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Situating mental health work in place: Qualitative findings from interviews with Veterans in Southeastern Louisiana and Northern California

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ABSTRACT

Most chronic illness management occurs outside clinics and hospitals, in the everyday lives of individuals. We use data from semi-structured interviews with 37 veterans from Southeastern Louisiana and Northern California to illustrate how "health work" for mental health concerns are shaped by place. Using health work as an orienting concept for analysis, we discerned variation between the two study sites in how Veterans used interacting with the natural environment, cultivating time alone, and religious practice to manage their mental health and well-being. Through these findings, we advocate for a situated notion of health work that is mindful of how health-related behaviors are shaped by place and the attributes that constitute place.

1. Introduction

In 2012, each of the 10 leading causes of death in high income countries were chronic conditions, such as diabetes and heart disease (WHO, 2016). The vast majority of chronic illness management, including for chronic mental illness, takes place outside clinical settings, in people's communities and homes. Yet, in high income countries such as the U.S. and U.K., inpatient and acute care receive the lion's share of health care dollars, with less support for outpatient services, and virtually none for health promotion activities outside of clinical settings (Thorne, 2008). In response to the mismatch between the organization and delivery of healthcare and the everyday reality of managing chronic conditions, patients have been encouraged to take a more active role in managing their health (Epping-Jordan et al., 2004; Northrup, 1993).

In tandem, there has been increasing attention on how patients manage chronic conditions outside clinical settings, including studies focused on self-care, self-management, and "health work." Health work refers to the physical, emotional, or psychological activities people engage in outside clinical settings to regulate, maintain, or restore health and well-being (Mykhalovskiy and McCoy, 2002). Much of the literature concerned with self-management of chronic conditions, including health work, is dominated by studies about individual decision making around health (Nardi, 1983; Paterson et al., 2001) that have largely neglected how external influences, such as *place,* constrains (i.e., limits) the choices realistically available to any individual (Nardi, 1983; Ragins, 1995; e.g., Davidson, 2005; Weiner, 2011).

Like all health-related behavior, health work does not occur in a vacuum, but is constrained and/or supported by place. In this paper,

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we use "place" to refer to a distinct geographical area possessing a unique character. Attributes of place include the natural environment, social and cultural contexts, and structural conditions (Frohlich et al., 2001).

We had a unique opportunity to better understand how place shapes the way that people manage mental health and enhance well-being in their everyday lives by examining data from semi-structured interviews with 37 veterans at two geographically distinct study sites: Northern California (CA) and Southeastern Louisiana (LA). To account for the fullest possible range of activities, we privileged the perspectives of veteran *laypersons*, rather than that of medical professionals, regarding what constituted work around health and well-being. These data were collected as part of a study to adapt and test a mental health coaching intervention at these study sites by a multi-disciplinary research team of health services researchers.

The most common chronic mental health concerns among U.S. veterans are Posttraumatic Stress Disorder (PTSD), depression, anxiety disorders, and alcohol use disorders (Ramsey et al., 2017). In a recent study by Seal et al. (2009), 36.9% of veterans from conflicts in Iraq and Afghanistan were found to have received one or more mental health diagnoses, the most common of which was PTSD (n = 21.8%). As most veterans do not receive adequate treatment for these concerns, our study aims to encourage veterans to initiate mental health treatment.

In this article, we use health work as an orienting concept to demonstrate an accessible method for producing exploratory, qualitative evidence that is largely descriptive, and therefore close to participants' understanding of phenomena. Moreover, we promote a situated (i.e., located in place) notion of health work by marrying a concept from geographies of health (i.e., place) to concerns important to the broader scientific community. In taking a multi-disciplinary approach to understanding mental health work between two geographically distinct sites, we aim to shift attention among health science researchers from individual, compositional factors to the external, contextual factors that shape health-related behaviors.

1.1. Health work: an orienting concept

The earliest iteration of a concept of health work is Corbin and Strauss' (1985) sociological treatise regarding "three lines of work" in lay management of chronic conditions. Health work as a concept has since outgrown its sociological origins, and is currently referenced in disciplines as wide-ranging as anthropology, nursing, and public health. Analyses explicitly or implicitly referencing this concept include McCoy's (2005) description of health work among the socially marginalized, Clark's (1993) exploration of domestic health work among Mexican American women, and Liamputtong et al.'s (2015) description of lay management of prescription medication among HIV-positive women in Thailand. Although previous analyses may explicitly reference "health work," researchers have rarely sought to delineate it as an orienting concept for analysis (for exceptions see Mykhalovskiy and McCoy (2002), Mykhalovskiy (2008)).

Here, we empirically define health work as an orienting concept for understanding how health-related behavior is rooted in place, informed by local social and cultural contexts, and constrained by everyday realities. An orienting concept is an overarching concept used to generate lines of inquiry, hypotheses, and theory. Such concepts provide initial evidence that can inform subsequent research (Blumer, 1954; Layder, 1998) testing the effect of "compositional" (i.e., individual-level) and "contextual" (i.e., external) influences on behavior. Murray et al.'s (2012) analysis borrowing concepts from Bourdieu's practice theory (Harker et al., 2016) illustrates well how using an orienting concept to frame and analyze data permits fresh insights into health-related behavior.

We define health work as deliberate efforts undertaken by lay persons to care for self outside of clinic settings, including activities aimed at physical, psychological, social, emotional, and/or spiritual health (see Mykhalovskiy (2008)). This includes habitual efforts to: 1) regulate symptoms of chronic conditions, 2) manage everyday stressors that exacerbate or trigger health-related problems, 3) restore a sense of meaning, coherence, hope, normalcy, or control disrupted by chronic health concerns, 4) mend a social identity or concept of self challenged by chronic conditions, and 5) enhance well-being and satisfaction with life.

Our use of "work" draws upon Schutz's (1962) notion of purposive action shaped by physical, social, cultural, and structural realities, and Corbin and Strauss' (1985) notion of "work" in relation to chronic illness management. It includes activities which are encouraged or directed by clinicians, as well as those which are lay initiated and directed. Following Sadler et al. (2014), we furthermore emphasize *lay perspectives* of what constitutes work around health, rather than that of medical professionals.

We moreover augment prior definitions found in the health sciences literature by defining even non-normative behaviors as health work, including activities that are potentially detrimental to long-term health – if undertaken with the *intent to care for self* in some way. For example, although watching television may not be considered a healthy behavior by medical professionals, it might nevertheless constitute one form of health work to a lay person who uses it to reduce stress. We do not use this strategy to endorse these behaviors, but to permit a more accurate account of the full spectrum of work engaged in by our participants and to emphasize lay expertise in managing health and well-being.

Researchers have challenged geographers of health to more fully incorporate social, cultural, and political theories into analyses of health and place (Dorn and Laws, 1994; King, 2010; Kearns, 1993; King and Moon, 2010), and to describe the theoretical underpinnings of their analyses more explicitly (Philo, 1996). We aim to meet this challenge through our use of health work as an orienting concept. In our analysis, we describe variability in mental health work among veterans at two geographically distinct locations, demonstrating how place shaped this variability. We bring nuances to our largely descriptive analysis by balancing between external constraints (i.e., limitations) imposed on individual agency (i.e., power and control) and resourcefulness in how lay persons care for self within those constraints.

2. Methods

The ongoing parent study from which these data were obtained, "Motivational Coaching to Enhance Mental Health Engagement in Rural Veterans (COACH)," aims to adapt, implement, and test a motivational coaching intervention to engage veterans with mental health concerns in mental health care. All veterans enrolled in the COACH study were patients at Community Based Outpatient Clinics (CBOCs) within the Veterans Health Administration (VHA) system. The findings presented here arose from analysis of semi-structured interviews with veterans who participated in data collection aimed at adapting the study's mental health intervention to each clinic (Koenig et al., 2016).

2.1. Research setting and site selection

The VHA is the largest integrated healthcare system in the U.S. In 2016, the VHA system included 150 urban medical centers and more than 800 CBOCs serving mostly rural veterans. Our definition of rural uses the Rural-Urban Commuting Areas (RUCA) system, which considers population density and how closely a community is linked socio-economically to larger urban centers (Morrill et al., 1999).

We chose geographically distinct locations to maximize generalizability for the intervention's health outcomes, and medium to large rural clinics because of the imperative to provide evidence-based mental health treatment in VA clinics of this size. The following

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