, relationship history, dreams, and emotional responses, and the way they clash or resonate with personal relationships and immersion in the field" (Calabrese, 2013, p. 59). I engaged almost constantly with this level of reflexivity in analyzing my own reactions to events that happened at the Haven. For example, I often reflected on how

my positioning as a clinical-psychologist-in-training[12] shaped and informed my reactions to arriving at the Haven, as well as my critiques of the farm throughout my time there. From the moment I arrived at the Haven, I found myself wondering: "where are the therapeutic offerings?" And by therapeutic I meant clinical.

When I used the term clinical, I wondered where the therapy was (i.e. individual therapy, group therapy, etc)… For me, clinical both meant formal therapy services, as well as dedicated time to processing various aspects of resident's experience. In addition to wondering why there was not more group processing interwoven into the various activities of the Haven, (i.e. why wasn't there processing of the work residents did throughout the day, linking it to their own challenges or life experiences, or discussions of what it was like to complete a work project together)? I believe, I also associated peer groups or peer recovery work as clinical, though this association would certainly be disputed as peer recovery movements arose in response to the harmful and marginalizing treatments provided to individuals suffering from psychological distress. Peer recovery work is certainly not considered "clinical." My training in alternative approaches to healing psychological suffering is likely why I associate the two together, despite peer recovery work falling outside of what is considered "clinical," especially in terms of seeing the individual with lived experience as the healer, rather than the expert therapist who *treats* the

[12] The American Psychological Association's Dictionary of Psychology defines clinical psychology as the following: "The branch of psychology that specializes in the research, assessment, diagnosis, evaluation, prevention, and treatment of emotional and behavioral disorders. Clinical psychologists are doctorate-level professionals who have received training in research methods and techniques for the diagnosis and treatment of various psychological disorders. They work primarily in health and mental health clinics, in research, in academic settings, or in group and independent practices. They also serve as consultants to other professionals in the medical, legal, social-work, and community-relations fields" (APA, 2020). Additionally, my training in clinical psychology has involved much education in depth therapies, phenomenological and existential-humanistic traditions of psychology, that moves beyond conceptualizing individuals simply as suffering from symptoms and diagnoses. As further described in chapter five, the term clinical is hard to define and often elicits different definitions and responses depending upon various considerations (i.e. one's theoretical orientation, academic field of study such as anthropology, sociology, medical anthropology, and so on).

suffering individual.

In the beginning of my fieldwork, I conflated therapeutic with clinical, as I lamented the lack of psychotherapy groups and individual therapy sessions. I realized I arrived anticipating a plethora of clinical offerings and felt critical when these offerings did not exist in abundance. These criticisms and assumptions were largely related to my training and immersion in the clinical profession; however, a part of my cultural identity also influenced my occasional anger at the lack of clinical programming. This reaction, rooted in my class identity and socioeconomic background, is an example of socio-cultural reflexivity.

Calabrese (2013) defines socio-cultural reflexivity as "self-consciousness of one's cultural background and sociopolitical positioning as they influence ethnographic observation and description" (p. 59). Calabrese (2013) discusses how this type of reflexivity enables him to examine his own experience of Native American culture as a Euro-American (i.e. a member of a society with a history of racist oppression towards Native Americans). Similarly, in addressing my anger towards my perceived lack of "clinical" programming at the Haven, I realized my reaction arose from my background as a clinical-psychologist-in-training, but also the awareness that I could, most likely, never afford care at the Haven myself. Having grown up in a mixed working and middle-class family in a part of the Southern United States and putting myself through college and graduate school as a first-generation, financially independent student, the affordability of care is quite important to me. I found myself agreeing when residents posed the question: "Am I getting enough bang for my buck?" Interestingly, this question often came from residents whose stays were financed by their parents, and wealthy families. I was struck by how many residents, wealthy or not, wondered whether they or their family were paying too much for their stay at the Haven.

Given my class identity growing up, which I still feel identified with, I also came to the Haven assuming that the cost of services would not be an issue for the majority of residents; however, this bias dissipated as I began interviewing residents. Nearly every one of them remarked on the cost of the Haven, expressing concern about how it affected their family. Some felt guilty about how much the treatment was costing their families. Others felt they were not getting what they were paying for. Oftentimes, this attitude was referred to by staff as residents "being entitled," because of their family's affluence. Yet, I remained somewhat suspicious about this attribution, which felt like an easy way for staff to dismiss constructive criticism. Hearing resident concerns about the cost of their stay at the Haven made me take a step back and examine my own assumptions about class, and the centrality of the fee for resident concerns. I had inaccurately assumed that residents who came from affluent families would not be concerned about the fees.

In applying Calabrese's (2013) psychological and socio-cultural reflexivity to the beginning of my project, the next section focuses on the preconceptions with which I began my project at the Haven.

Reflexivity: Project Preconceptions

My interest in therapeutic communities began during my master's program, when I discovered the Soteria house project by Dr. Loren Mosher (1933-2004), a friend and follower of Medard Boss and R.D. Laing, and former director of schizophrenia research at NIMH from 1968 to 1980. Soteria—the Greek word for *salvation*—was an experimental community created in the 1970s for people experiencing their first psychotic episode. The *treatment* for residents (not patients) involved living with staff and volunteers in a community that allowed residents to go through their psychotic experience without stigma or any effort to arrest the process for a period

of up to three months, provided no one's safety was threatened, before introducing any medications. In this three-month interval before medications were administered, *treatment* consisted entirely in members of the community simply being with residents in a space of non-judgmental acceptance (Mosher, Hendrix, & Fort, 2004). Most striking was Soteria's emphasis on relationships as the primary vehicle for healing. Moreover, relationships were seen as critical; so *critical,* in fact, that a principle of Soteria's mission was to provide (if so desired) ongoing relationships with residents and staff.

Mosher believed hospital admissions and discharges could often inadvertently thwart healing (Mosher, Hendrix, & Fort, 2004). Mosher, Hendrix, and Fort (2004) write:

> Many of Soteria's graduates kept in *close contact with the community*. The relationships (at Soteria) were *personal*, and *therefore had implications beyond separation*, for the clients as well as the staff. At Soteria, therapeutic involvement went beyond the boundary of official relationships framed by admission and discharge. *Why? Because relationships were critical: If they didn't happen at Soteria, neither did change*. (emphasis added, p. 35)

Given his well-documented success rates, Mosher's perspective was surprising and refreshing, because prior to this moment in my academic studies, I had only been exposed to classical and ego-psychoanalytic approaches which critiqued such ideas, particularly the notion that continued connection was vital for healing. Thus, I began to imagine that therapeutic communities are places where attachment and a person's existential needs might dovetail more clearly (and be addressed more perceptively) by staff and "patients," than they are, generally speaking, in individual psychotherapy.

When I initially proposed this project, I hoped to investigate the degree to which

existential needs are experienced and addressed within therapeutic communities—or not. Inspired by the example of Soteria House, I was particularly drawn to individuals who had continued long-term relationships with their therapeutic community. The Haven seemed like the ideal site for exploring such themes, as my discussions with staff members disclosed that many early Haven residents had historically either lived out their days at the Haven or moved into a nearby town and continued to visit, and sometimes ended up working at the Haven as staff themselves.[13] However, as my research unfolded, I discovered that this is no longer the case. Given the changing demographics of the Haven—younger adults in their early to late twenties, many of whom are supported financially by their families for their stay at the Haven[14]—a resident's average length of stay is now merely three to six months. Moreover, residents now enter treatment with the expectation and desire of returning home[15]. Thus, stays for a year or longer, are essentially a relic of the past.[16]

Reflexivity: Shifting my Research Questions

Upon learning more about the changes in the population, as well as changes in the structure and vision of the farm, my research questions became focused on getting a sense of

[13] As of this writing in early 2020, the Haven has had to end the employment of longtime former Haven residents, due to liability concerns about how some of these employees still receive some services from the transitional programming. In some cases, these former residents have worked at the Haven for years. My sense is that these changes continue to erode a sense of long-term community.

[14] In discussions with long-term staff after I left the field, staff noted that throughout the Haven's history, 95% of the time, residents were referred by families, which is still the case today.

[15] As discussed with Ron, this was most often the intention of all residents, historically. However, sometimes, especially in the past, residents would arrive at the Haven and realize their lives may be better if they continued to live at the Haven long-term, rather than return to their families or the "outside world," if you will. This decision appears in part due to the different approach in work culture at the farm, versus the work expectations in the world beyond the Haven, where slowing down and working at one's own pace if needed is not often tolerated.

[16] As previously noted in my discussion with Ron, the average length of stay at the Haven has historically hovered around 6 months, though about 10-15% of residents stayed for much longer than this, with some residents later becoming staff members This number appears much lower than what most staff members seemed to remember about the past resident population in several discussions I had with staff members. As stated by Ron, this higher estimation of long-term residents is likely due to the memorability of such residents, especially as they became so central to the community.

what it is like to live and work in a farm-based therapeutic community, and what it is like to be a resident and staff member in a farm-based therapeutic community. As I immersed myself in the community and its daily operations, I became interested in the idea of work as therapy, or work as the defining principle of what makes the Haven successful or helpful to residents. Many of the staff, and a few past residents, mentioned several times that the work program is what sets the Haven apart from other treatment centers. At the same time, I observed diverse resident and staff perspectives on the work program and processed my own mixed reactions when I joined work crews with the residents. These questions are explored in chapters three and four of the dissertation.

Another set of questions that emerged during fieldwork concerns how, whether, or to what extent a therapeutic farm community like this retains aspects of its initial vision and approach, as it transitions into a treatment center. Historically, the Haven functioned as a safe working environment and community for "chronically mentally ill" adolescents and adults to experience working at a slower, more accepting pace, with the help of others in a community setting free of the stigma usually associated with their symptoms. Such an approach was theorized to help residents develop work skills and a sense of value and self-worth, rather than experiencing themselves as merely "mentally ill" patients who can no longer function in society as a result of their addiction or "illness." Returning to the world outside the Haven was less of a looming concern, as some residents stayed at the Haven for several years or indefinitely. Now the Haven is struggling to adopt a treatment model that retains the community centered principles and values of its origins.

Paradoxically, this last objective seems increasingly threatened by the Haven's effort to become more clinically (and by implication medically) oriented, in keeping with changing

standards of mental health care and the Haven's urgent need to generate revenue to stay viable in a world of sky-rocketing medical costs. In interviews with staff members, many were wary or apprehensive about becoming more "clinical," fearing they would begin to see residents as "diagnoses, disorders, and as patients," losing the Haven's former emphasis on residents' agency and value as community members. Not surprisingly, some residents expressed a lack of experienced agency. With the recent addition of weekly psychiatrist visits, individual therapy, and group therapy, many residents acknowledged that their struggles were being better addressed. Yet, some also felt more like "mental patients" than responsible members of a community. Such feelings of disempowerment are in direct conflict with the aims of therapeutic communities. Therefore, I became interested in what the transition from therapeutic community to treatment center entails, and what is gained and lost in the process. I also wondered if and how a therapeutic community could also be a treatment center, retaining the focus on community-based healing, without succumbing to the potential hazards of a medical model-based treatment center.

These questions and thought processes likely disclose another bias I brought to my work; my orientation to psychology as a human science, which is largely based in the existential-humanistic tradition. I value person-centered clinical care, the hermeneutics of faith (Orange, 2011), reducing power dynamics as much as possible in clinical work, and working to create an atmosphere of egalitarianism, alternative and expansive approaches to psychological wellbeing, including community-based healing. I am therefore inclined to be skeptical of a medical model, diagnostic perspective that reduces humans to symptoms and diagnostic codes. Indeed, it was such a bias that steered me towards therapeutic communities in the first place, as such communities were largely forged with humanistic aims.

Therefore, my training and education in psychodynamic, existential-humanistic psychology, and the value I place on alternative approaches to psychological suffering, is another "lens" through which I interpreted my data. That said, training in "clinical" discourse and the medical model understandings of distress also at times informed my experiences at the Haven. A frequent complaint from house advisors and non-clinical staff was that there should be "more clinical training" regarding diagnoses and ways of working with individuals with different clinical presentations. I, too, was shocked by the lack of "training" non-clinical staff received; particularly, when some residents' lived experienced seemed characteristic of possible dissociative identity experiences, or when residents experienced command hallucinations, or where severe trauma may have been a concern. On several occasions, when I had these thoughts, I struggled with my preference for non-diagnostic ways of seeing and working with people.[17] My desire for staff to be trained seemed to conflict with the lay person model of therapeutic communities I had long idealized. Eventually it dawned on me that this internal struggle of mine paralleled the process the Haven community as a whole was undergoing: how can we integrate a clinical treatment perspective with our non-pathologizing community centered approach to healing—or can we? This question remains central to this project.

Immersive Field Work

Immersive field work is the bulk of ethnographic research (Emerson et al., 2011). This involved living on site at the Haven. Knowing my desire to spend some time conducting research in a therapeutic community, a long-time friend asked me if I had considered the Haven. My

[17] Of course, in hindsight it feels clear to me that that this issue is not dichotomous. Training does not have be taken up with a pathologizing stance. Rather, training may help staff better understand what certain symptom presentations may look like, without prescribing such presentations as the only way to see and understand a suffering human being. This is the perspective I would urge the Haven to adopt. Once a medical model or diagnostic way of seeing people becomes dominant, we risk reducing individuals to their assigned diagnosis and thus seeing them almost entirely through that reductive lens.

friend said she knew some of the staff there and she would gladly connect us. After a few email exchanges and phone calls, I was invited to attend a meeting at the Haven for a visit and tour. I first arrived at the Haven on September 11th, 2017 for an informal meeting with administrative staff to discuss my project.

My arrival in September 2017 included attending a daily morning meeting that runs Monday through Friday, where staff and residents receive announcements and updates about the day's events. After that morning meeting, I took a brief tour of the Haven's grounds and spoke with administrative staff about my dissertation proposal and what I hoped to accomplish if permitted to conduct my research there. This visit lasted about two hours, and I was awed by the beauty of the place, several acres of sprawling farmland, where various farm projects allowed residents to spend a majority of their time outside working in nature. I was also impressed by the posters hanging around the central house on campus, where residents and staff met regularly for meals and for the morning meeting; posters that described various group offerings for residents. My interest was particularly piqued by the Hearing Voices Network poster attached to the door that opened into the kitchen. My initial sense of the Haven was that it afforded residents many therapeutic opportunities; however, as alluded to earlier, I was still defining "therapeutic" in terms of clinical offerings given my clinical training.[18]

Graciously, the staff agreed to host me for four months and it was decided that I would return in June 2018 to formally begin conducting my research. Prior to my arrival in June 2018, I visited the Haven in May 2018 to stay on-site for a week to get an initial sense of what life at the

[18] I should note that I also assumed the work program would include therapeutic processing of the work completed or what events transpired during the work program—so in saying I was expecting clinical offerings, I was not specifically expecting all "clinical" offerings to be in the form of individual or group therapy. I had imagined, mistakenly, that therapeutic or clinical services included work-based therapy, assuming that there was a processing component that related the work experiences to resident goals, or existential issues relevant to their healing.

Haven would be like. During my week-long visit in May 2018, I completed reflexive memos about my initial experiences at the Haven; however, no interviews were conducted as this visit was strictly to familiarize myself with the Haven and my transition to living there.

It was during this initial visit that I began to feel concerned about the apparent lack of clinical offerings. Consider this note from my first full day on site, May 7th, 2018: "The farm is gorgeous, but I am feeling surprised by the lack of therapy groups. It seems the farm is almost solely a working farm without any clinical components." I was also surprised when I no longer saw signs for Hearing Voices groups or any groups for that matter. I noticed on a huge whiteboard, in the common area of the central house, which outlined the daily schedule, that AA or NA meetings were happening in the evening; however, I saw no indication of any other group offerings. [19] Also, I wrote this note in the evening after a full day on site, having spent the majority of it working on the farm. Later in this same entry, I note that I already found myself not enjoying the crew work that day and feeling "suspicious of what is therapeutic here." Two days later on May 9th, I noted, "I keep feeling disappointed by the lack of clinical material or opportunities." I also wrote in parentheses "is there a lack?" noting my unceasing tendency to question my thoughts, feelings, and critiques.

Here then is evidence that my initial impressions of the Haven were critical, disappointing, and tied to my perspective as a clinician-in-training. When considering the history of the Haven, and in hindsight, it makes a certain amount of sense that the farm would not have many clinical offerings. Or does it make sense in the year 2018? I emphasize that my

[19] Later into my stay at the Haven, I learned that residents could attend a Hearing Voices group in town, in addition to some other mental health support groups that also took place in town, not at the farm. Additionally, most of the AA/NA groups were also held in town at local churches or community centers. Though I was happy to learn that there were these offerings in the community, many of them (Hearing Voices and AA/NA) are free groups, open to anyone. I began to wonder more about the fee for services and what that fee specifically covered in terms of "treatment."

disappointment and dissatisfaction were rooted in the absence of a combination of work-centered therapy, individual therapy, group therapy, eco-therapy, and group processing work; not a disappointment in the existence of a work program. In fact, when I began my work I was incredibly excited about the opportunities afforded by combining traditional "talk therapy" with the physical benefits of movement and work in a serene setting. Yet, I left the field that week in May feeling the farm was truly an expensive working farm with little clinical or therapeutic offerings.[20]

When I returned to the Haven on June 10th, 2018, I moved into a four-bedroom building on-site that traditionally housed house advisors. For the first month of my stay I lived alone in this house and during my second month I shared the house with various house advisors and Haven visitors until I left on October 14th, 2018.

On June 12th, 2018, I announced my project at the daily morning meeting and provided staff members and residents with the informed consent forms, available in Appendix A and B. No interview data was collected prior to June 12th, 2018. At this morning meeting, residents and staff were able to ask questions and decide whether they consented to the study. For Haven residents and staff who did not consent to the study, no information was collected from these individuals. All participants who provided consent were instructed that they could withdraw from the study at any time, and upon withdrawal, no new data would be collected, and past data would not be used unless it was already part of a past presentation. No participants withdrew from the study.

Each weekday began with a morning meeting at 9 am. Staff and residents would give daily updates and announcements regarding who was going to see the psychiatrist, who needed

[20] This tension around work as therapy and the integration of farm-work and clinical work is explored more thoroughly in chapters three and four.

to take trips into town for various reasons (i.e. specialist doctors' visits) and which residents were part of which work crews for the day. Some mornings, staff and residents would share music or poetry; however, I observed that morning meetings were typically dominated by staff providing updates, and residents seldom spoke.

After morning meeting, residents and work leaders would head out to their respective work locations to gather materials for the day's projects. Work often lasted from around 9:30 am until noon, at which point everyone took an hour break for lunch. At 1 pm, some residents enjoyed an additional thirty minutes of respite. Others would join their treatment team for meetings where residents' progress and goals were discussed and revisited regarding their stay at the Haven. At roughly 1:30 pm, work crews resumed their activities and concluded at 5 pm. Residents enjoyed an hour of free time before dinner at 6:00 pm, and I observed that much of this hour was spent congregating in the recreation house, where the wireless internet connection was. Many residents spent this hour on their laptops, while others played video games. Some residents would go for walks, play basketball or other sports on the lawn, and some returned to their rooms for an hour.

After dinner concluded at 7 pm, residents struggling with substance concerns would attend mandatory AA or NA meetings. Residents were required to attend so many meetings a week. For other residents, who were not experiencing substance concerns, not much else was happening during my first few months on site in terms of structured activities after 7 pm. In fact, during the hour between work and dinner, I was told, as were residents, that activities such as art classes and yoga would be available. However, oftentimes these events happened merely one day a week, and instead of structured activities existing during this time, residents were left to

commune with their computers.[21]

This schedule was pretty typical for the first two and half months of my stay at the Haven. Residents typically saw their counselors or therapists once a week for an hour, interspersed throughout the working day. Some residents also left their work crew for an hour or so once a week to visit with the psychiatrist. Weekends were much freer with no work scheduled. Some residents would take trips into town with house advisors, some completed work chores for which they were paid. [22] This period of unstructured free time also became a source of tension for many residents. I often heard clinicians and staff tell residents, "You've got to learn how to structure your downtime." At times like these, I thought to myself, "Sure, we all have to learn how to manage our own schedules and down time," and "Wow, residents pay so much to be here, shouldn't there be more offerings, such as weekend yoga, art offerings, maybe even clinical groups?"

What did ethnographic immersion look like during my four month stay at the Haven? I would wake up and attend morning meeting. Some mornings I joined work crews, which meant working with residents on the day's projects. For example, when working with residents on the farm crew, I helped with making fences for new grazing fields, feeding the animals, cleaning out barns, etc. When on the maintenance crew, I helped clear fields of debris, tossing branches from trails, cutting up fallen trees on the trails, etc. I tried to cycle through all work crews a few times to get a good sense of how they functioned. Initially I tried a different crew each day; however, a few weeks into my research, I decided to pick a crew and stay with it for several weeks to get a

[21] Perhaps one could argue that residents preferred to commune with their computers, and for some residents that may have been true; however, a full exploration of this idea is beyond the scope of this dissertation.
[22] It's important to note that only work deemed "chores" were paid labor. The work program overall was seen as part of the therapeutic programming at the Haven. If residents wanted to try to earn money they could elect to complete chores on the weekend (which included feeding farm animals) or throughout the week by helping out in the kitchen with cleaning.

more immersive and hopefully continuous experience of what that crew was like. This proved to be a better arrangement, as during my stay at the Haven, residents would pick a crew, and generally, stay on it for a couple weeks at a time. However, some residents swapped crews every week, and this led to changing group dynamics from week to week, which made it more difficult to experience continuity both in terms of the projects being completed[23] and as a group dynamic itself.

When not joining a work crew, I often attended and observed various meetings, including the work program meeting. In this meeting, members of the work program discussed the crew schedule for the week and various upcoming seasonal projects. I also attended and observed weekly clinical supervision meetings, a resident support services meeting that included clinical and non-clinical staff, a weekly house advisors meeting where house advisors and their supervisor discussed upcoming events, planned their work schedules, processed what was occurring in the community, and sometimes, though rarely, received clinical didactic training from the clinical staff. When not observing meetings or joining a work crew for the day, I conducted interviews with residents and staff. When not engaged in any of these activities, I was writing or transcribing fieldnotes or interviews.

Initially I struggled to create a set schedule for myself. I found myself experiencing pretty intense FOMO (fear of missing out)—if I was on one crew, what was I missing on the others? If I spent the afternoon hour after lunch attending a team meeting, what was I missing in the recreation building? What was happening in the kitchen? And what about the time I needed to

[23] The weekly or sometimes daily change of crew members seemed a particular challenge for crews like maintenance where many projects focused on building. During my research, I joined carpentry crew when they were building a tool shed; however, due to the irregularity of consistent residents on that particular crew, there wasn't a collective sense of having built the entire tool shed together. This was a challenge specifically communicated to me by the carpentry team leader.

write fieldnotes, conduct interviews, and transcribe all of these notes?

Some days I joined work crews either in the morning or afternoon and spent the other part of the day either conducting an interview, typing up fieldnotes, or transcribing interviews. About halfway into my stay at the Haven, a significant schedule change occurred where clinical staff added various therapy groups that residents could attend. At this point, my difficulty in maintaining a set schedule became more challenging as I wanted to attend and observe as many groups as possible. I also wanted to spend more time with residents and staff on weekends, given their lack of structure. I wanted to fully immerse myself in the experience and balancing this desire with my effort to record and transcribe fieldnotes, conducting interviews, etc., presented quite the challenge. In sum, I tried to balance my time observing and participating in the various events of the Haven with the tasks of documenting my ideas and experiences. In the end, I left the site with plenty of interviews to transcribe, as I reasoned that time spent in the community was more important, and the most limited resource I had with this project. So how did I document all of this immersion?

As immersive field work is the main emphasis of ethnographic work, fieldnotes are, arguably, the most important form of data. Emerson et al. (2011) define fieldnotes as "writings produced in or in close proximity to the field" and as writings completed "contemporaneously with experience" (p. 353). I experimented with jotting fieldnotes during my periods of observation. While jotting on work crew, I found the practice obtrusive and intrusive. I noticed residents watching me as I pulled out my small note pad and jotted notes. Interestingly, note taking felt less obtrusive when I began observing group therapies; however, the outdoor work environment did not feel conducive to jottings, and such action made it clear that I was an

outsider, and reminded all of us on crew that I was here as a researcher.[24] On rare occasions then I noted something in the moment during work crew, using mental notes or basic jottings (Emerson et al., 2011). I preferred to head to my room after work crew or during breaks from crew to jot down my observations—using in the moment jottings simply to note words that captured an experience I wanted to document. I would then write after a period of observation more fully fleshed out fieldnotes, in addition to reflexive memos.

As an example, here is a fieldnote I transcribed on June 27th, 2018. This note has been edited for clarity:

> On 6-27-18 I attended a team meeting for Sandra. Sandra identifies as a biracial, 21-year old, pansexual woman. She saunters slowly towards the lawn chairs where her team is gathered. I sit in the blue chair shaded by a giant oak tree. Her house advisor and resident support staff pull their chairs out into the sunlight. Sandra moves at an unhurried pace wherever she goes. Her therapist refers to her gait (and work ethic) as "leisurely" while her work crew describes her as "lazy" or "slow." Sandra has a beautiful, glowing smile, and a high-pitched, welcoming voice. She sits down in his chair, finishing her dessert of strawberries and cream while her team begins the meeting. I smile, noticing her not rushing through lunch, another example of her leisurely approach to life. Sandra has a welcoming and loving aura. She is friendly and welcoming of others. Some residents have described her as "always happy and upbeat." Though I suspect part of her leisurely movements may be a combination of both a more mindful and slow-paced approach to life and depressive feelings. Her gait reminds me of the psychomotor slowness associated with depression.
>
> The meeting is held on the main lawn outside the common house. In attendance are, Sandra (resident), Chad (support staff) Nancy (house advisor), and myself. Her therapist was not in attendance. Team meetings are held once a week and the resident support staff leads the meeting. Chad began by asking Sandra how things were going. Sandra reported having a good week and making progress on everything but her job application procrastination.
> Sandra arrived at the farm due to struggles with alcoholism. She has been at the farm for 3 months and is hoping to leave at the end of July; however, her family and team may want her to stay for longer. Sandra has planned to begin a job in August, so she, likely, will not approve of the request to stay longer. She was approved for more financial aid last week which means she can stay for longer and it seems her family wants this; however, whether or not she will stay remains unclear. During the team meeting she expressed that she did not want to stay for longer. However, in a conversation I had with her resident support staff member the day before the meeting (6/26/18) it seemed that she *would* be staying for an additional two months and this is what was desired for her, by

[24] Emerson et al. (2011) discuss these difficulties of in person jottings and recommend mental notes or basic jottings to help the researcher retain information about the field, without potentially alienating participants.

her parents.

During the team meeting, Sandra remarked that she had finally arrived at an understanding of how/why the farm is able to have people "pay to complete uncompensated labor." She explained that her sense of this phenomenon is that parents are willing to pay the expensive fees for residence here, to "get a break" or a vacation from their kids. Chad asked if Sandra felt this was true for her (of her own family) and she agreed that it felt that way. I found her comment on uncompensated labor interesting. Although some residents may derive a sense of enjoyment or accomplishment from the work done on the farm, and some may need the work in order to build "work ethic" and skills they didn't have prior to residing at the farm, Sandra has mentioned "uncompensated labor" when people are "paying a ton of money" to me several times since I've arrived. Must one be paid for labor? Can someone enjoy the labor without being compensated? And where is the line between free labor and meaningful labor?

The team meeting continued by asking Sandra to reflect on her likely "triggers" for relapse. She named being in social settings where others were drinking. "Seeing others drink, makes me want to drink again." She told her team that she wanted more direct feedback about taking intentional time to submit her job applications. She stated that she wanted, "gentle reminders," to be more conscientious about making sure she began working on her applications.

When asked what was most helpful about being at the Haven for treatment, Sandra remarked, there is "tremendous benefit in being away from using and being away from alcohol." She stated that there was benefit in having conversations with people who are different from you. She stated that conversations with residents could be therapeutic in terms of the opportunities for growth in living with people of different opinions and perspectives.
The goals set for this week were to better manage her time and goals with respect to her job applications. Some discussion was held about Sandra taking on the job of cleaning the kitchen on weekends for pay with the hopes that this would help her earn money and maybe better motivate her with respect to work, given her goals to begin a job in two months.

Writing fieldnotes took a substantial amount of time, and yet fieldnotes are invaluable in reorienting the researcher back to what transpired in the field, once the researcher has left the field site and begins data analysis. When not engaged in fieldwork as participant-observer, I was often conducting interviews with residents and staff.

Person-Centered Interviewing

Person centered interviewing is defined by Levy and Hollan (1998) as, "[an] attempt to develop experience near ways of describing and analyzing human behavior" (p. 313) by asking interview questions to elicit the participant's own perspective or point of view. Person-centered

interviewing, then, prioritizes the perspective of the interviewee or research participant (Levy & Hollan, 1998). Hollan (2005) remarks that prior to the pioneering work of Robert Levy on person-centered interviewing in anthropology, much social scientific research had little "grounding" in the lived experience of the people under study (p. 460.) Person-centered interviewing then seeks to privilege the perspective of the participant by asking questions to get at their lived, subjective experience. This method aligns with my commitment to the hermeneutics of faith, or trust, as described by Orange (2011). Donna Orange (2011) describes the hermeneutics of trust as our "attitude toward our patients: trusting that they are trying to communicate their truth to us, by whatever they are saying or doing, and that it is up to us to try to understand" (p. 40). Similarly, Josselson (2004) discusses how researchers apply the hermeneutics of faith in a research context, where the researcher interprets interview data as the participant attempting to give "voice" to their experience. Such an approach is contrasted with the hermeneutics of suspicion where a researcher searches for implicit meanings in the data. Here the researcher attempts to ascertain what the participant was communicating unconsciously.

My commitment to my client's, research participant's, or patient's subjective experiences is primary, and makes person-centered interviewing ideal for this project. My task in interviewing is to enter into, and honor, the lived experience of the participant—to attempt to hear and understand their experiences through their perspective, that is, to be experience near (Orange, 1995).

Person-centered interviewing involves asking open-ended questions followed by specific probes (e.g. "Can you tell me more about that?") to elicit responses from the participant. I completed 50 total interviews with participants. Some participants were interviewed twice. Of the 50 total interviews, I conducted 17 resident interviews (4 former residents and 13 current

residents), 25 staff interviews (23 current staff and 2 former staff), one focus group interview with five residents, and follow up interviews with 6 staff members, and follow up interviews with one resident. Four of the 50 interviews (three with residents and one follow up with staff) were removed from the study and not transcribed since their content did not relate to the aims and scopes of this project.

The interview was conducted as a semi-structured, person centered interview.[25] Wanting to understand the experience of living in a therapeutic community, my opening question was: "Tell me about your experience at this farm-based therapeutic community." This question is the most open, whereas follow up questions such as, "What is your experience of living at this farm-based therapeutic community?" or "What is your experience of working at this farm-based therapeutic community?" begin to narrow the focus of the experience (Levy & Hollan, 1998). More follow up questions aimed at better understanding various aspects of the farm experience: "Tell me about the work crews." "What are groups like at this farm-based therapeutic community?" Following Levy and Hollan (1998), I paid particular attention to the issue of social roles and how these are experienced and navigated within the community, and what over-arching role they play in treatment experiences at the farm.

Given my interest in exploring how this particular treatment site differs from others, I asked participants about previous experiences with mental health care. I also asked residents to compare their previous treatments, if applicable, with their experiences living on the farm. How are such treatments similar and different? How does a participant experience these settings? Much of the interviews focused on experiences with the work program, given its predominance in the program at the Haven.

[25] For a list of the interview questions I used please see Appendix C-E.

One set of interview questions (Appendix C) are specific to current residents living at the farm. A second set of interview questions (Appendix D) are specific to residents involved in the transitional programming or who are former residents.[26] A third set of questions (Appendix E) are specific to staff. Interviews were audio-taped and stored on an encrypted flash-drive and password protected online storage system for backup. Between the period of June 2018 and September 2019, I transcribed all interviews with the help of undergraduate research assistants, who were trained to follow the guidelines set forth by the Duquesne University Institutional Review Board for the safeguarding of human subjects. All research assistants were instructed how to anonymize the transcripts, removing any names mentioned by participants in the interviews, and removing all names of places, proper nouns, or geographic specific language associated with the study. Transcriptions were also stored on an encrypted flash-drive and password-protected online storage system. Each participant's interview was classified as resident, former resident, staff, clinician, or administrative staff with the date of the interview as the name of each file. No interviewee's name was ever associated with the interview.

Data Analysis

Data analysis consists of pulling all of the various pieces of ethnographic data together and beginning to make sense of the corpus of data (LeCompte & Schensul, 1999). Additionally, ethnographic analysis begins during the observation period and is ongoing throughout data collection (Emerson et al., 2011). The themes that I ultimately arrived at during data analysis were themes that I encountered again and again via observations, immersion in all aspects of Haven life, in discussions and interviews with participants, and in analysis of fieldnotes.

[26] My plans were to interview more residents involved with the transitional program; however, very few residents associated with that program consented to the study and thus I adapted these questions based on whether the former residents I interviewed were a part of that program or were not a part of that program.

Emerson et al. (2011), make an important point in their text on ethnographic methodology when they emphasize the ethnographer's role in creating theory from data. As they write, theory and themes do not emerge from the data unbeknownst and magically to the researcher (Emerson et al., 2011). In fact, the choices I made as a researcher in terms of what topics to explore more deeply or issues to emphasize are the result of my immersion in the field, my own unique psychology, personality, and sociocultural positioning as a researcher (which requires the practice of reflexivity), and information provided to me by my participants. As Emerson et al. (2011) write of the open approach to coding fieldnotes:

> But this open-ended process does not mean that the fieldworker completely ignores existing theory or has no theoretical commitments prior to reading through the notes. It does suggest, however, that for the ethnographer, theory does not simply await refinement as he [sic] tests concepts one by one against events in the social world; nor do data stand apart as independent measures of theoretical adequacy. Rather, the ethnographer's assumptions, interests, and theoretical commitments enter into every phase of writing an ethnography; these commitments influence decisions ranging from which events to write about to which member's perspective to privilege. The process is thus one of reflexive or dialectical interplay between theory and data, whereby theory enters in at every point, shaping not only analysis but how social events come to be perceived and written up as data in the first place. (p. 198)

While in the field, and now in my written ethnography, I strove to privilege, hear, and attempt to understand all participant perspectives. One of the greatest compliments I received the week I was leaving my field site was when a staff member told me they were impressed by how

objective I had appeared throughout my period of fieldwork. This comment was powerful, as I had strong reactions and feelings throughout my fieldwork (some of which I have already documented above) and yet I strove (perhaps to a fault) to question and interrogate my personal reactions and feelings, and I strove to try and understand the many tensions, decisions, and events at the Haven, from all participant perspectives. That said, another bias I bring to my work is one of valuing the voices of residents, patients, clients, consumers, those who are seeking services and are the recipients of services, as without them there would not be a "treatment center" or need for a therapeutic community.[27]

Thus, I entered the field with a bent towards the resident point of view, with a goal to help the Haven best support its residents. I also strove to immerse myself in various aspects of the Haven: resident activities, work program, clinical program, house advisor meetings, staff meetings. I interviewed participants across those domains to try and cultivate a full picture and appreciation of the various concerns and struggles at the Haven. However, though I worked to hear, understand, and represent multiple perspectives, as Emerson et al. (2011) describe, ultimately as the ethnographer I have chosen specific events and perspectives to emphasize in the writing of this ethnography. Though the dissertation represents a diversity of perspectives, I do emphasize certain criticisms and concerns, with a particular eye towards resident experiences and feedback.

Steps in Data Analysis

The first step in analyzing the written data of ethnography is to familiarize yourself with

[27] Moreover, I want to recognize the perspectives of individuals who hold the least amount of power in organizations. In this project, in terms of staffing, I recognize house advisors as having the least amount of power, though their jobs are instrumental to the functioning of the Haven. In fact, it is likely that house advisors know much more about the day-to-day lives of the residents, than other staff members, and yet they appeared a particularly neglected group of staff during my fieldwork, with respect to training, compensation, and allowing their voices substantial room in the discussions of both resident progress and the overall functioning of the Haven.

the data set, which requires intensive reading of the data corpus (Emerson et al., 2011). I continuously read and reviewed my fieldnotes and interview data while in the midst of fieldwork, to mark my changes in perspective and experience, and to inform ongoing observations and interviews. During this time, I began to jot down preliminary ideas and themes that continued to arise across all data. Once I left the field and completed the lengthy interview transcription process, I read through all field notes and interviews to get an overview of the data set.

After a careful reading, I began a line by line reading of transcripts to generate codes. Given the amount of data collected, I was unable to use the same step by step open coding process described by Emerson et al. (2011); however, I used a modified approach to coding. I began to highlight sentences, words, or phrases, and jot codes or ideas in a notebook I used while reading the transcripts on my computer. After generating codes from each transcript and fieldnote, I began to condense these codes into a smaller number of codes, seeing where codes began to overlap, and created file folders on my computer for the condensed codes. I then re-read each transcript and used a color coding system to mark up the transcript with respect to the condensed codes I generated. Each code was assigned a particular color and I read through each transcript, marking each code with the specified color. After color coding each transcript, I began sorting sections of the transcripts into their respective code folders on my computer.

As noted by Emerson et al. (2011), the ethnographer compiles many more codes and themes than is possible to explore or examine in one piece of writing. Thus, when it came to selecting themes for this dissertation, I returned to the themes or ideas where much of my data concentrated: issues relevant to the work program and notion of work as therapy, the transition from therapeutic community to treatment center and the resulting tensions, what is meant by

becoming clinical and the adoption of a medical model approach, which conflicts with the humanistic values of therapeutic communities, and the Haven's original mandate and modus operandi. These themes came up time and again during my data collection and in the review of interview and fieldnote data and seemed to be the central areas of concern for participants during my project.

Before moving into a chapter by chapter review of the significant themes of this project, I present an overview of the history of the Haven and an update on the present-day Haven. My hope here is to provide context for how the Haven began, what it looked like, and how subtle cultural shifts have challenged the Haven to transform into something different from its origins.

However, during my research it was difficult to procure a clear chronology regarding these changes. Frequently, when I asked participants, "When did the Haven begin to integrate more clinical programming," they would answer, "I'm not quite sure," or some would say clinical services were always part of the picture (referring to the psychiatric consultant) and many would give different timelines for when clinical services became part of the programming. The only clear marker of change was the hiring of a clinical director five years ago. This was the first time a clinical director position was held at the Haven, and after this hire, on-site psychotherapy was offered at the Haven. Due to the lack of clarity on how a clinical presence began at the Haven, I am unable to provide a definite timeline of change.

The question remains to what degree the Haven must transform and how might it retain its ethic of community inspired healing, while moving to more of a community-as-treatment center model.

The History of the Haven

The Haven began as a farm-based community for individuals suffering some sort of

psychological distress. Ron, a former executive director described the original intent and focus of the Haven:

> The original idea of the founders was to just take troubled young people and some of them were just slightly messed up. Some were making the transition into adulthood from adolescence and having a hard time. Very few of them had substance abuse, mostly alcoholism. As time wore on, the population began shifting partly because one of the closest friends, and advisor [to the Haven] was a psychiatrist, he said, 'I'm going to send you two people to work with to get you going, because I think what you could do for them would be helpful.

Chad described the Haven's origins as, "Our history is communal work on a farm," which started as, "almost summer camp, basically, then [we] started bringing in troubled young kids." Another research participant with an extensive history at the Haven described the early philosophy of the Haven:

> The philosophy here was get people here, get them landed, start them on a daily kind of living skills, food, medication…getting them out and busy so they can give their illness or bumps a chance to lay low. The whole therapy piece was within the mission statement of the farm—a therapeutic work community.

The Haven provided, what one participant called, "necessary work," for individuals living on the farm. Therapy was understood as working in community with all farm residents to build and maintain the Haven. Several participants remarked that in the beginning, residents were mostly older adults who struggled to manage in their day to day lives, but came to the farm, began to contribute to the upkeep of it, and ended up staying for a long period of time. As a longtime colleague of the Haven reminisced,

> We had many more older people, who couldn't really maintain their own lives [and] didn't have any other place to go. They fit into the farm community, they felt at home here. They contributed to the place and once they got to a certain point there wasn't anywhere else for them to move on. So, we had a lot of people who just became kind of pillars of the community, the older residents had been there for a long time and knew everything---it kind of gave it a kind of stability that was wonderful.[28]

The Haven began as a communal farm for individuals experiencing challenges in their adolescent and adult development, struggling with alcoholism, and eventually individuals experiencing chronic mental health challenges. Occasionally, Haven residents lived on the farm for several months to several years, if not indefinitely. As the Haven began to receive individuals suffering with chronic mental health challenges, the approach in working with such individuals appears humanistic. As described by Ron,

> The basic concept was, you're not a hospital, you are not a treatment center. You're a community of people who are living as close as its possible to live, (laughs) as an overgrown family or a small community. And the real essence of it was that people came, and the first question, it wasn't sort of, 'Well, what's wrong with you?' You know, it was, 'Well, what is your dream for the future? What are your talents? What do you find yourself enthusiastic and excited about?' So, it was concentrating on the other aspect of a person's life, not the pathology or illness.

[28] Please see previous footnotes regarding how these residents only represented 10-15% of the population.

In keeping with the spirit of moral treatment, the Haven focused on providing community and structure to help suffering souls return to a meaningful life. Meaning was, and still is to a large degree, attributed to meaningful work, "moving one's muscles," as I heard over and over again when staff described the work-based program. Pathology or illness was not the focus, as is the common focus from a medical or clinical perspective. However, Ron went on to state that you "couldn't do just that," in terms of only focusing on the health of the individual, as the residents of the Haven "had a problem which was totally interfering with their development in life." Thus, from its earliest days the Haven worked with individuals experiencing some sort of distress or challenge that necessitated attention and some form of care. This point becomes more important later as we discuss the Haven's transition from a community-based farm serving individuals in distress to an explicit treatment center with the goal of rehabilitation.

In terms of early treatment, the Haven worked with a consulting psychiatrist who provided medication consultation for residents; however, psychotherapy was not routinely offered for residents. Treatment, as it was considered in the early days of the Haven, was provided through work on the farm, engagement in the community, and by medication consultation if necessary. Overtime the Haven began transporting individuals who requested psychotherapy into town so they could seek such services; however, such treatment was not mandatory nor was it necessarily typical of a resident's stay. As described above, this aspect of the Haven has changed in the last five years, where residents now are assigned an individual therapist upon admission whom they meet with once a week. Thus, what is considered clinical treatment today, largely took the form of medication consultation in the early days of the Haven.

Perhaps what is unique to the clinical treatment during the Haven's origins was its humanistic ethic.[29] In recounting his work with the consulting psychiatrist, Ron stated,

> [the psychiatrist] grew up with a feeling that there were two components to working with people who were ill, and one side was yes, pathology of some kind….and the other side is, well, what is the other side and how could we help you build on that and control the other or get rid of the other, or whatever. He drew a very big line between these aspects. They both are absolutely essential. You've got to look after the health of [a person] and you've got to look after what's ailing.

This perspective is embraced by humanistic psychology and discussed by Maslow (1968) who advocated that psychology not simply concern itself with what's wrong with someone, but also to consider, what's right or going well. This focus is ultimately what Ron speculated as healing about the Haven,

> I think in a way it was the diversification of all the roles. It was the attention to both sides of the brain as it were. The healthy and not so healthy. A lot of people who came after years of hospitalizations, suddenly found, 'I'm not really feeling like I'm just a mental patient anymore.'

In addition to focusing on the health of the individual, humanistic psychology has historically rejected, and presently critiques, diagnostic categorization of human suffering and views such diagnostic discourse as oftentimes "dehumanizing" (Miller, 2015, p. 75). The value of not focusing on diagnostic labels is consistent with the values of therapeutic communities. For example, Loren Mosher and colleagues preferred to hire staff for Soteria House who had not

[29] An ethic I experienced that is currently in tension with the modern Haven. I explore this tension in chapter five of the dissertation.

worked or been trained in the mental health system because Mosher felt such individuals could better attend to the experiences of individuals with first-break psychosis than seasoned professionals (Mosher, Hendrix, & Fort, 2004). Mosher and colleagues believed that a professional's training often precluded their ability to be fully present with and understand persons in severe distress (Mosher, Hendrix, & Fort, 2004).

This value was also articulated by Ron in describing the young house advisors who spent the majority of their time with residents:

> The young people really have always, in my mind, been the essence of the place, because one of their talents is they don't know anything about mental illness and they learn…they're anxious to figure out, 'well, who is this person? Why are they considered so weird'…and they live so close to them working in the woods, working on the farm, cooking, washing dishes, going on canoe trips, and so on that their lack of knowledge and ignorance, you might say, was as valuable as the other people who've been here a long time.

Early on, the Haven's consulting psychiatrist worried about the potential harm a more clinical focus may cause:

> Our consultant was worried always, because he felt if you put in too much of the clinical aspect or the pathological aspect, it will put a stress and a strain on the belief that community or family…. that'll just be a problem. (Ron)

As we see in forthcoming chapters, with the United States adopting a medical model approach to healthcare, striking a balance between focusing on pathology and health has become quite a challenge for treatment providers. And yet, one key place where the Haven still appears to retain the humanistic ethic of the early therapeutic community movement is in its attempts to erase

visible distinctions between residents and staff.

Ron, in addition to several staff and residents I interviewed, remarked on the inability to tell residents apart from staff: “The division between sick and well was completely confusing. People would walk in the dining room and think, ‘Oh god, who were the patients or where are the staff?’” Throughout my stay at the Haven, I watched as new residents and staff would arrive and walk around the campus feeling confused about how to address others. As one resident noted during our interview,

> I didn't even know my first couple of days, I didn't even know (laughs). I'm like, wait, especially when I'm meeting people.... I’d be like, oh, ‘so how long have you been here?’ And they're like, ‘oh, I work here.’ So I stopped asking questions after that (laughs) and then I got the lay of land the by observation.

How did the Haven implement this approach to lessening the power dynamic between staff and residents? The emphasis on community played a central role, and the loss of such community emphasis seems at stake in the Haven’s transition to therapeutic community as treatment center. Remarking on the early days at the Haven, Ron described how there were no titles used at the farm: “There were no real titles. Almost all meetings were kind of open to whoever wanted to come…. There was no delineation [of] skills attached to anyone’s job.” It was expected that all members of the community would pitch in with all aspects of life at the Haven. As Ron explained,

> There was no clini-c--everybody was clinical, but everybody was also a work leader, et cetera, et cetera. And depending on the time of day and what was going on…if it was haying, you were no longer clinical, you were out haying. By having less emphasis on your title or your job description and more on, we’re all living in

this mess together. And it's a mess as long as we let it be one. But if it's disturbing us, we'd better have a meeting about it.

In the early days, community meetings, a staple of therapeutic communities, appeared instrumental in shaping the communal nature of the Haven:

> Sometimes I'd feel or he'd [Ron's friend and colleague] feel the morale of the place is just not right. We could feel it even if it wasn't particularly spoken and we'd just go off for a day to talk about it…We'd try to figure it out, well what could we do to involve the entire place in either recognizing that what we thought was wrong, was bad…but then saying why? Do you all agree, or don't you agree? And getting a feel for the entire place was a role that was so important. *And then trying to find ways to involve any or all of the community in open-ended meetings.* And they might be just one meeting or it might morph into a succession of meetings. *Asking the difficult questions is key and making sure that you're hearing not just the mos*t—there's always someone who never stops talking, tries to run it all or make their point of view come across loud enough, *that you have to keep working on people who haven't spoken,* you know, *'Does it matter to you or do you just go along with it?'* And that was one of the ways to raise morale always, *because when residents realized the morale of the place wasn't just 'how well it was run,' it was how well as a group of people we were interfacing with each other,* which is no different than any business or enterprise, but it's hard. There's no question about it. It's hard."

Earlier Ron commented, "*When someone was upset about something, you had to discuss it and figure out what does the community feel*?" (emphasis added)

Ron described the importance of involving the whole community, even silent members, to improve the morale and functioning of the community; highlighting that the purpose of the farm was not just about how well the farm functioned, but how members of the community are doing, person to person, in our attempts at living and being together. In listening to him, I felt both a stirring of envy for the lost idealism of the past, and a sadness at how the Haven no longer offers such community meetings. During my four months at the Haven, the community attempted to revive community meetings; however, the one meeting I attended[30] was not at all similar to the meetings Ron described in our talks. I continued to suspect that one reason the community felt less cohesive was likely the result of not holding these community meetings. Here was another disappointment I experienced during my early transition to the Haven; a lack of community wide meetings where the community struggled to co-create meaning.

The Haven Today

This dissertation explores the modern-day Haven—a community that in many ways, has changed appreciably over time. Though a clear chronology of these changes was unobtainable. The consistent thread throughout the Haven's existence is its emphasis on farm work as a way to disrupt and offer a balm to psychological suffering. Certain humanistic elements also remain in place as the Haven struggles to retain a communal approach to human flourishing, and yet changes in the cultural landscape, including younger residents, innovations in mental health care, as well as increased normalization of mental health services and help seeking amongst largely younger, educated, white adolescents and adults has pulled for the Haven to re-adjust its vision for how to help suffering adolescents and adults, and shifted the Haven towards a more clinical focus.

[30] Only one community meeting happened during my stay, as the attempt to reinitiate these meetings happened towards the end of my research. I describe the tensions of planning this meeting in chapter four of the dissertation.

Gone are the days where residents lived out their lives at the Haven and remained as aforementioned "pillars of the community." Today residents are mostly younger, 18 to late twenties, white individuals, largely suffering with substance use and sometimes substance induced psychosis-like experiences. Many residents present with what are considered symptoms of psychosis; however, during their tenure at the Haven those so-called symptoms remit while the person is not using the substance that brought them to the Haven. In addition to the substance use concerns, the Haven has seen a rise in "dual diagnosis," meaning residents who present with both substance use and mental health concerns. Consider the following quotations (drawn from various interviews):

> "When I started, I feel like we were more mental health, now we're much more substance and addiction type stuff" (Shelly).
>
> Interviewer: "How would you describe the population of residents who come here?"
>
> Felix: "I think it's changed a little. I feel like we had longer-stay, more chronic mentally ill people and as time has elapsed, we're finding a dual diagnosis population that's younger…"
>
> Interviewer: "Have you seen a shift in what residents are presenting with?"
>
> Chad: "I've seen a severity in the dual diagnosed person coming to the farm."
>
> Interviewer: "It seems like in the past, tell me if this, if I'm getting it right. It seems like the farm in some ways… people came here and they lived for a long time. They stayed."
>
> Tara: "Yes, with a different population."
>
> Interviewer: "A different population. How is the population different?"
>
> Tara: "We had many more older people back when…these older people who couldn't really maintain their own lives, didn't have any other place to go. They fit into the farm community, they felt at home here. They contributed to the place and once they got to a certain point there wasn't anywhere else for them to move on to

Depression, anxiety, so-called thought disorders such as psychosis or schizophrenia, and obsessive-compulsive disorder are cited as the most common mental health struggles (6-11-18 fieldnotes). One staff member, Tara, described the new Haven demographic in the following way,

> People used to come up here for two, three, four, five years, you know. But things have changed, the population has changed. Ninety percent[31] of them have [an] addiction and they're younger and they're not as mentally ill, and they want to get in, get out, get fixed, and get back to…[their life].

The push to get things fixed and going quickly was cited by multiple research participants as a significant change in the Haven's experience. Chad emphasized the change in Haven culture this way: "It's less mentally ill people who need to be walked through their day in a structural way. It's more 'ready to go in three weeks' kind of energy." This change in population, younger adults who appear to have families (chosen or biological) and lives they wish to return to, has also appeared to shift, somewhat, the meaning of community living. As one Tara described,

> It's hard to put a finger on defining this, but, um, one of the changes from earlier on that I have noticed is that people came here for longer stays and there was more stability in the community. So as a therapeutic community, the place functioned a little bit more with stability. Um, and there was less turnover. *I think it's harder to accomplish that sense of community when there's… people stay for, you know, our, our average length of stay is about six months.* (emphasis added)

[31] Some staff members disagree with the statement that the majority of residents suffer from substance use concerns and consider this a misconception, citing instead psychosis or thought disorders as the main presenting concerns. However, across all interviews and my own observations at the Haven, a common theme was that the farm was experiencing an increase in individuals seeking help for substance use concerns.

These changes, coupled with residents and families requesting clinical care at the Haven, have contributed to conflicting tensions and pressures for the Haven, with respect to its history as a work-based therapeutic community, and the attendant pressures to integrate a clinical approach. As I entered and left the field, it was abundantly clear that the Haven was mired in an identity crisis: striving to move forward and adopt a new perspective to serve its residents, while fighting to retain the important and foundational elements of its origins, Sadly, at times, it seemed these two aims were diametrically opposed.

Chapter Two:

Meaningful Work and Human Needs

"The work program is very important. It's the farm. It's how it was developed. It's been several years of what's worked!" (Miranda)

"The whole therapy piece was within the mission statement of the farm—a therapeutic work community." (Chris)

The Haven's history consists primarily of communal work on a farm for individuals suffering from psychological distress. Historically, communal work and living in community were viewed as being therapeutic themselves. It wasn't until roughly two decades ago that counselors began working at the Haven to provide crisis intervention services. Office-based individual and group therapy services were introduced even more recently. Thus, farm work has a long, and anecdotally successful, history of helping residents recover and flourish, as described in the quotations preceding chapter. When asked what was therapeutic about the Haven, one participant equated "the therapy piece" with the mission statement of the farm: "a therapeutic work community," with particular emphasis on the work as the catalyst. Another participant described the work program as how the farm began, and that it has worked for several years. In terms of the history of the Haven, the residents did literally build the community. Consider this quotation from Sarah, a longtime Haven colleague and former staff member of the Haven,

> Everybody in the community was really necessary to help the place go because there was so much to do and so many urgent needs for the place that I think it was possible for everybody there to feel enormously important to the survival of the place, and that must've been a great experience, particularly for people who had been having therapy in the hospital and you know, felt like they weren't worth much in that setting and here they were really needed to be part of the program

> and to lend their shoulders to whatever needed to be done, and to figure out things as they went along and to take care of the road, to drain the swamp, and to grow the vegetables, and to raise the meat and everything else. I think [it] was a very positive affirming experience for a lot of folks that came here. So, then it got, course the place got more and more comfortable as we had more and more farmers and more and more staff. But the spirit of the necessary work at the place was always at the, at the core.

In the beginning the Haven seems to have functioned largely as a commune for individuals suffering from some sort of psychological distress, one which emphasized sharing all aspects of the daily operations of the community. The Haven conceptualized work as central in helping people "get back to themselves" and find that they are not defined by their so-called mental illness, symptoms or suffering, but valuable members of society. As Heatherington et al. (2019) write, "the work [in farm-based therapeutic communities] is designed to inspire a sense of dignity, self-worth, and pride in doing for oneself and others" (p. 676). Such a focus on self-worth, dignity, and pride, was echoed by several staff members when describing the role and importance of the work program:

> It's what makes us special, can never go away. *It's the cornerstone of showing people that they have worth.* I don't care how much therapy you have, I don't care how much talking you do, just to do it is to believe it. You don't even have to do a pretty, doesn't have to be perfect or well or pretty. *It's about showing people that they are capable human beings and they have value. It's about moving your muscles and changing your thoughts, proving to yourself that you can add value to this world.* It provides structure. It provides social connection because you,

> again, people who have nothing to say can laugh over what happened in work program. *It's what makes this place work. We would go out of business without work program.* Like the setting is gorgeous. But people need something meaningful to do with their day, and it provides that meaning, it provides that purpose. (Elizabeth, emphasis added)

Mary Anne, a Haven staff member, also emphasized the importance of the work program as benefiting both the resident and community:

> So, it's the core of our daily program here. It also really works. I mean it's hopefully giving meaningful work for residents, which I think is such a key to the overall program and their healing and just feeling useful and needed. But it also really, part of it being meaningful is that it does also serve some necessary functions for the farm. I mean, the maintenance program they're following our forest management plan, keeping up with our conservation agreements, doing that they're providing wood for many of our buildings…[they] have wood-fired stoves. The staff buildings, our main house has a big wood boiler. There's, you know, each, each crew has its own piece that really would be, if it weren't doing what it was doing, like making food, growing food in the garden, farms producing food…it would really change a lot about this place, I think. So, it's just such a core of the farm and it's the historical basis of, you know… how it came to be, was work. People came to work here. And the fact that they had mental health issues really was secondary and that's kind of what brought them here, but wasn't the primary purpose necessarily of them being here at, at least to start with… before it really became intentional and like we can help people with mental

health. Let's bring them here. So, it was just the, I guess the really the, the core of this place.

Dean, a work team leader, provided insight into how the work program can provide in-vivo experiences for the emotional work of therapy, as well as noted many of the nuances of running a work-based therapy program:

> It's a farm based program and we take care of animals and we garden and we do a lot of outdoor, seasonal, agricultural work and because… sometimes if I'm talking more about it, I'll explain the tension between like finding work that meets resident's needs and where residents can be successful because that's actually the, *one of the biggest parts of a work program, is taking down some of the barriers to success because a lot of times people who have experienced mental illness have not had a chance to feel successful.* And sometimes they even like present as lazy. And I don't think it's really laziness. I think if you keep failing at things, the smart thing to do, to protect yourself is to stop trying. *So, it's to help the people see what they're capable of and help them be successful in building that kind of self-esteem is really so important* for all the other…. Almost like that sort of is like a precondition for the emotional work they're doing in the therapeutic work. Like they need to have that base of self-worth to do some of that harder emotional work. So, like we have.... it's real work, like we really need to feed these animals and grow these plants. And so, on the one hand we're accountable to something outside of ourselves, to nature, to the seasons, to the land, the animals, and yet we also have to meet the needs of residents in the program. Those things can feel like a tension sometimes if you have someone who's really struggling, but you

> also have this cow that has to get fed, like what do you do? And I think it draws on people. Residents especially. I mean if you're having a crisis, you're not going to feed the cow, go find someone else to feed the cow. But it does draw on people to come out of themselves and be accountable to things outside themselves. (emphasis added)

Here, Dean speaks to the value of a farm-based therapeutic community that "draws" on residents and staff to be accountable, not only to one another, but to something bigger than themselves: the community and the natural world which makes the Haven, as a treatment site, possible.

Historically, the Haven's focus was on working together in community, to build up a resident's sense of self-esteem, value, and worth. Though many visitors to the Haven may raise their eyebrows at what may seem antiquated approaches to work, Ron, the former executive director, explained that efficiency was not the goal of the work program. For instance, to cut a part of a tree, one would use a chainsaw. However, using a chainsaw precludes the experience of co-operation and connection. The lack of such tools was initially a source of frustration for residents. As Ron described how residents often reacted to having to use a bow saw for cutting down a tree:

> 'Oh God, you know, this is ridiculous. I'm never going to go out and saw down a tree with a person and a (inaudible) you, know I'm going to get the chainsaw.' What they [residents] began to realize was, 'Well, actually I liked talking to the guys on the other end of the saw…. and when I [use] a chainsaw, I can't hear anything.'

Using this particular technology to complete a task precluded the possibility for connection and conversation in completing the task. Thus, while a technology may help with efficiency and being able to tackle several tasks at once, it shuts down opportunities for person-to-person contact in a community:

> A [dish]washing machine changes the nature of washing dishes because if you are washing dishes as a team, along the sink, and someone's drying them, and someone is putting them away and so on, you can talk. You're not talking about dishes, but you can talk about anything you want. (Ron)

Thus, the early vision of the work program was in building community, literally and figuratively.[1]

In addition to building community, the work program focuses more on the process of the work, than the final product. Colin, a work team leader, echoed this priority in his descriptions of the work program:

> So, we're using work as a means to allow folks an opportunity to learn new things and hopefully in turn feel empowered, feel that they have something that they deem valuable and I don't know, you know, it might be a particular skill, but it might just be an accomplishment. It might be that they've never done this stuff before and suddenly they can see that they're capable of new things and do it. *It's not, work program is not just about turning out a bunch of dining room chairs, It's not just about the work.* One thing that I've used it for that I didn't quite know

[1] Sadly, as I discuss later in this chapter, technology seems to have changed part of this dynamic. I observed that now when residents are on dish duty, they either play a radio in the kitchen during their shift, or they wash the dishes while wearing earbuds. Not as much conversation now happens as a result. Though some residents may have been using music as a coping strategy, I did notice much less conversation and connection on crew, including dishes, than seems to have happened in the past.

> it would be is…um…in school, there's, you know, there's a bunch of information that's presented. Then you take a test and it's over and there's not a second chance so to speak. I mean, maybe there are some but… when we do something, it's a process. And if we don't do it right the first time, which generally doesn't happen, it's like, that's perfect and you can improve the second time. You can do it a third time taking it apart, do it again. And so, the idea that there isn't really doing it wrong, there's just learning the process.

I witnessed an example of this on carpentry crew. One day we were cutting rafters for a tool shed. I was working with Shelly, a resident who came to the Haven to address concerns related to substance use. We were using a skil saw and jig saw to make tricky zigzag cuts in the boards. At one point, Shelly made a deeper cut in the wood than was needed and became frazzled over the seeming mistake. As Colin, the crew leader, walked over, Shelly looked at him and exclaimed, "I don't want to keep doing this, because I ruined the board." He reassured her that she had not ruined the board. Though the board had a small gash in the zigzag, the board was still useable. I watched as Colin showed Shelly what to do when the board became stuck; how to pull the saw backwards and then move it forward again. As I watched them work together, the emphasis was on patient problem-solving and practicing a skill, not on making a perfect cut each time. Although originally skeptical and wanting to switch to a different task, after Colin's guidance and reassurance, Shelly continued on this crew for several weeks, helping to finish the rafters for the tool shed. Here, the focus on learning how to do something, with the understanding that mistakes will happen as one learns, and that perfection is not a goal, is an example of one of the many potential therapeutic benefits of the Haven's work program.

Throughout my time at the Haven, meaningful work was viewed as central to a resident's

experience and eventual recovery. I questioned what made the work meaningful, and for whom the work was meaningful. These are questions I grappled with throughout my dissertation process. I turned to the career counseling literature to better understand how meaningful work was defined and conceptualized, particularly as it seemed grounded in a wider philosophical and psychological literature of universal human psychological needs.

The next section of this dissertation explores the conceptualization of meaningful work through vocational and industrial/organizational (I/O), existential, and developmental perspectives.

Vocational Counseling and Industrial/Organizational Psychology Perspectives

The concept of meaningful work appeared most researched in the field of career counseling. This literature draws from vocational and I/O theories in psychology. Such theories presuppose a capitalistic frame of reference, and therefore the majority of studies measure meaningful work for *employed* workers: workers who are part of a system based on wage labor. It strikes me that a literature on meaningful work via unpaid labor would be mostly non-existent within the context of capitalism in the United States. In this framework, lower and middle-class individuals work to achieve basic survival needs. Work is not first and foremost sought for its meaningful nature, but as a way to survive and provide. To engage in unpaid meaningful work is usually either a luxury or expected of individuals who must complete unpaid internships and apprenticeships as part of their education and training within specific career fields.[2] Therefore, I am extrapolating findings from a literature focused on paid work, to the unpaid labor of residents at the Haven.

An important criticism of the research into meaningful work within a capitalistic system

[2] Psychology is one of those fields.

considers how class and socioeconomic status figures into an experience of meaningful work (Autin & Allan, 2020). As eloquently discussed by Autin and Allan (2020),

> Studies have operated under the assumption that workers have resources to act volitionally when seeking and obtaining work. Furthermore, previous studies have failed to examine potential differences in salience of meaningfulness for workers across the spectrum of social and economic privilege. (p. 242)

Moreover, they note that the literature has tended to take "elitist perceptions" on what is considered valuable work (p. 242). Additionally, these authors also note the literature detailing how individuals strive for meaningfulness "despite their contexts" (p. 243). They cite the literature on universal human needs as suggestive of who and why all individuals strive for meaningfulness in their lives, "despite their contexts" (p. 243). The ability to seek meaningful work, when defined as meaningful employment, is a privilege. In their own study on socioeconomic privilege and meaningful work, Autin and Allan (2020) found that workers across various socioeconomic backgrounds endorsed desires for meaningful work equally, though individuals in higher socioeconomic classes were more likely to experience meaningful work in their employment (p. 250).

Although the theories these authors describe refer to meaningful work as experienced via employment, I believe this concept of meaningful work is applicable to the unpaid labor completed at the farm, in terms of the psychological needs hypothesized as contributing to the experience of meaningful work. This belief is further supported by tying constructs such as self-determination theory to its grounding in the philosophical and existential literature on universal human psychological needs, as explored in this dissertation.

Drawing upon the work of Steger, Dik, and Duffy (2012), Kim and Allan (2020) write, "Meaningful work is the subjective experience that one's work has positive meaning, facilitates meaning making, and contributes to the greater good" (p. 77). Lips-Wiersma, Wright, and Dik (2016) note that meaningfulness "refers to the degree people find significance and value [in] their work" (cited in Autin & Allan, 2020, p. 242). Autin and Allan (2020) review how research literature previously conceptualized meaningful work as unidimensional—the degree to which workers reported their work as worthwhile and meaningful. However, recent research conceptualizes meaningful work as multi-faceted, including not only the worker's experience, but also the roles of others, generativity, and the meaning making process within working (Autin & Allan, 2020). Duffy et al. (2016) list three types of universal human needs salient for the experience of meaningful work: basic survival and power needs, social contribution needs, and self-determination needs. Basic survival and power needs include needs for safety, shelter, food, and access to sociocultural structures that provide support and opportunities for the fulfillment of survival needs (cited in Autin & Allan, 2020, p. 243). Social contribution needs include feeling a part of a larger community or a sense of working toward a common good within a community. Self-determination needs refer to the needs of autonomy, competence, and relatedness (Gagnè & Deci, 2005). Summarizing these needs, Autin and Allan (2020) write, "Together, fulfillment of these three sets of needs—survival, social contribution, and self-determination—is thought to underlie the mechanism through which [the concept of] decent work becomes meaningful" (p. 243).

In reviewing this literature on meaningful work, I was drawn to Gagnè and Deci's (2005) Self-Determination Theory (SDT), as it seems congruent with the philosophical framework of existential and universal needs described by Erich Fromm, and the need to experience a sense of

industriousness for healthful human development elucidated by Erik Erikson.[3] According to Gagnè and Deci (2005), SDT distinguishes between autonomous motivation and controlled motivation, where autonomy requires a sense of volition and having choice in decision making (p. 333). Controlled motivation then is motivation from an external force, rather than an intrinsic desire to complete a task (Gagnè & Deci, 2005). For intrinsic motivation to occur, basic psychological needs, including autonomy, competence, and relatedness must be met (Gagnè & Deci, 2005). Gagnè and Deci (2005) specify that these needs are universal human needs and necessary for psychological health. Speaking to their perspective on the universality of these needs, they write, "Something is a need only to the extent that it's satisfaction promotes psychological health and its thwarting undermines psychological health. Using this definition, the needs for competence, autonomy, and relatedness are considered important for all individuals" (p. 337).

Kim and Allan (2020) further note the literature on well-being tends to support how SDT needs (autonomy, competence, and relatedness) are associated with finding meaning in life, life satisfaction, a subjective sense of well-being, and positive affect (see Kim & Allan, 2020, p. 79 for a list of sources on these various domains). Although not researched as much, Kim and Allan (2020) point to some limited studies that associate the psychological needs of SDT with work related well-being (in particular they list: Hetland, Hetland, Schou, Andreassen, Pallesen, & Notelaers, 2011; and Baard, Deci, & Ryan, 2004). They write, "Taken together, there is reason to suspect a positive relation between SDT psychological needs and meaningful work" (Kim & Allan, 2020, p. 79). Further, the Psychology of Working Theory (Duffy, Blustein, Diemer, & Autin, 2016) posits that meeting these self-determination needs leads to experiences of

[3] Universal existential and developmental needs via the work of Fromm and Erikson are described in the following section of this chapter.

meaningful work. Whereas this dissertation is not focused on employment, the concept of psychological needs, particularly the needs for autonomy, competence, and relatedness, are three areas of self-experience that the Haven, at least implicitly, aims to cultivate in their work program and therapeutic community.

The experience of autonomy, competence, and relatedness are essential needs for human flourishing. Important is that these needs, as theorized by Fromm and Laing, *do not presuppose* a capitalistic system. They are generic human needs that are constantly operative throughout the lifespan, and meaningful work is one avenue of addressing these needs. Before exploring work, or the experience of competence and mastery, as an existential need, I provide a brief history of the concept of existential or universal human needs within philosophy and psychology.

Existential Perspectives: Universal Human Needs

The concept of existential needs emerges from a rich philosophical tradition dating back to Martin Buber (1878-1965) with his writing on the fundamental human need for an I-Thou encounter or relationship, a fundamental need for a human to be recognized as a subject in her own right, and not as an instrument stripped of her subjectivity (Buber, 1923). The concept of existential needs is also evident in the work of Alexandre Kojeve (1902-1968), whose interpretation of Hegel's master-slave dialectic, asserts a fundamental human need for recognition (Kojeve, 1969). The need for recognition is later taken up by R.D. Laing (1927-1989) as a universal existential need (Burston, 1996). Further, Erich Fromm (1900-1980) posited several universal human needs in his works *The Sane Society* (Fromm, 1955) and *Anatomy of Human Destructiveness* (Fromm, 1973).

For the purpose of this dissertation, I will bracket the philosophical reflections of Buber and Kojeve, and focus on the work of Erich Fromm and R.D. Laing, which have the advantage

of being rooted in clinical experience. R.D. Laing and Erich Fromm theorized that universal existential or human needs are required for the experience of mental health. When such needs are not met or achieved, psychopathology may result. These needs are explored below.

Erich Fromm (1900-1980) (1955) argued that sanity arose, not simply from the satisfaction of physiological or instinctual needs, but from the satisfaction of existential needs arising from our thrown condition as human beings. Fromm (1955) wrote that our most "intensive passions and needs are not those rooted in the body, but those rooted in the peculiarity of" (p. 26) human existence. Fromm (1955) originally identified the following existential needs: relatedness, transcendence, rootedness, sense of identity, and frame of orientation or devotion. In *The Anatomy of Human Destructiveness,* Fromm (1973) added the following needs: unity (similar to relatedness), effectiveness, and excitation and stimulation.

Relatedness refers to the need for a sense of union between individuals, while also allowing for one another to maintain their separate identities (Fromm, 1955). Such a union is motivated by "care, responsibility, respect, and knowledge" rather than a desire for domination or submission (Fromm, 1955, p. 33). Fromm (1955) writes that even if man[4] has satisfied his instinctual needs, his separateness and aloneness (Fromm's description of our thrown condition) results in alienation and distress (if not abated). Thus, relatedness is fundamental to "sane" functioning (p. 36).

Transcendence, or the need to be more than a passive participant in a world we did not choose, is also inherent to our thrown condition and is uniquely human (Fromm, 1955). For Fromm (1955), transcendence refers to the need to create (for sane development) or the need to

[4] Fromm uses the term man to refer to humankind. I retain his original language here but wish to note how the term excludes women and all other gender identities and assumes that the masculine or male is the norm and definitive of humankind.

destroy (when the need to create is thwarted which leads to psychopathology). Creativity is borne of love and care, the factors at play in the need for relatedness (Fromm, 1955). The need for rootedness speaks to the pain one feels when torn away from their "natural roots," as happens during the birthing process—the child is separated from the womb (p, 38). Moreover, this can be extended to the displacement one may feel when torn away from their actual birthplace or country of origin—rootedness speaks to a need to belong, to literally "have roots" in the world—to reclaim a sense of belonging, to feel at home in the world (Fromm, 1955). Such belonging for Fromm (1955) means finding "human roots" (p. 38). When feeling unrooted, man feels isolated and helpless—another way in which "insanity" or psychological distress manifests (Fromm, 1955, p. 38).

The need for a sense of identity refers to the human need to acquire a sense of singularity—a sense of who one is as a separate being (Fromm, 1955). This intense striving, as Fromm (1955) described it, is at play in the pathological forms of conformity often seen in the extremes of group behavior (e.g. staunch nationalism). The need for a frame of orientation and devotion refers to a system of thought or practice that gives meaning to life (Fromm, 1955). For many, this means following a particular religion which endows life with meaning (Fromm, 1955). An integral part of this process is the development of human reason and a striving for objectivity or truth which, Fromm (1955) notes, is secondary to developing the frame of orientation (e.g. "life has to have some meaning before I can begin to reason about it").

For Fromm (1955), sanity, or mental health, depends on our ability to meet our existential needs. Fromm (1955) defined mental health as, "the ability to love and to create, by the emergence from incestuous ties to clan and soil, by a sense of identity based on one's experience of self as the subject and the agent of one's powers…by the development of objectivity and

reason" (p. 69). Throughout *The Sane Society,* Fromm (1955) makes clear how pathology may result from attempts to meet such needs in unhealthy ways (e.g. the need for transcendence being met by destruction rather than creation, the need for identity being met by conformity with the crowd rather than authentic knowing of one's self and ideals, etc.).

Although never specifically enumerated or even discussed as such (Burston, 1996) Laing, like Fromm, believed in universal human needs. In *The Divided Self* (1960) and *Self and Others* (1961) Laing implied that the following needs are integral to human existence: The need for 1) authentic self-disclosure, 2) recognition, 3) relatedness to others, 4) ontological security, 5) transcendence, and 6) truth or freedom from deception (Burston, 1996). For the purposes of this dissertation, needs for relatedness and recognition are assumed to be vital to ontologically secure human development (Laing, 1960).

For example, in *The Divided Self,* Laing describes how recognition is necessary for the development of self-consciousness. Laing (1960) writes, "a necessary component in the development of the self is the experience of oneself as a person under the loving eye of the mother" (p. 116). Earlier, Laing (1960) highlights the importance of the mother as someone "who sees the child" and hence validates or confirms their existence through sight, verbal response, touch, or attention (p. 116). The development of personhood, a sense of being an I (the need for identity that Fromm [1955] points to as an existential need), comes from relatedness (a human need identified by both Fromm and Laing). Identity, for Laing (1960), can only be established in relation to, and with, another. Similar to Fromm's (1955) definition of relatedness as equating to love, Laing (1960) writes, "the need for one's total existence to be recognized" is the need "to be loved" (p. 119) and thus confirmed as a live, meaningful, human being. It is through this process that a sense of identity develops.

When such recognition fails or does not occur, that is to say when the need for recognition is not met, psychopathology will result. Absent genuine recognition, a false, conforming self develops which then leads to the development of ontological insecurity which precipitates or contributes to experiences considered psychotic (Laing, 1960). The ontologically insecure person lives continuously in fear of annihilation of the self. This person may fear being engulfed or swallowed up by another, they may fear any contact will lead to inner annihilation given their feelings of emptiness (implosion), or the fear of being reduced to a thing (petrification)—a similar difficulty Fromm (1973) identified for an individual who does not experience existential wholeness: being reduced to a thing or "nonperson" (p. 264). Such fear of annihilation seems to pervade the experiences of individuals commonly understood as psychotic. Laing (1960) writes, "But without the self ever being qualified by the other…and without being lived in a dialectical relationship with others, the 'self' is not able to preserve what precarious identity or aliveness it may already possess" (p. 139). Madness ensues.

Throughout *The Divided Self*, Laing provided clinical vignettes that point to the deep desire for recognition, but also the fear that recognition (at this point) will annihilate them: James, a patient of Laing's, states that "other people provide me with my existence" and that he only feels real with others around, but also cannot tolerate them being around, thus he adopts a 'false self' that allows him to be with others—he is not authentically James, because it does not feel safe, nor does he likely know what being authentically himself means (p. 113-114). Another woman states that she repeats her name over and over again in the mirror to remind herself that she is real and alive (Laing, 1960, p. 111). Throughout the text, Laing (1960) describes how schizoid (and potentially schizophrenic) patients are consumed by the question of feeling or being real or alive—how do I know that I exist, and that I shall not cease existing at any minute.

To recover from such experiences the individual must achieve ontological security, which can only be achieved through the validation and recognition of one's experience—in this case one's now psychotic experience. This sense of needing confirmation and validation of one's own experience is also expressed in attachment theory by way of our developmental need to feel securely attached, seen, and mirrored as a child.

Psychoanalytic Developmental Perspective: Erik Erikson

Building upon Freud's psychosexual stages of development, Erik Erikson (1902-1994) developed a stage theory of human development focused on psychosocial development, emphasizing the psychosocial challenges individuals face throughout the lifespan. Erikson's theory was phase specific, meaning throughout the lifespan individuals face specific developmental crises that are rooted in human needs[5] and conflicts. When a crisis for a specific phase is not resolved, an individual is stuck at that phase and cannot progress to the next stage. Psychopathology also results from the unsuccessful resolution of the crisis.

The first stage from birth until a year and a half is characterized by trust versus mistrust. Through regular and dependable feeding, care, and affection, a child can develop a sense of trust and hope in the external world. When a child experiences an inability to be attended to in such a caring and regular manner, a sense of mistrust develops, making it difficult for the child to feel secure and safe in the world.

The second stage, autonomy versus shame and doubt, occurs around 18 months to three years of age. Here we see children beginning to express a burgeoning independence. Children in this stage begin to experiment with tackling tasks themselves. By being able to act somewhat

[5] Some of these needs are virtually identical to the existential needs described previously. However, Erikson was a psychoanalytic theorist, not an existential one. Moreover, whereas existential needs are seen as universal and constantly operative throughout the lifespan, Erikson's developmental theory is phase specific—if an individual did not resolve one stage, they could not move onto the next stage.

independently, children begin to build a sense of self-esteem and confidence. When children lack the experience of experimenting with making their own choices or attempts to complete a task on their own, they develop feelings of inferiority or inadequacy, fueling shame and doubt.

In the third stage, initiative versus guilt, from age three to six, children begin experimenting with exerting more control over their environment via initiating tasks and play. A child who is encouraged to explore and direct their own play, develops a sense of capability and ambition. When children's play or initiative is thwarted by caregivers exerting more control over a child's attempts to direct their tasks or play, a child develops a sense of guilt, or a sense of wrongness about their play, desires, and ideas.

Stage four, industry versus inferiority, from age six until puberty, marks a period where children begin to experience pride in their own skills. In this stage schooling and peer group relationships begin to influence the child's social environment. Learning and playing with peers facilitates the experience of skill building and experiencing competency and mastery. Children also begin to experiment with more complex tasks, where encouragement from caregivers is vital to developing a sense of competence and mastery. Lacking an experience of unconditional support and encouragement at this stage, may lead to experiences of inferiority and inadequacy.

Stage five, identity versus role confusion, occurs in adolescence. Here adolescents explore questions of identity: Who am I? What are my values? What do I believe? The ability to establish values, beliefs, and goals leads to a sense of self or identity. When adolescents struggle to articulate values, beliefs, and goals, or their own experienced values, beliefs, and goals may differ from their caregivers or wider socio-cultural framework, feelings of confusion may result; particularly, if caregivers and social supports critique and punish the adolescent for experimenting with different ideas, values, or practices. Much of this adolescent phase includes

experimenting with various roles, identities, and social practices in attempts to discover one's sense of identity. Caregivers may thwart this phase of development when not encouraging the adolescent to explore various identities and social roles. Moreover, an unresolved adolescent identity crisis activates a regressive turn to the earlier conflict of industry versus inferiority, sending the individual backwards.

Stage six, intimacy versus isolation, occurs throughout the 20s and 30s, and involves the building of meaningful intimate relationships, including friendships and romantic relationships. In this stage, it is of particular importance to be able to maintain a sense of stable identity, while in an intimate and committed relationship. Where stable identity fails, an individual may find their own identity shifting to mirror their partners to a degree that the individual feels they are not a separate individual at all, rather they merge with their partner's values, beliefs, and practices. Unsuccessful navigation of this stage leads to feelings of loneliness and isolation, when individuals do not build meaningful networks of relationships, or when their own identity is unstable in relation to others.[6]

Stage seven, generativity versus stagnation, which occurs between the 40s into the mid 60s, involves navigating a sense of contributing to one's community or the next generation. Adults in this stage may be involved in tasks that will ripple out and continue to benefit others, after the adult has died. Stagnation may occur for individuals who have not developed meaningful relationships with others, communities, or achieved a sense of identity which often facilitates engagement in meaningful activities via one's deeply held values.

The final stage, ego-integrity versus despair, occurs from mid-60s until the end of life. In

[6] Important to note is that failure to navigate this stage may also be a result of societal and cultural forces that make establishing intimacy and relationships quite difficult. Developmental theories seem to place the "failure" on the individual, without accounting for wider systemic and cultural issues.

this stage the hope is that as an individual faces death, they feel their life has been meaningful and they experience a sense of accomplishment in looking back on their life. For individuals who experience despair, there is a sense of regret regarding their life and experiences.

Central to the focus of this dissertation is the stage of middle childhood, where the core psychological concern is industry versus inferiority. Within this stage of development, the child is trying to gain a sense of mastery which corresponds to the existential needs for relatedness, autonomy, competence, and effectiveness (Olfman, 2006). Additionally, the very tasks of the Haven's work program are set up to, at least implicitly, foster a sense of competence by giving residents specific tasks to complete. Oftentimes residents were tasked with building and maintaining fences, feeding and caring for animals, producing boards for building projects, among other tasks. Moreover, given the age of Haven residents, and their apparent struggles with maintaining employment or having adequate work skills, it appears the industry versus inferiority stage of development may be implicated in their struggles. However, during my time at the Haven, and after having read Erikson's (1974) *Identity Youth and Crisis,* I began to wonder about the role of identity confusion and how Erikson's psychosocial crisis of identity versus role confusion may be at play for Haven residents.

While gathering my data, I often heard about "failure to launch," where several residents struggled to finish or attend college, and/or maintain employment. In reading Erikson's (1974) *Identity Youth and Crisis,* I was struck by a couple of passages that reminded me of my experiences at the Haven. Discussing William James as someone who experienced identity confusion, Erikson (1974) quotes the following from a letter of James': "Much I would give for a constructive passion of some kind," (p. 151). Erikson (1974) continues to write,

> This nostalgic complaint we find, again and again, among the young college men of today…today doubt and delay are so obviously often due to the circumstance that young men and women find themselves involved in a doing into which they were forced by a compulsion to excel fast, before enough of a sense of being was secured to give to naked ambition a style of individuality or a compelling communal spirit. (p. 151)

Through Erikson's psychosocial theory, I began to wonder if the Haven residents were suffering from "identity confusion," which also left them struggling with the stage of industry versus inferiority. Perhaps parental expectations, coupled with the cultural pressure of having to determine what you want to do with your life by the age of 18 in America, placed residents in a position of "forced doing" to receive a college education, without having discovered a sense of being or identity; particularly, when their experiences are also compounded by suffering from symptoms associated with mental illness or substance use. Moreover, given the majority of residents are referred to the Haven by their parents, I also began to wonder about the resident's sense of autonomy and motivation in engaging with treatment at the Haven.

The work program can be instrumental in addressing these developmental concerns with residents, given the importance and value of work in helping individuals meet existential needs of relatedness, competence, autonomy, and effectiveness.

Work as a Means for Meeting Existential Needs

Work can elicit experiences of various existential needs, provided the work is not experienced as alienated. These include self-determination theory's (Gagnè & Deci, 2005) needs for relatedness, autonomy, and competence. Fromm (1995) explores how work prior to the modern era was experienced as meaningful, due to the worker's connection to the process of

work and the final product. Referring specifically to craftsmanship in the 13th and 14th centuries, Fromm (1955) writes, "Work was not only a useful activity, but one which carried with it a profound satisfaction" (p. 178). Quoting C.W. Mills, he writes of craftsmanship,

> There is no ulterior motive in work other than the product being made and the processes of its creation. The details of daily work are meaningful because they are not detached in the worker's mind from the product of work. The worker is free to control his own working action. The craftsman is thus able to learn from his work; and to use and develop his capacities and skills in its prosecution. (p. 178)

Here, the worker is a free agent in the work, and deeply involved with the entire process of work. Moreover, the worker is mindful and aware of the value and usefulness of their product. The worker is autonomous, in control of the creation, deeply involved in the process, and the work is purposeful.

With the modern and industrial working era, "Work, instead of being an activity satisfying in itself and pleasurable, became a duty and an obsession," (Fromm, 1955, p. 179). In this era, the worker becomes alienated from their work. The relationship between worker and product becomes fragmented. Workers became largely divorced from the entire process of the work; sometimes, and as is continuing today, the worker is replaced by technology. In the shift away from local economies, coupled with the growth of technologies, oftentimes workers are not even aware of where the product they are working originated, its purpose, and where it's going. Rather the focus is on completing the workers' small piece of the project in order to receive financial compensation. Moreover, as types of work became differentiated between social classes, workers of lower socioeconomic status lost much autonomy with respect to labor, and

work shifted from meaningful engagement to a necessity for survival (Fromm, 1955, p. 179). Workers became totally alienated from the means and process of production. Work became an assembly line experience, divorced from a larger context and purpose. Of the industrial worker, Fromm (1955) writes,

> He spends his best energy for seven or eight hours a day in producing 'something.' He needs his work in order to make a living, but his role is essentially a passive one. *He fulfills a small isolated function in a complicated and highly organized process of production, and is never confronted with 'his product' as a whole,* at least not as a producer, but only as a consumer, provided he has the money to buy 'his' product in a store. (p. 180, emphasis added)

Key to the experience of meaningful work, is a sense of involvement and ownership of the process of work (Fromm, 1955). Existentially meaningful work involves a sense of purpose with respect to one's work. I wondered if residents felt such a sense of purpose at the Haven. Did residents experience themselves as meaningful agents in the work program? Was the work meaningful to them? If the work was not experienced as meaningful, how could the Haven work to elicit and build needs for autonomy, competence, and relatedness?

Chapter Three:

The Haven's Work Program

Currently, there are four work crews residents may participate in: maintenance, which maintains the grounds and various buildings on campus; carpentry, for crafting needed furniture and other needed items, as well as various projects where residents can learn basic sawing and construction skills; farm, devoted to caring for the Haven's animals and basic tasks regarding the upkeep of a farm; and gardens, where residents plant and harvest various crops. Once a resident arrives at the Haven, they are scheduled to be on each crew for one day, during their first week, so residents can get a sense of how each crew operates and to select what crew they'd like to join for their ongoing stay. Residents fill out ballots once a week rank ordering their preferences for crews and residents can stay on a crew for as long as they like, or they can change crews each week. Each crew is overseen by a work crew leader and one or two house advisors. Residents work on crew roughly[1] from 9 am until noon, and again from 1:30 until 4.

Although I did not ask residents about their previous work experiences during interviews, many staff members described the residents as young men and women who are either having a hard time maintaining employment, or have never held a job before, given their family's financial status. Additionally, most residents had never worked on a farm before. Presumably, many residents have not worked, because they have economic privilege and do not need to work for the sake of survival.[2] As Christine, a staff member, said:

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[1] Residents may attend therapy services in the morning or be pulled off crew to attend in town doctors' visits, lab tests, or psychiatry appointments. During my observation period, the Haven was experimenting with holding all therapy appointments, group and individual, in the morning, so work crews would not be disrupted by residents needing to attend appointments

[2] I find myself struggling with this idea. Several times I heard staff describe residents as not having worked due to their family's wealth, which assumes residents had no other desire or need to work beyond financial motivation. Perhaps this is true, as noted in the following staff member's reference to a resident's comments about work; however, I find myself questioning whether residents would only be motivated to work for financial reasons. What about intrinsic motivation for a meaningful career, or vocation? What about enjoying other aspects of work such as

> So, I think that the work program is really the core of what we do here at the Haven. You know, that is the selling point for admissions. People still ask if you have a therapist and a psychiatrist and they care about that. But a lot of people that we see coming in have never had a job, or they've had a job that they just haven't been able to keep due to their psychiatric issues. A lot of it has to do with the population that we serve due to our cost. And… [this] means that they necessarily haven't had to work. So [resident name] always says like, "I want to get a job, but I've never had a job, cause I've never had to have a job."[3]

Many residents I interviewed struggled to finish school or maintain employment, or to find meaning in either what they were studying or doing professionally. Seth, a 20-year-old, white male, loved working. In fact, work program was his favorite aspect of the Haven, so much so, that getting Seth to engage in therapy was more challenging. Seth had an excellent work ethic, but he struggled to maintain jobs, cycling through jobs every month or so. It seemed that part of his difficulty was related to challenges with organization and communication. If a problem arose (e.g. a flat tire on his car which made him late to work), he often didn't call his supervisor to report the incident, or he just didn't show up. When experiencing a challenge, Seth was unable to ask for help or clearly communicate with his employer about what was happening in his life. Seth also struggled with romantic relationships. In fact, break ups often sent him into

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experienced independence and social contact? What about the existential aspects of work (MacMillan, 2010)? Though, if residents generally come to the Haven not understanding or valuing work beyond having a job for financial security, or are not the ones seeking out treatment, perhaps this idea speaks to why I found residents often disengaged on work program. Additionally, perhaps the young age of residents (early to mid 20s) may also speak to their dissatisfaction with work program; however, I also don't want to generalize the disengagement to either class status or age, as that feels much too simplistic and reductive. Such a generalization also absolves the Haven from having to grapple with whether it's work program is meeting resident needs.

[3] If the Haven's population is truly many young adults who have never had to work due to financial security, then the Haven has many opportunities to teach residents about the value of work and the possibilities for meaningful work. Perhaps, with this changing demographic, the focus on the value of work and on finding meaning in your work is the ideal focus for this population.

crisis. Though we did not address the relationship between his tumultuous romantic history and work history, I suspected that the pain of lost love, and the lost prospect of having a family, pulled Seth into a depression that kept him from showing up for work.

Jerry, a 28-year-old, white male, had experienced depression and substance use for most of his adult life. Jerry grew up in a traumatic environment, and felt this history likely contributed to his persistent feelings of depression. Jerry also described how he tended to cycle through jobs, because he became bored very quickly with each position. Yet, it seemed what most plagued Jerry was a history of childhood trauma, leaving him struggling with a deep depression that often cascaded into feeling suicidal. The emptiness Jerry felt in his psychic life, likely made finding meaning in work or school especially challenging.

Soft Skills

Given the number of residents experiencing a difficult time maintaining employment, the Haven focused on teaching residents "soft skills" associated with work expectations and performance, and job readiness. Such skills included: being prompt and punctual, demonstrating responsibility, and teamwork or delegation. Leslie, a staff member, described the soft skills in the following way:

> I think work program allows them to kind of develop those skills necessary…waking up on time to be there and being part of a team and how to deal with, you know, people that are above you in theory, um, that are giving you directions that you don't necessarily support, you know, how do you deal with conflict resolution and things. You know, half of the people when they leave here aren't going to be doing jobs that are you know, sawing wood or… But it's kind of the, the life skills that I think are so important to work program.

Another staff member, Sonya, described the soft skills in the following way:

> I think that it's really kind of the soft skills, let me call them. Not necessarily you know, do this, this and this. But rather, you know, these are the things that you need to do to actually work and to hold a job. And, like…. [staff member] always says, 'when people want to skip crew, if you had a real job, would you not go because of this reason?' And if they say yes, then like, okay, then you should be excused from crew. But if you say no, then you should go to crew. So, I know a lot of people really treat work crew as if it was a job. Which I think is good to prepare people for that expectation outside of here and to get them ready for that.[4]

Tonya, a Haven therapist, discussed the skills she feels work program is successful in teaching: "life skills, in terms of responsibility, expectations, teamwork, physical health, because most of the jobs are movement based. They're getting out and they're moving."

The Haven's work program, then, seems largely focused on teaching basic work and life skills necessary for holding a job, while also emphasizing the communal nature of work via farm work. This chapter has mostly explored descriptions and aspirations of the work program from the perspectives of Haven staff. What about the residents? The very people the work program exists for. How did they experience the work program?

Resident Experiences of Work Program

As noted previously, the work program is thought to instill a sense of meaning and purpose to the day, to help people feel they can contribute to the community and experience a sense of accomplishment, in addition to getting residents moving their bodies and engaging with the natural world. This idea, too, is the theory underlying farm-based therapeutic communities

[4] However, a few work program leaders I interviewed share their own ambivalence about whether the work program did, in fact, prepare residents for work in the outside world. This theme is explored later in this chapter.

(Heatherington et al., 2019; Loue, 2016). The emphasis on having a task to do, having a set schedule, appears helpful for individuals suffering from depression and low mood, in challenging residents to not stay in bed all day, but to get up and move. For residents who hear voices, some report that the work is a welcome distraction from the voices. This section reviews resident feedback regarding their experiences of the work program.

In interviews, residents shared many of the benefits of work program which included: clearing one's mind, being more present focused and less focused on one's past or distress, staying busy, contributing to the community, having structure, having a work environment that adjusted to the resident's needs, and learning skills. Nevertheless, some residents shared their critiques of the work program as feeling repetitive, not always meaningful, and some residents expressed ambivalence about the work program. These experiences are discussed in more depth below.

Positive experiences: Takes me out of the past, clearing one's mind, and cultivating a present focus

> Interviewer: Can you say more about what you appreciate about the work program?
>
> Shelly: I appreciate how it's, it takes me away from my past. And that brings me in the present where I'm focused and doing a job.

Seth shared this experience:

> Interviewer: So, what I'm hearing, it sounds like you do find work to be therapeutic. Can you say more about that? How is it therapeutic for you?

Seth: You get into a mode, it's just kind of helps you forget about things. It's like equipment work, tractor work, I would do that in a heartbeat. It's something… I can get my mind off things and just focus on that. That's what helps me.

Anna echoed this sentiment:

Interviewer: What was your experience of the work program?

Anna: It was really helpful. At that time I was in really good shape, and I just had kind of all of this energy all the time and having somewhere to put that towards… like I spent a lot of time on maintenance crew and during the summer when you're just sweating buckets every day… because it just gave me something to do that like really used my muscles and I kind of needed that kind of physical labor that did not really involve my brain too much, at that point because my brain was the issue. If I could stop thinking for a while, that was a good thing.

Positive experiences: Staying busy, having a set schedule

Wilfred: A work centric program seemed a good fit for me because staying busy is helpful.

Mary also liked the structure of the work program:

Mary: A set schedule is immensely helpful.

Positive experiences: Developing skills

Allan: Yeah. So far, the experience has been very eye-opening. I've learned a lot of life experiences, like that kind of lead me to trying to be more independent. Like mowing a lawn and doing your own laundry. Things that typically people learn when they're younger. Um, those were very good for me. Using an axe for wood cutting. I mean just things that are a little bit out of my comfort zone. Not

things that I didn't want to learn, but it just happened due to actively avoiding and stuff like that.

Shelly also named learning skills as important:

> Shelly: I like carpentry because it's like learning a skill. I feel like I get a little bit better at it each day. When I go back and do stuff. Um, it's fun to craft things and build stuff. It's satisfying to be like, all right, I built this much of a tool shed.

Here, these participants seem to speak to experiencing a sense of competence and mastery, building upon developmental tasks. In one case, these developmental tasks had been actively avoided, and the Haven has challenged this resident to learn and practice independent life skills. In the second example, the resident speaks to a sense of mastery and pride: "I built this much of a tool shed!" This resident is experiencing a sense of industriousness, "Look what I did and what I can do," feeling and seeing themselves as a capable human being.

Positive experiences: Feeling accepted and supported, mental illness not seen as a barrier to work

Residents described how their psychological suffering was not treated as a barrier to participating in the work program—in fact, staff would sometimes provide accommodations to help a resident be part of the work project, so their distress or difficulty did not preclude them from meaningful engagement with the crew. Additionally, some residents expressed how they learned that their distress or suffering could co-exist with participation in work or the wider social context. Therefore, anxiety, hearing voices, or depression did not render them unable to contribute to the project or community.

Charles: My mental state has been kind of upside down since I got here and like continuously the staff has been very supportive and helped me through that. Just honestly telling me that a lot of the things that I had to worry about were not considerations here. I was telling somebody a second ago that my first day they put me on maintenance crew, which was splitting with a hydraulic pump of the..... Hydraulic divider blade, whatever. Then taking the wood and stacking it up in a stack, which I thought was, you know, that it could only get worse from there. And then they told me I was going to be on farm. Then the next day they'd be mending some fences that needed mending. So, I like really kind of lost it to myself. I laid awake in bed thinking that night like, 'Oh my goodness, what have I got into? How do I do this? I'm not going to be able to work to the level that they want and it's just going to be horrible.' And um, it turns out that the next day, the way you put up fences, they had like five people on the job, and uh, it's just, it was an electric fence. So, you just kind of hammered the small stake into the ground and then tie the electrical lines. So, it, you know, it was very simple. It wasn't hard at all. And that is a good story to capture what, like kind of every little hurdle, every trouble that is, is put in front of us is what I mean to say.

It's very straightforward and (staff name omitted) is very patient and explained everything thoroughly and although it's not a quiet place, there's lots of drills running and things like that. It is in another way. It's kind of a socially quiet place which I like, you know, you're supposed to interact with others to, to accomplish a definite project every time, you know, and that's the only thing that's expected of you socially.

> Haying was one of the most fun things I've done so far and (staff name omitted) is just a really good person to constructively motivate you to do something, you know, he's a good team leader. I enjoy that. And uh, you'll just have a sense of direction, I think for a lot of people [they] *don't mind doing something, they just don't know what they would do.* Like they have some level of disorganization on a large level and *need some push in the right direction.* (emphasis added)

This resident's narrative describes fears related to competence and ability (i.e. I laid awake in bed thinking that night like, 'Oh my goodness, what have I got into? How do I do this? I'm not going to be able to work to the level that they want and it's just going to be horrible'). It also illustrates the importance of relatedness, of having a patient and knowledgeable mentor to provide support when feeling fearful and anxious about one's abilities, and the awareness that many residents likely need support and direction to engage meaningfully with the work. This resident's story shows how having a patient and strong mentor helped decrease his own fears and anxieties about the work: having a person who believes in you, teaches you how to accomplish the task, and builds you up for your accomplishments is key in overcoming the fear: "I'm not going to be able to do this."

Another resident described how his anxiety could "cripple" him and keep him from engaging with others. However, the work program challenged him to get up and work every day, despite his anxiety, teaching him that he can experience "intense emotions," and still engage within the world:

> Interviewer: So, for you, the work program…you're doing something meaningful kind of getting out and working....

Wilfred: Yeah. I mean problem isn't so much the anxiety, it's that the anxiety can cripple me in doing things and so if I can just practice getting out and doing things then it's okay to be anxious and it's okay to be...to have these intense emotions, because if it's not, it might. It's definitely unpleasant. Um, if I had an option, I would definitely choose to not be this anxious, but, you know, it's, the problem is not so much anxiety itself, it's the way it can shut me down.

Another resident cited the emphasis on getting up and working, despite how you feel, as instrumental in addressing his depression:

Oliver: When you're depressed, you want to sit down, slow down, back away. *And the only way out of the depression is a combination of empathy and movement*. *It's the exact opposite of what you want to do*. *And a place like this, we have to get up in the morning. We go to work. We push through it*. And the cool thing is that if we really can't work, we have the resources here to work through those problems. You know, it's like if you're, if you're having a panic attack and you can't get out of bed, you know, that's not the end of the world here. *You know, back home, it's like you do that too much, you lose your job. But here it's like it's a safe place to recollect and regenerate and process.* (emphasis added)

Positive experiences: Meaningful work

A recurrent theme in some resident narratives was that work felt therapeutic when it involved engagement with a task that contributed to the larger community.

Interviewer: The farm calls itself a therapeutic community. What does that mean to you?

Mary: It means that they sort of give you something to work as a baseline, like instead of just in my case, I was sitting in my room, lying in my room, depressed and getting weekly therapy, but it wasn't really helping. They're making me get out and do something and that is a huge part of why the therapy that they do offer, which is really good therapy, is so effective because you're not just sitting in your room and going, okay, whenever the therapist gives a suggestion and then not doing it.

Interviewer: Here you actually have to go out and do things.

Mary: Mmhm

Interviewer: What is your experience of the work program?

Mary: Yesterday, I was picking a ton of raspberries really reaching into the bush and getting every one I could and just doing that… and I actually really enjoyed doing that. I got a sense of satisfaction out of getting all the ripe ones.

Interviewer: Can you say more about what that felt like? That satisfaction?

Mary: I guess just like someone was saying, 'oh no, we're running out of raspberries,' and like *getting more raspberries for the farm to have, for the farm to share and potentially make food with or something that felt nice. It felt fun.* (emphasis added)

Shelly shared the sentiment of enjoying contributing to the wider community:

Shelly: Carpentry is cool because you're building things, you're using measurement and exact. You're using it or being precise and skills are being used and you're working with tools, a blah, blah, blah. It's just, it's cool because, you know, saws are cool*, building things that other people will use is cool.* And then

gardens is cool because you're working in the dirt and getting your hands in the dirt and *growing life that people will consume.* That's what I really like about gardening. (emphasis added).

Jerry named the sense of working with others as a positive aspect of work program:

Interviewer: What is your experience of the work program?

Jerry: So, the work so far, I've been loving it. Like I said, I was on maintenance… I think it is really good to be active, you know, uh, most of the jobs, that I've held traditionally have been, you know, your standard office environment, whether it's a cubicle or even working from home, which I did for a little while and everyone was always so jealous of that. They're like, 'Oh you're at home, you can do whatever you want and there's so much free time.' And I'm like, yeah, but 'I'm also just by myself all day.' So, I think getting out and like I said*, being active, being outside, working with the crew, working with a group of people that, you know, you all have a common goal to achieve,* whether it's, you know, a smaller task for the day or a larger task over, you know, a longer period of time.

The staff are doing the same thing that we're doing. You know what I mean? *They're in it with us.* Uh, you know, we're all working towards a common goal and you know some of the, like I was kind of touching on earlier where we didn't really get into deep conversation so to speak, you know, I've had some, some of those conversations during crew, you know, if I was working with a guy one on one or something like that, you know, we'd really get to know each other. So, in that sense, I think that it's been, it's been really, really good. (emphasis added)

These residents emphasize how contributing to the community, to something larger than themselves is therapeutic and helpful. All residents share about the communal nature of the Haven: “getting food for the farm to share and eat, building things others will use, growing life that people will consume, working with a group of people towards a common goal,” a sense that staff are “in it with us.”

Mixed and Ambivalent Resident Experiences of Crew

Though residents shared many positive feelings associated with the work program, residents also shared some mixed and ambivalent feelings about their experiences. In particular residents noted, at times, feeling the work was a “mixed bag,” repetitive, or not meaningful.

Ambivalent experiences: Mixed Bag

> Wilfred: Crew is a mixed bag. It's like stimulating enough to give you something to do but it's also...they want you to feel bored.
>
> Interviewer: They want you to feel bored?
>
> Wilfred: Yeah.
>
> Interviewer: Can you say more about that?
>
> Wilfred: Uh, well for a while I just, yes. So, let's just say hyper-stimulated myself, academic work and all that fun stuff. It really keeps you occupied when you're working on it. But this is a little bit different. I mean, for example, I'm just painting some stands, like there's like 20 of them that I need to paint. You kind of go into autopilot.
>
> Interviewer: Right…

> Wilfred: And that's it. That's what you're doing for the day or painting. So, what... Painting some tables or something like that? *Like it's work that's meaningful and it kind of gives you a little litmus test for how, how well you're doing. Like how hard is it to just do these basic tasks in front of me. Um, but yeah, it's not like you're gonna go home and be like, "wow, gee whiz, look at how much I did in a day."* Like, I mean, sometimes it's, you get that sense of satisfaction, like look at the tool shed and how much it's progressed. (emphasis added)

This resident shares that painting the stands is meaningful, particularly as it provides insight into how well he is doing that day; however, he comments that he is not going to go home and feel a sense of pride or accomplishment in the task. Such a comment also speaks to the differing needs of residents. For some, being able to complete such a task is significant in their ability to engage with a task; however, this resident feels that a different type of work is necessary for it to be meaningful.

Ambivalent experiences: Lack of meaning?

> Interviewer: What was your personal experience of the work program, having been there for a year?
>
> Enrique: Oh, it was good. But like I said, it becomes repetitive very quickly no matter how often you switch groups and stuff. Like you know, it changes from season to season as to what you're doing, but if you're on a farm it's like go feed the chickens, go feed the cows and it's the same thing every day. Carpentry crew is I don't know, like it's hard to stimulate me anyway, so like I'm not going to be stimulated typically by those things. I mean it's something to do, but a lot of people really enjoyed it so I mean my experience and it's not that I didn't, it's just

part of it's me, like I'm just bored, like out of my mind most of the time you know, so it's all subjective, right? As far as to what my experience was... I know there's lot of people [that] have really got a lot out of, I'm not sure how much I got out of it, other than I just know as a place where I was able to not hang myself and those feelings dissipated while I was doing these things, even if they are mundane or boring. So, um, yeah.

There's some people that really thrived in the work. Like some people just fucking love being on maintenance crew and going out and chopping wood. (Name omitted) really obviously had an affinity for being on farm crew. A lot of people, like at the end I was doing gardens a lot because we were doing weaving , I actually enjoyed weaving. But uh, yeah.

It's like a stopgap or a filler. Some of it's rewarding. Most of it's not. You can do projects on gardens, like the weaving. When you are doing the same thing...I fed the chickens, how rewarding is that? You feed them again the next day. I've heard the [they want] to set up a thing where they actually start making products, start selling, which I think is maybe a little too ambitious, but it's better than what they have going on now.

Ambivalent experiences: Paying to work

Interviewer: The farm calls itself a therapeutic community. What does that mean to you?

Jerry: Mm. Well, I thought it was kind of interesting that I think most of the therapeutic sense, at least from their perspective, comes in the actual work. Which

is fine, but I kind of joked around with my friends (laughs). It's like, "I'm paying these people to work like it should be the other way around." (laughs).

Shelly also named paying to work as an interesting aspect of the Haven:

Interviewer: What to you is therapeutic about this place?

Shelly: I think the lots of things, the work program, even though it's, *it is a little bit funny how we're paying to work,* like with school, like we're paying to work, um, but knowing that you can, that you can be working is good.

These residents speak to experiences of finding the work repetitive and mundane, and confusion about paying to work. I myself struggled with these feelings during my time at the Haven. From the beginning I questioned the identity and mission statement of the Haven, as when I first arrived I felt the farm was “solely” a working farm, as we completed various tasks on crew, but there was limited or no discussions or processing of the work on the crew. I witnessed residents check their watches, call the work “slave labor,” and question why they were paying to work, particularly when the therapy services were so limited when I arrived. I anticipated for upwards of $10,000 a month, residents would be receiving Intensive-Outpatient level services, seeing a therapist at least twice, if not more, times a week, in addition to a plethora of group offerings.

As I write this chapter and read the staff members descriptions of the work program again, I feel my own excitement and passion evoked by the ideas of what the work program can, and arguably does, do for residents. When I arrived at the farm, I felt invigorated by the idea of combining therapy services with communal work on a farm; however, as I write this chapter, and reflect on my past experiences, I still wonder to what degree residents experience a sense of self-

worth and pride in the work they are doing.[5] The excitement and passion I feel in reading staff members descriptions stands in contrast to many of my personal experiences engaging with the work program.[6] Sometimes I felt we were working simply for the sake of having something to do.

Working for Working's Sake

When I arrived at the Haven, I viewed the community through the lens of therapeutic treatment center, expecting that the emphasis would be on providing therapeutic services to residents—services that included farm work. However, at times the focus on work felt divorced from a therapeutic focus. Consider Annie's, a house advisor's, comment:

> I feel like there are always so many little tasks that we're doing that sometimes it's like we're not really grounding ourselves in the garden. You know, it's more of just like, 'oh, gotta do this, gotta do this, now this…' instead of like really taking the time to, I don't know, like plant a row of vegetables and like really get to know what we're doing. I also don't have much of a background in horticulture therapy or anything like that, but I feel like there's some therapeutic practices within horticulture therapy that could be implemented on gardens crew that are not, and probably the same for farm or carpentry or, you know, there's, I feel like

[5] Whether the work is experienced as meaningful also depends on how the resident was referred to the Haven. Isaac, a 32-year-old resident told me, "But to be honest, I came here because there was nowhere else to go, and because I had nothing else." Isaac also noted that often parents seek out the Haven for their children. This means it is the parent who researches and finds the Haven for their child. According to Isaac (and confirmed with various staff members) it is the resident's parents who often call for information or bring their child to the Haven. The resident is not typically the one seeking services independently. If a resident is not intrinsically motivated for a work program, will the work be experienced as meaningful?

[6] I also had positive experiences on crew. I felt a change in my mood as I began completing manual labor on the farm. Haying was an activity I enjoyed immensely more than I anticipated. The combination of physical work outdoors and living in community impacted my mental, emotional, and physical health positively. I describe a particularly meaningful experience on crew later in this chapter.

there's probably some evidence-based papers[7] out there of like ways to help people, you know, with mental health issues that we're not doing and we're just sort of like, like Gung Ho, like gotta get this work done instead of making it as therapeutic as possible.

What Annie described as "not grounding ourselves" in the work echoed my criticisms regarding the lack of work processing. I anticipated some discussion and psychoeducation about the antidepressant effects of gardening and working in the soil.[8] I also anticipated some discussion of the benefits to a person's mood as a result of being in nature. A few times on crew, I lamented lost opportunities for meditative practice while deep in the woods clearing trails, surrounded by serene sounds and abundant flora and fauna. Instead, we kept trekking along the trail, throwing sticks from the main path, never taking a moment to appreciate the beautiful and peaceful world we were lucky to inhabit.[9] As I worked with saws and hammers on carpentry crew, I was aware that mindfulness was required to complete the tasks, and yet we didn't explicitly integrate these perspectives into the work. Often, I felt as if the focus was on "getting the work done," as

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[7] While reading Richard Louv's (2008), *Last child in the woods: Saving our children from nature-deficit disorder,* I became aware of the use of horticultural therapy by Carl Menninger in the VA hospital system during World War II. Louv (2008) also writes, "In the 1950s, a larger movement emerged, one that recognized the therapeutic benefits of gardening for people with chronic illnesses. In 1955, Michigan State University awarded the first graduate degree in horticultural/occupational therapy. And in 1971, Kansas State University established the first horticultural therapy degree curriculum" (p. 45). For a review of evidence-based papers on horticultural therapy, see the American Horticultural Therapy Association: https://www.ahta.org, as well as their peer-reviewed journal, the *Journal of Therapeutic Horticulture*: https://www.ahta.org/publications.

[8] Particularly the role of mycobacterium vaccae found in soil, in increasing serotonin production. Glausiusz (2007) summarizing research by Lowry et al. (2007), writes: "The results so far suggest that simply inhaling M. vaccae--you get a dose just by taking a walk in the wild or rooting around in the garden--could help elicit a jolly state of mind. 'You can also ingest mycobacteria either through water sources or through eating plants--lettuce that you pick from the garden, or carrots,' Lowry says." See Lowry, C. A., Hollis, J. H., de Vries, A., Pan, B., Brunet, L. R., Hunt, J. R. F., Paton, J. F. R., van Kampen, E., Knight, D. M., Evans, A. K., Rook, G. A. W., & Lightman, S. L. (2007). Identification of an immune-responsive mesolimbocortical serotonergic system: potential role in regulation of emotional behavior. *Neuroscience*, *146*(2), 756–772.

[9] I imagine a common response to this critique would be, "we have work to finish." However, is a sole focus on completing work, and not attending to our immediate surroundings with gratitude, also a symptom of our wider American culture, and also perhaps at odds with the mission of a treatment center?

quickly as possible,[10] or simply getting it done period.

A note from my reflexive journal in mid-June reads, "During the week there seems to be a frenetic energy towards getting so much done that (to me) the farm begins to feel less therapeutic." Throughout my time at the Haven, in any discussion of programming changes or scheduling changes, the immediate reaction was, "how much time will that take from crew," or "we can't continue cutting time from crew." This relentless emphasis on crew[11] was especially notable when the idea of bringing community meetings back was raised. In August, as part of discussion in overhauling the daily schedule at the Haven, the idea of holding resident-led community meetings was introduced. During dinner one evening, I listened as two staff members discussed the community meeting scheduled for next morning. One staff member wondered how they could structure the meeting so that it wouldn't "prattle on for 45 minutes," and get in the way of crew.

The next day the community meeting was introduced by the executive director as a "forum for residents to have more of a voice" in the community, and for residents to have "an opportunity to give voice to issues in our community." After this introduction, the executive

[10] Naturally, some work does need to be done quickly and completed within the day to maintain the farm, especially care of animals; however, tasks such as trail clearing are ripe for the integration of eco-psychological and mindfulness-based interventions, to help residents cultivate a deeper appreciation for this incredible planet, and to learn self-soothing and wellness practices. Moreover, psychoeducation about lifecycles and animal husbandry could provide needed therapeutic and educative experiences for those grappling with ethical questions about consumption, food systems, and the processes of life and death.

[11] Of course, there are aspects of farm work that must take precedence. As Dean stated earlier, "the cow has to be fed." Yet, the urgency about work did not feel grounded in a larger, explicit, framework about why feeding the animals on time was important for the animals and the larger community. The importance of responsibility, which was expressed by many staff as a core soft skill learned on work program, seemed to be an implicit lesson, rather than an explicit one. Moreover, this urgency to "get to work" is juxtaposed with the limited amount of work that is accomplished sometimes. Consider this quote from Elias, a house advisor, "I think a lot of people argue that we don't really do a lot of work here. Crew can be really ineffective, like can really not get a lot done sometimes." I experienced this sense of ineffectiveness on crew when there were not enough tasks to go around. Sometimes I stood around with other residents, while others completed a task, simply because there wasn't enough for all of us to do. Though, in hindsight, this moment would have been perfect for a mindfulness activity, eco-psychological meditation, or just plain discussion to foster connection. Here too, I was swept up in the flurry of "work, work, work," and if there is no work, what do we do?

director asked, “what ideas do you have?” Curiously, the first person to speak was a staff member, not a resident, who stated, “Let’s be reasonable about time and topic.” One resident floated the idea of having a current events discussion, to which a therapist responded that the idea for the meeting was to discuss issues arising within the community, rather than a focus on events happening outside the community. At this point more staff members began to discuss the timeframe of the meeting: “If morning meeting happens at X time, then we will have so much time allotted for crew planning, then if the community meeting happens, we then have about twenty minutes for the meeting, before crew time.”

Here a resident chimed in to ask, “if we only have twenty minutes, can we have check ins?” A staff member responded, “That’s not what I envisioned for this meeting,” reminding everyone the focus was on events and issues occurring within the community. This discussion led to more debate about how long the meeting should be or how frequent. The idea was proposed that the community meeting could happen once a month. A resident stated, “if [the meeting] is going to get in the way of crew, maybe [it should happen] once a month.” In the end, the agreement was to hold a monthly resident led community meeting, and residents could designate topics for discussion. Though this was an important step in bringing community meetings back to the Haven, this end result was a far cry from the original intent of resident-led community meetings focused on issues as they arise within the community. Here, too, crew took precedence.

In terms of my own experience as a Haven community member, when I first arrived at the farm, much time was spent deciding which crews I would be on and for which days. One day I was observing an HA meeting, when one of the work program leaders called into the meeting to ask specifically for me, to determine which crew I was going to be on for the week. Unlike

residents, I had not submitted a weekly sheet requesting my preferences for the work program. It appeared the assumption was that I would be on crew all day. By not submitting this weekly request, I may have created challenges for the work program; however, this episode also reflects the confusing nature of the ethnographer. Who was I? What I was doing? Was I a staff member? I wasn't a resident. But I also wasn't a staff member. I believe the flurry over which crew I would be on reflected both the priority accorded to crew at the Haven, and an underlying confusion about my role.

I remember the moment I was told the phone call was regarding my crew schedule. I immediately felt frustrated and thought, "I'm here to complete a research project, not just complete labor on the farm…." I began to feel I was viewed simply as another set of hands to complete the farm work, rather than as a researcher trying to understand the wider context of the Haven. A similar reaction arose when I was assigned a task to complete working alone. I remember feeling frustrated as this task kept me from working with residents and unable to observe any interaction, which defeated the purpose of my study. In the moment, I felt I was being treated merely as a worker, and that my role as a researcher was devalued.[12]

Isaac, a 32-year-old resident, shared this view of sometimes feeling like "more of a worker….a set of hands," on crew:

> Isaac: You're expected to work and not like a job. You're basically like being used. You're expected to work, but you, the value of your work is not sometimes appreciated in regards to your own therapy, I guess, you know, if something needs

[12] I want to take some responsibility for this confusion. Perhaps I did not define my role well enough to the staff, who were often looking for more hands to help in the work. Is this because crew is the primary, and sometimes, the only program happening at the Haven? Is it because the farm is actually understaffed? Though I wanted and needed to participate on crew as part of my research, crew was not the only activity I was there to observe. I, especially, found the line of participant-observer hard to draw in the context of the work program.

to be done and you're here and like…. I joke about it, that it's like slave labor, but sometimes it's not a joke.

Interviewer: You said the value of the work often isn't appreciated in relationship to therapy. Can you say more about that?

Isaac: Yeah, yeah. It's just an, it's not…. When you come here you're expected to not pull your own weight really. But pull the weight of this place and there's like an expectation that, I mean for the last four days, you know, we've been like haying 1200 bales of hay from the barn, from the hayfields to the barn and there's a thousand bales of hay spread out in an open field and every resident that's here in 95 degree heat is expected to go on these trucks and collect all the bales of hay and group them together and then put them on the truck. And then the truck goes to the barn and there's five or six people in the barn. The residents there are expected to dump the hay in the barn and like fine. It's work. But, but it's needed by the farmer [13] like (staff name omitted)...needed by the farmer, to have this happen. And he's using the labor of those, of people who are here without really considering the fact that it's 95 degrees. [14] It's intensive work abuse.

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[13] Isaac raises a perplexing issue. Often, I struggled with the idea of residents paying such an exorbitant tuition to work on the farm. In many instances, like some residents cited earlier, I thought, 'Shouldn't we just get a job and be paid for the labor?' I began to question the notion of work as a therapy. This question is still one I struggle with. Though there are therapeutic benefits to a physical-activity-based program, and residents need help in learning and practicing work skills and learning the value of work, the Haven doesn't offer much (at current) in terms of clinical therapy services. That being so, the high cost of tuition for residents is somewhat perplexing. Such difficult questions, in my mind, point to a need for the reworking of the work program; particularly, with an emphasis on working within a community.

[14] At morning meeting before all crews chipped in to help with haying, a crew leader stated that if any resident did not feel comfortable haying, given the heat, a different crew opportunity would be available for them. Though this resident's experience seems to suggest he felt he had no choice in haying in the heat, and perhaps there are implicit and explicit reasons he felt this way, I never witnessed or heard any Haven staff member forcing a resident to work. Though I observed some unsafe working conditions at times, I never observed or heard a resident being coerced or told they had to do the work or would be punished. When residents felt ill, they either did not show up to crew, or would have a discussion with their HA, crew leader, or another team leader to discuss whether they should attend crew or not. Though some tasks were more intense than others, (i.e. haying in 90 degree weather), often I observed

Isaac's experience was that of being "more of a worker," and feeling he had no choice in performing tasks he was uncomfortable with. Though residents had some choice into how much effort they put into tasks, I wondered what left Isaac feeling he had no choice or autonomy. In referring to himself as "just a set of hands," he conveys the impression that the work he performs is not meaningful. There seems little evidence of experienced autonomy, competence, or relatedness in his descriptions. Again, I question whether work like this is meaningful and if not, how to make it so.

Meaningful Work: Meaningful to Whom?

Throughout my research, I heard the phrase "meaningful work," and that the Haven provided meaningful work on a farm. I wondered if the work performed by residents and staff was meaningful to residents, as I saw residents check their watches throughout the day and complain about performing "slave labor." Oftentimes, I struggled to find the meaning in the work we were completing. Given my own experiences and observations at the Haven, I began to ask, "meaningful work to whom?"

Noting my frustrations throughout work program and hearing how "work is what worked" in the past, I wondered if work felt more meaningful in the past, because the members of the community literally built the physical space together. Building the space that members inhabited seems inherently more meaningful than some of the tasks I participated in during work

working conditions that did not mirror outside working world expectations (i.e. Several breaks are taken on crew, residents can rest as much as needed, unlike the break schedule of many employed positions). One wonders why he felt he had no choice, or why he felt he couldn't raise his concerns to the community, his team, an HA, or another staff member. I did not observe the resident express these concerns to any staff member. Why does a resident lack the confidence to speak up about these concerns and how can the Haven cultivate resident agency and self-advocacy?

program.[15] Let's revisit the following quote from Sarah, a longtime Haven colleague and former staff member at the Haven:

> Everybody in the community was really necessary to help the place go because there was so much to do and so many urgent needs for the place that I think it was possible for everybody there to feel enormously important to the survival of the place, and that must've been a great experience, particularly for people who had been having therapy in the hospital and you know, felt like they weren't worth much in that setting and here they were really needed to be part of the program and to lend their shoulders to whatever it needed to be done and to figure out things as they went along and to take care of the road, to drain the swamp and to grow the vegetables and to raise the meat and everything else. I think was a very positive affirming experience for a lot of folks that came here. So then it got, course the place got more and more comfortable as we had more and more farmers and more and more staff and. But the spirit of the necessary work at the place was always at the, at the core.

Sarah's retelling of the earlier days at the Haven, suggests that the sense of "work as necessary" was currently lacking at the Haven. It also provides insight into how needs of autonomy, competence, and relatedness emerged in a context of building a community together. Residents who felt beaten down by stigma and a sense of uselessness could experience themselves as vital participants. Their psychological distress, did not prevent them from making valuable

[15] Tasks I completed, which felt meaningfulness, included clearing a trail of sticks and debris, cleaning out a garage where it felt we transferred one mess to another mess. A research participant also shared that she spent an afternoon ripping up old jeans in a sewing machine, a task she didn't find particularly meaningful.

contributions to the community, creating a sense of ownership and interdependence.

Alexis, a staff member, shared a similar perspective during our interview:

Interviewer: What is your experience of the work program?

Alexis: I think… so right now.... I think the way that it is, is good in teaching life skills, in terms of responsibility, expectations, um, you know, teamwork, physical health, because most of the jobs are movement based. They're getting out and they're moving. I would like to see the work be like it used to be. If you read the history of this place, I think the work used to have more meaning, so I would like to see the work they do be more intrinsically meaningful for them. Um, I have heard a lot of residents say slave labor, free labor, da da da, and I think that's because they don't feel the value. When you look at the history of this place, the reason those [individuals] had such a life changing experience when they came here is because they were building the house—the house that their family came to. And that's meaningful. Right now, going out and weeding the garden that doesn't even go to a farmer's market and barely gets used at our table is not so meaningful.

Interviewer: How does that, how does one define or who defines what is meaningful for the residents?

Alexis: Yeah, it's got to connect with them somehow…. So, a resident can learn how to take something from the ground to harvest. Learning how to run a book, a ledger, learning how to run a cash machine, learning how to greet a customer, learn how to make eye contact, you know, what does that feel like? It has, you know, so they can learn real social skills in real time, much like they do on crew

here, but it's buffered and contained. And those are skills, much like building a tiny house, that are transferable. You leave here, you take it with you. 'Oh I worked on building a house, you know, oh I worked in a garden that, you know, we had $20,000 in sales,' you know, to get a real....Then, they see the purpose in that. Um, but I do think that we could, we have all the, we've built all the infrastructure for all of these things and now it's time to bloom. Take them to the next level so that residents feel a connection. I think we've lost over time, they've lost that intrinsic connection to the value of the work. I think that's why farm gets the most satisfied--- Why everybody wants farm crew because it's real, you're caring for an animal, you're feeding the animal, you're making hay for the animal. I mean they see, you know, there's a responsibility, 'oh, if I don't go out and do my chore, that animal's not going to get fed.' You know? So. And people always clamor to farm crew and I think that's why, because it's probably the most meaningful work.

My research suggests that the Haven staff believes its current work program still achieves the goals of yesteryear, but I did not encounter many residents who explicitly felt valuable or meaningfully engaged in the work, or necessary and vital members of the community.[16] Adam, a staff member, reflected on the disengagement in the following way:

Interviewer: What are changes you see that need to happen in the work program?

[16] Of course, these observations do not reflect all resident experiences, and more staff members volunteered to participate in my research than residents. Moreover, as noted previously, some residents did acknowledge deriving benefits from the work program. However, I often experienced a mismatch between these comments and my observations of resident behavior and commentary on crew. Moreover, staff members shared with me resident reports of not finding the work meaningful or engaging.

Adam: It needs to be meaningful and relevant again, because it's lost a lot of that for people.

Interviewer: Are you hearing that from residents?

Adam: Absolutely. Um, and it just, like going out and working on [crew]. Like you don't feel like you're contributing in a meaningful way. I know that everyone has their own, their own needs when they come here, like someone who is experiencing psychosis[17], it's difficult to say, 'Oh, you know, here's how we're going to meaningfully be in this, this work crew today' and have that same level of expectation you might have for someone else. But for people who are stabilizing a little bit more and trying to feel more part of the community, it still feels like you're kind of just… just being a part of something that you're almost, um being patronized with.

Adam: Does that make sense at all? It's not, you know, it's like, oh, 'we'll just go saw this piece of wood,' or something and it's not, that's not, I'm not learning new skills or not kind of engaging in flow with it or anything. They're just feeling this.. like empty, kind of like meaningless time filler on some level. At least that's been some of what I've heard from people. I mean, and again, people come here with their own stuff, but there's got to be some truth to that underlying.... cause it's a very similar thread to a lot of people…. this isn't meaningful anymore. And it's frustrating.

[17] This comment does not speak to psychosis as a spectrum and seems to embody the medical model/diagnostic perspective. At times, someone experiencing psychotic experiences may not be able to engage in this type of processing; however, that is true of anyone in various types of distress. Experiencing psychosis is not in itself a barrier to processing.

Adam: It's something like.... There's a lot of monotony in any crew that you're on. Um, which again, I'm not really sure how you get rid of some of that, but the working for working sake thing resonates with me because whenever I've been out on crew, unless I'm really like trying to engage someone in a very deliberate way, um, I just can very easily go on autopilot and I just feel like kind of…a little robot like, oh, carrying my feedbag from this end to this end, what's next? And there's just not a lot of um, there's not a lot of pride in it either.

Adam: I think that's, that's the part that was probably what the work camp used to be. It used to be like you're really needed, you impact this place directly. Not like a, 'Oh, like, you know, if you feel like it, you can do this one kind of task' and like they don't really, they don't really own it. They don't really make it their, their experience. It's just kind of something that they have to be doing.

Interviewer: Right. And kind of a way just to pass time?

Adam: Yes, absolutely.

Interviewer: And what have your experiences been on crew as you've been on crew?

Adam: They've been kind of pointless.

Interviewer: Can you say more?

Adam: I just feel like even the work that I'm actually doing, it doesn't feel relevant. It just feels like so small and menial and um, I feel the people around me feeling the same way and there's a lot of downtime and you're just like awkwardly standing around because there isn't enough work to be done for everyone. Um, and *I think if we actually engage people with their potential, we could actually be*

doing a lot more with the space and the land and the, the stuff we have here for work crew.

Adam: And that's really hard to try to. Especially when I see that like in there, there are moments of connection and there are moments of joy on work crew. But a lot of it is just, is just filling space. (emphasis added)

My own experience on crew is mirrored in the staff descriptions above. Sometimes I felt the work I performed was largely busy work, something to keep residents occupied, rather than meaningful, community building work. For example, one day in mid-July just as we left to begin the chores for the day, a rain storm hit. Having to think quickly, the program leader brought us to a nearby garage where several of the Haven's tools were stored. We were asked to "organize" the building by cleaning out various shelves and toolboxes. Each of us on crew were responsible for a particular area of the garage. As we began re-organizing the garage, organizing and cleaning seemed to translate into moving a messy pile of things from one area of the garage to another. I helped a resident rearrange the tools in a toolbox and to toss out miscellaneous objects. A portion of these objects ended up on top of the toolbox, with no apparent place to put them, and feeling as if we were trading one mess for another, I thought, "What on earth are we doing?" I remember feeling quite frustrated during this event and wondering what the purpose of this work was. In reviewing my thoughts about this event, I wrote, "It feels like the work program functions more like babysitting residents rather than teaching them work skills."

Yet, even at times like these, I continued to wonder if there was something I was missing. Was I too critical? Was I "too intellectually minded"[18] to grasp the importance and meaning in

[18] In reading through resident charts, I read that a resident "may be too intellectually minded to find meaning in the physical work of the farm." Later in the dissertation, I write about how this comment stuck with me, as I wondered if it applied to myself, and the shame I felt on crew.

the physical work? Was I too oriented towards a clinical frame of reference? However, several staff members expressed similar frustrations and concerns regarding work program. Consider the following description from Ted, a former staff member:

> Ted: I did in my interview here. Um, I sat down with the two clinicians already here and I'm like, 'So when does the treatment happen?' 'That's it. You saw it.' 'What do mean I saw it?' I went on crew and I ripped up some old jeans. There was nothing therapeutic about any conversation that happened there. There was nothing that brought in the activity that they were doing and how it might relate to a skill they were lacking in or needed to practice or were struggling with in real life. And like, there was, we were just ripping up old jeans in the sewing machine and like there was nothing therapeutic about that at all. How was that, how is that treatment?
>
> When [residents] when fill out the surveys after they leave, they're like, we get bored. Like week one work is the same as if you're here 51 weeks. It's just the same. The times that I've seen people really pull together and be excited about what they do is when something like the tool shed goes up and everybody wanted to be on carpentry crew last year because I guess it's something very big and very tangible that you see coming down and then destructed and constructed in front of your very eyes, but I don't think we have enough of that kind of crew.
>
> You know, like weeding the gardens somewhere. I don't know, and I think even with the animals, for me, farm crew and like there's so many more opportunities we could do there instead of just farm crew being about throwing hay at the

animals and getting it done by the time four o'clock gets around. We have such an amazing opportunity to teach the value of life.

The cycle of life, those cows, we are going to eat them, and we should respect that. We should honor that and there's nothing to stop us having a relationship with them and respecting them and honoring them and giving them the best life we possibly can while they are with us because ultimately they are here to give up their life for our life. So, like there is so much more we could be doing with the animals on site. That would be therapy and therapeutic and we don't.

Interviewer: What are some of the things that residents have wanted to see change about crew?

They've wanted it to have like meaning. And typically, what that means is that they feel, I think like they're doing stuff for the sake of doing it, um, because they don't see beginning, a middle, and an end.[19] I think they also want to be challenged more on crew it feels like, from what they say. We are doing a lovely job of catering to folks that have (inaudible) symptoms and struggling more in just giving them something that they're capable of doing. But when they get more stable or they come with some substance induced stuff, so they start clearing from the substances and are able to hit the ground running and do more. They're feeling-- and crew staff on a couple of crews--- are also feeling like we're sort of not accommodating. Our ability to really challenge them or push more on crew is

[19] Here, I am reminded of Fromm's (1995) writing of the modern industrial worker, "He [sic] fulfills a small isolated function in a complicated and highly organized process of production, and is never confronted with 'his' product as a whole…" (p. 18).

more limited than what it is to slow it down to meet the needs of the folks that are more symptomatic.

I think that's why the tool shed last summer was something that everybody wanted to do because they could see it grow and *felt like they were contributing to something that had a purpose.* Um, for a lot of them, I think if they feel like they're doing it for the sake of doing it and they've also said, um*, it's, it's more about getting the task done,* um, and the task doesn't feel like it's anything (inaudible). Um, and I think, I mean, each crew is a little different, so I don't want to make disparaging comments, that cover all crews. I just know that's a general theme. *They really want to be pushed a little bit more, um, challenged more and have crew approximate probably more real-world job expectations*. Um, it's interesting because the other thing that I've, I've seen a little bit consistently over my time here, is the more well people get, the, even though they know it's a work program when they come in, the more like, 'well I'm just doing free labor for you and I don't get paid how come?' So, their mindset seems to shift *and I don't know if they felt more personally involved, connected, challenged, like engaged in what was happening on crew if they wouldn't feel that way.* It just seems not everybody, but there's a percentage consistently seem to say, *'well, why am I doing free work for you when I can actually do work offsite and get paid for it?' That attitude I've seen crop up consistently.*

Yeah. I don't know how much of what we do is sort of comparable to real world outside of here for the sector and the population of clientele that we get here. At one point we looked at, you know, a lot of them, I mean it's an online tech savvy

> world. Is there anything we can help them do online--- sort of more aligned with their interests and more aligned with what they're going to be needing to know when they get out of here? Um, *so the tenents of crew, getting up, suiting up, showing up as (staff member) says, um, it feels like once they got past that, then the actual elements of what they do on crew either aren't aligned with what makes sense to the clientele that we have here or it's repetitive enough that after a few months they're just like* (makes frustrated motion with hands, emphasis added).

Here, Ted speaks to the sense of "working for working's sake," or working specifically with task completion in mind, rather than with the desired focus on process and meaningful engagement. Though I witnessed moments of connection, focusing on the process rather than perfection, and staff working to build up a resident's capacity, more often than not, I observed and experienced the sentiments expressed by Ted, Adam, and Alexis. I again wondered if the much-cited meaning and value of the work program was more of an aspiration than a reality.

Not only did some staff describe resident's disengagement, boredom, and criticisms of having to pay to work, a few house advisors (the staff often tasked with getting residents to work crew for the day and supervising a significant portion of the work crew projects) expressed challenges in motivating residents to show up for work program. When I asked Catherine to describe the work program, the following was her immediate response:

> I feel like getting the residents to the work program is like the most strenuous part of my job in some ways. Because most of them don't want to work. Not… I don't want to say most of them. There are very specific ones who don't want to work or who are struggling with things or you know, we just feel like we're pushing them

and, and maybe I just need more support on like how to push somebody into hard labor, into manual labor.

Catherine, also expressed skepticism regarding the idea that work program was the most important part of the Haven, especially when considering the challenges of getting residents to work or stay on task. Referring to another staff member, Elias, an HA, reflects:

> She thinks that the work program is the most important part. And I thought I agreed because it seemed like.....(drifts off). But I realized that I really disagreed with that and I think very few people, I think very... a lot of people really focus on the work program as the most healing part. And I really disagree, and I don't know that that's a common opinion around here, but it is pinned against the way that we have to get people to work as HAs… doesn't feel like a community. Like I'm like, I don't know. And, and what I think is really important is like when someone has dish duty and they're complaining about having to work, I think it's far more like.... it's not like, 'for your individual benefit, you should be doing dishes because it really, you know, it's really good for you because you're working and blah blah blah.' *It's more like we're part of a community and everyone has to put something in that they don't want to, to accommodate for all those things that no one wants to do. And when you shirk your duty, that leaves so and so doing twice as much work. And I think that that's a really important way for residents to think. Especially, I think a lot of people, it's really hard for them to think outside themselves and so that'll be the first time that they realize that their actions affect other people.* And so that's how I want to talk about it. That's how I want to talk

about the duties that we have to do. *I think the work program focuses on how it helps you as an individual and, and I think the community aspect of it is far more important*...(emphasis added)

Elias is emphasizing the need to tie the work back to the community. If one member doesn't fulfill their responsibility, the whole community suffers. Elias's comments helped me articulate that the larger sense of community, and intention in the work program was missing. I rarely got the sense that residents felt part of a wider community, that their work had value for the community, or even that the resident felt engaged in the community or took some ownership of the community. I can't help but wonder how the lack of community meetings and forums for residents may have contributed to a break down in a sense of community. Community meetings play a significant role in most therapeutic communities and seem to foster a sense of agency and ownership for residents, as their voices are valued, attended to, and heard in these forums. Without any such forum, and with work lacking much intrinsic satisfaction, and no wider sense of identity as a community beyond the Haven's rhetoric and history, how could residents cultivate and experience themselves as agentic individuals within a meaningful community?

Chapter Four:

Re-envisioning the Work Program

While the Haven weathered a rocky transition from being a therapeutic community, where living in community *was* the treatment, to a work-based treatment center, it's understanding, and definition of the work program was also in need of some revision. I became more puzzled by the role of work after reading resident files. In these files, I noticed comments[1] such as, "Resident doesn't work as hard as other residents," or "Resident felt inclined to pull his weight," or "moves slowly." As I read these remarks, I wondered "What does this comment mean in the context of a work-based therapeutic community? Is quickness and efficiency a goal? Should it be?" At first, I felt opposed to these markers of accomplishment. Should the focus be whether the work is completed efficiently? I came to the Haven anticipating that work would be performed in service of residents' goals. So perhaps if their goal was to maintain employment, then learning skills in the service of efficiency, and being evaluated on these skills would make sense.

However, in reflecting on the history of the Haven as a community where people come together and work at their own pace, irrespective of prevailing cultural expectations about efficiency and timeliness for job performance, I struggled to grasp the rationale for focusing on efficiency and production; particularly, if the Haven's main objective was therapeutic. These questions again point to the competing visions of the Haven. Past residents were seeking a safe haven and a break from "normal" expectations of the "working world," but current residents come to the Haven ostensibly to learn skills, to find a job and maintain employment, and as a

[1] Notes that work program leaders completed about a resident's experience and performance on crew.

result, staff have mixed feelings on what the Haven is and should be doing. Here again, history and differing visions collide.[2]

Reflecting on Ron's explanation for why the Haven embraced work processes that took more time for task completion, I appreciate the Haven's former emphasis on community building and connection, and also feel sad realizing newer forms of technology have robbed mundane tasks like dish-washing of opportunities for interpersonal connection. When I participated in dish washing, or observed residents washing dishes, I often noticed they were either wearing earbuds or that they played the radio while working in the kitchen. Oftentimes the music was so loud, no conversation could occur.[3] Moreover, I did not sense that residents felt part of a wider community. It often felt as if residents were engaging in the work to fill time. Additionally, residents spent much time in isolation on their computers, or in their rooms during weekends. Here too, I struggled with the gap between the ideal of community-based work and the reality of alienated labor. So, what was the role of the work program? Could the Haven return to building stronger community? If more and more residents have shorter stays with the intention of returning home and being able to maintain employment, do the objectives of the work program need to change?

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[2] I question whether resident's sought services at the Haven primarily to address work-related difficulties. Though they certainly struggled with maintaining employment, there was a deep hunger among residents to share with one another their experiences of psychological suffering. Residents frequently requested more therapeutic services, specifically depth-oriented services, such as interpersonal processing groups, rather than coping skills groups. Many wished to see their therapist at least twice a week. Although most residents likely did need to experience being accountable, responsible, and to acquire other "soft" skills, there was also deep psychological pain that rarely seemed addressed. Addressing such suffering while engaging residents in meaningful work would probably remedy resident's difficulties better than focusing on teaching the soft skills of work performance and expectation, primarily.

[3] The role of technology in contributing to social isolation and the breakdown of community building is beyond the scope of this dissertation; however, this topic is important for future research, particularly as it is salient given how therapeutic communities are grappling with the role and place of technology in their midst, and the amount of time residents spend engaged with such technologies. The issue of how often to make the internet available to residents was a frequent topic of discussion because residents often opted to be on their individual computers during free time, which meant less time building connections and spending intentional time together in the community.

Working as a Team versus Vocational Training

Questions about efficiency and evaluation of performance on crew, when not tied to resident's goals, or a deeper grasp of how the work could benefit the wider community, are particularly salient when attempting to discern whether the work program should be more vocational, or skills based in nature. When I arrived at the Haven I was not taught basic farming or gardening skills,[4] and I was surprised there were not psychoeducational groups on job skills. I assumed the work program would be more "teacherly," and envisioned crew being more skills based, in terms of teaching skills related to farming, carpentry, and gardening. Instead, we went immediately to work without a tutorial on how to complete our assigned tasks. This was especially surprising given that most residents had not participated in farm work prior to arrival at the Haven. Perhaps the staff assumed I had the knowledge necessary to complete the task. However, like most other residents, I had not done farm work prior to my time at the Haven. Aside from carpentry crew, I often was assigned tasks without much direction or education. I also rarely observed new residents being taught introductory farming or gardening skills. Instead, we were told what tasks to complete and we went off with a feverish energy to get the work done. As Annie stated, "we gotta do this, we gotta do this."

I realized then that I had anticipated that crew would be more vocational in nature. Granted, I defined vocational in terms of teaching skills. I was not defining vocational literally—that the Haven would be a vocational school for farming. Though I did anticipate residents would learn farming skills in the process.[5] Yet, when asked what skills they taught, staff discussed "soft skills," about responsibility, showing up on time, and so on. That

[4] I explore this experience in depth at a later point in this dissertation

[5] Of course, residents did learn farming and gardening skills by doing; however, my expectation and hope was that the learning would be more educative, more based in teaching and mentoring,

being so, I began to ask staff how the work program was similar and different from vocational training. Vocational training is defined as training specific to an occupation or employment related to trades ("Vocational," n.d.). In interviews staff were divided on whether the Haven should be more vocational in general:

> Colin: I think in a vocational training program it's, the focus is more on the work and the outcome, and I feel like here oftentimes what's as important is the process of the group working together--it's as important as the product which they are seeking to create. So, and I feel like the expectations here, um, they don't always, especially don't always match what someone's going to encounter outside in the paid world of employment.

Dean, another staff member, also acknowledged that the expectations of work program do not often mirror work expectations in the outside world of employment:

> Dean: I feel some tension sometimes within like.... I can help somebody feel really good about the work they're doing, but if it's not going to be work that would be acceptable out in the world…. Like, I mean I'm not gonna it's not gonna be like boot camp on crew. I'm going to be nice. But where I think we all feel some tension, like knowing when somebody's work is the best that they can do in the moment and it isn't. I don't know. I'm not really finishing that sentence. I think. Yeah.
>
> Interviewer: But it wouldn't necessarily be acceptable in the work world outside of...

Dean: Yeah. Which is okay. They're not in the...they are at the farm, but I do feel like how can I help someone be more that.... But if I really can't, it's just not where they're at…. then….

Dean's comments highlight this tension in the moment. The ambivalence in his speech speaks to the shifting needs of Haven residents. Historically the Haven focused on providing a place to work that was more accepting, affirming, and slower paced than the "work world." However, now that residents stay an average of three to six months, and expect to return to the "real" world with the ability to work and maintain their employment, simply having a more affirming place to work doesn't seem to meet their primary needs.

Craig spoke to this sense of setting up people for failure, when they return to the world of employment:

Craig: So, this may be the actual first work experience they [a resident] ever had and their work experience is around 10 hours a week. Oh, coddling? It's not really work. Do you know what I mean? In fact, sometimes when we tell somebody they're doing such a great job and we send them out in the world, I'm afraid we are setting them up for failure.

Craig felt more optimistic about shifting the work program towards emphasizing and developing vocational skills, by developing a Phase system:

Interviewer: Something I've heard a lot here is.... that work program is not a vocational training program.

Craig: It's not, it's by definition it's not. But I sure think that that could help. You know, I mean to be a true vocational program, there's a lot to that. You know what

I mean? But I do think that if we did actually return to the concept of a phase program, we could at least separate the folks that are brand new from the folks that have been here for a while. To give the folks who've been here for a while a break to explore the next step, to be able to challenge their tools that they've learned. What they end up doing …some of this is good in that they end up helping mentor the new folks, which is a natural process, you know, and some of them, have opportunities for patience and kindness and that helps them realize that they've evolved.

A lot of times in trades, you get the guys, they can't read, the guys that can't drive because they lost their license. The guys that have alcohol or drug problems, in fact, it's kind of hard to fill a crew without having a few of those people. So, or I should say us, right? We're all, yeah. So, so the real-world dynamic of the trades is made up of folks just like us here, us, them. I think that without a lot of effort we could create an atmosphere to test folks resolve before they leave here. The transitional program has had some evolutionary problems. This used to be the long term residential care. You know, this was what the farm was built for. When they put in the transitional program, that kind of made this a short-term program, but some of the philosophies still revolves around long-term care. So that's been given over to the transitional program.

Colin offered another nuanced view of vocational training:

Colin: So vocational training to me would be that I am actually teaching them skills with the expectation that they're going to do it out in the world. And um, and so for me, I kind of teeter on that. But I don't expect that people that leave

> here are going to go be carpenters or anything. But I do hope that what they learn here, some of the hard skills….so the vocational is going to be focused on the hard skills, how to measure, how to cut, how to fasten, how to interpret prints. Like those would be the hard skills, the soft skills in my mind then would be about human interaction and success on a project and stuff like that. Feeling good at the end of the day. If it's vocational straight up then I'm going to be teaching it in such a way that at the end of the day, we will reflect back on what we did wrong or what improvements do we need to make. How can you be doing a better job at this? Because when you get out in the world, you're going to need to be competitive. And so that's just cut right out of it.

In listening to the work program leaders, I wondered how to bridge both worlds. As noted earlier, even in a shorter-term program, residents shared how helpful it was to work in an environment that accommodated their needs—an environment where they wouldn't be fired immediately for needing a mental health day. However, how could the Haven retain this important aspect of its mission and history, while teaching skills that could more explicitly develop a resident's sense of autonomy and competence? Though residents occasionally found and cultivated a passion on crew, I wondered if a more intentional focus on the work, might better engage residents. Moreover, as Elias beautifully elaborated, work in a community is important, because when one person doesn't do their part, someone else has to pick up the slack, and the whole community is affected. How could this lesson be better integrated into the work program?

One crew where I felt the sense of intention, community, capability, and meaning coalesce, was on carpentry crew, building a tool shed.

Meaningful Work Experiences

As I've described thus far, many of my work program experiences were unsatisfying, prompting me to question the value of the work to residents, and wondering how the program could honor its history, while perhaps becoming more skill focused, so residents would leave with some enhanced preparedness and skills. Alternatively, I wondered, how could the Haven use the work program to help residents build a sense of autonomy and competence—an aim that not only develops specific work skills, but addresses necessary developmental experiences?

I first experienced the power and significance of teamwork while working with Jerry on carpentry crew. We were cutting boards for a tool shed. Jerry and I walked to the woodpile stacked alongside the tool shed construction site. Together we lifted boards, unstacking the woodpile, to find ten 2x6 boards. After retrieving them, we made a balance beam from a saw horse and other pieces of woods. We placed each 2x6 board, one by one, on top of our makeshift balance beam. After balancing the board, and lining it up flush for the placement of the chop saw, Jerry instructed me to take a tape measure and measure 107 inches and ¾ on the board. I took a pencil and made a V at the exact measurement. After marking the board, we flipped it around and attempted to line the V up with where the saw blade would hit when engaged. Through careful coaching, Jerry helped me line things up, and I made my first cut. After making the cuts, we'd take the tape measure and check the board to see how we'd done. In at least 6 of the 10 cases, our measurements and cuts were exact. In other instances, we were close enough to exact for the boards to work. Once I successfully cut my first board, I pumped my fist in the air and shouted, "woohoo!" Jerry laughed.

As we performed this task, I noticed how much I enjoyed lifting the wood together, handing the measuring tape and pencil back and forth, and using eye contact (as we were

wearing noise cancelling headphones to protect from the sound of the saw and the generator, which powered the saws) to communicate about our task. Moreover, as we worked together, all labels and differences melted away. Jerry was not a resident receiving treatment for psychological challenges, and I wasn't a researcher. We were just two individuals, working together. Our roles outside of the task didn't matter. The experience felt liberating, I had a sense of what many residents, old and new, straight out of the hospital, may have felt on work program. Here, their psychological challenges didn't matter as much. Here, the focus was on working together and building something for the entire community to use—a task that felt quite meaningful in terms of its contribution to the larger community.

I also enjoyed Jerry taking the lead role in teaching me how to use the chop saw, and how to properly measure the boards for the needed cuts. Roles were somewhat reversed. Jerry was the teacher and I the student. I left the experience, hoping he had felt empowered in teaching me how to do something; that he had the knowledge I also needed to successfully complete the project. This experience is one example of the potential and power of a work-based program. My question is how can the Haven create more of these experiences? How can all crews create a more intentional and meaningful focus about the work?

Work Program: Colliding Visions

It appears that there are two competing visions of the work program: 1) working in community and 2) preparing residents for working outside of the Haven. Often these agendas didn't seem to intersect. Work program team members discussed their own ambivalent feelings about whether residents were prepared for jobs after leaving the Haven: would their work performance at the Haven be acceptable in the world beyond the Haven? Such a question must prompt ambivalence when the original purpose of the Haven was to create a community where

the outside world expectations of work performance no longer mattered. There was no evaluation. People could work at their own pace and working together was the focus. Yet, now the Haven tries to provide both a more affirming place to work and prepare individuals for workplace entry or re-entry. Or does it?

Though staff cited resident struggles with maintaining employment as a primary reason that residents come to the Haven for services, I did not often hear residents tell me they came to the Haven specifically to learn job skills. Residents shared with me about their ongoing psychological struggles (i.e. psychosis, drug use, depression, trauma) and sometimes they did mention that they wanted a program that integrated movement, physical activity and immersion in the outdoors, with therapy.[6] However, they rarely, if ever, mentioned wanting a work program specifically for work skills.[7] Whether or not this was the resident's presenting concern, I also, at times, grew frustrated with the Haven's focus on soft skills, feeling that this focus was not enough for many of the residents. Elias also seemed to share this view:

> We have to feed the animals…[that] is something that can get someone out of a funk. Like if they're not going to get out of bed, okay, they'll do it if like they feel like the animals' lives are in our hands. But I don't think we have a lot of those people. I think we have a lot of people who, based on the world we live in, feel really disconnected and isolated from others. And that's probably a big source of where their addiction started. (Name of resident) is like, he's like, he lost his mother when he was [a young child][8]and he's like, got huge complicated grief

[6] Consider this resident's rationale for seeking out the Haven: "I'd wanted to find to something where I was getting active and being outdoors and something different than your traditional program where you are kind of in groups, for 12 hours a day, seven days a week. Something a little different than that."
[7] In a focus group with five residents, three residents shared that if the farm only offered a work program, they would not want to pursue treatment at the Haven.
[8] Specific age is omitted to protect confidentiality.

about it. He's never talked about it. He doesn't like dealing with any sad emotions now. Like ever since then he hasn't been like…. it's just like such an obvious, like crux of the issue for him. And I just feel like it's, it's not acknowledged like, 'oh, right, his mother died, but that's a part of his history,' but it's not like he has any emotional life about it. I think he's afraid of connecting with people because he's lost someone really important to him and he's not going to connect with people because it's really scary, and until we kind of recognize how scary that is for him, he's not going to be a part of the community.

Elias says that the Haven doesn't have many residents who mainly need help getting up and being productive with their day. He emphasizes the psychological and traumatic experiences of residents, and how those experiences likely contributed to their disengagement in the community, given how hard attachment and connection are for someone after having experienced a significant loss. For Elias, addressing these experiences is primary for the resident, not keeping him busy with work.

I was also struck by the depth to which residents seemed hungry to share with one another. Halfway through my observation period, the Haven began offering more therapy groups on site. One group was a substance use support group. Though the group was largely focused on skills, one day in group, the typical quick check-in turned into almost 45 minutes of residents sharing and discussing their substance use experiences with one another. I remember feeling moved by the depth of their sharing and how well residents related to one another. Given the lack of groups in my first couple of months on site, I realized it had been two months and this was the first time I heard residents openly and so vulnerably sharing with one another about their experiences and struggles. I left that

meeting feeling their hunger for connection, and awe at the discussion that had just transpired.

This hunger was especially clear during a focus group I led with five residents, where they discussed their desire for an interpersonal process group, rather than more coping skills groups:

> Mary: I feel like there should be a group therapy because right now the only one that has anything like that is skills and even that's like...I like it, but at the same time it's like they're focusing on the wrong aspects. I feel like they're….
>
> Amanda: They're talking about terminology and....It's just like more ways to describe your feelings. *It's not like actually what you're feeling.* It's just like, 'This is the biosocial theory and lalalala'. I mean like it's interesting stuff. Okay. It's interesting but it's not like….. it doesn't help us like....
>
> Sam: *Get to the core.*
>
> Amanda: *Yeah, get to the core.*
>
> Mary: Having a name for something that's wrong with you can be empowering, but at the same time, yeah, there's no.... like these are groups based on specific issues rather than just a general group to sort of continue therapy. (emphasis added)

Residents appeared to long for experiences of deep connection with one another. In light of what Elias said, I suspected many residents were experiencing difficulties related to challenges in relationships that exacerbated, or sometimes were the source, of their challenges with employment or schooling. What if the work program shifted the focus on how to support residents, with specific grounding in a developmental and psychological framework, via the

work program? What if the work program, maintaining its orientation in providing a more affirming place to work, also incorporated a more explicit skills focus, beginning each crew, if necessary, with a lesson on the day's particular task. Work program leaders could emphasize a particular gardening, farming, or carpentry technique, teach residents how to use tools correctly and effectively, in addition to grounding the work task within the wider framework of community, and the task's benefits to the resident, with particular attention to the effects of working in nature.[9] In the next section I provide an overview of how the self-determination needs of autonomy, competence, and relatedness could be emphasized and built upon in the work program.[10]

Autonomy

Autonomy refers to having choice and willingness. In applying Gagѐne and Deci's (2005) Self-Determination Theory, the work program, (as I observed it) seemed to operate most often from a controlled motivation perspective. Controlled motivation involves an external force, such as a work crew leader telling you to complete a task, because they are your superior and therefore you must do as they say. Autonomous motivation involves your own intrinsic and willful engagement in a task. Although residents did choose their crews, the tasks were selected and planned for them, often without much resident input. As Fromm (1955) writes of the industrial worker, "He is put in a certain place, has to carry out a certain task, but does not participate in the organization or management of the work" (p. 180). Without an active

[9] There is abundant evidence noting the positive effects of nature on physical and mental health. For a good review of this literature see: Bratman, et al. (2019). Moreover, such effects are not limited to being in nature, but also simply having access to a view of natural scenery: Frumkin, H. (2001); Ulrich, R. S. (1984).

[10] One challenge the work program faces is with respect to the varying needs of the residents. Several staff members commented that each resident may be at a different level of motivation and skill. So how do you make the work engaging for all residents, but not too fast-paced, either? This challenge is beyond the scope of this dissertation, but does suggest there may be some merit in considering a Phase program as Craig discussed to address how crews can be structured.

involvement in the planning and processing of the work, and without other forums for resident voices to be prioritized, how could residents meaningfully engage with labor they had little decision-making power over?

Existentially meaningful work involves a sense of purpose with respect to one's work, and it is this lack of purpose that likely creates much of the disengagement on work program. Citing the experiments of Elton Mayo at the Chicago Hawthorne Works of the Western Electric Company, Fromm (1995) notes that workers engaged with their work and the experiment, "because they knew what they were doing, they had an aim and purpose, and they could influence the whole procedure by their suggestions," (p. 304). Though staff talk about this aspect of work program, where residents are involved in problem solving and are truly engaged and invested in the work projects, I didn't observe these situations very often. More often, residents carried out the work of the crew with little input. I also rarely saw residents offer suggestions about the crew projects.

My experience on crew was that the experts planned the tasks, and the crew members mainly carried out their tasks with little contribution to the planning.[11] Given that residents also lacked an outlet to voice their own opinions, suggestions, and questions, (i.e. lack of community meetings where resident voices were prioritized) it seemed rather that residents were more often treated as passive participants in the community. Work program likely operated from the same perspective. As residents did not feel a sense of community or a larger purpose to the work, they naturally began asking, "Why am I paying to work, when I could be paid to be working?" Such

[11] Certainly, this wasn't the case all the time and wasn't always consistent amongst crews. I did hear stories from crew leaders about how residents had played primary roles in problem-solving in crew; however, I did not witness this happen very often. The majority of my observations included watching work program leaders take the reins, while residents followed in terms of planning. However, I also could not be on all crews at one time and certainly missed instances where these very things were happening.

questions highlight an experienced meaninglessness with respect to the work. Residents seldom had a sense of completing work for a larger purpose, or that they were members of a community for whom the work was necessary and beneficial. To alter this experience, residents must experience a stronger sense of autonomy and investment in the work.

To shift the motivational frame from controlled to autonomous, residents could be asked about their goals for the work program during a first team meeting. Team members could also help residents identify how aspects of their presenting concerns could be addressed or challenged on work program. Residents may also benefit from various career inventories, particularly if employment and work is a salient concern. Such inventories, like the Meyers-Briggs Typology Indicator, could be administered during intake to help generate conversation and understanding around how a resident may present in the community and in work program. Additionally, a values inventory drawing from Acceptance and Commitment Therapy, may help a resident identify which of their values map onto particular aspects of the work program, to promote a better understanding of themselves and their growing sense of self and identity. If adding such assessments to the intake seems arduous and time consuming, perhaps the resident's initial orientation and intake period should take longer. The time invested in getting to know the resident and their goals is crucial to cultivating a sense of autonomy and making their stay worthwhile.

Teams can also spend time getting to know the type of work a resident enjoys. What skills are they bringing with them? Is there a particular crew they seem excited by? What are their fears or worries about a work-based program? Are there particular skills they would like to learn, such as gardening skills or specific construction skills? Even residents who struggle to maintain employment, may already have work skills, or work they enjoy doing. Seth is a good

example of a resident who loved working and had a considerable amount knowledge of machinery. However, his challenges with organization and communication made maintaining a job difficult. How can staff build upon his excitement and areas of passion? Seth liked building and tearing down machinery. Is there a context where he could apply such knowledge and gain growth and development in his skill area?[12]

Perhaps most importantly, the work program needs to better involve residents in the decision-making and crew planning process with respect to work program.[13] Referring back to an earlier quote from Fromm (1955), workers involved in the Mayo experiments, "knew what they were doing, they had an aim and purpose, and they could influence the whole procedure by their suggestions" (p. 304). How powerful for a resident to experience a sense of being able to influence crew via their own suggestions and ideas. As Fromm (1955) writes, "The worker can become an active, interested and responsible participant only if he can have influence on the decisions which bear upon his individual work situation and the whole enterprise" (p. 322). During crew planning, crew leaders should ask residents to take the lead more often. What are the resident's ideas about how to complete a task? What are the projects they feel the Haven needs to focus on? Are there particular tasks or projects the resident is excited or passionate about? Naturally, this level of engagement with residents can only take place once the resident has had an introduction to all crews and has an inkling of how the Haven functions and what their treatment will look like. However, more engagement and involvement of residents in crew

[12] Although I believe staff at the Haven were already integrating some of these suggestions, my recommendation is to make such questions and activities more intentional. Perhaps rearranging the focus of the intake process, with specific emphasis on the above questions, in addition to the necessary clinical questions asked during an intake. Moreover, there has to be more dialogue between work program and clinical program to make such intentional changes and in best serving resident needs.

[13] Carpentry crew seemed to do this fairly well, in that, residents developed a particular skill set and continued building upon those skills during their time on crew. Colin as a leader also seemed to take intentional time to get to know the residents and attempted to tailor projects to meet their interests, as much as was possible.

planning and project process will also help residents feel more like meaningful agents in the community, in addition to teaching them that they are capable and able to contribute, whether they come with farming skills or not.

Competence

A work-based therapy program is ideal for creating opportunities to foster experiences of competence and mastery. As residents practice certain tasks over and over again they can gain a sense of mastery with a particular task, such as learning the routine and needs of each farm animal as residents complete farm chores. Though there are currently opportunities to experience growth in competence at the Haven, with a more intentional focus on fostering competence and teaching skills, the work program can greatly improve. The work program has all the tools necessary, what seems to need shifting is the orientation to the work program. Rather than focusing on "doing the work to get it done," if the Haven reorients the work program towards a mission of "what are the residents learning today? What skills are we teaching them today? How can I help support this resident in their goal of learning X?" I believe the farm will experience a shift in how the residents relate to the work program, as well as in resident outcomes.

At the time of my project I mistakenly conflated skills-based learning with vocational training. The Haven may want to consider a more vocational focus if it aligns with a resident's goals or needs (i.e. "I would like to be trained as a farmer") but becoming more explicitly and intentionally focused on teaching skills will not detract from the current work program. Work program could begin each crew with a lesson on a particular tool, animal care issue, or harvesting and planting, and ask residents about their experiences with the tool or task at hand, (e.g. do any residents have experience in this particular area, if not, do you have specific

questions about the task or tool)? At the end of the work period, the crew could come together to reflect on the work they did. What was it like to build a fence together? What was it like to saw the boards for the tool shed? What did residents notice while engaging with the task? What they did feel or think as they completed the task? Are there specific technical questions about the task or about farm work in general? Such reflection communicates the value that is placed on work and on increasing self-awareness by asking residents to be mindful of the work, both as they do it and afterwards. Discussion also conveys concern about the resident's experience, as well as an investment in their work experience. Such discussion redirects the focus to the community and can also help residents begin to better see the role and significance of communal farm work.[14]

In preparing for my research at the Haven, I anticipated learning particular skills related to gardening, and how to use particular tools. Here, I describe how my own expectations colored my experience of the work program. This next section provides insight into how my own feelings of "incompetence" manifested behaviorally, and how my own psychological material was evoked by the work program.

Work Skills: How the Milieu Evokes the Psychological, a Personal Experience

Knowing that the majority of residents at the Haven had little or no experiences with farm work, I assumed the Haven would impart basic skills in farming, gardening, and construction, and looked forward to learning them. My father has worked as a farmer, mechanic, and logger throughout my life. Manual labor is my family history. Yet, it was not the type of labor I grew up doing with my family. Moreover, Haven staff appeared to assume that we already had the skills necessary for the tasks, and I was not prepared for the intense shame that

[14] As discussed with my dissertation director Daniel Burston, Ph.D., for residents to experience a lasting impact associated with these recommendations, a longer stay is necessary. However, this likely requires a decrease in tuition to allow residents to stay for longer periods, as well as a desire on part of the resident to stay longer.

ensued.

My experiences mirrored those of the residents at the Haven. I arrived at the Haven with limited experience with farm labor. Before I was born, my mother began reading to me, and after I was born she would say to me, "I want a different life for you. I want you to go to college and not have to struggle in the same ways your father and I have." This narrative seems typical for working class families who want their children to pursue education in hopes they can build a life not borne of such back-breaking labor and financial instability. Regardless, I grew up connected to this history and with appreciation for manual labor. When I arrived at the farm, however, I was unprepared for how quickly a sense of shame and feelings of incompetence would arise as I began to try this work with no instruction.

During my first week-long visit in May 2018, I remember several instances where I began to feel ridiculous on crew. One day I joined the gardens crew and was handed a garden hoe and pointed in the direction of the beds that needed hoeing. Admittedly, as someone who is easily prone to feeling shame, I already felt silly realizing I didn't have the slightest idea about the appropriate way to use this tool. Nevertheless, I walked to the garden bed with a resident and house advisor and uncomfortably began to work, feeling totally lost. As we began work in the garden, I felt ashamed in several ways: 1) I felt I fit the stereotype of the city person who comes to the farm with her "degrees" and "book smarts," but no ability or skills related to manual labor. 2) Given my family history, I felt ashamed at not having any of these skills or awareness of how to complete these tasks, which also brought up anger towards my family. I found myself wondering, "Why didn't my mother bring me into the garden to work with her?" My mother kept a garden at our house and I remember watching her work as I played outside. But I have no memory of her bringing me into the garden and teaching me about her planting. Instead my

experience was more like parallel play; my mother worked in the garden and I played in the yard separate from her. Although I have memories of my father constructing buildings and sheds or us hanging out in his garage while he worked on cars, I have no memories of helping him with the work. My memories of childhood are of being an observer of my parents' work, but not an active participant.

Throughout my time at the Haven I heard some residents referred to as lazy, or as documented in one crew note, "Resident doesn't work as hard as others." In reviewing intake paperwork, I was struck by a note that read, "It might be hard for someone so intellectually minded to find meaning in the physical work of the farm." I wondered out loud, "are physical work and intellectual-mindedness mutually exclusive?" Naturally, this note pulled at those familiar feelings of personal shame as well. Was I too intellectually minded to appreciate the physical labor at the farm? As I reflected on these evaluative comments, I remembered how excited I was for the physical labor aspect of the Haven. I was excited by the integration of psychotherapy with manual labor as a means to offer more holistic and dynamic healing. Though when I arrived and was handed tools without any explanation of how to use them, I became self-critical, felt ashamed of my lack of knowledge and skill, and began feeling disengaged with the work program, in part because it elicited self-loathing feelings.

How did those feelings manifest behaviorally? I felt frustrated and disengaged. I found myself more interested in conducting interviews and completing observations, rather than being on crew. As I read these charts, I began to wonder what my work crew evaluation notes may look like, and I thought, "I'd probably be called lazy too." Perhaps the disengagement I observed among crew members was not due simply to a lack of interest in the work, but to a lack of skill that evoked similar feelings of frustration and shame, which led to the disengagement.

This personal experience is one example of how being thrust into a new milieu evokes one's struggles, insecurities, and psychological material. If I was experiencing such intense reactions to the work program, I believe residents were having strong internal reactions as well. How might the Haven in general create the space to allow such material to be expressed, explored, and worked with in the context of the resident's goals and concerns bringing them to the Haven in the first place? As described by Tonya, a Haven therapist,

> It's not just about accomplishing the task, it's about fostering opportunities for connection and conversation, for insight and growth for people. *People's stuff comes up in the course of living daily life,* which I find is so much more effective than trying to address, you know, someone says, 'I have a problem with this' and trying to address it, you know, just in a conversation in here [in the office] when we're talking about it theoretically, *it's so much more helpful when it comes up right in the moment.* And so, work program provides opportunities for people's stuff to show up in the moment. Whether that's…you know… what are people's patterns for approaching challenge, problem solving and addressing conflict. (emphasis added)

My personal experience above highlights how my own history surfaced as a result of experiences on work program. Intense feelings provide the material for potentially rich therapeutic work, and I believe that if they were thoughtfully co-ordinated, the work and clinical programming could bring out these rich moments to foster greater self-awareness and transformative change. Though I could certainly *talk about* shame in my own personal therapy, being able to address it in the moment, and have the corrective experience of learning how to complete a task correctly, has the potential for significant growth and healing.

Teaching Skills

Should it come to pass, the Haven's reorientation to teaching skills could help residents achieve a sense of mastery, as well as provide opportunities to explore aspects of residents' identity related to work experientially, instead of only speaking *about this* in therapy. The work program provides amazing opportunities for residents to get on-the-ground working and learning skills. And if these skills are not immediately applicable (i.e. hard skills associated with measurement, sawing, use of tools) to jobs beyond the Haven, they can use them in their personal lives (i.e. perhaps a hobby or being able to do work around their homes), in addition to applying the soft skills also developed in work program.

Each crew could teach the fundamental skills associated with their area of expertise and see that residents learn these fundamental skills in their three to six months stay.[15] In that time period, residents may also take on the role of teaching new residents the work skills. This allows a resident who has acquired the skills, and perhaps expressed an interest in that crew, to then teach another resident. Here the resident's newfound sense of mastery enables them to take on the role of mentor, teaching another resident the very skills they learned in their early days at the Haven. Or if a resident already comes to the Haven with skills applicable to a certain crew, perhaps this resident could take on more of a leadership role in teaching or conducting projects. The Haven can reinforce a more equitable power dynamic when residents are also teachers, and the work crew no longer consists of residents doing the work directed largely by a crew leader. Helping residents take on more leadership roles that emphasize their ability to contribute to the community via teaching, also provides good role models to those with fewer skills and strengthens the communal aspect of the Haven.

[15] Though a longer stay is ideal for such experiences to have lasting impact.

Moreover, as Craig mentioned in his earlier comments, a phase program could differentiate between residents who are newer to the Haven and those who have been there for a couple of months or longer. A phase program may help the Haven restructure the work program where Phase One is more concretely focused on learning basic technical skills associated with all crews and helping residents determine goals and areas of interest for the work program. Phase Two may be where residents pick a crew where they want to focus and acquire more specific skills or practice some of the basic skills they learned in Phase One. Perhaps in Phase Two, residents could potentially commit to a crew for a longer period of time, to get more specialized experience on that crew. Phase Three may allow residents to take on more of a leadership role on a crew where the resident has devoted their time. Here the resident can become the mentor who teaches the basic skills to Phase One residents.

Relatedness

Thirdly, yet perhaps most importantly, is the emphasis on relatedness as a means to cultivating an existentially meaningful experience of work. As a therapeutic community, the Haven has the tools necessary to cultivate more awareness of how individuals impact and influence a community, and how the community impacts the individual. Moreover, the Haven is potentially an ideal setting to help residents better experience their interrelatedness not only to the human world, but also the natural world, to which we are intimately bound.[16]

During my time at the Haven, I was surprised by the lack of explicit discussion and intentional celebration of our beautiful environment. Earlier I described my experience trail clearing on maintenance crew, where I was so taken and moved by the beautiful woods where we worked for the day. However, we were so completely focused on trail clearing (i.e. throwing

[16] Evidence supports that experiences in nature also provide significant improvements in mood for people experiencing depression. See: Berman et al. (2012).

large branches from the walking and biking trails) that we did not take a moment to stop and take in mindfully the sights, sounds, and feelings (i.e. there was a gentle breeze as we worked) of our time in the woods. As we worked, I felt that this immersion benefited all of us, but also that we were acting as if we were separate and shut off from the natural world. This feeling was particularly salient while "removing" branches from the path to make it safer for humans to use, but not pausing to honor the unique ecosystems around us. Similarly, we never stopped to discuss what it was like to work in the garden, to have our hands in the soil, or to reflect on how work at the Haven was so different than the work most of us did outside of it.[17]

As a doctoral student, I spent the majority of my days prior to my dissertation research indoors writing or reading. I never stopped to work in a garden, as I was solely focused on the demands of my program, my studies, and the challenges of living as a graduate student. Recognizing the benefit of nature to my own mental health, I made time for walks at a park, or studying outdoors; however, I never spent time in manual labor. My time at the Haven had a profound effect on my physical, mental, and emotional health. I felt so much better on the farm than in Pittsburgh.[18] I knew that many residents were having similar experiences, but that we did not discuss this. A couple of the therapists and several staff I spoke with mentioned the importance of nature in providing healing for residents; however, not many residents discussed nature as a therapeutic element of their experience at the Haven. My sense was that, given our society's increasing alienation from nature, the effects of immersion in nature are often just taken

[17] I provide examples of ecotherapy practices Haven staff could integrate into work and clinical programming in appendix F.

[18] Evidence supports that relocating to more rural or urban green areas results in reductions of various types of psychological distress. See: Alcock et al. (2014). Pittsburgh, as a city, has a notorious reputation for its almost constant gray skies. Therefore, I experienced the combined effects of relocating to a rural area, with better weather conditions, and I traded working at a desk on a computer for farm-work. I also traded living alone for living in community. I felt more joyful, relaxed, and healthy, despite the confusion and frustration I experienced during my research. Combining physical work, immersion in nature, and living in community, truly improved various aspects of my psychological health.

for granted, rather than thematized and valued explicitly.

Psychology as a profession has also engaged in this pattern of divorcing human experience from the natural world. Theodore Roszak (1996), a historian associated with the movement of ecopsychology, documents that the American Psychiatric Association (1994) lists 300 "mental disorders" in the fourth edition of the *Diagnostic and Statistical Manual of Mental Disorders (DSM)*; however, distress associated with nature is only captured in the diagnosis of seasonal affective disorder. He pointedly writes:

> Psychotherapists have exhaustively analyzed every form of dysfunctional family and social relations, but 'dysfunctional environmental relations' does not exist even as a concept. Since its beginning, mainstream Western psychology has limited the definition of mental health to the interpersonal context of an urban industrial society: marriage, family, work, school, community. All that lies beyond the citified psyche has seemed of no human relevance—or perhaps too frightening to think about… No separation is more pervasive in this Age of Anxiety than our disconnection from the natural world. (Roszak, 1996, p. 1)

The number of mental disorders catalogued in the current *DSM-V* (2013) has grown, still retaining this focus on what Roszak (1996) terms an "interpersonal context of an urban industrial society" (p.1). Thus, Rosak's (1996) words, though written more than two decades ago, are still extremely relevant. We see the relevance of Rosak's (1996) writing in our current and worsening climate crisis, and in the proportion of adults in America who continue to report climate change as a growing source of stress in their lives (APA, 2019). Our alienation from nature has risen to catastrophic proportions, and despite growth in the ecological and ecopsychology movements, psychology still too often neglects an integration of the more than

human world in our work as therapists. Even in a beautiful natural setting like the Haven, where working in nature is a significant portion of resident experience, the explicit discussion and awareness of the impact of this immersion in nature was not cultivated.

In writing about relatedness as an existential, universal human need, Fromm (1955) writes, "Man is torn away from the primary relation with nature" (p. 30) as an effect of the person's birth. In the *Art of Loving,* Fromm (1956) emphasizes that the more one "separates from the natural world, the more intense becomes the need to find new ways of escaping separateness" (p. 9). Today we too often escape into our technological devices as a way to cope with isolation and despair. Given how our separation from nature exacerbates and fuels feelings of isolation and loneliness, the Haven is potentially the perfect site to address concerns of isolation and separateness from a communal perspective grounded in our relationship to other human beings, and our relationship to the more than human world. Therapeutic communities like the Haven can play a pivotal role in helping residents[19] understand our total dependence and interdependence with the natural world, and to restore a sense of connection to the more than human world.

As stated earlier by Ted, the farm has ample opportunities to teach lessons about the cycle of life via working with animals. Our interconnectedness with the more than human world can be experienced and learned through the work completed by all crews at the Haven. Rather than shielding residents from becoming close to the animals, residents can more explicitly learn about food systems and make decisions about their own ethical food consumption,[20] as a result of time spent caring for the farm animals. Lessons about closeness and grief are also abundant in

[19] Especially in light of our growing attachment to, and dependence on, our technological devices, which was a concern for Haven residents.

[20] When I first visited the Haven, after being introduced to the pigs, I asked the staff member leading the tour: "Do you see residents become vegetarians during their time here?" Watching the pigs run out to greet us, I myself felt a tug at my heart, and thought, "after working with these animals, how could I watch them be killed and then eat them?" Here is another issue that came up for me while at the Haven, that I suspect also arose for some residents as well, though no residents discussed with me such thoughts or experiences.

raising and caring for animals. Residents can directly gain experience with our connectedness in nature by growing and harvesting food from the garden. Gardens crew can intentionally teach residents how to grow, harvest, and prepare food; helping residents cultivate a deeper sense of where their food comes from. Have residents raised food before? If not, what is the experience like for them? How does growing their own food impact or change their relationship to food? To nature? Carpentry crew can teach residents about how natural resources are used to create shelter and structures we design for protection and leisure. All crews can help to cultivate a sense of gratitude for nature, in being aware and thankful for what nature provides, in addition to giving back to the more than human world. How can residents pay their gratitude forward in terms of taking care of the planet? The Haven has abundant opportunities to teach lessons about the very nature we are dependent upon, and how to honor that relationship and tend lovingly to the planet that sustains us.

Consider the following comment from Charles, a 29-year-old white male resident. Charles had previous experience in a horticultural therapy program:

> Interviewer: Have you spent any time on the gardens crew here?
>
> Charles: Yeah.
>
> Interviewer: So how is that similar or different to the horticultural therapy at this other place?
>
> Charles: Um, this is more.... It's a, it's a more developed garden and so it's more a developed garden and so in that, it has more people working together on tasks… instead of having, you know, one person turn a whole bed, um, then hoe it and weed it, and all that stuff. (Name of staff member omitted) has like five people working on the same bed and you know, I, I know the point of that may be like community, some kind of

> communal working together feel, feel like system. But like that's not the, it's not the point of how the therapy with plants works. I think it's developing more of a direct relationship with them by planting them, seeing them seed from seed, to planting to growing, and then fruition and then picking them and deciding whether or not you want to eat them. I think that it could be a more personal experience for each resident here and it was for me, there.

Charles was emphasizing a need to make the experience with plants more personal. He speaks to the need to experience a sense of relatedness with plants and planting process. However, I believe the Haven can combine communal work (i.e. having multiple people working on one garden bed for the purposes of building community via connection and talk) with helping residents cultivate intentional and personal relationships with the plants. This is where a lesson on planting and some introductory psychoeducation on our embeddedness and interdependence with nature, coupled with intentional time provided for residents to have contemplative experiences with the seeds and plants, can allow for the direct relationship Charles is asking for. A portion of crew time can focus on the lesson, psychoeducation, and contemplative or reflection time, while another portion can focus on completing a task. However, in order to make this shift, the focus of work program must shift from "working to get work done," to a holistic focus on resident and farm wellness.

Reorienting to Community

In reorienting the Haven towards a more intentional focus on skills and psychological development, working within the context of the community is key. When one member does not complete the task at hand, someone else must be pick up the work, and sometimes the entire community is impacted. Similarly, the work of the farm ideally benefits the entire community;

work is necessary for the functioning of the community. By emphasizing the role and importance of the work for the benefit of the community,[21] residents may better develop a sense that the work is meaningful and necessary to others beyond themselves. Moreover, residents will truly get a sense for the idea of teamwork, and how their decisions impact other residents and community members. Learning how work contributes to, and affects, the whole community is subversive practice in an American culture that so values and prioritizes the individual over and above the collective.

[21] However, this change cannot just be a rhetorical one. The shift is not just in saying the work benefits the community, but truly engaging residents in work that is necessary for the sustenance of the community. Naturally, some tasks that may not feel meaningful will have to be completed; however, work program should see that the majority of the work is meaningful and not simply work to fill space or time with.

Chapter Five:

Becoming "Clinical"

For many years, the work program was the therapy at the Haven. Yet, as a result of the changing population and presenting concerns of residents, and cultural shifts regarding mental health awareness and the profession of psychology, the Haven's clientele wants more clinically therapeutic services. In fact, residents and several staff members expressed a strong desire for more therapy services. Now the Haven is struggling to address mounting demands for clinical services while appeasing those who worry that as the Haven becomes more "clinical," the historic emphasis on community and work will be lost.

Although it is possible to integrate more clinical services at the Haven, the fears that this change would alter the ethos of the farm also seemed reasonable, given the Haven's apparent adoption of an individualistic medical model approach to clinical work. Such a framework is often at odds with a more communal approach to healing. Given the history of therapeutic communities, I myself was surprised by the adoption of a medical model approach to resident distress. This chapter explores the shift to a more clinical orientation at the Haven, the tensions engendered by shifting from a therapeutic community grounded in communal work, to a treatment center operating from a largely medical model perspective.

Defining Clinical: A Note

While analyzing the data, I realized that I never asked participants to define what they meant by the term *clinical*. Indeed, I assumed that we understood the term in the same way. While transcribing the data I realized this was an error. In hindsight, such a question would have provided more insight into how to integrate the work and clinical programs, and possibly creating a "clinical" model that would allay some staff concerns. Unless otherwise specified, I use the term clinical to refer to services provided by a licensed or non-licensed professional

within the fields of counseling, social work, and psychology. Clinical services include individual and group psychotherapy, psychoeducation, ongoing consultations or contacts between sessions, team meetings with other staff members, and intake and assessment procedures. When I refer to therapeutic services or practices, I include these clinical offerings, in addition to peer recovery groups or meetings, mindfulness/wellness activities led by any staff member, and work program, specifically when integrating an intentional focus on resident goals, wellness, and meaningful experiences with work.

History of Clinical Services

Clinical services are a relatively new phenomenon at the Haven. From its earliest days, the Haven employed a psychiatrist for consultation purposes and medication evaluation. However, this psychiatrist adopted a humanistic approach, as Ron recounted in chapter one. He emphasized the importance of focusing on one's struggles, as well as one's strengths: "You've got to look after the health of [a person] and you've got to look after what's ailing" (Ron). The sole focus should not be on pathology. During this time, if a resident desired psychotherapy, they could see a therapist in a nearby town. Psychotherapy onsite began roughly five to six years ago. Prior to psychotherapy being introduced as an onsite option, at some point between the early days of the Haven and its current operations, a mixture of licensed and non-licensed therapists worked on site, seemingly, as crisis response counselors and intake coordinators:

> So, there were always clinicians on staff,[1] but their role was to support the teams and do the case management and.... they were. They weren't in one on ones.[2] I

[1] The claim that there were always clinicians on staff was not agreed upon across all interviews. Moreover, it was challenging to get exact dates about when and how clinical or therapy services changed or were introduced at the Haven. From the beginning, the Haven did work with a psychiatrist. At which specific point counselors or therapists began working on site to provide intakes and consultations, while residents continued to attend psychotherapy in town, remains unclear.

[2] One on ones refers to individual therapy sessions.

mean people would meet with them [residents] when they were struggling or talk things over, you know, people, residents would meet with them one on one sometimes, but it wasn't a formal thing. So, for example, on crew, if someone's struggling, having a hard time, you might bring them. They [clinicians] were always available. If you could go find them and they almost always would be able to talk to them [residents]. Now, if you go up there, all the rooms are, the doors are shut and it says, 'in session,' so they were much more able to support residents kind of in the moment, and support the teams, and support the staff too actually… so that changed probably about three or four years ago where they started meeting one on one every week with residents, as therapists. (Alice)

Alice describes clinicians who performed case management duties and were available for what many call "crisis" experiences, when a resident was having a difficult time and needed some additional support. According to Alice, these clinicians were almost always available for in-the-moment support and consultation, whereas today's Haven clinicians are in offices holding individual sessions with residents, and much less accessible.

Rhonda, another staff member, described the history of clinical services in the following way:

Interviewer: So, when you came here, what did the clinical side of things look like when you started?

Rhonda: There was no....(hesitates). I would say there was nothing. There was nothing, they had master's level unlicensed people working here. But they were more in the position of onsite emergency people, crisis people. They didn't see people in a proactive regular way. They weren't part of any teams. They weren't

part of any treatment.[3] So, all they did was, they did the intake when someone came in and then were responsible for doing the discharge planning when somebody left.

And we also had a lot of people at the time that really needed to connect with them in the role of therapist versus emergency management. And so, I did not, I came here thinking there had been a clinical director position. It turns out they really hadn't, um, and the clinicians and they were like, 'we've not had any supervision in a very long time,' not had supervision and they were just spinning and hitting their head against a brick wall because they were hired thinking they were going to be clinicians[4] and come to find out they were basically onsite crisis people, only got involved when the other staff, couldn't manage it. That was where the therapy on site started.

Rhonda shared that the farm hired a clinical director whose job was to create a new treatment model for the farm. This director advocated for onsite therapy. Rhonda also felt that on-site therapy was necessary:

Rhonda: It just made sense. Why, from a perspective of a family, would you want to send your kid someplace and then have to spend more to send them off site to get another service? Can we actually know whether it's the farm's involvement that has done anything? It could be nothing to do with the farm and everything to

[3] Here is an example of how clinical words are used with different meanings. Clearly to Rhonda, treatment means ongoing and consistent. When she says there was no "treatment," she feels that crisis management, attending to a crisis in the moment, is not treatment specifically. Whereas work program leaders or non-clinical staff may see any consultation with a clinician as "treatment."

[4] Implicit here is the idea that being a clinician means providing more than intake, discharge planning, and crisis or emergency management consultations. Here is another place where there may be a break down in language and communication between clinical and work program. Alice states that the Haven has always had "clinicians," and for Alice clinicians are responsible for case management and emergency consultations. However, Rhonda, and the clinicians to whom she refers, see the role of clinician differently.

> do with the fact somebody had a really good outside therapist and we just house them so we just, you know. But from the very beginning and even still now, um, you get mixed messages like we don't need therapists, we don't want clinical, we don't want professionals as the community, and yet when the shit hits the fan [the clinicians] are the ones they want to be there and want to fix everything and hold everything and deal with everything. So, there are mixed messages across the board.

Even today, some residents decide to receive therapy services in town either in addition to, or in lieu of, their onsite therapy. However, therapy off-site is at an additional cost. Rhonda notes that prior to the introduction of on-site individual therapy services, residents paid a tuition to the farm, and then also paid out of pocket for therapy services in town. I was unable to gather a clear answer as to what the cost of tuition was prior to residents receiving therapy onsite.

As for the history of clinical services, the farm always had a psychiatric provider for consultation and medication evaluation. Therapy was a resource residents could receive in the community, at an additional cost to their Haven tuition. However, as of a few years ago, a clinical director was hired to construct a clinical program for the Haven.

"We Want Therapy," Haven Residents and Staff of Today

> I didn't come here just for the work program. I came here because, well I came here because my parents wanted me to, and other people said it would be good for me, but I came here because I just wanted to get better, and I don't think that work…. I think work is an element, but I don't think that work should be the primary focus. (Shelly)

In my time at the Haven, this resident's perspective seemed shared by most residents and many staff. When I arrived at the Haven, I mistakenly imagined that there would be multiple therapy offerings: intensive psychotherapy three times a week, multiple group therapy offerings, mindfulness meditation practices, among others. What I did not realize was how new the clinical program was. At the time of my research, residents received at least one individual therapy appointment a week, sometimes two if the resident requested it, though twice-weekly therapy was not the norm. The only groups running at the time I began my research was an on-site AA meeting, and residents could attend other AA/NA meetings in town. There were also a few other groups residents could attend in town, such as NAMI meetings and a Hearing Voices Network meeting. Halfway through my research, the Haven changed the daily schedule in order to provide therapy groups in the mornings. Such groups were largely psychoeducational and skills based, such as the Dialectical and Behavioral Therapy skills group. After some advocating by residents, staff added an interpersonal process group in October. Residents continued to see their therapist once a week. These clinical offerings were new and many staff remained suspicious, wary, or directly opposed to a more clinical direction.

Enrique, a former resident, attended the Haven prior to its offering ongoing onsite therapy. He noted his desire for more therapy, as we discussed the changes at the Haven since his stay:

> Enrique: I just wasn't completely satisfied with just doing the work every day. I think there should have been more like therapy and counseling.
>
> Interviewer: So, they have switched to this new model where clinical happens in the morning and they're starting groups, but I've also heard it's relatively new that they've had therapists on site doing therapy.

Enrique: They absolutely did not have therapy when I was there.

Interviewer: What did you do for therapy?

Enrique: I would come into town once a week and see a therapist. I just thought coming there [to the Haven] there would be more of that, one on one.

Here, Enrique also expresses a desire for more one-on-one or individual contact with a therapist. Oliver, a current resident, responded with the following comment after I asked him to describe his experience with the work program:

Interviewer: What's your experience with the work program?

Oliver: It's pretty damn good. *There's, there's a side of me that still wants more therapy, you know, three, four days a week or maybe even checking in every day, every other day,* you know, because when I was at (location omitted) I was like, 'I'm here for healing,' you know, I should be doing therapy a lot more, you know, I, *I think we all, we need way more therapy, way more active therapy and I'd love to see a system where they sort of, you know, wean you off of it, so you've got, you know, a buddy that you just work with all day every day and then as you progressed they slowly, you know.* So yeah. (emphasis added)

When asked about the work program, Oliver states that it is "pretty damn good," and then immediately launches into a description of how he'd like more therapy. In particular, Oliver describes a desire for intensive therapy (i.e. seeing a therapist multiple times a week) and a system where residents are "weaned off" therapy, perhaps moving from three sessions a week to two, to one, and so on, as the resident experiences growth and healing.

Residents were not the only participants who expressed a desire for more clinical services

and programing. Several staff, house advisors in particular,[5] seemed keen on creating more clinical services for residents.

> Leslie: I think the world has changed and we need to provide more of what our clients want.
>
> Interviewer: Going along with what you were just talking about… Do you have recommendations for the farm as a whole?
>
> Leslie: I think that… just more clinical. I think the groups are a good idea. I think there needs to be even more of them, probably.

Jacqueline also agreed that more therapy services were needed:

> Jacqueline: I would love if like there was more therapy integrated into this, meaning like emphasis is kept on the work program, but group therapy and stuff like that, which was talked about with the new scheduling. Just more therapy. Um, yeah, I think more therapy could help the work program and the work program could help more therapy, and stuff like that. So those are my personal beliefs.
>
> Interviewer: Anything you would change, you said more therapy, just about this community in general?
>
> Jacqueline: Yeah, more therapy for sure. Group therapy. More like one on one therapist time, like the, I would have the therapists like just integrated into the community a little bit more. So, like maybe they're a little less like lagged down with paperwork and so many residents… that they could join on crew or… I dunno…. just like go on more walks with residents and just like maybe a therapist

[5] Here again, younger individuals appear the most open and excited to offer more clinical programming, a sign of changing cultural values and messages, as well as the growth of psychotherapy as a profession.

> comes up to me and is like 'Hey, will you lead this thing with me today?' And I'm like 'yeah,' just being able to think about more things and integrate themselves [clinicians] into the community than they do. Yeah. And also, that would be a great example for like, HAs to like be able to mimic their behavior and stuff, as far as like being good at talking to residents…. being good listeners and stuff. So that could be good. So yeah. So, change about the community…. more, more, more therapy.

Jacqueline, in addition to recommending more therapy for residents, cites a desire for clinicians to join work program, and for more collaboration between house advisors and clinicians. She specifically notes the value of being able to learn from and "mimic" the behavior of clinicians. Implicit in this house advisor's comments is a desire to learn and receive more training and experience in ways of responding to and supporting residents.

> Naiyah: I just think that things have changed, you know, in my idea of…. Today… there's, you have to be competitive and at 10,000 bucks a month…. You better be thrown some clinical in there. I think. That's my opinion, because today's crowd isn't looking to just come up. They're fine working on the farm, but they want, they always complain. I often hear about, 'I don't get enough therapy. I don't get enough groups,' which is why we're making the change. Yeah. And I agree 100 percent, because you got to be able to compete.

Naiyah emphasizes that to be competitive with other therapeutic communities or farm-based communities that offer clinical services, the Haven has to offer more clinical programming. This staff member's recommendation is grounded in a desire to recruit and retain residents, so the Haven can remain viable.

Rory also shared this perspective:

> Interviewer: What do you find to be therapeutic about the farm?
>
> Rory: Well, I think the work program certainly does help get people in the habit of doing something healthy every day. It gets them around people, adds, socialization to their day, teaches them skills, it provides opportunities to find interests. And along the way I do think that there's naturally therapeutic conversations with staff members, and I think that the clinical side of the farm is therapeutic. I'm on the side of the fence that's pushing for more of that because we can, we can work a lot on, you know, it's somebody like (resident name omitted) who, you know, he can come in, he can work hard, and he'll do that nonstop, but that's not really, you know, he needs to work on what's underneath. He needs to work on structuring his downtime... and all of that, I think is done through therapy, like sitting down, talking therapy and yeah, I would like to see that expanded whether it's with more individual sessions or with groups or…. But for me as a resident, I did find a lot of therapeutic value in my clinician at the time, and my team meetings and dual diagnosis.

Fred, like Rory, values the work program, but also sees a need for more therapy services:

> Fred: I'd love to see more of the therapeutic side of the farm evolve. I think the work program is extremely unique, extremely important. I think it can evolve and needs to evolve for people to be ready to go back into the world.
>
> I think they're getting some of the clinical pieces from the therapists, which is so important. *It's not enough.* A lot of people that come here can't afford to see a therapist in town…. but should be seeing somebody more than once a week.

> Should be working on.... There needs, I mean… they're working on the programmatic… and the kind of treatment philosophy day of the farm in terms of how it's structured in terms of time. In my humble opinion, people need more than an hour with you (motions to interviewer). People need, an hour, probably two hours a week of some type of, um, sobriety involvement, whether it's reading a wrap book or, you know, having conversations with somebody online or having a one-on-one step meeting or reading from the big book or there's a lot of different recovery books out there that it may not work for you because you're an introvert and you've got schizophrenia, and meetings just freak you out. So how do we help Monica, who's dual diagnosed, on her addiction, to create a tool bag, you know, how do we help you find a power greater than yourself or something that you can reach to in a matter of a minute? (emphasis added[6])

This perspective, that residents should receive more time in clinical services was supported by a majority of the participants I interviewed. However, some longtime staff members, and many long-term supporters of the Haven (many whom are former residents) remained critical and concerned about integrating more onsite therapy services. These reservations appeared tied to a fondness for the earlier days of the Haven, where working in community sufficed in helping someone work through their difficulties, in addition to concern about how a clinical program could fundamentally alter the very nature and ethos of the Haven. As the Haven has begun this transition, changes have occurred that seem to have shifted fundamental and primary aspects of the Haven.

[6] Even the evidenced-based approaches of Cognitive Processing Therapy and Prolonged Exposure therapy for trauma recommend twice weekly sessions for clients, especially when working with "comorbid" trauma and substance use (Projansky, 2020).

Concerns about "Becoming Clinical"

A main area of concern regarding clinical programming seemed tied to former residents' memories of their positive experiences at the Haven. A common response I heard when discussing the Haven's attempts to implement more clinical offerings was a resistance from leadership and community partners, particularly individuals who had experienced the Haven as a resident years ago. The attitude seemed to be: if the Haven worked for them, then it should work just as well for current residents. Ted, describes how some individuals seem tethered to their past experience of the Haven:

> You know, there's so much history attached to the farm that it's almost, it almost keeps people stuck because especially… they know what they know from when they were here and that's how we [are] still appraised today. And so, it's, it's really hard for them to wrap their heads around, 'we need to do something different to meet the needs of today's consumers.'
>
> And you know what I hear consistently… their reflection and their nostalgia tells them that the farm was such a lovely, warm, fuzzy, loving place and it was community that did all healing. And I'm like, 'well that may well have been then.' …. I don't know, we seem to be stuck in the past and people's nostalgia, their nostalgic memories or their memories tell them that it was fantastic and wonderful. And um, it was the community that did all the loving and healing of people and we didn't need anything other than that.
>
> So, I wasn't here, so I can't say whether outcomes were different then, better then. Um, but it really does feel like people carry around their own warm fuzzies of the time that they spent here and want it to be that way for people without

recognizing that it's a really different world now. People come with different issues.

Ted further commented that "We are becoming a dinosaur if we're not careful, because it keeps us stuck in the dark ages." Ted felt strongly that not integrating more clinical programming would make the Haven less competitive as a treatment option, while not directly addressing resident requests for more therapy. The struggle to let go of the past was a common response from staff who were supportive of the Haven's transition in becoming more therapy focused:

> Naiyah: I know that there's a lot of people that have struggled with letting go of the old ways and I don't ever think the work program should be taken away, but I know the clinical piece is really important too. And so, I like the way they're looking at this new schedule where they're gonna make part of the day, the clinical piece, part of the day, the work program. And I think that's going to be nice, because the work program is very important.

Craig echoed this sentiment:

> Craig: One of the big pieces I see of struggle for the farm is the financial, and there's been this old school and new school of staff and the old school has had a real hard time of letting go of the wonder of the farm 20 years ago… of being a very tight knit community or family.

Fred also spoke to this sense of being stuck in the past:

> Fred: They [former staff] have fond memories of the way it was 20 years ago. We're not there. We're not in [date omitted] anymore.

These staff members emphasized that despite what the Haven may have provided several years ago, today's residents need something more than working on the farm. Here again, I wonder if

re-orienting the work program towards a more explicit focus on psychological development and work skills, could mitigate some of this tension. Especially considering that another strong reservation to integrating more clinical programming was that the work program would become "swallowed up" by clinical.

The former clinical director shared the following experience with me:

> I know the board when they said no, they didn't want me to be the director of therapeutic programming because that was another version… iteration of putting me in charge of everything. They were like, 'no, we don't like a professional licensed clinical person taking over because crews just going to get swallowed up there and disappear.' So, there is this fear of changing crew. Losing crew.

When discussing a desire for more clinical services, or changes happening at the Haven, many staff prefaced their statements by emphasizing the importance of the work program, saying that the work program should never go away. Such comments communicated an implicit concern that by agreeing that more clinical services are needed, they did not also support the work program. Thus, participants often included praise for the work program or emphasized how they didn't want to see it disappear. Though the work program hours may be reduced by adding more clinical programming, I did not observe or hear of any intentions to completely end the work program. Most participants praised several aspects of the work program.[7] However, this fear endured.

Some fear of clinical oversight of the Haven seemed grounded in the conviction that a

[7] As advocated in this dissertation, the majority of criticisms of the work program seemed to revolve around whether the work was meaningful or had purpose beyond completing the task. Criticisms never included a desire to end the work program, merely to alter its focus.

clinical approach was antithetical to community-based healing. When asking Dean to describe what therapeutic community meant to him, he described these concerns eloquently:

> Interviewer: And what does therapeutic community mean to you?
>
> Dean: It means that… well I *choose to say therapeutic community as opposed to community style treatment center. In community style treatment center, the treatment center is the noun* and. Well, no, I guess.... *I guess I want the community to be the noun and describing it as therapeutic as opposed to the treatment center being the noun and community sort of describing...* It's probably not true anymore and it's probably a source of a lot of tension. I think there, those of us...I'm getting deep... all the way. There are those of us... usually people who've been here longer who see it as a community *where being in community is therapeutic, and it provides the background for people to grow and make choices and take risks and make mistakes and learn from them and do all that in relation with other people.*
>
> Whereas *a treatment center* focusing....*is like a place that has a program and people are treated* in like… I know that's not really the reality, like it's more dynamic than that, but *it kind of sets up like 'we provide treatment' as opposed to like a place where people are experiencing things for themselves* and I don't see that... *there is a place for more traditional therapy stuff to happen within that. But I don't see that as being at the heart.* But I think I'm in the growing minority there, and it's causing a lot of like soul searching in me, because it's not like if I left here, I'd go to like work at a rehab or…. I'm here because um...the community part and the fact that we're people working with people with mental illnesses is

> obviously really important. But it's not, it's not like…. I find it interesting and engaging and um, yeah, *but it's not like I want to 'treat them' in some way so they get better. I want them to grow themselves.*

Dean describes a desire for community to be the healing agent. For Dean, community provides opportunities for residents to grow and learn about themselves in collaboration with one another, where residents are truly the ones responsible for their own healing and recovery. Whereas, a treatment center shifts the focus to "treating" residents, where residents are the passive recipients of "treatment" from a qualified professional. Dean wants residents to "experience things for themselves," to be active in their time at the Haven. Dean speaks to wanting to see residents not as patients in need of treatment, but as agentic members of a community, who can learn and grow together. Dean's comments clearly parallel the aims and principles of therapeutic communities, where community is theorized as the healing agent (Kennard, 1983; Mosher, Hendrix, & Fort, 2004). For Dean, the therapeutic community is the "heart" of the Haven and by becoming more "treatment oriented," the Haven will lose this community emphasis.

Hearing and reading Dean's words, I am flooded with thoughts and feelings. I feel a similar yearning for therapeutic communities where resident-led healing and community is emphasized. Providing clinical services does not have to be incompatible with community-centered healing; particularly, if the clinical program is guided by an existential-humanistic orientation. During my time at the Haven, I felt I was witnessing how the medical model framework was eroding the sense of community. Though I appreciated Dean's comments, I wondered why community meetings had ceased years ago, even before clinical programming became part of the Haven. If the Haven staff believed that being-in-community is the healing

agent, why were residents deprived of spaces where they could actively[8] express their voices in the community? This question is important because regular community meetings are a staple of therapeutic communities (Kennard, 1983), and an intentional focus on building community seems absent from parts of the work program. Regardless of whether the Haven shifts towards or away from a clinical orientation, more intentional focus on community is necessary.

Given my education in psychology as a human science and view of therapeutic communities as humanistic alternatives to hospital-based treatment, when participants discussed fears of "clinical"[9] reducing resident agency or a sense of community, I wondered why clinical work and community felt so opposed.[10] As I spent more time on site, I gathered that the clinical programming seemed widely grounded in a medical model framework. Such a framework does place residents in the role of being a "patient" in need of "treatment," by an educated "expert." If the Haven was operating from a medical model perspective, I could see how this might *implicitly* shift the focus to clinical services "being the treatment" residents needed, to the exclusion of community and work program.

Medical Model Orientation to Clinical Care

The medical model is the dominant approach to conceptualizing and treating psychological distress in the United States. Consider this quotation from Elkins (2009):

[8] By actively I mean, why were there no spaces where residents were actively encouraged to express their voices, such as resident led community meetings.
[9] "Clinical" as a noun, was a term used to refer to clinicians and clinical programming.
[10] Though I still believe clinical services and community-centered healing are not mutually exclusive, especially if grounded in an existential- humanistic approach to clinical care, given our wider systemic context of managed care, biomedicalization (Clarke et al., 2010), and how therapeutic services are rendered and paid for, it is virtually impossible to remove ourselves from the medical model. Yet, just as I am recommending the work program reorient its focus, if clinical program can reorient its focus to a humanistic model, I believe resident agency and an emphasis on community as primary can be restored. Even while working from within a larger medical model framework in this country.

> Mainstream clinical psychology is permeated by the medical model. Terms such as *doctor, patient, symptoms, diagnosis, pathology, mental disorders,* and *treatments* are the 'language currency' of the field. Furthermore, the *Diagnostic and Statistical Manual of Mental Disorders (DSM),* published by the American Psychiatric Association (2000) is regarded as the diagnostic 'Bible' by thousands of clinical psychologists, with few seeming to question its assumptions or use. Mental illness (or mental disorder) is the accepted term among mainstream clinical psychologists for numerous behaviors and subjective experiences that are problematic or that do not fit the cultural norm. Across America, in hospitals, clinics, and community mental health centers, doctors (i.e., psychologists and psychiatrists) 'diagnose' the 'pathology' of 'patients' on the basis of 'symptoms' and administer 'treatments' in an effort to 'cure' 'mental disorders.' *Empirically supported treatments and evidence-based practice* (terms suggesting a marriage of science and medicine) are the latest watchwords in the long history of the medical model in psychotherapy that stretches from Freud to the present day. (p. 70, emphasis appears in the original text)

The history of this approach has recently been shaped by the desire for psychotherapy to appear scientifically respectable, and the discovery of symptom reduction produced by various pharmacological agents on psychological distress. Elkins (2009) traces the medical model's history back to Freud and his desire for psychoanalysis to be seen as a legitimate science. Deacon (2013) notes that the medical model gained ideological power once antibiotics were discovered to cure general paresis (p. 848), and that medical procedures for "mental disorders" and psychopharmacology blossomed soon after:

> The discovery that general paresis was caused by a bacterial microorganism and could be cured with penicillin reinforced the view that biological causes and cures might be discovered for other mental disorders. The rapid and enthusiastic adoption of electroconvulsive therapy (ECT), lobotomy, and insulin coma therapy in the 1930s and 1940s encouraged hopes that mental disorders could be cured with somatic therapies. Psychiatry's psychopharmacological revolution began in the 1950s, a decade that witnessed the serendipitous discovery of compounds that reduced the symptoms of psychosis, depression, mania, anxiety, and hyperactivity. Chemical imbalance theories of mental disorder soon followed providing the scientific basis for psychiatric medications as possessing magic bullet qualities by targeting the presumed pathophysiology of mental disorder. (p. 848)

The medical model approach gained enormous traction after publication of the *DSM-III* in 1980. Previously, psychological distress was described mainly in terms of psychoanalytic ideas about personality structure and conflicts. Due to psychiatry's growing discontent with psychoanalytic theories, and the desire to reclaim psychiatry as a scientific discipline, Dr. Robert Spitzer, who chaired the committee that revised the *DSM-III*, structured the current diagnostic classification system that informs training and practice in counseling, psychology, and social work. Hailed by many biologically oriented psychiatrists as a hero (Lieberman & First, 2016), Spitzer's classification system dramatically changed the understanding of psychological distress:

> With biopsychiatry's 'diseases of the brain' displacing psychosocial notions of unconscious conflict or environmental stress, the shifting language of psychiatric diagnosis both expresses and makes possible fundamental transformations in

> psychiatric practice… The new language of the *DSM-III* lays the epistemic groundwork for a brain-focused, biologically based etiology of mental disorder and its contemporary corollary—pharmaceutically based treatment techniques. (Orr, 2010, p. 364)

This symptom-based classification system transformed human suffering into diagnosable disorders via a checklist. Moreover, it further cemented a power dynamic between the therapist and patient. So, what does this look like in practice?

Bohart and Tallman (1999) define the medical model approach to psychology as the following:

> In the medical model, the therapist is analogous to a physician. He or she is the expert on the nature of the client's problems and on how to remediate those problems. He or she forms a diagnosis of the client and then prescribes treatment. Treatment consists of applying interventions appropriate to that diagnosis. These interventions cause change in the client, thereby alleviating the symptom. (p. 5)

From a medical model perspective, a patient presents with a problem, identified by certain symptoms, which are then diagnosed as a disorder (if meeting the necessary criteria in the *DSM*) and a treatment plan is crafted to directly target those symptoms, with hopes of reducing or alleviating the symptoms altogether. Psychological distress is likened to physical disease and is treated as such.[11]

Despite its dominance, various critiques have been made against the application of this model to psychotherapy. First and foremost is the criticism that a medical model used to treat

[11] Regardless of attempts to reorient psychiatry and psychology towards psychosocial contributors to psychological distress via a biopsychosocial model (Engel, 1977), the focus on the biological basis of distress has remained dominant (Miller, 2015).

physical illness and disease simply does not map well onto psychological suffering. Psychological distress is different from physical illness. As Elkins (2009) writes,

> For example, much of what was called 'mental illness' was not the same as physical illness. For one thing, patients got better by talking about their 'mental illness,' whereas talking about one's physical illness had no significant effect. Furthermore, 'mental illness,' it seemed, was caused by personal and interpersonal difficulties, not by pathogens or physiochemical processes, as was true for physical illness. (p. 68)[12]

Deacon (2013) further elaborates how the assumptions of the medical model are not consistent with research evidence:

> Mental disorders are brain diseases caused by neurotransmitter dysregulation, genetic anomalies, and defects in brain structure and function. *Yet, scientists have not identified a biological cause of, or even a reliable biomarker for, any mental disorder.* Psychotropic medications work by correcting the neurotransmitter imbalances that cause mental disorders. *However, there is no credible evidence that mental disorders are caused by chemical imbalances, or that medicines work by correcting such imbalances.* Advances in neuroscience have ushered in an era of safer and more effective pharmacological treatments. *Conversely, modern psychiatric drugs are generally no more safe or effective than those discovered by accident a half-century ago.* Biological psychiatry has made great progress in reducing the societal burden of mental disorder. *However, mental disorders have*

[12] Elkins (2009) notes the differences between these difficulties and disorders with a genetic cause also listed in the *DSM,* such as Downs syndrome and Alzheimer's. Elkins (2009) states that this inclusion makes the manual even more confusing, and too easily suggests that all suffering is based at a genetic or psychochemical level.

> *become more chronic and severe, and the number of individuals disabled by their symptoms has steadily risen in recent decades.* Educating the public that mental disorders are biologically-based medical diseases reduces stigma. *But despite the public's increasing endorsement of biological causes and treatments, stigma has not improved and shows signs of worsening.* Increased investment in neuroscience research will lead to diagnostic biological tests and curative pharmacological treatments. *The pharmaceutical industry has dramatically scaled back efforts to develop new psychiatric drugs due to the lack of promising molecular targets for mental disorders and the frequent failure of new compounds to demonstrate superiority to placebo.* Such is the perplexing state of mental healthcare in the United States. (p. 847, emphasis appears in the original text)

As Deacon (2013) writes, despite evidence of its potential downsides, the medical model remains the dominant approach to conceptualizing and treating psychological distress.

Experiences of Medical Model Framework at the Haven

"I totally think that I could still do therapy with people and screen them for suicide, and still treat them like they're a person." (Vance)

As I spent more time learning about the clinical programming at the Haven, I was surprised by how often residents were discussed from a medical model perspective.[13] An example of how residents were often viewed from a medical model perspective is elucidated in the following excerpt from an interview with a staff member:

[13] I want to be clear that I am not placing blame on the clinicians for discussing residents from a medical model perspective. Given the hegemony of the medical model in training programs and treatment sites, it is not surprising that this perspective was well represented at the Haven. My surprise comes from the fact that this model conflicts with many of the values of therapeutic communities (i.e. peer recovery-oriented care, reducing power dynamics between staff and residents, community as central in facilitating healing experiences, problems in relationships as likely contributors to distress) and the existential-humanistic approach that informs many therapeutic communities.

> Steven: I think it [living and working together in community] allows us to observe people better and pick up on subtle cues, because I could go to the doctor and act completely different than I do when I'm at home… And I think that's what most people do. Even with their therapist. They, if they don't fully trust their therapist and, tell them everything that's going on where *they don't see it from the right perspective because they have a mental disorder* and their having *severe paranoid schizophrenia* they don't see that the water coming out of the faucet didn't randomly just get.... Somebody poisoned it for no reason. They say that to one of us and we're like, *'oh, that's a pretty big like, um, symptom.' They wouldn't see it that way. And they might not tell their therapist or their psychiatrist that.* But when you're constantly involved in the treatment, you get to see a lot more of who a person is. (emphasis added)

Steven's description of residents, reflects a medical model framework of understanding. A resident "doesn't see it from the right perspective, because they have a mental disorder." Such a comment is in line with the medical model which proposes that psychological distress is a mental illness, rendering the ill patient "wrong" and lacking in certain skills or understanding that a healthy, expert doctor or counselor will provide for the patient. The patient cannot have insight into their suffering due to their brain disorder. Such a perspective denies the resident any autonomy or insight into their own suffering, nor does it take seriously the latent meaning in these so-called symptoms.[14]

Most often staff described residents in terms of their symptoms or diagnoses during clinical staff meetings, in addition to the various medications the resident was taking. An

[14] For an excellent discussion of these implications see: Miller (2004).

example of this occurred during a staff meeting where two residents both experiencing crises were discussed. One resident, Brandon, had recently changed their medication. This transition seemed to be rocky and the evening before the staff meeting, they had begun yelling at a house advisor and fellow residents while out on a town trip. After returning from the trip, Brandon went to the admissions director and shared that they were feeling unsafe at the farm. Part of Brandon's lived experience was hearing voices. Brandon reported that their voices were saying they were not safe at the Haven. That night, Brandon slept in a house for individuals who may need extra support through the night.[15] The next morning, Brandon still felt irritable and concerned about their safety. During the staff meeting there was discussion as to whether Brandon should go to the hospital, in addition to conversation of how the current medication change seemed to induce these behaviors. Staff discussed how Brandon needed to find the right medication for stabilization.

Next, another resident, Talia, was discussed. She had walked into morning meeting that day shouting about her struggles with substances and that she wasn't going to work program that day. Staff discussed Talia's referral to the farm as "needing to develop a work ethic," and how hard it was for Talia to show up for work. With respect to her shouting and refusing to join work program for the day, a nurse mentioned the drug cocktail that was recommended for Talia's apparent crisis: Haldol, Lorazepam, and Ativan. Conversations continued about how to help Talia be compliant with this recommendation. While discussing both residents, the ways to resolve both crises centered on medication. In a follow up meeting regarding other residents, one clinician made the following statement, which illustrates the reliance on medications as the primary tool for crisis management: "we're *feeding* him Zyprexa to help with the crisis." I was

[15] Emergency staff are available in the evenings into the early morning hours for residents who are experiencing a difficult time.

particularly taken by the term "feeding," as it seemed representative of the overall reliance on medications in addressing and understanding suffering.

In the staff meeting, there was little to no discussion of what the meaning of Brandon's voices, or Talia's words that morning, may be.[16] What, other than medication changes, might be happening in the community to contribute to these experiences? Or, what (aside from medication) may be helpful strategies to understand what is happening for both Brandon and Talia?

After clinical and work program staff ended their discussion of Talia and Brandon, Alison, a young house advisor, posed the following question: "How can we support this person aside from giving them meds?" Please note this question was posed, not by a clinician, but by a house advisor.[17]In this staff meeting, I was reminded of Ron's admiration for the young house advisors who brought with them an open-mind and curiosity, unhampered by clinical knowledge and education[18]. It was house advisors (and some non-clinical staff members) who openly questioned the focus on pathology or illness. Leslie, another house advisor, shared the following:

> I think a lot of people, a lot of residents, I've talked to, I've dealt with this a lot too. I was like… am I, how do I know I'm okay? You know, like how do I know

[16] I found the reliance on diagnostic language interesting given that the Haven does allow residents to attend a Hearing Voices Network (HVN) group. Traditional HVN groups are radically de-pathologizing and do not use medicalized or diagnostic language. Emphasis is placed on the meaning of voices and "removing" the voices (or reducing the so-called symptom) is not always a goal for a participant. HVN works to help people live with and understand their voices, rather than see them as a symptom of disorder.

[17] Medications are helpful to several individuals. My comments are not to be understood as anti-medication, but to question why medications are viewed as the primary, and oftentimes, sole treatment for individuals whether they are experiencing a crisis or not, particularly in light of research suggesting limited effectiveness of psychotropic medication, in addition to studies highlighting increased effectiveness of combined therapy and neuroleptic medication.

[18] However, some of the most open-minded house advisors during my research had previous education in social work, psychology, or counseling. They were the biggest proponents of alternative approaches.

that I'm going to be okay? Um, and also embrace like my weirdness, you know, embrace like what I'm interested in. *And I think that this place has such potential to really help people realize that and to see like everyone has gifts,* like absolutely. There, that's something I truly believe in. And *I think that sometimes we just get really hung up on what your diagnosis is and working on your diagnosis rather than like, let's unveil what your gifts are.* And that way it's not a distraction, but it's who you are… And I think here we have that potential to really focus. I think there's a nice balance between yes, medically there are things we need to address. Um, but the more we focus on like who individually we all are and what our gifts are and, and we have so much free time here that like we… like everybody here can be like practicing things, new skills, anything, or see stuff. I don't know. Um, so I maybe I'd like to see more of that. You know, as a treatment center, like focusing more on… yeah, like what your gifts are. I know people come here to find themselves, but I'm not entirely sure how often that happens.

Later in the interview she continued to say this:

Leslie: You know, and that affects… totally affects how we interact with them. If all we see of them is like, you're bipolar, you know, you're dealing with this or, and I just, *I just think that the programming is so important to be offering like opportunities for somebody to learn about themselves.* And I think that goes back to the processing, like after crew. I think we need to process, not all the time cause that would just get ridiculous and stuff, but um, it wouldn't feel as authentic. I mean by that, but right. But I just, *I would love to see this place like helping*

people to really keep practicing with their natural gifts, and to find out what they are. (emphasis added)

Leslie articulates a vision for the future Haven that is consistent with Ron's memories of the former Haven. In this vision, there is a focus on "natural gifts" and an appreciation for "my weirdness," or uniqueness. Though Leslie acknowledges it is important to integrate medical or clinical concerns into the overall picture, Leslie feels that sometimes the Haven "gets hung up on what your diagnosis is and working on your diagnosis," detracting from a holistic view of the human being and what they also bring to the Haven, aside from their "mental illness."

One staff clinician was dismayed that the Haven's approach felt more like the care typically provided in mental health institutions, than a genuine therapeutic community:

> Vance: I never wanted to be the type of therapist that sees people through the lens of their diagnosis. I don't like to pathologize people, um, so significantly and talk about them as though they aren't capable or competent on any level because like, they all have that… in that thread, even if they're going through a hard time and like really trying to acknowledge the beauty and worth of each individual that comes through… and this place has seemed like that's what we promote. Like this is the idea that we've, we, you know, post on our website and everything, but um, it doesn't translate in practice as much. Like when we're throwing, you know, all of a sudden they're like lay people, lay staff[19] and I don't use that [inaudible], but like lay staff, like we're in the field just throwing out like, 'oh, he's psychotic.' 'Oh, he's manic,' you know?

[19] Please note that both clinical and non-clinical staff used these diagnostic labels when referring to residents, though I heard the language more often in clinical meetings.

Vance: And it's like stuff like that. It's just like what are we, what are we losing in this? Like what are, you know, it's, it's important to bring clinical aspects to this. It's important that there's a really deep understanding of what people might be going through. But we don't have to, we don't have to… like, tailor people's treatments to what you would see in a psych hospital or something, and sometimes it feels like there's that expectation here. Um, and I hate that. Like that's kind of what brought me here, um, is like the clinical[20] aspect of it, but I don't, it doesn't really resonate with me that, how it's been translated, if that makes sense.

Vance advocates a different clinical approach, one that isn't as heavily focused on pathology and which reduces the person to their diagnosis. Vance continued to discuss a sense of how the values of the Haven seemed to be "getting lost."

Interviewer: Can you identify the values that you feel are getting lost?

Vance: Yeah, I mean, um, *this idea of just coming here to be, to be seen and to be yourself and then to work through your stuff from a point of acceptance and feeling as though you are making a difference in the lives of others here* as well as um, the work that you're putting into that kind of consistency.

Here, Vance describes the earlier values of the Haven, which are more aligned with a phenomenological and depth-oriented approach to clinical work, consistent with the approach emphasized by Loren Mosher at Soteria House, where "treatment" was being and living together

[20] Here too, Vance seems to share a different definition of the term clinical. Vance was drawn to the Haven for the "clinical aspect," but Vance does not enjoy the medical model framework of referring to people as a diagnosis and treating them in the way one might observe in a hospital. As he says, "I never wanted to be the type of therapist that sees people through the lens of their diagnosis."

in community with an attitude of nonjudgmental acceptance of the resident.[21] Vance's comments (and the history of therapeutic communities) suggest that a different clinical approach is possible. Additionally, Vance's comments highlight that the issue with clinical work is not simply a problem of "having clinicians" on staff, but perhaps a problem with the primary clinical framework used in conceptualizing residents. Therefore, the challenges at the Haven cannot simply be reduced to differences between clinicians and non-clinical staff. Even clinicians are expressing discontent with the current approach.[22]

Vance continued:

> I think that that's just an idea that doesn't translate anymore and I don't know if it, it would be like changing up the work program[23] and how it's, it's engaging, but there's also like this whole feel of like, I don't know, people just... Let's see our values, let me stick to the question. Um, yeah. So, and again, it's hard coming from a clinical perspective because I've been trained like here are the ethical boundaries that you adhere to and um, the thing, the reason why I was drawn to this place is to not quite be so rigid around those ethical boundaries, like the things that I don't feel are deeply useful, and yet while that seems to be something we value here in terms of not, not discrediting boundaries, but just being more,

[21] This attitude of "being-with in nonjudgmental acceptance" is characteristic of the "presence" discussed by existential-humanistic psychotherapists. This approach is discussed in the following section of this chapter.

[22] The clinicians I interviewed endorsed a humanistic approach to clinical work. Many discussed the importance of the milieu, their desire to specifically work in a milieu, and their gratitude for the healing offered by the natural environment. These attitudes are all aligned with a therapeutic community approach and existential-humanistic values. However, it is difficult to escape the dominance of the medical model given our country's collective adherence to the medical model in our current approach to mental health care. The task is to critically question the model and find ways of working within, while approaching residents form a more holistic and person-centered framework, not formulating their distress solely in a diagnostic model.

[23] Here Vance suggests changing up the work program, a comment that highlights how clinical and work program were at times at odds with one another. However, it seems both the work and clinical program could benefit from changes in their orientation and focus.

um, I keep using the word authentic, but that's just what keeps coming up. Like more authentic with individuals we're serving, that seems to be lost.

Interviewer: Can you say more about what ethical boundaries you were hoping were going to be less rigid here?

Vance: Um, yeah, kind of like, so it's still, this is still evident in the way we engage with people because we're sitting and we're eating lunch with them. Um, you know, after an intense therapy session, you're going down and "How's the soup?!"

Interviewer and Vance laugh together.

Vance: So that happens as kind of a consequence of the way we live here. But I wanted that to happen with a little bit more intention behind it… around the idea that like you can, you can go and like own your stuff in this environment and still be like a worthy human being that exists with these people that you're owning this stuff with. Like just kind of de-stigmatize it a little bit... And I know sometimes that can be difficult when you're sitting and sharing these really intensively deep things with people. But honestly, I think that that's part of what gets people so lost in so much pain anyways, when we have to hide our shame. So, I think just kind of coming to a place of like really wanting it to be really community based and then me bringing the knowledge of someone's diagnosis and the best ways to help heal that to the table.

Here too, Vance, shares a desire to see the Haven become more community based, while addressing the boundary challenges a milieu like this presents. In the psychotherapy office, and to varying extents in hospitals, interaction with the therapist is ideally limited to the therapeutic

hour. Interaction beyond this is considered a boundary crossing and is often viewed as detrimental to the therapeutic "frame" (Gabbard, 2016). However, in a milieu setting, boundary crossings are integral to the process. As noted previously, some clinicians benefit from seeing a person in action and in relation with others, as a result of milieu-based therapy. The idea is that much more material, and perhaps more authentic material, comes up as a result of engagement in the milieu. As I discussed earlier, my experiences on the work program brought up strong reactions tied to deep-rooted psychological material for myself, experiences I may not have been in touch with, otherwise.

However, the milieu does present challenges as it can be quite difficult to go from discussing difficult personal experiences in therapy, to eating lunch with your therapist. Vance seemed to feel that there is a way to humanize this process more, to de-stigmatize our vulnerability and see ourselves as all deeply vulnerable humans trying to figure out how to live. If a resident can share their pain and shame, and still feel connected, part of a larger community, perhaps this demonstrates that you are a "worthy human being that exists with these people." To experience more acceptance and belonging instead of rejection, as a resident explores their shame and vulnerability, may deepen the healing process. Vance articulates a desire for an integrated clinical approach that puts community at the center of healing.

More effects of a medical model framework

Earlier, Dean articulated concerns about the potential erosion of a sense of community as the Haven becomes more clinically oriented. Dean discussed his preference for seeing residents actively experience things for themselves, as opposed to being "treated" for a disorder. Dean emphasized wanting to see residents grow themselves with the support of the community. Dean's description emphasizes seeing residents as active participants in their healing, rather than as

passive recipients of "treatment" for a mental illness. In asking Dean what changes he had witnessed as the Haven transitioned to a treatment center, he elaborated on what seemed to be an erosion of resident agency and self-responsibility:

> Interviewer: Do you notice a difference between how things were before it was more of a treatment center, and how it is now?
>
> Dean: One of the things I notice....is a lot more rules, a lot more rules and it seems a little more rigid. And I think what used to happen, and this was hard for people and I also think it was really valuable, different people had different ways of doing things and so residents could get mixed messages and that is not the end of the world, because what you do when you hear different perspectives of things, you have to integrate them into your own vision of like what's a good way to do something.[24]
>
> Dean: So, I mean I think that was a problem, but I think it was also an opportunity for people. If we are really consistent all the time. If we're always giving the same message. People become accountable to the rule and not to the judgment around what… So, we have so many rules now. I mean that is one thing I see, *and I see people interact with the rule and I don't see as much like interaction with the principle behind the rule*... But I think in general we're way more focused on what the rule is, *so I don't think it requires residents to be as dynamic in their thinking is like, what is the actual point of all this and how can I be a part of that and make choices around it.*

[24] This perspective also suggests a parallel process for Haven staff.

> Um, I think the way we treat residents is... there was a staff here for a long, long time… She always spoke to the adult in the resident and wanted to have rules that treated residents, most like adults. And there is no voice like that in the community now. And I think residents are treated less like adults. And I think again, more of those external structures that are telling people what to do and fewer chances to be like, what's the right thing?
>
> Oh, I think residents are less. Are treated less like adults. I think they act les like adults. I think the farm is safer and I think the farm is less. I don't think. I don't see people like growing in the same kinds of. I mean people are great, they're wonderful. They're exploring and growing. But I don't see the same. *You put that structure around them, they don't have to put it on themselves. Wake ups. We didn't use to do wake ups, okay, now people lie in bed and wait for somebody to come wake them up. How is that helping them?* Yes. You have more people get to morning meeting but you're not actually helping. So that's the kind of thing I think we did less of and there were maybe more problems, but it was more… (emphasis added)

Dean speaks to how residents take up the passive role of attending to a rule, but not attending to the principle behind the rule. He uses the example of staff waking people up to highlight that in this instance, there is little incentive for residents to wake up and come to morning meeting of their own volition. Although such a policy may be necessary for a resident struggling with side effects from a psychotropic medication, for others, their own initiative and sense of responsibility are taken away. Dean also emphasizes that the Haven is treating residents less like

adults[25] and asking them to behave less like adults.

Dean provided an example of how new treatment protocols seem to put the resident in the role of passive patient, taking away the opportunity for residents to actively and honestly confront their struggles:

> Dean: We can breathalyze people and we can search their bags and we can do UAs [urine analysis], and we do all those things and those are all external controls and I think there is a place for them. Not to be saying we shouldn't be doing those things, but the times like kind of the most powerful times that.... it's been like I knew somebody that.... I was working on the weekend. I knew somebody who had drugs on the farm, and like I couldn't search them. UAing them would be pointless. *It was just like you needed to talk to them and talk long enough and listen and eventually like they were like, 'okay, here'.* And they got out their wallet and got this little sliver of like I would've never found it. Like all those external things like if you're so focused on those, catching people like, and I understand with addiction, like you can't trust so that people are going to do the right thing, but you also. *If you take away the opportunity for them to do that* and you, you've set yourself up in a relationship that's like, okay, we're doing all these things.
>
> And then your role, you know, it's almost like.... your role is try to get around us. That's like, I.....like, yes, in some ways it's more savvy and more treatment center-

[25] Curious again is how a lack of community meetings or forum for residents to democratically engage with rules and policies at the Haven may create the iatrogenic effect of residents feeling powerless, child-like, and, less agentic. If residents are not involved in the rule setting or discussions of polices that directly affect them, how can they be expected to engage democratically in a community that does not create a specific place for their voices to be heard and acknowledged as important?

> y, more rehab-y. *But I also think you're losing the opportunity for someone to take care of their own, to be an adult or make adult choices*. And that is something that is like, yeah, I don't know what to do. And everyone else, like most people don't feel that way. I think there's a way for both things to happen. I think you can have external things because not everyone here is ready to do that internal work to keep themselves safe and they need the externalized stuff. *But there also needs to be ways that we're treating residents with the kind of respect and as adults that will help them make adult decisions even if they're also dealing with addiction issues.* (emphasis added)

Dean addresses the loss of opportunities for a resident to authentically engage with staff about their substance use. Dean suggests that this approach of "trying to catch" a resident with substances, puts residents in the role of the passive, ill-addict and the staff member who is in charge, in the role of the healthy expert. Here too, the Haven has implicitly adopted the disease model of addiction, the model used by Alcoholics Anonymous. The disease model assumes that the causes of substance use are biological, that use is uncontrollable, incurable and irreversible, and that use is characterized by spiritual or personal deficits (Pruzan, 2020). Such assumptions lend themselves to another hierarchal model of treatment where the provider is the expert and the patient is an untrustworthy reporter (Pruzan, 2020). Notably, AA and NA were the only substance use modalities (aside from individual therapy) used in treating substance use at the Haven during my first two and a half months on site. As I left, the Haven began drawing from other modalities, due to some resident's dissatisfaction with a model that emphasized calling oneself an addict and placed significant importance on a higher power.[26]

[26] The approach to substance use counseling was cited often by staff as something that needed to change. Many staff felt that the Haven was advertising that it "treated" substance use, while only offering AA/NA as options. As of

Similarly, Dean spoke to a change in observations of resident empowerment during this transition:

> I think residents had a lot more opportunities for empowerment. There [was] a lot more resident driven platforms of expression and self-monitoring and community monitoring. Monitoring could be the wrong word, but there was a lot more empowerment. *People don't feel a loss of it because if you've never had it, you don't think like, 'oh, I want that back.'* It wouldn't even occur to you to think that there might be ways as a resident that you could be, that would be empowering if you've never seen anyone else do it.
>
> I remember at some point, I can't remember in what context bringing up like a resident run support group, like a resident only support group, and people were like, oh, maybe it was just one person, but like 'we couldn't have them do that, you know?' And it could be, who knows what would happen in such a place. Like it could be terrible, and it could be wonderful, and it would probably be some of both. But just the idea that like, 'oh no!'

Here Dean spoke to an attitude I also observed at the Haven. Paula, a highly motivated resident in her late twenties, came to the Haven to address her longstanding depression. Two weeks into her stay at the Haven, Paula began to feel that not enough was going on in the evenings. She longed for more group opportunities and deep, vulnerable conversations with other residents. Seeing that the evenings offered much free time, and no groups beyond AA were happening on

2020, the Haven offers two recovery meetings of various modalities on-site, two recovery meetings off-site, an on-site 12-step group, and a peer-run-recovery meeting. The Haven also added a recovery coach who offers one-on-one recovery coaching. From the outside-looking-in it seems the Haven is now offering substantially more recovery-oriented services that do not draw solely from an AA/NA model.

site in the evenings, Paula discussed with her team an idea about developing a peer group. She described her motivations to me during our interview:

> Part of the reason why I wanted to start that peer support group, you know, I feel like just having something, something around to just kinda fill that free time would be good. And, and like I said, you know, that's kind of like a healthy and productive thing, I think you know, and...kinda all talk to each other and maybe help each other out or kind of whatever's going on. Because I've even found...uh.... because recently I downloaded a bunch of games from my computer and I'm like, they're really kind of, (laughs) that's not what I should be doing.... because uh, I've been pretty good about not trying to be on the computer or just kind of messing around, you know, I've been trying to fill my free time with reading or you know, something that's at least like semi-productive. But we'll see. I don't want to fall back into.... (laughs) because like at home or something, I would tend to just game.... just like waste my time on things. Uh, so I don't want to do that here. I guess I recognize that I am... potentially getting back into that (laughs) because then that's also, you know, an isolating thing, you know, you're not really interacting with people… So, I've talked to uh, you know, several of the other residents and it all seems to be very positive. I think, you know, kinda the next thing on my plate is kind of hammering down a day and time… People definitely seem interested in it so they'd be willing to come, so I'm going to try to work on getting a couple of different topics together. But, so I don't know if I even necessarily want to be super structured or you know, kind of just a thing where we get around and talk about what's going on. It could even be like a

> weekly check in or something, you know. How'd your week do or how'd your week go? Uh, is there anything you struggled with? Um, you know, basically getting feedback from other people. Uh, just kinda things like that. So, I'm kinda still nailing the logistics as to how it would actually run and operate. But I guess there's, there definitely seems to be some interest, you know, I know a lot of people have kind of shared that same free time sentiment that I have. They're like, 'we've got some much that's downtime, like, what am I supposed to do?' I'm like, you know, I'm just going to go to sleep or something like that. I'm like, you know, if we can fill, fill that time with something productive it would be good.

Paula took this idea to her next team meeting and the therapist told her this could not happen. The clinician commented that a group could not happen without a clinician present. Later in a group supervision meeting, I listened as the clinicians discussed the "risk" associated with having residents run their own group, without clinical oversight. Another clinician discussed how Paula's idea was motivated by her pattern of "overachievement issues."

The idea that a group can only happen with clinical oversight is reflective of a medical model perspective where patients are viewed as ill and in need of treatment from qualified professionals—not each other. Patients are seen as incapable of healing themselves. The idea is that given the mental disorders of the residents, it is not possible for them to run a group on their own. They are too sick for this. Moreover, another clinician then linked Paula's motivation to pathology in saying Paula was engaging in a pattern of overachievement. Again, Paula's idea is viewed through the reductive lens of pathology, rather than a strengths-based perspective honoring an idea to productively build community, connect vulnerably with others, and grow in

relationship with other residents.[27]

I had a strong reaction to this decision and rationale while in the field, and even now as I write this section of the dissertation I find myself frustrated that the desire and need to connect with other suffering humans, and to build the very community posited as healing at the Haven, was denied to Paula. Moreover, I was shocked by the rationale that residents (patients) could not run their own group, when peer-recovery groups had such a rich history in the existential-humanistic tradition of psychology, and particularly in therapeutic communities.[28] As Miller (2004) writes of the social dimensions of suffering:

> This is rarely understood in the psychological literature, where the diagnoses that stand for human suffering are seen as essentially individual phenomena. There is a kind of physical, social, and ultimately moral (e.g. "I deserve this pain") isolation in human suffering that is to be distinguished from how we live when we are not suffering. *We feel alienated and alone—outside the pale of the community. We feel not only the pain or hurt but also isolation from humanity.* This perhaps explains the widespread appeal and success of the relatively simple community intervention of developing support groups for those who have experienced trauma and, more specifically, *why it is so important to have the opportunity to tell one's*

[27] Throughout my time at the Haven I heard staff tell residents, "You have to learn to structure your downtime," when residents complained about the abundance of (unstructured) free time at the farm. That being so, it is curious that a resident proposed a resident-led support group as a productive way to spend part of that free time, a group that would build community amongst residents and offer opportunities for growth, vulnerability, and connection, and yet the resident's idea was turned down. Moreover, this resident was acknowledging her tendency to fall into a pattern of gaming on her computer, and she actively wanted to interrupt this pattern. Resident time on computers was a much-debated topic during my research. If such group activities are vetoed, what kind of downtime structuring were the staff looking for?

[28] I am glad to note that as of 2020, resident-led peer groups are now offered at the Haven. However, a participant noted that "traditional group therapy" was not offered without a clinician present. I find myself still curious about the distinctions between "traditional group therapy" where a clinician is seen as necessary and the peer groups that are now happening. Currently, a resident led recovery group is offered. Other peer groups occur off and on relative to resident interest.

> *story to others who will listen.* The telling reintegrates the individual into the community… We must extend ourselves to those who are suffering, for only we can end the isolation they experience. Although their suffering is, in one sense, theirs alone, it is not something they can end by themselves. We must offer support in the community. (emphasis added, p. 57)

Peer groups are vital in establishing a sense of connection and community. Suffering people need to connect with other sufferers to share our stories for our liberation and recovery. Such awareness is lost when suffering is reduced to mental disorder.

Dean summed up his feelings about the decision to not allow peer-led groups as follows:

> The safer thing is not to have one, that is the safe choice for the farm. Like nothing traumatizing[29]… But it would be so empowering for residents to run a group on their own that like, is it worth.... so the safe choice, don't have it, but the empowering and exciting choice and risky choice....and we keep going [with] the safer choice…. But I see, you know, it's a risk, but it seems like it would be such a worthwhile risk to be taking.... these kinds of risks.

The Haven's adoption of the medical model framework seems to have shifted the power dynamic at the Haven. Whereas in the past, residents experienced empowerment, and the community played a pivotal role in healing, the shift to seeing residents as patients suffering from mental disorders or addictions, who are therefore in need of clinical treatment, seems to have reduced resident agency and curtailed space for residents to be active leaders in their own care. As reviewed in this section of the dissertation, it has also limited treatment to a focus on medication

[29] Interesting here is the implicit assumption that a peer group could be traumatizing, while groups led by clinicians are "safe." One need only look to the history of psychology and psychiatry to see that the profession is not innocent of traumatizing groups and individuals. Again there is an idea of safety with professionals and a lack of safety between residents.

and crisis intervention, and limited the ability to appreciate and embrace the potential benefits of the milieu in residents' care.[30]

In order for the Haven to restore more balance with its earlier vision and therapeutic community roots, a shift in clinical orientation is necessary. Though we cannot entirely remove ourselves from the medical paradigm of care, a perspective grounded in an existential-humanistic-phenomenological framework can lessen the extreme power divide between patient and healer, cultivate more attention to the strengths and health of an individual, help residents become agents in their healing, and hopefully restore a sense of the milieu itself as healing.

A Different Clinical Approach: Existential-Humanistic Psychology

An existential-humanistic approach seems ideal for the Haven, as it lessens power disparities between residents and clinicians, and residents are not seen solely through the lens of psychopathology, but are encouraged to be responsible agents in their life journeys. Moreover, an existential-humanistic approach highlights the strength and potential of residents, as the goal is not simply symptom reduction, but to cultivate and define for one's self what is a meaningful life. Such an approach is grounded in a more contextual and multi-dimensional understanding of psychological distress, and explicitly values community and alternative approaches to healing.

Brief history of existential-humanistic psychology

Humanistic[31] psychology has a long history of critiquing the medical model perspective in psychology. O'Hara (2015) writes:

[30] For example, clinicians are unable to join work program due to their schedules and job demands. Yet, they miss a core part of the milieu in not being involved with work program. There was also less intentional time given to the natural world during my research.

[31] Existential-humanistic psychology is often described as under the "umbrella" of humanistic psychology (Schneider & Krug, 2017).

> … from the outset, humanistic psychologists have mounted a vigorous critique of the medical model of mental life that reduces communities to 'demographics,' persons into 'patients,' suffering into 'symptoms,' and healing and recovery into 'treatments.' Where 'medicalized' psychology has been reductionist, the humanistic tradition in psychology has been about the much bigger cultural stories—about individual fulfillment, the avoidance of war, a saner society, the well-being of humanity, and ensuring a more humane future for all. (p. 2)

Humanistic psychology largely began as a critique of psychology's primary focus on pathology, rather than focusing on health, creativity, wonder, and meaning (Maslow, 1968; O'Hara, 2015). The human potential movement of the 1960s strongly influenced humanistic psychology in its attempts to demonstrate that psychology was too limited in focusing on pathology: what of the potential humans have for growth, creativity, and transcendent experiences? Similarly, existential psychology opposed the reductionism of psychoanalytic and behaviorist theories, emphasizing a focus on knowing and becoming ones' self (Schneider & Krug, 2017).

Existential-humanistic psychology is informed by the existential-phenomenological philosophies of Husserl and Heidegger and was applied to the practice of psychology and psychiatry by Ludwig Binswanger and Medard Boss (for a review of this history see Moss, 2015; Rowan, 2015; Schneider & Krug, 2017). While the concept of suffering has all but vanished from the realm of clinical and counseling psychology, Miller (2004) elucidates how the existential-phenomenological tradition provided a psychology of suffering grounded in the work of Kierkegaard, Sartre, and Camus, as well as psychotherapists R.D Laing, Rollo May, and Alvin Mahrer (p. 59).

Shifting the focus from "disease" and "disorder" to suffering changes the focus from

"what is wrong with an individual," to a more balanced awareness of human possibilities. "To be aware of our suffering is to be in touch with the wellspring of our creative abilities to improve our lives and communicate with our fellows" (Miller, 2004, p. 48). Such a claim is in line with the approach of existential-humanistic therapists who use talk and experiential approaches to help a client explore their "relation to existence" (Schneider and Krug, 2017, p. 20).

Existential-Humanistic Therapy

Schneider and Krug (2017) describe how existential-humanistic practitioners stay open to the uniqueness of the individual, rather than formulating treatment plans based on diagnostic categories or psychoanalytic concepts that narrow their focus, rendering them oblivious to the complexity of the person:

> E–H theorists also endeavor to understand the phenomenology of a given client's struggle and to avoid diagnostic and psychodynamic presuppositions. Although such presuppositions can certainly inform the E–H practitioner's understanding, the E–H practitioner attempts to stay as open as possible to the living, evolving person who may or may not conform to preset categorization. For example, to understand the phenomenology of a client who is depressed, the E–H practitioner may explore how the client is relating to his depression, his lived experiences of the depression, and his particular meanings and feelings associated with his depression. (p. 22)

In existential-humanistic therapy, the client's own meanings are emphasized. Clients are co-participants in the therapy, not passive patients who are under the treatment of an expert healer. Clients are viewed as co-constructors of their realities, and as agentic individuals in constructing

experience (Schneider & Krug, 2017). "Understanding the process of existence through this meaning making lens underscores the need for therapists to sensitively attune to and explore the personal meanings and associated feelings of clients over and above dispensing a particular treatment or technique" (Schneider & Krug, 2017, p. 24). It is unique lived experience and meaning making that are important to the existential-humanistic therapist.

Certainly, therapists integrate various theoretical approaches in their work with clients. Likely the Haven therapists, most of whom identify with the humanistic tradition, do some of this meaning work in their therapies. However, I am advocating a radical philosophical shift in understanding and discussing residents.[32] An existential-humanistic approach is not simply a technique to be used in session, it is an attitude and ethos from which to understand and respond to suffering. Embracing such a shift would mean seeing residents as agents in their own recovery, as co-healers, rather than patients in need of treatment from a professional. Such a shift would move from discussing residents merely in terms of symptoms and disorders, to addressing their unique struggles and victories in trying to make meaning of their lives. Issues of meaning, isolation, and freedom would be deemed salient in understanding and responding to the residents' crises, rather than a relentless focus on the resident's medication. Moreover, an existential-humanistic ethic emphasizes the role and importance of community, and our embeddedness in the natural world (DeRobertis, 2015; Fromm, 1955). According to Schneider and Krug (2017):

> E–H theorists share four core aims: (a) to help clients become more

[32] Our orientations influence how we see and think about the people we work with. It influences how we understand illness and suffering (Miller, 2004). The language and positions we use influence how we think about and conceptualize clients, and how we understand what it means to live a good life, what values we hold about suffering and flourishing. This is why I advocate a rhetorical and philosophical shift to an existential-humanistic perspective, especially given the very concerns residents are bringing to the Haven, which suggest many are struggling with issues related to finding meaning in their lives.

> present to themselves and others, (b) to help them experience the ways in which they both mobilize and block themselves from fuller presence, (c) to help them take responsibility for the construction of their current lives, and (d) to help them choose or actualize ways of being in their outside lives based on facing, not avoiding, the existential givens such as finiteness, ambiguity, and anxiety. (p. 22-23)

The focus on taking responsibility for one's life is particularly salient given that Haven residents struggle with issues related to identity, work, meaning, and purpose. The difficulties with work that they experience are bound up within developmental challenges that go well beyond the Haven's emphasis of cultivating good work habits and soft skills. Additionally, this approach allows for the exploration of responsibility in the context of a community. What happens when residents do not take responsibility for their work in the community? How does such a decision impact the community? How can the community help residents learn about, and experience, our responsibilities to one another in the community? Said another way, from an existential-humanistic perspective, residents have the freedom to choose what they will do and what they will not do.[33] How does the exercise of this freedom impact the community and the resident?

Moreover, the milieu setting is ideal for cultivating presence and seeing individuals "mobilize and block themselves from fuller presence" within the community, as staff can witness these happenings and interactions in the moment. To that end, existential-humanistic therapists emphasize confronting possibilities experientially. The focus on embodied, experiential meaning-making seems ideal for the Haven, as a therapeutic community providing communal

[33] Again, agency, freedom, and choice are hard to exercise, or even be aware of, when there is not a space for residents to experience themselves as agentic members of the community. This is why restoration of resident-led community meetings is essential in changing current dynamics at the Haven.

work on a farm. Such a setting provides excellent opportunities for experiential learning. As explained by Schneider and Krug (2017):

> E–H therapists seek to understand a person as a human being in the world, related to his or her physical, personal, and social worlds. It is assumed that a person is not simply a collection of drives and behavior patterns within an encapsulated self… Consequently, the E–H theorist takes a step back from examining a person's drives and specific behavior patterns; with a wider scope, she or he understands these in the context of a person's relation to existence. These relations, which manifest as structures, are not abstract but actual, described by J. F. T. Bugental (1987) as *self and world constructs.* Although a person's self and world constructs may be obscured from conscious awareness, they are nevertheless evident (though perhaps implied) in the present moment, expressed through bodily gestures, vocal tones, dreams, and behavior patterns and not so much through words spoken. (p. 20-21)

A striking example of attending to the moment occurred during farm crew one afternoon. This episode also illustrates the missed opportunities for being present when one is solely focused on completing a task. Several residents and I were moving some cows to a new pasture. First, we set up a new electric fence around the pasture. Afterwards, we began moving the cows. Once they were in the new pasture, I watched in awe as several residents, many of whom rarely engaged with other residents, came alive and began cooing at the cows, reaching out to touch them. I watched as residents who I had never heard speak more than a few words, began talking animatedly to the cows. As I stood witnessing this moment of spontaneous connection between residents and the farm animals, the staff member leading crew that day kept working on the

fence. He turned away from the fence and looked at us standing in the field, petting and watching the cows. He called over to us: "I'm sorry I don't have anything for you all to do right now." "*Can you not see what is happening right now? In this moment?"* I thought. I felt simultaneously inspired by the interactions before me and saddened at how the focus on getting work done or "having something to do" distracted staff from these beautiful moments.

This is an example of dwelling in the present moment. Residents were present for and with the animals, while the staff member hustled to tie off the last of the fence. An outside observer (or staff member) might have thought we were lazily standing in the field. But such an observation misses critical interactions occurring between residents and animals, as well as resident to resident bonding. It is telling that this staff member once said to me (in the context of advocating for more clinical therapy services): "I think a hike in the woods can be great. But how therapeutic really, is that?" Immensely.

This staff member's comment highlights our collective dissociation from the therapeutic benefits of dwelling mindfully in nature. It also suggests an overreliance on viewing professional clinical services as the only legitimate form of "therapy." The concept of therapeutic experience does not belong solely to the psychology profession. Acknowledging that work, being in nature, and eating a meal together, can be extremely therapeutic might help all staff realize that the work of therapy is not only done in one-on-one sessions with a professional. Therapeutic engagement is not limited to the licensed professionals conducting therapy. *This is the value of a milieu-based treatment. This is the value of a therapeutic community.* The existential-humanistic focus on the present moment, experiential and embodied learning, can help reorient the Haven towards this focus. As stated by Schneider and Krug (2017): "For E–H theorists, accordingly, the deepest

roots of trauma cannot simply be talked about or explained away; they must be rediscovered, felt, and lived through" (p. 22).

Chapter Six:
Therapeutic Benefits

"Honestly, it's just a place you want to be plus therapy." (Wilfred)

I appreciate that type of mentality of like, 'they're people, not mentally ill patients.' (Wilfred)

Although the Haven relied largely on a medical model approach to psychological suffering, several residents discussed how the Haven felt worlds above hospital-based treatment. Apparent in many accounts is how the Haven retains a humanistic ethic with respect to the residents, in that many residents reported that they did not feel treated as patients at the Haven. Such comments further highlight that the Haven has the foundation necessary for reorienting its clinical framework. This chapter reviews what residents identified globally as the therapeutic benefits of the Haven.

The Haven versus Hospital-Based Treatment

One clear way in which the Haven surpassed other mental health care was in comparison to inpatient hospital treatment. Several residents remarked on how the Haven provided a better environment for long-term healing than did hospitals.

> Interviewer: To the extent that it is, how does this place feel different from where you were before?
>
> Wilfred: Um, much less rigid. I think there is a definite approach, sort of super analytic approach in the last place I was at, and that was kind of how things were done, which is helpful too when I was initially waiting and I think that's kind of what I wanted was a super analytic approach, but in terms of if I want to live in that world for a few months of my life and also pay quite a bit of money for that experience, I want somewhere maybe perhaps a little bit this, this place is relatively more laid back. *It feels like I'm treated more humanely.*

Interviewer: How do you feel more humanely treated here as opposed to the hospital?

Wilfred: I was in a relatively good setting with the hospital, but overall there's definitely *an emphasis on safety. You're monitored all day long*. For example, it's like the small things that kind of get to you over time, which is like that the bedsheets don't really fit on right. Like you're constantly just sliding around on this like rubber little plastic bed you're given. *You kind of have low autonomy,* feels like you're kind of, *even if it's the friendliest cage ever. It's still a cage.* And even if you voluntarily entered the cage. And you can leave a cage whenever you want to, but like obviously you're there for a reason and you're not gonna just.... your options are deal with, if you want to get better, deal with it. And there's certainly places that are much worse than where I was at. One person described, you know, in his home town that like he was talking, he was suicidally depressed and like the chief medical officer, the last place he was at, would text while there were interviews or something like that, you know, it's like, (laughs) yeah, yeah, it's, I laugh, but that's, that's my defense mechanism when something gets that dark. And so yeah, this was a stark contrast to that, but still there's not a lot of good options.

Interviewer: What is it like to have medical care, psychological care done in a setting like this? When it is more traditionally done in a hospital or an office?

Wilfred: *I think this makes more sense.* A lot of the philosophy I was engaged with in college was more or less looking at habits and habit forming and how maybe, *maybe a super like sort of objective setting like a hospital or an office may*

not be the best place to reformat your habits and I think that's a mistake that perhaps a lot of psychology might focus on too much… like targeting the mind, the mental aspect of it. *Whereas my anxiety for example, is a full body experience.* It's not just my mind going into it. I think that's what a lot of people experience with it, so in order to really address it, it seems like it'd make the most sense that I have to be in an environment that is a good place to relax and a good place to work at. And I think that's what's missed a lot in traditional psychology settings is that your...I mean the stereotypical thing is you're on the couch laying down talking. Yeah. That's kind of helpful in the beginning, but there's only so much work that I can do. *So, there's very hard limitations on it.*

I read a good article about depression and for a while it was the theory… was a low serotonin level and that was it, but for the most, so you take medication and your serotonin level should go up, but that doesn't work. (laughs) That really doesn't work for most people. I mean the efficacy for maybe a couple months, but then the feeling comes back, *because I think the article's main thesis is that there's deeply rooted causes in society that are complex, that are hard, that are environmentally based, I guess the smart biosocial model.* I don't know what the debates are like in psychology going on, I imagine I'm touching on a few. And so yeah, I'm sort of reiterating myself at this point, *but get me an environment that I actually want to be in. That's a starter.* (emphasis added)

When asked about his experience at the Haven, Wilfred remarked: "Honestly, it's just a place that you want to be plus therapy." Wilfred described the need for an environment that is conducive to healing and that the Haven as a treatment site "makes more sense." Wilfred

insightfully explains that his anxiety is a "whole body experience," and traditional psychological approaches focus too solely on the mind. Wilfred's comment is in line with human science criticisms of mainstream psychology (Giorgi, 1970) and the mind/body separation characteristic of Cartesian dualism. Therefore, the Haven as a site that integrates both verbal psychotherapy and physical work is ideal, as it integrates a holistic approach to suffering.

Interviewer: What do you like about the environment?

Wilfred: *Kind of like humanity of it.* Like it just, *you get treated uh, less like some sort of specimen being diagnosed with and stuff.* There's a lot less hypotheticals. Like, Oh, if you get these medications, do these things, you might become functional in the sense. But here it's like you kind of get to test that out and sense like, can I do my, like whatever crew, how easily am I getting through that each day they're just, that's a good, good, trick for me.

Interviewer: Yeah.

Wilfred: Sort of figuring out how well I am doing or not doing.

Interviewer: So, that's what you mean by less hypothetical because you actually get to try it out?

Wilfred: Yeah.

Interviewer: On crew?

Wilfred: Yeah. Versus if you're in like a talk session all day long, then you're kind of um, trapped. You can't, it's all hypothetical. You're just talking about what you might do or what you might not do. In my impression at least.

Interviewer: And here you actually can put it into practice. You're actually doing something.

Wilfred: And then it's, this place is different because you kind of have.... You're up doing stuff. *Actually, it's a wide-open farm. You can just go wander around if you want to. Well, no one is going to stop you.* That's a nice touch to it cause you don't feel like, 'all right. I'm one of the residents, like one of the patients here,' yeah, that, that was a nice touch as opposed to the psych hospital.

Interviewer: What do you think it is about this place that contributes to that? To not feeling like a patient?

Wilfred: *You're just not treated like a patient in a good way.* Like you're not in the...*there's not people always like monitoring you.* There's not. You're kind of given a lot of agency to do. I mean like, just get up, do your, do your work, go to meals, you go to meetings if you want to, you are kind of given the agency to do that. *And there's not a lot of people like wagging their clinical fingers at you.* Like, all right, "you gotta do X, Y, Z". I think, yeah, coming from a very clinical, *it doesn't feel like you're being put into a box here as well.* You're kind of...there's more free form. You don't, there's not someone hunting you down, being like, "What diagnosis do you have?"

I don't know. I mean like, I feel like it's a rare kind of place. It's like, "all right, we're going to give these mentally ill patients power tools and see how that works out." I appreciate that type of mentality of like, 'they're people, not mentally ill patients' (emphasis added).

Wilfred's account highlights that despite a reliance on conceptualizing residents from a largely medical model perspective, residents are not solely treated as patients. In fact, Wilfred experiences more agency and freedom at the Haven, as opposed to a hospital where he is

constantly monitored for signs of risk. Moreover, residents at the Haven are free to wander the grounds on their own. Unlike treatment in inpatient settings, residents are not constantly viewed through the lens of risk management, but as free individuals who can make choices. Wilfred's comments point to the tension I felt in hearing medical model language used so often at the Haven. The Haven takes a radically different approach of allowing residents more freedom. This freedom is seen in allowing residents to wander the grounds at their leisure, using tools and utensils that would be confiscated at hospitals, and in allowing some agency with respect to how residents spend their time. Thus, referring to residents as largely symptoms and diagnoses, and as unable to run their own recovery groups, felt baffling in an otherwise humanistic setting.

Although Wilfred found this freedom enlivening, Adrian shared that the freedom and space to wander was at first frightening, though she eventually appreciated this contrast:

> Adrian: And I remember when I first got here, like coming from a very clinical setting, I just, there definitely was not the same amount of support and it kind of was like a little frightening like, oh man, like I could go off and do whatever I wanted. And so, I think it's good that there's more support, especially if you have more people coming from that kind of setting.
>
> *I mean like in the hospital you have two fifteen-minute meetings a day with someone to check in and it was really jarring when I realized people here didn't necessarily want to just like talk about what was wrong with me.* Like if they were, you know, if the house adviser was approaching me it was probably to talk about, you know, some artwork or something and it was very jarring at first to not be able to kind of download twice a day like I had been used to.

I mean, I think that like while I was here, I kind of found a little bit more of that. One of the clinical people, her name was (name omitted). She's not here anymore, but like she kind of ended up filling that role partially like when I was really struggling. She's who I would go to because she did have a little bit more of a clinical background. Um, but I think it's, it was really nice to like just be able to have conversations with people *and after I got over the initial shock of it, I actually think it was probably better for me to not be constantly talking about myself.* Like have that happen, you know, it still happened. Like if, you know, that was part of your meeting with your [team] if you were seeing the psychiatrist that we were. *But having that not be every conversation all of a sudden, I think was actually probably more beneficial even though it was kind of jarring.*

Interviewer: How does this setting compare to receiving mental health treatment in other settings such as hospitals?

Adrian: *I mean, I remember the hospital being like really hypocritical because they're like, what you need to do is get outside and eat healthy and you know, spend time with people, but we're going to keep you locked inside all day and force feed you, you know, the stuff that is probably not healthy you know?* Um, and it just was like, I mean *I remember there was like a 13-day period where I wasn't allowed to go outside at all* and that was just like, *'come on, I just want to go out and get some sun, some natural light because you've got me in here with these fluorescent lights all day.'* And so, I think that I needed to have people around that were checking on me and I, *it was weirdly helpful being around people all the time. Like even the community aspect of the hospital at that point.*

There's a reason that I like kept getting out and going back pretty quickly. But the fact that you're not able to like put in place really any of the coping skills. I remember when I was here I started knitting a lot and I got, I had a medication change while I was here that did not work out, and I ended up having to go back to (name omitted for confidentiality) for a little while after I had been here for several months and I was like, 'hey guys [at the hospital], look at this new coping skill I got', They're like, 'no, you can't have yarn or knitting needles. What are you talking about?' *So that was like kind of devastating at that point.* Like this is something I was spending a ton of time here doing and that was really helping me. And while theoretically I understand why they don't want people to have yarn around, it was just like, come on. (emphasis added)

Adrian's narrative highlights the differences between a setting where Adrian is not seen primarily as a threat to herself by having knitting needles, and a setting where she is unable to rely on a coping skill due to the assumed danger in having needles and yarn on the hospital unit. Oliver also compared his experience at the Haven to inpatient experiences:

Interviewer: Can you tell me a little bit about your experience here at the farm?

Oliver: It has been a boon to my existence. I've been in treatment since [date omitted for confidentiality] and the road was, you know, *it was the typical mental health road, you know, ridiculous, spiritually taxing, energetically mind, body and spirit* and (name omitted for confidentiality) for all of its weaknesses was also a boon to me and the farm is a step-down program and it's been absolutely invaluable. And you know, I've been to places like this before and I'm just very glad that, um, I'm ready to absorb, you know, everything that the farm has to give

me and, it has a lot, a lot to offer. Therapeutic communities are the way of the future, I think. So. And I think that in my lifetime we're going to see a lot more places like these because, pardon my French, this shit works.

Interviewer: (laughs) Can you tell me more about what works?

Oliver: When you're depressed, you want to sit down, slow down, back away. And the only way out of the depression is a combination of empathy and movement. It's the exact opposite of what you want to do. And a place like this, we have to get up in the morning. We go to work. We push through it. And the cool thing is that if we really can't work, we have the resources here to work through those problems. You know, it's like if you're, if you're having a panic attack and you can't get out of bed, you know, that's not the end of the world here. You know, back home, it's like you do that too much, you lose your job. But here it's like it's a safe place to recollect and regenerate and process.

Interviewer: You said therapeutic communities are the way of the future. That's how you see it. How does a therapeutic community compare to other kinds of mental health treatment that you've had?

Oliver: (deep breath) It's a lot nicer. The whole (takes a breath, sighs*) in inpatient it's hard core.* Do this, do that, you know, they kind of.... *honestly, they break you down and it's really, really taxing.*

So, this compared a hospital? (laughs)

Interviewer: Yeah.

Oliver: (emphatic) *It's so much better*. I don't know how, how else to say? It's just better, more expensive but better and therefore it needs to be more accessible to people.

Joseph emphasized the importance of not being denied treatment for voicing his desire to continue using substances recreationally:

Joseph: I have never felt that they would not allow me to be here because I didn't feel that I was never going to use again. I've never felt that here. And that's a, that's a, that's a huge difference between the 21-day insurance covered rehab and this rehab. The first one I felt like, you know, it's like the psychiatrist, the case (inaudible). They were all like, like I… they would question you being there, if you expressed that you didn't want to be completely abstinent. And here when you expressed that you don't want to be completely abstinent, they warn you and caution you, but they don't like threaten you having to leave the program because you're not. That's not where your mind is geared.

Here too, Joseph highlights that the Haven takes a more open than punitive approach to decision-making around abstinence and substance use. All of these examples suggest that the Haven does relate to residents as humans with challenges, rather than primarily as mentally ill patients in need of constant monitoring. Moreover, even if there is a reliance on the medical model perspective, it is clear in these resident accounts that the Haven creates a more humane and encouraging environment for residents. This environment allows for a more nuanced and humane way of relating to, and with, residents.

Nature

In comparing the Haven to their experiences in hospitals, residents noted the value of being in nature:

> Interviewer: Would you see yourself recommending this kind of treatment facility to other people?
>
> Adrian: Absolutely. In a heartbeat. I mean, like I said, I was, I had an option to be in a place in (city omitted) that was staffed I think overnight, but you had to either be going to school or working during the day and I'd been working during the day, like that wasn't really that much different. The only difference would be the location and there would be overnight staff. So, *seeing that this was going to be much more supportive, I'm actually getting to be outside in nature so much… like that all was hugely beneficial for me.* And like I said, *I really hope that the changes allow insurance companies to like be willing to pay for it because for me this is what worked and what they were willing to pay for did not work.* (emphasis added)

Oliver shared this sentiment as well:

> Interviewer: What do you enjoy about working in the garden?
>
> Oliver: Nature has every energy that you need. Nature has everything in it. If you know where to look, nature can hand you the key to the energy that you need.

Stacey discussed how nature was an important aspect of her experience at the Haven:

> Stacey: Being out in nature is therapeutic. The air is so fresh and then you feel like you can breathe easy here. There's so much concrete everywhere in the developed world. So much concrete everywhere and it's gray and absorbs heat and

then you get to a place out in the middle of almost nowhere and you just feel the breeze and you feel the trees breathing and everything's breathing. I mean you just… It's just beautiful, beautiful and green and it soothes you.

Jerry describes nature as a huge benefit of the Haven:

Jerry: I think that the nature is definitely a huge benefit. The outdoors and um the you know, just so many different environments you have, you know, you could sit on the chairs in the grass and you know, have a conversation. I think it's much better than just being kind of a place, like the one hospital that I was in was essentially just one wing with like a conference room and you just felt so confined and not like trapped, but I mean, you were kind of trapped in a way. (laughs) I guess, you weren't able to go outside and, and you didn't really have freedom or, or anything like that. Whereas here it's like, okay, if you want to go on a walk through one of the trails or something like that, you can. I think that the environment is very therapeutic as well.

Hmm. I think the big thing here is, you know, getting outside, being active is definitely a huge part of it because, you know, at least when you're in the hospital, you know, um, at least I know obviously each one runs a little differently. But uh, you know, the one that I was in most recently, it's like we were lucky to even get outside for 15 minutes a day and that was basically just walking around like a small courtyard, (laughs) you know what I mean? Other than that, it was just like one hallway with one room and that was probably the size of where we are now. You know, that we had all of our groups in and it was much more structured. But um, you know, it was, it was just different because a lot of times we were just

sitting around and basically, you know, waiting for the next group and uh, like I said you weren't getting outside, you weren't really doing…Everyone was kind of just like sitting around or whatever. And uh, you know, like I can kind of see, you know, both sides of it. Like I said, I think the groups kind of are somewhat an important thing like learning different skills, but you know, I think what those hospitals are really for is like a short-term crisis thing and trying to get medications right and adjusted in a short amount of time, you know. Uh, so I think that's kind of like I said, it's a crisis type of thing. So that's kind of more what they're for, whereas this is really a more long-term uh.... situation where you may be trying to change some of your fundamental behaviors, you know. Whereas I feel like in, you know, a week time, if you're in the hospital for a week, you're not really gonna see any significant changes over that period.

Adrian notes the how the hospital reduces access to nature:

Adrian: I have always really liked being outside, and I was constantly told like a good coping skill is going outside, and you know, in the hospital you're not allowed to do that at all. So here I was really able to spend like all day outside.

Sober Environment

A few residents also noted the necessary role the sober community played in their evaluation of their substance use:

Tyler: So far, my experience here has been good. It hasn't been amazing, but it's been good. Definitely not bad. I think really, I just needed to not be smoking weed for an extended period of time to really evaluate my relationship with the drug.

Ethan echoed the benefit of a sober community:

Ethan: That first month or two I was, I didn't want to commit to living the rest of my life without substances and had I not been here, had I not had these structures that, you know, helped me not go to a drink, you know, in a moment where I had... was experiencing weakness. I probably would have gone that route. Um, yeah. So that, you know, the abstinence environment here certainly was huge for me.

Ethan: Yeah. And being, being around the other people in recovery, whether it's (names of staff members omitted for confidentiality) or you know, other residents here that.... I was so naive to what alcoholism or addiction really was, you know, before I, I felt like I wasn't an alcoholic if I didn't wake up in the morning and drink, and drink all day, every single day. There were several days where I did that, but it wasn't like I was doing that every day. I was certainly down the path to doing that. But, um, I, I didn't think I was an alcoholic and the longer I was here, the more meetings that I went to, even if I was resistant to going to meetings and I, you know, I had every excuse in the book, it's like I don't believe in God, I, you know, all these different things, of like, why I don't want to go to meetings. I still went and over time things started to sink in and I started to learn. And in doing so I learned about myself.

And over time I started to see how much life, how much better my life could be living without substances. And that was, for me, that was the missing link was I had, I had done so much therapy for my depression, my anxiety, but without getting rid of that coping skill, I couldn't ever really move past that. I've never, not

that you ever truly can, but I was unable to not just sink deeper and deeper into it.

So, I accepted that my life was much better, living sober.

Community/Milieu

Another major agreement amongst residents was the importance of community. For many residents, living and being in community was the most salient aspect of their experience.

Interviewer: How would you describe this place?

Sam: It's a great place. Great community, you know, it helps you, kind of forces you to interact with people more, you know?

Interviewer: How does it force you to interact with--

Sam: Because you have go to crew. You have to eat, well you don't have eat, but you're basically there for lunch. *Even if you don't eat, you're still part of the community.* It's not like if you live on your own. You just stay in your apartment or wherever and sleep all day.

Interviewer: You find that this place kind of helps you get out and interact with people?

Sam: Yeah. It helps me.

Interviewer: It helps you.

Sam: Helps me.

Interviewer: What do you find to be therapeutic about the farm?

Sam: The community.

Interviewer: How so?

Sam: Because you're not stuck in your own bubble. (emphasis added)

Katie discussed the value of milieu-based treatment:

Interviewer: When you talked earlier about… 'here the therapy works in part because they make you do things'. Are you talking about the work program as therapy or something else?

Katie: There's also the therapy, like we have weekly meetings with the counselor or therapist and team meetings and you can't just ignore your team for a week and like avoid them and BS and say, 'oh, I did it,' when you didn't. *They will know if you didn't do it and call you out on it.* The other day I was having conflicts with one person and she [team leader] took me aside and said 'I think you're being a bit bossy with this person,' and I took that advice pretty well.

Yeah. And they can really get a sense for who I am. *Whereas in therapy in the past, it's been sort of hard to explain my pain because just like there's just been so much that I can't really put it into words.* I'm not in the toxic home environment, that really conflict-ridden home environment. So, it helps a lot too...

Enrique shared how connections with others was most salient to his experience:

Enrique: *I think probably the people I met is probably best thing I got out of it.*

Interviewer: Can you tell me about what these relationships were like… how they were helpful to you?

Enrique: There's just a really good group of guys and girls that all really got along. I probably, I mean obviously as time goes by, like you know, you kind of fall out of touch with people... just moved on. They're living all over the country, but I still keep in contact with probably 10 to 15 people.

Interviewer: Wow!

Enrique: That and I worked at the farm. It was great to have a group of people you can play cards with. I noticed towards the end of my stay there was a lot of non-socializing in the main house. Used to be where they had wi-fi people would just sit there, be just a group people on their computers not saying a word to one another, which is not...*it's kinda counterproductive.* They kind of need to get away from that. I understand wi-fi access. *But it beats the whole purpose of the community. I mean it's, it's just a reflection of what's going on in the outside world.* When you go to like a restaurant. There's eight people at the same table and no one's saying a word to each other because they're on their phones. Maybe put more restrictions on the hours or something… *So don't know if the work program was anymore.. It was probably less effective than just being around people like interacting. Having human interaction.*

For Enrique, community was the healing agent. Throughout our interview he remarked on his struggles with loneliness and how being in a community with others was what alleviated so much of his suffering:

Interviewer: I'm curious, did you, when you were at the farm in community with people did you notice if that affected your mood?

Enrique: Being with people?

Interviewer: Yes.

Enrique: Oh, absolutely. *I was almost depression free when I was there*. I mean, I still had a lot of anhedonia, but I wasn't like despondent. Uh, so yeah, absolutely. I don't know if it's like a distraction. This is one of the biggest feelings you get when you're depressed, is loneliness. Even if you're in a room with a thousand

people. *But that didn't really happen*. Like there's people around like so and that's what you kind of miss. I mean going to [the transitional program], you still live with people, coming here is a little different because you're not eating dinner together, you're pretty independent. Uh, so uh, but you can't stay there forever… it's not the real world.

Interviewer: It seems sad.

Enrique: It's very sad for, especially for people like me, like I wish it worked a little differently.

Enrique notes that when he is depressed he can feel lonely in a room with a thousand people, yet in a room of Haven residents, he did not feel lonely. Enrique implicitly notes the bonds created amongst Haven residents, and he describes the pain of losing that community over time.[1]

Adrian, shared a similar story. Adrian stated that the Haven "saved my life, and part of the reason that it saved my life was because of the community. I mean a big part." Adrian described how as the Haven became more "clinical" in its orientation and sought licensure, the ongoing relationships she developed and maintained would no longer be allowed. Adrian discussed how this change would have negatively affected her while a resident:

Like when I was in (location omitted) there were house advisors here who I would still get together with outside of being on the farm and like it was really helpful to have them in that role, for that time and as I kind of moved on and like got better and didn't need, you know, I didn't want to have those unequal relationships

[1] In listening to Enrique speak, I was reminded of my original interest in studying therapeutic communities, the need for ongoing relationships, recognized by Loren Mosher in his Soteria House project. Indeed, my experience of Enrique was that he was doing "well" in the transitional housing, but he did carry with him a sadness and loneliness, and a deep desire to continue living in community. Enrique's comments also reminded me of Laing's (1967) criticism of placing a person back into the environment that originally contributed to their suffering, and how removing the healing agent (the healing community) was bound to lead to continued distress.

anymore. So even though I thought like I would be lifelong friends with some of them, it's the same way with people that I was here with, like there are certain people that if you had told me I would not be in contact with them at all, I would've thought you were crazy. But like there's part of me that doesn't, that's not in that mind frame anymore and that doesn't want friends that kind of bring me back there, if that makes sense. So, but I think that, you know, for the time that I was still part of the farm community and even a little bit after because like when I was working at down on (location omitted) *there was a house advisor,* (name omitted), *who… I'd come here and we'd work on jigsaw puzzles like once a week* and I don't think I'd be allowed to do that now. *And it was just like being with a friend, doing an activity that we both shared.* Like we both really like doing jigsaw puzzles. There was much more table space here than where I was *and if you had told me like I couldn't do that, that would have been really hard for me to handle at that point.* I mean, at that point I was out of the transitional program. I was seeing a therapist on my own. I was taking care of myself. *I wasn't, you know, relying on her to be some, to have some kind of professional role at that point. I really just wanted a friend to do puzzles with and this was a person who I knew, and it would have been devastating to like not be able… to be told that I couldn't do that.* (emphasis added)

Adrian speaks to the need to build friendships and have people to engage in shared activities with, beyond one's stay at the Haven.[2] Adrian also emphasized how the milieu presented many

[2] The desires and needs for ongoing relationships between Haven staff and residents were the subject of a presentation I gave at the Society for Psychological Anthropology's Biennial Conference in Santa Ana Pueblo, NM in April, 2019 (Lawson, 2019). Though beyond the scope of this dissertation, this topic is an ongoing area of interest and research with respect to community-based healing.

opportunities for her to directly engage with her social anxiety, with the support of the community:

> I mean one thing that I don't know how much they really do anymore is like we'd sit down with, you know, my [resident advocate] and my house advisor and come up with a goal. And like I said, like I couldn't go grocery shopping at that point. So, like the goal once, one time it was like we're going to walk into a grocery store and we can leave right away, but just they were really able to tailor it individually to what I needed and I get the sense that, you know, *there isn't so much of like one house advisor taking one resident to do an activity anymore, which I think is kind of sad because that's really what I needed at that point*. Like I remember one night it was just like part of, you know, kind of getting me back into the world. Like my house advisor took me grocery shopping and we got ingredients to make dinner and then we took that to [transitional house] and cooked the dinner for like the three or four of us and you know, that was totally just like to get me used to going into a grocery store and meal planning and following through on that meal planning. And so, it was kinda like I needed to learn those skills again because I had lost them in the interim. So really being able to have those kind of individual things done because you know, they'd go into town once a week and I could not get on that van to go on town trip because it was just so squished together with people. So, I needed like that more individual way to do it. So, I didn't have a panic attack on the way there, you know? (Adrian, emphasis added)

Each of these resident narratives note the vital role community, nature, freedom, agency, and being treated as a person, not a disordered patient, played in their experiences. Such accounts highlight the importance, and need for, therapeutic communities as alternatives to hospital-based treatment. These accounts also note the need for this care to be more accessible to individuals across the socio-economic spectrum.

The accounts are also interesting in how some residents appeared to experience the pathologizing effect of the medical model[3] less than did house advisors, several staff members, and myself. Although in a focus group of five residents, some did express a sense of being treated as "drug addicted crazy people," other residents in individual interviews shared their sense of being treated less like a patient at the Haven, unlike their experiences in hospitals. I believe this tension highlights how the Haven is both providing aspects of humanistic care, and at times relying heavily on a medical-model understanding of psychological distress and treatment. Heartening though are the significant differences between experiences in the hospital and the Haven. By virtue of having more freedom to wander and wield tools, the Haven is much more open, flexible, and honoring of the whole person of the resident.

In speaking to how easily the dominant culture of mental health care can enter an alternative space, I distinctly remember a moment on crew where I joined residents in making apple cider. As I approached the cider press, I saw residents holding paring knives. I immediately felt fearful and thought, "they shouldn't have those." Immediately after this thought, I felt ashamed of myself for that knee-jerk reaction. "They shouldn't have those," was a distinction between myself as someone "safe" to hold a sharp object and residents as "unsafe" individuals.

[3] This finding may also be because of the dominance of the medical model and how residents, who have been "treated" for mental health related concerns in hospitals or other settings may not know about other orientations or approaches in psychology. For residents or patients, the medical model is the "norm" for mental health treatment.

As if "being in treatment" made residents somehow less safe than me. Even with my own commitments to humane care and de-pathologizing psychological distress, I had this immediate reaction when seeing residents with paring knives. This is an example of how dominant discourses constantly infiltrate our ways of understanding and working. It is also an example of implicit bias.

Once I reflected on my thought process and corrected this internal reaction, I stood back in wonder and awe at the moment. I thought, "this scene would be unimaginable in a hospital." No shoelaces, no knitting needles, and certainly no paring knives. Yet, at the Haven, despite residents being in "treatment," they were not seen as constant threats to themselves, unable to complete a task that required a potentially dangerous object. In fact, residents interacted with potentially dangerous objects all the time: a number of farming and construction tools. Yet, unlike in a hospital setting, the assumption of danger was not primary.[4] I smiled thinking of Wilfred's comment, which sarcastically highlights the problem of stigma: "I feel like it's a rare kind of place. It's like, 'all right, we're going to give these mentally ill patients power tools and see how that works out.'" It seems to go a long way in recognizing a resident's humanity, and in reorienting the Haven towards a focus on the residents' health and possibilities for the future.

[4] Often in hospitals individuals are admitted during a crisis where reducing access to certain objects may be necessary. However, as noted in my example above, this mentality of dangerousness extends beyond periods of crises, and becomes a problem of stigma. In this example, we were engaged in a task appropriate for making cider. The simple awareness that people were in treatment for psychological concerns was enough to trigger this stigmatizing reaction in myself when seeing residents with knives. This example further illustrates the *danger* in how discourses and frameworks can contribute to stigma, rather than reduce it.

Chapter Seven:

Restoration of Community

The data reviewed to this point make clear that the Haven has the resources and foundation to enrich its programming with a focus on health, possibility, growth, and change. The Haven can reorient its focus to foster more autonomy and agency for residents. Clinical treatment does not have to render one unable to experience themselves as an autonomous agent in constructing their life. Nor must clinical treatment preclude a focus on community building.[1] It is possible, though difficult, for a therapeutic community to provide clinical care, while recognizing the clinical services are not the sole therapeutic element of healing. This chapter reviews suggestions for the Haven in how to restore a sense of meaningful community engagement.

Work and Clinical Program Integration

In chapter four, I provided various suggestions for increasing experiences of autonomy, competence, and relatedness in the work program. In particular, I advised integration of processing the work being completed, in addition to engaging new residents in discussion of their goals, values, and how such information may inform their engagement with the work program. In order to do this, collaboration between clinical and work programming is necessary. At the beginning stages of the intake, this would require communication between clinical and work program leaders, or a team-wide discussion. Later in treatment, such collaboration could mean having clinicians present on crew for a portion of the day. In asking staff about their

[1] Professional licensing and regulation can create barriers for building and sustaining community. This is the case with limiting former resident employment at the Haven, and in creating the requirement that residents and staff have no contact for six months once a resident leaves treatment. Though these policies are created as a way to protect individuals, they often bring consequences that shut down opportunities for sustained connection. A lengthy discussion of how this occurs is beyond the scope of this dissertation, though it is an important and relevant concept for future research.

visions for the future Haven, several work program leaders mentioned the desire to have clinicians more integrated into the work program, and the community more broadly. As Alice described earlier, now that the clinicians work primarily as therapists, they spend their days in their offices in individual sessions, and are no longer available for in the moment consultation, or to participate on work program. Moreover, clinicians do not participate in "weekend duty." All staff members aside from the clinicians work one weekend a month (sometimes more) on the farm.[2] As noted by several staff members, weekends present the Haven with many opportunities to observe and get to know residents in a different way than does the regular work week:

> So, if we had more money, I'd have six clinicians. I'd have two in the office in the afternoon every day. Not the same ones, but they alternate. And I'd make the clinicians go on work crew in the afternoon, they do all their sessions in the morning and they'd go… If we had more money, and we had six clinicians, they would be on duty, and they would get it and they would like it. They would like it because of the information they get on their clients, too, is totally different on a weekend than they get during the week. Downtime is like so hard for our clients to fill in. Watching them struggle with that is very telling. What they choose to do with that time is very telling. So, if we had more money, we would have six clinicians and they would rotate and they would get the perspective of seeing and interacting with other staff. More money, more money, more money. (Elizabeth)

Nancy echoed the desire to have clinicians present on the weekends:

> When you work weekends, you're not really working. You're hanging out with people and you're kind of, you know, you're doing activities and mak[ing] sure

[2] Clinicians are on call during weekends but are not present at the farm. They do not share the weekend duty rotation with other staff.

> that everybody's accounted for and the fact that clinicians aren't on weekend...I know they're on call… and that's why they're not, but I feel like even if they joined the weekend rotation that, that would help that divide because it really is, you know, they come in on Monday and they're like, 'oh, this, this and this happened over the weekend,' and they have input about it. But like you don't work weekends, so you don't really know how it actually is to try to be one person here, with the help of house advisors, but, and to try to manage, you know, 22 residents at this point, it's challenging. So, I think that that is a big part of it too, that um, kind of disconnect between different groups and even work program has their own group. (Nancy)

Both participants share their perspective that clinicians should be present during weekend shifts to observe the differences in weekend dynamics. Weekend involvement would mean more immersion in the milieu and provide clinicians with more insight into how residents engage with less structure, as well as provide, perhaps, more empathy for the various stresses of running the Haven with significantly less staff present.[3] Being on call while on site during the weekend may also be advantageous.

Many staff expressed ambivalence about having clinicians provide on-site therapy. Alice, among others, felt clinicians should be better integrated into the milieu and that residents should continue receiving therapy in the community, not on site. This idea is worth further discussion; particularly, if removing on-site therapy would significantly decrease tuition, and clinicians would become a larger part of the milieu, not merely crisis management technicians. However, I

[3] Frustrations over weekend happenings was often a conversation in staff meetings. I noticed that it was easy for clinicians or off-duty staff to blame staff or house advisors for residents not taking their medications on weekends (and various other mishaps), though clinicians were not present on the weekends to see how stressful a weekend could get for the limited staff, and thus how easy it may have been to forget to give a resident their medication.

feel my own ambivalence with this recommendation. I continue to wonder about Elizabeth's proposal for six clinicians, as well as how significantly the tuition would be reduced without clinicians providing individual therapy. Residents, and many staff, also spoke overwhelmingly about a desire for more therapy services. Sending residents into town for individual therapy, while holding groups, eco-therapeutic practices, mindfulness meditation, and having clinicians join work program at the Haven, may be one way of increasing clinical programming, while reducing client load for individual Haven therapists. However, I remain curious about the complexities of providing therapy on site versus off site.

Pertinent to the discussion of where individual therapy is provided, is the question of what is meant by the term "clinical." As discussed in chapter five, there were various understandings of the word. Rhonda sees "clinical services" as ongoing, consistent, individual therapy sessions. Alice refers to clinical services as crisis management, having clinicians on crew, and seems to view any contact with a clinician as a "clinical service." If there is no shared definition and understanding of what clinical service is, confusion and breakdowns in communication will continue. Clinicians may continue to feel misunderstood, de-valued (unless there is a crisis situation), and work program staff may legitimately not understand the differences between services, nor the separate roles the services play, or how ongoing therapy informs crisis response. Moreover, clinicians may expect to be offering individual and group therapy primarily (as seems true in Rhonda's accounts of previous clinicians' discontent at the farm) whereas other staff see the clinician's role to be available and active in the milieu. There appear to be varying expectations of the role of clinical services (and various expectations of the work program) based in issues of defining what is therapeutic and what are clinical services.

Another tension between work and clinical programming was how pulling residents off

crew for clinical appointments disrupted the work projects, in addition to residents' ability to change crew on a weekly basis. Consider Colin's comment:

> To have people trade it [crew] up, every Wednesday, you know, and get a new person, it's fine, *but to get all new people*…. and early on, that's how it was. And it's just really hard for me in coming from where I came from. At (name of organization omitted) it was, *the crew was a core* that was, *we established a crew and that crew stayed a crew*. And if there were challenges in the crew, you figured them out, you know, like a person could request to move, a student could request to move, but it was a big deal. And most of the time they couldn't do it until a semester changed and then they could. But what that did was it formed… I mean, you could teach things, build, you could, *you can instill more responsibility.* And I mean we knew each other, you know, like you got to feel, you got to solve problems together. It was not therapeutic at all in the same sense that this was..... Oftentimes, if someone started talking about their personal problems, it would be kind of shut down because it, cause it was a different, it was employment training… is what it was geared to, you know, and so personal problems on the job site aren't something acceptable. So, we didn't do the therapy thing but you still got to be with each other. And so, coming here I somehow pictured that the crew would form and obviously they're going to be people coming and going, but it would be much, much slower. You know, I'd have a core of whatever number of people and someone would depart but then it would be someone that came on a week later, but the core would sort of stay the same. It

> wouldn't.... Just lately it's been better than the last bunch of months. It's been pretty good.
>
> I don't know. *But I would love it if I could craft a crew and keep that crew and don't have to worry that.* So, I proposed with the new, the new schedule. So, Wednesday morning, fill out the ballots. Wednesday at noon, four of us get together and we kind of hash it out. Generally, they [crews] stay the same, but when more people sign up for different crews they've got to balance it out. We've got to balance it out. I proposed that with the new schedule that crew stay the same. And if a person who wants to change a crew, then they put in a request for that. (emphasis added)

Colin describes the difficulties in building community on a crew that often changes. If residents change crew each week, there is a lack of continuity for the crew, and certain projects take much longer to complete. Though I felt critical of this emphasis on crew at times (as I felt the clinical appointments were important for residents), an experience on carpentry crew helped me understand the complexity of running a work program while shuttling residents back and forth to appointments.

One morning in late September, I was helping saw rafters for a meditation room. With the most recent schedule change, therapy appointments were to take priority during the day. Crew still occurred in the mornings, but the majority of clinical appointments took place in the morning hours. I was waiting instruction on how to make the specific cuts for the rafters, when a resident remarked, “I’m going to be late for my meeting.” The crew leader had just returned from dropping a resident off at the main house (our work site was about a ten-minute drive from the main house where residents saw their individual therapists). He asked, “What time is it?” The

resident responded, “Five til’ eleven.” His appointment was at 11:00 am. The crew leader responded, “we’ve got to go now.” As the resident climbed into the truck, the crew leader hurriedly tossed the boards he had picked up for us to saw to the ground. He then jumped into the driver’s seat and took off with the resident.

I stood at the work station with two other residents, who were also waiting for a lesson on how to use the jigsaw. We had been waiting for at least half an hour to learn how to make the cuts and now were out of other work to do. Wilfred and I took the discarded wood and stacked it neatly in a pile. We then sat down and talked. Though I wasn’t bothered by the “lack of work to do,” and instead found it a nice opportunity to talk with the residents, I was aware of the stress the crew leader was feeling. We wanted to finish the meditation room before winter, and with running residents back and forth to appointments, he was away from the crew more than he was present. Crew ended at noon for lunch and his morning had been mostly spent shuttling residents back and forth to appointments, with very little progress made on the meditation room. I felt some disappointment in not having made more progress, though this was another experience where I felt confused and torn about the purpose and focus of the Haven. Although I felt disappointed about not advancing with the project, I also felt therapy was important. I continued to wonder how to solve these problems.

In terms of clinical and work integration, what seems necessary is real re-evaluation of the Haven’s mission. In discussing the role the work program can play in the revitalization of the community, with my dissertation committee member, Dr. Kevin Smith, he remarked, “I think that requires a continual return to a fundamental sense of what it’s all for, a willingness to acknowledge how things have gone flat, an interest in taking up the questions of what we’re trying to do—over and over” (personal communication, August, 20th, 2020). Although I’m aware

the Haven has gone through multiple visioning processes, the importance of asking "what is this all about?" is immense. As is the acknowledgement that clinical services are not the sole arbiter of therapeutic experience.

Rhonda felt that some of the resistance to having clinicians on crew was that work program staff felt this "diminished their role":

> Pre-clinicians coming on, [non-clinical staff] were pseudo clinicians themselves. They were in a role of [support staff] and the role was very much you jumping into [the] preclinical role with people. You're not necessarily having individual therapy sessions with people, but within the context of the team meetings or whatever they used to call them. They would be pseudo clinicians. I think their fear is that it diminishes their role somehow. I think it's, it, that's the little bits and pieces that I've witnessed that I put together that this, it diminishes their role and it also diminishes the part of their role that they really enjoy. They consistently say they really enjoy doing that part. *So, for clinicians on crew doing that, then what is their role on crew? What would they do on crew? Because that's the part they really enjoy is that conversation and the asking questions and sort of that pseudo clinical role.* And from that perspective, it feels like there's very little understanding or interest in learning how the two worlds can come together differently. How crew could be more intentional.

If Rhonda's hunch is correct, both clinical and non-clinical staff must approach their roles with humility and a willingness to understand "we're in this together," and we each play a vital role in the healing process for residents. Each department, and every staff member, bring unique insights, talents, and abilities to the Haven. The Haven needs the work program leaders as much

as it needs clinical staff. Approaching one another with humility, acknowledging and honoring the unique gifts each person brings, is the first step in rebuilding relationships, and in forging a cohesive integration of the clinical and work programs. However, the Haven must also answer the question of "what this is all about?" Is the Haven a working farm for people with psychological challenges? Is it a therapeutic community that provides work on a farm and clinical services as therapeutic modalities? What is the main focus? Can we find a common language to discuss our program and what we provide? Only in better determining the mission and purpose of the Haven can some of the fundamental questions addressed in this dissertation be answered.

Community Meetings: A Necessity

The absence of community meetings remains startling. I recently learned that the community meetings that began as I left the Haven have been discontinued. New leadership seems to feel community meetings are not the best forum for decision-making at the farm. Given the various ways in which community felt absent from work program, I am uncertain how the Haven is supposed to foster community without a forum for residents to voice their thoughts, feelings, and reactions as a result of their immersion in the community. The lack of community meetings also throws the Haven's identity as a therapeutic community into question.

Although this may have changed since I ended my observations, when I was present at the Haven there were no democratic spaces for addressing community wide issues at the farm. Residents could bring these issues to morning meeting, but the structure of morning meeting did not seem to lend itself to in-depth discussion of community issues. How had the Haven moved so far from the model Ron described so beautifully in how staff worked to address issues together as a community?

With the attitude regarding how residents could not run their own groups, I was moved by a focus group I led with five residents in late August. I provide an excerpt from the transcript to highlight both the content and process of how residents engaged with one another in this group. Even when disagreements or hurt feelings arose, the residents were able to navigate this together, mostly on their own, with minimal redirection from me. The following excerpt is from my first question to residents, asking them their opinion on having a resident-led community meeting:

> Amanda: I think that we should experiment with resident community meetings especially because it gives us a voice and autonomy, um, to, to come together and to share whether it's our conflict or our ideas about how to heal. And I think it could be like a therapy in a way. I'm like, I know that I understand where Mary is coming from, like the conflict can boil over and it could cause there to be some sort of a war in a sense. But I think that if the community meetings were seen as more educational and more kind of like broad in their discussion of, of personal conflict, like say the topic is racism and someone experienced racism at the farm instead of saying, 'well this person did this to this person and this is what we're going to talk about,' we could just talk about racism in general and how it affects us. Um, so we can avoid like the specifics and kind of just take a look at the world and at ourselves.
>
> Interviewer: The larger issue and maybe trying to take it away from personalizing?
>
> Amanda: Yes.
>
> Interviewer: Talk about it as a wider issue.

Amanda: Yes. And that goes with like sexism and misogyny but um, and um, or, or even just like feeling like....

Mary: Dehumanized?

Amanda: Yeah. Or, or whatever. Eh, I don't. I don't know. I'm trying to think of other examples but whatever it is we could, we could share our personal experiences. And if there is a, like an actual problem with somebody in particular then I think that that shouldn't, their names shouldn't be used, but that should be brought to like a staff member and talked…and discussed. Um, but just to like lay down the values and the morals of having the community and where we all work together and we're all trying to be on the same page and if there is conflict than I think that it should be, it should be discussed. I mean I'm wary to say that because I know that personal matters can be sensitive, but I think a group discussion is a good safe space. It should be a safe. I mean this should be a safe space for conflict to come up rather than like at the smoking shelter.

Interviewer: So, a safe space for conflict to be addressed.

Amanda: Yeah.

Daniel: I don't think more conflict resolution or issues, personal issues, you know, more of hashing out, you know, regulations and rules, pertaining to work and crew, cuz this is what this place is. It's a work based program, you know, that's, what the people who founded it... that's (inaudible). We've deviated from our founding. There still has to be some regulation issues, medical issues or whatnot and I get that, but still, we're a work-based program, not therapy based. Work based. We need to get back to our roots.

Mary: I think that removing the therapy, especially for a lot of the residents would be....

Daniel: No, I'm not saying. I'm not saying remove the therapy....

Mary: May I speak?

Daniel: Yeah.

Mary: I think that removing the therapy, because it seems like it's helping in some cases, maybe extending the work hours from 1:30 to four, to five and from 9:30 to 8:30 [beginning at 8:30 rather than 9:30]. That would be longer hours without having to disturb the groups or therapies because those can also coexist. They don't have. It doesn't have to be work, work, work or therapy, therapy, therapy. It's a work and the therapy program at this point.

Interviewer: I'm going to chime in here and say again, this is an experience of two different perspectives. For you, (looks at Daniel) you would like to see more work and would like this to be what it used to be, which was work primarily. All of it was work, and then Mary is bringing up this idea and perspective that it can be both, it can coexist and there can be work and therapy.

Daniel: I was thinking they should be able to individualize, you know, there may be people who need more therapy and less work because, you know, because they can't get from their house to breakfast on time or whatever. So those that can work and want to work and need that. That helps them keep sane, and keeps then sane, and not saying something they shouldn't, you know. Um, they need to have that option. We have a lot of work that can be done, there's tons of it around here, but they're just, that's, you know, that's what I was thinking with the community

meeting, resident meeting with a staff person. We can hash out also rules and stuff too. That way we can just individualize more, because that's what I feel like is not happening here. I mean, I get there's some reasons things can't happen, some things that have to be rigid, but it's therapy. A lot of people are here to stay sober, become sober. You know, a lot of.... we need to work on individualizing it more.

During the focus group I was impressed with Mary's ability to advocate for herself when Daniel cut her off, and with Daniel's ability to reflect and listen when Mary asked permission to continuing speaking. Moreover, I was moved by Amanda's vision of a community meeting that addresses cultural and systemic issues that are occurring at the Haven and in the wider world. Amanda courageously voices a desire to explore conflict in the community, that the Haven should be safe space to process such conflict. Mary and Daniel also offer up good ideas about how to make changes at the Haven and highlight a need for resident voices in decision-making.

Participants in the focus group discussed their experiences of limited agency at the farm and saw community meetings as one way to increase resident experiences of agency:

Amanda: In the resident community, because I mean, my idea was to have a community meeting every other week and I mean, it just seems like (name omitted) started to disregard my opinion even though, I mean, it was weird because, staff had this similar idea, like it was actually, um, (name omitted)'s idea. So, I, I was like, 'well, I agree with (name omitted) and I think it should be every other week.' And then it was just like, 'no, it's happening once a month' and then I'm sitting here thinking 'like once a month?' That's like such a rare. That's like, (laughs) yeah. What is it? Are we gonna be like dancing around the full moon? Like, what are we?

(room erupts into laughter)

Mary: We're all werewolves. You revealed the secret! (more laughter)

Amanda: Such a rare occurrence? Like we're not.... I don't know. I mean there are so many individuals here and it's going to be hard to accommodate everyone. Like Daniel wants more work and I want more therapy and I mean like everyone wants different things, but then in terms of hearing out the residents, I think staff doesn't really do that. Like, 'Oh, it's just the drug addicted crazy people!'

Participants: (immediate and simultaneous responses from all participants) Yes!

Eddie: Exactly!

Daniel: It's true.

Eddie: Yep!

(a lot of cross talk starts happening in agreement)

These residents felt that community meetings could be a place to foster more agency and autonomy, and that residents could have a more proactive voice regarding decisions that affect them.

As reviewed in chapter one, community meetings were a primary part of creating therapeutic communities. The aim was to have all members of the community involved in discussing and processing community wide events. In terms of Rapoport's (1960) principles of therapeutic communities, democratization seemed lacking at the Haven. There was not an equal share of power in decision-making, as it affected the entire community. Daniel, in particular, notes the need for residents to be involved in the "hashing out" of rules and regulations. All residents in the focus group agreed community meetings could provide more autonomy. I believe these meetings would go a long way in

helping residents feel more invested in the community, and as real, valuable members of the community.

Groups that Foster Community

As detailed in this dissertation, many residents seemed to desire deep connection with other residents. Earlier I wrote of my awe during a recovery group where residents shared about their own struggles. In this group, residents related to one another with support as each shared their stories of substance use. They related to one another with such kindness and ease, and I left that meeting wondering why it had taken me two months to witness something like this. Paula discussed her desire to run a peer recovery group to foster more connection and intimate sharing. The five residents in my focus group discussed at length their desire for "group therapy," which they notably defined as interpersonal process group therapy (despite the other group offerings currently running). It felt residents were aching for more intimate connection. Ethan, a former resident, now staff member, shared the transformative experience he had as part of a long-term dual diagnosis group:

> So, when I was here as a resident, we had dual diagnosis [group] every Wednesday.... There were, there were like four groups, which we had this outside therapist who she would, her entire Wednesday was, she would only do dual diagnosis group therapy for us. So, it was farm people and transitional program people. So, at different time slots for the day, you would go in there with like four or five other people and for an hour and a half you'd have group therapy, you know, with a lot of the center being around substance abuse stuff. And during that time, you know, you would spend, you could spend six months and have the same

> people in your group the entire time and you would get to know everything about them and the struggles they were going through. And you'd feel this connection of like, 'okay, we're going through the same stuff and we can do this together'. Uh, unfortunately she retired about a year ago and we've, you know, we've tried to bring in this group called (name omitted for confidentiality). But instead of 90 percent of the people with substance abuse issues going as when it was dual diagnosis, we have one or two people who were maybe about ready to transition out of here that are going and, you know, I don't, I don't know anything about the person that leads that group or really how it goes, but I think that that's a big thing we're missing, not only, I think group therapy is personally, I believe it to have tremendous positive effect. Um, and I would like it to see it not only in a dual diagnosis capacity, but for others with .... that aren't struggling with substance abuse.

Ethan describes spending six months in a group of four to five residents discussing their experiences with substance use and psychological challenges. A six-month long group, coupled with the small group size, allows for the building of intimacy and connection. As Ethan said, he and the members were able to see, "we're going through the same stuff," and "we can do this together." Such a group sounds as if it functioned to build stronger bonds between residents.

> The desire to better know and learn from one another was echoed in the focus group:
>
> Mary: Like, like with a lot of the misunderstandings come from a place of not knowing where the other person is coming from. Like *I think me and Eddie had a brief argument at one point and neither of us understood we were bringing our own, maybe not so much traumas but like pasts to the table and that because we*

didn't understand what put each other off, we ended up having a disagreement that could have very easily been solved if we've known each other better. If we had been in a process group together, maybe we could have spelled that out more, and gotten to know each other and never had an argument.

Eddie: Like, I was at a rehab before and we had like a group therapy like every day. And I think when you, when you learn things about... like yes, privacy is needed sometimes, I guess, *but when you learn things about people you can really like sympathize with them and when you can sympathize with someone,* not that you're feeling sorry for them, but sometimes you do kind of just feel sorry for someone. *You're less likely to get mad at them.* You know what I mean? Like, like, um, like I know for myself like if I know something about someone like, you know, like a really like terrible traumatic, like experience that they've had, or whatever. I can be more like… sympathize with someone when they do something that's very, like when they do or say something that's very off putting to me because I'm like, *'well, you know, if, if I experienced this, I, I probably would say this too, sometimes.*' If I went through this I would probably maybe feel this way about this too, you know?

Mary: Exactly!

Eddie: But when you, when you don't really know that much about the person, you just take what they say at face value without there not being any…

Mary: Exactly!

Eddie: Like a deeper, nothing deeper like behind it, you know?

Chris: It seems like AA and NA is the one-time people really share their stories.

(multiple participants say, 'Yeah!')

Eddie: Yes, but not even so much like....like at AA and NA, like yes, occasionally we'll have like a resident that shares their story at the in house meeting, but the AA trips that we go to, like yeah, people talk sometimes, *but they don't really share that much about themselves,* you know, where like, it wouldn't be something, you know, like really like momentous, you know, like, or that really shifts your view, you know, like of the person, you know.

Mary: Can I also add? That's also a problem because I am one of the people who does not have addiction issues, that then… that (AA) and the smoking shelter means *that I'm deprived of ways to interact with people a lot of time*. So, I can't necessarily get that same experience of knowing each other better.

(multiple participants agree by saying, 'Yes!')

Mary: And it's like at the same time I don't want to intrude into the space where other people are dealing with real alcoholism, where I'm just there to hang out. So, it's like, *it's like there needs to be more resources for non-addicts in general,* I think especially in that area. Nonsmokers, non-addicts are really excluded because they have no real connections to other people. *At least like at the smoking shelter, they all have this shared connection of smoking or if they're at AA they all for the most part have a shared connection of having a past with alcohol* and it's like...I don't know, it makes it feel more othering. Whereas if there was like a process group, it would at least be more of a way to connect with people.

Amanda: Yeah!

Eddie: So just to clarify, process group is like another word for group therapy?

Chris and Amanda: Yes.

Chris: *A process group is basically community*. It's not somebody lecturing you, it's a bunch of people. It's people just basically talking like this (referring to the focus group) could be a process group in a way.

Eddie: Yeah. I was just going to say, I just think group therapy is like, I just think so many things can be prevented with group therapy

Chris: *Like 8 people you get to know.*

(shared agreement: 'Yes!')

Mary: And have it rotate a bit?

Daniel: That's better than AA! (emphasis added)

I was moved throughout the actual focus group and I remain moved each time I read this transcript. These residents share a deep desire to better understand and connect with one another. There is a desire to know and be known. Eddie and Mary beautifully discuss how being in a group, or possibly even community meeting, together may facilitate their being more kind and understanding of one another, because they have a sense of what is happening with each other. If Eddie can better know about Mary's current struggles and past history, perhaps he can better understand and respond to her anger, frustration, or sharp comments in heated moments. Groups, such as the one these residents are asking for, foster and cultivate vulnerability, empathy, and connection. Incredibly, these residents are asking for those very things. Chris says that process groups are community.

Therapeutic communities are the ideal therapeutic sites for fostering community. As I write:

> If therapeutic communities can provide a home place able to evoke and potentially meet existential needs, perhaps they are a much-needed modality in the face of, what appear as, so many crises of alienation from community and home. As a site of restoring community, perhaps therapeutic communities could help us better address several issues: the American opioid crisis, American veterans returning from war who long and ache for a continued sense of brotherhood, our world's environmental crisis, our alienation from the more than human world, and existential homelessness. Therapeutic communities are a needed therapeutic modality, and future research should continue to investigate therapeutic communities for their healing aspects as well as how they may be a uniquely generative site for possible restoration of the maternal (Morrissey, 2015) and a way of addressing various crises that plague our country and world more broadly (Lawson, 2018, p. 10).

The Haven is part of a unique and special tradition of providing a space necessary in our world. Though the Haven has its challenges, it has the very tools and values necessary to re-instill a sense of community for residents and staff. All of the suggestions offered throughout this dissertation must first be met by increasing and strengthening the sense of community. Re-orienting the work and clinical programs to a focus on building autonomy, competence, relatedness, and person-centered care, must first be met by re-building community between staff members and honoring the unique perspective each person brings to their work.

Community meetings then are vital and necessary in restoring a sense of belonging, ownership, and autonomy for residents. To help residents invest in the Haven, they must feel as integral and necessary members of that community. Their voices must have a space to be heard,

and to inform aspects of Haven operation, polices, and procedures. House advisors must also be seen as vital staff members, as they engage with residents at a higher frequency and intensity than do other staff members. Though they are often young, they bring an openness, a curiosity, and vibrancy needed in continually rethinking how the Haven functions.

Though the Haven has areas for growth in both clinical and work programs, it is abundantly clear that residents do experience many benefits of a program combining verbal psychotherapy, physical activity, and immersion in nature. I hope the Haven can continue to ask itself "What is our purpose? What is this all about?" and better determine what it hopes to be in the future. A clear identity and mission is necessary in moving forward.

Conclusion: Research Questions and Findings

Though my initial research question asked to what extent does a therapeutic community meet existential needs (or not), as I entered the field, my questions shifted to: What is it like to live and work in a farm-based therapeutic community? What is the role of work at the Haven? Is work therapy? My final question was, to what extent can the Haven retain aspects of its initial vision and approach as it transitions into a treatment center?

In researching these questions, the main findings of the project seem to suggest that the Haven is a site of healing where some residents feel more humanely treated than in hospitals. Moreover, some residents state they experience more agency and freedom at the Haven than in hospitals. It is clear from my observations that the Haven does offer more freedom for residents, than do hospitals. Though some residents cited feeling like "drug addicted crazy people," and desired spaces to express and experience more autonomy, several residents cited various benefits of receiving care in a farm-based therapeutic community. Staff expressed varying perspectives on working at the Haven. Though most enjoyed aspects of the work, there was a tension between

work and clinical programming, and sometimes tensions within the respective departments. Such tensions seemed a result of conflicting mission statements or visions for the Haven—a lack of a coherent and agreed upon mission about the farm's purpose, and thus each staff person's purpose. These disagreements appear rooted in either fondness for the earlier days of the Haven, or in a desire for the Haven to offer more clinical services and function more as a treatment center.

To that end, overall there did appear a lack of autonomy and relatedness throughout the entire community. Residents appeared to experience low autonomy in work program and in the community more broadly, due to the dissolution of community meetings. Work program appeared to operate from a top-down approach where work program leaders made the majority of decisions regarding work projects, with little input from residents. The work also seemed divorced from a community focus. Often the work was emphasized as important for the individual, not the community as a whole. Moreover, the work was often not grounded in an explicit appreciation for the natural world, leaving residents and staff dissociated from the very environment where they worked, and further dissociated from community. All of these challenges seemed to perpetuate a sense of the work as meaningless or severely lacking in meaning.

A lack of relatedness seemed apparent between work and clinical program staff, due to fears and criticisms of how clinical programming may detract from the importance of the work program, and how it may detract from the meaningfulness of the non-clinical staff members' roles. Some clinical staff felt devalued and under appreciated by work program staff, and it seems some work program staff felt devalued and under appreciated by clinical staff. Part of this confusion appears related to differing definitions of what the "clinical services" actually are, and

what staff expect of clinicians.[4]Are clinicians there to offer individual and group therapy? Are they there to work within the milieu and provide crisis management and consultations? Can they do all of the above? Should therapy be provided off-site?

Along those lines, it does seem that as the Haven transitions to becoming more "clinical" in its orientation and focus, the locus of healing somehow shifted almost entirely, though implicitly, towards clinical programming. Clinicians are called upon to handle crises, due to their education and expertise in mental health, and clinicians are looked to for the answers regarding particular concerns with residents. Residents also overwhelming want more clinical services. Again, a clear definition and understanding of the "clinical services" does not seem shared by staff at present. With these shifts, it seems non-clinical staff may also feel they play less of a role in the healing process. However, work program also seemed to lack a certain vitality and intentionality about the work. If non-clinical staff do feel devalued, this may account for some of the lack of energy and intentionality. If not feeling devalued, but instead uncertain about their role in the overall structure of the Haven, such feelings could also lead to these outcomes. Again, the divisions and frustrations between programs seems related to a lack of a coherent and agreed upon vision for the specific aims and purposes of the Haven. What is the Haven? A working farm that offers respite? A therapeutic community that provides clinical services and work on a farm? Who is the Haven ultimately serving? What is the Haven truly?

In terms of the clinical orientation, the Haven operated from a medical model perspective that by its very nature reduces agency, autonomy, meaning, and equality between patient and doctor. As some non-clinical staff expressed their fears and reservations about "becoming a treatment center," their fears were realized in the use of a framework that views residents as

[4] This includes the clinical staff. Clinician's expectations of their roles were sometimes different than what work program staff expected of them, as seen in the descriptions of clinical staff by Alice and Rhonda.

largely passive, mentally ill patients in need of treatment from a mental health professional. Such a perspective leads to the sense that residents cannot run their own groups or don't have much insight into their suffering, because they are "ill." Of note is that this attitude seemed to affect staff (and myself as a researcher) more than it did residents.

Recommendations for Change

First and foremost, Haven staff must attempt to come together in defining what the Haven is, its purpose, and focus. In doing so, all staff members must be recognized for the unique roles they play and the gifts, abilities, and talents they bring to the work. In addition, all programming at the Haven must be understood as therapeutic or potentially therapeutic. Therapeutic practices and services are not solely the domain of clinical services. Work program, a walk in the woods, feeding animals, being in nature, art, journaling, cooking, building community, all of these aspects of the Haven are, or can be, therapeutic. In understanding the therapeutic value of the various aspects of the Haven's program, staff morale and engagement may increase, as all staff are seen as contributing something vital and meaningful to the Haven's work with residents.

More intentional focus on the therapeutic aspects of the work, including working in order to serve the community, is necessary to shift the Haven from a sense of "working to do get work done," to a sense of engagement and investment in the work. To that end, residents must feel they are vital to the work program and that their voices are important in crafting work projects. A more intentional focus on teaching skills will likely also instill more engagement and interest in the work program, particularly if residents' interests in learning such skills are explored first.

Integration of eco-therapy practices is necessary in helping residents and staff feel part of (and more explicitly appreciate) the more-than-human community of the Haven. Descriptions of

such practices are included in Appendix F. Importantly, many of these practices do not require the presence of a licensed clinician. Thus, whether a clinician is on crew or not, some of these practices can be integrated into work program, and evening and weekend programming.

The clinical orientation of the Haven should shift from being largely grounded in the medical model to an existential-humanistic framework. Such a framework emphasizes agency, autonomy, responsibility, and mindful attention to the present moment. This would mean taking a different philosophical stance in understanding human suffering and thus the residents. Residents would be seen as co-healers, not ill patients mainly helped by an expert clinician. Treatment does not primarily occur between a licensed "healer," and a patient who is dependent solely upon the doctor for healing and recovery. The healing happens between people in a relationship, and the meaning of a person's distress or symptoms is explored, not simply managed and removed by medication.

House advisors must be seen for the invaluable role they play at the Haven by virtue of living and working with residents nearly 24/7. House advisors also requested more training when I asked them what they recommended for the future. House advisors would like to see more support of their work, to be more integrated into various committees throughout the farm (in resident services committee meetings, their voices were notably absent during my observations) and to have more training with respect to mental health diagnoses, and ways of supporting residents with specific mental health concerns.

With respect to addiction services, though many people have been helped by AA, as with any healing approach, one model does not work for everyone. Moreover, empirical literature suggests that the positive predictors of change for those struggling with substance use are: client choice and client role in decision-making, collaboration between provider and client, use of an

empathic rather than confrontational approach, and a flexible approach to client motivation [i.e. motivational interviewing] (Pruzan, 2020; Miller & Moyers, 2014; Miller & Rose, 2009). That being so, other modalities may better address resident struggles with substance use. Modalities that emphasize the need for autonomous rather than controlled motivation, where the resident is an active agent in their recovery, may be most salient.

According to the Center for Motivational Change, currently the best performing approaches for substance use in terms of empirical research are: the Community Reinforcement Approach,[5] Brief interventions, Motivational Enhancement, Social Skills Training from a cognitive-behavioral approach, behavioral material therapy, and psychopharmacological interventions as adjunctive treatments (Pruzan, 2020).

To protect the safety of the community, the Haven must make use of some external controls (i.e. bag checks, breathalyzing residents). However, integrating more approaches that treat residents as agents in their own recovery, that actively draws them into the decision-making process, and pulls from other conceptualizations of substance use (i.e. motivational perspectives) will help restore a sense of agency and empowerment.

Residents also shared that they would like to see more staff members who are living in recovery. Working with staff who were in recovery from substance use was cited as an important agent in resident's own recovery—seeing others who were able to hold a good job, share openly about their own history and recovery, and serve as role models for residents, helped residents feel they could recover. Though the Haven did have several staff who shared openly about their recovery from substance use, residents cited a desire to see more staff who hear voices and have

[5] I learned of the Community Reinforcement Approach in a seminar through the Center for Motivation and Change in New York. This approach seems ideal for a therapeutic community where working with families is a significant part of the treatment. I provide a description of this approach in Appendix G.

recovered from difficult experiences with psychosis or other mental health difficulties.

Finally, restoration of community meetings is necessary. To build autonomy and a sense of investment in the community, residents (and staff) need a space to explore community wide issues and happenings. Moreover, they need a space where their voices are central in informing the decision-making process about community policies and practices (i.e. resident input on smoking policies, internet policies, etc.). Therapeutic communities' healing power relies in part on the community itself. Without such meetings, the role of community is diminished.

Researcher's Personal Growth and Self-Discovery

I experienced much growth throughout the process of conducting this project. First, I came to the project with much idealism regarding therapeutic communities. At the conclusion of my field work, I left questioning whether therapeutic communities were the ideal treatment modalities I hoped they were. Specifically, I wondered if the Haven could bridge all of the challenges it faced. I began to wonder if the Haven could ultimately function as a "treatment center" and retain its humanistic history and values. Although I have ideas for how the Haven can do this, I wonder about the feasibility and willingness of staff to try and integrate the suggestions made in this dissertation.

I also wonder about the financial realities of making these shifts. I was unable to gather detailed information about the financial world of the Haven. Although I was told the Haven was constantly running low on money, and that the majority of the money generated went toward staff salaries, residents and I remain puzzled about how and where the money went. Perhaps my puzzlement is strongly informed by my socioeconomic background, as I continued to feel that the Haven should be offering more services for the tuition. However, it seems offering more services would require more clinicians on staff and thus an increase in tuition, creating additional

barriers for even more families. On the topic of cost, as I detailed in chapter one, I experienced much growth in my own assumptions and biases. I assumed money would not be a topic or concern for residents. I was very wrong. Residents were concerned about the cost of the Haven, either in worrying about the money their families were paying, or in feeling they were not getting what they were paying for. I was impressed by the amount of concern residents, from families who could afford the Haven, felt about this topic.

Although my immediate impressions of the work program were quite negative, as I spent more time on site, I came to better value and enjoy the work. Whether I habituated to the environment and grew less critical over time, is a possibility. When I joined carpentry crew and farm crew, I felt more of the meaning described throughout this dissertation. Learning skills and caring for animals naturally elicited this meaning for me. Over time, I also realized that I too often thought of "therapeutic services" in terms of clinical ("professional") offerings. As I spent more time on site, I could appreciate how other departments might feel lost in the shadow of clinical services. I continue to hope work and clinical program can appreciate their respective value and collaborate more openly together in service of resident well-being and recovery.

In terms of the shame and memories evoked by my experiences on work program, I still hold many of those feelings. I still believe a better integration of clinical and work program could have helped me (if I were a resident) to work through these challenging feelings I experienced. As previously mentioned, when I did learn more skills on carpentry and farm crew, I felt enlivened and excited. Learning skills made me want to do the work. Again, what we label laziness is likely a symptom of not knowing what to do, rather than a character trait. My frustration dissolved when I learned how to use the tools necessary to complete a task, as did my shame, and I looked forward to the work.

Of particular interest to me is that after leaving the Haven, I feel the profound loss of not working outdoors anymore. As I sat at my kitchen table this summer and wrote parts of this dissertation, I could see my father outside driving a tractor, or building an addition onto my sister's house. I could identify the various saws and tools he was using, as a result of my time at the Haven. Many times, I longed to be outside with him building, rather than spending my days on the computer. Thus, my time at the Haven cultivated an even more profound awareness of our alienation from nature and how healing working outdoors can be. I continue to wonder how to take more of my future therapy practice outdoors, as leaving the Haven did make me question my choice of a career that will keep me indoors so often.

Most importantly, for myself as a researcher, throughout the study, I found myself appreciating and understanding (to the extent that I could) many of the perspectives that were shared with me during my research.[6] Despite my clinical background and preference for clinical work, I could see how pulling residents off crew and driving them back and forth to appointments was, at times, disruptive to work program cohesion. I could appreciate the tensions felt by various programs and felt a passion for trying to help the whole community bridge these divides and construct a program where community is the primary healing agent, with the support of increased clinical services, and meaningful work on a farm.

Finally, I feel ambivalent about sharing this work with the Haven. One of the central challenges in ethnography is when the researcher is so lovingly welcomed to the site, when she builds relationships within the community, becomes truly part of the community, and then may reveal in the final written product, aspects of the community they may have wished to keep

[6] As explored earlier, not allowing residents to run a recovery group without a clinician present was not one of those perspectives, as it is fundamentally in objection to my view of human suffering and flourishing, and my view of social justice.

secret, in hindsight. As Scheper-Hughes (2001) writes in the preface to the Y2000 edition of *Saints, Scholars, and Schizophrenics: Mental Illness in Rural Ireland*, regarding the difficulties she faced after the publication of her ethnographic research:

> I find myself revisiting questions about anthropological ethics and the politics and poetics of 'writing culture' and *especially about the difficulties of balancing one's responsibility to honest ethnography with care and respect for the people who shared a part of their lives and their secrets with me*. (emphasis added)

During my research I did become part of the community and have kept in touch with some participants throughout the last two years, both in order to stay updated on the Haven and to hear how they, personally, were doing. Given the beautiful welcoming I experienced throughout my time, it is difficult to share my own criticisms of the Haven. However, it feels necessary in trying to help the Haven improve their services for the residents, without whom there would be no Haven. Additionally, out of respect and care for the participants who shared so much with me, it feels ethically necessary to share their stories, concerns, criticisms, and suggestions for improvement. My hope is that I have conveyed, with respect, the varying perspectives at the Haven, while also taking a critical lens to the events that occurred during my four months of observation, in service of making the Haven a continued source of refuge, recovery, and healing.

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Appendix A:

DUQUESNE UNIVERSITY

600 FORBES AVENUE ♦ PITTSBURGH, PA 15282

CONSENT TO PARTICIPATE IN A RESEARCH STUDY

TITLE: From Needed Relationships to Needed Communities: An Ethnography of Existential Issues in a Therapeutic Community[7]

INVESTIGATOR: Monica A. Lawson, M.A, Doctoral Candidate, McAnulty School of Liberal Arts, Clinical Psychology Department, lawsonm1@duq.edu

ADVISOR: Dr. Daniel Burston, McAnulty School of Liberal Arts, Clinical Psychology Department, burston@duq.edu, 412-396-6514

SOURCE OF SUPPORT: This study is being performed as partial fulfillment of the requirements for the doctoral degree in Clinical Psychology at Duquesne University.

PURPOSE: You are being asked to participate in a research project that seeks to investigate the experience of living in a therapeutic community. In particular the project seeks to examine experiences unique to therapeutic community treatment.

In order to qualify for participation, you must be: a resident, or client of the Haven, and at least 18 years of age or older.

PARTICIPANT PROCEDURES: I will be observing the daily operations and interactions between staff and residents at the Haven. If you give consent to participate in this study, I may take notes about your experiences and interactions at the Haven.

I will be taking notes about the daily events and functions of the farm.

[7] This title reflects the tile of the former dissertation proposal. After collecting the data and realizing the focus of the dissertation had shifted, I changed the title of the dissertation.

In addition, you will be asked to be interviewed. The interviews will be recorded with an audio device and transcribed. Interviews will be held at the Haven, or at one of the transitional living facilities, they will last one to two hours, and participants may be interviewed up to three times. I may ask you to review the interview transcripts and you are free to refuse by telling me that you do not wish to review the transcripts.

I will ask you whether you would like to see the material that I publish from this project after it is published. If so, I will ask you to provide me with contact information that I can use to get in touch with you when the material is published.

These are the only requests that will be made of you.

You do not have to participate in this study in order to receive services at the Haven. Not consenting to the study will in no way interrupt or interfere with your treatment at the Haven.

RISKS AND BENEFITS:

All attempts to preserve confidentiality will be made; however, breaches of confidentiality are always a risk. No identifying information will be associated with interviews or notes taken during the study. In the event that this study is published I will use made up names to refer to participants. However, people who know you well, including your fellow residents at the Haven, may be able to tell who I am writing about, and they may be able to recognize you based on the things you say in interviews. It is unlikely that readers who have never been a part of the Haven will know who I am talking about in the published study; however, it is possible.

Although many people enjoy talking about their experiences, sometimes the content can become distressing.

In the unlikely event you become distressed please let me know in person and arrangements to speak to your support staff at the Haven will be made.

Benefits of this study include the opportunity to share and reflect on your experience as a resident at the Haven, to educate me on the community and workings of the farm, to speak to needs that may be overlooked in the broader

mental health community, and to advocate for possible changes in the mental health system.

COMPENSATION: There will be no compensation for participation in this study.

Participation in the project will require no monetary cost to you.

CONFIDENTIALITY: Your participation in this study and any personal information that you provide will be kept confidential at all times and to every extent possible.

Your name will never appear on any survey or research instruments. All written and electronic forms and study materials will be kept secure. Your response(s) will only appear with disguised names in the event that this study is published. Any study materials with personal identifying information will be maintained for 10 years after the completion of the research and then destroyed.

All audio recordings will be deleted 10 years after the completion of this project. Until then audio recordings will be kept secure.

RIGHT TO WITHDRAW: You are under no obligation to participate in this study. You are free to withdraw your consent to participate at any time by telling me you wish to withdraw in person or via email at lawsonm1@duq.edu. Your materials will be destroyed at this time and withdrawing will not affect your treatment at the Haven. Any data collected up until this point will be destroyed unless it has already been used in a presentation or write up for publication. No new data will be collected once you've asked to withdraw from the study.

SUMMARY OF RESULTS: A summary of the results of this research will be supplied to you, at no cost, upon request. If you'd like a copy of the results I will ask you to provide contact information where I can send the results.

VOLUNTARY CONSENT: I have read the above statements and understand what is being requested of me. I also understand that my participation is voluntary and that I am free to withdraw my consent at any time, for any reason. On these terms, I

certify that I am willing to participate in this research project.

I understand that should I have any further questions about my participation in this study, I may email Monica Lawson at lawsonm1@duq.edu or call Dr. Daniel Burston at 412-396-6514. Should I have questions regarding protection of human subject issues, I may call Dr. David Delmonico, Chair of the Duquesne University Institutional Review Board, at 412.396.4032.

Participant's Signature	Date
Participant's Printed Name	Date
Researcher's Signature	Date
Psychiatrist's Signature	Date

Appendix B:

DUQUESNE UNIVERSITY

600 FORBES AVENUE ♦ PITTSBURGH, PA 15282

CONSENT TO PARTICIPATE IN A RESEARCH STUDY

TITLE: From Needed Relationships to Needed Communities: An Ethnography of Existential Issues in a Therapeutic Community

INVESTIGATOR: Monica A. Lawson, M.A, Doctoral Candidate, McAnulty School of Liberal Arts, Clinical Psychology Department, lawsonm1@duq.edu

ADVISOR: Dr. Daniel Burston, McAnulty School of Liberal Arts, Clinical Psychology Department, burston@duq.edu, 412-396-6514

SOURCE OF SUPPORT: This study is being performed as partial fulfillment of the requirements for the doctoral degree in Clinical Psychology at Duquesne University.

PURPOSE: You are being asked to participate in a research project that seeks to investigate the experience of living and working in a therapeutic community. In particular the project seeks to examine experiences unique to therapeutic community treatment.

In order to qualify for participation, you must be: a staff member of the Haven, and at least 18 years of age or older.

PARTICIPANT PROCEDURES: I will be observing the daily operations and interactions between staff and residents at the Haven. If you give consent to participate in this study, I may take notes about your experiences and interactions at the Haven.

I will be taking notes about the daily events and functions of the farm.

In addition, you will be asked to be interviewed. The interviews will be recorded with an audio device and

transcribed. Interviews will be held at the Haven, or at one of the transitional living facilities, they will last one to two hours, and participants may be interviewed up to three times. I may ask you to review the interview transcripts and you are free to refuse by telling me that you do not wish to review the transcripts.

I will ask you whether you would like to see the material that I publish from this project after it is published. If so, I will ask you to provide me with contact information that I can use to get in touch with you when the material is published.

These are the only requests that will be made of you.

Not consenting to the study will in no way interrupt or interfere with your employment at the Haven.

RISKS AND BENEFITS:

All attempts to preserve confidentiality will be made; however, breaches of confidentiality are always a risk. No identifying information will be associated with interviews or notes taken during the study. In the event that this study is published I will use made up names to refer to participants. However, people who know you well, including residents, and fellow staff members at the Haven, may be able to tell who I am writing about, and they may be able to recognize you based on the things you say in interviews. It is unlikely that readers who have never been a part of the Haven will know who I am talking about in the published study; however, it is possible.

Although many people enjoy talking about their experiences, sometimes the content can become distressing.

In the unlikely event you become distressed please let me know in person and the interview will end.

Benefits of this study include the opportunity to share and reflect on your experience as a staff member at the Haven, to educate me on the community and workings of the farm, to speak to needs that may be overlooked in the broader mental health community, and to advocate for possible changes in the mental health system.

COMPENSATION:

There will be no compensation for participation in this study.

Participation in the project will require no monetary cost to you.

CONFIDENTIALITY:

Your participation in this study and any personal information that you provide will be kept confidential at all times and to every extent possible.

Your name will never appear on any survey or research instruments. All written and electronic forms and study materials will be kept secure. Your response(s) will only appear with disguised names in the event that this study is published. Any study materials with personal identifying information will be maintained for 10 years after the completion of the research, and then destroyed.

All audio recordings will be deleted 10 years after the completion of this project. Until then audio recordings will be kept secure.

RIGHT TO WITHDRAW:

You are under no obligation to participate in this study. You are free to withdraw your consent to participate at any time by telling me you wish to withdraw in person or via email at lawsonm1@duq.edu. Your materials will be destroyed at this time and withdrawing will not affect your employment at the Haven. Any data collected up until this point will be destroyed unless it has already been used in a presentation or write up for publication. No new data will be collected once you've asked to withdraw from the study.

SUMMARY OF RESULTS:

A summary of the results of this research will be supplied to you, at no cost, upon request. If you'd like a copy of the results I will ask you to provide contact information where I can send the results.

VOLUNTARY CONSENT:

I have read the above statements and understand what is being requested of me. I also understand that my participation is voluntary and that I am free to withdraw my consent at any time, for any reason. On these terms, I certify that I am willing to participate in this research project.

I understand that should I have any further questions about my participation in this study, I may email Monica Lawson at lawsonm1@duq.edu or call Dr. Daniel Burston at 412-

396-6514. Should I have questions regarding protection of human subject issues, I may call Dr. David Delmonico, Chair of the Duquesne University Institutional Review Board, at 412.396.4032.

_____	_____
Participant's Signature	Date
_____	_____
Participant's Printed Name	Date
_____	_____
Researcher's Signature	Date

Appendix C:

Interview Guide

Questions about life on the Farm for Current Residents

1) Tell me about your experience at this farm-based therapeutic community.

2) This farm-based therapeutic community calls itself a therapeutic community, what does that mean to you?

3) Is this your first therapeutic community experience?

4) What brought you to this farm-based therapeutic community?
   -or, How did you learn about this farm-based therapeutic community?
   --if participant mentions "mental illness" I will listen for how they describe mental illness—e.g. do they identify as "bipolar, schizophrenic, or mentally ill."
   --if participants mention mental illness I will ask them to describe their experience of mental illness.

5) What is your experience of living at the farm?

6) What is your experience of the work-based therapy program at the farm?
   Possible follow ups: -Tell me about the work crews, -What is your experience of being part of a work crew?

7) Tell me about your experience of the therapy groups at the farm.
   Or, what are therapy groups like at the farm?

8) Describe a "typical day" at the farm.

9) Tell me about how you experience the setting and location of this farm-based therapeutic community?

10) Tell me about how you experience free or down time at the farm?

11) What is therapeutic about the farm? What is not?
    Follow ups: What is helpful to you about the farm? What is not?

12) Tell me about graduating from the farm.
    Follow ups: What do you envision when you think about graduation? What does leaving the farm mean to you? What will leaving feel like? Do you imagine you'll stay connected to the farm in some way?

13) (If resident has prior therapy experience or treatment) How do you compare treatment at the farm with your previous experiences with mental health care? How is the farm similar or different from other treatments you've experienced?

14) What is like to have medical and psychological care traditionally done in hospitals or offices in a community where you live and work? What's it like to have this care in an environment where you work alongside support staff?

15) Is there anything I didn't ask that you wanted to discuss

Appendix D:

Questions for residents working with Transitional Programming and continued care

1) Tell me about your experience at this farm-based therapeutic community.

2) Tell me about the transitional programming and continued care available through the farm.

3) What is your experience of the transitional programming and continued care?

4) Tell me about your experience living at the farm.

5) What is/was it like to leave the farm and transition to the transitional programming?

6) How long do you see yourself to be involved with this farm-based therapeutic community through transitional programming or continued care?

7) (For a resident who continues a connection but may not be involved in transitional programming) What led you to establish continued connections with this farm-based therapeutic community?

8) (If resident has previous experience with mental health services) How is the treatment through this farm-based therapeutic community similar or different from your previous experiences?
Follow ups: This farm-based therapeutic community describes itself as a "therapeutic community" what is therapeutic about the farm and what is not?

9) What was your experience of graduating from the farm?

Appendix E:

Questions for Staff

1) How did you come to work at this farm-based therapeutic community?

2) How did you learn about this farm-based therapeutic community?

3) Tell me about your experience at this farm-based therapeutic community.

4) How would you describe this farm-based therapeutic community?

5) What, from your perspective, makes this farm-based therapeutic community therapeutic or potentially healing?

6) What, from your perspective, makes this farm-based therapeutic community non-therapeutic or potentially not healing?

7) What is it like to work at this farm-based therapeutic community? Likes and dislikes.

8) How would you describe the individuals who come for treatment at this farm-based therapeutic community?

9) Are there residents who do not do well here? If so, why do you think that is? Are there certain residents for whom this treatment site is not the treatment of choice?

10) From your perspective, what makes treatment "successful" for residents who do well here?

11) (For staff involved with transitional programming) What is it like to be part of transitional programming? What is the role of transitional programing?

12) (For staff involved with transitional programming) What is the purpose of transitional programming? How many residents graduate into transitional programming, and how long do they stay involved?

13) Have you worked in other mental health settings? If so, how is this farm-based therapeutic community similar and different from those other settings?

14) Is there anything I did not ask, but you would like me to know?

Appendix F:

Eco-therapy Practices

Below is a list of eco-therapy practices Haven staff can use with residents. These practices are adapted from Clinebell's (1996) text: *Ecotherapy: Healing ourselves, healing the earth,* and additional practices used in Dr. Will Adam's Ecotherapy graduate course at Duquesne University. Moreover, these practices are suggestions that can be modified as needed:

1) Nurture by Nature: Simply encouraging residents to spend more intentional time in nature. Additionally, staff can bring the time residents already spend in nature into awareness. Staff can ask residents to reflect on their experiences in nature or to attend more directly to their immersion in nature. What do they notice when spending time in nature versus time spent on their computers, indoors? Staff can encourage residents to spend an intentional 10-15 minute period in nature, in solitude (Clinebell, 1996, p. 194).
2) Sitting Spot Reflection: Have residents find a quiet place where they can develop a relationship with a particular plant, tree, or natural setting. Ask residents to spend 10 minutes or so a day in this same spot, paying attention to this particular plant, tree, or place in nature. What do they notice over time with respect to this plant or tree? If the resident spends multiple seasons at the Haven, what does the resident notice about the plant, tree, or spot as the seasons change? What do these observations bring up in the resident about their own experiences? Clinebell (1996) notes that this practice is similar to one followed by some Native Americans who spent intentional time with a part of the natural world, "becoming tuned to its energies and rhythms" (p. 198). [8]

[8] I had the great fortune to meet Dr. Lisa Lefler, associate professor and director of the Culturally Based Native Health program at Western Carolina University during my pre-doctoral clinical internship. In a seminar with Dr. Lefler, we discussed how the conceptualization of eco-therapy, and the growing awareness in medical and clinical fields of the importance of nature for human health, is information derived from, and part of, Native culture.

3) Horticultural therapy: cultivating relationships with plants, attending to the seasonal work of gardening, learning of the antidepressant effects of gardening, cultivating awareness of raising one's own food. Citing therapists from the Philadelphia Friends Hospital, Clinebell (1996) writes of the four areas of improvement experienced by patients engaging in horticultural therapy:

   Cognitive improvements result from awareness of the outside world and of one-self in it; learning new skills and language; acquiring decision-making and problem-solving skills and learning to work more independently and follow more complex instructions…*Psychological improvements* include feeling more productive and useful; increased self-esteem and self-confidence as projects are planned and completed; release of anger and aggressive impulses constructively (through vigorous weeding, hoeing, and pruning); more peaceful inner feelings and more openness to talking through their feelings and problems... *Social improvements* come by working in a small group towards common goals, by learning communicating and compromising skills, and by talking about a neutral topic: plants. *Physical improvements* are gained by exercise in a safe work environment with lots of fresh air. Patients' bodies improve as their muscles are retrained and coordination in both gross and fine motor activities is improved. (p. 22, emphasis in original text).

4) Animal bonding. Though a contentious topic at the Haven, there are opportunities for residents to grow in relating to animals. Although residents were encouraged to not get attached to some animals, as they were later killed, it is unlikely that

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However, little credit is ever paid to Native communities for their reverence of the natural world, as a result of America's racist oppression and colonization of indigenous people (personal communication, May 6th, 2020).

residents *do not* get attached at some level, nor is it truly therapeutic. As I observed the day we were moving cows between pastures, some residents naturally connected with animals in ways they struggled to connect with other humans. An acquaintance of mine discussed how it was taking care of a farm animal that first taught her that she could be responsible for something, that she could have meaning in the world, beyond her so-called "mental illness." There is also abundant literature on the calming and soothing effects of animals for various types of psychological distress. Beyond providing comfort and stress reduction, the work with animals presents a multitude of opportunities for learning about life cycles, responsibility, and ethics.

5) Nature-based-mindfulness-mediations. There are several opportunities for staff and residents to take a 5-10 minute break during crew to mindfully attend to the natural world. The day I was trail clearing is a great example. Out in the woods, it was the perfect environment to stop, observe, and listen to the sights and sounds around us, to reflect on the differences in our mental and physical states as a result of working in nature. Moreover, the practice of stopping to pay attention to the present moment is vital in our increasingly fast-paced world where producing is a constant demand. This practice can help build on the clinical work of teaching mindfulness, by actually practicing it in the moment. Moreover, mindfulness meditation is a common practice for stress reduction and increasing awareness of our parasympathetic nervous system. Such practice also helps cultivate an awareness and appreciation of the natural world.

This is a list of five suggested activities the Haven could make use of in integrating eco-therapeutic methods into its programming. For a list of many other activities please see Clinebell's (1996) text.

Appendix G:

Description of CRA and CRAFT

The Community Reinforcement Approach (CRA) is an empirically supported behavioral intervention aimed at involving a substance user's social network or significant others in the treatment of substance use (Smith, Campos-Melady, & Meyers, 2009). CRA draws upon the idea, and supporting literature (Ariss & Fairbairn, 2020), that the substance user's "community plays a significant role in recovery" (Smith et al., 2009, p. 4). CRA draws upon the principles of positive reinforcement, with a goal to "change aspects of the client's environment and interactions with their communities, such that a clean, sober lifestyle becomes more rewarding than the substance use" (Smith et al., 2009, p. 4). The Community Reinforcement and Family Training (CRAFT) approach is an empirically supported intervention focused on helping family members who are coping with a substance using family member who is either hesitant about, or refuses, treatment for their substance use. In CRAFT, the therapist works first with the concerned significant others (CSO) to identify strategies to more "effectively" work with their family member who is using substances but who is not in treatment or not fully engaged with treatment (Kosanke & Foote, 2020). This approach actively involves the larger social network, seeing them as integral to treatment, rather than placing the sole responsibility of recovery on the substance user alone.

CRAFT relies on three goals: 1) to get the substance using family member into treatment, 2) to decrease this family members substance use, and 3) to increase the concerned family member's happiness regardless of whether their substance using family member enters treatment or not (Smith et al., 2009, p. 22). CRA and CRAFT both use a motivational rather than confrontational approach (Smith et al., 2009; Kosanke & Foote, 2020). Both CRA and CRAFT

use functional behavioral analyses (i.e. identifying internal and external triggers, resulting behavior, and short-term positive outcomes of substance use, and long-term negative outcomes of substance use), sobriety sampling (i.e. a time-limited period of abstinence), communication skills training, role-playing, and problem solving aimed at anticipating obstacles and triggers in reducing substance use (Smith et al., 2009). For a good review of both approaches and case examples see: Smith et al. (2009).

Although there are aspects of this model I may question or disagree with it (i.e. viewing substance use largely from an operant conditioning lens), aspects of the approach seemed salient for the Haven. Given that the majority of residents are referred by their parents, CRA and CRAFT actively involve and educate the family as part of the treatment. Such an approach may help families in learning better communication skills, and to feel more empowered regarding their child's treatment and substance use. Families may also learn ways to positively reinforce certain behaviors, while reducing "enabling" behaviors. Families may also learn frustration tolerance skills in decreasing such enabling behaviors for their child.

CRA also identifies that some individuals may not want to completely abstain from substances and honors this desire. In this way, CRA is different from abstinence only models such as AA/NA. Such a model was desired by some residents during my research. CRA also draws upon a "jobs skills" framework, seeing work as a potential reinforcer and motivator in reducing substance use. The emphasis on job skills training appears consistent with a core feature of Haven programming (i.e. using work as a healing agent in recovery). Finally, CRA emphasizes a need to help individuals learn how to structure the time they previously filled with substance use (Smith et al., 2009, p. 19). Smith et al. (2009) note that therapists may have to help patients with this concern. I was particularly taken with the importance of this suggestion—that

the therapist may need to take a more active role in helping patients brainstorm and experiment with ways to fill their time, given the number of times I heard staff and residents discuss the problem of "structuring downtime." Rather than leaving residents to their own devices (literally and figuratively) in learning how to structure downtime, a more active approach in helping them try out new ways of filling this time may be beneficial.

Regardless of the use of CRA or CRAFT, many other modalities exist that integrate the family or social network into substance use treatment. Given the abundant literature on how interpersonal relationship distress predicts and contributes to substance use, in addition to how interpersonal relationships may play an instrumental role in helping one recover (see Ariss & Fairbairn, 2020), involving significant others in treatment seems necessary. In their metanalysis of significant other involved treatment (SOIT) for substance use, Ariss and Fairbairn (2020), conclude:

> Results indicated that, above and beyond the effects of individually-based active comparator treatments, significant other integration into SUD treatment led to an increased reduction in substance use and substance use problems. Importantly, improved outcomes for SOITs extended beyond the end of treatment, enduring as long as 12 to 18 months posttreatment. When examined as raw frequency metrics, the effect of significant other involvement equates to an approximate 6% reduction in substance use frequency beyond individually-focused treatments—translating to approximately two fewer days a month or three fewer weeks a year of drinking/drug use. (p. 536)

Modalities that involve the significant others in a resident's life may be a boon to the Haven's addiction services.

Appendix H:

List of Pseudonyms

Chris	Resident
Jerry	Resident
Seth	Resident
Charles	Resident
Wilfred	Resident
Mary	Resident
Allan	Resident
Oliver	Resident
Isaac	Resident
Anna	Resident
Sam	Resident
Enrique	Former Resident
Paula	Resident
Sandra	Resident
Brandon	Resident
Talia	Resident
Adrian	Former Resident
Joseph	Resident
Stacey	Resident
Tyler	Resident
Katie	Resident

Amanda	Resident
Daniel	Resident
Eddie	Resident
Shelly	Resident
Ron	Longtime Haven Colleague and Former Staff Member
Elizabeth	Staff Member
Chad	Staff Member
Tara	Staff Member
Mary Anne	Staff Members
Dean	Work Program Staff
Miranda	Staff
Colin	Work Program Staff
Christine	Staff Member
Leslie	House Advisor
Sonya	Staff Member
Tonya	Haven Therapist
Nancy	Staff Member
Annie	House Advisor
Allison	House Advisor
Elias	House Advisor
Alexis	Staff Member
Adam	Staff Member

Ted	Former Staff Member
Catherine	House Advisor
Craig	Work Program Staff
Alice	Staff Member
Rhonda	Staff Member
Leslie	House Advisor
Jacqueline	House Advisor
Naiyah	Staff Member
Rory	Staff Member
Ethan	Staff Member
Fred	Staff Member
Vance	Haven Therapist
Steven	Staff Member
Sarah	Longtime Haven Colleague