

Narrative Group Therapy with the Seriously Mentally Ill: A Case Study

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This paper describes a process set up to facilitate a group of people living with a serious mental illness. The group was based on Anthony's notions of recovery, and incorporated a narrative approach, while remaining consistent with Northen's groupwork model. Particular attention is paid to the preplanning and initial session of the group, to the use of letters and to the incorporation of a reflective team approach. Documentation of the discoveries made by the group members during its life is included in full.

The following paper outlines an attempt to conduct a group with people with a history of psychosis. The purpose is to:

- a) Demonstrate that it is appropriate, useful and very positive to do group therapy with individuals affected by mental illness in a rehabilitation context.
- b) Encourage narrative therapists to link their work effectively with group work theory, but also to encourage group workers to consider incorporating the narrative model into their work.
- c) Place the group in the context of postmodernism and a philosophy about recovery.

RECOVERY: A DIFFERENT NOTION

Traditionally, 'recovery' has been allied with the notion of cure. It implies a return to a unitary premorbid state. Anthony challenges such notions when he writes, 'The recovery vision expands our concept of service outcome to include such dimensions as self-esteem, adjustment to disability, empowerment, and self-determination' (1993: 16). He outlines nine principles of recovery for individuals affected by mental illness which are listed below (18–20):

1. Recovery can occur without professional help. Pro-

fessionals do not hold the key to recovery, consumers do.

2. A common denominator of recovery is the presence of people who believe in and stand by the person in need of recovery.
3. A recovery vision is not a function of one's theory about the causes of mental illness. Adopting a recovery vision does not commit one to either position on this debate, nor on the use or non use of medical interventions.
4. Recovery can occur even though symptoms recur.
5. Recovery changes the frequency and duration of symptoms.
6. Recovery involves growth and setbacks, periods of rapid change and little change.
7. Recovery from the consequences of illness (unemployment, poor housing, loss of rights and equal opportunities) can sometimes be more difficult than recovery from the illness itself.
8. Recovery from mental illness does not mean that one was not really mentally ill.
9. People who have or are recovering from mental illness are sources of knowledge about the recovery process and how people can be helpful to those who are recovering.

Anthony's ideas allow for many possibilities, and for him mental health consumers can achieve many states all of which constitute recovery. His ideas seem compatible with the guiding philosophy of the narrative approach, which is oriented towards challenging 'normalising judgements—the evaluation and classification of persons and relationships according to dominant 'truths' (Epston and White, 1989: 34). Whether or not Anthony would see himself as a postmodernist, his

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notions seem consonant with postmodernism, a movement which allows for moral plurality based on the idea that no one system of belief can ever reveal the entire truth (Howe, 1994: 520).

NARRATIVE THERAPY IN A GROUPWORK CONTEXT

Models of Groupwork

Reid (33–36) lists four types of group. None of the models below are absolute forms, and many groups include elements from a number of these types:

1. *The preventative and rehabilitative model* where the worker is the primary change agent, using a direct, often behavioural, influence. A psycho-educational group is an example of this model. Such groups often have homework, coaching, role plays, modelling education as key components (see Falloon, Boyd and McGill, 1984)¹.
2. *The social goals model* where the aim is to increase democratic participation by individuals in the community through the worker cultivating social consciousness and social responsibility. A residents' action group focused on issues such as the local environment, transport, or pollution is a good example of this type.
3. *The mainstream model*, characterised by common goals, worker and member authenticity, and mutual aid. The aim is for the group to reach a point where the initial leadership role performed by the workers is carried out by the members. Some years ago a co-leader and I helped to establish a Parkinson's Syndrome support group in a rural area. After nine monthly meetings with us, the members became ready to manage the group themselves. They conducted elections and began some action around issues to do with access for the disabled.
4. *The interactional model*, a group where members help each other with problem solving tasks. The worker's roles are to act as a mediator between members and society, to search for common ground between the needs of the individual and social demands on him/her, to detect and challenge obstacles which obscure common ground, to provide ideas and information which the group members do not have, and to 'lend a vision'. Goals are conceived as an intrinsic part of the relationship and not specifically set in advance. For example, I ran a group on a mental health ward teaching and role playing situations where members experienced communication difficulties. Interactions around real life problems were aimed at developing assertiveness amongst the members. Members were encouraged to give each other constructive feedback.

Helen Northen's Model

Northen's model of groupwork (1969) has elements of the interactional, mainstream and social goals models in that for her:

1. The group worker's goal is to improve the competency of individuals in dealing with their environment;
2. The worker's role is facilitatory and a primary aim is to promote an atmosphere of experimentation and flexibility (37);
3. Conscious observable material is far more the focus than unconscious material (76);
4. 'What is desirable is not similarity, but compatibility and complementarity' (96).
5. Facilitators need to devote particular attention to 'rejected isolates' in a group—withdrawn, non-participatory members (165).

The Narrative Model

The narrative model has evolved over a period of some seventeen years through a collaborative effort between Michael White and David Epston. The model commenced within a systems framework but as the work of White and Epston developed, a 'text analogy'—where the stories that people brought to therapy became the key area for work—seemed more appropriate. The notion that people can define their lives in many ways is central to the model. This assumption places it within the postmodernist movement. Producing a therapist defined unitary form is not the goal of the approach. On the contrary, diversity is validated and celebrated. An initial assumption of the model is to look at the person/s in their social situation. 'The narrative approach starts from the premise that the job of the counsellor/community worker is to help people identify what they want in their own lives, and to reconnect with their own knowledges and strengths' (McLean, 1996: 8).

White describes problems as developing an identity of their own which exerts influence upon individuals, couples, families and communities. Accordingly, one of the tasks of therapy is to externalise (White, 1988/9) the problem so that the degree of its influence over the person/s can be compared with the person/s' influence over it (referred to as relative influence, White, 1988). Externalisation assists

people to objectify and sometimes personify problems. This enables people to separate themselves from problems and see problems as things which affect them, things against which they can take action, rather than seeing themselves as problems (McLean, 1996: 55).

White believes that people experience problems because they are restrained in some way from taking a course which would ameliorate their distress. This is referred to as 'negative explanation' (White, 1986: 173). Restraints can take the form of beliefs, ideas, presuppositions—or external social controls like poverty, racism

and patriarchy. By contrast, 'positive' explanations assume that problems are caused by internal drives, motivations or external pushes and pulls on people. From this point of view lives are somewhat predetermined. Problems result more from internal pathology and give rise to labels that help to subjugate the less powerful. Freudian thinking can be seen in this light, as can some earlier notions of welfare that distinguished between the 'deserving' and 'undeserving' poor.

Ideas which are restraint supported form a script or text which becomes the 'dominant story' for the person/s with the problem. Through a series of carefully worded questions, White and Epston have developed an approach which allows people to generate new descriptions of their lives and in the process take charge of their problems. In the early writings these descriptions were known as 'double descriptions' but later as 're-authored' descriptions—connoting that the person/s through therapy rewrite their biographies in ways which emphasises their agency or control over their own lives. A strong thread throughout White and Epston's writings is the notion of the therapist engaging in a co-evolutionary process. This suggests possibilities for compatibility between the narrative model and Northen's model for group work, given their emphases on the client/s being the change agents and the worker taking on a facilitatory role.

Narrative Approaches in Groupwork

O'Neill and Stockell (1991) were the first therapists to write about the use of the narrative model in a group context. Their work is significant for the following reasons:

1. Any model which devotes itself in part to couple and family work is by definition concerned with people who have a prior (often strong) connection, but of course, the narrative model is also of great use with individuals. O'Neill and Stockell opened the way for narrative therapists to begin to apply the methods to individuals without any prior connection. The members of their group had only two common features—their mental illness and their male gender.
2. During the 1980s the narrative model established itself firmly as a legitimate method in the field of individual, marital and family therapy. In the 1990s the team at the Dulwich Centre have participated in consultations with the mentally ill and with Aboriginal communities. Attempts have been made to incorporate narrative ideas into mainstream education. It seems that any aspect of human life can be understood through the narrative perspective's lens. The model is developing a broader communal focus. O'Neill and Stockell's paper is an important step in this progression.

Michael White must be credited with externalisation as a rich and widely applicable method. It is a theme

throughout his work. The extent to which externalisation is a cognitive technique is a matter of debate. If its purpose is to create a sense of mental well-being via altered thinking, it is a cognitive technique. I have no doubt that both cognitive behavioural models and the narrative model, sensitively and competently practised, produce this outcome. This, however, is not the sole purpose of either.

When a narrative therapist externalises something like 'fear' or 'hurt' (or as did happen in the group discussed in this paper 'stigma', 'illness' or 'labelling'), a colloquial name is used facilitate discourse about personal experience. Relative influence questions are often asked by narrative therapists to promote the realisation that such restraining ideas and their accompanying subjugating practices are indeed challengeable. Once a 'unique outcome' is noticed, clients usually discover that they have already been able to challenge this subjugation, however minimally, and this is the beginning of the development of the alternative knowledge or the re-authored account. This re-authored account, which co-evolves between the client and therapist, presents opportunities for the client to see the relationship between the power and oppression of unitary or '*normifying*' knowledges and the individual experience of the client concerned. Standard references—particularly in the field of cognitive behavioural therapy and serious mental illness (Falloon et al., 1984)—do not to make reference to such techniques or constructions of therapy.

Cognitive behavioural models in the field of mental illness are excellent teaching methods which draw attention to the biological, psychological and familial factors associated with, for example, schizophrenia. Falloon et al. (1984), provide an excellent framework for communication training, goal setting, problem solving and symptom management. I have facilitated a group using this model and have witnessed its benefits first hand. The narrative model is more concerned with self-teaching; awareness and change which develops through the re-authored account. Cognitive behavioural models also seem to see the family as the only 'context' or 'environment' of the problem, whereas the narrative model defines context much more broadly, and addresses structural factors. If one incorporates notions of subjugation into one's work then, as Mullaly suggests, one attempts to use transformational knowledge to contribute to changing society from one that creates and perpetuates poverty, inequality, and humiliation to one more consistent with values of humanism and egalitarianism (1993: 26).

THE GROUP

The group that will be the subject of this paper was established under the auspice of an Area Mental Health Rehabilitation Service which offers group work, social and employment skills development, accommodation, outreach work, family educational and support work and individual work to adults with a serious mental illness—often schizophrenia, first or later episode psychosis, or bipolar disorder.

Table 1: Comparison of theories

	Group Work Model (Northen, 1969)	Narrative Model
Pre-Planning Phase	Setting aims and objectives, selection criteria, strategy for recruitment, practical arrangements (time, venue, frequency, food, provision, transport), preparation of invitations, information for staff, broad notion of themes of interest for exploration	Acceptance of referral, preliminary plan to invite clients to tell their story, some careful speculations about restraints which have contributed to the problem saturated lifestyle.
Beginning Phase	<ol style="list-style-type: none"> 1. Review what group members have been told already about the group; 2. Tell the group what the nature of the group leader's participation will be; 3. Present the facts succinctly in an informal manner; 4. Try to create a pattern of participation which recognises each members' efforts; 5. Suggest that members may respond to each others comments but with no pressure to do so; 6. Make comments which connect one member's comments to that of others—the group leaders' roles are primarily to promote interaction; 7. Discuss confidentiality; 8. Do warm up exercise which promotes interaction 	Join with every client. Commence unravelling the problem saturated description. Start punctuating events in ways which provide opportunities to highlight unique outcomes at the earliest opportunity. Start noticing restraints which one might externalise. Externalising conversations occur when counsellors objectify and sometimes personify problems. This enables people to separate themselves from problems and see them as things which affect them, things against which they can take action rather than seeing themselves as problems. Provide opportunities for clients to name restraints wherever possible. If this is too difficult offer colloquial nonjargon terms which clients are likely to connect with easily.
Middle Phase	Problem solving phase—a time of change and possibly also of conflict. Much more spontaneous interaction between group members. Leaders become more peripheral—skills used are support, communication skills, clarification, praise and highlighting of competence and skill amongst members. Group relationships are enhanced—their predominant qualities are trust, acceptance and interdependence.	Development of alternate stories and descriptions based on linking of unique outcomes which highlight strength, individual agency, consciousness of subjugating processes (e.g. fear, stigma, patriarchy, poverty, racism, sexism.) Commencement of documentation of alternative account. Counsellors/leaders can coauthor this with clients in the form of letters or thought provoking written statements.
Ending Phase	Recapitulation of achievements. Progress or regression of members is determined in terms of particular characteristics, background, problems and needs, rather than fixed uniform standards. Members often have a variable readiness for termination. The readiness of some may inspire hope in others who are not quite ready. Group leaders end with a strong message of hope about member abilities to manage the problems of life in the future.	Newer story becomes incorporated by the person/s and provides some self created principles for present and future conduct. Counsellors may even predict relapses and encourage the person/s to make preparations to challenge these based on discoveries made and documented in the course of counselling. Counselling can continue but with longer gaps in between sessions. Future meetings focus on reporting back about the journey and struggle against restraints. Further documentation of unique outcomes occurs. Counsellors can show interest in the audience which the persons are seeking to share their new account with to maintain its liveliness in perpetuity.

Table 2: Some possible narrative questions²

Questions	Type/Purpose
1. What restrictions did the illness place upon your life?	Unravelling/Exploratory question: To provide a starting reference point for the problem saturated account of the person's life
2. What was the impact of the label of mental illness or schizophrenia? How did schizophrenia affect your life? What parts of your life did schizophrenia or the label affect? Work? Family? Hobbies? Leisure? Courtship? Relationships? Sex?	Externalising questions and mapping the influence: These begin to place the effect of the problem saturated account outside of the person so that it can be observed and assessed by the person with the aid of the therapist and the group.
3. What were the first signs that you challenged your illness? What impact did this challenge have on you? What impact did it have on others?	Unique Outcome Questions: these questions are the prologue to the new account. They provide the start of the reauthored story.
4. How did you prepare yourself for this challenge/step? What helped you to become ready?	Readiness: change can require preparation. These questions help to encourage the idea that the person is a participant in the process—change does not occur by accident.
5. What actions by you made a difference here? Which seemed most effective? How? How did you take this step?	Landscape of action questions: part of therapy is 'doing.' It is not passive. These questions focus the person on activity.
6. How would you measure the influence you had over the illness? How did you measure the influence the illness had over you? What helped to tip the balance in your favour?	Relative influence questions are useful in challenging notions of subjugation to the problem and contribute to reauthoring.
7. What did you discover about yourself? How did these discoveries grow and develop? What were the defining characteristics? Or how would you characterise them? What impact did it have on you as you learnt more and more discoveries?	Landscape of consciousness questions: These questions emphasise the observer role for the client/s. The learning or self-reflexive component of therapy which encourages the person/s to grow.
8. What did others notice about you? Were there others affected by this challenge? In what way? Were there important people who did not notice this challenge? Family? Friends? Health Professionals? What did you make of this at that time and perhaps now? What more would you have liked them to notice?	Audience: These questions look at the social context of the person. They encourage a focus on feedback.
9. Who could have predicted that you could have challenged your illness in this way? What did they see in you which made them so confident of their prediction?	Experience of experience questions: These questions help the person to look at their audiences through life and to choose someone who had the potential to promote the reauthored account of the person's life.

Pre-Planning

Staff from the community and rehabilitation team were asked if they knew of any clients who could benefit from a group with the following purposes:

1. To invite participants with a history of psychotic illness to inform us about their experience;
2. To place them in the expert role where they provide guidance to us about what did help them and what didn't;

3. To promote independence and secondary prevention and reduce hospital admissions;
4. To reduce the need for intensive one to one casework;
5. To help the clients be clearer about when it is optimal for them to ask for help.

The criteria for acceptance were:

1. A history of psychosis;
2. No acute illness at the time of referral;

3. Communication skills sufficient for clients to participate in a group;
4. Voluntary participation.

In no time, ten referrals were received, after which personal invitations were sent out with the following wording

Invitation to a group to

Share your ideas about mental illness

Tell us about your skills, strengths and ways of coping whilst living with a mental illness

Tell us about your experience of mental illness

provide ideas about alternative ways of living with a mental illness

When follow up phone calls and personal contacts were made it was clear that the individuals had put a lot of thought into responding to each aspect of the invitation. One of the invitees could not attend but he wanted to make a contribution to the first session. I conducted an individual session with him and his thoughts about the above were conveyed to the group during session one. His contributions were received very favourably and in session two, the group members were interested in his welfare.

The group was conducted by a Social Worker and a Community Mental Health Nurse, both of whom had received training in the narrative therapy approach. There were eight sessions planned for two hours on one morning a fortnight. A break occurred after about one hour and fifteen minutes. When they returned after this break, the facilitators offered their reflections. Members were given an opportunity to respond to the reflections. This was done to ensure that the members heard the debriefings of the leaders. We told them that traditionally group leaders tend to debrief in secret and we wanted the members to be privy to our reflections—we thought they were entitled to know. The group members seemed to appreciate this and when the debriefings occurred members could occasionally be heard saying 'yeah' in the background. The comments seemed to serve the desired effect of validating and authenticating the worth of the members' knowledge and they provided further cause for reflection. Our intention was to convey a notion of 'working with' rather than 'doing to'.

At session four, with the agreement of group members, three new staff came to observe the group and add their reflections at its conclusion. These three then met with the group for a ninth meeting, without the original facilitators, we a qualitative evaluation of the group. Whilst they were thus not entirely without pre-conceptions, we thought that trust would be a big issue for the group, and members' exposure to the evaluators at session four helped them to build essential rapport.

The First Meeting

The first session was considered crucial, and nine out of ten invitees attended it. The steps for it are outlined in Table One, in the 'beginning phase' of the group work model. Northen's suggestions were received well and played a part in the collaborative atmosphere of exchange which developed in the group. In addition we felt it important to discuss issues of formation and cohesion³. We asked the members what they wanted the leaders to do if someone did not attend or decided to leave the group. They offered the following clear advice:

1. Every member should have full rein to decide whether to come or go;
2. The group needs consistent numbers otherwise it doesn't work;
3. If someone leaves they should be able to come back if they decide to;
4. Group facilitators should ring those who leave. There may be a reason for this which could be easily overcome;
5. The main points of each meeting should be summarised so that those who cannot attend still gain the benefit of the group.

We said that it was likely that some anger would come up for them, and that this might be linked to their experience of injustice. Again we asked for guidance from the group on this and they said:

1. Console the person;
2. Talk about it as it happens;
3. Decide upon an appropriate cut off point and go on. If someone is overdoing it simply tell them, 'Time's up';
4. Allow group members to express their anger in ways that don't hurt others;
5. Ask the person, 'Is there something I should do?', 'Is there something you need?'

This strategy of deferring to the group was informed by the suggestions of both the narrative model and Northen's model. The strategy helped members take on the role as the primary decision makers about the group, and emphasised that the workers' roles in this process were facilitatory rather than directive. They were designed to achieve what Northen refers to as a 'relationship of interdependence' (1988: 257). This feature is also often emphasised in models of therapy informed by feminist theory: '... the counsellor is not there to dominate or have power over the client' (Chaplin, 1988: 7). In a successful group, by the middle and end phases members are transacting primarily between themselves with leaders taking on a more peripheral role. These early steps were deliberate attempts to influence the group culture in this direction.

In order to invite members to comment on their contemporary experience we asked them to mention a tele-

vision show which most closely described their life over the last two weeks. After this segment the leaders said something like, 'You have shared with us much about television and how this influences your daily life—what restrictions has mental illness placed upon your lives?' Responses flowed very freely at this point. Again this question was informed by the narrative model. The notion of a 'restriction' (restraint) provided the first opportunity for members to begin to explore their relationship with their illness and its impact on their lives—it was the earliest step in the externalisation process. At the end of session one the participants were asked to consider a name for the group and to bring their ideas to session two. They chose the name A Haven for Active Minds.⁵

'Withdrawal'

'Withdrawal' is often assumed to be a feature of mental illness—especially schizophrenia. The initial referral criteria excluded severely withdrawn individuals. It is debatable whether group intervention could assist members who exhibited this behaviour, although there would be potential benefits if withdrawn members were mixed with less withdrawn individuals and the latter could act as encouragers or models for the former. I expected some level of withdrawal, particularly in the early stages of the group. There was little evidence of it. One member was occasionally quiet but even he was clearly listening all the time. By session four or five he was participating more actively. All members of the group were on medication and this too contributed to their ability to communicate and participate in the group. Members explained 'withdrawal' as a social consequence of stigma. The following extract from a letter by the group leaders to the participants summarises members' thoughts on this:

For one of you it had become so overpowering that it was at times impossible to talk about your feelings. You notice that neighbours in the housing development where you lived would not mix with you and a petition had gone around to have you removed.

People have told some of you bluntly, 'I want nothing to do with them'. You have to lie all the time to get by. The tragedy in Tasmania made things a lot worse [Martin Bryant's massacre of tourists and employees at Port Arthur]. Some people in the community think mental illness is contagious. They say, 'I don't want to catch that'. For men too it's often assumed that if you have a mental illness you're a rapist or an axe murderer. It's like you have to have a secret life and it is very isolating. You can tell when people develop a secret hatred towards you. People want to close you off. It makes you angry some times.

Given the above discoveries it is subjugating for 'withdrawal' to be defined as a pathological feature of illness when it is clearly a legitimate and reasonable response to a deleterious judgemental social context. It would be more validating to call it a 'unique life skill', an 'esteem maintaining quality'.

Outcomes

The outcome of the group was the alternative knowledge generated. The discoveries formed what the group members defined as 'recovery' in Anthony's terms. Their discoveries and their actions challenged unitary knowledges. Epston and White write:

... the externalisation of the problem can be utilized enroute to the identification and externalisation of the unitary knowledges ... it assists persons to challenge the 'truths' that specify their lives; to protest their subjugation to unitary knowledges ... externalisation opens space for the identification of and circulation of alternative or subjugated knowledges (1989: 34–35).

The group members' enormous range of discoveries during the eight sessions constituted the written testimony to this. The major ones are presented in List of Discoveries from the Haven for Active Minds.

In summary the key components of the group which were informed by the narrative approach and Northen's group work model were as follows:

Northen's Group Work Model:

1. The bulk of the planning for the beginning phase of the group was based on Northen's model. Raising in the first session the possibility that members might consider leaving the group highlighted the important issues of group cohesion and change in membership.
2. Northen suggests that in the middle phase change and conflict can occur (Northen, 1969: 189–221) and this was true of this group—two members left at this time, one later returning. Facilitation in this phase followed Northen's model in that increasing emphasis was placed on member interaction independent of leadership.
3. Ending phase: Northen's model suggests that members have a variable readiness for ending, and that there is a need to end with a message of hope (Northen, 1989, Ch 12). The issue of ending was introduced at about session seven. Some in the group felt a need for continuity. As leaders we addressed this by exploring and highlighting how an ongoing support group without facilitators would be different from the existing group. Our strategy was designed to assist members to prepare for this transition.

Narrative model:

1. Putting the group members as much in charge of the group process as possible i.e. an emphasis on their personal agency;
2. Allowing members to be privy to our reflections and the ideas of a reflective team;
3. Externalisation of issues like 'stigma', 'illness' and 'labelling';
4. A letter was used after each session to summarise

LIST OF DISCOVERIES FROM THE HAVEN FOR ACTIVE MINDS

The following discoveries and reflections about this group arose over a series of eight meetings. We want to share them with the community so that our voice is heard and in the hope that it helps others living with a mental illness.

SETTING UP GROUPS FOR THOSE LIVING WITH MENTAL ILLNESS

When we were asked for our advice on the way this group should be conducted we tried to deal first up with very difficult issues like 'What should members do if someone leaves?' 'What should members do if some anger comes up in the group?' and 'What if a member has a panic attack, how should this be handled?' If you set up a group like this please ask members these questions. We appreciate an opportunity to share our thoughts about them.

People with a mental illness are all different—unique. Even the episodes of mental illness we have are different. A group like the Haven for Active Minds is very special. It's a place where people living with a mental illness can be intimate. This need for intimacy is very important for both men and women. The so called 'well' community have a double standard. They are often quick to judge. In a group like this we can be ourselves.

A group like this can also help you get back that extra confidence you need. These changes occurred for some of us:

1. One member enrolled in a labour training program to get back into the workforce;
2. Another member does volunteer work at a local nursing home. The Director has allowed him to work more independently since the group started;
3. Another is considering a work program;
4. Another member would like to get back to talking to school aged children and adolescents about mental illness—to share his experience, to promote tolerance;
5. Another member was offered and accepted a place on a drug rehabilitation program;
6. One member was in work before the program started and has continued.

ON 'SOCIAL WITHDRAWAL'

Mental illness places a significant restriction on people's lives. 'Withdrawal' is thought to be caused by the illness. When you live with an illness you don't have any choice but to withdraw. The general public thinks that mental illness is contagious, and that men with an illness are axe murderers and rapists. People develop a secret hatred towards you and they want to close you off. It makes us angry some times. To cope with this when you have a mental illness you become very careful about the friends you keep. You become very discerning. It's a quality which sometimes sets us apart from the so-called 'well' people. It can be very lonely living with a mental illness.

SOME SUGGESTIONS FOR HEALTH PROFESSIONALS

Health professionals need to come down to earth more. They need to ask people living with a mental illness more directly what they want and what would help. There's not enough contact between us and health professionals. There needs to be more intensity. Very brief visits from health professionals suggest there is not really a lot of concern. We need someone beside us—someone who will help guide us. We need health professionals who think positively. Some health professionals do these things and it helps a great deal!!

The doctor you have is very important to your recovery. Doctors who listen and give you a big say in what happens help a lot. It's important not to have doctor with an iron fist. When a psychiatrist listens to your advice about medication this helps a lot. Psychiatrists should attend a group like a 'haven for active minds' so that they see how unique we are. It would put them on a more personal level.

When you live with a mental illness you want to be treated as a person first—not as an illness. 'Most people are exactly the same as us. We're a little more out of reality.' We use the creative side of their brain more.

ABOUT VOICES

When we experience voices we have found the following seems to help:

1. Tell them to go away;
2. Try to work out a logical explanation for what's going on—don't let the voices explain things to you;
3. One of us thought we have an 'inner mind' and a 'schizophrenic mind'. The inner mind is more logical.
4. Another of us thought we keep saying to yourself—'Everything has a rational explanation, there's no such thing as a mystical one'.
5. Discipline, routine, sleeping every night, focusing and reading all help to challenge the voices.
6. Telling our story through magazines like the 'Krunch'⁶ and getting involved in the project where you talk with school kids about life with a mental illness really helps. It's important to give something back.
7. Some voices are inspirational and some bad. It's important to get the voices into balance—if you get too much good 'it's like getting too much sugar.' Some voices are from the heart others from the mind. Many things contribute to the voices getting stronger. 'Little things get out of control and then it feels like a bomb has hit.' This occurred for one of us when the housing department sent a letter by mistake saying we would be evicted.

ABOUT MEDICATION

If you stop taking your medication your voices tend to increase. The person living with the illness needs to take a key role in determining which medication to take and its dose. The following suggestions help us to determine this:

List of discoveries from the Haven for Active Minds (continued)

1. The way you feel is very important. If you feel bad you've taken too much medication;
2. Talk to doctors and nurses. Nurses often know a lot about medication. Share your own thoughts with them and get their impressions too;
3. Tell yourself 'you don't have to be on a high dose forever'. This message of hope is very important.
4. Throughout the course of your illness you always have a choice—even when we are in the depths of a psychotic episode. To help remind yourself of this it helps to say, 'I'm gonna fight my way out of this.' 'I'm not a schizophrenic, it's just my thoughts.'

ABOUT PARANOIA

Paranoia was also discussed in some depth during the meetings. We wondered if 'fear' might be a better name for it. One member shared the following discoveries about how to deal with and overcome paranoia:

1. Focus on the letter 'R' for relax;
2. If you get a paranoid idea tell yourself, 'That's not going on.' Or say, 'That's enough', 'I don't want this', 'I can get there. I've been there before. It's like a war or a challenge.' 'Tell the voices to go away.';
3. Use a seasons metaphor. From a winter there will be a spring;
4. If you think people are talking about you or that they are feeling negative about you say to yourself, 'They can feel that way but I know I'm all right.'
5. Paste things on the wall at home like a 'stop' sign. Interrupt it. Count to 7. Rock your foot, relax. Do some deep breathing.
6. Be aware that paranoia can affect your body and it can show up as high blood pressure and feeling giddy.
7. The way you think affects your body. If you can think negative things you can just as easily think of positive things too.
8. You need to practice the above discoveries. It's only with practice that you get better at managing paranoia.
9. Paranoia can really be a sign of the influence of 'self doubt'.
10. It helps when you find a professional who has faith in your ability to 'take responsibility' for defeating paranoia. It helps if they listen to you and engage you in conversations about paranoia. They might be able to act as mediators between you and your family and loved ones to help educate them about what is going on—perhaps by sending them letters. It helps if they respond to me as a person first and not my illness.
11. Medication helps. One of us believes, 'I'm not half as paranoid when I'm on medication.'
12. Set yourself a goal for that day e.g. to do the housework, to do the washing—the practical things in life are important.

LABELLING

Receiving a label like 'schizophrenia' or 'manic depression' is scary. It's like you're on a bad trip.

'Labels are just a filing system'—they should be abolished. If this happened people would accept us more and there would be no more stigma. Health professionals seem to put a lot of time and energy into labelling. If we classify people it tends to determine how we treat them rather than asking them about themselves. The label seems more comforting for the observer. How did the community and health professionals become comforted by these labels? What would the community discover about itself if it didn't resort to labels? How would it be different?

There seems to be a lot of secrecy and misinformation surrounding labelling and it seems to repress us. During this group we've tried to take a stand against this secrecy. We need some say in how we view ourselves. When we can't do this there is a lot of suffering along the way.

SPREADING THE MESSAGE

The words 'public awareness' came up a number of times during the group meetings. We want our discoveries, our knowledge circulated in some way. We'd like to make the following suggestions to achieve this:

1. The media needs to know what the group did.
2. The negative and positive side of mental illness needs to be shown. We want the achievements of those with a mental illness emphasised more.
3. We want the community to know that people with a mental illness are sensitive and creative.
4. We want the message conveyed that we can still have a job when we have a mental illness.
5. We want to pass on our knowledge to the young. We want more funding to go into secondary schools to help this along.
6. One of us wants to write a book.
7. We'd like a van to feed people living on the street with schizophrenia.
8. We want to help people who usually turn us away.
9. We want people to know that when we live with schizophrenia we are more 'temperate'. We appreciate and value life more after not having had anything.
10. People with schizophrenia think more laterally. Even though we seem deluded some times it is not always bad—we might be feeling good.

List of discoveries from the Haven for Active Minds (continued)

11. Self-discipline helps one deal with schizophrenia.

12. People are more practical when they live with schizophrenia. On the other hand we feel 'exiled'.

TRAUMA

For some of us our trauma stems back to childhood. A group like ours helps us to feel there is someone there travelling with us to deal with this trauma. Trust is very important to achieve this. When this is achieved it helps you to deal with the trauma.

Mental illness often is caused by trauma like sexual abuse. It takes a lot of courage to admit that you were sexually abused.

ON CHANGE

Mental illness makes us reassess our plans for life. There are many losses we have to face—loss of a job, loss of skills, loss of university training, loss of partners and friends. Schizophrenia is often associated with 'failure'.

MENTAL ILLNESS AND SOCIAL INJUSTICE

Living with schizophrenia in some ways can be compared to living in a wheelchair. However, if you live in a wheelchair and you go to work you get a lot of praise. You don't get any praise if you live with schizophrenia and you attend work. People don't seem to recognise your achievement when you live with a mental illness.

The stigma we experience is experienced by other disadvantaged groups too—like the Aboriginals. They have been dispossessed—their independence has been taken away. Ours has too.

If the 'well' population stood up to stigma they would have a lot to gain too. This would include, a more relaxed at ease feeling, increased self esteem, friendship, and a sharing of stories of interest.

HELPING FAMILY MEMBERS

All of us in the group appreciated that when someone has a mental illness it can be difficult for their family as well. For some of us when the illness emerged we discovered that the close relationships we had were not quite what we would have preferred. The illness can be a significant turning point in relationships. For another of us living near family members has helped to reassure them that one is managing. One of us thought, 'I've gained an identity of my own.'

It is important to show compassion for members of your family. Don't blame them for the illness. If you or anyone does then it will make it hard for them to accept the illness. We'd like to offer the following suggestions to health professionals who are interested in helping families:

1. Explain things to family members. Try to educate them. A good way to do this is by comparing mental illness to a physical illness;
2. Group meetings like ARAFMI are useful but they need not be 'so segregated'. 'Sometimes carers are treated as being more important than sufferers'. When the illness is being explained to family members it is important for the person living with it to be there as well. It helped one of us a great deal to be there during the explanation. More family group meetings would be very useful.

To those living with the illness we suggest the following:

If you want to help your family understand what it is like to live with a mental illness you have to find some way of helping your family to understand that mental illness changes many aspects of your life. Through 'bringing out your inner feelings' family members can be assisted to understand that your circumstances have changed—that you may have a different reality; that you may view life differently. It's usually a combination of things which lead to these changes when you live with a mental illness.

STANDING UP TO SUICIDE

Suicide can become a real issue for those living with a mental illness. Some of us have thought about it seriously at a stage in our lives; one losing some close friends through suicide. We offer the following discoveries to those facing this very difficult problem:

1. Suicide is a choice on the road to recovery;
2. Faith in God, putting the needs of others before yourself, considering their feelings, accepting the support of family members and finding a safe place all help you to stand up to suicide;
3. Give yourself time to challenge suicide;
4. Start believing in yourself;
5. Going for walks and becoming active helps keep your mind occupied;
6. Take responsibility for yourself—see your psychiatrist or G.P.;
7. If you've gone off your medication consider re-complying.

RECOVERY

One of us summed it up the road to recovery well. We'd like to end with a quote:

'It's important to take control of your own destiny. When you do total responsibility comes back to yourself. You begin to discover your own abilities. You need to eat and sleep regularly. Communicate and look after your appearance and take charge of the practical aspects of your life. Through this you become a respectable person.'

The group, 'A Haven for Active Minds' has continued to meet. Attempts, at the time of writing, were being made to put the above discoveries into a book form. For further information about the ongoing activities of the group please contact Tony Vassallo, c/ PO Box 274, The Junction, NSW 2291. Ph +61 2 4940 8844; fax +61 2 4965 4713

the discoveries made by members and to promote further reflection and the creation of a new story. In this case the story was co-evolved not so much with the therapists but with other group members.

Further comments on the use of letters. The letters were addressed to the whole group and in the text no specific reference was made to the creator of each remark. Phrases like 'one of you', 'another' and 'some members' were used to suggest that the discoveries were the group's and grew out of the interaction. Stubbs (1980: 107) comments that writing has the advantages of accumulating recorded wisdom; making it easier to study and consider material critically and transforming the teacher-student (*therapist-client*) relationship by promoting independence in thought as there can be no knowledge without a knower existing independently in the written form. The members valued the letters greatly. When asked for feedback they asked the leaders to keep sending them. Some read them two or three times in between sessions. One wrote his own contributions and a comic strip and asked that these be circulated with the letters. They did help to increase the permanency of discoveries, as occasionally members would say, 'that issue came up in the letter' etc. In this sense the letters achieved the 'unsurpassed authority from the fact that *they were* not heard, but seen (Epston and White, 1989: 36)'. An extract from a letter (after session two) is quoted below:

One of you said that it is very important to remember that throughout the course of the illness 'you always have a choice'. Even when you were homeless and living on the street and in the depths of hourly psychotic episodes you said to yourself, 'That's not for me—I'm gonna fight my way out of it'. What sorts of choices have you all had along the way? Who has attempted to maximise the choices you have? What helped you to make choices? How important is choice in your recovery? What advice would you give to others who are interested in maximising your choices? ...

...There are more independent exchanges developing in the group. One of you made an interesting observation. 'No one has said anything completely irrational in this group.' Whilst sharing your reflections about each other one of you said, 'You have an intelligence level which understands.'

Evaluation of the group

As mentioned earlier an independent evaluation session occurred. The evaluators' background, discipline and level of experience were as follows—the mental health nurse was at registration level and he has worked in the mental health field (both acute and non acute) for a period of twenty years. The social worker was at graduate level. He had about twelve years experience in the child and family health field and he had been using the narrative model in his work for about the same time. He worked too in child protection and with the Victorian School of the Deaf earlier in his career. The psychologist has a postgraduate degree in psychology and 31 years experience in the mental health field. He also has considerable experience in the child and family health field

and he works in private practice. Members were asked within an unstructured format about their experience of the group and what they found useful and not useful. The reviewers were also asked to inquire about the practical arrangements of the group—the venue and the two week break in between sessions. No claims are made as to the scientific validity of the evaluation. There was not the time or the funding to do a full scale qualitative and quantitative evaluation but it is recommended that this be considered for future groups.

The following findings are from the evaluation report:

The members found that since they attended the group their lives have changed in a number of ways. They find that they have more confidence, they have developed friendships, laughter and fun and a sense of trust has been restored to them. Some of the members noted that they felt they were getting on better with their families since attending the group. They thought their families were not as worried about them and they seem to be getting out more and not just sitting around ...

... The notion of self-acceptance was very important. One person felt that some of the decisions they were able to make, day to day ones such as going out or staying in, they could accept and did not have to worry about. One member commented that the group had helped people to get the normal side of themselves going and this had developed further as they became more active.

Members thought the two week gap in between sessions was appropriate. It gave them time to ponder on each session and the letter arriving during this break assisted them. Members also thought the group facilitators were 'not only attending the group as professionals, but more that they were here for themselves ... they were more down to earth, not by the book and moulded with us ...'

Members felt easy and comfortable in the group. 'There was no pressure and no judgement.' There were suggestions about further groups, which included that the ideas which were generated should be given to other groups in the future. Developing some type of pamphlet or handout might be an appropriate way of conveying this knowledge. More input on the effects of medication and alternative medications might be helpful and future groups should learn to appreciate that everybody has different views and is a unique individual. 'Members agreed that if another group was arranged the members from this should come back for an introductory session ...'

CONCLUSION

In this paper an attempt has been made to document the planning, formation and running of a group to assist people living with a mental illness. It is common for the opinions and discoveries of group members to be considered important but the extent to which this principle is honoured in practice is open to debate. It is hoped that other professionals are encouraged to take more influence over their circumstances and facilitate the expression and amplification of service users' rights

and knowledge in whatever field they work in. It is assumed that this is occurring. Let's see more work of this kind published.

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Endnotes

¹Falloon, Boyd and McGill's model, while family based, has been adapted for use in a group context.

²These questions are based on various papers by Michael White (2), (4), (6).

³I am grateful to Gaye Stockell for her ideas on the wording of the invitation.

⁴Jill Gibbons helped enormously with planning this aspect of the group session.

⁵For about 5 years the Dulwich Centre Team have been assisting with a similar group called 'Power to Our Journeys.' For a detailed discussion of the this group please see Denborough, D. (Ed.) 'Companions on a Journey: An Exploration of an Alternative Community Mental Health Project', *Dulwich Centre Newsletter 1997*, 1, Adelaide, South Australia.

⁶This is a magazine produced by clients of the Rehabilitation service.

*It's safest to address the note to 'Care of Conroy's sheep',
For five and twenty thousand head can scarcely go astray,
You write to 'Care of Conroy's sheep along the Castleraegh'.*

Banjo Paterson: 'The Travelling Post Office'.

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