

**RECOVERY FROM 'MENTAL ILLNESS' AS A RE-  
ENCHANTMENT WITH LIFE: A NARRATIVE STUDY**

A Thesis Presented to the University of Dublin, Trinity College, for the  
Degree of Doctor in Philosophy

by

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May 2012



## DECLARATION

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Michael Watts

Title: Recovery from Mental Illness as a Re-enchantment with Life:  
A Narrative Study

SUMMARY

**Background:** Since the 1960s there has been a steady rise in the number of people who question the dominant medical understanding of mental illness and recovery. In Ireland, the Irish Government formally adopted a policy in 2006 which committed policy-makers to effect a transformation within the Irish Mental Health system from a medical to a recovery ethos and practice (Department of Health and Children 2006). One of the impediments to such a transformation is that, as yet, there is no widely accepted theoretical base for recovery that might provide an alternative to that of the medical model. Recovery research, which relies on the experience of ordinary people for its knowledge base, is still in its infancy, with many more studies required before it can claim or satisfactorily demonstrate theoretical validity.

**Aim:** The aim of this study was, therefore, to develop a second-order narrative, drawn from the experience of members of GROW in Ireland, that would provide a coherent conceptual framework and understanding of recovery through mutual help. GROW is an international mutual help movement working in the area of mental health, which has a national network of groups in Ireland established since 1969.

**Methodology:** This study employed a narrative epistemology, using as its data the narrated experience of ordinary individuals with personal knowledge of 'mental illness', treatment and recovery. Data were gathered from members of GROW in Ireland situated in eight of GROW's nine areas of operation north and south of the border. Participants consisted of twenty-six experienced GROW members, each with a minimum of three years' participation in GROW and who were currently actively involved in leadership roles. Data were collected through interviews. Each interview was analysed using a mixture of inductive and deductive methods of analysis. In addition, memos and a series of mind maps and tables were used to facilitate analysis. Collectively, all of the interviews were woven into a second-order narrative of recovery through mutual help.

**Findings:** On the basis of an analysis of participants' narratives, recovery from 'mental illness' was conceptualised as 'a re-enchantment with life'. The process of re-enchantment was described as taking place in three linked, but non-linear phases. Participants collectively described the starting point of recovery as a desire to escape from 'a place of terror', which medicine describes as 'mental illness'. Rather than resulting from a single linear and physical cause, participants implicated multiple levels of life in the construction of 'a place of terror'. Terror was linked to many unresolved external traumas, which gave rise to cumulative feelings and thoughts of terror. Common to all the participants' accounts was the lack of resources to either counter the source of terror, heal the damage caused or reverse the deepening sense of isolation and mutual alienation from others that participants experienced.

The second phase in the recovery journey was described as ‘a time of healing’, which began when participants made the decision to leave their isolation and join the larger social body of the GROW community. Healing began with the awakening of positive feelings of hope, belonging and friendship, which were triggered by receiving a warm and emotional welcome from other GROW members. Feelings such as hope first affected participants in their bodies, and these somatic stories began to give rise to new and positive thoughts and relationships with other members of GROW. Key to this transformation was the fact that in GROW, relationships were reciprocal. Participants reported not only receiving friendship, love and leadership, but also being called on to give them back to others. In this way, their unique experiences of suffering were transformed into a resource for others. One of the key healing experiences was of bearing witness. Participants reported the healing effects of being encouraged to tell their story within the heart of a warm and loving social body. Similarly, bearing witness to the suffering and recovery of others normalised participants’ own experience, liberated them from stigma and became a source of hope and meaning for the future. GROW also challenged participants to systematically extend their involvement in GROW activities outside the weekly meeting as a preparation for a full re-integration into mainstream society.

The third phase of the recovery journey began with a realisation that re-involvement in society was not something to be feared, but ‘an opportunity to become’. Participants described GROW as acting as a link between ‘mental illness’ and life. They reported healing as a gathering of spiritual qualities, such as courage and strength, and as being empowered to choose to absorb tensions rather than avoid them. Within chosen niches in society such as education, work or leisure, participants described how they became fully independent individuals who thrived on life involvements. They reported a growing sense of well-being, a sense of becoming mature and a desire to contribute to the social good.

Although presented as three discrete categories, the relationship between the categories was circular. The recovery journey often involved setbacks which could plunge participants into new feelings of terror, with increased need to be supported and encouraged through the help of their weekly GROW meeting. Over time, however, progressive efforts towards an ever-growing independence meant an increased ability to become an independent agent and to find a positive sense of identity and belonging.

**Conclusions:** The findings provide a conceptual framework which articulates a description of recovery that differs dramatically from the medical view. Within this version of recovery, even severe forms of ‘mental illness’ become reversible. They successfully challenge the biomedical view about causes of ‘mental illness’, the appropriate use of medication and the nature of recovery. Recovery is described as a progressive form of personal liberation, through which participants emerged as strengthened individuals with a zest for life and a desire to contribute to the well-being of others. Together with findings of other studies emerging from within a worldwide recovery movement, they increase our knowledge of the experience of ‘mental illness’, the positive and negative effects of current treatments, and provide a hopeful and practical view of how to help people recover.

## ACKNOWLEDGEMENTS

I would like to thank my supervisor, Agnes Higgins, for the constancy of her support, before and during my period of study. Agnes' good judgement, good humour and unflinchingly high standards; her availability and continuing passion for the subject of recovery became a principal enabler. I also wish to thank Chris Stevenson, who was co-supervisor for the first twelve months and who similarly supported and encouraged me. Thanks to Brian Keogh, who helped critique my writing, and to Jo Murphy Lawless, Denis Fitzpatrick and Anne O'Connor, all of whom found time to read and comment on different chapters, and to my wife, Fran, and daughter, Liz, for their proofreading.

I am grateful to the spirit that prevails in Trinity's School of Nursing and Midwifery, a spirit that is generous with information, time and encouragement. I found the opportunities to discuss progress, share experience and get through the highs and lows of research with others, by e-mail or at the monthly support meetings, to be of great help.

Regular meetings with Geralyn Hynes in a coffee bar in Kilkenny, at a table piled high with books and articles generated a genuine atmosphere of discovery that was significant.

I would like to thank GROW in Ireland for the opportunity to undertake this research, for paying most of my fees and for allowing this project to become the focus of my work. The research would not have been possible without the GROW members whose stories were its substance. I have learned so much from listening to you all that I will be eternally grateful.

I would like to thank Eileen, John, Anna, Helen and all the staff in Kilkenny who supported me with quiet encouragement and by having faith in me, Gertrude and Stan for their discussions and comment.

Finally I have to thank my wife Fran, my children and indeed grandchildren who have been the chief co-creators of, and inspiration for, my own narrative of life. I thank my parents for the gift of life and all the people in Shean, Kilmaley, County Clare who were so much a part of my own recovery.

I would like to dedicate this thesis to any young man or woman who is currently struggling to recover from 'mental illness' and whose spirit may be weary. In particular, to members of GROW's special groups in the Central Mental Hospital and Arbor Hill prison. I also wish to dedicate it to Con Keogh, the main inspiration for GROW, with whom I had many inspiring conversations and who died recently at the age of 90.

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## CHAPTER ONE: AN OVERVIEW OF THE THESIS

### Introduction

The nature of what is commonly described as ‘mental illness’ and what constitutes recovery from that ‘illness’ are extremely complex human issues, about which there is much current debate. Many polarised views exist within a plethora of ingrained political, academic and economic philosophies, attitudes and vested interests. While at a micro level ‘mental illness’ often has devastating effects on an individual’s life, at the macro level ‘MENTAL ILLNESS’ has become a multi-billion-euro industry, supportive of a hierarchical mental health system. As a result, in Johnstone’s (Johnstone 2000:v) view, psychiatry ‘Is required to be the agent of society while purporting to be the agent of the individual, and its main function is not treatment but social control’.

At the very heart of the debate about the nature and treatment of ‘mental illness’, two views currently collide, namely the biomedical and recovery perspectives, giving rise to tensions, polarised views and a crisis of beliefs, which is also reflected within the field of psychiatry and beyond. Consequently, Brendel (2006) advocates a pragmatic approach to both theory and practice of care. The dominant biomedical view seems entrenched in a belief that ‘mental illness’ is simply another manifestation of physical illness, a condition which in its more serious forms is lifelong, unremitting, degenerative and dependent on medical intervention. The authority of this view is actively supported by legislation such as the Mental Health Act 2001 (Government of Ireland 2001), by the media and by a privileged academic discourse that is seriously compromised through financial incentives from the pharmaceutical industry (Whitaker 2010, Rappaport 2005). The biomedical view of ‘mental illness’ identifies a chemical imbalance within the brain as its primary cause – a cause which has little or no contextual connection to other levels of life involvement. Recovery is therefore synonymous with cure or a restoration of the brain’s chemical balance through treatment with prescribed psychiatric drugs.

The dominance of the biomedical view is reflected in authoritative definitions posted on the websites of the Irish College of Psychiatry and Irish psychiatric hospitals and in literature available from organisations such as SHINE which are aimed at educating the public. Authoritative utterances such as these tend to ‘trump’ and

overrule the possibility of any other interpretation (Frank 1995). For example, the website of the College of Psychiatry of Ireland declares:

‘Schizophrenia is a chronic brain disorder that affects more than 1% of the population’. Its primary cause is identified: ‘Chemicals in the brain are not balanced properly, which then results in the symptoms of delusions, hallucinations and thinking difficulties’.

‘While there is no cure for schizophrenia presently, treatments are available which can reduce the intensity and frequency of the symptoms, and many people are able to recover from the illness to lead fulfilling and productive lives. Because schizophrenia involves an imbalance in brain chemicals, medications are very important in order to manage the illness. It is vital for people with schizophrenia to take their medication consistently’

(College of Psychiatry of Ireland 2012).

Similarly, SHINE’s website describes:

‘Bipolar disorder, or manic depression, is a medical illness that causes extreme shifts in mood, energy and functioning. These changes may be subtle or dramatic and typically vary greatly over the course of a person's life as well as among individuals. Over 10 million people in America have bipolar disorder, and the illness affects men and women equally. Bipolar disorder is a chronic and generally lifelong condition with recurring episodes of mania and depression’ (SHINE 2012).

The medical view is currently being challenged by a ‘recovery model’ that suggests ‘mental illness’ is created at multiple levels of being (Amering and Schmolke 2009, Rappaport 2000, Rowe 2008). Through the recovery lens, ‘mental illness’ is, in fact, a form of emotional overload or identity crisis – a crisis from which people can (and do) emerge as fully autonomous and even strengthened citizens. In this view, ‘mental illness’ has meaning and is related to many physiological, cognitive, social and cultural levels of life involvement. Physiological ‘symptoms’, which are interpreted by the medical model as evidence of a chemical imbalance, are, in the recovery view, a by-product of emotional trauma which is related to real relationships and events, but not their primary cause. Recovery, in this understanding, involves finding, accessing and developing personal resources and learning to tackle multiple past and present causes of emotional turmoil.

As well as recovering from ‘mental illness’, people frequently have to come to terms with serious side effects of potent and addictive psychiatric drugs (Whitaker 2010,

Rowe 2008), which can have catastrophic health consequences in the long term. They also have to overcome the deeply ingrained social prejudice of dominant community narratives about the ‘mentally ill’ (Rappaport 2000) that depict them as untrustworthy and as a potentially dangerous ‘other’ – a view that, according to Levin (2001:8), is actively promoted by the media and ‘has its fingerprints all over the system’. In Ireland, these prejudices are reflected in the findings of two National Disability Studies (National Disability Authority 2002) on Irish attitudes to people with ‘mental illness’, where 55% of the sample believed ‘mentally ill’ people should be denied sexual relationships and that children with ‘mental illness’ should be excluded from schools. Such deeply held prejudices adversely affect opportunities for reintegration into society once a person has been cast in the role of ‘mentally ill’.

It is within this context that the Irish Government, by officially adopting recommendations from ‘A Vision for Change: Report of the Expert Group on Mental Health Policy’ (Department of Health and Children 2006), has called for a transformation of the mental health system from one which views ‘mental illness’ through a biomedical lens to one that fosters a whole new concept of recovery. The difficulty of this aspiration is compounded by the lack of studies needed to provide a clear definition of the nature and process of non-medical recovery, and the current implicit view of medicine that the only valid form of knowledge comes from scientific inquiry. ‘A Vision for Change: Report of the Expert Group on Mental Health Policy’, by recommending that ‘service users should participate at all levels of the mental health system’ and that the ‘imbalance of power between service users and professionals should be acknowledged and addressed’ (Department of Health and Children 2006:28/29), demonstrates a willingness to redress this situation.

This piece of research, which uses as its subject matter the recovery stories of 26 members of GROW (an international mutual help movement working in the area of mental health), aimed to explore recovery stories and to develop an understanding of the process of recovery from ‘mental illness’ through involvement in the GROW community. The objectives of the study were to:

- Explore the recovery experiences of a cohort of GROW leaders.
- Explore how various types of help facilitated, aided or impeded recovery.
- Explore the role mutual relationships such as friendship, reciprocity and leadership play in a person’s recovery.

## What is GROW?

GROW is an international mental health movement. It began in Australia in 1957, coming to Ireland in 1969. GROW adapted the twelve-step methods of Alcoholics Anonymous (AA) to suit the needs of people striving together to recover from ‘mental illness’. GROW provides its members with a written program containing many recovery principles and, through a weekly meeting, systematically challenges and supports them to construct a recovery plan based exclusively on their unique needs. Most of all, GROW constitutes an ongoing, warm and caring community based on principles of mutual help. A more in-depth description of GROW is included later within the thesis.

GROW has a clearly-articulated and perhaps unique perspective on recovery. It sees recovery as a process of personal empowerment and identity transformation which may start within, but soon outgrows a medical view of ‘mental illness’. GROW acknowledges that hospitalisation, diagnosis and treatment may be a valuable starting point for recovery, but that these forms of ‘therapeutic’ external control must quickly make way for the development of friendships, personal resources and a belief system that enables a person to leave medication and other forms of help behind. Perhaps GROW’s view is best summed up in the words of its manifesto:

‘People are no more born to be mentally ill than they are born to be alcoholics, drug addicts, criminals, sexual deviants, slaves, ignorant or poor. These things are neither in our genes nor in our stars. People get that way through social influences and personal failure – that is through learned habits of false thinking and disorganised living. But they are not incurable. Learned attitudes can be unlearned with help so long as it is the right kind of help. The only essentially good help is that which sooner or later – the sooner the better – enables the mentally ill to activate their innate resources and take over the understanding, management and sharing of their own lives. Their primary helpers, therefore, must be other friendly human beings who know from experience how to do just that. All other helpers, including doctors, are necessarily subordinate, good in their place, but harmful when they do not make way for that vital self-activation through mutual help’

(GROW in Ireland 1994:48).

## Generating the idea

The idea for this research began formally when I applied to the School of Nursing and Midwifery in Trinity College Dublin in 2008 and was accepted as a student there. However, ‘recovery’ from ‘mental illness’ is something that I have been

interested in and confronted with for very many years. As a young man, I was given a diagnosis of ‘pathological shyness’ and prescribed Librium. At that time my life was seriously curtailed by a terrible fear of people and of life, and an inability to function socially. I found the experience of diagnosis and treatment to be quite disempowering, my label suggesting to me that I had no control and therefore no hope for the future. Some four years later, the reality and devastation of ‘mental illness’ was again brought home when my wife, Fran, experienced a psychosis after the birth of our first child. Fran was diagnosed with puerperal psychosis, schizo-affective disorder, schizophrenia and eventually bipolar disorder. Family life became exceedingly chaotic, with many spells in hospital and a growing cocktail of drugs. We both became members of GROW in 1976 and we both recovered. For both of us, recovery included becoming involved in various meaningful niches in society. It also led us to become independent of medication and professional help. As part of my own recovery, I returned to university and completed a BA in psychology and then a Masters in systemic theory, both of which were very helpful at many levels.

I have been an employee of GROW in Ireland since 1983. During that time I have met many people who have recovered from various kinds of ‘mental illness’; sadly, however, I know many people who have not done so, whose lives have been blighted by both ‘illness’ and long-term medication, and who appear to have remained very much on the fringes of society. At a personal level, this research offers me a chance to study recovery through the stories of people at different stages of their journeys and to allow an understanding to emerge of what really brings about recovery.

In 2002, I was very honoured to be asked to be a service user member of Ireland’s newly established Mental Health Commission (MHC). In that role, I was chairperson of a subcommittee that published the Commission’s first discussion document on recovery, entitled ‘A Vision for a Recovery Model in Irish Mental Health Services’ (MHC 2005), which strongly advocated a change from a medically-minded to a recovery-oriented mental health system. The experience of being on this committee and of becoming more aware of the different ‘dialogues’ around recovery fed a desire to learn more and became another prompt to undertake a study of this nature.

## Selecting a narrative approach

A narrative approach to this study appeared to be the obvious choice for two main reasons. Firstly, Julian Rappaport (1988), who headed up a four-year evaluation of GROW in Illinois (1984 -1987), suggested that organisations like GROW work by creating a community narrative that is strong enough to combat the dominant negative cultural and professional narratives in which people suffering from ‘mental illness’ become embedded. He therefore suggested that the experiential narrative of ongoing involvement in a loving community empowers people to transform their own sense of identity, from one that evokes a tale of dependent terror to one which provides an independent tale of joy (Rappaport 2000). Salem et al. (1988) advocated that the role of mental health professionals should be to discover, and help create, niches in the community that provide other powerful community narratives which also facilitate this transformation.

Secondly, narrative is an integral part of the process of recovery through GROW. From early on in their membership, GROW members are encouraged to tell their stories of becoming ‘mentally ill’, of progressive personal growth and of recovery and, in so doing, to identify the very things my research seeks to illuminate, i.e. what causes ‘mental illness’, who or what is helpful in the recovery process and why. Based on my reading of Rappaport’s work (e.g. 1988, 1995, 1998a, 2000, 2005a, 2008) and my knowledge of the working methods of GROW, I considered a narrative approach as an ideal methodology to answer my research question. A narrative study in which people are asked to ‘tell their stories’ very much fits GROW’s own methodology and should therefore be familiar to those taking part.

Experience as a valid form of knowledge has, until recently, largely been ignored as relevant to the formation of an effective and informed mental health system. By listening to people who have experienced ‘mental illness’ and medical treatment and have recovered, it was hoped that common emergent threads would appear that could be woven into the beginnings of a conceptual framework, or a second-order narrative. The narrated experience of participants would provide first-hand information about the nature of recovery, the processes involved in bringing it about and insights into what has been helpful and unhelpful along the way. It was hoped that this study would also provide information about the effectiveness of GROW in Ireland, a mutual help organisation that is largely funded by the Health Service



Executive (HSE) and might prompt similar evidence-based studies of other mutual help organisations involved in the mental health system.

### A personal statement

Cresswell (2007) notes that the beliefs and attitudes of the researcher have the power to shape both the nature and the outcomes of research. I therefore feel it is important to try to articulate what I believe with regard to both a biomedical and a recovery stance on recovering from ‘mental illness’. I believe the judicious use or non-use of medication is absolutely central. While medication was supremely dominant in Fran’s treatment and was a minor feature in my own, I wonder if other interventions would have been equally effective. Fran was offered no alternatives to medication in the form of counselling, psychology or any other type of professional therapy, and she remained on very high levels of drugs for a period of fifteen years. I personally see medication as, at best, a temporary form of external control that may be appropriate when a person is in either chaos or despair, and which should perhaps be used in the same way that a cast is temporarily applied to a broken leg. In this case, it can prove to be a lifesaver and its prescription, an act of mercy. At worst, I see it as an extremely damaging and unnecessary burden which damages a person’s health and weakens their ability to find solutions, as well as providing an enslaving and demeaning social script and identity.

I have a strong wish to really come to understand all of the personal and interpersonal processes that are involved in recovery. Deegan (1995) suggests that recovery is a journey, rather than a destination. However, I believe that along that journey many definitive outcomes exist which suggest that recovery has taken place. Among these outcomes I would include the ability to choose not to use medication, the ability to choose to work and to live independently, and the ability to be at home with other people.

### Format of this thesis

The thesis is presented in three sections. Section one (chapters two and three) focuses on literature in the areas of recovery and mutual help. Chapter two traces the development of professional theories and practice which, over time, have

characterised our mental health system and influenced perspectives on recovery. Chapter three traces the evolution of mutual help, a type of help whose epistemological base is rooted in lived experience. This chapter also explores the nature and origins of GROW and gives an overview of research already conducted in collaboration with the GROW community.

Section two (chapters four and five) examines the epistemological and philosophical underpinnings of narrative research and the medical, scientific and sociopolitical contexts in which this study is set. It then brings the reader through the process of the research, from initial conception to ethical approval, recruitment of participants, methods of interviewing, transcribing and analysis.

Section three (chapters six to eleven) presents and discusses the findings, conclusions and recommendations drawn from the study. The findings are presented in four chapters and describe participants' narratives of recovery through three phases. Recovery begins with a desire to move from 'a place of terror' and involves 'a time of healing', in which reciprocal relationships are key. Healing prepares people to re-engage themselves in society and represents 'an opportunity to become'. Together this process is described as a 're-enchantment with life'.

The penultimate chapter of the thesis provides an in-depth discussion of the findings in the context of the extant literature. The final chapter addresses the limitations of the study, including its validity or trustworthiness. It attempts to address the implications of the findings for GROW, the education, training and practice of professionals, the role of non-professionals in recovery and the successful implementation of the aspirations contained within 'A Vision for Change: Report of the Expert Group on Mental Health Policy' (Department of Health and Children 2006).

## CHAPTER TWO: LITERATURE – STORIES ABOUT ‘MENTAL ILLNESS’ AND RECOVERY

‘There is a difference between knowledge and wisdom... When we teach our students about the heart, we teach them that the heart is a pump. Wisdom would have us understand that there is another heart; the heart that can break; the heart that grows weary; the heart that leaps with joy; the one that lives in my body and in your body’ (Deegan 1995:91)

### Introduction

Throughout history, mankind has created stories seeking to explain the phenomenon of ‘mental illness’ and to suggest various treatments or processes that enable, facilitate or constitute recovery from that ‘mental illness’. This chapter reviews and explores some of these stories. I use as a starting point the argument, advanced by Rappaport (2000) and others (Frank 1995, Bruner 2002), that all important knowledge is obtained in storied form. This chapter therefore seeks to contextualise my research within a heteroglossia of historical, political, philosophical, professional and economic stories about recovery from ‘mental illness’. It is within this context that the stories of my collaborative participants, as presented later in this thesis, ‘live and move and have their being’ (Christian Community Bible 1999, Acts 17:28). Prior to discussing the various stories of recovery, I will discuss the use of certain terms within the thesis and my rationale for selecting them.

### Use of terms

There is much debate within current literature on the use of terms such as ‘mental illness’, ‘mental disorder’ (Mental Health Act 2001), ‘emotional distress’ (Fisher 1995) or ‘developmental challenge’ (Alanen 2009). While the most appropriate term for ‘mental illness’ and its real nature are hotly debated issues, the term ‘mental illness’ currently remains the most widely used description in both professional and lay conversation. I have decided to use this term throughout this thesis, even though it is a term that is medically-laden. In fact, by being so medically-laden, the words ‘mental illness’ may reflect the growing body of opinion that recovery from ‘mental illness’ implicitly includes recovery from a system that relies too heavily on medical diagnosis and treatment (Department of Health and Children 2006, President’s New Freedom Commission on Mental Health 2003). In addition, GROW, the organisation

whose members inform this research, use the term ‘mental illness’ in their literature (GROW 2001:24), even though they take issue with the medical interpretation of this phrase. At a personal level, I consider it more important to inform people’s understanding of the meaning of ‘mental illness’ and the many implications attached to different understandings, rather than to describe the phenomenon as something like ‘emotional distress’, even though this language is closer to my own belief system. The quotation marks around the term ‘mental illness’ are intended to show that it is a socially constructed term and to indicate that a change in nomenclature could be introduced later as part of a radically new story of recovery, if one emerges or is ever adopted.

I use the word ‘stories’, rather than ‘discourses’ (Smith 1998), ‘dialogues’ (Bakhtin 1981), ‘perspectives’ (Price 1979) or ‘paradigms’ (Kuhn 1962), because this study employs a narrative approach – an approach which invites its participants to tell their own spontaneous personal story at a particular moment in time and within the ‘space’ of an unstructured or at times a semi-structured interview. To subsume the more formalised and ‘authoritative’ cultural and professional narratives, discourses, dialogues, paradigms or perspectives in which these experiential accounts are embedded, under the rubric of ‘story’, hopefully serves to elevate the value of knowledge forged through lived experience. By using the word ‘story’ for all types of narrative, I indicate a belief that personal stories based on an experience of ‘mental illness’, treatment and recovery need to be added to the traditional hierarchies of knowledge upon which psychiatry is based (Evans 2003). To do so would question the assumption that because some stories are deemed ‘authoritative’, they carry more validity than others (Bakhtin 1981). This view is reinforced in the mental health policy document ‘A Vision for Change: Report of the Expert Group on Mental Health Policy’, which recommends that the experience of service users inform ‘every aspect of the evolving mental health system’ (Department of Health and Children 2006:4).

### Putting recovery into context

While the notion of recovery from ‘mental illness’ has always been with us, it is a concept that has been gathering momentum since the emergence of the recovery movement in the 1960s (Amering and Schmolke 2009). This movement has its

origins in the experience and ‘intellectual property’ of people such as Chamberlin (1978), Deegan (1995) and Fisher (1995) (all people who have self-identified as having recovered from ‘mental illness’); ‘disaffected’ psychiatrists like Bregin (1991), Szasz (1961) and Browne (2008); individuals within other branches of the mental health system (Higgins 2008, Humphreys 1996, Rowe 2008, Barker and Buchanan-Barker 2005); and service user-led organisations such as GROW (1957), Irish Advocacy Network (1999), Mad Pride (2008) and, most recently, the Irish Critical Voices Network (2011). Anthony (1993), and Amering and Schmolke (2009), suggest that further catalysts for a changing understanding of the concept of recovery lie firstly in ‘the widespread implementation of deinstitutionalisation and the increasing ascendance of the community support system and the practice of psychiatric rehabilitation’ (Anthony 1993:521); and secondly, in the development of a social model of disability highlighting the socially constructed nature of all ‘illness’ and the stigma and discrimination experienced by those so-labelled (Amering and Schmolke 2009). In addition, Whitaker (2010) (an investigative journalist) seriously questions the credentials of the currently dominant pharmacological model and other medical claims about contributions to recovery through an examination and comparison of published scientific evidence.

Already, many governments in the developed world have sought to incorporate the idea of recovery into their mental health systems. The US ‘envisions a future when everyone with a mental illness will recover’ (President’s New Freedom Commission on Mental Health 2003:1). Similarly, New Zealand’s publication, ‘Recovery Competencies for Mental Health Workers’ (Mental Health Commission New Zealand 2001) and the UK’s policy document, ‘The Journey to Recovery – The Government’s Vision for Mental Health Care’ (Health 2001), both seek to make recovery the main aim of their mental health systems. In 2005, the Irish Mental Health Commission (MHC) published a discussion document entitled ‘A Vision for a Recovery Model in Irish Mental Health Services’ (MHC 2005). The content of this was in line with a number of the Commission’s strategic priorities, in particular ‘To promote and implement best standards of care within the mental health services’ (MHC 2005:4). Implicit in this priority was a move from a medical to a recovery-oriented mental health system. Around the same time, the Expert Group on Mental Health Policy was established to formulate ‘a blueprint for a modern, comprehensive, world-class service’ (Department of Health and Children 2006:4).

When published, the recommendations contained within ‘A Vision for Change: Report of the Expert Group on Mental Health Policy’ (Department of Health and Children 2006) were quickly adopted as Government policy. At the heart of this document is a call for:

‘A person-centred treatment approach... whose interventions should be aimed at maximising recovery from mental illness and building on the resources within service users and within their immediate social networks’  
(Department of Health and Children 2006:8).

One of the core aspirations contained in the document is that:

‘The existing experience, knowledge and skills of service users should be valued even though these may challenge those of some professionals’  
(Department of Health and Children 2006:28).

Both of these recently published documents were consolidated by a published implementation framework commissioned by the Mental Health Commission which also contained a vision for a transformation of the mental health system, from one built around and dominated by the ‘biomedical model’, to a system that focuses on and nurtures recovery (Higgins 2008).

The emergent recovery model questions the permanence of ‘mental illness’ and suggests that recovery is primarily the responsibility of the ‘mentally ill’ person and not just of the professional. In so doing, it challenges the traditional, paternalistic, pessimistic and dominant medical view of ‘mental illness’, championing a radically ‘alternative’ understanding of the nature and prognosis of ‘mental illness’. This has implications for the role of all of the different stakeholders within the recovery ethos (Ralph and Corrigan 2007), with Stickley and Wright (2010) noting that:

‘In the UK there has been a shift in focus from the role of the individual in their own recovery journey towards the responsibility of service providers to ensure a recovery focused service’ (Stickley and Wright 2010:1).

Recently, many Irish organisations have indicated their interest in recovery through published documents, for example ‘Towards Recovery’ (Schizophrenia Ireland/Lucia Foundation and the Irish Psychiatric Association 2003); ‘Our Personal Stories of Recovery’ (Eve Limited 2008); and ‘You Can Do It But You Can’t do it Alone:

Young Adult Personal Stories of Recovery Towards Mental Health’ (GROW in Ireland and HSE National Office for Suicide Prevention 2010).

### The concept of recovery: an exploration of meaning

The word ‘recovery’ has multiple meanings derived from different epistemologies, giving rise to radically different beliefs and practices. These differences are deeply divisive, centring around the nature of ‘mental illness’ and who is chiefly responsible for its diagnosis, treatment and management (Amering and Schmolke 2009, MHC 2005). The recovery debate does not simply divide people into groups of professionals and service users. Within psychiatry there is ongoing tension between those who believe ‘mental illness’ is primarily due to neurological causes and those who favour emotional and relational explanations (Brendel 2006). Within the service user population, some prominent individuals have come to view ‘mental illness’ as a biological condition requiring lifelong medication (Saks 2007, Redfield Jamison 1997), while others vehemently oppose this view, maintaining that recovery, by definition, means an eventual cessation of medication and professional help (Coleman 2004, Fisher 2008, Lehmann 2002). The acrimony of the debate can be gauged from titles of publications written by both professionals and service users, such as: ‘Toxic Psychiatry’ (Bregin 1991); ‘Recovery: An Alien Concept’ (Coleman 2004); ‘Manufacturing Victims’ (Dineen 1999); ‘Punishing the Patient’ (Gosden 2001), and indeed from daily e-mails posted on a newly established Irish-based Critical Voices Network, such as this one:

‘The only good thing going on in the mental illness system is the work being done to end the mental illness system and institute the system of mental development from the child mind to the adult mind. No one benefits from the mental illness system’ (Irish Critical Voices Network 2011).

Perhaps the most widely published definition of recovery within the growing body of literature is provided by Anthony, who describes recovery as:

‘A deeply personal, unique process of changing one’s attitudes, values, feelings, goals, skills and roles. It is a way of living a satisfying, hopeful and contributing life even with limitations caused by the illness. Recovery involves the development of new meaning and purpose in one’s life as one grows beyond the catastrophic effects of “mental illness”’

(Anthony 1993:13).

Deegan (1995) describes recovery as a ‘way of life’: in her words, recovery does not refer to an end product or result.

‘Recovery often involves a transformation of the self wherein one accepts both one’s limitation and discovers a new world of possibility. This is the paradox of recovery, i.e. that in accepting what we cannot do or be, we begin to discover who we can be and what we can do’ (Deegan 1995:13).

Amering and Schmolke (2009) suggest that when compared to the simplistic, linear, medical explanation of recovery that dominates the mental health systems of the developed world, these two definitions speak

‘A completely new language of life aspiration and opportunity and try to capture a process of many facets, faces and forms’  
(Amering and Schmolke 2009:9).

Andresen et al. (2003:588) have identified four models of recovery: the medical, the rehabilitative, the empowerment and the psychological models. The next section of this chapter will explore each of these models.

### The medical model of recovery

The positivist medical model assumes that, at least in its more serious forms, ‘mental illness’ is a lifelong, degenerative disease with strong genetic links, that is caused by a biochemical imbalance within the brain (Hoff 2008). Within this model, ‘mental illness’ can be successfully diagnosed and symptoms can be treated if one can find the right medication. But it can only be treated by the scientific expert, who alone REALLY understands its nature and cause. Recovery is thus understood to be a complete absence of ‘symptoms’ and is largely dependent on a hierarchy of skilled professionals – led and dominated by psychiatry – and which requires little input from the service user. Kloos (1999:326) suggests that, within this model, recovery becomes synonymous with compliance with a medication regime and with symptom reduction. Critics point out that, to date, there is no scientific evidence to indicate the existence of a biochemical basis for ‘mental illness’ and that diagnosis is a particularly unreliable individual qualitative process (Lynch 2001, Whitaker 2002, Charon 2006). Charon (2006), Frank (1995) and Kleinman (1988) all suggest that the medical view of ‘mental illness’ fails to see the effects ‘disease’ has on the person



and tends to treat the person as though they were the disease. Many service users have written of the hopelessness experienced on receiving the ‘lifelong sentence’ of serious ‘mental illness’, the enforced nature of treatment and the often devastating side effects of medication (Deegan 1995, Saks 2007, Sacks 2007).

The medical story of ‘mental illness’ is a paradigm which has gone through many transformations between the seventeenth and twenty-first centuries, while retaining many constant identifying characteristics. All the theories put forward have been greatly influenced by scientific, political, social and economic interests and ideas of the time all have assumed a biological or genetic linear cause. In its initial stages, each newly ‘discovered’ cause and accompanying treatment was heralded as a ‘major scientific advance’. Claims of successful cure were often grossly exaggerated and negative outcomes hidden, excluded or at best minimised, with few negative professional consequences for those involved (Scull 1979, Bregin 1991, Johnstone 2000). Efforts have been consistently made to ‘educate’ other professionals and the general public to accept new biological ideas through aggressive marketing campaigns and financial incentives, with alternative approaches to ‘mental illness’ and recovery being seldom mentioned within psychiatric journals.

Thomas Willis (1648), is accredited with being the first person to construct a medical paradigm of ‘mental illness’ (Whitaker 2002:6). Philosophies had concluded that man was separated from the beast through the faculty of reason, and in this context Willis decided that insanity was caused by a loss of reason. Its cure lay in the restoration of reason through professionally administered ‘tortures and torments’. In Willis’s words:

‘Maniacs often recover much sooner if they are treated with tortures and torments in a hovel instead of with medicaments’  
(Willis 1648 cited in Whitaker 2002:6).

And so the stage was set for a whole range of theories and practices that were advanced and practised by a branch of medicine that Scull (1979) speculates was desperate to gain academic credibility. Treatments included spinning chairs, prolonged baths while sewn into sheets, repeated near drownings, beatings, exposure to extreme hot and cold, injections of a wide variety of substances and, of course, chains (Scull 1979, Johnstone 2000, Whitaker 2002). Henry Cotton (1919), no doubt

influenced by the successful cure of syphilitic paresis, speculated that insanity must be caused by bacterial infection of the brain. The most obvious cure therefore was the removal of the seat of infection – first tooth extraction, then tonsils and then parts of the bowels. Cotton's work was recently described in the *Lancet* as 'a tale of such gothic horror that the author must assure his readers the events he recounts really happened' (Hudson Jones 2005:361). Despite this, 'when the fallacies of Cotton's claims and the harms of his treatments had been investigated and reported by other psychiatrists, their reports were disregarded or suppressed' (Hudson Jones 2005:362). Psychiatry confidently marched on with a whole new batch of revolutionary treatments which included insulin and malarial coma treatment, the widespread use of Electro Convulsive Therapy (ECT) and lobotomy. All of these identified various parts of the brain as the central cause of 'mental illness', all achieved academic and practical dominance and all damaged countless lives while making extravagant claims about positive outcomes (Whitaker 2010, Whitaker 2002, Healy 2004).

In parallel with these types of medical treatment, Darwin's revolutionary theory of natural selection presented Western thinking with a moral dilemma. It could be argued that, left to itself, nature would seek to eradicate any serious human aberration such as insanity. In this context, the Eugenics movement, triggered by Darwin's cousin Francis Galton, argued that genius was genetically inherited and had little to do with surrounding nurture (Galton 1869 in Whitaker 2002:43). 'Mental illness', on the other hand, was authoritatively stated to be caused by 'bad brain plasma' or 'cacogenic genes' (Davenport 1911:241). Eminent psychiatrists began to see insanity as the end stage of a family's germ plasm deterioration:

'The insane patient gets it from where his parents got it – from the insane strain of the family stock' (Maudsley 1895 cited in Whitaker 2002).

Within this thinking, it was essential that society protect itself from insanity. This was accomplished by mass segregation of the insane and the introduction of sterilisation programmes. In 1935, Nobel-prize-winning physician Alexis Carrel gave voice to the idea that the insane 'should be humanely and economically disposed of in small euthanasic institutions supplied with proper gases' (Carrel 1935:318). By 1914, Eugenics was being taught in 44 American colleges of psychiatry, and by

1924, nine thousand papers had been printed on the subject (Whitaker 2002:53). A travelling show entitled ‘Some People are Born to be a Burden on the Rest’ toured America, educating the general public. Nazi Germany and the second world war gave rise to the full horrors and implications of eugenic thinking, and Hitler’s 1933 sterilisation bill was seen by American psychiatrists as a public endorsement of the value of their work:

‘The leaders in the German sterilisation movement repeatedly state that their legislation was formulated only after careful study of the California experiments’ (Smyth 1938 cited in Whitaker 2002).

In May 1954, Smith Kline and French introduced the new ‘wonder drug’, chlorpromazine, to the American market. Its introduction was to be the start of yet another new and authoritative medical story, heralding ‘an age characterised by the idea that drugs can cure mental illness’ (Moncrieff 2007:1). Writing in 1997, Shorter summed up this belief:

‘Chlorpromazine initiated a revolution in psychiatry, comparable to the introduction of penicillin in general medicine, ensuring for the first time that schizophrenic patients could lead relatively normal lives and not be confined in institutions’ (Shorter 1997:255).

Chlorpromazine was the first of a growing array of chemical treatments that have since been marketed as providing specific cures for an increasing number of specific ‘mental illnesses’. Theories explaining the aetiology of ‘mental illness’ in terms of serotonin and dopamine levels were constructed by drug company researchers, who then paid key opinion leaders – prominent psychiatrists – vast sums of money to endorse these theories in their roles as spokespersons for the American Psychiatric Association (JAPA) and National Institute for Mental Health (NIMH) (Whitaker 2010:285). These theories are now central to the academic training of new psychiatrists and other mental health professionals and, through them, the general public. Whitaker (2010) follows the stories of Prozac, Xanax and Risperdal, which were marketed as containing cures for depression, anxiety and schizophrenia, respectively, and contends that they all follow the same pattern: the construction of a plausible ‘scientific story’; the distortion of research facts and the active repression of negative findings; the payment of high profile psychiatrists for the story’s endorsement; and a massive promotion using all the modern powers of advertising and the popular media. Today, drug treatment is often the only form of help offered

to people seeking relief from ‘mental illness’ in Ireland (Dunne 2006, Department of Health and Children 2006). A UK survey found that 98 – 100% of inpatients were prescribed drugs and that most take several different ones at the same time (Healthcare Commission 2007). The pharmacological story of ‘mental illness’ and recovery is based on the premise that new, powerful drugs can work on specific areas of the brain, restoring a chemical balance within the brain and thus generating mental health. When seen in the context of previous medical stories about ‘mental illness’, one has to ask how much of the thinking behind the pharmacological story is ‘fact’ and how much is imagination. People are told that these drugs counter a chemical imbalance in much the same way as anti-biotics counter infections, yet there is no hard evidence to support this (Bregin 1991, Healy 2004, Lynch 2001). Some studies show that long-term outcomes for people with schizophrenia and depression are far better for those not treated with psychiatric drugs than for people who are treated (Harding et al. 1987, Mosher et al. 1975, NIMH Regier 1988). There is a growing awareness of harmful side effects, including weight gain, diabetes, shortening of life, iatrogenic illnesses, suicidal and homicidal feelings, which have ended in violence, and interference with brain and body growth (Whitaker 2010). It is not surprising that Rappaport (2005) believes that an ‘unholy alliance’ has been formed between science and state – an alliance that has sacrificed human values in a mad rush for prestige, profit and power. Despite all the question marks about the pharmacological interpretation of ‘mental illness’, for the majority of people drug therapy remains the treatment of choice, with demands for antidepressants, tranquillisers and other drugs used within psychiatry exponentially on the increase (Feldman et al. 2006).

### The rehabilitation model of recovery

The rehabilitation model of recovery, based on the medical view, also assumes that ‘mental illness’ is a permanent condition. ‘Mental illness’ is likened to spinal injury: while the injury itself can never be cured, with rehabilitation, a person can find ‘some semblance of the life they had before the illness’ (Andresen et al. 2003:588). Critics of this model point to the fact that many people become trapped in ‘the sometimes desolate wastelands of mental health programmes’ (Deegan 1995:3) and never get back into mainstream life and employment. In America especially, more and more people are being given lifelong disability pensions because they have been

diagnosed with (and treated for) serious forms of ‘mental illness’, and among this population there is no expectation that people can and will recover (Whitaker 2010). While DeSisto et al. (1995) suggest ‘that rehabilitation services predict better longitudinal courses and outcomes for serious “mental illness”’, in Rappaport’s view:

‘Even the most successful programmes make no difference once they come to an end. The cure model of care, which assumes a time limited treatment, followed by withdrawal of services as the person makes it on his or her own, seems to be quite inadequate for many people’

(Rappaport 1998:4).

Several Irish-based studies give more than a flavour of what the Rehabilitation view of recovery means in practice (Farragher et al. 1996, Whitty et al. 2006, McCrum and MacFlynn 1990). Farragher et al. (1996), in a retrospective study of 297 psychiatric patients admitted to inpatient rehabilitation over a fifteen-year period, described the outcome as satisfactory (Farragher et al. 1996:1120). The evaluation of satisfactory outcome included facts such as four patients committing suicide, 55% experiencing acute psychiatric readmissions, 17% becoming new long stay patients and, of 76% discharged into the community, two-thirds requiring supported housing. The stated reason for regarding these statistics as satisfactory was that ‘the main criticisms of deinstitutionalisation did not apply to these patients. No one became homeless’ (Farragher et al. 1996:1120). Perhaps because expectations of recovery had been set at such a low standard, these statistics appeared to represent a positive example of recovery.

Whitty et al. (2006) studied the effects of attendance at a 32-week, full-time lifestyle management course (the REACH programme) in a longitudinal study involving a group of people experiencing a first psychotic episode. They found improved measures and self-reports on quality of life scales, but noted that the ‘potential benefits of such interventions may not extend into reduced use of hospital beds’ (Whitty et al. 2006:25). In fact, a matched group of participants who did not attend REACH, but received standard care, had a significantly lower number of days in hospital. McCrum and MacFlynn (1990) found that during a three-year period, almost half of the participants in a rehabilitation programme failed to maintain an ability to live in different forms of sheltered accommodation within the community

and returned to full-time hospital care. The article reported that older people tended to cope better with residential accommodation and speculated that this

““Success” is the result of transferring from one type of institutional care to another which has many similarities’ (McCrum and MacFlynn 1990:171).

Eve Holdings (an Irish-based rehabilitation training centre) produced a collection of personal stories of recovery which suggests a view of recovery that includes an ongoing dependence on many professional and medical forms of help. One of the trainees, Angela, whose story is included, describes a definition of recovery suggestive of ongoing dependence on and support from Eve’s rehabilitation workshop, regular home visits from nurses and ongoing help with ordinary activities such as maintaining a small urban garden (Eve Ltd 2008).

### The contemporary recovery models

Just as the previously discussed model of recovery could be subdivided into medical and rehabilitation views, so could the contemporary recovery model be separated under the terms ‘empowerment model’ and ‘psychological model’ (Andresen et al. 2003). Both views deny the biological foundation of ‘mental illness’ and interpret physiological symptoms as a by-product of severe emotional distress in the absence of sufficient resources to tackle that distress (Aherne and Fisher 1999, Aherne 1999). Within this contemporary model, recovery involves the empowerment or transformation of the service user and the increasing accessibility of spiritual, material and social resources (Brown and Kandirikirira 2007). Medical treatment may be helpful, especially in the early stages of recovery, but taking medication should be the free choice of the service user and be just one option along with others, such as cognitive-behavioural, family and music therapies and non-professional social involvements (Dunne 2006).

### The empowerment model of recovery

The empowerment model’s origins can perhaps be located in Paris in 1793, when Pinel, newly appointed by the Revolutionary Council to oversee hospitals, removed chains from lunatics held in the hospital of Bicêtre. This act, no doubt inspired by ideals of liberty, brotherhood and equality, heralded a move from brutal neglect

overseen by ‘mad doctors’ to acts of great kindness, the building of personal relationships and a gradual immersion in community. Meanwhile, Hannah Mills, a member of the Quakers who died of ‘ill treatment and neglect’ within the York Asylum, inspired William Tuke to build a ‘retreat’ for ‘mentally ill’ members of the Quaker community (Whitaker 2002:20). This retreat was governed by religious values rather than by medical wisdom. With an emphasis on empowering involvement and relationships, the Quakers rejected the ‘therapeutics’ of the doctors of the time as interventions at which ‘humanity should shudder’ (Tuke 1813 reprinted 1996:128). In their place, they took a ‘general pragmatic approach’ (Scull 1979:69), making use of anything which appeared to work and aiming to minimise any form of external coercion. In Ullmann and Krasner’s view:

‘Moral treatment was not a single technique, but rather an approach involving every aspect of daily living being utilised for its therapeutic (empowering) effect’ (Ullmann and Krasner 1975:136).

Moral treatment attracted interest from different philanthropists and through Dorothea Dix, who herself had recovered from ‘mental illness’ as the guest of the Quakers of York, it spread to America. Ironically, Dix’s American championing of moral treatment was, in part, responsible for its demise. Instead of small units, large, unmanageable numbers of ‘mentally ill’ people were brought together, budgets were cut and according to Scull (1979), the medical profession sought legal authority to become the only people allowed to run mental institutions. Thus, leadership in American psychiatry passed back into medical hands and moral treatment virtually disappeared, surviving from then on in small isolated examples.

In the 1920s, Harry Stack-Sullivan began to use his personal experience of teenage isolation and mental health difficulties to develop an interpersonal theory of recovery (Perry 1982). He strongly argued that psychiatry belonged more in the humanities than in scientific medicine and was perhaps the first psychiatrist to employ recovered ex-service users as key members of his staff. In the 1960s and 1970s, psychiatrists like Foudraine (1974), Laing (1966), Browne (2008) and Mosher et al. (1975) established therapeutic communities of various kinds. Foudraine (1974) related how he needed to retrain his staff from managing, to being in relationships with the ‘mentally ill’. In his view, the most valuable co-workers were untrained cleaning women, people to whom the patients revealed themselves most as human beings.

Loren Mosher (1975), head of schizophrenia studies at NIMH (National Institute for Mental Health), believed that psychosis could arise in response to emotional and inner trauma and in its own way was a coping mechanism. He established Soteria House, a retreat where people would experience ‘sincere human involvement and understanding’, the idea being ‘to treat people as people, as human beings with dignity and respect’ (Mosher et al. 1975:459).

This involvement appeared to empower those concerned, better enabling them to deal with their ‘illness’ and with life. Mosher reported that, in comparison to a similar group of people treated in hospital with drugs, at the end of two years Soteria patients had ‘lower psychopathology scores, fewer hospital readmissions and better global adjustment’ (Mosher et al. 1975:461). Significantly, 42% of Soteria patients had never been exposed to psychiatric drugs, 39% received them temporarily and only 19% had needed medication for the two-year period (Mosher et al. 1975).

In Finland, since the late 1960s the work of Alanen appears to have revolutionised not only the treatment, but also the incidence of schizophrenia.<sup>1</sup> Western Lapland had a rate of schizophrenia three times as high as other parts of Europe (Whitaker 2010, Mosher et al. 1975). Today, the long-term outcomes of people experiencing this psychosis in this part of Scandinavia are the best in Europe, and the incidence of new cases has dropped radically. Alanen (2009) believed that:

‘Hallucinations and paranoid utterances of schizophrenic patients, when carefully parsed told meaningful stories. Hospital psychiatrists, nurses and staff need to listen to the patients’ (Alanen 2009).

Alanen has developed a need-adapted treatment of psychosis which places family therapy at its centre. Published results of its effects found that 61% participants were asymptomatic after five years. Most recent research indicated that 43% of those treated in this manner never needed drugs (Alanen 2009).

This section has described different examples of the ‘mentally ill’ being empowered to satisfactorily take over control of their lives and the symptoms of their ‘mental

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<sup>1</sup> This fact alone is significant. The APA has always maintained that the incidence of schizophrenia is fixed at 1% of the world population, independent of cultural factors.



illness'. Common features of empowerment included living in an atmosphere of warm and friendly involvement and of being trusted and respected as a human being.

### The psychological model of recovery

Andresen et al. (2003) describe the psychological model as:

‘Falling between the rehabilitation model and the empowerment model...  
And which is most compatible with consumer beliefs...’  
(Andresen et al. 2003:588).

Psychological recovery refers to the establishment of a fulfilling, meaningful life and a positive sense of identity, founded on hopefulness and self-determination. While the empowerment model perhaps concentrates on the external provision of resources, the psychological recovery model traces internal processes of change through interactions with these ever-present and proximal processes. As already stated, Rappaport (2000) suggests that recovery begins when individuals become involved in a potent community narrative that challenges and counters the dominant negative cultural and professional narratives in which they are immersed. According to Rappaport (2000), this healing community is not professionally led, but involves the mutuality of equal relationships. Rappaport (2000) studied and compared identity transformations among members of three separate minority groups of people living within actively supportive communities. He found that the same positive transformations took place among gay members of the Catholic Church, black students within a white-dominated education system and members of GROW.

The psychological model (or what could be called the narrative model) of recovery is also described in the writings of Frank (1992, 1995, 2000a, 2000b, 2002, 2004) and can be discovered within the philosophy of Bakhtin (1973, 1981). Frank believes that illness, or severe trauma, has the power to create chaotic new stories which disrupt a person's ability to deal with life. In his view, a person is first of all plunged into chaos, a chaos created by the 'articulations of an inarticulate body' (Frank 1995:5). People emerge from chaos through a series of quests, through the rebuilding of identity and through others bearing witness to their suffering. Slowly, a new story is synthesised, where the meaning of pain becomes central. Bakhtin (1973, 1981) describes life as an ongoing process of re-authorisation of the self through inclusive

dialogue and the appropriation of ideas contained in a heteroglossia of stories. While his ideas were not specific to recovery from ‘mental illness’, they include learning to deal with the alien voices of trauma and authority, and are therefore highly relevant to an understanding of processes of recovery.

Perhaps the medieval ideas of conversion put forward by St Thomas Aquinas (1274) are forerunners of the psychological model. Aquinas wrote of three types of conversion – the intellectual, moral and religious – each of which account for the ongoing development of the human being. Each conversion is triggered by a dissatisfaction with a present state of being: boredom leads to the trial of new ideas; an inability to change leads to depression, which in turn facilitates a change of heart and a positive transformation born of pain.

Hyde (1998) sees a purpose in the Dionysian chaos represented by ‘madness’ – ‘as a basic response to inescapable traps of the human condition’ and as a means to challenge the Apollonian status quo (Hyde 1998:19). This social purpose within ‘mental illness’ was a view held by Laing (1966), who likened people with psychosis to pilots who sensed that society was flying in the wrong direction and therefore peeled off from its formation to go in a different (and supposedly better) direction. Within these two models of recovery, namely the empowerment and psychological, certain guiding principles would seem to be gaining consensus, such as becoming hopeful, following your dreams, being supported by people who believe you can recover, taking risks and experiencing emotional reciprocity (Aherne & Fisher 1999).

### The economic story

Underlying the existence and promotion of different approaches to recovery from ‘mental illness’ is the ever-present influence of money. On the one hand, seemingly promising recovery projects such as Soteria House are forced to close because of lack of funding, and on the other hand the multi-billion dollar pharmaceutical industry actively promotes the chemical imbalance theory of ‘mental illness’. ‘Mental illness’ not only disrupts the lives of individuals – it places huge emotional, social and financial burdens on families, local communities, employers and the state. The World Health Organisation has predicted that depression will become the major burden of illness in the Western world by 2020 (WHO 2002). In America, there

appears to be an alarming epidemic of chronic ‘mental illness’, compounded by escalating incidences of iatrogenic illnesses which, in Whitaker’s view (2010), are ‘caused’ by long-term medication. Growing numbers of people are being given lifelong disability pensions, and many who have no insurance appear to increasingly end up in prison, where mental health care is absent or completely inadequate (Pfeiffer 2007). The readmission rate to Irish Psychiatric wards lies at 72% (Daly and Walsh 2011), which suggests that in this country, the reality of recovery within the vast majority of traditional services is, indeed, a myth (Whitwell 1999).

In Ireland in 2006, the cost of mental health problems was estimated at €3 billion (O’Shea and Kennelly 2008) and in the UK £77 billion (Sainsbury Centre for Mental Health 2003). The WHO (2005) estimates that the economic cost of mental health issues could, in real terms, already amount to 4% GNP of European Union States. Behan et al. (2008) calculate that indirect cost of ‘mental illness’ are approximately double the direct cost of mental healthcare. Turner et al. (2010) estimated that people with serious ‘mental illness’ are nine times more likely to be unemployed than the national average. Against this background, the percentage of the total health budget assigned to mental health within Ireland has slowly fallen from 13% in 1984 to 6.0% in 2005 (O’Shea and Kennelly 2008), and currently stands at just 5.4% in 2011 (Keogh 2011, personal communication).

### The cultural story

Public attitudes to ‘mental illness’ indicate alarming levels of prejudice among the general public in Ireland and abroad. Carling (1995), and Huxley and Thornicroft (2001) found that attitudes towards people with mental health difficulties have been more negative than attitudes towards people with other disabilities. A 2002 National Disability Authority (NDA) survey ‘contained serious messages about how people with mental health difficulties are perceived’ (NDA 2002). For instance, only 55% of those surveyed thought that people with mental health difficulties should have the right to employment, and a similar number felt that people with mental health difficulties should not have the right to fulfilment through relationships and sexuality. In a follow-up survey in 2007, the National Disability Authority found that less than 40% of respondents thought that children with mental health difficulties should attend mainstream schools (NDA 2007:23). MacGabhann et al. (2010), in a

research study commissioned by Amnesty International, interviewed 306 people who self-identified as having had a 'mental illness'. Using a well-validated discrimination and stigma scale devised by Thornicroft (2006), they found that 61% of their sample had experienced discrimination by members of their families, 58% by mental health professionals, and 80% had been discriminated against in the area of keeping or finding work. In the U.K., Morris (2005) found that almost one in two people with mental health problems had experienced hate crime or harassment. Together, these findings strongly indicate that the label of 'mental illness' carries with it many negative cultural stories which warrant Rappaport's (2000a) claim that, collectively, they constitute a 'Tale of Terror'. People with the label of 'mental illness' not only need to recover from that 'illness' and from frequent negative side effects of medication; they also need to learn to integrate or recover from the alien voices of stigma and discrimination that are alive within society.

**Research into the experience of recovery: service users' perspectives**  
Internationally, there is a growing acknowledgement of both the value and the scarcity of research that uses as its subject matter the experience of those people designated 'mentally ill'. Davidson et al. (2007) conducted reviews of written autobiographical accounts of recovery and of qualitative research involving interviews of various kinds with recovering service users. They found several common themes, including:

'A redefinition of self, the importance of being supported by others, renewing a sense of hope and commitment, accepting illness, being involved in meaningful activities and expanded social roles, managing symptoms, resuming control over and responsibility for one's life, overcoming stigma and exercising one's citizenship' (Davidson et al. 2007: 150).

The authors point out that a weakness of using written first person accounts of recovery is that 'they tend to stay on the surface of the phenomenon in question' and give little insight into the processes involved in recovery (Davidson et al. 2007:154) .

Brown and Kandirikirira (2007) undertook narrative research based on the recovery stories of 64 service users who considered themselves to be either in recovery or recovered. This work, commissioned on behalf of the Scottish Recovery Network, set out to raise awareness of things that either hinder or help recovery and to highlight approaches effective in promoting and encouraging local action. The

authors identified six internal and six external elements necessary to initiate and maintain a recovery narrative. Internal elements included: belief in self and developing a positive identity; knowing that recovery is possible; having meaningful activities in life; developing positive relationships with others and your environment; understanding your illness, mental health and general well-being; and actively engaging in strategies to stay well and manage setbacks. External elements consisted of: having friends and family who are supportive but do not undermine narrator's self-determination; being told recovery is possible; having contributions recognised and valued; having formal support that is responsive and reflective of changing needs; living and working in a community where other people could see beyond your illness; and having life choices accepted and validated (Brown and Kandirikirira 2007:7).

Carless and Douglas (2008:576) analysed the narratives of eleven men with serious 'mental illness' to investigate the role of exercise in 'the reconstruction of a meaningful identity and sense of self'. They identified three 'narrative types which differ significantly from (and may be considered alternatives to) dominant illness narratives':

- An 'action narrative' about going places and doing stuff.
- An 'achievement narrative' about accomplishment through effort, skill and courage.
- A 'relationship narrative' of shared experiences and an opportunity to talk about these.

Each of these narrative types contained the seeds of recovery by recasting passive recipients of care as active collaborators in their own mental health.

In Ireland, there is very little published research into the narrated experience of recovery (Higgins 2008, Kartalova-O'Doherty and Tedstone Doherty 2010). Casey (2002) analysed the single transcribed narrative of one man who was experiencing serious 'mental illness'. While not focusing directly on recovery, Casey (2002:203) used the study to examine 'the tensions between Gary's internal voices and beliefs and the external voices of surrounding culture and psychiatry'. From this study Casey concluded that nursing care must be sensitive to and respond to personal meanings embedded within the narratives of service users, a view already espoused

and regarded as key in the recovery work of Mosher et al. (1975). More recently, Kartalova-O'Doherty and Tedstone Doherty (2010), in a grounded theory study involving the recovery narratives of 32 participants, noted that:

‘The lack of a coherent theory of mental health recovery acceptable by service providers, family carers, service users and the broader community is one of the barriers for developing recovery-oriented services in Ireland’  
(Kartalova-O'Doherty and Tedstone Doherty 2010).

The theory emergent from their study suggested that recovery from ‘mental illness’ involved processes of reconnecting with self, with others and with time. In this study, hope, acceptance and validation by others helped to motivate a necessary decision to fight for recovery, rather than surrender to the role of permanent invalid. On the other hand, hopelessness, diagnosis and treatment side effects, being treated like a disease rather than a person, long spells in hospital, poverty and stigma worked against the will to recover. The authors concluded that in order for the health services to be truly facilitative of recovery, a paradigm shift is required. Vital to recovery are the need to be listened to and to be encouraged to tell your story, and an ongoing involvement in community. At present, Irish mental health services do not appear to provide these vital elements (Kartalova-O'Doherty and Tedstone Doherty 2010). Hospital, while providing basic essentials such as food and safety, was described as a lonely place – a place lacking in ‘normal human interaction’, the antithesis of what is needed to recover or to motivate a desire to recover. Respondents also advised that recovery involves fighting for less medication. Their results showed that while medication could help a person to calm down, so too could being in relationship with others. Interestingly they found that ‘synchronising self and others in time’ by taking part in planned social activities helped in the vital processes of healing the past, benefiting from the present and anticipating a meaningful future (Kartalova-O'Doherty and Tedstone Doherty 2010:16).

While these isolated studies appear to endorse the value of a continued exploration of the subjective experience of recovery, they focus on people’s use of traditional services and on professional help. There is currently no research in Ireland that has specifically explored the experiences of people who have used other forms of support provided by peers and mutual help groups such as GROW.

## Summary and conclusion

This chapter has explored four different meanings of the word ‘recovery’ and it has looked at the implications for mental health systems when one or other of these is central to that system. In the current climate, where governments are advocating a move from a medical definition, a lot of confusion exists around the meaning of the term ‘recovery’. It is easy to assume that everyone is talking about the same thing and that some kind of transformation has already taken place within the mental health services of Western psychiatry. It is necessary to ask when reading publications about recovery, ‘which recovery are we talking about?’ and ‘what is the evidence that this type of recovery really represents positive change?’ This chapter has sought to review a wide range of professional, cultural, political and economic stories constructed to explain ‘mental illness’ and facilitate recovery from that ‘illness’. It noted that although many governments are currently seeking a radical change in the delivery of mental health services through a shift from a medical to a recovery orientation, an examination of the concept ‘recovery’ reveals a confusing cacophony of stories, paradoxes, epistemologies and definitions. The chapter reviewed explanations of ‘mental illness’ and recovery that evolved since the start of modernism, and which reflected current dominant thinking of the time. It explored how these ‘stories’ of illness and recovery shaped professional practices and affected personal outcomes for the ‘mentally ill’. Two very different understandings, representing different epistemologies, emerged. The medical lens consistently represented ‘mental illness’ as a fixed, lifelong condition with a simple linear, biological cause. In this positivist explanation, recovery meant an appropriate dependence on some form of professional help and different forms of physical intervention. The medical story was tempered somewhat by a rehabilitation model which recognised that medical treatment alone was not enough to effect recovery. The current recovery lens views ‘mental illness’ as the temporary consequence of emotional overwhelm, a multi-faceted ontological state from which, provided the right resources can be found, people can successfully emerge. In this view, recovery involves a personal transformation, including a transformed identity, nurtured through involvements in ongoing healing relationships. The recovery model is represented by two views, concentrating on external processes of empowerment and internally-generated identity transformation, respectively.

The chapter noted how the mental health system is influenced by economic factors, which in turn favour the medical view. Although ‘A Vision for Change: Report of the Expert Group on Mental Health Policy’ (Department of Health and Children 2006:25) recommends ‘the development of peer provided services’ and extra funding being made available to that end, the reality is that the budgets of organisations such as GROW have been reduced in the last few years. It is hard to see how real change can come about without the political will to fund alternatives to the medical model and evaluate their effectiveness.

The chapter then provided an overview of studies highlighting current negative cultural narratives made manifest through attitudes to those labelled ‘mentally ill’. It ended with a review of a small number of existent studies which have used personal stories as their data source, noting that while there has been some such research conducted in Ireland, none has yet concentrated on recovery processes involved specifically in peer support and mutual help.

The next chapter examines the origins and nature of mutual help, and the philosophy and practices of GROW. It also reviews research already published about the philosophy, practices and outcomes of GROW membership.



## CHAPTER THREE: LITERATURE – GROW AND MUTUAL HELP

‘Man is by nature a social creature: an individual who is unsocial naturally and not accidentally, is either beneath our notice or more than human’  
(Aristotle, 328 BC cited in Kerney 2008:146)

### Introduction

The previous chapter reviewed explanations of ‘mental illness’ and definitions of recovery which had evolved since the start of modernism and which reflected current dominant thinking of the time. The chapter ended with a review of examples of recent research which explored personal experiences of recovery. This research study seeks to understand the role that mutual help plays in recovery from ‘mental illness’ and specifically the role played by GROW, an international mutual help support group, within that process. This chapter therefore begins with an examination of the nature and origins of mutual help, which were antecedents to GROW. It then describes the philosophy and practice of GROW itself and explores its current status in Ireland. The chapter ends with an overview of the findings of a number of research studies that have involved GROW.

### The concept of mutual help and the helper principle

While Riessman (1965) first reported the benefits of mutual help in 1965, it would appear that it is ‘a universal principle involved in all levels of successfully living together’ (Patent 1995:5). Hamilton (2008) suggests that the sacred texts of most cultures contain a reference to the idea of mutual help. Common to Christianity, Judaism and Islam is the commandment to ‘love your neighbour as yourself’ (Isaiah 8:20). Within this premodern and universal guideline for living, there is no hint or suggestion that ‘All men are born unequal’.<sup>2</sup> In fact, the expression ‘neighbour as yourself’ suggests that, as human beings, we are all equally valuable as part of a community of persons. The idea(s) of mutuality (equality and brotherhood) have also been at the centre of secular revolutions and communist philosophy, which saw any form of inequality contained within traditional hierarchies as evidence of a deep-seated social evil (Marx and Engels 1848). Katz estimates that in the two decades

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<sup>2</sup> ‘All Men are Born Unequal’ was the title of the sermon by Reverend William Matson of the Methodist Episcopalian Church which won him the first prize of \$500 during a campaign aimed at educating the American public in 1905 and sponsored by the Eugenics movement (Whitaker 2002:55).

following Riessman's formal recognition of mutual help as an important human resource, there were 'some half million separate self-help groups in North America embracing several million member-participants' (Katz 1981:129). Because of the number and variety of these groups, arriving at an all-encompassing definition of mutual help is difficult – a difficulty further compounded by the interchangeability of the concepts of 'self-help' and 'mutual help'. Katz and Bender (1976) created the following general definition which is still widely accepted and cited:

'Self-help groups are voluntary, small group structures for mutual aid and the accomplishment of a special purpose. They are usually formed by peers who have come together for mutual assistance in satisfying a common need, overcoming a common handicap or life-disrupting problem and bringing about desired social and/or personal change. The initiators and members of such groups perceive that their needs are not, or cannot, be met by or through existing social institutions. Self-help groups emphasise face to face social interactions and the assumption of personal responsibility by members. They often provide material assistance, as well as emotional support. They are frequently 'cause' oriented, and promulgate an ideology of values through which members may attain an enhanced sense of personal identity' (Katz 1981:135-136).

Katz later appended this definition by making the following observations:

'Personal participation is an extremely important ingredient; bureaucratisation is antithetical to mutual help. The members agree and engage in some actions and typically the groups start from a position of powerlessness. Finally the groups fulfil needs for a reference group, a point of connection and identification of others, a base for activity and a source of ego reinforcement' (Katz 1981:137).

Maturana and Varela (1992) suggest that mutual help may operate at a much more basic level than the consciously social. All living cells 'language' or communicate with one another to bring about a constant state of healthy equilibrium through a self-regulating negative feedback loop, a process known as autopoiesis. Browne (2008:246) identifies five different levels within which this principle operates: the cell, the individual creature, a collection of similar creatures, an aggregate of species, and, finally, the biosphere. The idea of the human being as an example of an autopoietic system(s), that is itself part of a wider system, has huge relevance and implications for the structure and practice of mental health services.

The current mental health system is constructed as a hierarchy rather than a network of essentially equal parts. It is a hierarchy that tends to ignore the experience of one part of the system (the ‘mentally ill’ person) and favours another (the scientific expert). The medically constructed model of ‘mental illness’ also views the human body as a hierarchical system where the activity of one organ – the brain – unilaterally controls all the other parts of the physical system and is therefore the sole cause of ‘mental illness’.

Pert (1998) questions the assumption that control must necessarily be hierarchical:

‘A network is different from a hierarchical structure that has a ruling “station” at the top and a descending series of positions that play increasingly subsidiary roles. In a network, theoretically you can enter at any nodal point and quickly get to any other point; all locations are equal as far as the potential to “rule” or direct the flow of information’  
(Pert 1998:184).

In her view, focusing on one part of the body such as the brain becomes a distortion of reality. The brain is situated not only in a physical body, but also within cognitive and social bodies, all of which can affect its operations; ‘thus it could be said that intelligence is located not only in the brain but in cells that are distributed throughout the body’ (Pert 1998:185). In Pert’s view, all parts of the system are equally important to the maintenance of that system and so everything becomes relevant with no one overriding locus of control. Within the philosophy of mutual help, each participant is valued equally and the actions of each affect the well-being of the whole.

Riessman coined the term ‘helper therapy’ or ‘the helper principle’ after observing various self-help groups and concluded ‘the act of helping another helps the helper more than the person helped’ (Riessman 1965:28). By the early 1970s, this principle was being noted in many premier psychiatry journals as more researchers found that helping others was beneficial in a variety of contexts (Rogeness and Badner 1973). Christensen and Jacobson (1994), in a comprehensive review of 42 studies, compared professional interventions with those of mutual help. They found that mutual help was equally and often more effective than psychotherapy provided by professionals. In light of this finding, Christenson and Jacobson advocated ‘role changes of professional therapists from direct service providers to programme

developers' (Christensen and Jacobson 1994:8). Riessman (1990), reflecting on the negative social and personal consequences of only receiving help, also recommended a radical restructuring of the hierarchical unidirectional nature of health services. He noted that receiving help tends to underline inadequacy in the one receiving it and to create dependent relationships. These relationships become more and more unequal because of the social status of the professional help-giver who gains self-esteem through the act of giving help, a benefit denied to the one receiving help. He concluded that 'if help-giving is so beneficial and help-receiving so problematic, the task would seem to be to restructure that helping process so that more people could play the helping role' (Riessman 1990:31).

Salem et al. (1988), who were part of a team that researched the effectiveness and methods of GROW, also advocate a changing role for mental health professionals. In their view, instead of being the primary helpers, mental health professionals should:

'Help people find niches in society which are based on mutual rather than unidirectional relationships instead of trying to be the sole providers of help themselves' (Salem et al. 1988:407).

The challenge for a mental health system would therefore seem to be to find valid ways that the experience and knowledge of all concerned can be seen to be of value, whether a person has been cast in the role of expert by training or expert by experience.

### Origins of formalised mutual help groups

A significant antecedent to formalised, non-hierarchical forms of mutual help such as GROW, and one which fits the definition provided by Katz and Bender (1976), can be found in the Oxford Group. This revolutionary movement began in 1921 in the aftermath of the Great War and was founded by Lutheran Minister Frank Buchman. Far from being composed of people with any recognised problem such as addiction or 'mental illness', the group sought to attract highly influential people. The Oxford Group's aim was to practise:

'The sharing of our sins and temptations with another Christian life given to God and to use sharing as witness to help others, still unchanged, to recognise and acknowledge their sins' (Driberg 1964:2).

As such, the Oxford group was firmly grounded in the concept of a reciprocity of human weakness and the potential for positive change through mutual help. Later, Alcoholics Anonymous (AA) grew directly out of a connection between members of the Oxford Group and AA's co-founders, Bill Wilson and Bob Smith (1935).

AA is now described as the father of mutual help and has become a model for many other twelve-step programmes. Post (2008) comments that:

‘Close to 350 anonymous twelve step programmes exist in the United States, thus many millions of Americans know about the twelfth step (a call to mutual help) through a self-help organisation’ (Post 2008:2).

GROW, which is the focus of this study in turn, was started by a group of AA members.

#### GROW: an international mutual help movement

GROW is a uniquely structured international mutual help movement working in the area of mental health. It began in Sydney, Australia, in April 1957 and has since spread to several other countries, including New Zealand, USA, England, Trinidad and the Philippines. It came to Ireland in 1969 (GROW in Ireland 1994:32). GROW was founded by a group of men and women who had all experienced serious forms of ‘mental illness’ and had been discharged from psychiatric hospitals after treatment. While not regarding themselves as alcoholics, they met through involvement with AA because ‘there were no groups in the community (no group therapy even in hospitals) in those days for mental patients’ (GROW International 1979:10).

As members of AA, they ‘discovered the mutual help group method’ that was to form the basis of their own recovery programme (GROW International 1979:7). The camaraderie, warmth and direction offered by AA gave them the idea to seek permission from AA to begin adapting its program and methods to ‘work more systematically on [their] own special problems of rehabilitation’ (GROW International 1979:10).

The most influential person among this founding group was Con Keogh, a Catholic priest and theologian. Con had obtained doctorates in divinity and philosophy before

suffering an acute psychotic breakdown, for which he was hospitalised for 11 months with a diagnosis of paranoid schizophrenia. Perhaps what made Con so crucial to the formation, rapid spread and longevity of GROW was the fact that he had been highly trained in both ‘scientific inquiry’ and had experience of serious ‘mental illness’. Thus he had expertise in both forms of knowledge, a combination that lent authority to the emerging ideas and practices. During his own recovery and throughout the development and expansion of GROW, Con used his academic training to become the organisation’s epistemologist. In this role he painstakingly abstracted common threads of experience and wove the evolving ontological principles and insights into a practical and coherent psychology of mental health, aimed at and built on the experience of ordinary people. The founding group chose the name ‘Recovery’, ‘to emphasise the goal and the solution rather than the problem’ (Keogh 1979:11).

For a number of reasons, Recovery changed its name to GROW in 1972. It was considered that the new name, ‘GROW’, would avoid confusion with an American organisation, ‘Recovery Incorporated’, and serve to clearly delineate GROW’s own identity. The word ‘GROW’ also indicates a view that all living things grow and that all human beings, wherever they may lie on the spectrum of mental health or ‘illness’, have the potential to grow, at least in wisdom and in maturity. At this point, GROW formally widened its aim of recovery from ‘mental illness’ to include the general goal of personal growth, thus making provision for anyone to join.

### **GROW’s status in Ireland**

GROW is the largest mental health mutual help movement in Ireland, with a national network of over 130 groups – a number that almost equals the total of all other mental health support groups.<sup>3</sup> GROW describes itself as consisting of four essential features:

- The GROW Program.
- A group method.
- A caring and sharing community.

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<sup>3</sup> A search of various websites and conversations with key employees in other support groups operating in the area of mental health in Ireland showed that AWARE currently has 63 groups, SHINE has a total of 55, 25 of which are Phrenz groups, or groups aimed at people suffering from ‘mental illness’ and 30 of which are for relatives. Recovery Inc. has 24, making a combined total of 132. Figures compiled by GROW for January 2011 showed a total national attendance at its support meetings of 2,154 people within that month.

- A legal and organisational structure.

## The GROW program

GROW's program consists of a written philosophy contained in a wide range of books and writings.<sup>4</sup> At the heart of this written material is a pocket-sized manual, officially entitled 'The Program of Growth to Maturity' (GROW 2001) but known universally as the 'Blue Book'. The 'Blue Book' is built around 12 Steps of Recovery and Personal Growth<sup>5</sup> and 12 Stages of Decline and Maladjustment (See appendices 1 & 2). Its 83 pages contain a collection of carefully worded principles and strategies aimed at explaining the nature of mental health, personal growth and recovery and empowering its readers to systematically work towards the achievement of these as goals. Its first principle is 'The Principle of Personal Value', which states:

'No matter how bad my mental, physical, social or spiritual condition, I am always a human person loved by God<sup>6</sup> and a connecting link between persons. I am still valuable, my life has a purpose and I have my unique place and my unique part in (humanity)<sup>7</sup> my Creator's own saving, healing and transforming work' (GROW 2001:7).

GROW's last principle, entitled 'Universal Benefit' suggests that 'each person's recovery or growth aids the transformation of the world' (GROW 2001:76).

'The Principle of Personal Value' challenges the dominant cultural, professional and historical notions that the 'mentally ill' are social 'burdens' and generally 'cacogenic', and therefore are not entitled to full citizenship (NDA 2002). The principle of universal benefit illustrates GROW's belief that we are all connected within a series of interdependent personal and interpersonal systems. GROW also challenges the notion that 'mental illness' is something that only happens to a minority of people, by equating it with many other qualities and behaviours which

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<sup>4</sup> GROW's writings include a number of published books: 'Readings for Recovery', 'Readings for Mental Health', 'Growing to Maturity'; collections of personal testimonies e.g. 'Soul Survivors' (Volumes One and Two); training manuals e.g. 'GROW Program Training Manual', 'GROW International Organisational Manual', 'Personal Growth and Community Building through Leadership' (Parts One and Two); and philosophical writings by its founder, Con Keogh, e.g. 'Friendship'.

<sup>5</sup> The use of the terms 'recovery' and 'personal growth' illustrate that GROW is open to anyone and that mental breakdown is not a condition of membership.

<sup>6</sup> Non-believers omit the word 'God'.

<sup>7</sup> Non-believers omit the phrase relating to 'my Creator'.

are common to every human being. It suggests that the line between mental health and ‘mental illness’, moral goodness and moral badness, belief and unbelief, sexual normality and sexual deviance, sound drug use and drug abuse, love and selfishness ‘does not pass between this and that discernible group of people in society but down through the heart of every single one of us’ (GROW 2001:42).

While the GROW program is contained in written words, these words only become meaningful through the interactions of GROW events. Central to these is the weekly meeting, which follows a highly prescriptive group method.<sup>8</sup>

### The group method

The term ‘group method’ refers to the highly structured agenda of the weekly GROW meeting (See appendix 3). GROW officially describes the weekly meeting as ‘a school of living’ (GROW Undated:4). The aim of this school is to enable each person to develop their unique character and realise their own giftedness and value. Each member reveals him or herself to the group by giving a ‘personal testimony’ or a weekly ‘report on progress’, and by their behaviour at the meeting. In this way the meetings become places of reciprocal witness, a witness that acknowledges both the suffering and limitations of each person, and the ‘giftedness and potential represented by each and every human being’ (GROW Undated:1). No one is there primarily to offer help to others, although each person is expected to progressively become more involved in both helping others and allowing others to offer help in return. The acts of helping and being helped form a reciprocal bond that animates the meetings. A second reciprocal bond within GROW is the function and activity of leadership. Leadership involves everyone ‘to the extent that he becomes an active member, helping others as well as himself to find and stay on the GROW way’ (GROW 2003:41). This is very different to the traditional understanding of hierarchical leadership that exists, especially in the area of mental health. Leadership within the mental health system is equated with levels of education and position.

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<sup>8</sup> Each member of GROW has an individual copy which they bring with them to the weekly meeting and which acts as a workbook in between meetings. GROW meetings have no ‘dues of fees’, are anonymous and strictly confidential. A GROW meeting takes place once a week and is limited to a minimum of three and a maximum of fifteen members. A GROW meeting lasts for between 90 minutes and two hours. Members are expected to attend the same meeting each week – unlike AA, where people may attend as many different meetings as they wish. The main purpose of the meeting is to help each person find a way towards recovery or greater personal growth based on their unique needs and situation.



Leadership in GROW is seen as a shared responsibility. For example, the person selected to lead the weekly meeting will be supported and encouraged by all the other members.<sup>9</sup> However, leadership is also acknowledged as any positive or caring act performed within the group, such as making tea, or just simply smiling at somebody (GROW Undated:14). GROW members are encouraged to move systematically through three distinct phases or levels of leadership in which they are known as beginning, progressing and seasoned GROWers. To become a seasoned GROWer, a person must be a minimum of three years in GROW and have successfully fulfilled the role of Group Organiser or Recorder, two roles crucial to the management and ongoing welfare of each of GROW's weekly meetings. It is from seasoned GROW membership that participants in this research were drawn.

### **GROW's caring and sharing community**

Rappaport (1988:4) described the weekly GROW meetings as 'the glue that holds a whole community together', indicating that the weekly meeting is only one small part of a range of involvements and activities that together comprise a whole community. Members of GROW are encouraged to meet informally in between meetings and GROW holds regular socials, outings, training events, live-in weekends and workshops are held as well as bi-monthly leadership, Organisers' and Recorders' meetings.<sup>10</sup> Other, optional activities such as public meetings, fundraising events and orientation meetings all provide opportunities for involvement in the wider community. In addition, GROW is involved in the education of mental health professionals.

### **GROW's legal and organisational structure**

In Ireland, GROW operates through a Charter Agreement from GROW International and is a registered charity and company, limited by guarantee. GROW employs a number of national and regional staff, but most leadership roles are unpaid. GROW is funded largely by the HSE with an annual budget of €1,600,000. GROW's constitution prohibits taking funds from the pharmaceutical industry – an easy source

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<sup>9</sup> New members of the group will be expected to take their turn at leading after a minimum of three months' attendance.

<sup>10</sup> While each person in a GROW group is present primarily to work on their own life, each group is administered by an Organiser and Recorder. The people fulfilling these roles in different groups come together every two months to apply GROW's principles of mutual help to the groups they represent.

of income but one which, in GROW's view, would seriously compromise its values and practice. As GROW has developed, it has been necessary to build in a professional management structure. In order to ensure that it remains a 'user-led' organisation all its teams, its national and regional structures must constitutionally consist of two-thirds GROW members, the other one-third providing necessary expertise in areas of finance, employment or health and safety legislation. GROW has developed a number of policies designed to protect its own members. Alcohol is banned from GROW events such as live-in weekends, and sexual relationships between members of the same group are strongly discouraged and banned between people in formal leadership roles and 'ordinary' members. All GROW events are confidential and the right to anonymity is respected. Unlike AA, however, members may choose to waive their anonymity and to publicly identify themselves as members of GROW by telling their personal story of 'mental illness' and recovery.

### **GROW's views on the nature of 'mental illness' and the process of recovery**

GROW's views on the nature and cause of 'mental illness' and the process of recovery are complex. They do not easily fit into any of the four definitions described by Andresen et al. (2003), referred to in the previous chapter. GROW appears to use elements from all four of these definitions and, as such, adopts a 'both/and' rather than an 'either/or' approach. The GROW program occasionally uses the term 'mental illness' (GROW 2001:42,54), or refers to people as being 'mentally sick'. GROW states :

'We know from experience that mental disturbance entails different levels of dysfunction and disability, amounting to an increasingly incapacitating disorder, which certainly merits the name of mental sickness and even of severe 'mental illness' (GROW International 1997:44).

However, rather than attributing the cause of this incapacitating experience to a chemical imbalance within the brain, GROW identifies four causes which it calls 'Nature' (heredity or constitution), 'Nurture' (society or culture), 'Personal Action' and 'God' (or overall cause) (GROW 2001:44). In GROW's view, it is personal action that is mostly responsible for people becoming 'mentally ill'. GROW sees 'mental illness' as being the end result of 'social influences and personal failure – that is through learned habits of false thinking and disorganised living' (GROW

2001:48). GROW believes that psychosis is not caused organically, but ‘is a sign and systematic effect of entrenched (though nonetheless learned and habit enforced) attitudes and behaviour which provide an ‘organic component’ to the emotional trouble’ (GROW International 1995:62). While ‘mental illness’ can be the end result of a person’s own ‘maladjusted’ way of living, it can also be primarily caused by the abusive actions of others. Whichever is true, or ‘whoever is most to blame’ (GROW 2001:24), it is the responsibility of the person directly affected to get well. GROW sees a role for medical intervention as part of recovery, describing it as:

‘Strictly necessary, or uniquely helpful, as compared to any other available means of care, when the disturbed individual is incommunicado and/or out of control. Used at such times the doctor’s medication is a boon and a blessing’  
(GROW International 1995:61).

However, GROW is critical of the long-term use of medication, seeing drugs as a temporary form of help which should ‘be gradually reduced and finally terminated’ (GROW International 1995:63). In a recent circular to all GROW countries, GROW International emphasised this belief in the temporary use of medication by requesting that any future book of personal testimonies should only include stories from people who are no longer taking medication, suggesting the view that recovery includes the ability to cope with life without this form of ‘help’ (GROW 2011, personal communication).

As a researcher and from a personal point of view, I am of the view that it is possible to fulfil all the recovery criteria specified by GROW (GROW 2001:61) and still to be using medication. Equally, it would be possible to stop taking medication but fail to meet GROW’s criteria, which include things like being at ease with others. However, because of the centrality of the idea of ‘mental illness’ being a lifelong condition that requires lifelong medication, to be able to choose to dispense with medication presents a particularly important challenge to the authority of medicine. Also, if, as Whitaker (2010) suggests, long-term medication has serious health consequences, then evidence that it is not necessary in the long term is important information.

GROW views the recovery process as comprising two parts. The first part involves diagnosis and treatment, and during this time hospital, medication and professional help may well be key. Each acts as a form of external control, making the emotional

chaos of ‘mental illness’ somewhat manageable. However, this is only the start of recovery and should quickly lead to a process of ‘rehabilitation and prevention’. In this part, the external controls of medication, hospital and professional help are progressively replaced by friendship networks and the person’s increased internal resources and growing ability to deal with life.

GROW states that the primary helpers in recovery must be ‘friendly human beings who know from experience’ how to recover.

‘All other helpers, including doctors, are necessarily subordinate, good in their place, but harmful when they do not make way for that vital self activation through mutual help’ (GROW in Ireland 1994:48).

According to GROW, professional help should also be aimed at awakening a person’s own resources for living and should soon begin to replace the use of drug therapy, because:

‘Whatever drugs do, they do not approach the psychological or sociological causes of emotional disturbance... Whenever a person takes a drug as an adjunct to psychotherapy he is necessarily limiting the area in which he accepts responsibility’ (GROW International 1995:61).

GROW argues that a Recovery Model is perhaps better described as an Educational Model. People learn how to successfully deal with the challenges of life. Medication may act as a temporary form of ‘cast’, in the same way that a broken leg may need to be stabilised within a cast. Just as it would be unthinkable to only treat the pain of the broken leg and fail to enable a person to walk, so is it wrong to expect long-term medication to change a person’s way of dealing with life and to treat them like a permanent invalid.

GROW also recognises the spirituality of the human condition as central to recovery (GROW 2001:69). This is not reflected in the content of ‘A Vision for Change: Report of the Expert Group on Mental Health Policy’ (Department of Health and Children 2006), which consistently refers to an understanding of the human person that is based on biological, psychological and social factors. GROW describes two forms of spirituality: horizontal and vertical. Horizontal spirituality is the spirituality that is present between people – it is something that is expressed as love,

encouragement or a warm smile. Vertical spirituality refers to a person's beliefs and the effect these may have on their values, thoughts and behaviours.

Recovery from 'mental illness', according to GROW, is defined by six principles. People are said to be recovered when:

- They are coping well with their duties and feel basically secure and contented.
- They are friendly and co-operative with those around them.
- Their main habitual supports for facing life are built-in habits of personal maturity (understanding, acceptance, confidence, control and love), 'accompanied by an increasing awareness of the presence and power of a loving God'<sup>11</sup>. Not the doctor, nor the pills, nor even the group.
- The old, irrational feelings, which may return from time to time, don't change the person's thinking or behaviour.
- The person completely integrates their past breakdown. That is to say, they don't fear another breakdown; they no longer have any great sense of stigma; and they are even positively glad they had a breakdown because it turned out to be a breakthrough to better and happier living.
- They find that an expanded mental outlook, where the quality of their friendships and their deepened spiritual life has made each one a new person (GROW 2001:41).

### International and Irish research into GROW

Research into GROW was initiated by its own leaders and began in 1981. The main body of work was a four-year study conducted by Professors Rappaport, Seidman and Toro of the University of Illinois in conjunction with GROW leaders and members. The programme of research set out to explore:

- The efficacy of GROW.
- Its effective ingredients.
- Its success as a social movement (Seidman and Rappaport 1981:1).

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<sup>11</sup> There are many references to God in the GROW Program, but alternative wording is provided for non-believers, and groups may, if they so wish, hold meetings for non-believers. New members who profess a difficulty with the idea of God are advised to substitute the word 'good' for the word 'God' to get an idea of its meaning.

The project included a feasibility study which involved practical discussions with GROW leaders about how research could be conducted with minimum disruption to its meetings and methods. The feasibility study looked at the type of analysis methods and tools required and how these might need to be specifically designed or adapted for such a study. There followed longitudinal and cross-sectional comparative studies, a documentary analysis of GROW literature, interviews with GROW leaders and members, a survey of mental health professionals and participant observation of over 1000 meetings. Rappaport continued to write articles based on the findings of this research into the twenty-first century (Rappaport 1981, Rappaport 1987, Humphreys and Rappaport 1993, Rappaport 1995, Rappaport 1998, Rappaport 2000, Rappaport 2005, Rappaport 2008). Other studies include one by the World Health Organisation (WHO) (Turner-Crowson and Jablensky 1987), three in Illinois, (Kloos 1999, Corrigan et al. 2002, Corrigan et al. 2005), four in Australia (Young 1990, Shannon and Morrison 1990, Finn 2001, Kercheval 2005) and one in New Zealand (Clarke 1992). While most of the above research has taken place in America and Australia, a number of small studies concerning GROW have been carried out in Ireland (Dunne and Fitzpatrick 1999, Henry and Dunne 2003, Dunne and Meehan 2003, O'Donnell et al. 2008). Collectively, this represents quite a body of work and has provided answers to many basic questions about GROW's nature, methods and effectiveness. Although the studies included the use of some in-depth interviews and narratives with people who attend GROW (Kennedy 1995, Finn 2001, Corrigan et al. 2005, Kercheval 2005), no major analysis of recovery narratives has been undertaken.

#### GROW membership: who comes to GROW?

Salem (1987), one of the PhD students involved in the initial four-year collaborative study, found that GROW supports a broad clientele and, most importantly among them, a marginal group who are not receiving adequate support from traditional services. Using cluster analysis of community adjustment interviews with GROW members (n=292) and the Hopkins SCL-90 to measure levels of symptomatology, she identified 5 homogenous groups. They included:

- i) People living independently who were in employment and looked after themselves.

- ii) People who were unemployed but still living independently (this group included 'home makers', students and people who were retired).
- iii) Semi-independent, unemployed or partially employed people who were beginning to need ongoing help from family and government sources.
- iv) Unemployed, semi-independent living people with high levels of symptomatology and a history of antipsychotic medicines and,
- v) People with high levels of symptomatology who live in sheltered environments (Salem 1987).

Most significantly, she found that while people in clusters (i) and (ii) (those with less serious problems) emerged early as leaders and found the leadership role easier to assume, significant leadership did emerge from the last two clusters, namely those with significant 'mental illness' problems. This last finding was corroborated by Kennedy (1995), who interviewed six of GROW's most involved and influential leaders in America, some of whom came from categories (iv) and (v). Turner-Crowson and Jablensky (1987), in a WHO study that compared GROW with Recovery Inc, Schizophrenics Anonymous and Emotions Anonymous, found that GROW was the most comprehensive from the point of view of the range of people it could help. While all four organisations offered help to people with various kinds of 'mental illness', GROW was seen as offering 'a framework for developing social group action projects' (Turner-Crowson and Jablensky 1987:14). On the basis of this study, the WHO document recommended that governments develop policies making self-help available to everyone. They noted that GROW in particular might have the same spreading power as AA, 'given appropriate encouragement' (Turner-Crowson and Jablensky 1987:42).

Stein (1987) used structured interviews with 97 new GROW members to identify a variety of social support networks in which they were involved. Cluster analysis of their replies revealed four different social support clusters:

- i) Large, dense family networks.
- ii) Large, dense helping networks dominated by professionals.
- iii) Small, loose-knit friendship networks .
- iv) Small, dense friendship networks (Stein 1987:4).

He concluded that people in support networks dominated by professionals learn to see relationships as ‘non-reciprocal’ and that this may constrain opportunities for the development of a sense of equality and reciprocity in other relationships. On the other hand, in his view:

‘Cluster (iv) [small dense friendships] is associated with more positive evaluations of help received and better mental health indices. This is exactly the sort of network GROW tries to develop for people to join’  
(Stein 1987:22).

Within Ireland, Henry and Dunne (2003) (n=318) and O'Donnell et al. (2008) (n=341) conducted separate surveys of Irish GROWers using a questionnaire. Their studies highlighted that people in all age categories come to GROW. The age span ran from 15 to 75+ years of age. However, young people are under-represented in both surveys, with only 1% (Henry and Dunne) and 3% (O'Donnell et al.) of the total membership under the age of twenty. The findings from this study also revealed a near-equal mix of men (48.4%) and women (51.6%). Of those attending GROW in Ireland, 91% reported having received professional help; 85% had been on medication and almost 60% had experienced hospitalisation. This finding would also be reflected in Shannon and Morrison's (1990) work involving 167 GROW members in Australia. Using a mental health history, a general health questionnaire and a social adjustment scale, they found that 81% of GROWers had sought professional help, and 70% had used prescribed drugs and exhibited ‘significant levels of morbidity’ or serious psychoticism. While the studies listed above give some idea about who comes to GROW, there is no current data directed at discovering which social groups do not attend GROW.

#### Positive outcomes from GROW membership

Some studies have identified positive outcomes from GROW membership. Kennedy (1989), in a comparative longitudinal study, found a significant reduction in days in hospital among GROW members with ‘the most severe and recent psychiatric history’. She compared the number of days in hospital of these 31 GROW members with a matched group of people who did not attend GROW. Data on the numbers of days of hospitalisation was collected from hospital records for the 32 months prior to attending GROW and 32 months after. Findings suggested people who attended GROW reduced their admission days from 179 to 49 over the 32-month period. In



comparison, non-GROW members who had a total of 175 days hospitalisation prior to the study continued to have 134 admission days within the same period. She concluded that these findings represent significant savings to the mental health services. However, it must be noted that in the intervening years the policy on admission to hospital may have changed significantly. Rappaport et al. (1985) gave an overview of their four-year, mixed-methods study, which included using the Moos' Social Adjustment Scale at intervals of one, three, nine, fifteen and 27 months. In this study they assessed:

- The nature of social relationships.
- Community adjustment.
- Symptoms and cognitive adjustment.
- The role of GROW in members' lives.

They noted that significant improvements in mental health correlated directly with length of time in GROW. They concluded:

‘Those in GROW for nine months or more were significantly better off than those in GROW for three months or less in terms of having larger social networks, a higher rate of current employment and lower levels of psychopathology on several dimensions including psychoticism and depression’ (Rappaport et al. 1985:18).

Williams and Young (1989), Shannon and Morrison (1990) and Finn (2001) all found an ongoing and systematic reduction in levels of prescribed medication and reliance on professional services among GROW members, a reduction which Williams and Young (1989) described as appropriate, noting no relapse over time. Finn (2001), using a mixture of surveys (n = 907), long-term observation of five groups, interviews with 28 new GROW members at the start and after six months, and the Ryffs (1989) Quantitative Scale of Psychological Well-being found that benefits included better communication, improved social life management and problem-solving skills and a better quality of life among GROW attendees. Reischl et al. (1988) used a behavioural observation scale of GROW members in thirteen different groups and interviews with 194 growers at three-month intervals over a period of 27 months to explore long-term effects. They noted a significant decrease in ‘sulking behaviours’, defined as ‘isolating and brooding’ and an increase in ‘social and emotional engagement and in the giving of help to others’ (Reischl et al. 1988).

Kennedy (1995), using an ethnographic approach, examined changes in world view that occurred in six long-term GROW leaders in Illinois. Through observation of meetings and interpretive analysis of in-depth interviews, she found four distinct and significant phases of GROW membership, namely:

- Lead-up to GROW.
- First contact.
- Leadership in GROW.
- Life beyond GROW.

She also noted four areas of change in beliefs or world view. Changes occurred in beliefs:

- About self.
- About others.
- About spirituality.
- About mental health and the nature of 'mental illness'.

Kennedy suggested that all of these changes were directly influenced by the distinct phases of membership in GROW. In summary, the GROWers described that the alternative world view which GROW offered them, particularly concerning the 'definition and resolution of their mental health problems', provided them with a new life path, which led to self-esteem through 'ordinariness', active participation in their own recovery, friendship with others and a belief in a higher meaning in their lives 'in spite of and perhaps even through their problems' (Kennedy 1995:v).

Some years later, Kercheval (2005) used semi-structured interviews with eleven women ranging in age from 28 - 65 to explore their experience of GROW membership. Thematic analysis of these interviews suggested the women experienced a high degree of sense of community and friendship in GROW groups. The women also reported a positive transformation of identity, facilitated by the opportunity GROW provides for development through reciprocal relationships experienced within the groups (Kercheval 2005). Interestingly, Kercheval found that there is equality in GROW groups between men and women, an equality found lacking in these women's general experience of society and in the mental health system. As one interviewee described it:

‘I think GROW is special in that even though we are men and women, first and foremost we are people, there is not this incredible consciousness of your gender so dialogue flows freely between the sexes’ (Kercheval 2005:50).

In the same year, Corrigan et al. (2005) also used interviews with 57 GROWers to explore what they perceived as the most important processes for their recovery. Cluster analysis of the interviews identified self-reliance, industriousness and self-esteem as key ingredients of their recovery. Recovery was distinguished as a process – an ongoing life experience, as opposed to an outcome a feeling of having been cured or having overcome a disorder (Corrigan et al. 2005). While research has shown many direct benefits of GROW membership, over time it also provides some insight into how these improvements were facilitated.

#### How does GROW facilitate recovery?

Salem (1984), while seeking to understand the failure of deinstitutionalisation in America, described GROW as a positive example of an effective community care programme because of its ‘assertive and individually tailored’ approach (Salem 1984:4). She found in general only 3% of people continued to attend community-based programmes once transport and encouragement to attend was withdrawn. In GROW, real efforts at encouraging ongoing involvement were made through the efforts of fieldworkers and other GROW leaders, who continued to provide lifts for people and became genuine friends. Writing at the end of five years’ involvement with GROW, Salem et al. (1988) noted that GROW was more than a mutual help group – it was an ongoing community. In the words of Salem et al.:

‘GROW is unique in that it extends beyond weekly meetings to form a community for living. GROW becomes an integral part of the individual’s life. There is a strong emphasis on development of friendship networks and each person is expected to be both a helper and to receive help relying on the ‘helper therapy principle’ (Salem et al. 1988:407).

Salem et al. (1988:407) identified three therapeutic characteristics in GROW. GROW provides stability and is not affected by mental health trends and policies. It is available 24 hours a day, if necessary, and provides a whole menu of activities, in which new members are actively encouraged to become involved. Salem et al. (1988:407) also concluded that mutual help organisations are cost-effective and

‘rather than viewing the “mentally ill” as a drain on society, these organisations view them as potential resources for helping one another’.

Kloos (1999), in a comparative study of residential programmes run by GROW and by the state, examined links between recovery and the cultivation of identity within the context of those micro-environments. Using participant observation, reviews of literature and interviews with two individuals in each setting, Kloos’ findings suggest that the residential programmes embody two distinct local cultures, which he described as an ‘ascribed’ and an ‘achieved’ hierarchy. In Kloos’ analysis, relationships in the state residential could be ‘understood as an ‘ascribed hierarchy’ where people have specific roles based upon personal characteristics (whether a label of psychiatric disability or professional qualification)’ (Kloos 1999:263). Consequently, within the ascribed hierarchy there is no ‘common ground where staff and residents are seen as social equals or even potentially equal’ (Kloos 1999:264). In this context, residents had no role in decision-making or the running of the centre and there was no consideration of a leadership role for anyone who had been diagnosed as ‘mentally ill’, even if a person ‘recovered’. In contrast ‘the GROW setting represents an ‘achieved hierarchy’, where residents assumed responsibility for the functioning of the setting as they demonstrated their rehabilitation and capacity for leadership’ (Kloos 1999:263). Within the GROW residential, participants took an active and progressive role in leadership. The boundaries between ‘staff’ and ‘residents’ became indistinct and ‘even more remarkable, staff members talked openly about having their own problems and of the usefulness of the GROW program as a tool of living’ (Kloos 1999:263). Here, there was an evident reciprocity between staff and residents in terms of leadership and human life experience. The two settings also placed different emphases on the importance of medication. In the state-run setting, ‘all progress is tied to compliance’ (Kloos 1999:293). Medication is seen as necessary for life and central to recovery. In GROW, medication is ‘a minor part of daily living’ (Kloos 1999:293). GROW members are encouraged to take medication while they develop the resources to do without it. It is seen as one of many tools, rather than being the central focus of recovery. A final difference in outcome from Kloos’ study lay in the range of possible selves mentioned by residents. In the state residential programme a shared goal was one of ‘achieving independence’ and becoming responsible for taking medication (Kloos 1999:297). In GROW, people mentioned many goals such as going back to education, or pursuing

a role that matched a person's skills. Kloos concluded that his study appeared to support William James' (1842-1910) idea that meaning and identity are created in social contexts and that different settings will give rise to different identities and different goals for the future.

Rappaport (2000b, 2000a, 2005a), commenting on the comparative study conducted by Kloos (1999), speculates that GROW works primarily by providing a transforming positive and meaningful role for each of its members, which in turn generates a transformed view of self. Reflecting on his team's research, he sees GROW as a 'mediating structure that introduces its members to an ongoing, welcoming and sustainable community' (1988:2). He also suggests that the medical view of psychology 'consistently fails to see the contextual nature of "mental illness"' (Rappaport 2005). Finn also noted the contextual effects of community provided by GROW which, she writes, 'endorses a value system within which people have the opportunity for identity transformation' (Finn 2001:14).

Maton and Salem (1995), after a longitudinal study and comparative analysis of a number of mutual help organisations, concluded that organisations like GROW are able to facilitate the life transformation of their members by possessing the characteristics of an empowering community, which they identified as:

- A belief system that inspires growth.
- An opportunity role structure that is pervasive, highly accessible and multifunctional.
- A support system that is encompassing, peer-based and provides a sense of community and leadership that is inspiring, talented, shared and committed to both setting and members' (Maton and Salem 1995:631).

Finn et al. (2009) reported the emergence of two overarching themes involved in recovery which they have called 'life skills development and change in self-perception'. In their view, both are facilitated at three distinct levels: between individuals, within the group setting, and through involvement in the wider GROW community. They describe these levels as representing a 'social ecological paradigm framework' (Finn et al. 2009:306). Life skills development included movement along an active-passive continuum, interpersonal development, bridging skills out

into the community, developing change mechanisms, education, learning by doing, helping others, and motivation. The end result of Finn et al.'s research

‘Pointed to a sense of identity transformation where identity transformation is herein defined as a radical positive change in self-perception. This transformation was spoken about in terms both of acquiring coping and interpersonal skills and of increased self-confidence and self-esteem’  
(Finn et al. 2009:310).

Zimmerman et al. (1985:7) noted the role of leadership within this transformed view of self. They observed an identifying feature of GROW is that it tends to create ‘undermanned settings’ (Zimmerman et al. 1985:7). In this context, new members are challenged to step forward to fulfil these roles, whether they feel ready or not. Corrigan et al. (2002), using an ‘Nvivo’ analysis of the Blue Book, found 272 separate texts comprising thirteen valid recovery processes. In a later study involving interviews with GROW members, Corrigan et al. (2005:723) found that the most prominent of these recovery principles were: ‘being reasonable’; ‘decentralising from self by participating in a community’; ‘surrendering to the healing power of a wise and loving God’; and ‘growing daily closer to maturity’.

In summary, research has given some insights into the process of recovery from ‘mental illness’ through involvement with GROW. Recovery through GROW is identified as a form of identity transformation. This transformation comes about through ongoing involvement in GROW’s empowering community, where friendship and being involved in reciprocal caring and leadership become the main vehicles of recovery.

#### How GROW differs from other forms of help

A final outcome from research into GROW highlighted differences between GROW’s methods and those of other forms of help. Toro et al. (1987), using Moos’ (1981) Social Climate Scale, compared 33 GROW groups with 25 psychotherapy groups and found that:

‘Mutual help groups exhibit higher cohesion, more leader support, member independence, task orientation and order and are lower in expression of anger aggression and innovation when compared to psychotherapy groups’  
(Toro et al. 1987:430).

They also noted that, as well as the differences listed above, ‘mutual help favours problem solving and socialising more than traditional therapeutic activities’ (Toro et al. 1987:431).

## Summary

This chapter has reviewed the origins, practices and development of mutual help as an important feature of organised human living. It described mutual help as a means of creating supportive communities which successfully tackled various types of human problems. In a mutual help group, each member of the community was equally valued, whatever their status or level of education. The chapter also described the development and current status of GROW as a ‘third-generation’ example of a mutual help movement, with roots in AA and the Oxford Group, as an international movement and as the largest such organisation working in mental health in Ireland. Finally, it reviewed existing research conducted collaboratively with GROW in America, New Zealand, Australia and Ireland. An overview of this research provided information about various aspects of GROW’s nature, methods and outcomes. It showed that GROW attracts a very wide membership. This membership includes people with the most serious and persistent forms of ‘mental illness’, as well as people who have not been diagnosed as ‘mentally ill’ but who join for reasons of prevention or personal growth. Positive outcomes from GROW membership were directly related to length of membership, and included a transformed identity and view of others and of the real nature of ‘mental illness’. Recovery included significant reductions in medical treatments and significant gains in self-esteem, personal empowerment and involvement in social networks. These positive changes were brought about through the ongoing friendship provided by fellow GROWers, the weekly meeting and by the wider activities of the GROW community. Leadership as a reciprocal activity and a shared responsibility of all was shown to play a significant role in recovery.

Despite the fact that GROW is one of the leading support groups in the promotion of recovery in Ireland, there is very limited research exploring people’s experience of membership and its impact on their recovery journey. Hence, the aim of this study is to explore the experiences of a cohort of GROW leaders who identify themselves as

having recovered from 'mental illness'. The next two chapters concentrate on methodology. Chapter four looks at the epistemological challenges entailed in conducted such a study and chapter five describes how these challenges were overcome and how the study was conducted.



## CHAPTER FOUR: PHILOSOPHICAL AND PRACTICAL UNDERPINNINGS TO THE RESEARCH METHOD

‘Everyone has a story and it is unique. No amount of detail or analysis can exhaust the mystery of any one of us’ (Stan, GROW 1996:17).

### Introduction

The previous chapters began by describing a series of authoritative stories which sought to explain ‘mental illness’ and which have been constructed since the beginnings of modernism. Together they represented a polyglot of voices that, over time, have shaped our current mental health system. It was noted that among these voices there was an increasing reliance on and a growing dominance of knowledge derived from medicine and through methods of ‘scientific inquiry’, and a complementary systematic disregard for and suppression of any other view. The chapters went on to follow the rise of mutual help and, more specifically, of GROW, a mutual help organisation that has developed in parallel to these professional discourses. GROW is part of what many commentators (Ralph and Corrigan 2007, Amering and Schmolke 2009) describe as a ‘recovery movement’, a centrifugal voice that is increasingly calling for change by challenging the centripetal voice of science and which has its origins in knowledge gained through experience. Perhaps most significantly, the opening chapters highlighted a relative scarcity of qualitative research in the area of mental health, which goes some way to validate the voice and experiences of people who use mental health services. It was also noted that despite a number of studies designed to explore the effectiveness and methods of GROW, there was no major study that was based solely on the narratives of individual members. The current study is therefore important. Firstly, it uses as its basic epistemology the personal experience of people affected by ‘mental illness’ and in this way partly redresses the current over-reliance on empirically based ‘authoritative’ knowledge. Secondly, by interviewing 26 GROW members, it seeks to construct a second-order narrative that will help establish and define a plausible understanding of the recovery view. A second-order narrative is defined by Elliott (2005:10) as ‘the account a researcher constructs to make sense of the social world and of other people’s experiences’, and as such can serve as a means to the construction of a new theory.

Good qualitative research requires making explicit the philosophical assumptions, paradigms and frameworks upon which it is based and within the contexts of which it is being undertaken (Cresswell 2007). These assumptions and frameworks have the potential to shape both the outcome and the process of research. This chapter therefore discusses different views on the nature of reality and different methods employed to study that reality. In particular, it explores the philosophical underpinnings of narrative inquiry, the qualitative research method employed by this study. It also offers a critique of the narrative interview and processes of thematic interpretation through which a second-order narrative is constructed. Finally, it explores the validity or trustworthiness of knowledge that is born of reflected experience and gathered in this way. The chapter starts by examining objective and subjective forms of knowledge.

### Objective and subjective knowledge

In chapter two I made the argument that all knowledge is contained in storied form and that these stories represent two very different ways of knowing. Bruner (2002) and Frank (1995) have described them broadly as ‘scientific inquiry’ and ‘experience’. The first – scientific inquiry – constructs knowledge through a series of observations of the object of study. In this view, reality exists ‘out there’ and is independent of the observer. Knowledge is slowly accumulated by observing the object of study under a series of reproducible and strictly controlled conditions. Within this epistemology there is an assumption that ‘social observations [such as the study of “mental illness”] should be treated as entities in much the same way that physical scientists treat physical phenomena’ (Johnson and Onwuegbuzie 2004:14). Social entities [such as ‘mental illness’] therefore exist independent of the ‘objective’ observer, are not affected by situational contexts (such as the unique individual), and can therefore be quantified.

The second source of knowledge – experience – is constructed from ‘emic’ descriptions of what reality [in this case, ‘mental illness’] is like from the inside. Within this epistemology, reality is constructed from a person’s experience. It is therefore neither fixed nor independent of each unique individual. In fact, reality differs from individual to individual, and even within the same individual it is constantly changing with the ever-changing contexts of life. In this view, the

observer can only gain knowledge by seeking to understand the constructed realities of unique individuals. He is not neutral or objective, but brings his or her own value-laden view to the study, a view which affects the interpretation of what is 'real'.

Scientific inquiry, or 'positivism', has its roots within modernism. Modernism itself represented an epistemological paradigm shift. When Copernicus (1473 -1543) and Galileo (1564 -1642) challenged the church's claim that the earth was at the centre of the known universe, they did so on the basis of observation of the external reality of the movement of the planets. By this act, they shifted the source of knowledge from the revealed authority of the church to scientific reasoning. A modernist approach continues to assume that both a physical and a social reality exist within objects and people 'out there' and that this external reality is available to be observed and described by the neutral and independent researcher. In this view, reality is independent of mind and consciousness (Crotty 1998). Smith (1998) has differentiated two forms of such realism. 'Naïve realism' assumes that reality is potentially fully understandable and completely independent of the observer. 'Critical realism', described by Lincoln and Guba (2000) as a post-positivist perspective, modifies this view to accept that knowledge is always an approximation. Furthermore, there is a growing acceptance that the values, prejudices and preconceptions of the scientist can influence the 'reality' of his findings (Smith 1998). In the world of mental health, psychiatry adopts a positivist standpoint. In this view, diseases or 'mental illnesses' exist, and these diseases can be objectively identified and treated with appropriate medications. The most valued form of validation for this method of inquiry is the randomised control trial which, in theory anyway, rigorously tests the 'truth' or effectiveness of theory and practice by measuring the effects of treatments on specific, diagnosable forms of 'mental illness'.

Knowledge gained through experience is described within literature as 'constructionism'. Constructionism claims that the social world is constantly in the making. In this view, reality is understood to be both individually and socially constructed and therefore subjective (Frank 1995, Rappaport 2000). These constructions exist as subjective realities, contained individually within the cognitive processes of uniquely contextualised minds and collectively through cultural and professional stories that have been co-constructed over time. From a constructionism

perspective, knowledge is neither passively received nor discovered through the senses, but actively constructed by each unique individual as they engage with the world. The methodology used to explore constructed realities or subjective experience is called ‘qualitative inquiry’. Qualitative inquiry takes many forms and may be used to study individuals, communities or cultures.

This research aimed to explore recovery stories and develop an understanding of the process of recovery from ‘mental illness’ through involvement in the GROW community. As such, a qualitative method of inquiry known as narrative research was considered appropriate to meet this aim. The next section traces the methodological roots of narrative inquiry.

### Narrative research: background and roots

Holloway and Freshwater (2007:3) describe narrative research as a ‘common way of carrying out qualitative research, a method that has recently gained in popularity’. In its simplest and most common form, it is the gathering and analysis of ‘related’ or ‘told’ human experience as a valid source of knowledge (Cresswell 2005). Mankind has always used stories and images to try to explain life. The prehistoric cave drawings of Aurignac (32,000 years ago) are thought to have been a way of transmitting information. Czarniawska suggests that:

‘The beginnings of narrative analysis can be seen in the hermeneutic studies of the Bible, Talmud and Koran. Here, in “premodern times” Western man sought basic information about who he was (identity), how he should live (ethics and law), and what was the purpose of life (meaning)’ (Czarniawska 2009:1).

The use of narratives of experience only began to emerge as a valid source of knowledge in the twentieth century through the studies of Russian Folklore and stories of Polish migrants and other minority groups (Bruner 2002). In social research, an interest in using stories only really started in the 1980s (Elliott 2005) and gathered momentum in 1991 with the launching of ‘The Journal of Narrative and Life History’ (now published as ‘Narrative Inquiry’) in America, published by Erlbaum Associates. In its modern form, the term ‘narrative inquiry’ has been used across a range of disciplines, from linguistics, literary criticism, phenomenology, anthropology and sociology (Holloway and Freshwater 2007), philosophy,

education, theology and psychology, to economics, medicine, biology and environmental science (Webster and Mertova 2007:7). According to Plummer, narrative inquiry has a wide range of applications for issues such as illness, identity, health behaviour, education and criminology, and can help us to better understand ‘why people re-offend, divorce or become prone to diseases and how society may begin to change its attitudes’ (Plummer 1995:174).

According to Gubrium and Holstein (2009), personal stories have been a main tool of social science since the mid-nineteenth century, when Henry Mayhew (1862) conducted observational surveys of London’s ‘humbler classes’. Until then, the poor and uneducated were considered incapable of offering useful opinions, much less of contributing knowledge to the epistemological pool. Knowledge was the province of an exclusive ruling elite. If you wanted to know anything about the poor, you asked a politician or an administrator (Gubrium and Holstein 2009). Mayhew’s research was highly significant in that it was the first example of ordinary people’s stories being considered as a basis for knowledge. The idea of the expert as the sole authoritative source of knowledge is still very prevalent within the mental health system. Professional narratives are described by Frank (1995) as authoritative. In his view, the

‘Modern experience of illness begins when popular experience is overtaken by technical expertise including complex organisations of treatment. Folk no longer go to bed and die, cared for by family members and neighbours who have a talent for healing. Folk now go to paid professionals who reinterpret their pains as symptoms, using a specialised language that is unfamiliar and overwhelming’ (Frank 1995:5).

Frank argues that the process of being ‘overwhelmed’ by the authoritative medical story or voice disempowers individuals and renders their own knowledge as invalid. He advocates that bearing witness to the experience of suffering through illness (and treatment) is vital to the creation of a truly caring health system. This is achieved through narrative research. While narrative research can use as few as one personal story (Casey 2002), a study like this which makes use of 26 interviews makes it possible to create what Elliott (2005) has called a ‘second-order narrative’, or the bones of what Callaghan (2011) calls ‘an underdeveloped theory’ (personal communication). Many writers such as Frank (1995), Charon (2006) and Kleinman (1988) have noted that the experience of illness, treatment and the effects these have

on the lives of those experiencing them are currently ignored and seen as irrelevant to the process of healing. 'A Vision for Change: Report of the Expert Group on Mental Health Policy' (Department of Health and Children 2006) recognises the value of listening to the voice of both the person with 'mental illness' and those most closely associated with them. A narrative approach was selected for this study for a number of reasons already outlined in chapter one. Firstly, research by Rappaport (1988) suggested that the process of recovery through GROW involves a narrative and identity transformation. This is facilitated through immersion in an enacted and ongoing community narrative strong enough to counter dominant and negative professional and cultural narratives which imprison individuals in the construction of 'mental illness'. Secondly, GROW members are familiar with the concept of personal narrative and storytelling, and therefore should be at home within this type of inquiry.

#### The nature of narrative research

There are many definitions of narrative research or inquiry. Holloway and Freshwater (2007) give the root of 'narrative' as the Latin 'gnarus', meaning 'knowing', while 'story' comes from the Greek and Latin 'historias', which also means 'knowledge' (by 'inquiry'). 'Histos' means 'web' or 'tissue'. Elliott (2005) suggests that the word 'narrative' derives from the Indo-European root 'gna' which means both 'to know' and 'to tell'. From these etymological roots, narrative inquiry might thus be defined as:

'Abstracting and separating individual experiences told as 'stories' from a web of cultural and professional scripts and conveying these to an audience in the hope of enriching our understanding and identifying possible areas of constructive change' (Holloway and Freshwater 2007:5).

This definition is interesting because it casts the experience of individuals as a valuable resource for change and improvement of services. Personal stories have the potential to show how the grand(er) narratives of science, management and economics positively or negatively affect the lives of those receiving the service.

Elliott (2005) has identified three defining features of personal stories or narrative: stories are 'chronological', they convey 'meaning' and they are 'social', or told to an audience. While narrative is often associated solely with qualitative forms of

research, Elliott (2005) notes that there is a growing body of quantitative research that makes statistical use of aspects of narrative method. Narrative research involves the gathering and analysis of stories told by people who have personal experience of different facets of life. These stories can be found in many sources, including fictional accounts.

### Narratives and stories: is there a difference?

Within the literature, the words narrative and story are used interchangeably, which can be confusing to the reader. Rappaport (1995), Schank (1990), Frank (1995), Bruner (2002) and many others advance the idea that because all important knowledge is obtained in storied form, all can be described as narrative. Rappaport (2000) uses the term 'narrative' to describe a range of stories that have been constructed to explain social phenomena such as 'mental illness' and recovery. These narratives exist at different levels and illustrate different epistemological knowledge bases that shape our understanding and our attempts to deal with these phenomena. Within the mental health system, Rappaport (2000) identifies cultural, professional and community narratives which are all involved in shaping the personal stories (or narratives) of each individual member of society and which will affect the nature of our mental health system and what constitutes recovery from 'mental illness'.

In narrative research, the term 'narrative' is usually applied to stories born out of experience and told by people who have not been formally schooled in any professional theory. Smith (1998:327) has described narratives as 'a basic and universal mode of human expression', while Labov and Waletzky (1967:12) confine them to 'the oral versions of human experience'. Narratives are always 'about' something, such as illness, recovery, or disability, which Freeman (2003:335) calls 'aboutness'. Frank suggests that in the areas of health and ill health, our bodies are, in fact, a form of narrative. In his view, the:

'Stories that ill people tell come out of their bodies. The body sets in motion the need for new stories when its disease disrupts the old stories. The body, whether still diseased or recovered, is simultaneously cause, topic and instrument of whatever new stories are told' (Frank 1995:2).

Frank differentiates between stories and narratives. According to Frank (1995:27), a ‘story is the tale a person tells’, whereas a narrative is ‘a general structure encompassing a number of particular stories’.

Elliott (2005) suggests that personal stories are best understood as first- and second-order narratives. In other words, ‘first-order narratives are the stories individuals tell about themselves. They are constitutive of individual identities and have therefore also been called ontological narratives’. In contrast, second-order narratives are ‘the accounts we may construct as researchers to make sense of the social world and of other people’s experiences... a collective story’ (Elliott 2005:12/13). Hanninen (2004) differentiates between different modes of narrativity, namely the ‘told’ narrative, the ‘inner’ narrative and the ‘lived narrative’. It is the first of these, the ‘told’ narrative, that researchers most make use of. The told narrative reflects and makes explicit the ongoing inner narrative. However, the told narrative also affects the inner narrative, and the telling is affected by the listener, or who we think the listener is as we listen to ourselves and imagine what others think and say about us.

### Plot and causality

In their simplest form, narratives are continuous stories with connected elements that include a plot, a stated problem and a cast of characters (Sarbin 1986). Elliott (2005:7) illustrates the idea of plot, using the following example of E.M. Forster’s (1963 [1927]) argument from literature:

“‘The king died and then the queen died’ is merely a chronicle, whereas ‘The king died and then the queen died of grief’ is a plot because it includes an explicit causal link between the two events in the sequence.’

(E.M. Forster 1963 [1927], cited in Elliott 2005:7)

Of course there are many other possible causes: ‘the prince poisoned the dinner and so the king died, and then the queen died’; ‘a man fired at the group and so...’

In the world of ‘mental illness’, this idea of attributing different causes to the same descriptions of events is well illustrated by Corry and Tubridy (2001), who present the views of a different range of experts to the same case histories. Each expert interprets the same ‘facts’ in a different way and suggests a different level of cause –



biochemical, cognitive or relational. Ricoeur (1984) has been cited by Holloway and Freshwater as saying that:

‘Plot, or emplotment, is the cornerstone of narrative structure... It is the intelligible whole governing the succession of events in a story’  
(Ricoeur 1984).

Other people suggest that rather than being found, plots are made (Elliott 2005, Kvale 2009). This is why a person using narrative research must become reflexive and develop the ability to question their own bias and prejudice for and against certain explanations and understandings of plot. They must also bear in mind that a story may be an account of what it ‘felt like’ rather than what ‘actually happened’.

Narrative research strives to understand the links between events and relationships experienced by the narrator and the perceived ‘plot’ or meaning constructed from those experiences. Rappaport (2000) notes that plot is constructed at many levels. In the case of ‘mental illness’, medicine attributes cause at the level of biochemistry. The plot is therefore based on this notion of biochemical cause. Price (1979) has identified four levels of professional ‘plot’, which suggest that the cause of ‘mental illness’ exists at the biological, cognitive, interpersonal and social levels.

In the research setting, the type of story told (and indeed the type of story heard) will depend to a large degree on the perceptions of the ‘other’ involved in the interview. The researcher must therefore become aware of his own world view and seek to free or suspend himself from that view so that he can hear the voice and see the unique face of the person being interviewed. Levinas (1969) suggests that this suspension of our own thoughts and prejudices in order to be open to the ‘Other’s’ story is, in fact, the basis of Ethics. This research makes use of the interview; the next section therefore explores the origins and nature of the narrative interview.

### The narrative interview

Personal stories are commonly gathered through qualitative interviews (Holloway and Freshwater 2007). Qualitative inquiry includes a range of interview techniques, ranging from highly structured interviews, observations or questionnaires to the semi-structured or unstructured interview. Traditional qualitative interviewing tends to be asymmetrical in terms of power relationships, with the researcher cast in the role

of expert and as the person defining and controlling the parameters of the interview. In contrast, narrative interviews move towards a symmetry of power, involvement and co-creation, as the researcher shares or hands control of the creation of a narrative to participants, encouraging them to talk about their own selected experiences (Holloway and Freshwater 2007). The narrative interview aims to encourage reflective and spontaneous storytelling which explores the experience and value system of the teller, rather than the priorities of the listener. Narrative interviews, while aiming to be unstructured, take on elements of the semi-structured interview when they contain prompts designed to explore areas of experience of interest to the researcher. Flick (2009) suggests that the first part of a narrative interview should concentrate on encouraging spontaneous narrative, with minimum interruptions from the researcher, while later parts might be more reflective, with the researcher asking for more information about specific parts of the interview.

While scientific knowledge strives to be objective and value-free, in narrative research interviewers do not try to be independent, objective onlookers exploring a reality 'out there'. They 'engage their emotions, they are not neutral or distant but empathic and close to the narrators' (Holloway and Freshwater 2007:3). They are not trying to prove or uncover an 'unchanging reality' but are there more to listen to another's experience or personal construction of a social reality. They could be described as creating an unthreatening and inviting space which encourages honest reflection. Narrative research is, therefore, both art and science. 'Art in that it concerns a creative act (co-creating a story) and science in that it is methodical and systematic' (Holloway and Freshwater 2007:3).

Kvale (2009) agrees that a good starting point for interviewing is to see it as a craft: a form of conversation that will enable us to 'understand the world and lives of the sample of people selected for research' (Kvale 2009:xvii). The word 'craft' is an ideal metaphor for conducting an interview. A craft is a creative skill, but it is also a type of boat that enables its occupants to safely sail across all kinds of waters, whether they are deep or shallow, safe or dangerous. The interview can thus be viewed as an interpersonal vehicle that allows the two people involved to sail across a wide range of personal experience, much of which has deeply affected the course of a person's life. Kvale (2009) also posits that interviews produce knowledge that is embedded in a sociopolitical context. Interviews thus have the potential to show how

authoritative stories interact with, and have the potential to shape, the personal story of the teller and, in turn, how this affects his or her identity and ability to make independent sense of the world (Bakhtin 1981).

Reason (2003) sees the science of personal experience as an attempt to move 'beyond grand narratives toward localised, practical knowings that are based on experience' (Reason 2003:206). As such, narrative has an important role to play in informing the health system of the effects of illness and different forms of treatment on the lives of those it is meant to serve, offering, in Launer's (1998) view, an 'exciting tension between the complex narrative which the patient brings into the consulting room and an apparent understanding by the doctor of what is really going on, as formulated in a diagnosis or an idea about pathology' (Launer 1998:93).

#### The context of modern-day interviews

Interviews as a means of generating personal stories would seem to fit today's cultural climate. In the words of Silverman (1997), we live 'in an interview society, in which interviews seem central to making sense of our lives' (Silverman 1997:248). The fact that this was not always the case provides evidence of changing cultural stories about knowledge and how these impact on the views of individuals. Rudyard Kipling's nineteenth-century response to a request to be interviewed seems amazing today:

'Why do I refuse to be interviewed? Because it is immoral! It is a crime, just as much a crime as an offence against my person, as an assault, and just as much merits punishment. It is cowardly and vile. No respectable person would ask it, much less give it' (Kipling 1899:35).

Today, we are literally surrounded by radio and television programmes that have been built around interviews. Interviews are widely used for conducting systematic social inquiry; nowadays, everyone is seen as having knowledge that is worth discovering through the interview. As 'there is an assumption that each and every individual has a sense of self that is owned and controlled by him or herself – even if the self is socially formulated and interpersonally responsive' (Holstein and Gubrium 2003:35).

## Conducting the interview

‘The human nervous system is a wonderfully dynamic entity composed of an estimated one trillion cells... It resides in a body composed of fifty trillion cells’ (Bolte Taylor 2009:13).

I use this quote to start a discussion about interviews in order to suggest that if one human being is so magnificently and vastly complex, any interaction between individuals is going to be even more so. Bolte Taylor (2009) only refers to the complexity of the physical make-up of a person. The human being is also social, intelligent and spiritual. If, as Maturana and Varela (1992) suggest, even the simplest single living cell will ‘language’ with another and ‘co-create’ a ‘relationship’, then at the human level of dialogue, meaning, ever-changing and yet constant building of identity, the interview is worth approaching with a sense of awe. A meeting between two human beings both situated within the vastly complex human body and both having evolved through memory-laden time is almost limitlessly ‘cue-sensitive’.

Central to epistemological and methodological discussion about interviews is the notion that the interview is:

‘Not merely a tool, but a very part of its subject matter; it is not just a means for collecting data’, but ‘is itself a site for the production of data and can become the focus for inquiry in its own right’

(Benney and Hughes 1956:138)

Despite our familiarity with interviewing and its widespread application, the way researchers are thinking about and using interviews and their data is currently being revolutionised. As Gubrium and Holstein (2003) put it:

‘Interviewing has come a long way since the days of the neutral face-to-face conversation with a purpose between strangers that ostensibly produced facts of experience’ (Gubrium and Holstein 2003:5).

There is a growing awareness that meaning is socially constructed and that the interview itself has an influence on the type of knowledge it produces. It is not a simple question of one independent person asking another equally independent person to reveal what they know – it is more a question of multiple selves and multiple experiences within both parties languaging with each other to reveal unique

and transitory mimeses of experience which are acceptable to both. The research interview was initially seen as a straightforward process where the interviewer received knowledge (facts) from the interviewee. The passive participant waited for questions from an interviewer, who acted as the coordinator of a more or less symmetrical conversation. He or she supplied his or her own answers from his or her own cache of experience. Today, we recognise that all conversations are co-constructed. While this is true in ordinary conversations, it is perhaps especially important in interviews. The interviewer has been given a role with many connotations and culturally-embedded meanings. Many of these will be framed in the context of remembered authority. Being interviewed might have connotations of 'being sent to the headmaster', being 'grilled by the police', being 'diagnosed for treatment', or 'being a celebrity'. The interviewer is cast in the role of 'an expert', the interviewee is 'put into the hands of the interviewer'. Any interaction between human beings relies on a myriad of cues. In her description of an interview with Sunita, an Indian woman who experienced infertility, Riessman (2008) repeatedly refers to the way answers to her questions were shaped in ways that Sunita thought would be most interesting to her: 'Sunita responded by educating me about her culture' (Riessman 2008:33). This statement suggests that had the interviewer been from the same culture as Sunita, she would have responded in a different way. Conversely, Riessman also refers to ways that her own focus of interest interrupts the story Sunita is trying to tell:

'My interview here does not illustrate good narrative interviewing because I did not follow Sunita down her trails but instead returned to my agenda'  
(Riessman 2008:33).

It is important that the interviewer be aware of who the other thinks (s)he is, because this will shape the choice of content of the stories told. It is also important to be aware of the effects of the behaviour of the interviewer. Mishler (1986) argues that the behaviour of the interviewer commonly interferes with the story of the interviewee. Holstein and Gubrium (2003) also focus on the quality of relationship between interviewer and interviewee. Narrative researchers have responsibilities to counter the traditional view that sees interviewees as 'epistemologically passive' and to encourage and elicit lived experience, which then becomes the data for analysis.

## Personal disclosure within the interview by the interviewer

Debate exists about the appropriateness and effects of personal sharing within the interview. Weiss (1994:79) suggests that there should be no personal disclosure as 'the interview is about the respondent, not about the interviewer'. This stance assumes a distant and hierarchical relationship between the interviewer and participants. Elliott (2005), on the other hand, argues that appropriate personal sharing has the potential to humanise and equalise the research relationship, which can help put the participant at ease. In contrast, Wedenoja (1992 cited in Cotterill 1992), herself an interviewee and then a collaborator, reported that sharing on the part of the interviewer triggered a self-censoring process in her. She began to 'second-guess' what she might want to her say. She also concluded that rather than putting her at ease, self-disclosure seemed to be more for the benefit of the interviewer (Wedenoja 1992:33 cited in Cotterill 1992).

From a personal point of view, I would see decisions about disclosure being very much a part of the art of interviewing. A judgement would need to be made in the context of each individual and on the basis of how 'empowered to speak' each person might be. Frank (1995) has suggested that all stories act as rallying standpoints which attract and are nurtured by the recognition of others with similar experiences. In this light, self-disclosure could be a valuable means of sharing power, providing an antidote to the hierarchical nature of the interview and the traditional alienation of those who have experienced 'mental illness', or as already stated it could be perceived as interfering in the flow of narrative. What is important is that the researcher acknowledges the influence that disclosure during the interview may have had on the data collected. Once data has been gathered through the interview, it then needs to be analysed.

## Data analysis

In a study such as this one which uses as its data the stories of 26 individual members of GROW as they recovered from 'mental illness', the challenge for the researcher is to build a coherent recovery story representative of each of these stories. This is achieved through a systematic and rigorous method of thematic analysis.

Thematic analysis has been described as ‘a poorly demarcated and rarely acknowledged, yet widely used analytic method’ that is employed across the social sciences (Braun and Clarke 2006:77). It offers an

‘Accessible and theoretically flexible approach to the analysis of qualitative data and should be seen as a foundational method for qualitative analysis’  
(Braun and Clarke 2006:77).

Thematising meanings is one of a few shared generic skills across a whole range of qualitative methods such as grounded theory, conversation analysis, interpretive phenomenological analysis or discourse analysis (Braun and Clarke 2006). The process of thematic analysis I used in my research loosely followed a six-stage process suggested by Braun and Clarke (2006:87). This consisted of familiarising myself with the data by reading and listening to the interviews and noting down ideas; an initial coding of interesting features across the whole set of interviews; the collating of codes into potential themes and gathering data related to each potential theme; a review of themes and the generation of a thematic map; definition and naming of each theme and production of a report. The aim of analysis is to develop a plausible story line or second-order narrative that accurately reflects the plot contained within the sequence of events narrated by each individual participant. The following chapter contains a description of how this analysis was carried out.

### Reliability and validity

Cresswell and Miller (2000) note that writing about reliability and validity in qualitative research is extremely challenging on many levels. It is a subject about which multiple perspectives ‘flood the pages of books articles and chapters. The difficulties begin with a confusing number of terms that are used synonymously including authenticity, goodness, verisimilitude adequacy, trustworthiness, believability, plausibility, validity, validation and credibility’ (Cresswell and Miller 2000:124). I wholeheartedly agree with Cresswell and Miller’s observation that researchers can become increasingly perplexed in attempting to understand the concepts.

Webster and Mertova (2007) define reliability as ‘the dependability of the data, while validity typically refers to the strength of the analysis of the data, the

trustworthiness of the data and ease of access to that data' (Webster and Mertova 2007:89). Several authors have identified common ways for establishing reliability and validity in qualitative projects (Lincoln and Guba 1985, Maxwell 1996, Merriam 1998). Indeed, Cresswell and Miller (2000) list the following nine procedures commonly used in qualitative research literature: researcher reflexivity, triangulation, disconfirming evidence, member checking, prolonged engagement in the field, collaboration, audit trail, rich and thick description, and peer debriefing. While researchers routinely choose to engage in one or more of these methods, Cresswell and Miller (2000) also point out that there is little guidance available to a researcher as to why one procedure might be selected over another. Because narrative inquiry and storytelling research seek to explore individual interpretations and world views of the human condition, there is a consensus (in related literature) that it should not be judged by the same criteria used in realist methods of scientific inquiry (Elliott 2005, Polkinghorne 1989, Riessman 2008). Webster and Mertova (2007) argue that narrative research seeks to uncover individual 'truths', the meaning behind people's unique experience, rather than generalisable and repeatable events. For this reason, terms such as 'reliability' and 'validity' need to be redefined to fit the context in which they are being applied. A personal story may be neither an exact record of what happened nor an exact replica of a 'world out there'. It is merely one person's account of how they view things. It may make use of metaphors such 'it was like climbing a mountain' or 'it was like walking through glue' to describe a real event, such as getting a doctor to listen or the achievement of a goal. Elliott (2005:23) suggests 'stability, trustworthiness and scope' as being terms relevant to the discussion and suggests that 'narrative research is more concerned with descriptions (of events, emotions, decisions, turning points) than with measurements. However, a researcher must still ask himself whether the accounts uncovered in narrative research are accurate or valid representations of reality, albeit a subjective reality'. Rosenblatt (2003) suggests that questions of validity can be separated into questions about the quality of the interview, questions about the quality of the texts created to represent the interview and questions about the quality of analysis. While for each of the three areas it is impossible to establish an absolute validity, there are different things a qualitative researcher can do to persuade self and reader that the research is worth taking seriously and, therefore, valid. It is a researcher's efforts to ensure a high quality in all these three areas that is described as and represents rigor, which in turn invites trust in the whole research process. By clearly describing the processes



involved in each stage of the research, it becomes possible to show an evident and repeatable ‘empirical process’. The process used to enhance validity claims within this study were drawn from Riessman (2008) and Cresswell and Miller’s (2000) list of validity procedures. How they were interpreted and applied will be discussed in greater detail in the next chapter.

## Summary and conclusion

This chapter has looked at the epistemological and ontological underpinnings of two research methodologies, namely the objectivist and constructionist views. It outlines the different bases for knowledge about ‘mental illness’ and recovery, represented by the dominant objectivist medical view and the subjective experience of the person who has become ‘mentally ill’ and who is therefore a useful informant on the effects of that system. It offered a discussion on both the process and outcome of narrative methodology and explored some of the challenges and debates around this methodology and the interview method. It put forward some arguments for why narrative research is appropriate in the context of current policy on mental health and the aims of this study. It examined the process of the interview as a place where knowledge is co-constructed within the context of the dyadic relationship between interviewer and interviewee and described ways that encourage a sense of freedom to reveal personal understandings. Lastly, it explored some of the debates around ensuring the validity of this method through a systematic and rigorous methodology. The next chapter will chronicle how I put a narrative methodology to use within the context of this present study.

## CHAPTER FIVE: USING A NARRATIVE METHODOLOGY

‘One of the reasons for an eager espousal of a narrative approach in both the humanities and the social sciences might be that it is useful to think of an enacted narrative as the most typical form of social life’  
(Czarniawska 2009).

### Introduction

The previous chapter discussed the philosophical underpinnings of different research methodologies and ended with a review of principles and methods involved in narrative research. This chapter describes how I sought to operationalise these principles within this study. It begins with a brief description of the study’s aims, objectives and the research setting. It describes how access to participants and the necessary ethical approval were obtained and discusses the process of data collection and analysis. Issues of reliability and validity as they apply to this study are explored, and the chapter ends with a profile of participants and an overview of the findings.

While much has been written about the theory and findings of narrative research, it proved extremely difficult to find explicit guidelines for conducting in-depth interviews, for analysing data using a narrative approach or for providing grounds for the reliability and validity of the findings. Thus, the process of carrying out this research was a personal learning curve at many levels.

### The aim of the study

The study’s aim was to explore the recovery stories of a number of GROW leaders.

It’s objectives were to explore:

- The recovery experiences of a cohort of GROW leaders.
- How various types of help facilitated, aided or impeded recovery.
- The role mutual relationships such as friendship, reciprocity and leadership played in recovery.

## Inclusion criteria

To be included in the study, participants needed to meet the following criteria:

- Have a minimum of three years' involvement in GROW.
- Have been involved in GROW leadership at a formal level.
- Have received a diagnosis of 'mental illness' and either have been prescribed medication or hospitalised.
- Consider themselves as having recovered from a 'mental illness'.

People were excluded if they:

- Had not been involved in GROW for three years and had not been actively involved in formal leadership roles.
- Had no experience of treatment within mental health services.
- Were attending the same group as the researcher.<sup>12</sup>

## The research setting

The study was conducted among members of GROW in Ireland who were involved in leadership roles and met the eligibility requirements outlined above.<sup>13</sup>

## Gaining access

To gain access and permission to conduct the study, I approached GROW's board of management in 2007. I pointed out that a piece of research would provide the board with valuable information about the effectiveness of GROW in Ireland and would allow for comparison with research findings from America and Australia. It would also be in accord with recommendations contained in 'A Vision for Change: Report of the Expert Group on Mental Health Policy' (Department of Health and Children 2006), advocating that evidence-based research be carried out within different parts

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<sup>12</sup> This was one of the conditions imposed by the Faculty of Health Sciences' ethics committee.

<sup>13</sup> Leadership in GROW is divided into three levels of involvement. In the first six months of membership, '*beginning GROWers*' learn to be involved in many shared acts of group leadership. After this period, '*progressing GROWers*' take on formal leadership roles within the group or within a GROW fieldworker unit. '*Seasoned GROWers*', which is the category of leadership from which this sample has been drawn, will have had a minimum of three years' GROW membership and will be involved in GROW's management regionally or nationally.

of the mental health sector. Following discussion and a presentation, the board approved the study (appendix 4 is letter of approval).

### Recruitment of participants

Participants were recruited through a number of initiatives. I made a personal presentation to all fieldworkers and office administrators outlining the nature and purpose of the research and its inclusion criteria, thus ensuring that they were accurately informed about the study and willing to assist in recruitment. Members of GROW regional teams and fieldworkers subsequently acted as gatekeepers, distributing information leaflets (appendix 5) to group members within each region and verbally informing them about the nature of the research. GROW's newsletter, 'GROWing', was also used to inform people about the project (appendix 6), and posters (appendix 7) were placed in GROW offices throughout the country. Given the broad advertising and recruitment strategy, it proved easy to find participants. A total of 30 people who met the inclusion criteria quickly indicated their desire to become involved, either by phoning me directly or by making contact through a fieldworker<sup>14</sup>. Whenever a person enquired about participation, I rang or met with them to explain the nature and goals of the research and to answer any questions they might have. I also provided them with a detailed written information leaflet (appendix 8) and a statement of interest form (appendix 9). The information leaflet ensured people of confidentiality and the ongoing voluntary nature of the research and offered them an opportunity to take an active role in the dissemination of the results on completion of the study, should they chose to do so. Out of the 30 people who initially made contact, 29 completed the expression of interest form; however, two people later withdrew for unknown personal reasons and one person contacted me after I had finished conducting the interviews, extremely apologetic that he had forgotten to contact me sooner. In total, 26 people were interviewed; a detailed profile of these people is included later in the chapter.

### Data collection: interview

Data for the study was gathered through the use of a single, audio recorded, in-depth interview over a period of four months. Interviews were as unstructured as possible,

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<sup>14</sup> The word 'fieldworker' is the job title of a paid employee of GROW who works with a network of up to ten groups within a given area, supporting its members in a variety of ways and occasionally visiting each group.

beginning with a general question inviting each person to tell me the story of their recovery. Of all the different types of interview, it is the in-depth unstructured interview that is most likely to elicit narrative (Riessman 2003). It proved impossible in all cases not to use prompts (appendix 10) and so my interviews must be described as semi-structured. Prompts were used minimally if a person's story failed to cover certain areas of interest. The interviewer in narrative research is not an objective expert, but a 'good host' whose aim is to make the respondent feel valued and at ease (Kvale and Brinkmann 2009:17) and to elicit knowledge through friendly conversation. Interviewing is an art that can only really be developed through practice and, while I have carried out many interviews through my work, this process of one-to-one research interviews was new. In the next section I describe the interview process and my efforts to be a 'good host'.

#### Interview process: creating rapport

Interviews are, in many ways, artificial situations. Although all my participants had been involved in leading GROW meetings (a role which involves facilitating interviews with other group members), and although all would have told their recovery stories many times, I believe the idea of a personal in-depth interview would naturally create some anxiety. I certainly was anxious, especially in the beginning. I was anxious about my own ability to put people at their ease, to listen appropriately, to prompt discussion without disrupting or influencing narratives and to sensitively explore different aspects of another person's world. I was acutely aware that the behaviour of the interviewer does affect the outcome of the interview. To minimise anxiety and to become a 'good host', I endeavoured to adopt an encouraging and reflective attitude that would enable me to judge the ongoing state of 'at easeness' of both myself and the person I was interviewing. I was also anxious about whether the technology I was using would work, whether sound levels would be adequate and whether batteries would last. For the first two interviews I used both a digital and an old-fashioned tape recorder, in case the former did not work.

A few of my interviewees were obviously anxious at the start of the interview. One person, for example, started by presenting me with an article she had written some years previously outlining how GROW had helped. She seemed to doubt her ability to spontaneously tell her story, so I gently asked her not to worry and just begin to

talk. The interview turned out extremely well and at the end she commented that I was easy to talk to. Another participant began by apologising for not being better prepared. In order to dispel anxiety as much as possible and to give people a chance to ask questions about the forthcoming process, we spent time chatting informally before the interview began. In almost all instances I was offered a cup of tea, which I accepted, and I used this time as an opportunity for friendly conversation. When I thought both of us were ready, I checked if this were so, and at that point demonstrated (and tested) how the recorder would work. I also made it clear that if a break were needed for any reason, this was fine. Before each interview commenced, I asked people to sign the consent form (appendix 11) and fill in a short biographical data form (appendix 12) and I reiterated the aims and methods of the interview. I also re-stressed that should they wish, they were free to withdraw their consent at any stage of the interview or request that any particular part be deleted. I thanked each person at the end of their interview and checked that were they comfortable with its content.

After my first few interviews, I became very aware that my common response to the emerging stories was to say ‘wow’ in a range of different tones. I began to develop this natural response as an aid to curiosity. I found the interviews completely absorbing and was repeatedly humbled by the readiness of each participant to share their experience and to actively describe events that had happened in their lives. On reflection, I believe I quickly adopted an attitude of warm and respectful curiosity and that my genuine admiration for the generosity, courage and resourcefulness of each storyteller did cast me in the role of ‘good host’ (Kvale and Brinkmann 2009:17). Interviews started with the general question ‘Can you tell me how GROW has helped you to recover from “mental illness?”’ As stated, I had a number of prompts ready (appendix 10) to steer the conversation in the direction of specific areas of interest, should these not be spontaneously referred to. As unanticipated themes emerged from the analysis, such as the role that providence or chance played in recovery, these were added to my prompts. In most cases I didn’t have to prompt. People seemed more than ready to talk about their experiences of receiving help and to reflect on whether the help had been beneficial. Participants seemed to genuinely appreciate the opportunity to explore their experiences with an actively interested ear, and most people, over the time of the interview, touched on the main areas of interest without any prompts from me.

Learning to tell your story is very much part of the process of GROW. Each GROW member will learn to tell it in a number of ways. First, they will give a once-off ‘story of suffering or need that led to GROW’. After that, each GROW member is expected to give an evolving story of ‘recovery or outstanding growth through GROW’. GROW provides each person with guidelines for giving a personal testimony (appendix 13).<sup>15</sup> In addition to this, participants in this study (because they are ‘seasoned’ members) will be familiar with giving what GROW terms ‘leadership’ and ‘organisers’ or ‘recorders’ testimonies. Because of the familiarity GROW members have with telling their story in different ways and with reflecting on what has been helpful and unhelpful to their recovery, there was an expectation that this research would tap into a very rich seam of reflective experience.

Mishler (1986) suggests the aim of the interview should be to empower the respondent. Empowerment comes about in a number of ways, including challenging and countering the idea of interviewer as expert. Throughout the interview, I sought to encourage the spontaneous flow of narrative by being deeply interested and appreciative of the emerging stories. I think the fact that I am a fellow GROW member as well as a researcher facilitated the equality of the interviews and enhanced communication through a mutual familiarity with GROW’s language and philosophy, which it would be impossible for a non-GROW member to possess. A number of comments received after I checked my interpretation of people’s stories indicated that the interviews had been a positive experience:

*‘I can confirm with ease your take on my story and your findings from it. It all rings completely true for me and even now is a great help to see it put in such a clear way’ (Frances).*

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<sup>15</sup> A personal testimony is divided into two parts: the first describes how and why a person became ‘mentally ill’ or joined GROW; the second gives an account of how they have recovered or begun to recover. The story includes descriptions of tasks, the involvement of other people and ways the GROW program helped, and ends with a plan for the next steps of either recovery or growth. A leadership testimony begins with a description of a person’s idea of leadership when they joined GROW and follows the beneficial effects of taking on leadership roles and how this has helped in recovery. An organiser’s or recorder’s testimony tells the story of a group within which they took on a formal leadership role. This testimony will outline the growthful effects of learning to manage a group and role group management plays in recovery or growth.

## The interview as a form of supportive intervention

Many writers have suggested that taking part in an interview can have a positive or therapeutic effect on the interviewee (Mishler 1986, Elliott 2005). I certainly found that it also had this kind of positive effect on me in my role as interviewer. Each interview left me in a state of admiration for the person interviewed and, I believe, enriched my own knowledge of the experience of 'mental illness' and the process of recovery. A number of people made comments which suggested that the interview had also been a positive experience for them. One person, Richard, contacted me by e-mail and his satisfaction with the interview was clearly evident by what he wrote:

*'I hope you had a safe journey back to Kilkenny. I really enjoyed your visit and hope you can find an excuse to call up this way again before too long'*  
(Richard).

Comments like this reassured me that the interview process, with its deep reflections on the past, were not experienced by the participants as distressing. Within two days of completing an interview, I wrote a 'Thank-you' card to the person involved. Unsolicited and spontaneous feedback through two fieldworkers indicated that this was greatly appreciated and that the whole experience had been positive for the participants.

## Interview location and time

Interviews were conducted at a time and place selected by each participant, which included their own homes, GROW offices and, on one occasion, a room in a hotel. I conducted only one interview per day, where possible; however, if the interviews involved extensive travel, I sometimes completed two. I organised the timing on such occasions to ensure that I had a good break in between, and I used this time to write memos, reflect on the interview and prepare for the next unique encounter. At the end of each interview, I asked each person if they would like a transcript of the interview. This would have given them an opportunity to check its content and, if unhappy, to request parts to be deleted. Only one person requested a transcript, which was duly sent. Interviews ranged from one hour and four minutes, to two hours and thirty-five minutes.



I was continually amazed and humbled at the very personal nature of disclosure made by some participants. People freely discussed many extremely personal issues which are normally considered ‘taboo’. Descriptions of family tensions and violence, sexual abuse, suicide and the death of loved ones formed part of the subject matter of many of the narratives. After each interview, I made it very clear that, should a person have any second thoughts about anything they had said, I would remove this from the transcript. Only one person professed such concerns in an e-mail the day after the interview:

‘I have been thinking about the interview yesterday and I wondered about guarding my identity as I gave you more information than my usual testimony. Can mention of named towns and colleges be made more general, or will you just use brief quotes in your thesis?’ (Helen)

My reply put her mind at rest:

‘Helen, thanks a million for yesterday. Everything of that nature will be made totally unrecognisable and I will change all towns and colleges as soon as I get the transcript’ (Mike).

#### Data analysis: the paucity of the written word

This chapter, like all the chapters contained in this thesis, comes to you via the mystery of the written word. I write now, you read whenever; and as you do, you arrive at some understanding of what it is I am trying to say. This chapter is different to the previous chapters, in that it is an introduction to once-off, unstructured interviews conducted with living people speaking spontaneously, and does not refer to carefully revised and professionally honed books or peer-reviewed articles whose aim is to represent or promote a particular point of view. I wish that technology had advanced to a stage that you could not only see each written word but also hear how those words were spoken just by looking at them, and also see the body of each speaker or their ‘analogic language’ which is the context from which they were spoken. Words evolve from within a human being, an embodied ‘phenomenon’ which, among many other things, contains memory, imagination and emotion as well as meaning (Rappaport 2000). They also evolve in the context of relationship, because words are always spoken to someone – in this case most obviously me, in my role as interviewer. While the written word can span dimensions of time and distance and give an ‘idea’ of meaning, it cannot accurately describe ‘how things

really were' at the exact moment of utterance. It is almost like being given the words to a song without the music. To bring that song alive, a conductor or musician would need to know each note and the strength and tempo with which it should be played. Even then, two conductors would undoubtedly elicit different versions of the intended score.

For instance, in Tom's story, the statement that '*Relationships were not a very successful thing in the family background*', seems to me, when read, to become a rather flat and almost quantitative fact. I can almost see a clinician dryly writing it down on a chart as something to be added to a growing list of symptoms and possible causative factors. However, if you listen to the audio recording of how these few words were spoken, you enter into Tom's living world as he allows himself to remember the past. In this case, he does so in order to explain to me how (and from what) he has recovered. Just as Tom gets to the word 'successful', his voice breaks into a soft, almost disbelieving chuckle. This laugh, in my interpretation, contains both incredulity and exasperation at the long list of separations he has just recounted: his grandparents separated, his mother separated, his aunt who lived with them separated, and none of his uncles married. Within that chuckle there are touches of despair; you can almost see and feel the horror he experienced at home as he allows himself to witness just how 'different' and 'separated' his childhood had become. It also hints at resilience – it is a brave man who can laugh at his own misfortune. Maybe the chuckle also contains his thoughts about his own future – will this be his story too... Who knows? At this stage I can only try to recall Tom's body language. We were sitting opposite each other in the conservatory in comfortable chairs. I think I can see his body straighten in the chair and his face mirror the emotion I now remember in his voice. I can see his spirit as much as anything. The spirit of a man who was told he would never work, never learn to drive, probably never have any friends unless he decided to live permanently in a psychiatric hospital. The spirit of a man whose life had been weighed down by intolerable side effects of medication and the horror of self-harm. Today, Tom is married, runs a successful business and has a wide range of social interests. He has taken no medication for over twenty years. It is impossible (or so it seems to me as I start to write this piece on the analysis of unstructured interviews) to capture the human richness of each person for a reading audience.

I hope that the example of Tom given above will show that, in my interpretation of each interview, I have tried to really put myself inside the experience of ‘the other’ and provide rich, thick description that conveys the essence of his experience. I have immersed myself in the data for prolonged periods of time, listened to each audio recording several times, listened while reading the transcript and taking notes, in the hope that I can convey more than just the related facts. I have frequently stopped to take notes and explore various emergent themes suggested by both spoken (digital) and enacted (analogic) language. Having acknowledged the huge difficulties involved in interpreting so many words containing so many memories, the next section sets out the methods I used to process the content of these interviews.

### Preparation for analysis

Before a formal process of analysis took place, each interview was carefully transcribed, cleared of any identifying information and given a pseudonym to protect the person’s identity. I transcribed the first interview myself, but then solicited the services of a professional transcription service. I began the data analysis immediately after completing interview one. I analysed data by using a form of thematic analysis that was informed by the writing of Braun and Clarke (2006) and described in the previous chapter.

### Analysis method: the procedure

I searched many textbooks in vain for an all-encompassing and foolproof analysis ‘method’. Questions to various speakers at conferences or workshops and my supervisors<sup>16</sup> produced, at best, a set of principles on which I could attempt to make a start. Very early on, in the first six months of my study, I took one story from GROW’s Soul Survivors book (GROW International 1995) and began an analysis using codes. This was a useful exercise, even though it resulted in a bewildering number of codes (appendix 14). Following further reading, the idea of employing both inductive and deductive methods of analysis was well-received by the School of Nursing and Midwifery’s continuation board. In essence, I would work deductively, looking out for the emergence of particular kinds of stories that had become apparent through my reading of books and research articles and which might influence a

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<sup>16</sup> I began this research with two supervisors, one of whom ceased acting in this role when she changed employment. Hence, I sometimes refer to ‘supervisors’ and sometimes to only one.

person's understanding and experience of recovery. I would seek to understand if and how, the medical model and other dominant cultural narratives surrounding 'mental illness' had impinged on people's hopes, ideas, behaviours and recovery. I would also be listening for examples of the effect that GROW's story had on a person's spirits. At the same time, I would be working inductively, carefully searching for emerging patterns of experience that came directly from the interviews and of which I had no prior expectation. I also had some idea of themes that I wanted to explore based on GROW's idea that there are six main areas of help involved in recovery. GROW uses the generic term 'tranquilliser' to describe each of these, which include hospitalisation, medication and professional help from a variety of sources; friendly, non-professional help; a person's own attempts at self-help and the effects of a person's overall world view; and whether this included a belief in God or was a secular philosophy (GROW 2001:8).

I undertook an introduction to the software package, 'NVivo 8', and subsequently arranged a further one-day training when I had completed my first six interviews and had had them transcribed. I began a type of analysis which involved looking at each statement and placing it into a range of 'codes'. When I shared my progress with my supervisors, they warned that many people critique 'Nvivo' on the basis that it may result in analysis becoming mechanical, removing me from my own personal interpretation. They suggested that it should, at best, be a back up to my own emerging understandings. This view was reinforced with casual conversations about my work with other academic staff within the School of Nursing and Midwifery. During this time, a lot of anxieties began to set in. I calculated that I would have approximately 500,000 words of transcript and could envisage literally thousands of codes.

A breakthrough came after a discussion with my supervisor, who suggested that a first step (as suggested by Braun and Clarke 2006) was to thoroughly familiarise myself with each story as a 'whole entity'. I did this by listening to the recording while reading the transcript and by making notes in the margin. My supervisor specifically suggested that I make a short synopsis of each, noting down the main plots contained within each story. I then reread the synopses to see what subplots they contained. As I worked through the stories it slowly became obvious that each story naturally fell into three separate sections. Each contained descriptions of:

- What life was like before attending GROW.
- What happened within GROW.
- What happened to people after becoming involved in GROW.

As I made a synopsis of Mathew's story, I was struck by a statement he made about recovery. Mathew had spent many years battling with what he described as '*severe delusions and psychosis*'. He had been hospitalised many times. When I asked him if he could sum up for me what recovery meant to him, he told a story that described how he moved from his '*small self to a bigger self*':

*'I was trying to be a better person, not just, well on the one hand for myself to get better... I saw it as a way of getting better – getting out of my own small self, trying to give something back or give or loving or whatever. Getting out of my own small self and getting into my big self – that was kind of recovery'*  
(Mathew).

I began to see how the three divisions I had noted could be seen as representing a move from a single physical self to a small social body represented by a GROW group, and from there to even larger social bodies – the wider GROW community and then society. I mulled over this idea for a few days with growing excitement. Every time I returned to one of the transcripts or listened to one of the recordings, the idea of being imprisoned or isolated in the physical body – a body surrounded by thoughts that reinforced a sense of terror – jumped out. Equally powerful were the positive descriptions of feelings experienced on coming into contact with GROW. It all resonated with the title of an article written by Julian Rappaport (2000) in which he described stories of oppressed minorities as 'tales of terror', which became transformed into 'tales of joy'. It also reminded me of Con Keogh's idea that as human beings we live within three bodies, which he called the 'house of flesh', the 'house of brethren', and the 'house of God', each depending on a different basic activity for its survival – breathing, friendship and prayer (personal communication).

I began to see from the descriptions handed to me through the interviews that each person, without exception, described a process of isolation in a somatic and emotional body which had become a place of terror. Each person had become trapped in this physical body that was dominated by negative, often reactive and destructive feelings – feelings that robbed them of their ability to think 'rationally'

(although they retained their ability to think logically) and which articulated ‘tales of terror’. Their lives became consumed with trying to combat or alleviate these feelings. They lived in a shrinking morality which was based on impossible concepts of GOOD, such as *‘if only I could be alone maybe everything would be OK’*; *‘if only I could die the pain would stop’*; *‘if only I could get revenge I would feel alright’*. I was reminded of the line from Scripture that says ‘for those whose light has become darkness, their darkness will indeed be doubly dark’ (Matthew 6:23).

I also noticed that, without exception, people reported quite dramatic and instant changes in their feelings once they had become involved in GROW. These changes were sustained as they became more and more involved. GROW represented ‘a time of healing’, a period of time when others became a second kind of self. This healing period was not the end of the process of recovery; rather, a preparation. As several people suggested, GROW acted as a connecting link between ‘illness and life’. There came a point where people began to choose what kind of life they wished to live. They began to actively seek ‘niches’ in society where they could develop their personal ‘goods’, exercise their newfound ability to choose and develop their own unique character – or, in GROW’s words, to take their ‘responsible and caring place in the community’ (GROW 2001:5).

From this I drew a conceptual map or framework (appendix 15) which had three themes or phases. I initially named them as a ‘house of terror’ or a ‘house of pain’; a ‘house of healing’ or a ‘house of friendly others’; and a ‘house of becoming’ or a ‘house of meaning’. I later changed the titles of these themes to ‘a place of terror’, ‘a time of healing’ and ‘an opportunity to become’.

The first theme, ‘a place of terror’, described and explored the experience of ‘being’ in isolation. The second theme, ‘a time of healing’, explored the experience of GROW membership, and finally the last theme, ‘an opportunity to become’, examined life after healing. I made the changes to the titles of each phase after discussion with people who suggested that the first theme titles appeared to be fixed (and therefore deterministic) and may have missed the fluidity of the process that people were describing.

It was from this conceptual framework that my method of analysis began to evolve in a more in-depth and comprehensive manner. With the framework in mind, I reread through each story many times and coded relevant segments of the interview into each of three themes identified (see appendix 16 for examples). For example, within the theme ‘a place of terror’, I coded different types of feelings that were described, the effects these feelings had on thoughts and behaviour and the effects behaviour had on relationships and, lastly, ‘causes’ ascribed to the feelings (appendix 17). As I began to work through each story, it became clear that each narrative contained many stories and that these were often stories of ‘causes’ and ‘effects’ (appendix 18) operating at very different levels.

At the most basic ‘physical level’, people reported terror as a physical feeling. Factors that contributed to that state of terror included physical causes such as drugs (prescribed and illegal or self-prescribed), alcohol, or adrenaline which came from the body’s own instinctual safeguards. People described a whole range of feelings (which psychiatry labels as symptoms) that collectively appeared as the cause of terror. Despair, rage, hatred and powerlessness were all mentioned. The next level of causal factors included thoughts and imaginings ending in conclusions such as:

*‘Other people are just selfish so what is the point in getting involved?’  
(Peter)*

*‘I am a bad person’ (Richard)*

*‘There is a plot’ (James)*

*‘I want to kill that bastard’ (Jess)*

Next came reported behaviours of others, family members, peers, teachers and mental health professionals. Interestingly, these behaviours might be divided into positive and negative behaviours in the same way symptoms of schizophrenia are described as positive and negative<sup>17</sup>. Positive behaviours (things people did) included abandonment, rape or childhood abuse, rejection or betrayal. Negative behaviours (things people omitted to do) included reports of ‘non-listening’, a lack of warmth

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<sup>17</sup> I have deliberately chosen to describe destructive behaviours of family members as ‘positive’ or ‘negative’, despite a question from one reader who suggested ‘positive’ was an odd description of these behaviours. I think that to compare these behaviours, which contribute to a state of terror, to the nomenclature used to describe ‘positive’ and ‘negative’ symptoms of schizophrenia serves to narrow the distance between the person so diagnosed and the proximal processes within which he or she lives.

and a lack of meaningful contact. As an outcome of this level of analysis, I began to develop an ecological representation of each person, composed of concentric layers of involvement. This diagram became a formalised mind map, which I used to explore each story (appendix 19). Further tables enabled me to examine possible relationships between different levels of story (appendices 19b-f); I then developed a diagram that helped me create a timeline, which allowed me to put a chronological sequence on data and to seek to examine plot in a different way (appendix 20). All these tables and diagrams allowed me to place different parts of different stories in relation to each other. I found it added great depth to my ability to explore each story dialogically (Bakhtin 1973, 1981) and to see how meaning is abstracted from an interplay of external contexts and internal processes. As the analysis progressed, I developed similar forms of ‘mind maps’ and tables to explore the processes of ‘healing’ and ‘becoming’ for each individual and began to understand pictorially how new stories of hope and joy could counteract the many negative stories that contributed to terror. In this way I systematically worked through each story, identifying themes under each heading and building a picture of the relationship between somatic, spiritual, cognitive and social stories and abstracting first-order narratives which could then be woven into a second-order narrative (Elliott 2005).

### Data saturation

Data saturation is said to occur when no new sub-themes are found that would significantly add richness to the results (Glaser and Strauss 1967). I believe saturation was reached when I had completed around twenty interviews. However, by this time I had already arranged interview times with the remaining six participants, and while their contributions were valuable in that they continued to confirm findings, they didn’t reveal a great deal of new information. Having said this, I am conscious that, had I continued to interview further participants, additional negative cases and disconfirming themes may have emerged.

### Ethical issues

Ethical approval to conduct the study was granted by the university ethics committee (appendix 21).



## Informed consent

Usher and Arthur (1998) suggest that informed consent is a legal requirement that has evolved out of a recognition of a person's human right to be treated as an autonomous agent. Informed consent is perhaps particularly important in a study that involves people who have experienced 'mental illness'. Treatments, including hospitalisation, ECT and medication, are sometimes given to people diagnosed as 'mentally ill' without any form of consent. Participants were therefore informed in writing about the study. This information (appendix 8) included the aims and purpose of the study, the methods that would be used to collect data, and an outline of the procedure that would be used to protect their identity. Before each interview started, this information was reiterated verbally and the voluntary nature of participation, the right to withdraw from the interview process at any time or to request the removal of some parts of the interview was stressed. Any misgivings or questions were openly discussed. Participants were asked to sign a consent form (appendix 11) and agree to audio recording before the formal interview began. This was used as another opportunity to stress the voluntary nature of participation and the option of withdrawal of consent at any stage in the study. None of the participants objected to having the interview audio recorded.

## Confidentiality

'It is a key ethical principle that the anonymity and privacy of those who participate in the research process should be respected... However, it can be very difficult to ensure that a case does not become recognisable'  
(Elliott 2005:142).

The difficulty of presenting data contained in the recovery stories of people involved in GROW and rendering them completely unrecognisable is perhaps accentuated by the fact that GROW is a relatively small organisation and each person will have told their story in different settings. The likelihood of people being identifiable within the GROW community is high. Participants assured me that this was not a problem. In order to ensure maximum possible levels of both anonymity and confidentiality to the non-GROW world, the following procedures were adopted:

- Each audio recording and written transcript was first of all given a code number and subsequently a pseudonym. I considered using just a number rather than a pseudonym, but rejected this idea for a number of reasons. The

stories told to me were so human, thus I was of the view that it would be disrespectful to refer to people by number. I was conscious that people who have experienced ‘mental illness’ frequently complain of being treated like a disease rather than as a person (Frank 1995) or of ‘all being treated just the same’ (Higgins et al. 2010), and using numbers would add to the institutionalisation, sameness and ‘otherness’.

- All references to the real name of the person and the names of anyone mentioned by them, or the names of places and institutions that might help identify a person by location, were changed.
- Audio recordings and written transcripts were stored on my password-protected computer and were erased from the recorder as soon as they had been copied.
- A written copy of each transcript was stored in a locked filing cabinet, to which I have sole access, in my private and locked office.
- The recordings were transcribed by a professional agency (recommended through the School of Nursing and Midwifery) and copies of each transcript and recording were anonymised as soon as I had received them. The only person to see parts of the transcripts was my supervisor and she did so only after each had been anonymised.
- Before each interview I reminded each person that there were limits to the confidential nature of the interview and that if I felt these limits were being crossed then I would have to take appropriate action (see appendix 22).

### An unexpected issue regarding confidentiality

I was delighted to receive an expression of interest in the research from one participant who was a member of a GROW group but was living in a high security unit. The person had seen the advertising literature and had made contact with me by letter through a fieldworker. The letter posed a significant challenge in terms of respecting the person’s confidentiality and right to participate. If I were to interview this participant, I would have to arrange an appointment through the staff at the unit and I would have to inform them of the reason for the appointment. I suspected that any letter I wrote to the person might be opened and read and thus involve a breach of confidentiality. I therefore rang the principal social worker within the service and outlined my dilemma, without disclosing any information about the person. She

assured me that I would be able to write directly to the person and that his letter would not be opened. I then wrote to the person, including a stamped, addressed envelope and requesting that the person discuss the research with their doctor and gain permission for an unsupervised interview, which was given.

### Protection from harm

My application for ethical approval included procedures that would be followed if an interviewee became distressed during or after an interview. If this occurred:

- I would acknowledge the participant's distress.
- The interview would be stopped and either temporarily or permanently discontinued.
- Immediate emotional support would be given to decide on appropriate action.
- If further support was needed, the participant would be referred to a GROW fieldworker, friend or GP.
- A list of national and local support agencies would be made available if needed.

Despite the fact that all participants shared very deep and personal reflections on their lives and although that this did, at times, bring up strong and vivid emotions, they all assured me that they were 'happy in their distress' and I had no reason to call on outside help. The act of acknowledgement of the distress and a willingness to support the person through that distress was enough to carry them through these emotional parts of the conversation. Frank (2000b) has made the argument that caring for a person involves a willingness to witness that person's suffering; I got the impression that my listening to distressing memories in a supportive manner was experienced as an act of caring witness. After one interview, I had a profound sense of unease and so I phoned the person to thank them and give them the opportunity to express any distress that might have been caused. Their response was one of warm satisfaction with the interview. I then asked the fieldworker in that area how the person was doing and was assured that she was 'flying it'.

### Challenges in gaining consent

Gaining ethical approval for this study provided evidence of the presence of different and dominant understandings around the concepts of 'mental illness' and indeed

recovery from ‘mental illness’. As part of the application for ethical approval, I purposely did not identify the participants in the study as ‘mentally ill’ or use the category ‘vulnerable’. Using the recovery lens and my own experience of recovery, I made a detailed argument why such a classification would be the antithesis of the whole recovery philosophy. If you describe yourself as having recovered from ‘mental illness’ (a criterion for inclusion within this study), you are no longer ‘mentally ill’. The ethics committee, however, requested that I:

- ‘Describe the group as particularly vulnerable’.
- ‘Tick the box “mentally ill”’.

When I responded to the committee with a further explanation for my rationale, I was informed that ‘ethics committees are not forums for discussion’. Emanuel and Grady (2006:93) suggest a current ethical paradigm of ‘collaborative partnership’ (between service users, their representative organisations and ethics committees). This community partnership paradigm ‘rejects professional paternalism’ and recognises that ‘risks and benefits both during and after research are best evaluated by involved communities’. This statement can surely be interpreted as saying that ethics committees should, in fact, be precisely what this committee denies – ‘forums for discussion’. In the end, an uneasy compromise was reached and I stated that my participants might be considered as ‘vulnerable’ because they belong to a group that has previously experienced ‘mental illness’. However, I did not ‘tick the box’ describing them as ‘mentally ill’.

When I first applied to the ethical committee, my attention was drawn to the issue of roles, discourses and identities. It was suggested that for the purpose of this research I must emphasise that my primary identity is of researcher. The fact that I am a GROW member, someone with their own experience of recovery through GROW, seemed to be seen as something I should distance myself from. To me, this went against the idea that narrative interviews strive for equality between participants (Mishler 1986). Rappaport (1998a:3) described the importance of researchers establishing a ‘human relationship’ with GROW members in order to bridge the gap caused by labels and roles. Many commentators highlight the fact that barriers are constructed by the labels of professional and ‘invalid’ and point to the desirability of connecting as ordinary human beings (Kleinman 1998, Charon 2006, Frank 1995). Wengraf (2001) suggests another barrier to interviews is seated in the problem of

language. Not only do people with different backgrounds bring different discourses to the work of the interview – each of us uses what he calls our own ‘idiolect’ (Wengraf 2001:64). In light of the nature of my research which, in part, is seeking to discover how GROW’s community narrative empowered people to recover, I would have thought my identity as a fellow GROW member and my familiarity with GROW language would place me in an advantaged position. However, at all times I behaved professionally as a researcher and this gave me a stance that focused the research on the processes of recovery.

### Enhancing reliability and validity of the study

In the previous chapter I made the argument that the concepts of validity and reliability that underpin quantitative research need to be redefined for use in qualitative studies. While the physical sciences strive to explore a real and fixed reality out there, qualitative research deals with constructed realities that Rosenblatt (2003) argues lie at the boundaries of ‘fact and fiction’ (Rosenblatt 2003:225). Qualitative research seeks to uncover people’s understandings of events in life, rather than seeing these events as realities with ONE TRUE MEANING. If we are at the boundary of fact and fiction, we need to think of concepts such as reliability and validity in a different sense. Perhaps we might use the words, but change the meanings. Riessman (2008:185) suggests that ways of thinking about validity and ethics are ‘the products of the paradigms that spawn them’ and that the onus therefore lies with each individual researcher to persuade audiences with specific forms of rhetoric which reflect those paradigms, whether these be ‘realist or interpretive tales’. In this way, the validity of a project can be assessed from within the situated perspective and traditions that frame it and which the researcher must therefore make clear. Riessman (2008) has identified specific criteria for demonstrating the validity of a research study and for the individual’s unique interpretations. Two of her ideas are applied to the current study, namely ‘Historical Truth and Correspondence’ and ‘Coherence, Persuasion and Presentation’. In addition, I also used some of the processes suggested by Cresswell and Miller (2000). In the next section I set out how I interpreted and applied these ideas to ensure that my research was conducted in a rigorous and systematic manner.

## Historical truth and correspondence

Historical truth is important to this study, which has set out to explore processes involved in recovery through mutual help. By constructing an alternative ‘truth’ to the one put forward by psychiatry, this study has introduced the question of what truth is and how it has been constructed – how have medical ‘truths’ in the past eclipsed or suppressed other possible explanations? The concepts of historical truth and correspondence have relevance at many levels. For example:

- Do the stories told by participants contain verifiable truths? Were reports of hospitalisation, medication, reported life events ‘true’? (In this study, I accepted that they were.)
- In the light of these reported facts, how do reported effects [of abuse or re-enchantment] correspond to the accounts of others with similar experiences?
- From the contextual point of view, do the accounts provided by different chapters of this study correspond to historical facts? For example, did Francis Galton really exist? Was it true that Freeman and Watts performed thousands of lobotomies? How much did this affect the general treatment of people with ‘mental illness?’
- Is my interpretation of the evolution of the story of psychiatry believable and, if so, who supports my interpretation?

While establishing the validity of a study by verifying facts, Riessman (2008) notes that, in qualitative studies, ‘facts’ are not as important as verifying the meaning of these facts for different individuals and groups. As will become evident in the next section, a number of strategies, such as member checking and triangulation, were employed to verify interpretations of meaning. In this way, the validity of this study was perhaps provided by a correspondence between participants’ descriptions of the construction of ‘places of terror’ rather than establishing a series of ‘things that happened’. The study revealed similar intrapersonal and interpersonal processes at work in the construction of terror within the different accounts of participants, all of whom had lived in very different contexts and who reported very different experiences.

## Coherence, persuasion and presentation

Riessman (2008) suggests that ‘coherence, persuasion and presentation’ is a related facet of trustworthiness. In practice, the application of this principle required asking

questions such as: ‘How well does the story hold together?’; ‘Has it been linked accurately to theoretical argument that support or question it?’; ‘Are there major gaps that raise questions that need to be addressed?’; ‘How plausible is the researcher’s interpretation to potential audiences?’

My supervisor repeatedly got me to reflect on the fact that reporting these research findings involved telling a plausible story to a particular audience. In a way, the researcher’s role is like that of a defence lawyer whose brief includes persuading a jury. The metaphor of a jury and lawyer illustrates the truth of Rosenblatt’s argument that qualitative research lies at ‘the borders of fact and fiction’ (Rosenblatt 2003:225). In a court of law, it is ultimately the relative plausibility of the story of the defence or prosecution that determines the validity of the evidence. Whatever the verdict, it has very real consequences for the defendant. Depending on the plausibility and presentation of the opposing views, the defendant will either be freed or sentenced – perhaps to death or to life imprisonment. In view of the differences of outcome uncovered in this research, between a lifetime of medication or one of personal empowerment and liberation, the metaphor illustrates the importance of the persuasion, coherence and presentation of constructed truth.

As stated, I was also influenced by Cresswell and Miller (2000), who consider issues under three headings: the researcher’s lens; the participant’s lens; and the lens of informed people outside the parameters of the study.

### **The researcher’s lens**

Cresswell and Miller (2000) use the term ‘the researcher’s lens’ to describe ways in which the researcher’s own efforts and understandings can enhance validity.

#### Disconfirming themes:

Perhaps because of my own experience of recovery through GROW and the possibility that this might blind me to differences in the experience of others, I have tried to be alert at all times to what Cresswell and Miller (2000) call ‘disconfirming themes’. These are instances when one or more people report experiences that would seem to refute an emerging theme. For example, David, in a discussion about the possibility of providence being a factor in recovery, completely ruled this out. James

too was diffident about committing to any definite view about the realm of life mystery because it was too close to his experience of severe 'mental illness'. Both Sue and Peg described how being asked to take on leadership roles had a negative effect and, in fact, led to a setback, while for most people the experience of leadership was attested to as a positive part of recovery and personal growth. In addition, despite the overwhelming number of negative experiences of medication, hospital and professional help, and a personal belief that they often do more damage than good, I sought and included many examples of positive experiences of medication, hospital and relationships with mental health professionals. A fact that drew the comment from one of the people scrutinising the findings: 'If these are so good, why would someone want to attend GROW?' By including both positive and negative accounts of medication, the question of its usefulness remains a subject that invites further research and further debate.

#### Researcher reflexivity:

This involves the researcher self-disclosing their assumptions, beliefs, biases and values which may shape their inquiry. One of my strengths as a researcher in this study is a deep knowledge of the GROW program, of its methods of operation, of my own recovery from 'mental illness' and of the recovery of my wife, Fran. This knowledge allowed an ongoing personal comparison of emerging findings with GROW's story of recovery, my own and Fran's. However, I was also conscious that I may bias the analysis; therefore, throughout the study I consistently tried to uncover and acknowledge my own philosophical position and beliefs. I did this during the supervision process and documented my ideas within the thesis. For example, in chapter one, I clarify my own thoughts about the nature of recovery and the role of medication.

#### Prolonged engagement in the field:

Fetterman (1989) argues that validity is enhanced where researchers stay at the research site for a prolonged period of time. I found that my own continued membership of GROW (before and during this study) was helpful to the validity of this research. As a member of a special GROW group aimed at helping people live life to the full in the context of chronic physical illness, I constantly found myself listening to and observing the testimony of others differently than I had before the



research. Comparing these testimonies to the content of the interviews and the emerging themes was a further source of data validation.

#### The audit trail:

For Riessman (2008), rigor is best established by systematically informing the reader of the methodology used through an audit trail:

‘Students need to document their sources and bring the reader along as they establish a trail of evidence and critically evaluate each piece in relation to others’

(Riessman 2008:188).

My supervisor proved to be an invaluable resource in encouraging and demanding a pedantic approach to research detail, and I have endeavoured to communicate how I rigorously analysed each story using a series of tables, mind maps and diagrams. This methodology would allow others to use the same framework for a comparative analysis of the results, as it provides an audit trail that can be followed back to the interview process itself and in this way establish a validity for the method of research. However, I am very aware that different people, using the same material, may well have come up with different interpretations, just as different people will no doubt give different accounts of the same event, the same journey, or even of the same family of origin. That doesn’t mean that one was right and the other wrong; it is, rather, evidence that, as human beings, we all construct meaning.

#### **The participant’s lens**

While the previous three validity procedures have used the lens of the researcher, the next three shift to the perspectives of the participants in this research.

#### Member checking:

Lincoln and Guba (1985:314) suggest that member checking is ‘the most crucial technique for establishing credibility’. Member checking involves seeking feedback from research participants to confirm the credibility of the researcher’s interpretations of data. I must confess that I did this with some trepidation because I had taken part in a PhD research study as a participant in the past and remembered feeling very angry and let down when the final thesis was published. This was

because I felt that the conclusions drawn from my contribution were taken out of context and had been inaccurately represented. However, grasping the nettle, I decided to send out lengthy parts of findings chapters to the individuals who featured most prominently within them, with a request for honest feedback. I was extremely relieved and heartened by their responses. For example, one person wrote:

*'I am extremely happy with the way my quotes were interpreted'.*

Another suggested that their story was represented

*'Very well and accurately. It is very interesting to get your academic perspective on these events'.*

At the end of the research, it is my intention to provide each participant with an electronic copy of the thesis, including a note asking that I be informed directly about reactions to my interpretation of these stories so freely and generously entrusted to me. At a recent community weekend I presented the main findings of the research and then asked if these reflected the audiences experiences. I suggested anyone who wished could leave a piece of paper indicating 'yes' or 'no'. I received 74 'yesses' and one 'no'.

#### Collaboration:

Cresswell and Miller (2000) argue that credible data comes from close collaboration with participants throughout the process of research. Participants are involved in the research as co-researchers. Before the research began, in the design of information leaflets and in the way that I explained its nature and purpose, I described this research as collaborative. Part of the purpose was to inform GROW as an organisation and the Irish Government's expert group on mental health policy about the nature of recovery through GROW. All participants have been offered an opportunity to train to help disseminate the findings. I believe that the participants therefore saw themselves very much as collaborators within this endeavour.

#### Thick, rich description:

Denzin (1992:83) describes thick descriptions as 'deep, dense, detailed accounts'. Thick descriptions do more than relate facts: they aim to 'produce for the reader the feeling that they have experienced or could experience from the events being

described in a study'. Throughout the findings chapters, I have included substantial sections of rich and thick description and in chapter four I use thick, rich description to describe the interview process and the paucity of the written word.

#### Lens of informed people outside the parameters of the study

Cresswell and Miller (2000) propose a third source of validity may come from individuals external to the project, such as readers brought in to attest to the credibility of the study. I sent findings to various external auditors, including the National Program Coordinator of GROW in America and GROW's current national chairperson in Ireland, and their responses are reproduced in appendices 23 and 24.

#### Peer debriefing:

Cresswell and Miller (2000) define peer debriefing as a review of research data and process by someone who is familiar with the research and with the phenomena being explored. In addition to my supervisor, a number of people fulfil that definition. For two years, in the preparation for the research I had regular meetings with a fellow PhD student. During this time, we compared notes, read and commented on each other's material and explored the ideas of Bakhtin. I sent the findings chapters to various people, who provided tough, but extremely valuable, comments. I also presented findings at three international conferences, and my presentation won 'Best Student Oral Presentation' at the 2011 International Nursing Conference in Trinity. I have been asked to submit three papers to different journals.

Despite all of these strategies, this research does raise some issues about the rigor and validity of the findings. A high proportion of my research sample (30%) were paid employees, seven having the role of fieldworker and one office administrator. A question might be asked whether the large number of employees would, in some way, skew or bias the results of the research. However, I found that the role of fieldworker was reported as an extension of other forms of GROW leadership, and I could not see any major differences in interview content. All of the people interviewed had fulfilled some formal leadership role and leadership played a role in their recovery. There is also a possibility that my being a fellow GROW member could have shaped the interviews in some way. It would be interesting, in future research, to compare stories elicited by a non-GROW researcher. If significant

differences came to light, then this would suggest that narrative flow was in some way influenced by my status as a researcher and a GROW member.

### Profile of participants

A profile of those taking part in this research was obtained using a short biographical data form (appendix 12). In total, 26 people were interviewed: fourteen women and twelve men. The participants came from eight of GROW's nine geographic regions: South-East (4), Northern Ireland (2), Mid-West (2), West (2), East (6), South (1), Midlands (5), North-West (3). Their ages ranged from the 30s to the 70s, and the average age was 45. The average length of time in GROW was 11.6 years, with a range between 1.5<sup>18</sup> and 30 years. Sixteen (62%) of the sample had been hospitalised at some stage for a diagnosed 'mental illness'. All had been prescribed medication for their 'mental illness', and all had been diagnosed with a specific 'mental illness' at some stage. A number of participants reported multiple descriptive diagnostic terms (see table 5.1).

All of the participants were experienced GROW leaders, all very proficient at facilitating GROW meetings. Twenty-two had served as group organisers, sixteen as group recorders and nineteen had played a role in supporting groups other than their own. Seventeen of the participants had served as members of regional teams and four, of national teams. Eight were GROW employees, seven working as fieldworkers and one as an office administrator. Other forms of leadership involved media work, representing GROW on various bodies such as NSUE, delivering training or helping to organise GROW events (see table 5.2).

The findings chapters include various numbers of direct quotations from each of the participants. While many individuals have been quoted frequently and some less so, all the participants' voices are reflected in the findings (appendix 25). However, I tried to select those quotes and experiences which best illustrate each theme or sub-theme.

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<sup>18</sup> While inclusion criteria stipulated a minimum of three years in GROW, one person was accepted for the study who had only been involved for eighteen months. I did not realise that she did not meet the inclusion criteria until the interview and as there was a considerable distance involved I decided to include her and to use her story to see if there were obvious differences in her story when compared to those of others with a much longer involvement.

**Table 5:1 Demographic and ‘medical’ profile of participants**

Pseudonym	Gender	Age	Number of hospitalisations	Prescribed medication	Participants’ reported diagnoses
Peter	M	30s	1	✓	Manic depression, OCD, autism.
Tom	M	40s	2	✓	Schizophrenia, depression.
Jess	F	40s		✓	Depression, anxiety, panic attacks, OCD.
Kate	M	40s	1	✓	Depression, anxiety.
Mags	F	50s	6	✓	Manic depression, depression, anxiety, nervous breakdown.
Jack	M	40s		✓	Mild depression.
James	M	30s	1	✓	Depression, generalised social anxiety, depersonalisation, psychosis.
Paul	M	30s	4	✓	Schizophrenia.
Mathew	M	30s	10	✓	Schizoaffective disorder, bipolar disorder.
Nan	F	60s		✓	Chronic anxiety, depression, agoraphobia.
Sue	F	40s		✓	Chronic depression and anxiety disorder.
Peg	F	60s		✓	Chronic anxiety, anorexia nervosa.
Ruth	F	70s	2	✓	Depression with anxiety.
David	M	40s	8	✓	Schizophrenia, schizoaffective disorder.
Charlie	M	30s	1	✓	Personality disorder, 'antisocial', addiction.
Gretta	F	60s	1	✓	Depression.
Helen	F	50s	2	✓	Paranoid schizophrenia.
Penny	F	70s	5	✓	Depression, alcoholism
Vicky	F	50s		✓	Depression.
Pat	M	30s		✓	Agoraphobia, depression.
Francis	F	60s		✓	Reactive depression.
Danny	M	40s		✓	Depression, loneliness.
Richard	M	40s	1	✓	Depression.
Cathy	F	50s	3	✓	Bipolar mania.
Lynn	F	50s		✓	Anxiety.
Claire	F	60s	1	✓	Depression, panic attacks, bereavement.

Table 5.2 Profile of participants' involvement in GROW

Pseudonym	Years in GROW	Roles in GROW							
		F	O	R	GS	RT	NT	FW	Ot
Peter	20	✓	✓	✓	✓	✓	✓		
Tom	13	✓	✓			✓			
Jess	23	✓	✓	✓	✓	✓		✓	✓
Kate	12	✓	✓	✓	✓	✓		✓	
Mags	16	✓			✓	✓		✓	
Jack	7		✓	✓	✓				✓
James	5	✓	✓		✓			✓	✓
Paul	3	✓		✓					✓
Mathew	7.5	✓	✓	✓					
Nan	18	✓	✓		✓	✓			✓
Sue	12	✓	✓	✓	✓	✓			
Peg	30	✓	✓	✓	✓	✓		✓	✓
Ruth	20	✓	✓		✓	✓			✓
David	11	✓	✓		✓	✓	✓		
Charlie	3.5	✓				✓			
Gretta	8	✓	✓	✓	✓	✓	✓		
Helen	9	✓	✓	✓	✓				✓
Penny	10	✓	✓	✓					✓
Vicky	4	✓	✓	✓	✓	✓		✓	
Pat	15	✓	✓	✓	✓	✓			
Francis	10	✓	✓	✓	✓	✓	✓	✓	✓
Danny	18	✓	✓	✓	✓	✓			
Richard	14	✓	✓		✓				
Cathy	8	✓	✓	✓	✓	✓			
Lynn	1.5	✓							
Claire	4	✓	✓						✓

Key

PN: Pseudonym

F: Group facilitator

O: Group organiser

R: Group recorder

GS: Group support

RT: Regional team member

NT: National team member

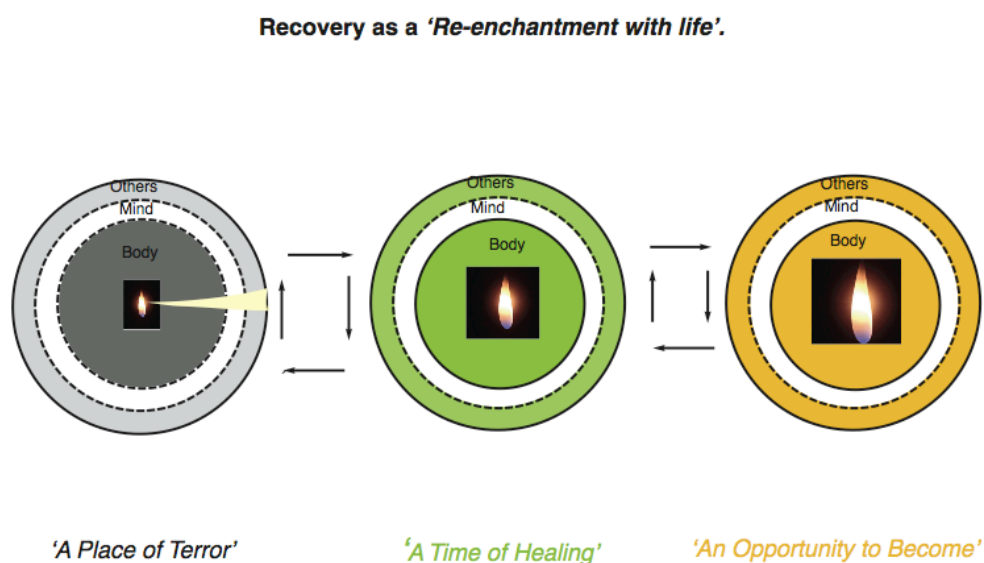
FW: Fieldworker

Ot: Other leadership roles (giving testimony on radio, fundraising)

## An overview of the findings: recovery as a **'re-enchantment with life'**

The aim of this study was to explore the recovery stories of a number of GROW leaders and to explicate the part that GROW played within this recovery. What emerged from the analysis of these interviews was a second-order narrative suggesting that recovery from 'mental illness' can legitimately be described as a process of 're-enchantment with life'. While the theme of 're-enchantment with life' has emerged as the main or most accurate overall descriptor of the recovery process, it is a process that took place in three distinct but non-linear phases, which I have described as moving from a 'a place of terror', to 'a time of healing' and finally to a place conceptualised as 'an opportunity to become'. Recovery as a 're-enchantment with life' is represented graphically in the diagram 5.3.

Diagram 5.3 Recovery as a re-enchantment with life



This diagram represents 'a re-enchantment with life' in three phases. The concentric circles diagrammatically represent the human being as living within a series of very different bodies. Each circle represent a different level of personal involvement with life, moving from the physical to the cognitive and social. The flame represents the life that exists within each person; the white 'cognitive body' represents the individual's mind, which acts as the mediator between what is happening inside and

outside the physical body. The cognitive body (or mind) thus interprets stories of identity emanating from the emotions and from a network of widening social relationships.

The process of 're-enchantment with life' began from a place of overpowering and terrifying emotions, experienced within the physical body, which turned that body into a living 'place of terror'. These emotions – which had many levels of origin – had, over time, served to cut each person off from meaningful relationships with others. This resulted in a state of extreme isolation and a growing inability to determine what was real and what was imagined, what was important and what was unimportant. Life within a 'place of terror' was reported as becoming increasingly difficult, with many participants describing a sense of total despair. Terror was described at a number of levels. As well as terrifying emotions, sources of terror included a person's thoughts and destructive relationships with a wide range of others and were fuelled by the existence of dominant negative cultural narratives about the 'mentally ill'. Participants also implicated alcohol and drugs (both illicit and prescribed) in arriving in a place of terror and, for many, attempts at help or rescue became part of the experience of terror.

'Re-enchantment with life' began when participants attempted to escape from 'a place of terror' and broke through this terrifying isolation by attending GROW. Participants gave a variety of reasons for attending GROW. For many, it represented a 'last chance' after a disillusionment with the failure of professional help to bring about recovery. Others reported being advised and encouraged to attend GROW by their psychiatrist or psychiatric nurse. Still others attended because of local publicity, or out of curiosity and a hope that it might help.

'Re-enchantment through GROW' started within the physical body, when feelings of terror and despair were disrupted or momentarily displaced by glimpses and feelings of hope, warmth and welcome. These initial 'body stories' encouraged each participant to become increasingly involved in the larger social body of GROW which, over time, came to represent a 'time of healing'. Healing was slowly effected through ongoing involvement in enacted stories of personal value, hope and potential for the future. A 'time of healing' was not a straightforward linear process, but often involved setbacks. Nevertheless, over time and with the encouragement and support



of GROW members, participants moved in the general direction of recovery. In time, involvement in GROW prepared and encouraged people to selectively and progressively become involved in niches within society. 'A time of healing' presented GROW as an incubator of hope and healing. Each person was drawn towards a transforming realisation of their own value through a reciprocal mix of witness, belief, friendship and leadership, and slowly began to emerge from terror, confirmed by the ongoing affirmation and challenge of others. 'A time of healing' also contained descriptions of invaluable relationships and experiences that occurred within the mental health system. Membership in GROW facilitated a selective reflection on the healing role of a range of professional treatments.

The last phase of recovery as a 're-enchantment with life' was described as a delight at being able to find a meaningful life through a selective involvement in society. Society – which had recently been experienced as a source of terror – now proved to be a place where individuals could continue to blossom through involvements in work, education or leisure. A 'time of healing' within GROW had effected a personal transformation which made this possible. An 'opportunity to become' was, thus, not the end of recovery but the beginning of a new life where, increasingly, each person became master or mistress of their own identity and where their former suffering and terror now became a source of help for others. Participants at this stage reported taking responsibility for themselves and learning to make wise life choices. They moved on from GROW and discovered accessible resources within areas of work, education and leisure. Successful involvements in society encouraged a desire to give something back to society as a result of their personal healing, and therefore, participants typically reported contributing to the 'social good'.

The next four chapters of this thesis detail the findings from this study. Chapter six explores the sub-theme titled 'a place of terror'. Chapters seven and eight examine 'a time of healing', which is divided into two chapters with respective sub-headings of 're-enchantment through GROW' and 're-enchantment through professional help'. During the interviews it became obvious that, while 're-enchantment with life' came about mainly through healing and reciprocal relationships experienced within GROW, many people also highlighted examples of healing through relationships with mental health professionals. Chapter nine tells the story of life after GROW. 'An opportunity to become: re-authoring a new story' explores people's descriptions

of becoming meaningfully re-involved in various aspects of society. Each chapter begins with selected short quotes taken from the interviews, which graphically encapsulate the essence of the processes being discussed in that chapter. Each theme is then explored under a number of sub-themes. To capture the story and illuminate the issues being discussed, verbatim quotes from participants are used. These quotes have been selected as exemplars and provide deep individual descriptions of the processes at work, which are generally representative of all the participants.

### Summary and conclusion

This chapter focused on how the theoretical and methodological principles of narrative research were applied to this study. It reviewed methods of recruitment, data collection, and analysis, and efforts made to ensure confidentiality and anonymity to those who took part. I have tried to give an accurate picture of how a method of analysis evolved and how this analysis gave rise to a conceptual framework from which to present the findings of the study. It was not a linear process, but one that consistently developed through a dogged practice of reflection and a constant and creative recoding of data. The chapter discussed the strategies I used to enhance the reliability and validity of both the data and my interpretations. The chapter ended by providing a biographical profile of the study's participants and giving an overview of the second-order recovery narrative constructed from their experience. This narrative represents recovery as 'a re-enchantment with life', a process that took place in three phases. The following chapter describes the first phase of my second-order narrative, entitled 'Mental illness: "A place of terror"'.

## CHAPTER SIX: 'MENTAL ILLNESS' – 'A PLACE OF TERROR'

*'I was terrified to tell, terrified to ask'. 'I was consumed with the idea of suicide'. 'I was out of control'. 'I was terrified of being given ECT'. 'It was like driving a car with no brakes and no steering wheel'. 'I was in hospital when my wife told me she was leaving me'. 'My grandson and son both committed suicide'. 'My husband beat me, but so did his mother'. 'When he raped me I felt dreadful'. 'I was abandoned at eleven'. 'My mother would take a stick to me when I was having tantrums'. 'I used to imagine the children lying in a ditch, dead'. 'I thought I had lost my soul'. 'I was sexually abused at eight'. 'I was terrified'.<sup>19</sup>*

### Introduction

This chapter begins the presentation of the findings of this study. It focuses on the first theme of the process of recovery from 'mental illness' as a 're-enchantment with life', conceptualised as living life within 'a place of terror'. The chapter is presented under three sub-themes: 'external sources of terror'; 'the embodied experience of terror'; and 'attempting to escape a place of terror'. It starts by tracing the genesis of terror to a wide range of harmful social involvements experienced – for example within families, schools, and neighbourhoods, and through encounters with people in authority. It then examines individual accounts of the long-term effects of living in terror, and finally, it explores the efforts participants made to escape from terror.

### External sources of terror

The content of these interviews challenges the proposal put forward by psychiatry that 'mental illness' ('a place of terror') is primarily a physical condition where a chemical imbalance within the brain is the dominant, linear cause (Brendel 2006). Within this study, participants described and identified a wide range of factors, events and relationships that contributed to each individual arriving in 'a place of terror'. These external sources of terror included families, neighbours, peers and authoritative others, such as teachers, who were all implicated by participants. Their stories provided evidence of being involved in many traumatic events such as physical and sexual abuse, bullying, neglect, poverty, and tragedy. Internalised emotional stories of terror were described as emerging from negative and harmful

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<sup>19</sup> This opening paragraph is a compilation of statements made by different people in the course of their interviews. Collectively, they highlight the lived experience of terror, while at the same time illustrating many levels of 'cause'.

life experiences which took place within unique social worlds. For example, Charlie's terror was rooted in early family experiences and was precipitated by abandonment and physical abuse:

*'I would have experienced abandonment from my mother at eleven. I just craved her love... I never got it – I got beatings. My father would also beat me and, as I was the youngest, my older brother would beat me too. It was just in the house. I was very, very young. I had no safety'*  
(Charlie).

For Vicky, the actions of a neighbour became her primary source of terror:

*'I was sexually abused as a child. It went on for two years; it made me feel dreadful'* (Vicky).

Neither Charlie nor Vicky had anyone they could tell about the terrifying situation they were in, and this lack of a caring other(s) or sympathetic witnesses were common features of all the accounts of arriving in 'a place of terror'.

While the primary cause of terror could be close to home and involve the behaviour of one or two specific individuals, many participants described how terror could have multiple sources and emanate from within many levels of their wide social body. Events and experiences involving family, school, friends, 'authoritative' others, tragic life events, and cultural mores often provided a consistent stream of negative feedback, which together created a cumulative sense or story of terror. Richard's testimony illustrates this well. It begins with a description of his school and teachers:

*'I had learning difficulties as a kid. I couldn't please my teachers – attention deficit disorder, or dyslexia, or something. I managed to become 33rd in a class of 33, several years in a row'* (Richard).

With a diagnosis of Attention Deficit Hyperactivity Disorder (ADHD), the medical view might explain Richard's situation as stemming from a simple biochemical imbalance or structural deficit within his brain. However, his story soon revealed many other contributory factors, factors that Bronfenbrenner (1977) describes as 'proximal processes'. Proximal processes are experiences 'that occur in the immediate settings containing the developing person, and the larger social contexts, both formal and informal, in which these settings are embedded' (Bronfenbrenner

1977:513). Richard clearly described many such proximal processes. Beginning with his family (an ‘immediate setting’ strained to its limits), he later implicated many social and cultural contexts such as the church, the role of men within society, and the deaths of his father and a friend, which all collectively contributed to his growing sense of terror:

*‘My mother was over in England and for her it was really foreign. No family support and the kids just kept coming and a few miscarriages as well, she was constantly pregnant and having to deal with kids’. (Richard).*

Richard’s primary source of support and nurture, his mother, was under immense pressure. You can feel the chaos in her life – a foreign place, no family support, constantly pregnant, the agony of miscarriages, trying to care for her children:

*‘And my father did what was expected of fathers: work all the hours God would send. He was a builder’s labourer. There were times when I wouldn’t see him for weeks. He would be tired and wouldn’t want to deal with noisy kids. Anything to do with children was “women’s work”’ (Richard).*

Here, a cultural story adds to the pressure: ‘anything to do with children was “women’s work”,’ and so Richard’s father also became inaccessible. Within this context, consistently negative messages – including constant beatings – were coming from home and school:

*‘I couldn’t please my teachers, I couldn’t please my parents. I came to think I was a bad person’ (Richard).*

And then:

*‘What really put the tin hat on it, this priest came in to prepare for confession. And oh, he went into great detail about how awful we were and, like, you know, God was hanging on the cross because of my sins and the only way to get sins forgiven was to go to confession. And not only that, you had to be truly sorry for the sins that you’d committed, and what did that mean? It meant that you’d never ever do that sin again. You know I was only, like, I forget, eight or nine or something, but I knew at that stage I had done things as a child, and I’d said to me parents “I’m sorry, I won’t do that again” and invariably I did. So I knew’ (Richard).*

Richard’s view of being a bad person was reinforced by a priest and, through him, by the supreme authority of God himself. He was bound for hell at the age of 8 or 9 and

'knew' that he was 'done for'. Richard had been involved in many authoritative and proximal dialogues about himself. His mother, father, teachers, priest, and now God were telling him the same negative story. He had no one to go to for reassurance. And then the family moved back to Ireland. He went to an Irish-speaking school and was completely lost. And then his father died, and shortly afterwards:

*'I had a friend in England and he was killed. As I was virtually illiterate I hadn't written to him and remember the wild sense of upset and loss'*  
(Richard).

Two deaths. Here, 'life' was adding a cruel story of its own. Richard's own inadequacies became a source of personal shame and blame. Richard's life had become a theatre of terror. All his fellow actors, including God, illustrated and emphasised his badness through their behaviour or analogic language. Everyone rained blows upon him, and these blows included the death of people he loved and his own illiteracy. On top of this, he knew he was damned.

Pat described a similar slow build-up of terror, implicating many of the same sources and introducing still more:

*'I didn't like school. I was always anxious and nervous as a child. I was bullied. A lot of it is bullying when they see someone is nervous'* (Pat).

For Pat, a major source of terror was bullying by his fellow pupils. The teachers, instead of protecting him, added to the bullying:

*'There was one Brother, he was nothing short of a bully. He should be up for abuse. He used hit me and call me names. He thought nothing of giving you a couple of bangs on the head with his fist. I was twelve. That rattled me altogether. I never spoke about it at home'* (Pat).

Bullying wasn't only physical but included taunts that Pat was 'mentally ill'. He lived near a large psychiatric hospital and from an early age had absorbed cultural stories of madness. The insinuation that he was mad was terrifying:

*'Part of the bullying involved young fellows jeering at you, because you lived near the mental. One time a Christian Brother asked me my address and he said "Go and behave or we will send you into (name of hospital)", and the titter from the boys... I was humiliated'* (Pat).

Pat's place of terror was being built over time and one of the sources of terror was humiliation, which has been identified as an ingredient of torture (Roth et al. 1987). Another was the cultural story being applied to him, that people experiencing 'mental illness' are alien.

A significant number (7) of the participants, including Vicky, who was mentioned earlier, reported childhood sexual abuse as a source of terror:

*'He [the abuser] is dead but whenever I pass the house it creeps up. I knew something was wrong, but felt powerless. It affected the way I was in later years' (Vicky).*

Many studies have linked this experience to a range of 'symptoms' in later life such as behaviour problems, post-traumatic stress, fear, and low self-esteem (Spataro et al. 2004, Weiss et al. 1999, Kendall-Tackett et al. 1993). Being sexually abused has many possible effects and evokes many different stories. Like humiliation, it is a recognised form of torture used to subdue 'the enemy' (Bradley and Tawfiq 2006).

For others, terror began suddenly through the occurrence of once-off, tragic life events. For example, Claire's son and grandson both unexpectedly took their lives by suicide. Claire was so shocked:

*'I was hospitalised with a suspected heart attack, and it wasn't really a heart attack... After all the symptoms, it was only grief' (Claire).*

Ruth identified a life of ongoing, gruelling poverty and hard work as her source of terror: she had ten children and her husband was an invalid, so she had to run the family business. Her husband died, she had a hysterectomy, her mother died, and she worried about her children. Despite this hardship and sadness, Ruth 'put her emotions down', with the result that she couldn't express things like anger. She didn't even have time to cry. She thought that even if she had found the time to express her anger and sadness, no one would have had the time to listen.

*'You didn't have time. I've seen my mother, I've seen my aunts and uncles, I've seen another friend we went to see one time and her husband had rheumatoid arthritis. They were [names family business]. And she had fourteen children. And my mother says "Mary, how are you?" She says "If I had time I would cry". The only way they could deal with life was to put their*

*emotions down. I have found that when you push emotion down you don't express emotion – you can't express anger' (Ruth).*

Many people identified the use of a physical substance such as alcohol or drugs as further sources of terror:<sup>20</sup>

*'It started when I won a bottle of vodka at bridge. I am the only senior player in [mentions area]. It became my night out from the kids. I became regional president in 1984, a lot of drink involved' (Penny).*

Gretta identified the long-term use and sudden cessation of a commonly prescribed treatment as starting a downhill slide into a place of terror:

*'I had a happy childhood, grew up, married; I had no trouble with my children. The only possible reason was withdrawals from hormone replacement therapy (HRT), which I was on for years. I heard on the radio that HRT causes cancer, that was probably what started the problem. The whole system was knocked haywire. I just stopped. I was six months going downhill' (Gretta).*

James identified smoking cannabis as his primary source of terror:

*'At first, the cannabis was almost an escape. But then it started going the other way, into a kind of bad situation. It was like getting on a roller coaster' (James).*

A recurrent feature of the stories told was the absence of someone to talk to about the experiences and the resultant terror. Frank (1995) identifies bearing witness to suffering as key to healing. Time and again, trauma went unheeded, unheard and unwitnessed. For example, Jess, a soldier, recounts:

*'I was in the army for seventeen years, during which a lot of negative things happened. I was involved in taking bodies out of the water that time the Air India crash. You are overseas and you're looking at a fight. I was there when someone got shot. You never get counselling, just a pat on the back, nothing about the thoughts that are there in your head afterwards. Soldiers didn't talk between themselves, never asked how you felt. I was left with all this negative stuff about not being looked after by the army' (Jess).*

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<sup>20</sup> I debated whether to include the use of drugs and alcohol as 'a source of terror' or as an 'attempt to escape from terror'. It is probably both, a fact that illustrates the reciprocal nature of cause and effect in the generation of feelings of terror.



Jess revealed a strong cultural story that soldiers [men] are not meant to be affected by job-related trauma.<sup>21 22</sup> This belief is in direct conflict with his own experience [that] *'the thoughts are there in your head afterwards'*. Individually, soldiers accept this script and so don't even talk between themselves. And Jess's suffering wasn't only from the army:

*'We'd lost four kids through miscarriages. I just love kids. It all started to unravel and fall apart. Losing the kids was soul-destroying, I often wished my life was ended' (Jess).*

Tragedies such as the series of miscarriages had never been resolved; they were, as Jess said, *'soul-destroying'*. The use of the word 'soul' hints at a different level of discourse. Jess is spiritually wounded:

*'I wasn't able to go to work. Just couldn't face being with people. I struggled every day just to get out of bed and realise I had a life' (Jess).*

The participants' reports contained rich descriptions of a wide range of real and damaging life events that became 'sources of terror'. These traumatic events, which involved the behaviour of a wide range of other people, were never resolved or acknowledged by a caring other. The long-term effects of trying to live in a world where legitimate pain went unacknowledged and unresolved increasingly dominated people lives, systematically imprisoning them within 'a place of terror'.

### The embodiment of terror

Traumatic life events such as sexual abuse, bullying, ridicule, and harsh treatment from a wide range of others were consistently identified by participants as initial sources of terror. The initial experience of trauma evoked an emotional response which, according to Frank (1995), disrupted their familiar life road map or sense of 'what's what' and plunged each person into a growing sense of chaos. Over time, this sense of chaos began to affect the way participants thought and behaved. The interplay of unresolved chaotic feelings, thoughts and actions created building blocks for the construction of isolated 'places of terror'. The most immediate effect of the

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<sup>21</sup> Whitaker (2003) reports that soldiers in the USA are now routinely diagnosed with mental illness and that a large proportion descend into chronic mental disability.

<sup>22</sup> Rappaport (2005) suggests that psychology fails to see the relevance of life contexts to the existence of 'mental illness' and so sees no need to listen for and to accounts of traumatic stories.

traumas was an upsurge of powerful and valid feelings, each articulating a [somatic] story of distress. The following are indicative of what participants said:

*'I had this wild sense of upset and loss' (Richard).*

*'It [sexual abuse] made me feel dreadful' (Vicky).*

*'It [sexual harassment by an employer] was disgusting, it was revolting. I was so distraught' (Lynn).*

As already noted, perhaps the most striking feature of these accounts was the repeated assertion that there was no one available to witness these terrible hurts – no one to either help heal the wound or to protect from further harm:

*'No one knew. I was terrified to tell anyone [that I was so anxious I planned to kill myself]. I could not talk about it' (Kate).*

*'I couldn't tell them about the abuse (Jess).*

*'People were just too busy to notice [my growing distress] – they didn't have time' (Ruth).*

Frank (1995) suggests that while bodies are extremely articulate, they speak in a language we cannot immediately understand. Trauma plunges the person's mind into chaos as it desperately seeks to translate distressing feelings into coherent thoughts that will help make sense of and resolve the chaos. Nan, Mathew, Cathy, and Danny aptly describe this chaos:

*'It was as though I expected something awful to happen, that feeling of gloom and doom. I didn't feel the world was a safe place' (Nan).*

*'There was a lot of unease, feeling alienated, that sort of thing' (Mathew).*

*'I didn't know what had happened to me' (Cathy).*

*'Everything came on top of me; I had a feeling of not being able to go on' (Danny).*

Bruner (2002:5) describes the experience of encountering the unexpected as 'perpeteia'. He gives as an example the story of Little Red Riding Hood, who was

greeted by a hungry wolf instead of the kindly grandmother she expected. A ‘peripeteia’ is a turning point, something which dramatically disrupts the direction and expectations of a person’s life. Charlie met abandonment instead of the maternal love he sought; Vicky met a paedophile in the guise of a respected and trusted neighbour. Pat was humiliated by a Christian brother, from whom he could legitimately have expected safety; Lynn experienced sexual harassment from a trusted employer she thought of as a friend. Each of these events created a turning point which undermined an ability to trust one’s accustomed sense of reality. Seligman (1995:62) has suggested that the experience of terror (phobias and panic attacks) triggers ‘catastrophic thinking’. In his view, the mind desperately seeks to find reasons for the terror, and in some cases intense feelings of fear may give rise to thoughts or feelings which have no basis in reality, although they seem to have some basis in logic. Charlie and Danny illustrate this point in their accounts of trying to find a reason for the feelings they were experiencing following being sexually abused:

*‘You don’t think of it as abuse. You don’t even name it – you internalise it and think it is your fault, and at some level you kind of spurn this inner person. You are kind of a lost child’ (Charlie).*

*‘I was sexually abused, I suppose, when I was young, so I suppose it made it that I couldn’t really trust people’ (Danny).*

Both of their explanations involve the concept of trust. Charlie decided his feelings were an indication that he was not trustworthy, and Danny thought that he could no longer trust anyone else. Both of these false conclusions led to increased levels of isolation and set the seeds of an ongoing separation and alienation from others.

Over time, unresolved feelings connected to experiences of terror began to affect participants’ thoughts and their ability to deal with the world. Richard’s experiences led him to believe that he was bad; Sue came to the conclusion that no one liked her. Kate began to think that her death would benefit her husband and young daughters, and Nan began to believe that if she could hide from the world, the terror would go away:

*‘I had just got to the stage where I felt that suicide was the only way to get rid of this, what I was going through. And then death became a better option*

*than the pain I was in. So I thought, like, maybe if I just kill myself, it will be all over, and of course I had a million excuses as to why and how my husband and my two little girls would be better off without me' (Kate).*

*'And my world just got smaller and smaller – the only place that I felt safe was in my bedroom' (Nan).*

Participants' accounts of arriving in 'a place of terror' revealed a complex reciprocal relationship between feelings of distress and subsequent thoughts and behaviours. For example, in the quotation below Sue graphically describes how terror experienced in her physical body gave rise to thoughts that, in turn, became a further source of terror:

*'I would get physically sick at the thought of going home. The thought of eating would make me sick. The thought of putting me into hospital nearly freaked me out. I would be shaking all the time and getting sick. I wanted someone to take out the adrenal gland. It was like getting an electric shock, you just feel this energy shooting through you' (Sue).*

For Sue, everything had become terrifying; she could no longer act normally. She appeared to be living in what Bakhtin (1973) described as 'adventure time'. Adventure time represents a total lack or loss of personal control. Things just happen. Life is driven here, there and back again, and this is terrifying. It is like being shaken by life. Life takes on the guise of an uncontrollable monster. Tom described a terrifying crisis, linking it to a build-up of many unresolved issues experienced over time. The crisis, which he described as 'like a fizzy bottle', triggered by thoughts about his past social traumas, eventually spilled over and manifested itself in his behaviour towards himself:

*'The social-related problems I had sort of escalated then... It's like a fizzy bottle – you shake it, it's going to blow... And then my mind started really going weird then and I started cutting myself, started hearing voices in my head. I was taking razor blades and cutting myself up; I belted my fist through a greenhouse, cut my whole arm deeply open' (Tom).*

Mathew and James also described losing control of their thoughts and how disturbed thinking then affected their behaviour, which in turn generated more feelings of terror:

*'I thought I had lost my soul and the only way to get it back was to drown. I saw Buddhas in the sky. I was very alienated, and troubled' (Mathew).*

*'I was at my wits' end. I didn't know where to go. My mind had lost the run of itself, or I had lost the run of my mind. I had no control over the thoughts which were coming into my mind – it was like driving a car with no steering wheel and no brakes. It was terrifying. My thoughts became paranoid. I was just sure there was a plot happening. It was a different dimension in terms of reality. I felt as though I had walked through a demented gate, you know, like you see on films – it was almost separate. At the height of it I was doing well to get an hour's sleep. I had very, very vivid dreams, you know, and a lot of times I couldn't be sure if I had dreamt something or whether it was actually happening' (James).*

Mathew and James have both '*walked through a demented gate*', entering a really terrifying world where it was impossible to tell what was real or what was unreal. Unlike Tom and Kate, whose destructive behaviour was aimed at themselves, James sensed the problem came from others and his actions were therefore directed at protecting himself:

*'There was a lot of strange stuff going on. It started to turn a bit darker... I felt vulnerable... People were out to get me. I started getting these waves of anger – "And I'm going to do something about this..." I felt very distressed; I didn't know what I was going to do... Just snap at any stage. I was in my bedsit alone and all these thoughts were coming. People were out to get me and I said "well I'm going to go out and sort this out, like". I got a bread knife and put it in my sock. I went walking the streets; I thought everyone in the whole world was out to get me, and that people were pretending they weren't part of the plot. So I drank a few beers. I just got up the middle of the town, the outskirts, and I said I just wanted to know what was going on here – you know, "I've lost it"' (James).*

While the above stories illustrate the way violent emotions and terrifying thoughts escalated to create life and death issues, each of the people concerned still retained enough insight or control to stop themselves from taking their own life or actually harming others. And yet embodied terror can go beyond the limits of reason, with devastating consequences. For example, Paul began to weave the ordinary behaviour of others into a terrifying delusion and committed a serious crime while in that 'delusional state':

*'I was totally paranoid about my friend. I believed he was plotting to kill me. I would have nothing to work against this idea. That was the whole centre of my belief... My friend suggested I go to a hotel and have a sauna; I went in*

*and started to undress and three guys came in with a big bin which I assume is for towels, I thought they were going to cook me and then throw me into this bin. So I dressed and literally ran out of the hotel. I was having a lot of these delusions and was probably paranoid as well. It [killing my friend] happened on a Friday and I was brought to the local police station. I knew what had happened but still believed everything else was real. I believed my friend was a drug dealer and that I had finally uncovered this and he wasn't going to let me get home. I didn't believe he was dead' (Paul).*

Paul's world had become a terrifying nightmare of life and death. He had '*nothing to work against this idea*', no one to check whether his reality was true. Tragically, while in this state, he killed his friend. To add to the terror, Paul woke up in prison and slowly realised his actions within that nightmare had been real:

*'I was just very scared. My cell was barely lit; there was a wire mesh inside. I couldn't read in the light. I just slept for weeks and weeks with my hands handcuffed behind my back and shackles on my feet' (Paul).*

In this story, Paul had become the total embodiment of terror. His terrified feelings gave rise to terrifying thoughts, which in turn drove him to terrifying acts. Paul's body had become a place of terror.

While Paul's situation was dramatically terrifying, many other participants felt pushed to the edge by ordinary things, such as meaningless work and day-to-day relationships. David highlights the impact of meaningless work:

*'I got a job in [names company]. I hardly talked at all. I was busy but unhappy. No hope for anything. After five years I thought "I can't take another five years. I will finish everything"' (David).*

Penny reported feeling increasingly trapped at home with small children in a new town where she knew nobody:

*'That was the start of the depression – I had nothing to do, it was a bad start to married life' (Penny).*

Another effect of living with unresolved terror was that, over time, terrifying feelings seemed to spawn many other negative and destructive emotions. A number of participants recounted the build-up of feelings of hatred, resentment, rage and powerlessness, as indicated by the following:

*'I was so full of hatred, I wanted to kill the bastard' (Jess)*

*'I resented my parents and would go on for hours about them' (Helen).*

*'Self-hatred... I experienced others as negative' (Peter).*

*'I should have had rage printed across my forehead and tattooed all over me'  
(Charlie).*

*'Rejection, that was a big, big thing - I had no sense of who I was' (Frances).*

*'I knew something was wrong but felt powerless' (Vicky).*

Being increasingly swamped by a toxic mixture of destructive feelings had the effect of shutting people off from life. It was marked by a complementary absence of life-giving feelings such as being worthy of giving and receiving love or experiencing joyfulness and security:

*'I would have been happy to give up on life' (Peter).*

*'I wanted to die, to escape the pain' (Kate).*

*'I thought if people got to know me, they wouldn't like me' (Sue).*

In summary, terror was first experienced as a feeling. In the first instant, that feeling was valid, a pretty normal response to an abnormal situation – a call for something to be done, a call for care. Because there was no resolution, the feelings began to undermine a person's ability to deal with life. An increasing inability to trust self and others was central to an ongoing process of contamination by terror. Life was slowly transformed into a living nightmare as terror fed off a mixture of other toxic feelings such as hatred, anger, and despair. These feelings, in turn, began to negatively affect participants' ability to think and behave in a healthy manner, systematically shutting them off from positive relationships with others.

### **Attempting to escape from 'a place of terror'**

Participants reported making various attempts to escape from terror, many of which only served to exacerbate their situation. One of the most frequently reported

strategies was a withdrawal from relationships with others, which led to an increasing sense of isolation. Isolation from others is documented as a form of torture (Hresko 2006). According to Bakhtin (1973), an ongoing integrative dialogue with others is the process by which we maintain our sense of identity and value. Isolation makes it impossible to know who 'I am'. However, isolation was often reported by participants as a personal choice – as a way of escaping. For Peter, negative experiences such as being taunted about his looks, being punished by teachers and being neglected by his family helped create negative stories that justified a withdrawal from social contact:

*'I experienced other people as being negative. I had no friends, not even family members. I became a very angry person, ranting about the state of things. I thought "What's the point of getting involved with other people? They are just selfish"' (Peter).*

However, this withdrawal and the resultant absence of feedback from others left Peter swamped by waves of feelings that turned the dislike of others into hatred for himself:

*'Mood swings when you are down, no goals are set when you are up; you try and do ten things at once. Self-hatred and dual personality. Mr. High, Mr. Low. Emotions all over the place' (Peter).*

Kate similarly takes up the theme of the negative impact of isolation. The effects of 'retreating into myself', emphasised her difference from others:

*'I felt that absolutely no one understood me. I felt that I was different. I retreated into myself when things were difficult' (Kate).*

In another example of becoming isolated, Gretta described her decision to give up work, which only made the situation worse:

*'I got to the stage when I didn't want to go to work, and I loved going to work... I was even worse off then, I missed the company... Knocked the bottom out of it altogether' (Gretta).*

Other participants reported becoming isolated as a result of the actions of others. For example, Vicky found her husband isolating:



*'I felt totally suffocated, I felt my husband controlled everything' (Vicky).*

This control extended to the realm of work, and when Vicky decided to find employment, her husband forbade her to do so. When she protested, he became sexually abusive, undermining her determination to escape from isolation:

*'I wanted to take up a part-time job – he wouldn't allow it. We got into an argument about it. I was to meet a friend of mine the next day, I remember, to go somewhere about this job, and I was determined to go. I was sick in my stomach at the thought of going because of the way he was. He was determined I wasn't going and to make his point, he... He forced sex on me, which I now recognise as rape. I hated him for it, I hated him for it at the time because I felt so horrible and I felt so dirty and used and everything else, but I thought like once you're married that's it, you know – you take what you get, in other words' (Vicky).*

At the time, Vicky's husband's strategy worked and it was several years later that she eventually left him, after continuing to live in what she described as '*resentful silence*':

*'Resentful silence, that would have been me, just boiling over or trying not to boil over rather because I would know there would have been consequences for that too' (Vicky).*

Vicky's description of the impact of her relationship with her husband resonates with Seligman's (1972) theory of learned helplessness. Vicky's efforts to escape the terrifying situations led to punishments, which gave rise to more terror, and a sense of helpless silence set in, which added confusion to the terror.

Other stories described parents discouraging their children from mixing with other children, families moving to new areas where the participants knew no one, teachers and classmates excluding and ridiculing. All of these situations led to the same isolation and loss of positive personal stories that could support a person's mental health and sense of being 'at home' in the world.

A small number of people reported making radical choices that they hoped would alleviate a growing sense of terror, but in reality only served to increase its levels within their lives. Vicky's parents persuaded her not to run away with an older man at the age of thirteen; even so, she married very young and ended up in two abusive

relationships. Charlie described how attempts to escape his own abusive family by moving in with a kind, motherly figure placed him in even greater danger:

*'I was eleven and the woman of this house was, what I thought at this stage... offering what I couldn't get in my own home, which was acceptance and love. But basically she was supplying me with drinks and drugs and there was sexual abuse... I went looking, I went looking for safety... I could smoke there, I could take drugs there, I could drink there – but it came at a price'*  
(Charlie).

At some point in their struggles, each person in this study sought professional help in an attempt to escape from 'a place of terror'. For some, this course of action played a small part in their healing (see chapter eight). However, many others' experiences of mental health services only served to provide new stories of terror. One of the main reported negative experiences of dealing with mental health professionals was a consistent lack of interest in them as individuals with unique and meaningful stories of suffering. Even within the system of care, there was still '*no one to tell*'. Participants were never invited to tell their stories of suffering or why they thought they needed help. No one appeared to have the time to listen. They were offered neither compassion nor practical help to deal with unresolved issues. Mathew suggested the main reason for this was because the professional lens through which he was viewed rendered his experiences of life irrelevant:

*'They are really only concerned with symptoms and how the medication is responding. They are trying to find out your symptoms and they are worried about medication. Is he drugged too much or not enough?'*  
(Mathew).

Time and again, participants described a lack of interest in them as persons and a lack of warmth within the therapeutic relationship. Danny described a first visit with a psychiatrist, which he found disturbing:

*'I found that I couldn't make sense of what he was on about. I mean, he was writing and I was trying to read what he was writing. He wasn't looking at me when he was talking to me. He wasn't making any contact at all, so I was wondering what's he rambling about. When I look back on it, like, when he was talking, he was talking and writing and writing and asking me questions and writing but he wasn't actually looking to my face, you see – do you know what I mean?'* (Danny).

Mathew and David experienced the same lack of personal interest over a long period of time from the nurses and other practitioners:

*'I can nearly count the times on one hand where a nurse would actually talk to me... even for three or four minutes. It just didn't happen' (Mathew).*

*'The longest conversation I had with any professional was ten minutes in twenty years. Extraordinary, isn't it?' (David).*

Levinas (1969) suggests that care of a human being consists of two parts. While one part may involve making professional interventions, such as diagnosis and treatment, by far the most important form of care is centred on a compassionate understanding of the uniqueness, the needs, the value, and the suffering of the one to be cared for. Care means 'gazing into the face' of the unknown other (Levinas 1969:110). It involves the emotions and, most importantly, it involves the expression of compassion. However, for many participants this was absent. Even when participants did meet with friendly professionals, the medical lens through which they viewed the world only served to heighten their distress. For example, David became involved with a friendly doctor; however, the overall effect of these meetings was still a reminder that he was 'mentally ill':

*'He would ask me how am I, how are things and we would get on well because I kind of liked him to talk to, he's good fun. So I'd go and see him and I'd enjoy seeing him. But he just prescribed medicine and he would confirm to me that I was mentally ill' (David).*

Peter's doctor conveyed the same disempowering medical story by appearing on television, a media that amplified the authority of his view as it cast him in the role of expert. The effect of this was to rob Peter of any hope for the future and to remind him of the doctor's lack of warmth towards him, 'a cold fish' rather than a human being:

*'My psychiatrist appeared on television. He was doing research that maintained that people like me with 'mental illness' have different brain structures. He was a cold fish, an expert on brain structure. I probably would have been happy to give up on life in hindsight. I thought at that time that I was permanently damaged and would be stuck in some kind of workshop for life' (Peter).*

Kate identified two factors which she believed undermined the possibility of being listened to and of being properly understood and realistically helped. The first was a lack of time on the part of the professional, and the second was an inability on her part to identify and articulate what was wrong:

*'The GP has an average of five or six minutes to give to you and if you are suffering from a mental health difficulty... You know [what] I mean, Mike... I often sat down in front of the doctor or the psychiatrist and they would say to me "How are you?", and I can honestly sit here and say that I consider myself – and always have – a fairly intelligent, articulate person, and I had no words to describe how I was feeling' (Kate).*

Because Kate could not articulate what was troubling her and the doctor had so little time to listen, she was first of all given medication and then hospitalised – an experience that she found traumatic:

*'Absolutely nothing, nothing existed – you just shuffled, you know what I mean? ... Most of us just strolled around the square all day and, you know, I remember taking on this kind of slow walk thing, that we were just kind of strolling around this square' (Kate).*

For many others, the hospital experience was also extremely negative, an experience that generated numerous fears. David said *'I was terrified out of my wits for three months, every minute of every day'*. Mags also reported being terrified, fearing that she might be given ECT, as at one point she was given, without consent, a new drug that was being tested. Penny listed a litany of events, people and surroundings from within the hospital which added to her sense of terror:

*'It was horrible; it was depressing. The door locked and you were sleeping in a dormitory upstairs at night – I was frightened in it. The men's dormitory was there and they, three that were on at night – one woman and two men, nurses – their office was between... They used to go asleep, and sometimes at six o'clock in the morning this man would walk in, say the "Our Father's" and I was terrified. And the toilets were dirty, and it's one thing I'm very, you know, particular about' (Penny).*

Mathew was also disturbed by the behaviour of another patient while in hospital and discharged himself after three days:

*'A very psychotic man would come up and pretend to shoot me; this was disturbing me' (Mathew).*

For Cathy, being in hospital had ominous portents for the future. She felt she would stay there permanently, it was stigmatising and only added to her fear:

*'It was a big stigma and a big realisation, "Oh my God, I'm in hospital. I'm not going to get out. This is me, locked up"... The fear' (Cathy).*

For all the participants in this study, medication was the first, the main and often the only kind of treatment offered. Despite psychiatry's claims for scientific accuracy, overall it seems to have been experienced as very hit-or-miss. In some cases it had immediate and terrifying side effects:

*'They [the tablets] made me vomit. I would go out and my legs would turn to jelly. There were all sorts of things. You would get mentally confused, your hands would be shaking, you would start coughing' (Pat).*

*'The tablets started me shaking, and shaking, and shaking' (Ruth).*

Peter's experience of medication was traumatic; he experienced what he called a 'high', which he believed was caused by the prescription of an antidepressant:

*'I found it traumatic... I went on this massive high, it felt like if you keep pumping air into a tyre [and] it explodes. It felt like my brain would blow up like a balloon and burst... I was put on an antidepressant and hospitalised for being high, and not being low. I discovered afterwards that if you are manic and you're given an antidepressant there is the danger it will send you too high and that's what happened to me' (Peter).*

For other participants, addiction to prescribed medications often became a huge problem:

*'Addiction was a core element of my problem, I took on the responsibility of giving up drink and switched to prescription drugs, which I ended up abusing' (Charlie).*

*'I started taking this medication and I became very, very dependent on tranquillisers. To go outside the door, you see, was a nightmare for me and I'd have to pop tranquillisers, I was popping them all day and, you know, if I had to do the smallest task I'd have to be taking tranquillisers before I left the house' (Nan).*

*'It dawned on me that I needed more tablets to get the same kick. I often took more than sixteen' (Kate).*

As well as addiction, many people, such as Kate, spoke of terrifying withdrawals when they began to wean themselves from medication. The withdrawals were even more terrifying than the worst of Kate's 'mental illness':

*'I suffered the most intense withdrawal symptoms. Yeah – oh Jesus, I mean what never happened to me in my worst day of being ill, happened to me when I was coming off of the drugs... That was, I saw things that weren't there – hallucinations – and that was absolutely terrifying' (Kate).*

Many people found that if they stopped taking medication, they were automatically discharged from seeing a psychiatrist and denied any other kind of help. Peter found it extremely hard to stop taking medication. During this intense period of struggle, he received no encouragement, and when the doctor heard about it there was no discussion – just a sense that what he had done was wrong. The doctor seemed to be waiting for Peter to relapse. To him, recovery involved maintaining medication:

*'The interesting thing when I stopped taking any meds in '96, the doctor stopped seeing me as though saying "If you won't take it, there is no point seeing me". I sense he was waiting for me to crack up' (Peter).*

Tom had a similar experience. When the medication failed to alleviate his suffering, he asked the doctor when it would begin to work. The authoritative answer fueled his growing sense of terror. It wasn't just the doctor's words, but the 'embodied subjectivity' (Burns 2006) of his gloominess and the low level of expectations that left Tom feeling that even when the current 'rough time' was over, there was very little that he could hope for:

*'So I says to [the doctor] "Look, I can't go through life like this here". I says "When does this medication work?", because I think sometimes we think it's a bit like a physical illness – you take the tablets, you rest, and you're going to get better – but there's more to it of course, "mental illness"... And I says "I want to get better", I says "I want to get a job, I want to get a car, I want to get friends, I want to try and get somewhere in life there, all these things..." And he sort of looked very gloomily at me, and he said "Well now Tom, you're going through a rough time, very bad time". He says "I'm surprised you're actually able to go home at all", and he says "Well, you'll be on medication for life. I don't think you'll ever hold down full-time work. Friendships will maybe be difficult but you'll make friendships within the hospital". He said "You'll never drive, never drive. You'll never have a house of your own, never have relationships"... All those things. It was a total write-off. It was huge. I would have been nineteen, I was only nineteen that stage. So at nineteen, you're sort of getting written off for life... Everything*

*was very gloomy forecast. And I away home, and all I could think about for the next week or two was, "Wow, what do I do now?" (Tom).*

Maybe the stark 'reality' of the medical view, embodied in the manner of the psychiatrist, challenged Tom's spirit, because he decided to try to help himself by slowly giving up his medication. As he did so, he met a mixture of experiences. First of all, his body began to articulate alarm and he had withdrawal symptoms. Then his mind began to clear, which he put down to clearing his system of drugs:

*'Oh, there was times I found I nearly ended up back in the hospital again, it was very difficult to get off. But I did get to the stage where I only needed the anti-psychotic one occasionally, not every day. My mind thinking was a lot clearer, I was getting a lot of these drugs out of my system' (Tom).*

The next step was to communicate with the doctor, but his words and actions were met with incredulity:

*'And he sort of looked at me over the glasses, like this here, and he says "Lad, you're having me on! You just can't do without them!"'*  
*(Tom)*

The doctor's whole training, authority and belief system was being challenged; what Tom had just said was impossible. When Tom refused an offer of immediate medication, instead of offering other kinds of support, the psychiatrist ended the whole relationship, and with a smile, he delivered a prophecy:

*'And so he says "Well, there's no point in you coming in here then, so I'll discharge you. Aha, but..."', he says, and smiles, "I think you'll be back sooner than later". But I wasn't back for another nine years, when he retired' (Tom).*

David also reported meeting some mental health professionals who insisted that medication was indispensable to treatment. He had been treated with many different drugs over a period of twenty years, none of which worked satisfactorily. A new drug was tried:

*'Some new tablets sent my heart crazy, so I was brought into hospital and the doctor took me off everything. I was completely OK. They thought it was amazing, completely staggering. I told him it must be GROW and he said "How can it be anything to do with GROW?" and yet he changed my*

*diagnosis from schizophrenia to depression. He still thinks it was drugs that made me well' (David).*

Kartalova-O'Doherty and Tedstone Doherty (2010) reported that participants in their recovery study had to fight to have medication reduced. Tom described how he had to fight to access to a non-medically trained mental health professional:

*'They never suggested I see a psychologist. They seemed to be very much in control, down there. I didn't know till later years that there was one'*  
(Tom).

Richard, who believed his 'mental illness' was closely related to a failing marriage was never offered marriage guidance:

*'Why would it help, when I had such a wonderful wife...'* (Richard).

The story of how Tom finally managed to see a psychologist more than illustrates the iron grip of the medical story which had been so much a part of the construction of his 'place of terror'. He was convinced by a social worker that a psychologist would be helpful:

*"Right Tom", she says, "I want you to go and talk to your GP and tell him that you need to book in to the psychologist". I says "I never heard tell of one". And she said "your psychiatrist, he'll not even mention that, and he might even try and stop it. I'll try and intervene a wee bit there", but she said "I have to be very careful in this" in case she gets into trouble, but "don't be afraid to push your GP, and even the psychiatrist as well"' (Tom).*

The fear which Tom experienced through dealing with what Holmes et al. (2006) describes as a 'micro fascist body of knowledge' (a body that actively seeks to eliminate other voices) was shared by the social worker, who was afraid she would get into trouble by providing an alternative or complementary type of help. She warned Tom to expect a negative reaction if he requested a referral:

*'The psychiatrist definitely didn't want me to see one. She said "There's no point in you going there", and I said "No, I want to give it a bash here". And so the GP then, he pushed her [the psychiatrist] as well, so eventually she [the psychiatrist] passed me on to another psychiatrist, who was probably the worst one I've ever seen'* (Tom).



This interchange would seem to represent a denial of human rights: Tom was being denied access to alternative professional stories about his ‘mental illness’.

This section has explored accounts of how participants unsuccessfully sought to escape from terror through a systematic process of self-isolation, moving away from identified sources of terror and seeking help through the mental health services. In all cases, attempts at escape proved counterproductive and only added more experiences of terror from a range of additional sources.

### Summary and conclusion

This chapter has explored participants’ experiences of ‘mental illness’ as a progressive entrapment within ‘a place of terror’. Firstly, it identified multiple ‘external sources of terror’, described as traumatic and harmful events and relationships with a wide range of other people. In so doing, it challenged the dominant medical view that life contexts are irrelevant to the genesis of ‘mental illness’, and that mental health is solely dependent on a balance of chemicals within the brain. Two common features of these harmful encounters were the absence of a caring other, who could either heal the hurt or put an end to the source of terror, and a breach in trust. The ability to trust oneself and at least one other has been identified by Anthony (2000) as an essential ingredient of mental health.

Participants then described the ‘embodied experience of terror’ as a process of progressive isolation and alienation from others. Valid but unresolved feelings, which arose from real life traumas, gave rise to negative thoughts about self and others. These thoughts, in turn, nurtured further destructive feelings of hatred, rage, helplessness, and despair. Participants reported increasingly becoming prey to destructive feelings and thoughts which, in some situations, rendered them ‘delusional’ and led to destructive behaviour towards self or others. Finally, the chapter described participants’ accounts of ‘attempting to escape a place of terror’. The commonest attempts to escape were to withdraw from relationships with others or to seek professional help. Participants described how, instead of proving helpful, both of these strategies exacerbated the sense of terror. The mental health system failed to provide a compassionate and listening ear or to empower participants to deal with their initial sources of terror.

The next chapter addresses what happens when people begin to escape from ‘a place of terror’ and explores ‘a time of healing’ within the GROW community.

## CHAPTER SEVEN: A TIME OF HEALING –BECOMING RE-ENCHANTED THROUGH GROW

*‘That night going home I felt I had been lifted’. ‘I felt that I’d got hope, and hope had never occurred to me before’. ‘I felt so comfortable inside in that room’. ‘It was the very same, it was your best friend that you’d met after years’. ‘There were all these smiling faces looking towards me’. ‘That fear I had sort of left me, I felt at home very quickly’. ‘I felt “If I am going to get better, this is the only place that this can happen”’. ‘From the get-go, I connected – I had lost that sense of connection’. ‘To meet these people that seemed to understand me was amazing, absolutely amazing’.*

### Introduction

This chapter continues to explore the processes of recovery from ‘mental illness’ as an experience of ‘re-enchantment with life’. It concentrates on the phase of recovery entitled ‘A time of healing: becoming re-enchanted through GROW’. The chapter is divided into eight sub-themes which describe the various ways people were enabled to heal through membership of GROW. It begins with a description of accounts of ‘struggling to attend’, and goes on to describe the initial experiences of GROW, conceptualised as ‘experiencing a warm and emotional welcome and the genesis of hope’. The manner by which hope was nurtured is explored through the sub-themes of ‘experiencing friendship and reciprocal relationship’ and ‘experiencing GROW as an extending family’. The sub-themes ‘experiencing challenge and support’, ‘learning to take responsibility for recovery and the role of leadership’, ‘the healing power of goodness’, and ‘learning to author a new story’ were also prominent in participants' accounts of ‘becoming re-enchanted through GROW’.

### Struggling to attend

It became clear from the participants’ accounts that a decision to attend GROW could be difficult. Attendance was often motivated by a desire to escape from the chaotic effects of ‘mental illness’, a general mistrust of people and, frequently, a disillusionment with professional forms of help. For example, Mags struggled with the idea of attending GROW for a number of years before finally becoming a regular member. In the end she joined more or less out of desperation:

*‘I had tried everything and I knew what was ahead. It had been going on now for nearly seven years. I had felt suicidal over the break-up of the engagement;*

*I had two attempts, and then this last time I was in hospital and I thought "Right, that GROW crowd, I'll give them another shot", because I knew what "Plan B" was' (Mags).*

Mags decided to attend GROW because she was afraid of her suicidal feelings and what they might lead to, and because encounters with professional help were increasingly ineffective. Similarly, Peter went along because his experiences of the mental health system had become part of his despair – perhaps GROW might offer an alternative:

*'There was an article about GROW in the local paper. I went along because perhaps GROW offered a way out' (Peter).*

Kate and Danny both reported attending because a relative brought them along. For both, attending GROW appeared a better alternative than hospitalisation. Helen reluctantly went when a nurse in a day centre suggested it might help. For others, even when a decision to attend had been made, coming into the group involved a long-term struggle. Jess clearly describes the difficulty of breaking through his isolation and overcoming his fear of others:

*'At the start, I resisted. I just couldn't face being with people. For six months actually, I'd sit in my car and I would go home and my wife would say "Well, how did you get on at the meeting?" and I'd say "It was grand". I sat outside the building every week for six months and then I got so bloody cold I had to come in [laugh]' (Jess).*

Irrespective of the initial struggles and the variety of issues that motivated the participants, once they had made the decision to attend their first GROW meeting, many described the strikingly powerful and instant effects it had on them and the power of the initial welcome.

### Experiencing a warm and emotional welcome and the genesis of hope

All the participants spoke of experiencing a warm and emotional welcome. Words such as 'safe', 'wonderful', 'enjoyable', 'mind-blowing', accompanied by accentuating adjectives such as 'so' or 'really', all described spontaneously awoken and positive feelings. It was as though the group was experienced as a powerful human tranquilliser, a social or spiritual body which calmed the wild horses of emotion. In fact, it was more than being calmed; there was also a recognition of

something positive and promising, as suggested by the following quotes:

*'I got a sense somewhere in the back of my head I could identify and relate to what was going on; I connected, and I had lost that sense of connection'*  
(Cathy).

*'That fear I had sort of left me, I felt at home very quickly'* (Penny).

*'There is something mystical about a good GROW group. You reach each other at a level of deeper understanding and just this sense of shared humanity. You get a sense there is a spiritual presence'* (Peter).

Peter talked about the idea of spirituality, something that transcended the individual human being. For some, that spiritual presence was represented by emotional warmth and the overtly expressed friendliness of others. Friendship became a tangible spirit, emanating from different people:

*'The minute I walked in the door there was a feeling of warmth, a feeling of not being on my own any more. It was a warmth, it was a smile'* (Cathy).

For others, the first meeting was recalled as an experience of being understood and a promise of recovery. For Nan, there was a spirit of reciprocal recognition:

*'At my first meeting, I was desperately nervous, falling off the chair with anxiety. That was the beginning of my recovery. It was so wonderful – to meet people that seemed to understand me was amazing. I felt "If I am going to get better, this is the only place that can happen"'* (Nan).

Nan felt that she was understood; that her suffering had been recognised. Her spirit lifted as she, in turn, recognised the group as her place of healing and as her emotions changed from anxiety to wonder. Pat's curiosity was awoken and he, too, sensed that this was what he needed. The group was, above all, friendly:

*'I said "This is great", the one thing that stood out amongst everything else was how friendly they were'* (Pat).

From these few statements a picture emerged of an awakening sense of belonging, of being valued and empowered. Many participants suggested that it was the awakening of hope that became the primary catalyst of recovery. Hope has emerged recently as a member of the 'positive psychology family', which recognises this spiritual

resource as a vital ingredient of well-being (Chang and DeSimone 2001, Snyder et al. 2002). According to Snyder et al. (2002), hopeful thoughts drive the emotions and evoke a sense of well-being at both a personal and a social level, offering the promise of love, meaning and belonging.

Mags was at the nadir of despair when she attended GROW. At that first meeting, she recalled hearing a young woman telling her story. This experience not only encouraged and positively challenged Mags, it gave her hope:

*'She was looking a million dollars, fully recovered and so warm and friendly. I felt that night going home that I had been lifted slightly. I felt I'd got hope, and hope had never occurred to me before! I just feel today you can't go into a supermarket and buy hope' (Mags).*

For years, Mags had been struggling with 'mental illness', and on seven separate occasions she had gone into hospital looking for help. She had taken 'any number' of different tablets and seen many psychiatrists, and yet, during all that time, 'hope had never occurred to me before!' In fact, professional help had become a part of her current despair. Now, within the space of two hours, there was hope, a hope that beckoned her. Hope, felt deeply within her body, contained a new story which rallied her spirit, tentatively offering a new direction, inviting the first step on a new and exciting journey:

*'I think that's the very first step, hoping that, you know, I can get well and stay well. That was the start, the example of the other person in the group who made such a huge recovery from such unthinkable and terrifying stuff'*  
(Mags).

The story Mags heard was about recovery 'from such unthinkable and terrifying stuff'. It put her own troubles into perspective, rendering them more manageable and creating the beginnings of empowerment. Over the next six weeks her hopeful feelings began to consolidate:

*'I felt, you know, "I'll go next week", so I went. I wasn't sure exactly what I expected; I wasn't even capable of thinking that far ahead, because I had nearly ended it. I was just struggling from day to day at this stage. I felt I was getting something out of it but I couldn't quite say what. It started with hope'*  
(Mags).

Bakhtin (1973:181) has described the appropriation of ideas as part of an ongoing process of human growth and change. In his view, there is an unspecified time lag between the 'trying on' or 'ventriloquation' of a new idea and when that idea becomes meaningfully part of a person's own identity and story. In keeping with Bakhtin's ideas, it appears that at the early stage of recovery Mags could not articulate what the promise of hope would be. Hope was first experienced within her body (Frank 1995), but required the passage of time before she could discover or construct a meaning from that feeling. This hopeful feeling encouraged her to go back to the meeting the following week. In another interview, Frances spoke about the resonance of ideas, which may well be part of appropriation:

*'Someone can say something, you listen and it's gone. When it resonates, it not only stays but it does some kind of transformation as well. It can be physical and emotional, everything. It changes, it's not come and gone. I suppose GROW resonated with me all along. It called me forth, if you like, and it's still doing it' (Frances).*

Jess described his first meeting as an encounter with joy:

*'It was so enjoyable. There was one man there around my own age, even a couple of years younger. He was being grilled but he took it on so well. If someone had spoken that way to me I would have said "You can feck off", but they weren't talking to me, they were talking to someone else. That was a learning experience. I said to myself "Jesus, I should be able to do that, I should be able to sit and take that kind of constructive criticism". But they weren't just criticising now, they were praising him for simple little things like, you know, for getting outside his front door because he suffered from agoraphobia. I felt so comfortable inside in that room with these people'*  
(Jess).

Jess witnessed an encounter that challenged his understanding of what Frank (1995:8) calls his world view, or sense of 'what's what'. Another man, who could be him, was being challenged and encouraged to step out of fear. There was no sense that the group saw being afraid as a sign of weakness. He was praised for having the courage to confront that fear. He was summoned to bear witness to his own courage, and that summoning of the other touched Jess. It was as though there was an interchangeability of self. Jess was able to see himself as the other young man, just as Mags was able to relate to the woman who gave her testimony. Through witnessing the 'other', who could be him, Jess glimpsed new possibilities of becoming, new hopes of a different future. He was placed in what Bakhtin (1973)

has called biographical time, a time that is at the cross-section of the past and future, a place that suddenly contains resources in the form of other people. People, who Jess '*just couldn't face being with*', suddenly became '*so enjoyable*'. The common testimony of participants described the initial experience of attending a GROW meeting as one of positive emotional and spiritual impact. Awakened feelings of hope, joy and belonging encouraged an ongoing healing transformation, which was then nurtured through the medium of friendship.

### Experiencing friendship and reciprocal relationship

The experience of friendship was mentioned, time and again, as being the medium through which seeds of hope and joy were nurtured and which, in time, gave rise to new thoughts, new relationships and a new sense of identity. Boulding (1956) sees friendship as transcending the limitations of being human. For him, friendship is part of 'a theology of creation'; friends encourage each other 'to let go of life-draining images and roles imposed on human beings by social and cultural expectations' (Boulding 1956:31). Friendship, when seen in this light, liberates those it touches from the identity of 'mental patient' or 'cacogenic other', and renders them human and tangibly valuable. Friendliness, initially experienced as an outpouring of warmth and welcome, was repeatedly described by all the participants:

*'It was the very same, it was your best friend that you'd met after years'*  
(Gretta).

The ongoing experience of being subjected to overt acts of friendship appeared to create a channel – a spiritual umbilical cord – through which personal resources such as hope, courage, wisdom, acceptance, and love were transferred from one person to another within the nurturing womb of a community. Friendship made people realise they belonged and were no longer outsiders, and that it was possible to change:

*'I wasn't someone who mixed [with others] but they made me so welcome I got hope and began to open up'* (Penny).

*'Part of the support is encouragement to change'* (Vicky).



Friendship within the group managed to transcend barriers of age, sexualities, gender, religion, and social class. All these differences appear to be superficial in the context of mutual help, as illustrated by Peter:

*'Mary was talking about having this paranoid notion that people were always talking about her. And I was having the same thoughts because I was so isolated. We connected, though I was the youngest, at eighteen, with this 76-year-old woman who was the oldest there' (Peter).*

Gender stereotypes are also set aside, with men and women interacting as fellow humans, rather than sexual beings (Kercheval 2005). For example, Kate is helped through many a sleepless night by Pat:

*'Pat was a night security man, we were a match made in heaven. I couldn't sleep and he was working all night. Part of his job was every hour he had to go on a check. In between he would phone me and we would talk for hours' (Kate).*

David also describes his experiences of a person, who happened to be a woman, as an inspiration:

*'There was a woman called Jenny, she's organiser here in x Street. She'd ring me up on a Saturday. I had problems with feeling rejected. She's kind of an inspiration. I mean, she was no different from me but she was an inspiration to me at the time' (David).*

For Vicky, the opportunity to have ordinary friendships with men was something she had not been allowed to have:

*'It was good to make friends with men and women. I wouldn't have been allowed to meet men. It was quite strange – it felt quite awkward at first. I felt like a bold child. Now having men friends is not a big issue' (Vicky).*

Peter contrasts the experience of a group of people honestly striving to overcome problems collaboratively with the traditional hierarchical and non-reciprocal relationships that exist within health or education. For him and for many others, the experience of '*honestly striving together*' became an uplifting experience of a positive power that was greater than, and could transcend, the spirit of any isolated individual:

*'There is something mystical about this realisation of how we are interconnected. We are all unique, but we have these common struggles and we can have a positive effect on each other. It is very different to the whole doctor-patient, teacher-student thing of the more educated person trying to pass on wisdom. It reminds of the Bible saying "Where two or more are gathered in my name..."' (Peter).*

Riessman (1965) noted that the key benefit of mutual help was being able to give, as well as to receive. Within the group, friendship, that at first appears unidirectional, flowing from the existing members of the group to the newcomer, soon becomes reciprocal. Claire gives an example of this by describing her experiences. Early on, all she could do was be there in her pain, where nothing was asked or expected from her:

*'I would try to say little things, but I'd cry, and somebody was always there to rub my arm or put their arm around me' (Claire).*

However, within a short time Claire joined others in reaching out to a newcomer, a young man:

*'He wouldn't speak. He was shy. He just blossomed into this very confident young man now, and we encourage him, we give him a clap' (Claire).*

Claire described her experience in the group as a live and compassionate drama. In scene one, she dared to reveal her brokenness and vulnerability and this was met with expressed acts of compassion. Group members rubbed her arm and put an arm around her; they closed around her woundedness and confusion. Then, in scene two, she was called to become a vehicle of compassion for another, a young man who had joined the group. In this way, 'love' worked in her, through her and as her.

Participants' accounts of the healing power of friendship revealed how group members enacted their stories of love for one another through their body language, the expression in their eyes, through the emotion of tears and laughter held within the timbre of their voices. It also showed that each person was quickly called to be a friend by expressing their compassion for others. In this way, the terror of being 'mentally ill' was transformed into a reciprocal belonging, creating what Schweitzer (1931) called 'a brotherhood of suffering'. As Konstan (1997:108-109) suggests: 'friendship [compassion] dances round the world [the GROW group] proclaiming to

us all to wake up for happiness’.

An emergent theme from the previous chapter was the continued absence of a caring other(s) who could bear witness to a growing sense of terror. An important part of the reciprocity of friendship involved compassionately witnessing other people’s stories and being encouraged to tell your own story. For David, hearing other people’s stories validated his struggle so far:

*‘The idea that I’d struggled for years and that my struggle was somehow worthwhile – this was the initial effect of hearing people tell their stories’  
(David).*

Witnessing other people’s stories broke the bonds of isolation, making participants realise that they were not alone:

*‘The testimonies, I found that really valuable because I realised that there were a lot of others who had been through traumas’ (Paul).*

Listening to others’ stories opened the way for participants to tell their own. Rappaport (2005a:796) suggests that telling personal stories creates meaning and has powerful effects on human behaviour, as ‘they [stories] tell us not only who we are, but who we have been, and who we can be’. In other words, telling one’s story can be transforming:

*‘It began to make me feel differently. I felt a different person because I could now talk about issues. I started to think more positively about myself, to look at my better points and strengths and how I can change things’ (Vicky).*

*‘So, a lot of time, [I would] talk to the group about my story and that was healing – not only the telling; it was healing because people knew what I felt – they empathised, they understood, they were interested’ (Mathew).*

Many participants reported carrying immense personal burdens such as rape, sexual abuse, bullying, abandonment, betrayal, failure, tragedy, and loss. Healing involved being invited to talk about these things, knowing they would not be judged, labelled or shunned because these things had happened. Healing witness involved unconditional and positive acceptance and affirmation. Perhaps just as important as finding a solution to a problem was having a safe place where it was OK to have

problems, as described by Charlie and James:

*'The first level where GROW helped me was the idea that I'm going to have a safe environment, em... to actually share some of my so-called madness' (Charlie).*

*'That two hours every week was a real sanctuary, a great resource. That I could go in and just be there in a safe environment and just talk a little bit was like lifting a great burden' (James).*

Vicky describes how *'telling the untellable'* to her group helped her. In her interview, she described innumerable things that had happened to her and which she had never talked about, such as childhood sexual abuse, losing twins through a late miscarriage, being beaten by her husband and mother-in-law, and being raped:

*'GROW allowed me to recognise my feelings. It gave me permission. All my life I have had this anger thing... "It is wrong to lose your temper; it is selfish to say no". GROW was a safe place to say things and to learn that it is OK to say no, or to get angry if a situation warrants it' (Vicky).*

For Vicky, being listened to and being believed allowed her to own and take control of her feelings and to begin to work her way out of her emotional prison by changing her thinking and behaviour. In this way, she began to heal herself, as positive thoughts and actions opened up new possibilities. The experience of listening to other people's inspirational stories of suffering and recovery and, in turn, being actively encouraged and affirmed for telling your own story was reported as one of the most important events within a *'re-enchantment through GROW'*. Its effect was to create a *'brotherhood of suffering'*, to which each person recognised they belonged.

### Experiencing GROW as an extending family

Several people used the term *'family'* to describe their experience of being part of a weekly GROW meeting. Chambers (1999:349) define family as *'a group of people related to one another or otherwise connected'*. Repetti et al. (2002) identify the family as playing a vital role in the healthy mental and physical development of children. They suggest that abuse, neglect, poverty or tragedy, experienced at an early age in the absence of a nurturing family, adversely affect physical and mental health in later life. The participants in this study described the group as a family

which provided a second chance – a place where healing occurred even in the face of ‘chronic and irreversible’ hurt. As Peg states:

*‘GROW was a little bit like being born into a different family and being given another chance’ (Peg).*

For Richard, GROW became a place where he experienced the love that was absent in his childhood relationships:

*‘I was loved back to health. The time people gave me when I was ill, the effort people made for me, it was wonderful’ (Richard).*

For Claire, the group, as family, provided a place where she could be healed and recover from the tragic double suicide of her son and grandson. A relationship with a young man in her group began a healing process and a way back to life:

*‘This young [man], he’s in his thirties now, but he’d come in two years from a marriage breakup. He was only two years married and this is a man who’d buried his brother by suicide and had a pretty bad life as a young child. He’d lost his mother. She died from schizophrenia when he was only twelve. He had a really bad life and as he said, he got married then. He had a home and then the marriage went wrong. And we were sort of very close because, to me, he’s the son I lost and I was the mother he lost, so we got that bond’ (Claire).*

Claire appears to confirm Frank’s (1995) suggestion that suffering is a call for compassion and the necessary basis for establishing a loving community. By embracing her new son through suffering, her devastating loss is eased. As well as providing a new form of family unit, GROW could provide a chance to reconnect with the family of origin. For example, Kate reported that:

*‘GROW allowed me to start reconnecting with my family and with my mother. The relationship with my family started to recover’ (Kate).*

However, the concept of ‘GROW as family’ through membership of a weekly meeting soon led to a much wider involvement within an extending GROW community. Rappaport (1988:8) described GROW groups as ‘the glue which held a whole community together’. As each participant met the challenge of involvement outside the group, so the concept of ‘GROW as family’ was extended through a widening net of relationships. Later on in the process of recovery, these would pave the way for finding meaningful roles within society.

From the very beginnings of membership, people reported being actively encouraged to make contact outside the weekly meeting and to become friends with other members of their group and with members of their families. In this way, Penny described how her GROW family was extended between meetings and included a non-group member:

*'If I felt down and maybe was crying here on my own... and if I rang Madge, crying, Bobby [Madge's partner] would be in in five minutes. She lives a couple of miles out and he'd bring me out and wouldn't bring me back maybe 'til ten o'clock and I'd come back laughing' (Penny).<sup>23</sup>*

Here, the medical discourse which described Penny as 'sick' and in need of professional treatment was challenged, replaced by a dialogue of compassion and fun. Instead of being 'mentally ill', Penny was re-cognised as lonely. She was offered no medication or professional therapy, but friendship and human kindness; there was no waiting list or fee involved to make sure that she valued the help she was getting. Involvement in the lives of another member of the group and her husband helped redefine Penny's view of herself and she '*came back laughing*'. Some participants described attending social events involving members of different GROW groups and how this led to the discovery and development of a social or spiritual gift. For example, Peg discovered she could sing:

*'We had twelve step [informal social] in M's house and I sang one song with the light out. This was great growth for me. I suddenly realised I could actually do things. I discovered I could sing' (Peg).*

Singing later became a vehicle through which Peg extended her social networks outside GROW. She later reported singing at mass, joining a folk choir and visiting a women's prison to sing.

A major social event in the GROW calendar is the community weekend, which is attended by up to 150 GROW members from different groups around the country. These were repeatedly reported as being significant in the process of 're-enchancement through GROW'. In the same way that attending a first GROW meeting could require effort, attending social events often meant overcoming barriers of fear.

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<sup>23</sup> This kind of informal interacting perhaps presents a nightmare for health and safety legislation but is indicative of the necessary risks involved in recovery.

Pat's interview revealed a lifetime of being bullied – by other children, by teachers and by managers at work. This may well explain his being 'terrified' at the thought of spending a whole weekend in the company of unknown other people:

*'I went on the weekend and I was fecking terrified, but several GROWers came and I was brought down in a car. I was absolutely blown away. I said 'What in the name of God...' It was great, and was a major step for me. I think it is just to see so many people with difficulties and friendship and people shaking hands with you, a fellowship' (Pat).*

Pat's experience of 'GROW as an extending family' was extremely positive. Instead of being bullied and humiliated, he discovered fellowship, people shook his hands and he [his fear] was 'blown away'. For Cathy, the weekend was a reminder of good things that had made her life valuable before she entered her 'place of terror'. 'Experiencing GROW as an extending family' in the context of an informal sing-song freed Cathy from the intense isolation of her 'mental illness'; it filled her with feelings of freedom and enjoyment and empowered her to sing:

*'There was a sense of freedom. The Friday night was a very relaxing thing. We all sat and it reminded me of when I was very young and having family get-togethers and singing, curled up on a chair and laid back. And I just sang because everybody was singing and it was nearly like this great freedom. It was lovely. I really enjoyed it' (Cathy).*

For Helen, attending a weekend softened her view of other people, changing her behaviour towards her family. It was also the start of extending social networks outside GROW by attending other things (like Comhaltas Ceoltóirí Éireann and the Irish Country-Women's Association, ICA):

*'I was delighted with it [the weekend.] It was very friendly and warm and encouraging and refreshing. I was delighted, and it was social as well and then that Christmas I started thinking about my little nieces and nephews and I softened towards people, and the confidence I got socialising in GROW; I started going out to other things' (Helen).*

Richard came to understand what was happening to him at a workshop given at one of the weekends. It proved hugely educational:

*'I remember going to a weekend and thinking "I want to get back here again". Gertrude did her workshop about the wheels of a car. I was riveted, thinking "This explains things so well". The car wheels are like feelings in your*

*physiology. It also encouraged me with music in front of people. It was lovely to watch some of the dancers. It was a complete escape and a place of great fun' (Richard).*

Without attending the weekend, Richard would have missed the workshop. Later he reported 'extending his social network' by going back to full-time study. However, like all the other participants, it was the nature of the weekend that impressed him most. Music, dance, warmth, friendship and laughter were regularly mentioned as the most healing parts of extending social networks. The weekends away also allowed Fran to measure her own progress and bring together the selves of past and present and to be encouraged towards a future. The Fran who first attended GROW was revealed as very different to the Fran who had developed so far, and this provided proof of recovery and growth and of a re-authoring of self. The sense of narrative possibility, of being able to change her story, was reinforced by remembering the selves of others she met at different times and recognising the freedom attained by having journeyed so long and so hard together:

'I couldn't see progress on a weekly basis. But at weekends you met people you hadn't met for six or twelve months and you realised how much you had changed and how much they had come on. One of the blessings of a weekend was a realisation that I had really grown' (Fran).

The participants' accounts have shown how membership of a weekly meeting led to 'experiencing GROW as an extending family' and to being encouraged towards a wider involvement. This process was described by participants as challenging, and it involved facing personal fears and taking social risks. The next section explores GROW's role in supporting and challenging its members as they break out of fear and isolation and sometimes experience relapse and setbacks.

### Experiencing support and challenge

Participants described an evolving relationship within the GROW groups that involved both support and challenge. Healing and recovery are not linear processes; they are exceedingly complex, and relapses are common (Deegan 1995, Saks 2007). Participants recounted how the support of the group was particularly valuable during times of relapse. For instance, if someone stopped attending a meeting they would be contacted and encouraged, rather than forgotten or blamed for not attending:



*'The first time I had a relapse, thank God I had the phone anyway, I was getting phone calls from the GROWers as well, the contacts were being made' (Pat).*

In the next passage, Peter clearly illustrates how he was supported through a time of crisis triggered by his decision to withdraw from medication. Another member of the group was able to offer support and moderate the intensity of the relapse (exacerbated by Peter's worried parents), by advising a slow withdrawal from medication:

*'My instinct was that meds didn't suit me. I stopped taking [names antipsychotic,] which meant I couldn't sleep. I thought "Fuck it, I'll stop the lot", so I decided to stop. My parents were very worried. They met with someone in the group [from GROW] who had successfully come off medication. I agreed to talk to her. She said "Don't go off everything at once", so I decided to stay on [names another drug] but came off all the rest. I was very close to going back into hospital - it was one of those crucial moments in my life' (Peter).*

Ruth experienced depression in the midst of her recovery. While she could 'feel nothing', the group provided her with warmth and the promise that if they could recover, then so could she:

*'The depression came back. I don't know why. I could feel nothing, absolutely nothing. If somebody had fallen dead beside me I couldn't have felt it. It's a horrible thing. I'll never forget the warmth of the meetings. Over the six weeks, I heard stories of people who have managed in their lives, and the best was [that there was a way back]' (Ruth).*

Sue experienced 'relapse' when she took on the leadership role of group recorder. When she found her new role too difficult, there was no fuss, no judgement, no labels such as 'failure'. Another member of the group stepped in and took it on until she was ready:

*'They asked me to be recorder, but I had to do everything perfect (laughing). I wasn't able to do the recording the very first time. I just couldn't do it. So I gave it up and somebody else actually took it on... I came back to be recorder, I suppose within a year of that. Eventually I became organiser of the [names group]' (Sue).*

Sue's account shows active support through an ongoing flexibility. Leadership in

GROW is viewed as a function rather than as a position, but the opportunity to lead was held open until she was ready. Relapses were reported by many participants. Some described a return of their 'mental illness', while others associated relapse with reducing medication and with taking on leadership. Whatever the reason for a setback or relapse, the other members of GROW remained a constant resource, providing contact, encouragement, reassurance, warmth and hope, and at all stages accompanying each participant through the temporary struggle it entailed.

While membership of GROW began with the full acceptance and support of the person as they were, it soon evolved into a challenge to change. Participants were challenged to respond to friendship, to take on leadership, to widen their social networks, and to make the necessary personal changes to tackle life problems. Challenge was always accompanied by encouragement and endorsement:

*'To get endorsement from the group was great. The one thing I was lacking was endorsement for anything. I wasn't giving myself any. If I hadn't the group, I wouldn't have done my tasks' (James).*

Challenge and risk taking were carefully tailored to a person's current stage of recovery. They were systematic, one step of growth leading to another in a manner reminiscent of Wolpe's (1973) systematic desensitisation and hierarchy of fears. Each challenge carried with it a reasonable amount of risk and became a stepping stone to greater life participation:

*'The group gave me the task of taking time out for myself. I am now thinking of going on one of the region's social days out - this is something I just couldn't have thought of doing before' (Lynn).*

Challenge involved building trust in others in the group. A challenge could awaken negative feelings that took time to come to terms with. These feelings could arise when attempting an accepted and agreed task. For Sue, having the support of a trusted other made new things possible, even in the face of strong negative feelings:

*'(My task) was to leave the house, just walk to the edge of the estate - it was terrifying to begin with. The very first thing I actually did as a task was go for a walk with somebody. I always remember, it was a beautiful September morning and I did the walk and after I had a cup of coffee, and I came out and I had actually done that - I don't believe I actually did that, you know. It was again somebody else having faith in me - that "Yes, you can do this" (Sue).*

Sometimes the group directly challenged and supported people to look at key relationships or attitudes to others, which could be very distressing:

*'They really challenged me that night about my marriage. I was really upset and I was like "What the hell do they want me to do here?" Liz came out of the meeting and calmed me down. I realised that although I had felt very hurt and put upon, maybe they are right' (Sue).*

While the group challenged Sue, her distress was recognised and someone was there to comfort and reassure her. The challenge of the group, based on a very personal knowledge, led to her dealing with real problems she was loathe to face. At first she reacted with anger, but then acknowledged 'maybe they are right'. This was also the case with Jess:

*'When I had explained the abuse thing (how I wanted to kill the bastard), Mary said "Why don't you 'let go and let God' ". And I just sat there and said "Please..." (I didn't say this to her, it was in my head) "... You didn't listen to me, you know". It wasn't just the night watchman, it was the Christian Brothers, the way they treated us. I hated all of them. I remember sitting there one night at home and it was like a light came on, you know, to "Let go and let God". It had nothing to do with God, it had nothing to do with whether Mary believed in God or not – it was to do with me finding some way of getting the pressure off' (Jess).*

Through this mixture of support and challenge, Jess came to a new understanding through which he was liberated from his toxic hatred and futile lust for revenge. Participants described how, through a process of supported challenge, they became systematically empowered to tackle increasingly complex life issues and, in so doing, came to a growing realisation of the need to take responsibility for their recovery.

### Learning to take responsibility

An emergent theme of healing within the stories of the participants was one of learning to take responsibility. It was a realisation that sometimes came as a personal insight or through an intervention of the GROW meeting. Kate was in a group for many months when:

*'It started to dawn on me that neither the doctor nor the pills were going to effect a cure. The penny dropped – I had to do my part' (Kate).*

Helen reported that it was the group that made her realise that her attitude towards her family was something for which she must take responsibility:

*'When I was still fairly sick, the first piece [of the book] that was quoted to me was 'responsibility'. The bit that struck me was "No matter how we came to be sick, it's our own responsibility to become well". We should not be blaming other people entirely for our problems, because at least some of it is our own doing. And this blaming really struck me, because at the time I was terribly negative and if I got the ear of another adult, I would start giving out non-stop about my family' (Helen).*

Taking responsibility for their situation clearly cast participants as active agents in their own recovery, rather than as passive recipients of treatment and cure. Taking responsibility involved many areas of life. Peter reported how GROW helped him to take responsibility for his life habits and also for his relationships with other people:

*'GROW was a means of learning to connect with other people... to communicate with other people so I could learn better to understand other people; also that I was able to express myself. A regular sleep pattern was something it took me a long time to learn. I began to look after my diet and avoid stimulants' (Peter).*

Sleep, diet, exercise, meditation, spending time with others and alone were all mentioned frequently as areas where participants took responsibility. Kate took responsibility for her anxious body, rather than relying on medication:

*'Quietenning my physical self, listen to my body, to my heartbeat, try and get in touch with me' (Kate).*

Jess began to take responsibility for his emotions, learning that he could:

*'Let go of all that anger and hatred I feel towards everyone' (Jess).*

Taking responsibility also involved making decisions to find work, or get involved in education or leisure activities outside the GROW community areas – a theme that will be returned to in chapter nine. While taking responsibility began with learning to care for oneself and for relationships with others, it soon extended to taking responsibility for the quality of the GROW meeting and for the wider GROW

community. Taking responsibility for GROW meant becoming involved in leadership and learning to care directly for others. GROW describes leadership as ‘love showing the way’ (GROW Undated:35). In GROW, leadership, like friendship, begins as an outpouring from the established members to the new ‘other’, but quickly becomes reciprocal. GROW involves its members in three stages of leadership which it calls beginning, progressing and seasoned levels (GROW Undated:5). In the first few months, people learn how to tell their story, give a report on progress, take a turn at facilitating a meeting or at making the tea. They are encouraged to reach out to other group members, especially new members. All of these group involvements are seen as acts of leadership; all involve taking responsibility for the group as well as for personal well-being, and all bring with them direct benefits which are a part of ‘healing and re-enchantment through GROW’:

*‘I found it great in GROW that I was able to give opinions and advice from my own experience’ (James).*

*‘Leading the meeting was a big one – I was afraid of my life I would do something wrong. It was an achievement’ (Vicky).*

This chapter opened with Mags discovering hope at her first meeting. After a few weeks, she began to understand herself as someone with something to give to the group and began to take responsibility for its quality:

*‘After about six or seven weeks, I did something that I would never have done: I offered to make tea. I just kept saying to myself “If they can do, it I can”. Another week I helped with the wash-up and the other person started to chat to me, in very ordinary stuff like the weather and the news and I felt safe in it’ (Mags).*

In the progressing stage of GROW leadership, people are both invited and expected to take on formal leadership roles within the group and to become actively involved in leadership outside the meeting. A common theme in the interviews was the profoundly positive effect of being asked to take on the roles of Organiser or Recorder, both leadership roles with a key responsibility within GROW:

*‘I remember M asking me would I accept the challenge of becoming organiser of the group and I remember inside, while I wasn’t able to express, was this huge, that feeling, it was like my heart got bigger inside in my chest.*

*I've had positions of authority in the army and none of them have meant as much as being asked to be organiser of the Thursday night group' (Jess).*

Perhaps the idea of taking on responsibility for the group through a formal leadership role had such a deep and healing effect on Jess because it was in direct contrast to the hegemony of the traditional mental health system and indeed Jess's place of work, the army. Within these contexts, leadership is always equated with status, rank, and qualifications. In contrast, Jess saw this request as affirmation of his positive qualities as a human being. For Richard, taking on the responsibility of becoming an Organiser provided a way to escape from his self-made prison of perfectionism:

*'A liberating idea [from GROW] is that it's OK to do things badly at the beginning. I would try to avoid criticism by being perfect. I was asked to be organiser and thought I couldn't, then I thought it would be ridiculous not to do it just because I couldn't do it perfectly. GROW gave me permission to have a go at things' (Richard).*

For Nan, being invited to become a leader confirmed her value. People could see qualities in her that she couldn't see in herself, and this gave her self-belief:

*'I went every week to my meeting, I was hanging on for dear life... [I] went on the program and did little things... [It] started with something simple – making tea – and after a few months I was leading a meeting... Only after a short time, I think a year, God bless them, they asked me would I become organiser. And of course this was so unusual to me because I couldn't believe, I didn't believe in myself, but they obviously saw something in me that they liked' (Nan).*

Within GROW, leadership gradually extends outside the nurturing womb of the weekly meeting. Many people reported a sense of progressive healing by becoming involved in, and taking responsibility for, the 'bigger picture' of GROW. This involved activities such as supporting other groups, giving talks in schools, and joining the regional or national team:

*'We started travelling to other groups and realised "God, we aren't the only one". I went to a leadership meeting. Getting a bigger picture was extremely helpful. It was terrifying at first, but there was part of me that was really excited. These people can see something in me' (Kate).*

*'I joined the regional team. It is good to see all the ins and outs of the organisation' (Pat).*

In this section, participants stressed the importance of taking responsibility for their own actions as an important part of recovery. Taking responsibility for themselves soon extended to taking responsibility for their GROW group and progressively for the wider GROW community, through involvement in increasingly more responsible leadership roles at local, regional, and national levels. Taking on leadership is described in the GROW program as being a shared activity that is ‘good’, both for the individual and for the organisation. The next section explores the notion of ‘goodness’ and the significance that ‘doing the ordinary and good thing’ plays in the journey to recovery.

### The healing power of goodness

The word ‘goodness’ is defined as ‘virtue, excellence, benevolence’ (Chambers 1999:415) and is a recurring theme in the process of ‘Re-enchantment through GROW’ as related by the participants. Philosophers such as Aristotle (384 - 322 BC), Aquinas (1225 -1274 AD) and Kant (1724 -1804 AD) and all major religions have long associated moral goodness with the pursuit and acquisition of health and happiness. One of GROW’s first principles advises ‘Do whatever ordinary and good people do, and avoid whatever ordinary and good people avoid’ (GROW 2001:7) and to ‘Never say I can’t, if the thing in question is an ordinary and a good thing. Do the ordinary thing you fear, do the ordinary thing that repels you’ (GROW 2001:32). The promised benefits of striving to be good and developing right habits of thinking and acting are, according to GROW, that ‘My feelings will get better as my habits of thinking and acting get better’ (GROW 2001:10). Participants’ accounts included many descriptions of striving ‘to be good’ and confirmed the healing effects of adopting this as a life strategy:

*‘They [my practical tasks] were all to do with facing my fears. All to do with, you know, doing the ordinary and good thing and learning, I suppose, learning not to be afraid of the symptom – that was a huge thing. I had to work on that for a long time to not, not adding fear on top of the fear I was feeling already. And it took time, I really had to work on it to fight that fear; in time, I did begin to feel good and to feel good about myself, and my relationship with God helped a great deal’ (Nan).*

The GROW program contains multiple references to God as being a healing resource (GROW 2001:7, 8, 9, 44, 71), and while belief in God is optional within GROW,

some participants reported how the word 'God' became synonymous with the word 'goodness', and in this way God [as goodness] became a very practical part of their inner healing and re-enchantment:

*'At the start, I struggled with the God thing. Changing the word 'God' to 'good' really made sense for me. It rang a bell. To believe in the good was huge, it has helped me overcome an awful lot' (Jess).*

For James, a developing belief in the power of goodness brought about a crucial change in his whole belief system, enabling him to open himself up to the healing power of goodness and to escape from a 'place of terror' where the devil was in charge:

*'I had come to the conclusion that goodness in the world is just a futile effort. The devil is in charge – that was my world view. Then it was explained to me to substitute the word 'God' with the word 'good' and then to look at goodness. I found the more you open yourself up to particular belief system, that's the way your belief system will be. If you look for bad, you will find bad in the world. You have to feed the good' (James).*

Richard describes how GROW, as a practical theology, began to influence his life choices:

*'GROW has become very much a part of my theology, the idea of goodness. If God is love, He is prompting us to do the ordinary and the good thing' (Richard).*

David rejected the idea of God, but still professed a belief in the power of goodness and in an ethics of healthy living:

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*'I don't have a belief in God and ignore that part [of the GROW program.] I believe in good in the sense of Aristotle's ethical living' (David).*

Many participants testified that a part of the healing 're-enchantment through GROW' was a realisation of the existence of goodness within themselves and of their intrinsic personal value:

*'I was given part of the program on personal value. I read that for about ten months, and all it was, was words on a page. They meant nothing to me. I*



*read it every morning because it was my ongoing part of the task. And I remember one day I read it and it meant something' (Kate).*

To Kate, the idea of her own value involved an interior struggle with the very core of her being. GROW empowered her to change her values. It happened almost like a conversion – ‘*One day I read it and it meant something*’. For Frances, GROW provided a means to take ownership of her giftedness:

*'I knew I have gifts but I wouldn't have believed in them. GROW enabled me to see them, I found that very good' (Frances).*

Consistently striving to be good, either by choosing to ‘Do the ordinary thing you fear’, or by increasingly becoming involved in helping others through leadership, provided a systematic road to ‘re-enchantment’. By using the idea of goodness as a signpost for their daily actions, participants began to change. Goodness in GROW is not just a personal ethic, but something that is experienced through the friendliness of others in the group and through twelfth step work. In this way, it reflects claims by Waddell and St Augustine that:

‘Our friends make us good, for it is in this activity of sharing the good that each of us, in his or her love for that good, becomes a source for the other person’s goodness’ (Waddell 1989 cited in Kerney 2008).

‘Friendships become schools of learning love and leading human beings to the love of God [good]’ (St Augustine 354 – 430 cited in Kerney 2008).

Happiness and a sense of well-being were reported as positive end results of choosing to be good:

*'Feeling good about yourself is a wonderful, positive energy... Recovery, to me, means being happy with life; to appreciate the good in the here and now, enjoy a cup of coffee, to be able to plant a bulb and know there will be a flower in spring' (Nan).*

*'I am in a strong place in my life now, a place where I wake up feeling happy' (Jess).*

*'I remember one Saturday night I was going home after a night out and I got this strange feeling. After a while I recognised it. I was actually feeling happy. I liked that one' (John).*

Time and again, participants used the word 'good' to describe a range of experiences within GROW. Many people reported being enabled to see good in themselves through the endorsement of others. The act of choosing to do the ordinary good thing, which included taking responsibility through leadership, was reported as an important part of recovery. What was clear from participants' accounts was that all their efforts at recovery represented a process through which they began to learn how to 'author a new story' and co-create a new and positive identity.

### Learning to author a new story

The final healing strategy described by participants was 'learning to author a new story'. Rappaport (2005a:796) suggests that many disadvantaged groups of people such as the 'mentally ill' are imprisoned in negative identities because the only narratives available to them are either 'negative, narrow, written by others for them, or all of the above'. Goffman (1990) and Scheff (1984) have both described the negative impact a psychiatric label has on a person's identity and on hope for the future. Pat described how fellow students and teachers at school taunted him with madness because he happened to live near to a mental hospital. Richard described how he got the same negative message about himself from his parents, teachers and even from God. Vicky described how she became the passive recipient of many negative identities through her interactions with others. Consequently, for all the participants, early childhood 'stories' became a prelude to songs of despair that were later labelled 'mental illness'. Learning to re-author another story of identity was a gradual process that is best exemplified by Frances's story, as in many ways it mirrors other participants' experiences.

The main difficulty Frances faced when she came to GROW were the 'negative scripts'<sup>24</sup> she had received about herself from a whole range of others and the negative sense of self this engendered over time. Frances was born illegitimate. One of the definitions of the word 'legitimate' in Chambers' dictionary (Chambers 1999) is 'genuine'. The word 'illegitimate' is not so different etymologically from the word 'invalid'. By being illegitimate she had been created less than genuine. Illegitimacy

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<sup>24</sup> Tribble (1984:1) writes that 'stories are the style and substance of life, they fashion and fill existence'. 'They mingle cultural norms with agency'. She uses stories from the Bible to show how cultural norms, which are in fact 'given' social scripts, can both hide and reveal stories of terror.

had been the socially constructed label and identity; the unasked for, unwanted story of her life:

*'I had no sense of myself. I didn't know who I was. I had very strong hang-ups about being illegitimate. I had learnt a lot of lessons from people in the society in which I lived, from neighbours, from my own family, from my foster family, from children in school, that I was different, that I was less. Even religion entered into it. My overriding feeling was of insecurity, of rejection. Rejection is a big, big thing' (Frances).*

As Frank (2000b:355) points out, stories, when told, attract other stories – they are a 'call for a relationship'. By being alive, Frances was telling her story. The 'utterance' (Bakhtin 1973) of illegitimacy became a magnet for negative stories. It was a word that drew them from everyone. Surrounded by negative stories, Frances' personal story became illegible; hence her statement that 'I didn't know who I was'. For Frances, her family of origin, her foster family, her neighbours, her classmates, even her belief in God reflected back the same message: 'You are different!' 'You are less!' 'You have no right to be here!' These stories blocked out any possibility of knowing who she was other than 'ILLEGITIMATE', or for Pat 'MENTALLY ILL', for Richard 'BAD', or for Vicky 'POWERLESS'. These 'utterances' carried authority. They became statements of fact, ruling out the possibility of creative new alternatives:

*'It was only when I came to GROW that I realised my thinking was completely skewed and I was given a different way of thinking' (Frances).*

Frances was being bombarded by external stories that worked against her. Internally, she was undermined by her feelings and her thoughts, and then:

*'I went to my first GROW meeting and a person gave her testimony. It was about being adopted. I was looking at her because I thought she was telling my story. I was looking around as well. I remember going home that night and saying "In the name of God, why have I carried this?" And I felt so much lighter that I said "Now there is nothing that I need, there is nothing I can't talk about" – that was such a block and burden to me. I really went home ten feet taller that night' (Frances).*

Frances described a moment of social intercourse literally impregnated with the seeds of personal rebirth or transformation of her identity. Firstly, she heard her 'own' story being told by another in a different and positive way; it instantly

challenged her beliefs her thoughts, her senses about herself. As Sennett suggests, 'stories give lives legibility' (Sennett 2007:148). Suddenly, through the lips of another, a new life giving story was being breathed into her. Her own inability to know who she was was swept away. It lifted her spirit; she felt 'ten feet taller'. She didn't only have to rely solely on the testimony of the unknown storyteller – the faces of others in the group reassured her:

*'None of them are running her down. They are completely with her. Of course, when she finished, a lot of affirmation started and people were saying lots of nice things about her' (Frances).*

There was no sense of rejection, and not only did she glimpse her own life story differently but she witnessed a different response from her GROW family. Her story had changed, she had changed and others had changed. After the meeting, Frances' reflective response to her experience of that first group is to 'cry out' 'In the name of God, why have I carried this?'

Sue also described how expressions of friendship in the group transformed her feelings and subsequently her thoughts about herself, and thus initiated a process of transpersonal healing and the authoring of a new story:

*'I felt when people got to know me, they wouldn't like me. Therefore I didn't want to get to know anybody. When I joined GROW one of the first people I connected with was Liz [pseudonym]. She used to call me "Her lovely Sue". She used always give me a great hug at the end of the meeting. And she'd be "Oh you are my lovely Sue". She was the very first person that awakened that belief that I'm OK and not this horrible person that I had in my head' (Sue).*

Sue was touched by Liz. Touched physically, through the ready warmth of a hug, but also existentially and spiritually, by the way Liz called her by a new name. The words '*My lovely Sue*' enabled Sue to see herself as she might be... as she already is in the eyes of another, someone who is lovely. She was invited to shed the story of the horrible person. Liz's behaviour acted as a positive and powerful peripeteia. By physically touching Sue, she removed the 'leprosy' of fear and stigma that clung to her and which separated her from others. Over time, Liz's repeated words '*Oh you are my lovely Sue*' provided a constant and reassuring reference point, a mirror that she could rely on to see a new and emerging version of herself.

Many participants, including Frances, described what happened in her first meeting as providential. What were the chances of her hearing that particular story on that particular night? Was this an example of Jung's idea of synchronicity? Jung (1965) came to believe that life was not a series of random events, but rather an expression of a deeper order. He based this on experiences within his own life and within therapy. A female client was relating a dream which featured a golden scarab beetle; as she spoke, a real golden scarab beetle began to tap at the window. The scarab in Egyptian mythology represents rebirth. From a religious perspective, Jung (1965) suggested that synchronicity shares similar characteristics of an 'intervention of grace'. Jung also believed that synchronicity served a similar role in a person's life to dreams, with the purpose of shifting a person's egocentric conscious thinking to greater wholeness, providing:

‘A glimpse into an underlying order in the universe which manifests itself through meaningful coincidences that cannot be explained by cause and effect’ (Lundstrom 1996:176).

Synchronicity is close to the Christian idea of providential provision, the Buddhist idea of karma, or GROW's idea that the human being operates at three levels<sup>25</sup>, one of which includes the supra-personal level of mystery, meaning, providence, and destiny (GROW 2001).

The authorisation of new stories involves a dialogical process, hearing new stories from others and allowing them to become a part of self. These new stories are liberating because they show a way out of the 'authoritative' script that has previously negatively dominated a person's life. They give a person permission to begin telling their own story in a new way. The word 'authority' has its roots in the Latin 'augeo'. Augeo means to increase or to cause to grow. In the mental health system, authority is often experienced as a form of domination. The 'authority' of the medical story robs a person of agency and severely limits the possibility of growth. Testimonies of recovery that are heard in the mutual help context give real authority... authority to grow. By being involved in the ongoing friendly dialogue

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<sup>25</sup> GROW's program suggests that 'In me as in every human being there are three levels of natural involvement:- the sub-personal level of my instinctive life, notably my instincts for self-preservation, sex, and aggression; the personal and interpersonal level of my conscious reflection, rational communication, affective life, and social activity with others; and the supra-personal level of overall meaning, mystery, providence, and destiny. (GROW 2001:53)

that is the GROW community, participants were empowered to realise their value and to author new personal stories which led to re-enchantment with themselves and towards recovery.

## Summary

This chapter has explored processes involved in ‘a time of healing’, specifically exploring the process of ‘becoming re-encharnted through GROW’. In many ways, healing through GROW was shown as the reverse of the processes that had led people into a place of terror. It involved rebuilding trust between self and others and began with ‘a struggle to attend’, which often involved overcoming high levels of fear. Healing was revealed as a dialogical, non-linear process that took place over time. It began when participants experienced ‘a warm and emotional welcome’, which gave rise to feelings of hope and belonging. These feelings were nurtured through an ongoing ‘experience of friendship and reciprocal relationships’. GROW became an ‘extending family’, providing both the challenge and the support necessary in the ongoing struggle for recovery and mental health. Recovery was shown to include ‘taking responsibility for oneself and also for GROW’s community’ by risking involvement in many forms and levels of leadership. Healing involved personal transformation at many levels of being and was led by a guiding principle of always striving to ‘do the ordinary and the good thing’ and a belief in the ‘healing power of goodness’. Participants often mentioned a belief that as well as being supported by other GROW members, they were also subject to personal help from a benign providence. The healing process was described as an active process, representing a personal struggle to make sense of, or integrate, the many levels of story or dialogue of which identity is composed. Participants testified that fruits of change were experienced as happiness and a deepening sense of well-being. There was a collective sense that people in GROW knew the way to recovery and by observing them, participants would be able to find and follow that way. And it was a way both ‘of’ and a way ‘to’ life that was characterised by friendship, hope, and compassion, all of which became part of a positive identity. The overall effect of ‘becoming re-encharnted through GROW’ was a ‘re-authoring of story’, the shedding of stigma and a growing awareness of personal value and of valuable personal qualities, and the co-creation of a new and positive identity.

GROW encourages its members to find resources in society. These resources include professional help. The next chapter follows the healing process into different parts of the mental health system and is entitled 'A time of healing: re-enchantment through professional help'.

## CHAPTER EIGHT: 'A TIME OF HEALING'– 'RE-ENCHANTMENT THROUGH PROFESSIONAL HELP'

*'When the psychiatrist said to me "Look, I think you should spend some time in hospital", I was absolutely delighted'. 'The hospital environment is a lot better than prison'. 'In hospital you can talk to people, it's good'. 'I was seeing a lot of people the same as myself'. 'They got me a cup of tea, it was great, I felt better after ten minutes'. 'Even when those nurses were off duty they asked for me – it made me feel great, the very best'. 'A social worker befriended me'. 'The psychologist was helpful'. 'The therapist actually came out to my home'. 'Medication was helpful, especially to help me sleep at night'. 'Medication combined with therapies has been a factor in my being in recovery'.*

### Introduction

This chapter extends on the theme of a 'time of healing', this time exploring the sub-theme of 'Re-enchantment through professional help'. While containing examples of healing that occurred within the mental health system, it is important that the chapter is read in the context of the number of stories recounted in chapter six, where the formal mental health services became part of many participants' 'place of terror'. Positive accounts of the healing effects of the mental health system were quite rare and were often quite ambivalent, with participants mentioning both positive and negative experiences. They were dependent on accounts from a minority of participants and, when framed in the context of the wider picture of the health services described in chapter six, they represent only a small, though important, part of the landscape of recovery. The chapter addresses healing experienced under three sub-themes and starts by exploring people's experience of 'hospital as a place of sanctuary'. It then describes examples of 'healing professional relationships', identifying intrinsically beneficial qualities within those relationships, and finally it examines the sub-theme 'medication's role in re-enchantment'.

### Hospital as a place of sanctuary

Sixteen of the twenty-six people interviewed had experienced hospitalisation within the formal mental health system. The commonest positive experience of this aspect of professional help was the idea of 'hospital as a place of sanctuary'. The Chambers (1999:897) dictionary defines sanctuary as 'a sacred place of refuge or a place



offering safety'. The idea of hospital being a safe and welcome sanctuary was commented on by James. For him, the sanctuary was from his terrifying thoughts and the terror of what he might do to himself or others. In chapter six, James described 'waking up' in the middle of town in the early hours of the morning with a kitchen knife concealed in his sock, having decided to '*sort [his paranoia] out*'.

*'When the psychiatrist said to me "Look, I think you should spend some time in hospital", I was absolutely delighted. Absolutely delighted. I was at my wits' end. I didn't know where to go. I was having plenty of suicidal thoughts as well – I really couldn't see a way out. Yeah, it was just what I needed to get away from it like. She said "I think you should go in", and I said "Great"' (James).*

Even the thought of hospital provided immediate relief for James, as he saw it as a possible way out [of terror]. For Kate, hospital proved to be a sanctuary from what she might do to herself and from her terrible levels of anguish. It was a place in which she was able to calm down. She was admitted to hospital after telling her psychiatrist she was very suicidal, and admission helped her through that crisis:

*'Maybe I calmed down. I was deemed highly suicidal when I went into the hospital... Maybe I had calmed down a bit, you know' (Kate).*

For Penny, hospital was a sanctuary from discord at home and a place where she received personal support from her psychiatrist:

*'Dr C thought that I actually was better staying there [hospital] the weekends rather than coming home. I came back worse than I went because I'd come back to silence, you know. J [husband] and I weren't getting on at the time' (Penny).*

In this hospital, Penny experienced being trusted, a relational quality that has already been identified by Anthony (1993) as crucial to recovery:

*'I was allowed go down the village into [names town] if I wanted to, and I felt that was just amazing, and that meant an awful lot to me because I had been locked in in [names hospital]' (Penny).*

Trust was particularly important for Penny because in a previous experience of another hospital she had been locked in a ward against her wishes. Like some other participants, there were other positive features of being in hospital that Penny valued and which encouraged her to stay:

*'I spent a long time there. It was great, I had my own room ensuite, the sun shone and we played croquet and at night we played games' (Penny)*

Here, Penny's description could have been of a Quakers' 'retreat', where people were treated with kindness and respect, encouraged to become involved and where the surroundings were made beautiful. In contrast, Paul compared his experience of a secure unit to being in prison for a crime he had committed, for which he was subsequently found to be guilty but 'insane'. In his view, hospital was a sanctuary away from the violence of prison life, as there was a care programme in the hospital and staff were more respectful:

*'I think the hospital environment is a lot better, say, than the prison environment. And the whole care programme itself [is] more respectful, they are more caring. You see, prison is a rough place, there is always trouble everyday. There are always fights – you would certainly have one fight a week anyway' (Paul).*

For some participants, in addition to being a safe place where they could escape from various dangers and fears, hospital was also a place to meet other people. For Mathew, being able to talk to people, or just having people around in case he became suicidal, was a valuable part of the sanctuary of hospital:

*'It's nice to have your own personal space – quite often when you're very unwell, you are suicidal and you want people around you, but at that stage your own room, I have to admit, is great. You can go into your own room and you can lie down on your bed and you can rest. You can pop out, down to the coffee shop, talk to people – it's good, you know' (Mathew).*

Gretta went into hospital with the expectation of being cured; however, it was contact with the other patients that she found most helpful. Her spell in hospital changed her idea about 'mental illness'. Initially she believed 'mental illness' was a form of physical illness or injury which could be cured by expert intervention. She quickly learned that it was something she had to learn to deal with herself and also that it was something many people were battling with and that she was not alone. For Gretta, it was the forming of peer relationships that was the most important part of her hospital experience. The other patients helped her deal with the effects of 'mental illness' on her life:

*'To me, depression was the same as any other sickness: if you fall and break your leg, you go to hospital; if you're depressed, you go to hospital. You come home and off you go again. I went into the hospital then and in there it showed me a complete different light, because in there I was seeing people, a lot of people the same as myself, and I saw then how they were kind of coping with it, and I wasn't the only one as miserable... There was a reason for it... I was OK, and it was a great help. The doctor wasn't really that helpful, no – I really think I had more support from the people that was in the hospital' (Gretta).*

Paul also valued meeting other people with similar experiences to his own:

*'It [hospital] has been a lot better for me [than prison] because I suppose I'm in a place where I have met a lot of guys who have gone through a similar experience, and I think it was better for my recovery' (Paul).*

Some participants reported that while in hospital they were encouraged to attend GROW and so, as well as meeting others with the same experience, hospital provided an introduction to members of GROW:

*'The doctor was great – he was supportive about my attending GROW, he seemed glad I had found something that was helping' (Kate).*

*'I heard about GROW while in hospital' (Penny).*

*'I heard about GROW at an orientation meeting in a day hospital. A very helpful community mental health nurse insisted that I go to the GROW meeting and it was a great idea' (Helen).*

*'She [my psychiatrist] gave me this list [of GROW meetings] anyway and she said would I go to an evening meeting. I wouldn't, I said. There was a morning meeting: "Will you go to that?" So I went down... I went to the first meeting, and the first thing she asked when I came back the next week, "Did you go to the meeting?" I said "I did, and I liked it". And she says "You know, the improvement is written all over your face"' (Pat).*

While hospital can be seen as a very real sanctuary, many people mentioned negotiating with doctors so that they wouldn't need to be hospitalised. In the example below, the suggestion by Jack's general practitioner that he should be hospitalised spurred him on to attend a psychiatrist. Jack's general practitioner showed concern and respected Jack's wishes. Consequently, the next day Jack was introduced to a psychiatrist (on an outpatient basis) who put him on medication and made regular appointments to see him. This is exemplified in the following

quotation:

*'I went to see my GP and told him I was very suicidal. He wanted to section me. I was thinking "I don't want to end up in hospital". The only reason they would let me go home was my sister would stay with me all night, and my sister stayed with me that night. The next day I saw a psychiatrist, so I told him the way I was feeling, so the psychiatrist put me on medication then. I saw the psychiatrist every week, long-term, and then after then, about [every] three months, then every six months' (Jack).*

In summary, for some of the participants in this study, hospital was described as a valuable sanctuary, providing a safe place where they could escape from a range of fears. Part of that sanctuary was meeting up with others who had similar experiences, and for many it was while in hospital that they were introduced to GROW, which offered the hope of sanctuary upon discharge. Hospital was a place where some participants experienced being trusted, an important aspect of recovery. Hospital was also a place where significantly healing interchanges took place between participants and a range of mental health professionals, who they met because they were in hospital.

### Healing professional relationships

Participants have already indicated in this chapter that a healing benefit of hospital was the chance to meet other people who had experienced 'mental illness'. However, the hospitals also provided some people with access to helpful relationships with mental health professionals. The following accounts show a range of reported interactions with nurses, social workers, psychologists, and psychiatrists that proved to be significantly healing. For example, Mathew describes his interaction with nurses:

*'I remember when I was suicidal in [names hospital], a very kind nurse brought me into the nurses' office. Himself and another nurse were doing some paper work. They were talking to me and they had a kettle in there. They got me a cup of tea. I felt better after ten minutes talking, I obviously didn't feel great but I felt the better of it, you know. And it took me out of that place, which was great, you know' (Mathew).*

Here, the two nurses, who were probably breaking rules by inviting Mathew into the nurses' station, demonstrated the same calming effect that participants spoke of

experiencing when they attended a GROW group. The nurses' office became a place of healing intimacy. The nurses were 'very kind' and, in just ten minutes, Mathew was taken out of that place of terror where he felt suicidal and out of control. The nurses' actions of making tea, putting labels aside and including Mathew in their social world had a deeply calming effect. Their relationship shifted from being hierarchical to reciprocal, three people sharing a cup of tea. Many writers have described situations where a report of suicidal feelings led to seclusion and suicide watch, which in many cases proved traumatic and exacerbated feelings of terror (Pfeiffer 2007, Lehmann 2002, Chamberlin 1978). However, in Mathew's case, his distress led to kindness and inclusion. Frank (1995) suggests that many health professionals avoid witnessing their patients' suffering, preferring to adopt an efficient, cold and clinical manner; in this case, the nurses effectively broke that mould. Similarly, it was the human warmth and recognition of him as a person that Tom found most helpful in his relationship with some nurses:

*'They [two trainee nurses] were "people persons", they were a bit like GROWers in some ways because they were very interested. They were exceptionally good. I was able to talk about some issues. And I found then, I said "There's great relief here, I actually can talk about some things..." One of the things that made me actually feel the very best though, was feeling the connection, the friendship – even when those nurses were off duty, they were asking about me through other staff' (Tom).*

Tom described another healing relationship, this time with a social worker who befriended him while he was in hospital. He immediately recognised her spirit of friendship. She spoke to him as one person to another and offered him some of the practical help that he so badly needed. Tom's description clearly resonates with Bakhtin's (1981:181) idea of carnival, where socially constructed rules and labels are suspended to facilitate genuine human contact.

*'A social worker befriended me. And she says "The psychiatry system", she says, she whispered down low, she says "The psychiatry system is not great here at times, I'm not even allowed to be talking to you. So", she says, "I am just going to talk to you quietly in the corridor"' (Tom).*

Like the nurses, the social worker asked Tom about himself, not about his feelings or symptoms, but about his goals and dreams:

*'She asked me a wee bit about myself. I told her I was trying to get the GCSE. When trust built up, I went to her home. It all had to be done secretly. It turned out that her husband was a teacher in the same college and he gave me some private lessons free' (Tom).*

The fact that 'it all had to be done secretly' illustrates that the carnival atmosphere of Tom's relationship with the social worker and her husband did not extend to the highly controlled atmosphere of the hospital. It might also signify that some social workers may dispute the medical view that 'mental illness' is caused by a chemical imbalance, attributing cause to the existence of social problems and many forms of deprivation (Price 1979). By befriending Tom and inviting him into her home, the social worker was breaking hospital rules – but by breaking those rules, she was rebuilding a sense of trust and human connection. She was also taking a professional risk, a theme that will be returned to in more detail later in the chapter:

*'They were a couple who were just so keen to get people moving on and she says "I'm just so delighted with your story", she says "It's fantastic. It's our privilege to try and help you..." She also arranged through my GP that I would see a psychologist. She said "There is a six-month waiting list but I will try and speed it up. Don't be afraid to push your GP and psychiatrist"' (Tom).*

Here, the social worker introduced the idea that it is a privilege to try to help another human being, underlying Riessman's (1965) observation that to help someone is personally therapeutic. This attitude 'gets people moving on'. Because of her position as a mental health professional, the social worker had specialist knowledge about the system and a network of other professionals whom she could access and influence. She used this 'professional clout' on Tom's behalf. By providing information about appropriate and available resources and by being personally supportive, she brought some control to what was happening to Tom. His sense of 'chaos' (Frank 1995) or of being in 'adventure time' (Bakhtin 1973) was being moved towards control and order.

Paul reported a healing relationship with a psychologist who recognised the traumatic effects of his severe form of 'mental illness' and helped him begin to deal with these:

*'I'm seeing a psychologist – she is really good, excellent, and has been doing a lot of trauma work with me' (Paul).*

Claire described a close relationship with her doctor that played a key role in her healing. After the trauma she experienced following the double suicide of her son and grandson, she was offered an appointment with a psychiatrist. Claire was surprised by the professional tools her doctor brought with him which went against her expectations:

*'I saw him go with the box of tissues the first day I went, and I wondered "Why is this guy doing this?", you know? Of course, he knew what he was dealing with, that I was going to cry as soon as I started to speak about it... As it turned out, he's from the town and I actually knew his family and his brother had been... one of my son's best friends, so I was able to speak, you know. He really listened, he was very good and very helpful. He asked me am I suicidal; I just said "Yeah". "Have you any plan how to do it?" I said "Yes, tablets" – I had it all in my mind... So he [asked] then, you know, throughout a week talking, "What about the rest of your family... Do you think of them?" ...So yeah, I did find that helpful and I still attend the psychiatrist but only every couple of months, they just keep an eye on my medication and that'*  
*(Claire).*

Bakhtin (1981) talks about the idea of 'Otherness' and how each of us defines him or herself in terms of the 'Other'. In terms of the doctor-patient relationship, there is an expectation of the 'Other'. The professional 'Other' will diagnose and treat. The 'mentally ill' or suffering other will comply because 'Dr knows best'. In this account, the doctor recognised and acknowledged Claire's suffering and she, in turn, was able to experience him as caring and compassionate. He was no longer the 'Other', a remote Doctor – 'He is from my town'. With this friendly man, there was no sense of 'otherness'; she described him as 'very good and very helpful'. He prescribed sleeping tablets, which Claire found helpful. The compassionate person who was the doctor was able to enter Claire's place of terror and offer practical help. By bringing with him a box of tissues he was signalling that it was OK for Claire to be distressed. He was with her in her suffering and showed no fear of her pain. It was interesting that the story ended with the statement that the psychiatrists she sees now 'Just keep an eye on medication and that'.

In addition to being listened to and being treated with respect and kindness, some participants recorded instances where professionals encouraged them to take risks as part of their recovery: Penny was encouraged to go down town alone while in

hospital, in spite of her apprehension; Pat and Kate were encouraged to join GROW; Tom was encouraged to follow his dream of returning to adult education – all of which involved levels of risk. Risk taking has been identified as an important part of recovery by Shepherd et al. (2008). They suggest that ‘Risk taking needs to be differentiated into risks that must be minimised (self-harm, harm to others) and risks that people have a right to experience’ (Shepherd et al. 2008:8).

In keeping with the idea of therapeutic risk, Nan described receiving practical help from a behavioural therapist who made home visits and began to encourage and empower her to risk breaking out of her ‘place of terror’. The authoritative voice of the therapist and her presence were able to set Nan’s life in a new direction, helping her to learn to overcome her fear and risk ‘basic’ involvements such as shopping and going into a church:

*‘After a while I got to see a therapist and she actually came out to my home here... A behaviour therapist – she came with me to, you know, [names a supermarket chain] across the road and into the church and just basics, you know... Came walking with me... I found her good. You know, she was good.  
(Nan).*

Mags also reported a supremely healing relationship experienced with a new and young psychiatrist that involved elements of taking risks she had ‘a right to experience’ and which proved highly significant in her recovery:

*‘Dr D said to me “You know, you are making a lot of progress. I’m very satisfied with your progress since you started going to GROW”. I had gone longer than I had for a long time without breaking down. I had broken the cycle and it was great for me that she thought that’ (Mags).*

First of all, the doctor was supportive of, and interested in, her membership of GROW, which itself involved the risk of trusting non-professional forms of help. Dunne and Fitzpatrick (1999) found that a common fear of mental health professionals was that membership in GROW would interfere or threaten the professional relationship. Mags then described a conversation that would prove to become a major contribution to her recovery:

*‘And then she said, “NOW, I won’t be able to see you for a week or two because I’ll be on holiday”, and I said “Oh lovely, where are you going and*



*everything?” And she said “And where are you going?”, and I said “Well I have holidays coming up but I’m not going anywhere as usual and I might go home”. “I wouldn’t recommend that”, she said – she thought that was part of the problem. But she said “Where have you ever dreamed of going?”... I said “I’d love to go to the States!”, and she said “Why don’t you?” (Mags).*

This interchange was important on a number of levels and revealed both Mags and her doctor as being involved in multiple risks. Shepherd et al. (2008) note that most risk taking is shared between the person in recovery and those helping them. In this reciprocal conversation between two human beings, the doctor risked stepping outside professional boundaries by sharing her personal life, and Mags risked being further diagnosed as she was unguardedly open about her own ideas and relationships. It was a dialogue, starkly different to the medical monologue that in the words of David ‘*Only confirmed to me that I was mentally ill*’, or that ‘*They are only interested in finding the right level of medication*’ (Mathew). Mags and her doctor risked having a conversation about life, about choice, and about authorship. It asked questions of the other: ‘What would you like to do or to become?’. In this intermingling, Dr D was able to challenge Mags to reflect on her behaviour. She became a person with opinions about Mags’ personal resources. Introducing the idea that Mags had the power to choose was empowering, as Mags was recast as someone whose current choices were perhaps involved in nurturing the ‘dis-ease’. Dr D also risked sharing her beliefs about the family being a part of the problem. By telling this particular story she took a standpoint, she committed herself to the idea that Mags’ illness was somehow related to her personal context, which included her thoughts, behaviour, and relationships. Rappaport (2000) suggests that the medical view of ‘mental illness’ sees it as independent of any context. The idea that family can be ‘the cause’ of ‘mental illness’ is flatly rejected by organisations such as NAMI (2011) and SHINE (2011), whose publications describe schizophrenia and bipolar disorder as ‘chronic medical illnesses’ that affect the same numbers of people worldwide and are therefore, by implication, independent of family or cultural context. The young doctor therefore takes a professional risk by giving voice to this particular idea. On Mags’ part, perhaps the most significant risk began with the doctor’s use of the word ‘dream’. ‘Where have you ever dreamed of going?’ Many commentators such as Deegan (1995) and Aherne and Fisher (1999) have noted the importance of dreams as a part of recovery. Positive dreams open up new

possibilities... Mags replied ‘I would love to go to the States’. The doctor then asked simply ‘*Why don’t you?*’

Mags’ account continued:

*‘So I hummed and hawed and I made a whole lot of negative responses and she said “Think about it and look into it”. So then I went to the group (GROW) and I said... Would I take it as a task, you know, to go on a holiday somewhere, and of course I got 110% support, “Go for it”, and in 1979 – which wasn’t that long afterwards – I went to America alone’ (Mags).*

Here, the value of having a GROW group and professional help working in accord became apparent. The group’s ready endorsement of Dr D’s challenge provided real grounds for confidence that encouraged Mags to take the risk. The group was saying ‘We believe in you’, and so she ‘dared’ to travel:

*‘And I really enjoyed it. It was a great experience... You know, the combination of the group and that. When I came back from that then I felt... “I’m a long way on”. I began to really find my feet, after doing the States – I wasn’t as scared of a recurrence or a relapse, definitely not as scared... I would say I was cajoled into going rather than choosing. I think the task from the group was to buy the ticket!’ (Mags).*

The trip to America had reduced Mags’ fear and endorsed hope for the future. If she could follow this dream, she could follow other dreams. She was beginning to learn that the future could be ‘An opportunity to become’, and the enduring experience of enjoyment provided physical proof that her efforts at recovery were bearing fruit.

While hospitals could provide direct healing links to a range of professionals, some people reported seeking professional help through other formal structures, such as work. James reported receiving help from a psychologist provided by his employer. Similar to the other participants, what James reported as helpful was the fact that the psychologist was interested in what he had to say and what he wanted. He was not trying to diagnose a disease, but to understand him as a unique individual. After listening, he empowered James by giving him some tools to work with:

*‘It was helpful. I think I only went to three sessions... For the first half an hour he [the psychologist] said “OK, explain to me what you want out of this”, and I gave him a run down... [Of] the issues that I was experiencing... So I explained to him that was the situation... It was very informative... He*

*explained to me, look, that he was going to try and explain to me what I was doing and then give me some tools to work with. And a lot of them were very similar to what GROW was doing; there wasn't any major difference'*  
(James).

Perhaps most importantly, the psychologist was able to provide a new story which explained his terror in an empowering way. James' paranoia wasn't the result of a disease, over which he had no control, but was caused by his own defence mechanisms, which he could learn to understand and control. He was empowered to deconstruct his paranoia by understanding that his fearful thinking was primarily triggered physiologically, and the idea of a 'plot' was an example of what Seligman (2007:50) calls catastrophic interpretation. In this way he was enabled to re-author his story through processes similar to those experienced within GROW:

*'The first thing he said to me was that this kind of obsessional thought and this kind of suspicion of people was actually a kind of a defence mechanism that I'd built up that is supposed to help me, but it had gone over the edge – it had gone a bit too far, you know? It's the same as if, you know, you walk into a dodgy neighbourhood – it's there for a reason, you are supposed to feel a bit suspicious just to keep yourself safe, but I had gone the far end, to a total extreme... It made a lot of sense to me. I only went to two or three sessions with him, you know. And it was all about affirming myself, which was definitely complementary to GROW'* (James).

Kartalova-O'Doherty & Tedstone Doherty (2010) found that recovery consisted of reconnecting with self, with others and with the future. These participants' stories suggest that reconnecting can begin anywhere, with anyone, and is dependent on the quality of a relationship, rather than any professional qualification or psychiatric label. Within my study, the participants evidenced the value of trained professionals combining human warmth and equality with specialist knowledge and practical help. The most important thing for Tom and others was that they felt that the professionals cared for them and were interested in them as people. A criticism of all forms of medical care is that it is focused on 'caring for' the disease, ignoring the person (Kleinman 1988, Frank 2004). In this study, good practitioners demonstrate care in the sense that Levinas (1969) defines care: they are interested in the person, and it is the warmth and interest within this relationship that helps the person. A warm and appreciative interest in them as unique and valuable individuals is also perhaps the defining feature of being healed through involvement in GROW.

### **Medication's role in re-enchantment**

The prescription and taking of psychiatric medication lies at the heart of the medical model of 'mental illness' (Lynch 2001, Whitaker 2010, Browne 2008). All 26 people in my study reported being prescribed medication. While chapter six included many reports of medication proving to be distinctly unhelpful, for some participants it played a beneficial role in the process of recovery. When James was hospitalised, it took a while for him to notice that his fear was diminishing. In James' view, medication helped combat his obsessive and fearful thinking and allowed reassuring feelings of appreciation to provide 'a breathing space':

*'On the second week I was put on an antidepressants. I didn't find any effect, but one day I was down town and suddenly realised I had been able to daydream like I used to, like normal people. The fears had gone away for a while. For five minutes I found myself appreciating the flowers – so the medication gave me a little breathing space' (James).*

Paul believes it was a combination of medication and other therapies that helped bring him into recovery. By slowing him down, medication paved the way for Paul to begin to benefit from more personal forms of help:

*'Medication, combined with therapies, has been a factor in my being in recovery. The medication just slowed me down. It didn't bring my thinking back to normal. The delusions were still very heavy. The first signs of recovery were after about three months on medication' (Paul).*

Medication helped Nan sleep. Even though she experienced withdrawals when she stopped taking it, in her view it was worthwhile:

*'The medication did help a bit, but I was going round in a fog. I was taking medication for four years and finally stopped taking the tranquillisers. My sleeping pattern came back. I had withdrawals, but they were no worse than the panic attacks I had overcome' (Nan).*

Claire was also enabled to sleep:

*'Medication was helpful, yeah, it was, especially to help me to sleep at night. That's the main thing – sleep' (Claire).*

In both Nan's and Claire's experience, medication served a practical purpose and allowed sleep to come and proved to be a valuable temporary form of help. There

was no mention of a changed brain chemistry, just the necessary sanctuary and opportunity to sleep.

For Sue, medication was a real lifesaver, enabling her to relax enough to eat, the thought of which had filled her with terror:

*'Relaxants kept me alive, they helped me to eat' (Sue).*

Peg found medication helped her cope with a marriage breakdown, although on its own it was not the answer:

*'When my marriage broke up, I took antidepressants for a year and a half, it helped tremendously. It took the edge off, but I knew it wasn't the answer'  
(Peg).*

From these various accounts, it is clear that medication may play a valuable role within the recovery process. Medication can *'take the edge off pain'* (Peg), it can reduce levels of fear, or it can slow a person down. It can alter a person's somatic story, temporarily reducing distressing feelings and thus providing a starting point for change. In this view, it acts as an external aid to control, similar to a plaster cast encasing a broken limb, which allows healing to take place. However, participants' accounts of the benefits of medication were far less specific than their descriptions of the healing role of hospital or significantly helpful relationships with people. Statements such as Peg's that *'antidepressants helped tremendously'* fail to demonstrate exactly how they were helpful, other than they *'took the edge off pain [ful feelings]... but was not the answer'*. Many people successfully left medication behind, although this journey involved many side effects. Of those remaining on medication, all expressed a desire to one day be medication-free. Mags speculated that their reason for staying on medication may be fear:

*'And they're very, very well and they're still on it, and I wonder really why – I think it might be just a fear. A fear of a relapse, or another fear that they're being persuaded to continue with it... Being scared of what might happen'  
(Mags).*

## Summary

These narratives show that the formal mental health system can play a valuable role in a 'time of healing' and in a 're-enchantment with life through professional help'. Hospital can be experienced as 'a place of sanctuary' from overwhelming negative and terrifying emotions; from fear of what participants might do, either to themselves or to others; from destructive crises and relationships within the family; and from experienced life traumas. Other people who are also in hospital can become a part of that sanctuary by bringing about a realisation that they are not alone or different from others. 'Healing professional relationships' with individuals trained in a variety of disciplines can play a crucial role in the healing process if they form a genuine relationship with the person being helped. This type of relationship often involved younger members of staff who perhaps had not become institutionalised, or professionals whose beliefs about the nature and cause of 'mental illness' differed from those of the disempowering medical model. Participants described healing instances of 'carnival', when labels and rules were put aside and warm human interactions such as friendship and reciprocal intercourse proved significant to the healing process. Risk taking was a theme that ran throughout these stories of healing. Risk taking was described as a shared activity between the participants and the mental health professionals with whom they were involved, each facing different forms of personal risk. In addition, many participants found medication could play a role in recovery as 'a re-enchantment'. Medication was described as a resource that could enable a person to begin to help themselves. It modified the body's story of terror and could be lifesaving, by paving the way for more personal forms of help. One might ask why, if the formal mental health services were so good and so effective, people would feel the need to join GROW. This chapter must be read bearing in mind all the negative experiences reported and where the mental health services became part of the person's place of terror. Indeed, many of the contributors to this chapter also reported many negative encounters with the services.

Recovery from 'mental illness' does not end with 'healing', but necessitates becoming re-involved in society. The next chapter focuses on the theme 'An opportunity to become: re-enchantment through authoring a new story', which is the final of the three phases of recovery. It follows people's stories as they discover compatible niches in society which continue to provide new stories of positive identity and meaning.

## CHAPTER NINE: AN OPPORTUNITY TO BECOME– RE-ENCHANTMENT THROUGH RE-AUTHORING A DIFFERENT STORY

*'Becoming fully alive'. 'Able to contribute'. 'Living life to the full'. 'Taking the good with the bad'. 'I don't have to be somebody to suit somebody else all the time'. 'I began to sense I needed a challenge'. 'I sensed that even though work was pushing me beyond my limits, it was good for me'. 'You're sent out to build up your own social network'. 'I got involved in the local parish committee and I really blossomed'. 'Recovery is like a stool – it needs more than two legs'.*

### Introduction

This chapter presents the findings of the last of three phases of recovery from 'mental illness' and is entitled 'An opportunity to become: re-enchantment through re-authoring a different story'. The chapter follows the progress and ongoing transformation of participants as they emerge from the nurturing community of GROW and become meaningfully and independently involved in society. It uses a mixture of long, rich, in-depth descriptions by distinct individuals to explore complex processes involved in the creation of new identities, and shorter interview quotes to describe shared effects of being involved in those processes. The chapter has been divided into four sub-themes. It starts by examining how participants regained control of their lives by 'becoming empowered to choose'. The sub-theme 'the empowerment of social involvements' describes processes experienced when participants became involved in various existing social niches. The positive benefits of involvement are explored under the heading 'becoming mature and re-authoring past experiences of suffering', and this is then linked to 'becoming part of the social good and the notion of providence'.

### Becoming empowered to choose

To become the author of your own story, or to successfully define who you are, is the goal and ongoing struggle of each individual human being as they strive to deal with the ongoing politics and pressures of life. This process of self-authorisation would also seem to be central to recovery from 'mental illness' for the participants in this study. Recovery, as described by participants, was experienced as a form of liberation from many socially constructed and externally generated stories of negative difference. It also involved learning to successfully manage chaotic,

terrifying and alien feelings and thoughts, and internally generated somatic and cognitive stories, evoked in response to these experiences. Chapter seven illustrated how the process of ‘learning to author a new story’ began within the family atmosphere of a GROW group. Now, as participants rejoined society, they continued to experience the same process of identity transformation. This was as a result of developing new and positive relationships with others and learning to choose new ways of being in the world. Bakhtin (1981) has suggested that the ability to choose is central to the process of constructing a meaningful and positive identity. Choosing involves being able to evaluate and satisfactorily integrate a heteroglossia of stories told about oneself, many of which are alien.

As discussed in chapter six, participants described ‘mental illness’ as living in ‘a place of terror’. A key ingredient of that terror was a sense of powerlessness and a subsequent inability to make effective or meaningful life choices. The sub-theme ‘a place of terror’ illustrated how choices made in an attempt to escape from terror often exacerbated a sense of negative identity and, indeed, terror. Consequently, even the act of ‘choosing’ became disempowering. During ‘A time of healing’, participants were encouraged and supported by the GROW community to begin to experiment with choosing empowering ways of thinking and behaving, even if these new ‘life habits’ initially precipitated fear or anxiety, or triggered a setback. For example, Sue described choosing to go for a walk, which involved overcoming high levels of fear that kept her trapped at home. Pat attended social activities and broke his sense of isolation, and Kate assumed leadership roles that contradicted her sense of worthlessness. Within GROW, the ongoing practice of choosing – to do tasks, take on leadership roles, become involved socially, develop personal gifts and talents by overcoming feelings of either fear or repulsion – provided grounds for confidence for a productive involvement beyond GROW. Participants described being supported by their group as they became progressively more involved in niches in society. Society now became an invaluable part of the quest for a positive identity and a developing ability to deal with life. The following quotes from Cathy, Peter and Mathew illustrate how participants began to choose and benefit from the risk of challenging involvements:

*‘I began to sense I needed a challenge’ (Cathy).*



*'I sensed that, even though work was pushing me beyond my limits, it was good for me' (Peter).*

*'I got a leadership role as class committee person and I took on the challenge – not so much to help my fellow man, but for my own personal growth' (Mathew).*

The positive fruits of making choices within and outside GROW created a new language of possibility, with empowering realisations such as:

*'Others are the same as myself' (James).*

*'I can do this' (Peter).*

*'I am allowed to be' (Frances).*

*'I sensed I belonged' (Nan).*

The future slowly became transformed, from something to be dreaded into an exciting and ever-present opportunity for change and 'a re-authoring of story':

*'It took two to three years. I started to relax and people started to get more friendly. The more I became relaxed, the more people relaxed around me. It started falling into place' (Tom).*

*'When I left the army I was left with choices. My wife encouraged me to go back to education' (Jess).*

*'I began to reduce medications. It was like I had almost fully recovered' (Mags).*

*'I was able to go out and mix and do different things, go to shows, and drive' (Jack).*

By repeatedly making worthwhile choices, participants gradually claimed positive ownership of their own sense of who they were and who they might become, while still remaining cognisant of the often negative dialogues happening around them. Learning to choose and to benefit from involvement with others represented a movement from what Bakhtin (1973) describes as 'adventure time' to 'biographical time'. In 'adventure time', life is driven; choice becomes limited, because there is a loss of effective internal and external control. In 'biographical time', a person

becomes able to make rational decisions, identify available resources and begin the process of winning control of their destiny. Bakhtin (1973) equates this to assuming agency, where agency is about learning to take control of the authorship of one's identity.

In summary, participants' accounts suggested that GROW prepared them to recover by encouraging choice within the group. Making new and positive choices offered glimpses of a new identity, which was then tested and confirmed through a series of involvements in society. It was within the wider society that participants confronted and dealt with the day-to-day realities and demands of independent living, and became fully empowered to shed the terrifying personal, family, professional, and cultural identities of being 'mentally ill'. The next section explores processes at work when participants become involved in society.

### Becoming empowered through social involvements

Social inclusion has long been recognised as essential to the maintenance of mental health and a key ingredient for recovery (Huxley and Thornicroft 2001, Cobigo and Stuart 2010). In the document 'A Vision for Change: Report of the Expert Group on Mental Health Policy', it is suggested that the ultimate goal of recovery must involve an 'integration into mainstream community life' (Department of Health and Children 2006:14). GROW believes society contains all the resources necessary to continue the processes of recovery and personal growth started within the GROW community (GROW undated:14). Rappaport (1995) has suggested that many of these resources are contained within existing social niches and are discovered in the form of identity-transforming stories. In this view, involvement in society acts like the developing fluid in a dark room. Through regular immersion in the medium of inclusive others, new facets of the unique face or identity of the real person begin to emerge. A number of participants explicitly stated that social involvements outside GROW were essential to recovery. For example, Cathy and Peter described their experience in the following quotations:

*'You are sent out to... Whether it's personal development or dance classes, wherever a person needs to go. I don't think somebody in GROW can "become" if you keep together... You're sent out to build up your own social network so you don't become isolated within GROW and stigmatised again –*

*that would cause people to be stunted nearly' (Cathy).*

*'For the recovery model to work well, you need different things. I compare it to a stool: if a stool has one or two legs, it's unstable, but if it has three or four it becomes really stable. For me, having GROW was good, but having work as well has made my mental health better. Things like hill-walking helped too' (Peter).*

One of the most significant niches of involvement reported by many was employment:

*'I love the people there [mentions a day centre]; I would not miss going. I call the bingo numbers, it is my work' (Penny).*

*'Working with people with [names a disability] taught me a great deal about myself' (Peter).*

*'I changed from the night to the day shift – I had been using the night shift to isolate myself' (James).*

The importance of employment in the recovery journey, whether paid or unpaid, was reiterated by the majority of participants and is illustrated well by Kate's experiences. Kate and her husband were both unemployed, with three small children. After two years in GROW, Kate felt she was ready to return to work. Returning to work required courage, a spiritual resource that had taken two years to gather:

*'One of the biggest things was returning to work... It was the beginning of taking my responsible and caring place back in the world. [In GROW] I had gathered the courage that, you know, "I can do this – indeed I have to do it". It was necessary that one of us had some work and was earning some money, so I went back and I did a job, and it was probably one of the best things that ever happened to me' (Kate).*

Just as being a patient in the hospital had proffered a social script that defined Kate's identity, so did being employed. Being hospitalised represented a belief that Kate had become a danger to 'herself or others' and couldn't be trusted. By giving her a job and putting her in charge of a 'million dollars' worth of machinery', her employers demonstrated a tangible story of trust. Being involved in the GROW group had provided reasonable grounds for confidence for Kate to trust herself enough to successfully step into that story. While negative memories of the past were still very real, the ongoing experience of employment allowed Kate to sense they could be

overcome:

*'It [the job] was full-time and it was a night shift. At the time, I wouldn't have left myself in control of flushing the toilet, but they were leaving me in control of a million dollars' worth of machinery and I think "Jesus, if they knew..." It was really helpful. I went somewhere for eight hours and was too busy to think of myself... Though I used to have my moments – I would go out to the loo and close the door and try to breathe and try to get a grip, and I would take my medication because I would still be taking medication at the time. It was about diverting your attention; this job was diverting my attention away from concentrating 24 hours a day on my feelings' (Kate).*

Kate's experience resonates with accounts of other participants, for example Jack also talked about the importance of keeping his mind occupied:

*'So I feel better going to work... At home thinking, all these things come to your mind... Being in work keeps your mind occupied – it's very important' (Jack).*

By continually allowing her mind to dwell on herself, Kate, like Jack and others, was constantly rehearsing the negative stories of the past, which maintained the fearful emotions connected with past interactions with others. Diverting her attention made room for the emergence of new stories at many levels. These included new feelings or 'somatic stories' of accomplishment, realisations or 'cognitive stories' such as 'I can do this', 'interpersonal stories' of appreciative acceptance from colleagues, and a 'cultural' and 'authoritative story' in the form of a contract and monetary reward. So, just as terror in chapter six was seen to spawn other destructive feelings such as hate, rejection or resentment, Kate was beginning to experience and nurture a family of positive feelings. She became empowered to 'exert due control over her destiny', which was matched 'against deterministic forces', and in so doing she was developing and experiencing agency and character which enabled her to 're-author her story' (Ogawa 2005:90).

Work wasn't an end in itself – it was '*the beginning of a new life*'. Paid employment provided real resources to cope with 'deterministic forces', such as the implications of the label 'mental illness' and of living in an area 'notorious for crime and drugs', which threatened the well-being of herself and her family, respectively. Being in paid employment empowered Kate to choose to move:

*‘That job was great for me: it was the first step onto the beginning of a new life. The fact that I returned to work, and my husband got work quickly afterwards, enabled us to buy our first house. I loved the area I was living in, but it became notorious for crime and drugs, and it would not have been a nice place to bring my children up in’ (Kate).*

Payment for work is one of the rituals that Bruner (2002:45) says ‘frames things in such a way as to be seen as beyond debate’. Many writers such as Anthony (1993) and Patel and Kleinman (2003) have identified poverty as the most common source of ‘mental illness’, and suggest that ongoing poverty, coupled with low levels of education, mitigates against recovery. In the factory, it was also impossible to avoid inclusion:

*‘In an environment like that where you have so many people, you can’t sit on your own – there are 300 people out for a break at the one time. You get sucked along with the crowd. You go out for a smoke break and there are twenty outside. You can’t help but be drawn in’ (Kate).*

Being part of a friendly workforce reinforced the realisation first experienced in GROW that ‘I am not so different from others’. From being someone who had lost the ability to ‘connect’, suddenly Kate was connected with 300 people, a context which allowed a new testimony of her own wellness to slowly find expression. The dialogues involved loosened the hold of ‘bits and pieces of memory’ that came from another time, ‘*where I felt suicide was the only way to get rid of this*’ (Kate) and when she ‘*was looking at a lifetime of maybe me going in and out of psychiatric hospitals*’ (Kate). Frank suggests that testimonies of wellness present as ‘some fragment of a larger whole that the individual witness makes no pretense of grasping in its entirety’ (Frank 1995:139). Kate had entered a time of positive becoming – an ongoing process, of which she was only partly aware. Fragments of daily experiences, such as throwing herself into work, huddling with others over a cigarette, opening her pay packet, experiencing the satisfaction of being trusted, dreaming of a new home, all became multiple sources of new memories. They were experienced primarily as hopeful or joyful feelings, somatic stories, a new song in her heart, a heart that was no longer just a physical pump but a ‘heart that leapt with joy’, (Deegan 1995:91) and which confirmed her as a unique, valid and valued person. Kate continues:

*'I remember one of my first social nights out – without any of my safety nets like GROW or my husband– was actually in that job. I went out one night for the Christmas break and again that sense of "I'm actually out for a night and my husband isn't here", that whole sense of standing on my own two feet was exhilarating, to say the least' (Kate).*

Kate described a real sense of having become an independent self. It was exhilarating, and Kate's body articulated a positive story. Unlike the hope that first beckoned at the start of GROW and which, in some mysterious way, was transferred to her from others, this exhilaration was the end product of her own 're-authoring' or 'storywork'. It was confirmation that she was journeying in the direction of becoming her 'ideological self'. Kate's exhilaration is still not the end point any more than working in a factory, but a call for further choices:

*'All these things were laying the foundation for me to go on to bigger and better things' (Kate).*

Slowly, Kate began to realise '*I can do this*'. '*I can be(come) me*'. Bits and pieces of a larger whole were gestating to emerge as temporary 'nows' on a journey of becoming. 'In the beginning was the word and the word was made flesh'(John 1:1), and the words that were now surrounding Kate were 'LIFE' and 'HOPE' and 'POSSIBILITY'. These words were literally becoming her flesh:

*'All of these things were a challenge, and every challenge I took on drove me forward a little step. And every challenge I took on maybe made me look at or want to do something else' (Kate).*

Kate had begun to challenge herself; she had 're-authored' her life as a positive, unfolding mystery containing 'an opportunity to become'. Like Walt Whitman, she could triumphantly sing:

'I CELEBRATE myself;  
I breathe the fragrance of myself, and know it and like it;  
The distillation would intoxicate me also, but I shall not let it.  
It is for my mouth forever - I am in love with it' (Whitman 1963:1).

For Kate and for many other of the participants, the 'distillation' that 'would intoxicate' (Whitman 1963:1) included going back to education:

*'It was a huge chip on my shoulder that I had never completed my education and[it] contributed to my feelings of inadequacy' (Kate).*

The Leaving Cert. was another first step, and then:

*'I decided that doing Humanistic Integrated Counselling would really enhance the qualities I already had – it would give me the added bonus of knowing on a professional level. I felt that I had a lot of the skills that it took to be a counsellor. I was very supportive, kind, genuine; I was very empathic towards people who had suffered in the same way I had' (Kate).*

Kate continued to re-author her own story. In fact, re-authorisation had become a systematic process, each step opening up new possibilities. She was now aware of some of her inner qualities and from choosing to get 'any' job, she was now empowered to choose one that suited her temperament. Bakhtin (1981) sees authorship as 'the force which drives development' and 'the experience of dialogue' (Bakhtin 1981:341). According to Bakhtin, authorship is the end result of an intense struggle with, and a liberation from, a polyglot of different voices, many of which are alien. Kate's decision to add to her curriculum vitae the 'authoritative utterance' of a professional qualification placed her within another social ritual that, again, formally 're-authored her story', at once 'liberating her' and moving her up the social pyramid.

Kate's story has illustrated the way that an involvement in work acted as a vital beginning to recovery. In time, this led to a return to adult education and the freedom to choose a professional identity and qualification. Similarly, for others, involvement in a wide variety of leisure and educational social niches were significant in the process of 'becoming re-encharmed through social involvement' and in 're-authoring a different story'.

Golf played a key role in James' recovery, providing him with '*lessons in going forward*' and allowing him to understand himself in new ways:

*'In work they had a golf society. I went along to the first golf outing and everyone there was very courteous and there was no bravado – it was a very relaxed atmosphere, you know' (James).*

Just as in the early days of James' involvement in GROW, at the golf club there was a relaxed atmosphere and he immediately felt at home. He soon realised golf had an unexpected agenda:

*'The one thing I noticed about golf was that my anger levels would build up – you know, tension. I could start off OK... Not being able to hit it, now that's perfectly natural in golf, but for me it was building up to real bad levels of stress. Yeah, so the task was to be aware of it. I also noticed that when the anger would build up, also my sense of perception would lose itself. The more my anger built up, the more I felt that people were out to get me' (James).*

In the previous chapter, James described how a psychologist had explained paranoia in a way that made sense. Now, golf triggered that paranoia, and allowed him to 're-author' new ways of dealing with it. Golf had become a biofeedback mechanism, through which he could practice the choice of control:

*'I realised there was a link there between the two, anger and people being out to get me. So a lot of the tasks that I had were to play golf to relax. It's in all the golf books (laughing), saying "It's all about the journey, it's about enjoying it, don't think of the result", so some of the golf books have it' (James).*

Through playing golf, anger had been identified as a 'deterministic force' that could be countered by the simple act of conscious relaxation:

*'You know, not rushing around the place. And then you are about to tee off, you see people arriving at the last minute – they are the ones that are anxious, so you can kind of say, you know, you can judge it. So all that was GROW-related, but the golf definitely helped me in terms of understanding my temperament, without a doubt. Now I play with different people every week, just put my name down, and some people are very relaxed and some people will get the clubs and throw them into hedges. And I can look at that person and go "Well that was me a year ago, you know" (laughing)' (James).*

James' temperament was becoming legible and he was enabled to 're-author his story', from one which cast him as alien, dangerous and different from others, to someone who was essentially the same as others, with whom he could now feel at home.

Other people in this study reported choosing to become involved in a range of leisure activities such as creative writing, public speaking, dancing, music, cycling, singing, hill-walking, their church, yoga, Gaelic football and theatre, all of which became



micro schools of learning through experience and all of which readily welcomed new members. From these examples, it seems that becoming involved in any activity that involves equal relationships with other people provides new dialogues and relationships that can become a means of 're-authoring a new story'. Participation in social niches served to transform or 're-author' deterministic tales of negative difference into tales of mutuality, belonging, trust, and possibility.

Poverty and a low level of formal education have already been identified as key factors in the genesis and maintenance of 'mental illness' (Anthony 1993, Patel and Kleinman 2003). While Kate (and others) described how a return to education removed a sense of stigma, many participants reported that going back to formal education helped them to understand life and in this way to become empowered to 're-author their story':

*'I discovered philosophy. Gabriel Marcel, a Christian existentialist – he kind of believes in our relationships with people we create. We're creative in our relationships with other people, and hence the meaning of harmony in relationships is what it's all about. I became more philosophically aware'*  
(David).

For David, making sense of life was the important thing. He was already in secure employment:

*'I don't hope to do anything with it, just study – I mean, I get a kick out of it. I started getting good marks on some of these philosophy exercises and I haven't done that before ever... Well I had school, but I hadn't really. I don't want to do any work, I want to study'* (David).

He had also discovered something he loved to do and a place where he was able to shine and see himself in a different light. This is a theme taken up by Cathy, who studied theology:

*'It was wonderful to sit in a class; I think I loved it. I did a three year course... I qualified for that. That whole issue of wanting to get to know what is it all about... I think I wanted to know God better. It was very helpful because I got insight into the spirituality side of it – to know how, you know? We do things... That's a choice we took at that particular time. Don't, sort of, analyse it – just say "Well, that was a learning process", like "What would I do different the next time?" And that was theology. It was very practical'* (Cathy).

Theology taught Cathy how to understand herself and made life more manageable by opening up the possibility that ‘I would do [things] different the next time’, and thus opening a future that holds the promise of ‘re-authorship’. Mathew studied theology independently through reading books. He had lived with a psychiatric identity for many years:

*‘For seventeen years, they [the psychiatrists and nurses] wouldn’t tell you much. They might spend a minute or two telling you about whatever it was. It was on my own but I actually went out and found out about what ‘mental illness’ is – first of all what ‘manic depression’ was and then what ‘schizoaffective’ was’ (Mathew).*

Mathew wanted to know more about the reality of ‘mental illness’ [apart from the crippling medical story] and began to search for new explanations that would perhaps allow him to understand himself in a new way:

*‘I suppose it was maybe triggered by the illness – all those sort of crazy experiences kind of triggered an interest in spirituality, probably after the age of 31 or 32. I was reading an awful lot of spiritual books, I must have read nearly getting up to about 80 or 90 spiritual books in the last eight or nine years’ (Mathew).*

All the different books provided fragments that offered new ways of understanding all the ‘crazy experiences’ about which, for seventeen years, professionals ‘*wouldn’t tell much*’.

*‘In a practical way, in the last few years it’s helped me. I saw a common thread between Christian mystics and Taoism and Zen. Your thinking mind becomes your ego and your self, and it separates you from the world and makes you hung up with the past, the future and your desiring more for self. Your own security or your fear for yourself basically cuts you off from God, yourself, other people, your true nature – cuts you off from peace’ (Mathew).*

Just as work stopped Kate thinking about herself, thus providing space for the ‘authorisation’ of new stories, Mathew found the practice of meditation brought the same result.

*‘A lot of it is just slow your thinking down, come out of your head. The real part of you, the part of you that feels most alive and most spacious and most for life is not the fearful little voice in your head – it’s the silence, it’s the soul or the spirit down here, the heart or the soul. The spirit down here, it’s quiet –*

*it's not thinking, it's not conceptual intelligence, it's just pure consciousness, pure awareness' (Mathew).*

In the study of meditative techniques, Mathew had stumbled on (or been led to) a new therapeutic strategy inspired by studies which show that Buddhist meditation techniques are '*useful for patients who have not responded to more traditional forms of psychotherapy*' (Whitaker 2010). Mathew, whose definition of recovery was the idea of moving '*from a small self to a bigger self*', is now extending the idea of a bigger self to include the idea of God or life, something which is in us and around us. In Hindu philosophy, it is called the 'Atman', or the universal spirit that unites all human souls – souls who live in individually constructed realities called 'Maya' or 'illusion'. In Christianity, it is called the 'still, small voice of God', whose fruits include love, joy, and peace (Corinthians 12:7). It is a voice that is beyond our understanding and one we can only glimpse. In biological terms, meditation has been shown to tap into the body's own ability to produce tranquillising chemicals such as the endorphins (Newberg and Iverson 2003, Øktedalen et al. 2001).

Max Weber (2000 [1904] :86), while being an avid supporter of the vast potential of science, noted that modernism and science tended to rob life of enchantment. Scaff (2000) summarises the idea of disenchantment as representing a loss of a 'sacred sense of wholeness and reconciliation between self and the world provided by myth, magic, tradition, religion or immanent nature'. It heralds a disruptive sense of 'abstraction, alienation, homelessness', rendering life meaningless, a state that 'Begins to gnaw at the vital core of modern experience' (Scaff 2000:105).

Helen's story illustrates how studying theology played a key role in countering this sense of disenchantment:

*'I'd had a difficult life and I got suicidal feelings at one stage. I was unemployed and I was isolated... I had no money, and I wasn't happy at home. I couldn't get this thought out of my head [that I wanted to take my own life]; now, I didn't think I would act on it. I really didn't think I was in danger, but it's not a nice thought to have and it stayed for about fourteen and a half months, but I found my faith was a help because taking your life is against it'*  
(Helen).

Helen was struggling with disenchantment – there was no reconciliation between herself and her world; she was unemployed, isolated and unhappy. She began to

contemplate suicide. The last remnants of her faith were a help because within that faith, suicide was wrong:

*‘And then when I got over the suicidal thoughts, I discovered, sure I hardly believe in God at all – you know, a God of love and mercy and compassion – after going through what I went through’ (Helen).*

When the suicidal feelings lifted, Helen was confronted by a dilemma of faith and signed up for a degree in theology. She was expecting a rational discourse that would enable her to make a purely rational decision about the existence of God,

*‘But in the end it was very quickly resolved by somebody whom I thought was unusually good – that really resolved it, because I said “When you meet somebody spectacularly good, it reassures you and reassures me”, and I said “Even if I have bumpy patches in my faith, I will stay with the practice of it”. What I will never forget was his compassion. He had immense compassion, especially over a very bad incident that had happened to me with a staff member the first time I was in university. He was so upset he could hardly talk and he put his hand on the table to strengthen himself to get his voice and to hold himself up’ (Helen).*

Instead of intellectual discussion and rational argument, Helen met someone who was ‘unusually good’ and experienced the re-enchantment of compassionate witness. Compassion was something expressed and understood through the heart and experienced through the body. She goes on to describe her experience of the rest of the course:

*‘It was very intellectual... The content I have forgotten, except a remark made by one lecturer from [the writings of] St. Paul – you know, that Christian love is practical... I said to myself “The few people that I have contact with, if I can do practical good for them... Christian love is practical”’ (Helen).*

A fragment of Helen’s memory of the course which stands out was that Christian love is very practical. Bakhtin (1973) has said that words are dead unless seen in the interpersonal context of dialogue. By meeting compassion through a social involvement, Helen found a way she can be in the world. Today, Helen works with others who are recovering from ‘mental illness’, carrying a message of recovery that ‘re-authors’ and challenges the rational disenchantment of the medical model.

For Richard, science was the attractive educational niche:

*'It occurred to me that, well, I've always loved science, really, really... [But] my experience and qualifications were years out of date... I thought "If I could do a one-year course..."' (Richard).*

Richard was subsequently awarded a first-class honours degree and then found employment as manager of an ecological project.

For Nan, re-authoring her story through society began with her relationship with members of her family and with neighbours:

*'[It began] with my relationship with my husband and the girls as they grew up and into adults... When I was 'unwell', the last thing I wanted was to meet neighbours and stand talking. It's amazing now that I can just go over, I can go into town, I can go to mass and do the ordinary things... I did a few interviews on radio and so all of that helped' (Nan).*

Her experience differed to that of other participants because her social involvements were all informal; nevertheless, they showed profound 're-authoring' of who Nan was and how she behaved in the company of others.

In summary, work, education, and leisure have been described as social niches that enabled people to experience 'becoming empowered through social involvement' and to choose and 're-author new stories' of belonging. One of the results of being involved in these niches was a sense of becoming more mature, of being better equipped to deal with life and of being able to 're-author past experiences of suffering'.

#### Becoming more mature and re-authoring past experiences of suffering

Alanen (2009) suggests that 'mental illness' is best understood as an enacted struggle in the transition from adolescence to adulthood. While the GROW group helped people start to mature, recovery meant learning to deal with life in society, where 'the safety nets' of GROW and family were no longer present. Indeed, GROW equates mental health and recovery with maturity. Maturity is described as 'a coming to terms with oneself, with others and with life as a whole' (GROW 2001:45).

For Cathy, recovery meant learning to cope with ordinary things such as conflict and disagreement, which would previously have generated overwhelming feelings of

distress and had contributed to her becoming 'mentally ill'. Recovery involved 're-authoring' her understanding of past suffering, so that conflict with others became both acceptable and manageable. By re-tracing her footsteps and re-joining a committee she previously identified as one source of her 'mental illness', she learned that she could now embrace life's difficulties. As a consequence, she had a sense of maturing and of being better able to deal with life:

*'I suppose for me it's learning maturity as an adult: that I didn't always have to agree, and it was OK to disagree' (Cathy).*

Peter found that, in work, he was compelled to learn to control his anger when he was dealing with other people:

*'I developed the ability to form friendships and learned how to deal with people, even when they were very difficult. I learned to wear a mask and to keep my negative feelings under control' (Peter).*

In this way, he was enabled to 're-author' his view of himself and to experience the liberating effects of behaving differently with others.

Richard slowly learned to accept the pain of an unwanted and devastating marriage separation, through a combination of adult education and work involvements:

*'Mountains slowly became [re-authored as] molehills and life became manageable' (Richard).*

Frances learned how to free herself from internalised rules and regulations that had impeded her ability to love. For Frances, love involved finding social contexts such as teaching, in which she experienced a sense of becoming fully alive:

*'I took longer than others to throw off all the rules and regulations that were blocking me from being able to love... I am never more alive than when I'm in front of a group, I am convinced that this is my forte. I just come alive – I come alive. Recovery is "becoming more strongly, wisely and more lovingly the same", unlearning the lessons that I needed to unlearn and putting in place lessons that I had to learn. The wrong thinking that I had was changed, if you like. 60% of this came from my own feelings, and the rest from the real actions of others' (Frances).*

Nan, too, spoke of learning maturity and described the effects of becoming mature as

a process of 're-authoring' her relationship with herself and with time:

*'I began to believe in myself, that's all I can say. My philosophy would be to get up in the morning, be as happy as you can, do the best you can... Another technique that helped me was "living in the now" – enjoying the moment, just this moment that you will never have again, you never had or you won't have it again – it's just, you know, living in the moment. I find that great' (Nan).*

In Nan's view, learning to deal with society allowed her to enjoy the little things in life and, consequently, an emerging confidence began to replace the familiar 'story' of fear:

*'With time, I did begin to feel good about myself and I actually learned to love myself, which was a great thing. My relationship with God helped a great deal. It's the small things in life that keep me happy, it's the small things, nothing big – you know, smelling a rose, for instance, is a lovely thing, sitting out in the garden and having a cup of coffee, the small things... The confidence you gain in GROW, no one can ever take that away from you – it's there for life, and it's wonderful to feel good about yourself. I think GROW is a testing ground; it helped me enormously with my own personal life' (Nan).*

Many participants reported that a part of becoming mature involved learning to embrace and find meaning in different forms of suffering. This was very evident in Nan's account. Nan has a daughter, Leah, with cerebral palsy, for whom she is a full-time carer. Maturing involved accepting this situation, which contained truly awful memories. As a child, Leah would get up to 100 seizures a day and Nan had been in despair until a visit to Lourdes:

*'Leah is now 31 years of age, she's a very happy girl or woman really, but she still requires full-time care. So of course I do have days when I get up and I say "You know where is this going, you know where is it going..." I have a wonderful devotion to our lady of Lourdes... I do believe it was just becoming so bad that it was either me collapsing completely or put Leah into residential care, you know – something had to happen. I was up against a brick wall' (Nan).*

Today, Nan has completely 're-authored' the way she sees Leah's brain damage. She describes it almost as a blessing which has given her daughter's condition a marvellous purpose.

*‘People come up to me and Leah, it's like a magic energy in her. You'd see it if you meet her, she touches off people. And I think Leah is here for a reason... People have said to me "...Sure look at Leah... She's no speech or anything and yet she's so happy... It's remarkable"' (Nan).*

Many other participants described ‘re-authoring past suffering’, and the next section reveals how they often transformed that personal suffering into social capital or ‘part of the social good’, by using their experience to reach out to others in similar need.

### Becoming part of the social good and a notion of providence

Throughout this research, the theme of 'goodness' has been a constant feature. In chapter seven, ‘healing as re-enchantment through GROW’ was shown to involve an ethical transformation, with a continued emphasis on choosing to ‘do the good and ordinary thing... the thing you fear... the thing that repels you’, rather than doing what your feelings might suggest (GROW 2001:3). Taking responsibility for doing ‘the good thing’ was often linked to experiences of transcendental good, which people described as providential. In this section, the theme of ‘doing good’ is extended into becoming a part of society, learning maturity and directly contributing to what Bourdieu (2008) and Putman (2000) describe as 'social capital'. Putman (2000) notes that there appears to be a general decline in community involvement as society becomes more individualistic and more involved in work. Hyyppä and Mäki (2003) found that in communities with high levels of social capital, individuals had higher levels of well-being and health than those in matched communities with lower social capital. The stories of recovery by the participants suggest that recovery reverses the trend of withdrawal from community and, in fact, encourages and spontaneously generates social capital. Participants reported a desire to give back to their local community – a desire that was born out of their experiences of suffering.

When Kate trained as a psychotherapist, she realised her past suffering was a resource that in some way set her positively (rather than negatively) apart from others on the course. Her view of both herself and others had been ‘re-authored’ and transformed:

*‘It was invaluable when it came to talking about yourself – what I had learned in GROW was like manna from heaven. They [the others on the course] were so removed from themselves when it came then the real crunch in that kind of training, which is that if your own house isn't sorted out, you cannot sit with another person's pain – you just can't’ (Kate).*



Kate's suffering had become meaningful, the spur that initiated a desire to change:

*'It is the[se] things that teach us lessons in going forward... Because of that suffering. I wanted to recover, I wanted to learn, I wanted to change my life, and become. Exactly: just become, you know... my suffering taught me to do that' (Kate).*

Claire lost her grandson and then her son to suicide. In the last chapter, we saw how in GROW she found that '*re-authoring her suffering*' led her to care for a young man in the group. Later, she described GROW as giving her strength to contribute to the social good in a bigger way:

*'It made me that strong that after about two years I thought "What can I do about this now to help prevent suicide?" I got it into my mind I'd like to bring something to [names region] and I heard a lady on the radio one day; she lost her son, a sixteen-year-old, and she started a youth suicide campaign. So I got in touch with her' (Claire).*

Claire's devastating loss was no longer the end: it was 're-authored' as the beginning of a story of outreach. Despair was slowly transformed into a rallying call, a standpoint that attracted others. What Frank (1992) has termed 'the pedagogy of suffering', a pedagogy that transformed suffering into deeply understood compassion for others, came calling across the airwaves. Claire recalls:

*'And I thought it was going to happen tomorrow – I had no idea the work that does go on, but anyway we got there after about two years, loads of fundraising events and things like that, and we now have three phone lines operating in [names town]' (Claire).*

Claire soon learned that setting up a helpline was a big job – a journey that required huge effort and unfolded over a long period of time. She went on radio and told her own story; people rallied round. And as she told her story, a community began to grow around her. Claire was identified by others as a woman of strength and compassion, someone who had suffered. She came to represent the suffering of others. By publicly telling her story, she 're-authored' a dialogue many people had been unable to engage with. Claire's story went beyond words. People entered into it when they saw her walking up the street, when they looked into her face, and when they remembered her son. Claire's story was in the air of the town and the whole town responded:

*'Suicide has been a taboo subject for so long' (Claire)*

Claire became the yeast of change. Everyone knew someone who had died by suicide, everyone was affected by the unfolding story. The firemen volunteered to do a first-ever fundraiser. She regularly went on radio and was featured in newspaper articles.

*'Oh, please don't tell me I'm great. I'm not great – this is personal therapy for me, you know. But if I can help other people to prevent a suicide, which is the main thing, and then if not, to be there to help them, the family, afterwards, you know? And that's where I get strength, you know – I want to do this, I want to help people not to have to go through what I went through' (Claire).*

Bakhtin (1981) describes two kinds of discourses, which he calls 'centripedal' and 'centrifugal'. Centripedal language represents the dominant authoritative discourse which society is expected to accept as 'true'. Centrifugal language questions this central authority and exists within the fringes of society. The centripedal language of our mental health system would have us believe that 'mental illness' has no connection to life events, except to a chemical imbalance with the brain. In this view, suffering is unnecessary and meaningless. Cure is synonymous with a cessation of suffering. Claire's story is a centrifugal voice; her voice challenges the medical view. Claire's story turns suffering into compassion for others and becomes a story which breaks the hold of the certainty of science. It is these new stories which give mystery back to life and allow personal growth and re-enchantment beyond the label of 'mental illness'.

Without exception, all the participants in this study reported using their experience of suffering as a reason to give back, both as leaders in GROW and through social involvements. Paul, for whom social involvement was severely restricted because he was in prison or a secure unit, reported finding a meaning in his suffering which encouraged a desire to give back:

*'It has humbled me because I feel I owe a lot of people so much, particularly my family, so when I did (or when I do) get my liberty, [I] would like to feel that would be somehow able to pay them back' (Paul).*

Paul reported becoming sacristan in the unit's small church and took on a leadership role within GROW. There is, potentially, a wide community of people for whom Paul's story might act as a special beacon of hope. GROW runs one special group in a prison where most inmates have committed crimes that society is very slow to forgive. As one member of this group said, 'The real sentence begins when a person is released'. Paul has begun this journey and the more he can recover, the more he can potentially be of value to other people considered serious outcasts.

Throughout all stages of their recovery, participants consistently provided descriptions of unexpected and meaningfully healing events, meetings and interactions which could not have been foreseen, and that were very often interpreted by them as being providential:

*'I would say things happen to me that are beyond explaining, except as part of providence' (Peg).*

*'Providence features greatly in my life. I have come full circle and ended up a few miles from where I was brought up. I no longer need to avoid my neighbours' (Frances).*

*'You have to be ready to make changes – being ready and providence are linked' (Pat).*

*'If you only get involved in something small, you meet people that lead to the next one and so forth and so the net widens' (Tom)*

*'The glory of God involves people being fully alive and their talents being used and recognised, and to see them in full flow according to their gifts is really wonderful' (Frances).*

As already noted in chapter seven, this idea that 'chance events' lead to greater order and meaning is reflected in Jung's concept of synchronicity (Jung 1965). Jung believed that life was not a series of random events, but rather an expression of a deeper order, 'Unus mundus'. From the religious perspective, synchronicity shares similar characteristics with an 'intervention of grace'. It is not dissimilar to the Buddhist notion of karma or the Christian idea of trusting in the munificence of a loving God. This sense of providence, rather than coincidence or chance, is common in my interviews:

*'The job was almost like divine intervention; the hours just suited and matched my husband's' (Kate)*

*'It was amazing that he just happened to be coming out at that time and he told me that I did the right thing' (Paul)*

*'Chance meetings that can turn your life around' (Peg)*

*'My sister happened to be over from [names European country] and asked me 'Do you want to get well?' I had been reading the story of the man at the well and was thinking of attending GROW' (Ruth)*

While many participants actively promoted the idea of the existence of a warm and personally-interested providence, others dismissed the idea for various reasons:

*'I would be nervous of interpreting things like providence – it could be madness again. If I start attributing significance to incidents that happened, I know I am going in the wrong direction' (James).*

*'I don't have a belief in God' (David)*

*'I think there is a spirituality and it is rather dangerous in the area of mental health because some people can become sick because of a twisted belief in a certain kind of spirituality. It's funny, I was ranting to Mary recently that one or two people I know in GROW and [a community where he works] for whom religion is a big thing, and all these fuckers spend their time loving God because they haven't time to love their fellow man in a sense – you know, inverted spirituality. I think there is a danger of people with mental health problems that vertical spirituality can lead to mental illness and horizontal spirituality is seeing the goodness in other people' (Peter).*

Participants' accounts in general indicated that personal beliefs in the area of spirituality are an important factor in recovery. Spiritual belief is also an area of growing interest in psychiatry. A special interest group in this area is the largest within the Royal College of Psychiatrists (Cook 2011). Rappaport (2005) suggests that science has, in fact, taken the place of God, and that a 'value-free' God is undermining our ability to be genuine human beings by reducing life to the biological level.

## Summary

This chapter has explored the positive effects of choosing to become involved in society after 'a time of healing' within GROW. Social involvements provided 'an

opportunity to become' and were part of the process of 're-enchantment through re-authoring a new story'. It described how GROW empowered participants to 'gather' spiritual qualities such as courage (Kate) and strength (Claire) that enabled them to succeed in a much less supportive, and still larger, social world. It was suggested that failure to become involved outside the supportive environment of GROW could lead to another form of isolation – ghetto-isation – and stigma. Involvement in appropriate niches within society, whether in work, education or leisure, provided new, exciting and positive stories of identity, which enabled participants to 're-author a new story'. Participants' accounts revealed relationships within chosen social niches to be based on mutual relationships, where others were revealed as 'the same' as myself. These new stories, in turn, provided meaning for life and enabled a 're-authoring of past experiences of suffering'. In so doing, they opened up a series of meaningful possibilities for the future. Involvement became an ongoing process, where '*one thing led to another*' as each person began to be enchanted by the experience of '*becoming fully alive*'. Recovery was described, in fact, as a re-enchantment with self and with life and, as such, liberated people from the negative professional and cultural stories or ready-made scripts provided for those designated 'mentally ill'. It was experienced as an incrementally increasing sense of well-being or of physically felt contentment. Involvements in GROW were revealed as a precious rehearsal for taking a responsible and caring place in society. Participants suggested that maturing as responsible adults involved learning to choose to absorb hardship, to accept challenge, and to render suffering as meaningful.

Participants indicated that recovery from 'mental illness' transforms them, from being a costly burden on society to being an invaluable and generous resource for other people who have become 'mentally ill' and for those professionals who are trying to be of help. The chapter ends with a discussion about the possible existence of a benign providence and the role this providence might play within re-enchantment through different forms of personal intervention.

The next chapter is a general discussion of these findings, relating them to the wider discourses concerned with the stories of 'mental illness', mental health and recovery.

## CHAPTER TEN: DISCUSSION OF THE FINDINGS

### Introduction

The previous four chapters have presented the research findings of this study in the form of a 'second-order narrative'. Elliott (2005:10) defines a second-order narrative as 'The account a researcher constructs to make sense of the social world and of other people's experiences'. While containing some discussion and references to relevant literature, the previous chapters were largely written in isolation to contemporary thinking about 'mental illness', recovery, and the ontology of the human being. This penultimate chapter therefore provides a more general discussion about the relevance of the findings in the context of ongoing historical and evolutionary dialogues within the areas of 'mental illness', recovery, and caring. It will also look at the findings in relation to proposals contained within 'A Vision for Change: Report of the Expert Group on Mental Health Policy' (Department of Health and Children 2006). This chapter will explore the framework of recovery, conceptualised as 'a re-enchantment with life' through six sub-themes, entitled: 'challenges to the medical model', 'a comparison of care', 'the role played by GROW's narrative', 'goodness and providence: towards an ecological theology', 'authoring a new story' and, finally, 'a last note on validity'.

### Recovery as a re-enchantment with life: challenges to the medical model

The findings of this study are important because they clearly challenge the medical understanding of 'mental illness'. Currently, it is this view which dominates the mental health system and it is a view which the Irish Government wishes to replace with a more recovery-oriented philosophy and practice. Kartalova-O'Doherty and Tedstone Doherty (2010) noted that one barrier to developing recovery-oriented services in Ireland was the lack of coherent recovery theory. By clearly illustrating and describing processes involved in recovery through mutual help, this study provides an important alternative conceptual framework. In time, this framework can help to develop a coherent and tested theory of non-medical recovery. The first section of the discussion therefore looks at a range of differences between the participants' experiences within the micro-cultural contexts of mutual help and a medically-underpinned mental health system.

A difference to the psychiatric view that was immediately evident from participants' accounts was that, in their experience, both 'mental illness' and recovery through mutual help involved multiple levels of cause. People reported becoming 'ill' because a lot of bad things happened to them, and described recovery in terms of different levels of personal and interpersonal transformation. In contrast, upon seeking professional help, participants' overwhelming experience was that medicine sought only a single, biological cause (a chemical imbalance within the brain) and almost exclusively ignored the possibility that unresolved and traumatic life events might have relevance. Participants' accounts not only revealed a wide range of levels of cause, but also illustrated that all of these levels were intimately and circularly related to each other. A range of normal emotions such as terror, disgust or anger, naturally evoked in reaction to traumatic events, were subsequently shown to be related to negative and destructive thoughts about self and others – thoughts which began to affect behaviour and relationships.

While the medical view depicts 'mental illness' as a 'general medical condition' (American Psychiatric Association 2000), similar in nature to a physical illness like diabetes, participants' accounts presented a different understanding. The embodiment of 'mental illness' was described by participants as a process of mutual alienation from self and others. While 'mental illness' was, indeed, primarily experienced within the physical body, these accounts suggest that it was not only a physical phenomenon, but rather a mixed form of physical, spiritual, existential and interpersonal malaise. Participants' experience of recovery suggested that, rather than involving an ongoing chemical rebalancing and dependence on ingested medication, recovery from 'mental illness' came from within and could be a positive and life-transforming experience. In this view, the symptoms of 'mental illness' became a sign that something was wrong at a much wider level than the merely biochemical. Participants' accounts of attending GROW revealed how their understanding of 'mental illness' changed and how this change became an important part of recovery. While many initially believed the medical story and accepted medical help in the expectation of a rapid cure, over time they began to realise that recovery began with a spiritual and personal awakening. Participants described an emotional epiphany that closely mirrored St Francis' prayer (See appendix 26), which seeks a transformation of despair into hope, sadness into joy, hatred into

forgiveness, and darkness into light. In this way, in the minds of participants, the discourse of recovery was expanded from the biological to the spiritual level of transformation, and included both as vitally interconnected parts of the human condition, in mutual rather than hierarchical relation. 'A Vision for Change: Report of the Expert Group on Mental Health Policy' (Department of Health and Children 2006), while attempting to broaden its definition of 'mental illness' from a biological condition to one which involves biological, psychological and social factors, appears to have failed to recognise the existence and importance of the human spirit and the vital role played by spirituality. Spirituality was shown to be closely related to emotions, which were affected by relationships with others, and to each individual's belief system about the nature of God or the meaning of life, described by GROW as 'horizontal' and 'vertical' spirituality.

Many participants described being informed by mental health professionals that their 'mental illnesses' were lifelong. The overall effect of this was, as Deegan (1995) suggests, an erosion of hope. While medicine sought 'cure' through drugs, participants' experience suggested that, if prescribed for too long, medication became a part of the problem. Not only did they often create profoundly negative side effects, which might be bearable in the short term, the prescription of lifelong medication confirmed a lifelong identity of second-class citizenship. Within this prescribed identity, there was little hope of being able to access resources such as employment, independent housing, friendship networks or the ability to drive, which most of us take for granted. The pessimistic medical prognosis was dramatically challenged when, at GROW meetings, participants reported hearing personal testimonies from people who had recovered – not only from 'mental illness', but from various diagnostic labels. These living exemplars of recovery were often no longer taking any medication, were fully involved in life and no longer had any sense of stigma or fear of a further breakdown. Over time, participants found that they, too, could safely reduce or cease medication. Moreover, as they continued to recover, feelings of fear and alienation, diagnosed as 'illness', were replaced by deep feelings of well-being and meaning. Many commentators (Lynch 2001, Bracken and Thomas 2009, Browne 2008, Humphreys 1996) currently suggest that the medical view, which effectively condemns people to an unnecessary lifetime of disability, is a form of what Fricker (2006) has termed 'epistemic' or 'hermeneutic injustice'. Brendel (2006:1) acknowledges that, even within psychiatry, this 'epistemic' or



'hermeneutic' schism represents 'a serious but abiding conceptual crisis'. Over the years, some psychiatrists have written to suggest that not only is there a possibility that the medical interpretation of 'mental illness' is a 'myth' (Szasz 1961), but it is a 'toxic' myth (Bregin 1991) and one that 'can seriously damage your mental health' (Glasser 2003:1). The catastrophic long-term effects of medical treatment, according to Whitaker (2010), are increasingly being revealed as seriously detrimental to both mental and physical health, with long-term 'users' having increased risk of diabetes, chronic heart conditions and a seriously curtailed life expectancy. Seligman (2007) has suggested that some 'mental illnesses' such as 'panic attacks' and 'phobias' have been shown to be personally constructed forms of 'catastrophic thinking' or interpretation made by the sufferer. After studying participants' accounts of recovery and treatment, the possibility must be considered that the medical view may also be a form of professionally constructed catastrophic thinking. For many participants in the study, it was a disillusionment with long-term medical treatment that instigated a search for an alternative approach and brought them to GROW.

It must be stressed that, similar to participants in other recovery-focused research such as Brown and Kandirikirira (2007), and Kartalova-O'Doherty and Tedstone Doherty (2010), some participants in this study did find the use of medication and hospitalisation helpful. In the majority of these cases, they helped people through short-term crises. Brendel (2006) suggests that a pragmatic approach to recovery needs to be adopted, where the medical model needs to be radically integrated into a community model. This means that, instead of being a single and often enforced method of treatment, it becomes one option that service users can use as and when they wish. At the moment, participants' accounts suggest that all other forms of help are seen as secondary.

Within the experience of attending GROW, the goal of recovery was also transformed into something that primarily became the responsibility of the participant, rather than that of the professional. Participants reported no longer being passively dependent on remote, unidirectional, expert professional relationships. Within GROW, they became equally valuable parts of a living community, within which they could give help to others as well as receive help from them. Riessman (1990:31) noted that only being in receipt of help 'Tends to underline inadequacy in the one receiving it and to create ongoing dependency'. Participants described how

they were challenged and encouraged to increasingly develop their own resources for overcoming unruly emotions, rather than expecting the medication to effect a cure. Moreover, these personal efforts at recovery became acts of leadership, blazing a recovery trail that others could then be encouraged to follow.

This section has traced differences in participants' experience of professional and mutual help. These differences challenge the medical view in areas of cause, methods of treatment, and expectations and outcomes of recovery. It noted a major difference in the idea of who was chiefly responsible for recovery, whether 'mental illness' had meaning, and whether the experience of participants had leadership value or not. The next section relates participants' reported experiences of recovery to the nature of care encountered within the mental health system, within GROW and within society once they had recovered.

#### Recovery as a re-enchantment with life: the nature of care

Participants' accounts of recovery from 'mental illness' provided insightful descriptions of distinctly different forms of what is referred to in 'A Vision for Change: Report of the Expert Group on Mental Health Policy' (Department of Health and Children 2006) as 'care', but which is referred to in the GROW Program as 'love' (GROW 2001: 34, 62), and which might also be termed 'social inclusion' or 'full citizenship'.

Perhaps the most defining feature of participants' experience of professional care was that it was aimed primarily at care of the physical body, while neglecting care of the social and spiritual person. This reflects Deegan's (1995:91) observation that professionals are 'Taught that the heart is a physical pump', but are not taught that a heart is also 'A heart that can break or jump for joy and a heart that lives in someone'. Accounts described feelings of being ignored as a person and of a frequent '*lack of connection*' between the caregiver and the recipient of care. Frank (1995), Kleinman (1998), and Charon (2006) have all noted the alienating effect of being treated as a disease, rather than as a person, and of being in a relationship with a disinterested professional other. Descriptions of professional care suggested that the main aim of care was to 'ensure that the right levels of medication' were found. Descriptions of care within a hospital setting (which frequently involved locked

doors) suggested that the primary concern was for order and safety, rather than for the cultivation of warm, flexible and hopeful relationships. This led to a custodial, rather than a therapeutic, approach to care. Many participants noted a lack of what GROW (2001:53) has identified as ‘interpersonal level(s) of natural involvement’ between themselves and their professional carers. These are listed as ‘conscious reflection, rational communication, affective life and social activity with others’ (GROW 2001:53). In fact, within participants’ descriptions of relationships with mental health professionals, there was typically little mention of warmth, shared reflection or personal communication, and the activities of the professionals were very much separate from those for whom they cared. Relationships with professionals appeared to be dominated by labels, which emphasised difference and defined very different roles for the person behind the label of ‘doctor’ or ‘nurse’, and the person behind the label ‘schizophrenia’ or ‘manic depression’. As a result, there was little contact between the human beings behind the labels. Stein’s (1987) research into the effects of different social networks on recovery found that, where networks are dominated by professionals, service users came to expect all relationships to be non-reciprocal and, thus, remain alienated from society. Hynes (2010), in a study of the care of people with emphysema, found that institutional care involved a polyphony of voices which competed with the needs of the person. The needs of the ward, the ward staff, the budget, the unions, health and safety legislation, when coupled with a medical view of illness, often eclipsed the needs of the service user.

Perhaps care administered by the mental health system can be described most accurately as effective love, a love that consisted of doing things ‘for’ and ‘to’ the person, rather than ‘with’ them. Thus, while often helping people through a crisis by providing physical safety and nourishment, in the long term this kind of care tended to emphasise difference and create ongoing dependence on a detached and professional hegemony. Foudraine (1974) reported how he had to retrain his nursing staff precisely along these lines, so that their role changed from one of ‘managing’, to ‘being with’ the people they were helping to recover. On the other hand, participants’ accounts of being cared for within the mutual help setting of GROW described experiences where love was available in three distinct forms, described by GROW as ‘effective, affective and reflective’ love. GROW also defines love as ‘The appreciation and affirmation of another human being as another self and my equal in

worth' (GROW 2001:62). Rappaport (1988) noted that GROW is effective because it provides ongoing community rather than temporary professional intervention. A community is a social and spiritual body that is characterised by the reciprocal relationships that exist between its members, and which can be depended on to be there. Participants' accounts of attending GROW typically described experiences of a warm and compassionate welcome (affective love) and the almost instant awakening of resources such as faith and hope, which also involved positive feelings. Within GROW, participants were encouraged to consciously reflect on their own lives and to share these reflections with the other members of the group. Over time, the group became a feedback system based on very personal knowledge of the needs and strengths of each member and was thus able to help each individual fulfil their unique and evolving needs. Shared social activity was also reported as significant to recovery, as participants were encouraged to venture further and further outside the shelter of their own weekly meeting. In this way, GROW brought alive all the interpersonal levels of social involvement by encouraging conscious reflection, rational communication, sharing of positive emotions and social activity, many of which were absent from relationships with professionals. The conditions found in GROW were also found to exist in many social niches accessed by participants, which suggests that equal relationships and mutual help are the norm for mental health and well-being.

One of the key forms of care, very apparent in GROW and absent within the mental health system, was what Frank (1995) has called 'the act of bearing witness'. Participants' accounts of arriving in 'a place of terror' all revealed a consistent absence of personal and compassionate witness to their suffering, and this lack was also a noted feature of professional care. Because of the medical idea that 'mental illness' is a physical phenomenon, even within the mental health system participants could find 'no one to tell'. In GROW, participants reported many experiences of being involved in reciprocal witness. Not only was their own suffering acknowledged as they were encouraged to 'tell their story', but they were invited to witness the suffering and recovery of others. In this way, while the mental health system emphasised difference and separation between service users and professionals, relationships within GROW emphasised the common humanity of all concerned. While acknowledging that some accounts of professional care highlighted

warm, human connection and good communication between professional caregivers and participants, which were highly significant to recovery, they were the exception.

Many participants reported that professional forms of care tended to discourage risk taking as a part of recovery and, in so doing, provided them with very low expectations for life and little hope for the future. This would seem to go against recommendations contained in the Mental Health Commission's (MHC) 'Framework for Development', which states that 'The first principle underpinning a recovery approach is hope and optimism about the possibility of recovery' (Higgins 2008:9). Within GROW, participants reported being consistently encouraged to take risks in areas such as the development of leadership skills, becoming socially involved, developing personal gifts, negotiating reductions in medication, and seeking alternative forms of both professional and non-professional help. Risk taking within GROW was reported to be empowering and involved overcoming fears and winning control of their own lives. The Mental Health Commission position paper (2008) suggests that care should be both 'person-centred and empowering' (MHC 2008:5). While GROW would seem to fulfil both of these objectives, professional care was experienced as disempowering and disease-centred, rather than person-centred. An interesting feature of participants' accounts of recovery was the role played by GROW in preparing them to access the same kind of ongoing loving care in wider society. Participants reported slowly developing the personal resources to successfully access a variety of social involvements as equals outside GROW. Their descriptions of these involvements revealed that relationships within these contexts were based on the same principles of mutual help that had been experienced within GROW. Within the mental health system, the emphasis was often on providing ongoing involvement in rehabilitation programmes based on difference between staff and service users, which made it difficult to move on.

By studying participants' descriptions of care within the cultural contexts of the mental health system and within mutual help, a number of questions are raised about the nature of care and who is best positioned to provide it. These questions have been addressed by writers such as Lavoie et al. (2006) and Levinas (1969). Lavoie et al. suggest that we start to understand the nature of care by considering its end, namely the human person, and they refer to the work of Levinas (1906 -1996):

‘Levinas’ definition of care suggests that the mission of care is not only to care for the body of the person as you might care for a butterfly collection, but to take care “of the other” (Lavoie et al., 2006:226).

In this view, care therefore involves :

‘Seeing what the person before us really is, instead of what the professional eye picks up from this or that person’. (Lavoie et al., 2006:226)

It involves what Levinas (1969:50) terms ‘gazing into the eyes that are visible through the mask’ – the eyes reveal the unique story of that person’s life, their memories, their sense of identity, and the meaning they have assigned to life events. Levinas (1969) sees care as a moral obligation that should transcend both disease and professional labels, because we all have experience of knowing what it is like to be human, and it is the humanity in each of us that is called upon to care. In order to care for each unique person, we need to identify what Levinas calls the ‘good soup’ by which the other lives – a soup composed of air, light, entertainment, work, ideas, and sleep. It is this ‘type’ of care that seems to be startlingly lacking from a mental health system that is only interested in ‘*symptoms and discovering whether I have enough or too little medication*’ (Mathew). However, it is this kind of care, where the ‘Other’ becomes the subject rather than the object of care, and whose revealed subjectivity determines the nature of the care that is provided by the mutual help experience of GROW. GROW is a place where each person becomes intimately known within the contexts of their woundedness, their beliefs and their unique usefulness to others.

This section has examined and contrasted different forms of care present within professional and mutual forms of help. Many commentators who also compared professional forms of care to those involving mutual help (Riessman 1990, Christensen and Jacobson 1994, and Rappaport 1999), have all suggested that findings like these suggest that professionals should re-examine their role as primary caregivers. The differences revealed in this study, if acknowledged by policy-makers, could provide a starting point for discussions between professionals and service users, which might be instrumental in bringing about positive change. These suggestions will be examined in the next chapter. The next section examines the influence of GROW’s philosophy and methods on recovery.

### A re-enchantment **with life: the role played by GROW's narrative**

The previous section looked at differences in care experienced by participants, within the mental health system and as members of GROW. As already stated, Rappaport (1988) suggests that GROW successfully facilitates recovery by immersing its members within an ongoing supportive and transforming community narrative. This narrative is powerful enough, according to Rappaport, to successfully combat the dominance of many deeply ingrained and negative cultural and professional stories attached to 'mental illness', which collectively erode a sense of positive identity. Rappaport concludes that immersion in this healing and enacted narrative therefore has the potential to transform personal 'tales of terror' (the 'illegible life scripts' and negative social identities imposed by society), into new and liberating tales of belonging, personal value, and possibility, which he describes as 'tales of joy'. Cain (1991) also demonstrated links between identity change and cultural narratives in a study that focused on members of Alcoholics Anonymous (AA). She suggested that AA members arrived at a 'new identity' by drawing on 'a culturally shared knowledge' and by 'coming to reflect and incorporate the knowledge organised by the AA system of beliefs' within their own lives (Cain 1991:211). Part of the purpose of this research was, therefore, to see how much of GROW's narrative permeated individual accounts of recovery and thereby provided evidence of its positive contribution in support of Rappaport's (1988), Finn et al.'s (2009), Kennedy's (1995) and Kloos' (1999) claims of relational links between personal identity and GROW's organisational culture.

GROW's narrative is described as composing of four 'essential features' (GROW 2003:4):

- A written program or guiding philosophy.
- A group method that activates its members.
- A constant loving community.
- A formal legal and organisational structure.

Participants' accounts provided abundant evidence that each of these 'essential features' was involved in their recovery. For example, many different parts of the written program were consistently quoted as being critical. All of GROW's first five principles, 'personal value', 'self-activation', 'mutual help', 'ordinariness' and

‘friendship’ (GROW 2001:7), as well as many others, regularly featured in participants’ accounts. These principles were often recited verbatim and were constantly referred to as ‘pointing the way to’ and clarifying processes involved in recovery. However, these written principles were also described as very real behavioural and cognitive tools to be put into practice in the context of the struggles of day-to-day life, supporting Finn et al.’s (2009:4) view that GROW is ‘A layman’s cognitive behavioral therapy kit’.

Participants frequently recounted having been challenged and supported to undertake liberating practical tasks, social involvements and leadership roles, all of which involved putting GROW’s ideas into practice. These challenges took place within the context of weekly or bi-monthly leadership meetings and were an integral part of GROW’s self-activating group method. As Bakhtin (1981) suggests, words do not just exist within a dictionary – they are enacted, or as Vygotsky puts it, (enacted) language becomes the key to understanding identity and mediates psychological functioning:

‘By being included in the process of behaviour, [language] alters the entire flow and structure of mental functions’ (Vygotsky 1981:137).

Participants’ accounts illustrated how the ideas presented by GROW were appropriated into individual members’ personal attitudes, thoughts, and behaviours. Over time, through what Bakhtin (1981:381) has termed a process of ‘internal persuasion’, these then became the ethical guidelines by which each participant sought to live, and through which they developed a viable and independent ideological self. Tappan (2005) suggests that the most useful unit of analysis for understanding the development of an ideological self are ‘units of mediated action’ (Tappan 2005:50). For participants, these mediating units were shown to involve the 272 individual ideas and thirteen recovery principles identified by Corrigan et al. (2005) to be contained within the GROW program. The most significant of these were, according to Corrigan, ‘Learning to think by reason rather than by feelings or imagination’; ‘Decentralising and becoming involved in GROW’s community’; and ‘Surrendering to the healing power of a loving God’. All three of these recovery principles featured consistently in participants’ accounts.



Participants also stressed that it was the ongoing cultural context of GROW's community that empowered them to choose to consistently perform these difficult and life-changing tasks. Change became possible through experiencing the active and loving 'care of others', which provided many spiritual resources. People reported that over time they 'somehow gathered' spiritual strengths such as wisdom, acceptance, hope, courage, strength, and love through immersion in the healing language of what was described as 'a brotherhood of suffering'. This immersion enabled them to deal with, and absorb, alien stories from the past and to slowly shed the sense of stigma that is so much a part of being 'mentally ill'. In the final stages of recovery, participants reported how they were enabled to continue to find the same nurturing community within niches in society, and were therefore enabled to live out GROW's final three steps of recovery: 'Taking a responsible and caring place in society'; 'Growing daily closer to maturity'; and 'Carrying GROW's message to others in similar need' (GROW 2001:5).

Frequent references were also made to the positive effects of being asked to assume leadership roles and of having the opportunity to help others as well as being helped. This leadership was first described as involvements within the weekly GROW meeting, but then quickly extended to taking on more formal leadership roles. The positive effects of becoming a group organiser, member of a regional or national team, or a fieldworker all formed part of these testimonies of recovery, and gave validity to Riessman's (1965) claim that it is more therapeutic to give than to receive help. By taking on formal leadership roles and by engaging in various management committees, participants became an integral part of GROW's fourth feature, its 'Legal and organisational structure'.

Participants' accounts also contained descriptions of how GROW's recovery narrative countered the medical story, which engendered beliefs and fears about the permanent nature of 'mental illness' and often added to participants' sense of powerlessness and terror. Kennedy (1995) found that a change in understanding about the nature and course of 'mental illness' was one of six world view transformations that took place through ongoing immersion in GROW. Participants' accounts frequently referred to and endorsed parts of the GROW program which Corrigan et al. (2005) suggest give a wider notion of its overall philosophy, in addition to providing practical guidelines for living. For instance, GROW (2001:44)

suggests that there are four causes ‘Which influence our personal life and health’. These are listed as ‘Nature’, ‘Nurture’, ‘Personal Action’ and ‘God’. Participants regularly referred to all of these ‘causes’. Moreover, descriptions of their experience of professional help gave credence to GROW’s suggestion, contained on the same page, that ‘In the past, untold harm has been done to people through one-sided, incomplete and distorted views of the causes at work in them’ (GROW 2001:44). Participants’ accounts of being professionally helped illustrated an almost exclusive reliance on medication and a view that nature is the dominant (and only really relevant) cause of ‘mental illness’. There was little evidence that the mental health system recognises the importance of nurture, personal action or the possibility of an overall cause or God.

The GROW program (GROW 2001:53) also puts forward the proposal that within every human being ‘There are three levels of natural involvement’, which it identifies as ‘a subpersonal instinctual life’, ‘intrapersonal and interpersonal involvements’, and the ‘suprapersonal level of overall meaning, mystery, providence and destiny’. Participants’ accounts frequently contained very moving and rich descriptions of all of these levels of involvement. They described the devastating effects caused by uncontrolled instincts of sex, aggression or self-preservation, and the opposite experiences of alienation and healing that may come through social involvement and personal thoughts and feelings. Most strikingly, their stories contained many examples of events which were explained in terms of mystery, meaning, destiny, and providence. GROW’s ideas about the existence and the transforming power of ‘horizontal and vertical spirituality’ (GROW 2001:69) were very much evidenced by participants’ accounts. Their testimony illustrated how the human spirit is lifted through involvement with warm and caring others. Many also described the value they placed on religious practices such as meditation, prayer and involvement in a church, and on their hope and belief in the existence of a loving God. For many, a belief in God appeared to act as Nietzsche’s (Kaufman 2000:58) ‘why’, enabling them to endure in the face of unbearable forms of suffering.

Finally, participants’ accounts of recovery through immersion in mutual help closely corresponded to GROW’s identification of six distinct forms of tranquilliser. GROW (2001:8) divides the journey of recovery into two parts. The first part, which may involve hospital, medication and professional forms of help, is described as

‘Diagnosis and Treatment’. All of these forms of help are understood as temporary external forms of control. The second part of recovery, which GROW describes as either ‘prevention’ or ‘rehabilitation’, involves the individual replacing these forms of control with more personal forms of external support, such as friendship networks. It also involves the development of internal control through reawoken personal resources and the calming effect of a positive world view and a belief in God or the healing powers of nature. The medical view of recovery rules out this transition from external to internal forms of control because of its understanding of the lifelong nature of some ‘mental illness’. Participants’ accounts illustrated a steady progression towards independence and an increasing ability to leave impersonal forms of external control behind. Two-thirds of participants reported that they no longer needed any medication or professional help; many would have had diagnoses of enduring ‘mental illness’. Participants’ accounts also provided insights into some of the difficulties involved in making this transition. They described horrendous withdrawal symptoms, which were often ‘*worse than the worst of my illness*’, as well as periods of acute self-doubt and an unwillingness on the part of family and professionals to allow the emergence of a new and independent self. In fact, many reported their efforts to wean themselves from medication were actively opposed and sabotaged by threats that if they stopped taking medication, all forms of professional help would be withdrawn. On the other hand, many participants provided very descriptive examples of people (either the group or individuals) having a tranquillising effect that was more more dramatic and instant than the effect of even the strongest medication.

Kartalova-O’Doherty and Tedstone Doherty (2010) also included the idea that relationships with others can have the same tranquillising effect as medication. Participants described learning self-calming techniques such as deep breathing and meditation, some of which have been shown to increase the brain’s (body’s) ability to produce serotonin (Huang 2009, Rubia 2009). Participants also described developing personal resources and learning new ways of dealing with life that incrementally empowered them to deal effectively with life and all its crises. Finally, as already noted, many participants attested to the tranquillising effects of a belief in the power and healing of an immanent and loving God. This section has explored and provided evidence for the proposal, put forward by Rappaport (2000) and also noted by others (Finn et al. 2009, Kloos 1999, Kennedy 1995, Cain 1991), that

recovery through GROW involves a transformation of identity brought about through immersion within an enacted and ongoing community narrative.

### Recovery as a re-enchantment with life: the role of goodness, towards an ecological theology

Two related themes persistently emerged from this study, and were illustrated within a significant number of participants' stories: the idea that 'goodness' was an important tool within the recovery journey and that, while the help of other people was vital, 'providence' was also often believed to play a part. From its beginning, recovery was revealed to involve a reordering of values, which represented a transformation of ethics, or of what participants believed to be 'good', that provided an increasingly solid foundation for facing life into the future. During all stages of recovery, participants' understanding of 'good' progressively changed as they began to re-order their lives. Instead of seeking the 'good' of isolation as a possible means of escape from terror, participants increasingly realised the value of involvement with others and of learning to absorb tensions, rather than seeking to avoid them. Instead of feeling powerless to deal with problems which fed the sense that 'they were no good', participants were empowered to tackle difficult situations and, in this way, began to realise their own power and worth. Within the healing community narrative supplied by GROW, the guiding ethos for making choices became the intention to 'Do the ordinary and good thing you fear or the ordinary good thing that repels you', rather than doing what fearful or wishful feelings or imagination suggested (GROW 2001:32). In this way, recovery and mental health were revealed as by-products of a reasoning mind that increasingly chose to think and act in healthy ways. Participants reported that a re-evaluation of their habits of thinking and acting increasingly led to a sense of well-being and feelings of safety, belonging and happiness as they learned to successfully interact with life.

The idea that goodness exists within participants was also reported as important to recovery. It was a realisation that often came through the experience of others '*seeing something good in me*'. This realisation came about in a number of ways: through the enacted behaviour of others; being asked to take on leadership; being praised; or being spoken of in positive terms such as '*you are my lovely Sue*'. Throughout recovery, participants' views of suffering also changed radically. Instead

of viewing ‘mental illness’ as something shameful, participants began to realise that their unique experiences of suffering were, in fact, an invaluable qualification to become a member of what Frank (2002:115) has termed ‘the pedagogy of suffering’ and to become a valuable resource for others. Participants’ accounts provided many examples where shared suffering became a ‘place of healing’, a place of understanding where others could shelter. As well as becoming a resource for other sufferers and a means of shedding the stigma of ‘mental illness’, Frank (1995:141) highlights the role that suffering has to play in the education of professionals by quoting a young woman identified only as Gail:

‘People suffering walk in different dimensions. We have access to different experiences, different knowledges. And there are so many of us too. What would happen if we all knew what it really meant and we all lived as if it really mattered (which it does)? We could help the “normals” (people who aren’t suffering) and the whitecoats (the professionals) both. We could help them see that they’re wasting the precious moments of their lives, if they would look at us who don’t have it. I am convinced that only sick people know what health is. And they know it by its very loss’  
(Gail, cited in Frank 1995:141).

Participants’ accounts revealed a relativity within an ethical view of recovery. For example, ‘goods’ such as medication, hospital and professional help only remained ‘good’ if they were allowed to make way for more personal forms of help. Where these forms of help were imposed or viewed as lifelong necessities, they were transformed into unnecessary and harmful barriers to recovery. So, in the same way a plant is treated differently at different stages of its growth – now requiring shelter, now thriving in unsheltered conditions – so conditions for recovery changed as participants began to recover.

Many participants spoke of a developing sense that their efforts at recovery were aided by providence. Some reported that they felt that God had a special reason for them to be here and had personally intervened to foil attempts at suicide or to provide resources that were tailored to their needs. According to Koenig (2008), psychiatry has tended to pathologise religious beliefs or display ‘little integration of [spirituality] into assessment of care of patients’ (Koenig 2008:201). Similarly, none of the participants in this study reported any interest being expressed by practitioners in their religious or spiritual beliefs, despite the importance given to them at a personal level.

An emerging theory that resonates with this aspect of the study's findings, and provides a way to make sense of them, is one that proposes an ecological theology. At the heart of this view is the idea that as unique human beings or 'unknowable spirits', we are embedded not only within a widening series of human bodies – our own physical body, the body of a family, a school, a place of work, a society, a country, the world or the universe – but we are also embedded within the 'body of God' (McFague 1993), which is all of these and more.

'The world is our meeting place with God, as the body of God it is wondrously, awesomely, divinely mysterious. God is not only transcendent but is immanently concerned with and involved in every single part of creation' (McFague 1993:vii).

In this view, God becomes 'mother, lover, and friend of the world' and of each of its individual creatures. The idea that, as creatures, we are all embedded in the body of God is, in McFague's view, matched by the idea that God, as spirit, also lives within each one of us. So, when one of us experiences suffering, so does God, and when we strive towards liberation, liberation in the form of God is already there within us. Participants' accounts contained many examples where unexplained events happened 'providentially'. If God is present within each part of creation, then 'He' can arrange events and relationships to happen that would not be expected to occur. Finn et al. (2009) concluded that participation in GROW already affirms a social ecological understanding of the human condition. In her study, she identified

'Multi-factorial processes of change at and across three levels of analysis, within the group, within the wider GROW community, and within the individual' (Finn et al. 2009:302).

An ecological theology extends this view of interrelatedness in two directions. Firstly, it highlights the relatedness that exists internally between feelings, thoughts, and behaviours. Externally, it connects us all to local, national, and worldwide society and to the whole of creation.

While the medical model and debates around its scientific and ethical status continue to occupy centre stage, and while the neurological branch of psychiatry continues to remain the centripetal voice within the mental health system, many spiritual

centrifugal voices are beginning to seek an audience. At a recent conference held in Dublin, entitled 'Mental Health, Practical Theology and Spirituality', a number of speakers (Cook 2011, O'Sullivan 2011, Flanagan 2011) suggested that we are entering 'the age of post-psychiatry'. Suggestions were made about the need for professionals to spend time eliciting the spiritual and religious beliefs of their clients, rather than diagnosing and treating symptoms. Participants' accounts revealed that many had a huge interest in theology and philosophy, which suggests that belief and meaning are central to recovery. GROW recognises two forms of spirituality: 'horizontal' and 'vertical'. Horizontal spirituality is provided by the presence of friendly and encouraging people, who literally revive each other's flagging spirits. Vertical spirituality comes from belief in the existence of a living God and the creation of meaning within lives that entail and encounter a great deal of suffering. Rappaport (2005) has suggested that psychiatry and science have taken on the mantle of religion. Their proponents have become their high priests, and psychiatry has become a belief system that is increasingly oblivious to charges, even from within its own ranks, that the 'scientific basis' on which it has been constructed is extremely shaky. It is also a religion that has formed an unholy alliance with business and with national governments, who are under the increasing control of financial and political forces. This study presents the possibility that belief is an integral and universal part of the human make-up. In this view, the question whether or not a person believes in God is transformed into the question of seeking to understand which God(s) each individual believes in and worships. Participants suggested that the words 'God' and 'good' presented the idea of God as goodness – a goodness that could be experienced through enacted behaviours within a community. Goodness became a resource for healing within individual bodies and between people. Moreover, goodness also became a resource for the community, as those who recovered shared a desire to be good to others. In fact, at the heart of the principle of mutual help lies the need to be able to help others as well as receive help. Psychiatry presents another range of goods in the form of professional help, medication and hospitalisation. Brendel (2006) suggests that the way forward lies in a pragmatic approach, carefully reflecting on which goods work – where, how and in what contexts.

This section has looked at the nature and healing effects of goodness. It suggests that one explanation of participants' repeated sense of providential help is that God is both immanent and transcendental, and therefore is present within the body of all

individuals. It also suggests that the question of the existence of God is secondary to the question of which God(s) people believe in and how these beliefs affect all of us. It represents knowledge as a form of belief that is endorsed within different and ongoing community narratives. The next and final section addresses the question of re-authoring a new story.

### Recovery as a re-enchantment with life: re-authoring a new story

Participants' accounts represented recovery as a progressive re-authoring of a new story about their own identity and about the nature and meaning of 'mental illness', recovery, and life. It was a process which occurred in three stages. In the first stage, a 'place of terror', participants described experiencing the 'authoring' of a terrifying and negative sense of identity. This was co-created over time, through the experienced 'linguaging' of unresolved life traumas. The essence of this story was 'spoken' at many levels and experienced primarily within the body, which became 'populated' by overwhelmingly negative feelings of despair, terror and powerlessness. These feelings were cognitively translated or 'appropriated' into a story of alienation and 'otherness' – a story that appeared to be confirmed by the behaviour of others and through the many cultural and professional narratives attached to 'mental illness'. Bakhtin explains:

'Language is not a neutral medium that passes freely and easily into private property of the speaker's intentions; it is populated – overpopulated – with the intentions of others' (Bakhtin 1981:293).

Rappaport (2000) identified different levels of interrelated story, revealing a personal story embedded within, and affected by, social, cultural, and professional narratives. Within a 'place of terror', participants' personal stories became overwhelmingly 'overpopulated' by the negative and authoritative stories of others. The behaviour or language of others provided destructive and illegible social scripts. To make matters worse, these stories were dominated and confirmed by the professional narrative or 'authoritative utterance' of psychiatry. In this view, the personal sense of alien difference was caused by a lifelong and irreversible personal quality, which they were powerless to change without medication. Tappan (2005), Frank (1995), and Bakhtin (1981) all suggest that an authoritative utterance 'Demands that we acknowledge it, that we make it our own' (Tappan 2005:54). 'It demands our



unconditional allegiance, it cannot be changed or altered, it cannot be doubted – it has complete authority’ (Bakhtin 1981:342) as ‘it trumps all other stories’ (Frank 1995:5).

In the second stage of recovery, participants reported discovering that change was, in fact, possible and that an exciting new personal story about life and their own identity was readily available. This new story began with the awakening of feelings of hope, joy, belonging, and personal value, which became available through involvement with caring others. Over time, these feelings were translated into new thoughts that were increasingly ‘populated’ or mediated by the positive and inclusive language or ‘intentions’ of the other members of GROW. Participants reported a growing awareness of key elements that would transform their stories. First of all, they were valuable; secondly, recovery was possible; thirdly, their own efforts at recovery were crucial; and fourthly, they were no longer alone, but could rely on others for support and even expect help from a ‘wise, strong, and loving God’ (GROW 2001:78). All of these story elements together represented an experience of ongoing liberation. A sense of cold alienation was replaced with a sense of warm belonging; a sense of passive dependence, replaced with one of active participation, independence, powerfulness, and leadership. A sense of life’s meaninglessness was replaced with a humbling sense of purpose and a desire and opportunity to help others. Bakhtin (1981:345) describes these liberating experiences as ‘internally persuasive discourses’, stories told inside the person at the emotional and cognitive levels, but fuelled and endorsed by the behaviour or language of others.

In this study, participants’ accounts were full of ‘amazing’ new and independent ‘words’, experienced as different forms of love which provided what Frank (1995) calls the ‘fragments’ from which they were enabled to construct new and internally persuasive discourses. Bakhtin (1981:122) introduces the idea of ‘carnival’ as an effective means of releasing people from the imposed authority of hierarchical ‘knowledge’ and authoritative discourse. Carnival has its roots in the middle ages when, for one day in the year, people put aside hierarchically loaded labels and met as equals. In Shields’ (2007) view, a hierarchy always results in the marginalisation of some people and the privilege of others:

‘Marginalisation becomes oppression and inclusion becomes privilege’  
(Shields 2007:101).

Carnival is temporary. It enables people to begin a process of change. Carnival includes the wearing of masks, the trying out of new languages and identities. This concept fits the reported experience of members of GROW at a GROW meeting, where:

‘Matters pertaining to diagnosis and treatment and technical language of psychiatry are banned from group discussions’ (GROW 2001:20).

Within GROW, the psychiatric hierarchy was suspended. New ‘masks’ were tried out, including the masks of ‘personal value’, ‘leader’, ‘friend’ or ‘lover of life’. GROW also allowed people to shed social masks of age, social status and sexuality. Carnival encourages a battle for change and an ‘intense struggle’ to become author of your own story:

‘Such an intense struggle within us for hegemony among various available and verbal and ideological points of view, approaches, directions and values. Ideological development as ideological becoming entails gradually coming to authorise and claim authority for one’s own voice, while remaining in constant dialogue with other voices’ (Bakhtin 1981:346).

Penuel and Wertsch (1995) suggest that the goal of sociocultural inquiry is to understand the relationship between the person and the social, cultural, historical, and institutional contexts or stories in which the person lives. The answer, according to Tappan (2005), lies in studying the relationships between different levels of cause, in examining what happens ‘in the middle’ and in trying get some sense of their mediating function. What the stories in my research have done for me to is provide rich emic descriptions of how mediation through involvement in GROW works at all the levels mentioned by both Price (1979) and Penuel and Wertsch (1995). The analysis of stories in this research has allowed me to glimpse rules of personal transformation through the appropriation of ideas contained in stories generated at many levels, starting with the language of the body. Within GROW, healing stories are generated through an alternative, authoritative second-order narrative contained within its written program and articulated through the ‘languaging of the group’. The interviews contained rich descriptions of mediating behaviour at the emotional (somatic), cognitive and social levels. These descriptions became ‘lenses’, whereby

the healing interactions of recovery could be observed as clearly as the interactions between white cells and those of a cancer or infection can be studied through the lens of a microscope. This study suggests that when people join GROW, they are frequently unable to concentrate or even begin to try to understand the written (or even the spoken) word. The language of negative feelings dominates all other dialogue, so that even being in a room with others takes enormous courage. These 'terrors' are felt most clearly in the immanence of the physical body. GROW acts as a powerful tranquilliser by creating a context or an ontological presence whereby these feelings are calmed and, within the space of that calm, the possibility of positive change can become a reality. The group makes resources available in the form of positive psychological stories about the self, spiritual resources such as hope, and physiological resources such as calm.

The third stage of re-authoring a story sees people emerging from GROW equipped with all the resources they need to be able to thrive within selected niches in society. Here, they discover positive social identities through assuming a variety of roles in employment, education, and leisure. Their time of healing in GROW is revealed as a precious rehearsal or preparation for emergence as independent individuals who have now developed the resources to choose who they want to become. Rappaport (2000) has suggested that the higher a person goes in the social hierarchy, the easier it is to find new resources in the form of positive identity stories. For participants, this was evidenced by a growing ability to choose different jobs, educational courses or leisure activities.

Participants' accounts consistently referred to the dimension of time in relation to the re-authoring of identity. Time has also been identified as significant by a number of writers (Bakhtin 1981, Frank 1995, Ricoeur 1984, Browne 2008). Bakhtin (1981) suggested that identity transformation becomes possible as a person moves from 'adventure time' to 'biographical time'. Similarly, Frank (1995) described the claiming of a positive and personal identity as a movement from a time of chaos to a time of testimony. Ricoeur (1984) introduces the term 'narrative time' and suggests, as a first working hypothesis, that 'narrativity and temporality are closely related' (Ricoeur 1984:50). Browne (2008) introduces the concept of what he calls the 'frozen present'. In this view, events in the past are carried within the physiological and psychological layers of our storytelling make-up. They are not in the past,

because we always live in the present. However, their existence impedes the free progression of a new becoming because they bind us to terrors of the past. I was repeatedly struck by the fact that my storytellers didn't tell their stories in chronological order; their stories went back and forth in time like a busy working loom, taking threads from early childhood and mixing them with the here and now. For example, a stay in hospital many years ago was juxtaposed next to a recent experience in the GROW group. Many writers also refer to the idea of a collective past that shapes who we are as human beings. Jung (1936) perhaps most famously speaks of the collective unconscious, a kind of species-related memory which is filled with archetypal images:

‘The collective unconscious is a part of the psyche which can be negatively distinguished from a personal unconscious by the fact that it does not, like the latter, owe its existence to personal experience and consequently is not a personal acquisition’ (Jung 1936:99).

Tolle (2005:129) refers to a collective pain memory and suggests that some people are more sensitive to this than others, and Seligman (2007), likewise, suggests the presence of a collective awareness of danger. Kartalova-O'Doherty and Tedstone Doherty (2010) were also confronted by time and, in fact, defined recovery as ‘A reconnection with self, with others, and with time’. I understand from this that instead of being dominated by the past, be it traumatic events or authoritative utterances, recovery involves a reconnection with the resources of the present, an ability to make sense of the past and the awakening of reasonable hopes for the future.

In chapter five, I described how I developed a graphic model that could be used to better understand the nature of a human being (appendix 19). It was initially composed of a series of concentric circles, each representing one of four levels implicated in the cause of ‘mental illness’ and identified by Price (1979) as ‘biological’, ‘intrapersonal’, ‘interpersonal’ and ‘social’. As participants’ accounts expanded the number of causes to include such possibilities as providence, I subsequently extended the number of levels contained in the diagram.

The many references to time meant that the model I was using needed to represent this dimension. Hoffman (1984) had already introduced the idea of human life being

lived within a what she called a ‘time chain’ (see diagram 10.2 p. 220). When I add this dimension of the past to the diagram that evolved from the stories told in my interviews (appendix 19), it also allows speculation and consideration about as many layers of story as is needed (see diagram 10.3 p.221). The body is embedded in an individual story or ideology, which is embedded within a series of other stories: the family, culture, the church, the modernist story of science; these stories, in turn, are embedded within an evolving biosphere. If McFague’s (1993) suggestion is true, then at the very heart of the physical body of each individual we can find the presence of a loving, healing, and suffering God with the power to liberate. As well as existing within the historical dimension of time, each of us is also growing into a future – ‘we are always becoming’ (Bakhtin 1981). If you then look at the dimension of the future – a future that meets at certain points (future presents) in time and space – I would suggest that, to complete a model of the human being, a cone needs to be added to the diagram. In this way, we have a diagram that could be interpreted in many ways. It could be seen as an ‘existential ship’ that is carrying mankind across the space of time and hopefully discovering a place to land. The image that I like personally is one of ‘an existential pencil’ that can write the parallel stories of each individual – stories that will be coloured by that person’s character and which are words made flesh. The most important mediator of this story is the space between the person’s body, whose feelings articulate well-being or alarm, and the other stories represented by mind, family, peers experts, etc. This is, perhaps, the thing we choose to call personal character, and this is what determines the kind of story each person writes. Personal stories will therefore be recognisable by the character of the writer and the contexts in which they have been immersed; they will thus appear fearful, courageous, optimistic, pessimistic, extrovert or introvert, truly loving or interpersonally harmful. Participants’ accounts can be revisited in terms of different aspects of character, displayed at different times. Within a ‘place of terror’, individual character was defined by words such as ‘terror’, ‘powerlessness’, ‘rage’, but also by qualities such as endurance and courage. Within a ‘time of healing’, individual characters display hopefulness, forgiveness and empowerment, and these qualities grow to fruition through involvement in society and through ‘opportunities to become’.

This section has represented recovery as a process of re-authoring a story of life and of identity. It ends with the presentation of a model of the human being, constructed

through an analysis of participants' accounts of recovery from 'mental illness', that allows us to reflect on and understand the relationships between the many levels of story in which each one of us lives. Thus, it fulfils Price's (1979) claim that the central purpose of psychology is no longer the discovery or understanding of a linear cause, but the creation of a model of the human being that accounts for relationships between a wide range of interdependent causes.

Diagram 10.2 The time cable

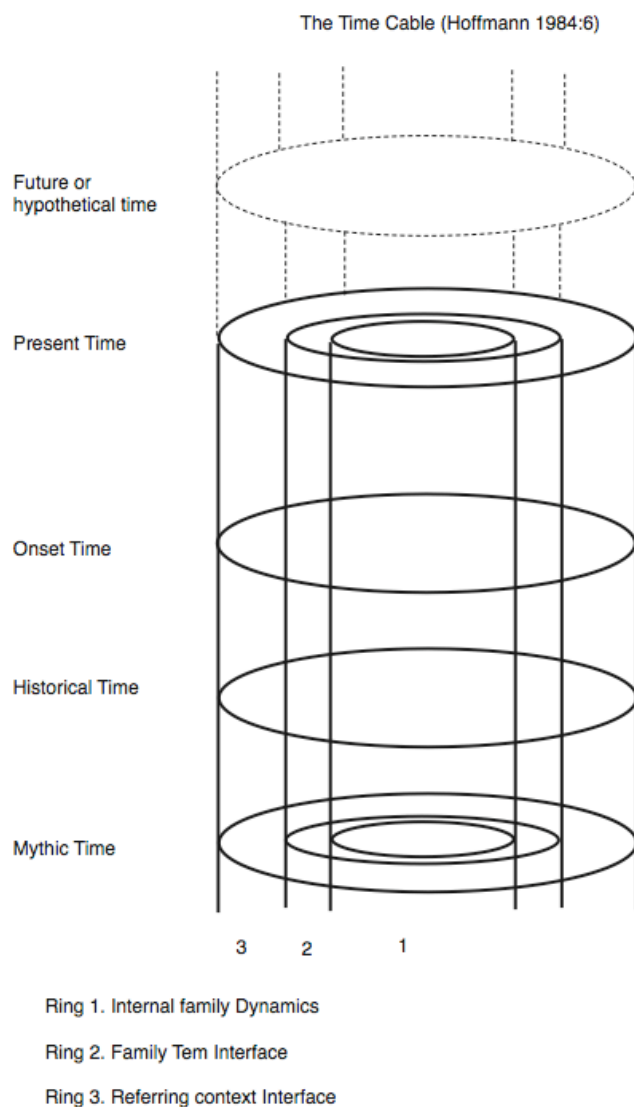
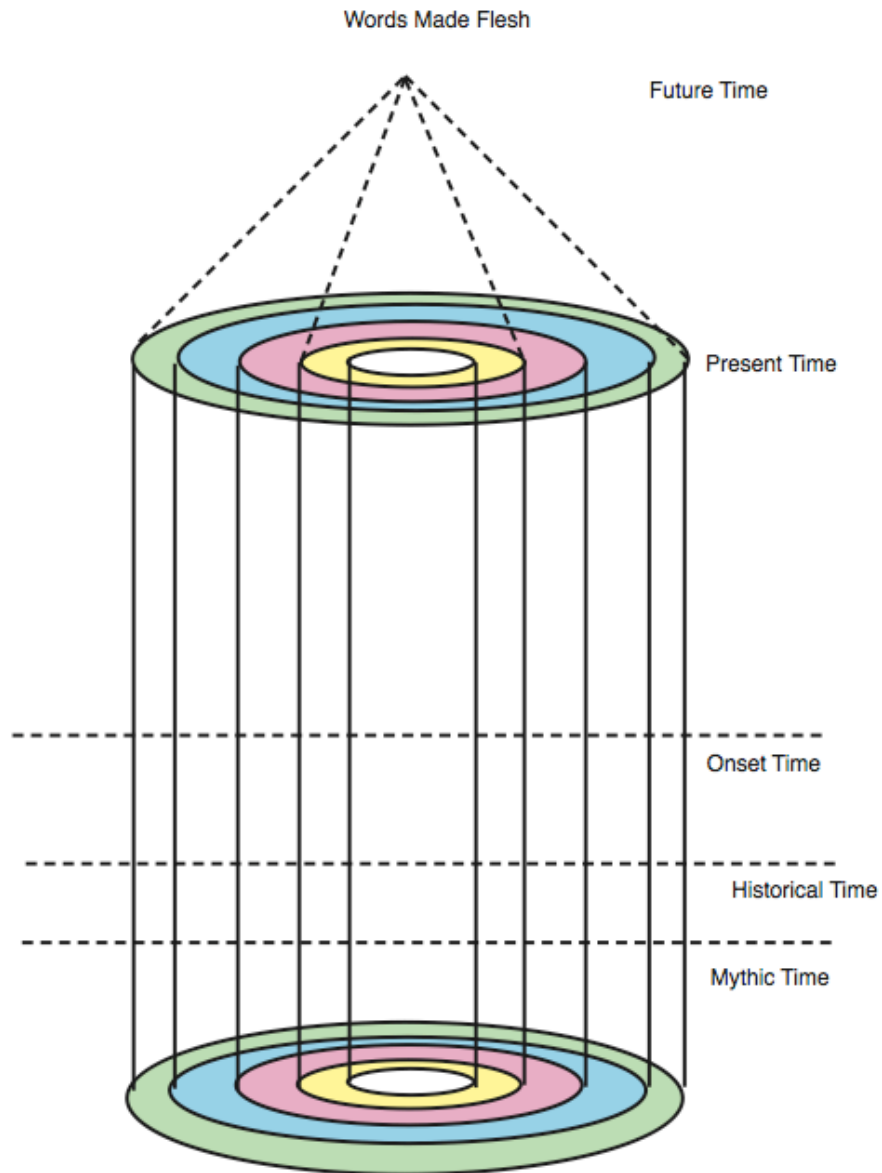


Diagram 10.3 A model of human being: words made flesh or existential pencils



A Model of the human person illustrating the relationship between different levels of body, mind, family, culture and time. The diagram offers a metaphor of a person as an ever changing and yet consistent existential pencil, constantly seeking authorship of his or her own positive story of becoming. This diagram represents mind as the primary mediating tool in the process of becoming

## A last note on validity

Many writers argue that not only is the validity of qualitative inquiry problematic, but so are the ‘positivist’ methods of ‘scientific inquiry’ upon which the mental health system and psychiatry are currently based (Whitaker 2010, Moncrieff 2007, Brendel 2006, Anthony and Huckshorn 2006). Claims of validity in diagnosis, research, and practice have all been questioned, and even ridiculed, by champions of the anti-psychiatry movement. Nagle (1959) suggests that, rather than being a valid science, the biological model of psychology is, in fact, pre-theoretical in nature and its validity is therefore not yet even a serious question. In light of the lack of proven validity of a scientific approach, Brendel (2006) poses the crucial question: ‘Is psychiatry an empirical science that aims to diagnose and treat abnormal behaviour, or is it a form of humanism that addresses the inner workings and meanings of people’s subjective experience and existential concerns?’ Like Riessman (2008), he advocates a pragmatic approach, suggesting that validity or truth can only be established in the future by a careful evaluation of all forms of help, conducted in partnership between professionals service users and their carers. In the context of the current study, assessing its value from a pragmatic point of view raises the question: If these findings can reasonably be regarded as ‘true’, how useful are they, and to whom? I would argue that they are extremely useful to:

- People who may experience ‘mental illness’ in the future.
- Current service users who, like participants, have found that the current mental health system has become a part of their ‘place of terror’.
- Families concerned about a particular member who is ‘mentally ill’.
- Mental health professionals who can be relieved of cognitive dissonance associated with a pessimistic and out-of-date mental health system and current training.
- The government, who stand to save billions of Euro and be provided with a highly motivated, individual and new form of leadership.

Some groups may be less ‘enchanted’ with these findings, such as hard-line practitioners who are convinced of the validity of a strictly medical approach and drug companies, who stand to lose considerable sources of present and future income. A second question must be asked if a pragmatic lens is used: ‘How practical is it to build the recommendations of this research into future practice?’ I would



argue that it is highly practical. Rather than involving massive extra spending, a mutual help approach to recovery requires a major re-ordering of resources. In a way, what is required is a transformation of service that mirrors the re-ordering of personal values identified in the accounts of individual participants as they began to recover. Riessman's last criteria for establishing validity asks the questions: 'Does the study contribute or have the potential to contribute to social change?' and 'Does a researcher work with a group to collect and interpret stories foster social justice?' Davies (2006:182) asks researchers to reflect on their own contribution 'To creating and withholding the conditions of possibility of particular lives'. In addition, Lather (1986:270) suggests that a further question to ask is whether the research 'Empowered those who took part by amplifying and emphasising hitherto silent voices of suffering'. In relation to this study, I believe it can confidently answer all of these questions in the affirmative. By articulating a plausible and appealing second-order narrative from the stories of 26 individuals, this research serves as a valid point of view. Participants' accounts highlighted many aspects of the mental health system that represented different forms of epistemic injustice and showed that membership in GROW prepared people to take advantage of a wide range of possibilities that became accessible within society. By articulating this story, the relatively powerless voices of participants become a more potent centrifugal voice, which is able to rationally challenge the centripetal and authoritative voice of psychiatry. The potential for effecting meaningful social transformation very much mirrors the processes of personal transformation revealed through participants' testimony. Participants' accounts showed how personal recovery involved a battle with a 'polyglot of voices, many of which were alien' (Bakhtin 1981). Collectively, as a force for change these voices begin to be empowered to bring about change in a similar way that members of the feminist, black and gay communities have shown is possible.

### Summary and conclusion

This chapter discussed the findings of this study in relation to current scholarship within the area of 'mental illness' and recovery. It has done so under a number of sub-themes, which have compared participants' experience of two very different forms of knowledge and two different types of care, namely mutual and professional help. It began by highlighting many of the participants' experiences of mutual help,

which challenged the appropriateness of current medical practice, which tends to focus on the disease, rather than on the person. It sought to explicate descriptions of different forms of care, explored their effectiveness and asked questions about who can best provide care and where this care can most readily be found. It also explored the idea that identity is closely related to the contexts in which individuals are embedded and traced the relationship between identity transformation and participants' experience of GROW's community narrative. It suggests that the 'medical model', as currently constructed, may be viewed as the community narrative within which many of the mental health practitioners have been educated and which they have inexorably come to accept as true. The findings suggest that identity spans a wide range of levels of existence. These include the levels of instincts, feelings, thoughts, relationships with others and, finally, the level of making meaning from experience. Identity is mediated by a personal character that increasingly learns how to deal with all of these levels of existence. By introducing the idea of an ecological theology, it offered a world view that could account for the common experience of participants suggesting the existence of providential care. It looked at recovery as a process of ethical transformation and the role and nature of goodness. The discussion concluded by presenting a model of the human being that allows an examination of the relationship between many different levels of 'story' which, over time, shape and influence the direction of our lives and our sense of who we are. Finally, the chapter revisited the subject of validity from a pragmatic approach and noted that, while the authoritative medical story assumes a superior level of validity, it is, in fact, just as pre-theoretical in nature as the conceptual framework elicited from this study.

The next and final chapter of this thesis begins with a discussion of some of the study's limitations. It then goes on to explore the implications of the emergent second-order narrative of recovery for GROW as an organisation, for both lay and professional education, for professional practice, and for the structuring and funding of a 'recovery-oriented' mental health service as advocated in in 'A Vision for Change: Report of the Expert Group on Mental Health Policy' (Department of Health and Children 2006).

## CHAPTER ELEVEN: LIMITATIONS, IMPLICATIONS AND RECOMMENDATIONS OF THE STUDY

### Introduction

The final chapter of this thesis begins with a discussion of some of the study's limitations. It goes on to explore the implications of the findings for GROW as an organisation, for both lay and professional education, for future research, and for professional practice. It then addresses implications relevant for the policy needed to underpin the structuring and funding of a 'recovery-oriented' mental health service as advocated in 'A Vision for Change: Report of the Expert Group on Mental Health Policy' (Department of Health and Children 2006) and represented by the findings of this study. The chapter concludes with a personal reflection on the process of the study and the impact of the process on me as a person and a researcher. By advocating a transformation of mental health services from a medical to a recovery ethos, the authors of 'A Vision for Change: Report of the Expert Group on Mental Health Policy' (Department of Health and Children 2006) have effectively polarised these two views. In fact, the situation is far less clearly defined, as demonstrated by the findings of this study. This research therefore concurs with Brendel's (2006) call for a pragmatic approach to recovery, where the debate shifts from an 'either/or' to a 'both/and' position.

### Some limitations

While the conceptual framework of 'recovery (from 'mental illness') as a re-enchantment with life' sought to accurately describe the recovery experience of a group of GROW participants in Ireland, the findings, implications and recommendations of this study need to be read in the context of the following limitations:

- This study was limited to seasoned members (over three years' membership) of GROW in Ireland. While there was strong consensus among all participants about the experience of 'mental illness' and recovery, it is not possible to assume that new members or non-members of GROW would concur with this 'community narrative'. The study, therefore, cannot claim generalisability beyond this group. However, it does act as a 'standpoint' that

will attract agreement or disagreement (Frank 1995) and, consequently, is a useful part of an ongoing investigation which could contribute to the construction of a new theory of recovery.

- This study involved the recollections of those interviewed, each person being asked to look back and summarise periods of time that included many decades. It is possible that the interview situation influenced these memories and created a bias towards the effectiveness of GROW. This could be especially true for GROW employees who participated, who might have felt the need to show a positive bias towards the organisation. It could be argued that the GROW members who volunteered for this study may have had particular agendas that they wished to be heard.
- Although the study included a wide age-range and almost a balance of men and women, young people (under the age of thirty) were conspicuously absent. The lack of representation of this age group was a distinct weakness.
- My own position in the GROW organisation and my own experience of GROW as a means of recovery from ‘mental illness’ may have influenced my interpretation of findings and the way that participants shared their stories.
- My early novice status as a researcher, in both conducting interviews and analysing and interpreting data, may well have adversely affected the results; however, feedback from the participants suggest that my interpretation reflects their experience.
- The concept of data saturation was arrived at in this case by a personal feeling rather than by any objective standards. Other researchers may well have decided earlier in the research that saturation had been reached or may have decided to include more participants.

In spite of the limitations of this study, the results provide grounds for identifying a number of implications and for making recommendations in the areas of education, research, practice, and policy.

### Implications and recommendations

Kartalova-O’Doherty and Tedstone Doherty (2010) note that one of the difficulties in undertaking a transformation of Irish Mental Health Services from a medical to a recovery ethos is the lack of ‘a coherent theory of mental health recovery capable of

guiding clinical practice' (Kartalova-O'Doherty and Tedstone Doherty 2010:610). This research provides a coherent second-order narrative of recovery that potentially has many major implications for the re-structuring and delivery of mental health services. By exploring participants' experiences of recovery through mutual help and their experience of treatment within the medically-dominated mental health system, the study has highlighted many major differences between the two. All of these have implications for GROW as an organisation, and for society in terms of education, research, professional practice, and policy.

### Recommendations for GROW

The results of this study suggest that GROW can be effective in its work with many individuals and different groups of people who may be vulnerable to becoming 'mentally ill' or trapped within 'places of terror'. They also suggest that GROW often seems to work in isolation from, rather than in partnership with, the formal mental health system.

It is therefore recommended that:

- GROW should work to establish many more groups for people who may not be able, or may not want, to attend its current community groups. These might include groups for the elderly (within nursing homes), non-believers, members of the lesbian, gay, bisexual and transgender community, people with long-term physical illnesses<sup>26</sup> and members of other marginalised groups and/or ethnic minorities, such as Polish immigrants and the Travelling Community.
- Participants' accounts frequently identified adolescence and school as a particularly traumatic time of life. Continuing high suicide levels among this population would suggest an ongoing vulnerability and alienation. It is recommended that GROW should seek to bring the resource of mutual help into secondary schools.
- While some participants reported that psychiatrists or nurses had recommended they attend GROW, research (Dunne and Fitzpatrick 1999) and the accounts of participants suggested that professionals do not routinely

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<sup>26</sup> GROW currently runs one group for people with long-term physical illnesses which has a membership of 15 -18 people.

see GROW as a helpful adjunct to mental health services. GROW should make more efforts to communicate with practising mental health professionals and provide information about the value of the mutual help offered by GROW.

- Participants' accounts revealed a consistent lack of alternatives to the medical model, and especially to non-medically-oriented residential care. Therefore, it is recommended that GROW seek to establish a GROW residential community similar to residential programmes currently in existence in America and Australia.
- Because of the scarcity of good qualitative research within the area of recovery, and because GROW is so well established in Ireland, it would seem beneficial for GROW to seek to initiate further research in areas such as the role of leadership in recovery.

### Recommendations for education

This research revealed many significant differences between the dominant biomedical view of 'mental illness' and the empowering and hopeful story told collectively by participants in this study. In order to transform our mental health services from a biomedical view to a recovery ethos, efforts must be made to educate every member of society by clearly articulating and making them aware of such a hopeful and practical alternative to the biomedical view.

It is therefore recommended that:

- An animated film be commissioned that educates the very young about a hopeful alternative view of the nature of 'mental illness' and recovery. Education materials need to be centred around young heroes and heroines who display symptoms of 'mental illness' that are clearly related to traumatic life events. The film should clearly illustrate different processes of personal empowerment, including friendly help from strategic others such as parent, neighbour, teacher, doctor, or friend. After viewing by a class, the teacher might be trained to elicit comments and re-emphasise the main message of hope contained in the story.

- Third-level educational institutions involved in the education of mental health professionals should make efforts to ensure that this alternative view of recovery and empowerment is given equal importance to the biomedical model within curricula.
- Practising professionals working in the area of mental health should be required to undertake education into the philosophy and practice of recovery.
- Education materials for families of people diagnosed as ‘mentally ill’ should be redesigned to reflect the hopeful understanding of recovery reported by participants in this study.
- In today’s media-dominated information age, efforts need to be made to ensure that education and information coming from the media give voice to the empowerment view of recovery, as reflected by participants in this study.

### Implications and recommendations for research

The literature review carried out for this study suggested that there is a severe imbalance in favour of knowledge gained through positivist methods of scientific inquiry, rather than qualitative methods relying on experience. In comparison to the number of studies based exclusively on positivist methods dedicated to promote the biomedical model, there is an appalling scarcity of research that validates and promotes a different view.

It is therefore recommended that:

- Further research be conducted to test the validity of the results of this study by conducting a similar study among people with similar psychiatric histories who had recovered without the help of GROW. In this way, the second-order narrative abstracted from this research can be expanded or revised.
- To expand the findings further, a number of studies be conducted among: younger GROW members; members of GROW who have been involved for a minimum of three years but who have not become involved in ‘seasoned levels of leadership’; GROW members who were diagnosed with different forms of ‘enduring mental illness’ who no longer take medication; and people who left GROW after a short period of time but who also consider themselves to have recovered.

- The majority (66%) of participants in this study reported that they had completely stopped needing medication. In the light of this, and because the prescription of psychiatric drugs is so endemic within Irish mental health services, it is recommended that further research is needed into factors that facilitated and hindered people to successfully come off medication.
- A follow-up study on this sample be conducted to explore whether the reported process of re-enchantment has continued across time.

### Recommendations for practice

The task of transforming mental health services from a medical to a recovery orientation has many far-reaching implications for practice. In light of the findings of this study, the overall aim of services should be to provide conditions that would start and nurture a journey of recovery ‘as a re-enchantment with life’. At the heart of these conditions lie warm, encouraging and reciprocal relationships that bear witness to each unique individual. Practice needs to undergo a transformation, from one based on the hierarchical and clinical management of illnesses to one that concentrates on the unique individual, fosters empowering, reciprocal relationships and is aimed at the resolution of current life problems and the effect of past traumas.

It is therefore recommended that:

- The diagnostic interviews used by medical practitioners be complemented with detailed life histories that include an exploration of spiritual beliefs and a sensitive search for sources of past personal trauma.
- In light of the findings of this study, mental health practitioners should become more focused on designing recovery programs that focus on discovering ‘therapeutic niches’ in the community, as opposed to clinician-led care plans, which emphasise diagnostic labels and drug compliance.
- This study suggests that psychiatric drugs should be used minimally as a temporary aid to recovery, rather than as the main, often lifelong, form of treatment. It is recommended that practice be aimed at helping people to come safely off these drugs and that the prescription of drugs become a last resort, after many other forms of treatment have been offered and tried.



## Recommendations for policy

Any kind of transformation within the mental health services, be it personal or social, involves supreme and sustained effort. Just as participants in this study needed to develop the will to change, there must also be a similar determination and will to implement policy. This is very difficult when the mental health system is so inseparable from the interests of massive, multinational drug companies, different professional groups, personal ego and power issues, including different academic agendas. There are a few things the Government could perhaps do to help bring about a systemic transformation.

It is therefore recommended that:

- Recommendations in the areas of education, research and practice outlined in this study be incorporated into Government policy.
- Policy-makers regularly invite new recommendations relevant to establishing a recovery-oriented mental health service. For instance, this research suggests that the word ‘spiritual’ should be added to the biopsychosocial definition used in current mental health policy.
- Accrediting bodies for the education of mental health practitioners include recovery and mutual help as criteria for approval of all education programmes

## A personal reflection on processes within this study

The final section of this thesis comes in the form of a personal reflection on the processes involved in all stages of this study and the effects this has had on me as a person. I feel it is appropriate that I end the study with these reflections, which will allow the reader to see the person behind the researcher and, in this way, add my own personal narrative to those so generously provided by the participants in the study.

When I set out on this PhD journey, I had little idea of what it would entail. I was expecting to learn, and that was definitely my biggest hope. I wanted to learn more about a form of recovery that challenged the limitations of the medical approach, and I passionately wanted to be able to use that knowledge to help bring about change within the mental health system. I knew from my own experience that recovery was

possible, and I had met and read about many other people who had recovered, and yet I couldn't really explain how it came about, or whether my own experience really corresponded to theirs. What I was not expecting was the experience of personal transformation that has come about through the process of study. What is more, it has been an experience very similar to the transformation described by participants as part of their recovery through GROW and then through involvement in social niches such as education. On reflection, I think what this study has given me is a tangible experience and subsequent understanding of the processes by which we can be empowered to develop through learning and by which we construct a unique personal 'ideologue' or world view. It has also made me realise how difficult it becomes to view the world through other people's eyes once we have appropriated a particular view. I have become aware that belief and identity are closely linked. As Frank (1995) intimated, my beliefs represent my standpoint and are what I stand for.

I cannot help but be struck by a 'triangulation of similarities' between the personal processes and outcomes of:

- Being involved in the process of this study.
- My own recovery from 'mental illness' through GROW.
- Participants' accounts of a recovery that began in GROW and was sealed through involvements within social niches.

Similarities included the experience of being warmly welcomed into the academic community of Trinity's School of Nursing and Midwifery. This was reminiscent of participants' accounts of receiving a warm welcome from GROW and then of finding social niches within which they were empowered to 'flourish' (Gaffney 2011). Just as inclusion criteria for my study demanded a minimum of three years membership in GROW, it is just over three years since I began this study. Similar to participants' accounts of interpersonal processes crucial to both 'healing' and 'becoming', my experience is one of having been challenged and supported to consistently push myself to my emotional, cognitive, and relational limits. Like participants, I frequently experienced setbacks. For instance, many times, attempts to write coherently collapsed. Words appeared to take on a life of their own, behaving like glue and refusing to make sense, or at other times appearing to dance in front of me, filling me with unjustified euphoria and the feeling I had 'cracked it'. Sadly, however, these feelings quickly evaporated on reading what I had written. At one

stage, the words I was wrestling with gave me the impression they were pulling faces at me. My supervisor instructed me to ‘ignore the faces’ and continue to write. On reflection, many of these extremes of feeling were almost delusional, which suggests perhaps that delusion is an ordinary and often enriching part of life. Other setbacks were caused by finding the subject of study too large and unwieldy; being required to pay attention to detail to a hitherto unimagined degree; an inability to find references or to understand how ‘Endnote’ worked. Again, like the participants, I found my way out of these setbacks by applying the GROW principle to ‘do the ordinary and good thing I feared, or the ordinary and good thing that repelled me’. Levels of both fear and repulsion were often extreme. In the case of this study, it often involved backtracking or daring to search for new sources of information, or scrapping sections of writing that had appeared vitally important. Like participants, I, too, at times, felt that providence was on my side. I remember once finding a particularly helpful article on my desk when I arrived in one morning, and I still have no idea where it came from. I also count as providential my choice of supervisor, as well as meeting another PhD student who regularly visited Kilkenny (where I live) and with whom I explored the start of the journey.

What is different about the ‘me’ that set out on this PhD journey and the ‘me’ that is just arriving at this place in the journey is that I now have a conceptual framework that describes a recovery process. At the beginning, I set out with what was really a very strong feeling or conviction that the mental health system needed to change. This feeling has now been transformed into recognisable and plausible ideas. This conceptual framework, although it came through me, or perhaps was constructed by me from the participants’ narratives, appears to me to have its own identity. While the process of writing the thesis is like building a house or making hay, the actual content of the conceptual theory feels more like something that has been born through me and the participants, yet is separate to me and the participants. It has an identity of its own, like a child that has genetic links to many others that go back generations. I look at it in wonder because it contains ideas and words, such as the main theme of recovery as ‘a re-enchantment with life’, that I did not consciously choose. The theme of enchantment fits and it was interesting this morning to read that the Irish Critical Voices Network have just established a mutual help group for ‘disenchanted staff, to harness their influential experience towards change’ (Irish Critical Voices Network 2012, personal communication). I had not expected to find

such clear links between feelings and thoughts and was delighted with expressions such as ‘epistemic or hermeneutic injustice’ (Fricker 2006) and ‘catastrophic interpretation’ (Seligman 2007). Nor was I expecting the theme of providence to be so prominent. It was, in fact, the first major sub-theme that struck me and it has had a profound effect on me. Possible providential happenings have been such a feature of my own and Fran’s life – people we have met and who have loved us, money that appeared at crucial times, links between prayer and outcomes, and yet I never really acknowledged them as such. Hearing others’ accounts has given me permission to believe in the wonderful possibility of a warm and loving God who loves me. It genuinely amazed me to find McFague’s (1993) theory of an ecological theology. My whole understanding of God has changed in another way. Rappaport wrote that science has become a god; I have come to believe that we all have our gods. It is no longer a question for me whether God exists or whether people believe in God, but a question of which gods exist and which gods we worship. I really love the idea, generated through GROW and mentioned so often by the participants in this study, that ‘God’ is another word for ‘Good’. In this view, I can make profound personal sense of John’s Gospel (John 1:1): ‘In the beginning was the word and the word was God, and the word was with God...’ and the word was good. Throughout this study, I have come to glimpse people as ontological words who, through their enacted behaviour, become a form of language through which we learn about ourselves and co-create identity and set ongoing seeds for the future.

Central to my journey of change, as well as the accounts of the 26 participants, has been a polyglot of ideas contained within the voices of people like Julian Rappaport, Mikhail Bakhtin, Emmanuel Levinas, Arthur Frank, Rita Charon, Loren Mosher, Ivor Browne, and Sally McFague. While participants’ accounts represented the voice of ‘Everyman’ as they found a way out of terror through participation in mutual help, these ideas have, together, provided ‘fragments’ that I have appropriated over time, in the same way that participants appropriated parts of the GROW program until they became a coherent whole. Just as I was excited by participants’ stories, so too was I excited to discover the ideas and stories contained within the reading done in the early stages of the process. Together, they have told a story of a people (including myself) wearing particular labels or masks which block our ability to be in human relationship with each other – something which is mutually alienating. Charon (2006), for instance, spoke about a negative triad that exists between doctors and

their patients, which she described as ‘blame, shame, and fear’. Frank (2004) calls for a generosity between doctors and patients. I believe that the current mental health system, with its chronic lack of resources, badly serves both professionals and those who seek help. It is so overloaded that real human relationship is impossible to sustain. My wish now is to meet the people behind the medical theory that shapes our health services. To me they are, in part, people waiting to be convinced that an alternative, as represented by the findings of this study, could be true. It is such an exciting alternative, I cannot doubt that hearts within the psychiatrists and other practitioners who rely so much on medication and hope so desperately for the discovery of a new gene or a new tablet, would leap with joy if they could watch the dormant life within their wounded clients begin to find voice. To me, genuine co-operation between medical practitioners and people who become ill is the most exciting form of mutual help, and one that begs further exploration. The real value of this research is that it has given voice to personal experiences of ‘mental illness’, treatment and recovery by using a narrative methodology, and has endorsed the value of that knowledge. The findings provide one more piece of evidence that can inform our current understanding of these important issues and help bring about change in a system that so often relies on impersonal findings of ‘objective’ science.

## REFERENCES

- Aherne, L. & Fisher, D. (1999) Personal Assistance in Community Existence. In *Power 2 U Center* (National Empowerment Center. ed.) Power2U, Lawrence MA.
- Aherne, L & Fisher, D (1999) *A Recovery Guide: Recovery at Your Own Pace*, National Empowerment Center, Lawrence MA.
- Alanen, Y. (2009) Towards a more humanistic psychiatry: Development of need-adapted treatment of schizophrenia group psychoses. *Psychosis*, 1(2), 156 - 166.
- American Psychiatric Association 2000: Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision, Washington, DC Psychiatric Association
- Amering, M. & Schmolke, M. (2009) *Recovery in Mental Health: Reshaping Scientific and Clinical Responsibilities*, Wiley-Blackwell, West Sussex.
- Andresen, R.O., L. Caputi, P. (2003) The experience of recovery from schizophrenia: towards an empirically validated stage model. *Australian and New Zealand Journal of Psychiatry*, 37, 586-594.
- Anthony, W.A. (1993) Recovery from Mental Illness: The Guiding Vision of the Mental Health Service System in the 1990s. *Psychosocial Rehabilitation Journal*, 16(4), 11-23.
- Anthony, W.A. (2000) A Recovery Oriented Service System: Setting Some System Level Standards. *Psychiatric Rehabilitation Journal*, 24(Fall), 159-168.
- Anthony, W.A. & Huckshorn, K.V. (2006) *Principled Leadership in Mental Health Systems and Programs*, Center for Psychiatric Rehabilitation, Boston.
- Aquinas, T. (1274 ) *Summa Theologica*. Benzinger Books, New York.
- Bakhtin, M. (1981) *The Dialogical Imagination*, University of Texas Press, Austin, Texas.
- Bakhtin, M.M. (1973) *Problems of Dostoyevsky's Poetics*, Ardis, Ann Arbor.
- Barker, P. & Buchanan-Barker, P. (2005) *The Tidal Model: A Guide for Mental Health Professionals*, Brunner Routledge, New York.
- Behan, C., B., K. & O'Callaghan, E. (2008) The Economic Cost of Schizophrenia in Ireland: A Cost of Illness Study. *Irish Journal of Psychological Medicine*, 25, 80-87.
- Benney, M. & Hughes, E.C. (1956) Of Sociology and the Interview. *American Journal of Sociology*, 62, 137 - 142.
- Bolte Taylor, J. (2009) *My Stroke of Insight*, Hodder and Stoughton, London.
- Boulding, K.E. (1956) *The Image: Knowledge in Life and Society* Ann Arbor Paperbacks, London.
- Bourdieu, P. (2008) The Forms of Capital. In *Readings in Economic Sociology* (Biggart, N. W. ed.) Blackwell Publishers, Oxford.
- Bracken, P. & Thomas, P. (2009) Beyond Consultation: The Challenge of Working with User/Survivor and Carer Groups. *Psychiatric Bulletin*, 33, 241-243.
- Bradley, L. & Tawfiq, N. (2006) The physical and psychological effects of torture in Kurds seeking asylum in the United Kingdom. *Torture*, 16(November:1), 41-47.
- Braun, V. & Clarke, V. (2006) Using Thematic Analysis in Psychology. *Qualitative Research in Psychology*, 3, 77-101.
- Bregin, P.R. (1991) *Toxic Psychiatry*, St. Martin's Press, New York.
- Brendel, D.H. (2006) *Healing Psychiatry*, MIT Press, London.
- Bronfenbrenner, U. (1977) Toward an Experimental Ecology of Human Development. *American Psychologist*, (July), 513-531.

- Brown, W. & Kandirikirira, P. (2007) *Recovering Mental Health in Scotland*. Scottish Recovery Network, Glasgow.
- Browne, I. (2008) *Music and Madness*, Atrium, Cork.
- Bruner, J. (2002) *Making Stories: Law, Literature and Life*, Harvard University Press, Cambridge, Massachusetts, London.
- Burns, M.L. (2006) Bodies that speak: examining the dialogues in research interactions. *Qualitative Research in Psychology*, 3, 3 - 18.
- Cain, C. (1991) Personal Stories: Identity Acquisition and Self-Understanding in Alcoholics Anonymous. *Ethos*, 19(2), 210 - 253.
- Carless, D. & Douglas, K. (2008) Narrative, identity and mental health: How men with serious mental illness re-story their lives through sport and exercise *Psychology of Sport and Exercise*, 9(5), 576 -594.
- Carling, P.J. (1995) *Return to community: Building support systems for people with psychiatric disabilities*, Guildford Press, New York.
- Carrel, A. (1935) *Man the Unknown*, Penguin, New York.
- Casey, B. (2002) Reconciling Voices. *Journal of Psychiatric and Mental Health Nursing*, 9(5), 603 -610.
- Chamberlin, J. (1978) *On Our Own: Patient-Controlled Alternatives to the Mental Health System*, Hawthorn Books, Inc., New York.
- Chambers (1999) *The Chambers Dictionary* Harrap Publishers, Edinburgh.
- Chang, E.C. & DeSimone, S.L. (2001) The Influence of Hope on Appraisals, Coping, and Dysphoria: A Test of Hope Theory. *Journal of Social and Clinical Psychology*, 20(2), 117-129
- Charon, R. (2006) *Narrative Medicine: Honoring the Stories of Illness*, Oxford University Press, Oxford.
- Christensen, A. & Jacobson, N.S. (1994) Who (or What) Can do Psychotherapy?: The Status and Challenge of Non-professional Therapies. *Psychological Science*, 5(1), 8-14.
- Clarke, P. (1992) Mutual-Help Groups and Mental Health Professionals: Barriers and Implications for Co-operative Relations, Unpublished Masters Thesis, Department of Psychology, University of Auckland, Auckland.
- Cobigo, V. & Stuart, H. (2010) Social inclusion and mental health. *Current Opinion in Psychiatry*. 2010 23(5), 453-7.
- Coleman, R. (2004) *Recovery: An Alien Concept*, P&P Press, Fife.
- College of Psychiatry of Ireland (2012). Website address: [www.irishpsychiatry.ie/Helpful\\_Info/mentalhealthproblems/Schizophrenia.aspx](http://www.irishpsychiatry.ie/Helpful_Info/mentalhealthproblems/Schizophrenia.aspx). Accessed April 2012.
- Cook, C.C.H. (2011) Theology, Transcendence and Mental Health. Paper presented at *Mental Health, Practical Theology and Spirituality Conference*, All Hallows College, Dublin (10<sup>th</sup> June 2011).
- Corrigan, P.W., Calabrese, J.D., Diwan, S.E., Keogh, C.B., Keck, L. & Mussey, C. (2002) Some Recovery Processes in Mutual Help Groups for Persons with Mental Illness I: Qualitative Analysis of Program Materials and Testimonies. *Community Mental Health Journal*, 38 (4), 287-301.
- Corrigan, P.W., Slopen, N., Gracia, G., Phelan, S., Keogh, C.B. & Keck, L. (2005) Some Recovery Processes in Mutual-Help Groups for Persons with Mental Illness; II: Qualitative Analysis of Participant Interviews. *Community Mental Health Journal*, 41 (6), 721-735.
- Corry, M. & Tubridy, A. (2001) *Going Mad: Understanding Mental Illness*, Gill and MacMillan Newleaf, Dublin.
- Cotterill, P. (1992) Interviewing women: Issues of vulnerability and power. *Women's studies international forum* 15, 593-606.

- Cotton, H. (1919) The Relation of Oral Infection to Mental Diseases. *Journal of Dental Research*, 1, 269-313.
- Cresswell, J.W. (2007) *Second Edition Qualitative Inquiry and Research Design: Choosing Among Five Approaches*, Sage, London.
- Cresswell, J.W. & Miller, D.L. (2000) Determining validity in qualitative inquiry. *Theory into Practice*, 39(3), 124 -130.
- Cresswell, J.W. (2005) *Research Design: Qualitative, Quantitative and Mixed Method Approaches*, Sage, New Delhi.
- Crotty, M. (1998) *The foundations of social research: meaning and perspective in the research process*, Sage publications, London, Thousand Oaks, New Delhi.
- Czarniawska, B. (2009) *Narratives in Social Science Research*, Sage, London.
- Daly, A. & Walsh, D. (2011) HRB Statistics Series 15. Activities of Irish Psychiatric Units and Hospitals 2010. Health Research Board, Dublin.
- Davenport, C. (1911) *Heredity in Relation to Eugenics*, Henry Holt, New York.
- Davidson, L., O'Connell, M.J., Tondora, J., Steaheli, M. & Evans, A.C. (2007) Recovery in Serious Mental Illness: Paradigm Shift or Shiboleth? *Professional Psychology: Research and Practice*, 36(5), 480-487.
- Davies, B. (2006) Collective biography as ethically reflexive practice In *Doing Collective Biography* (Davies, B. and Gannon, S. eds). Open University Press, Berkshire, pp. 182-189.
- Deegan, P. (1995) Coping with Recovery as a Journey of the Heart. *Psychiatric Rehabilitation Journal*, 19:3, 91-97.
- Denzin, N. (1992) *Symbolic interactionism and cultural studies: The politics of interpretation*, Blackwell, Oxford.
- Department of Health and Children (2006) A Vision for Change: Report of the Expert Group on Mental Health Policy. Stationery Office, Dublin.
- DeSisto, M., Harding, C.M., McCormick, R., Ashikaga, T.V. & Brooks, G.W. (1995) The Maine and Vermont three-decade studies of serious mental illness. II. Longitudinal course comparisons. *British Journal of Psychiatry*, 167, 338 -342.
- Dineen, T. (1999) *Manufacturing Victims, What the psychology industry is doing to people*, Constable, London.
- Driberg, T. (1964) *The Mystery of Moral Re-armament: A Study of Frank Buchman and His Movement*, Martin Secker and Warburg Limited, Oxford.
- Dunne, E.A. (2006) The Views of Adult Users of the Public Sector Mental Health Services. Mental Health Commission, Dublin.
- Dunne, E.A. & Fitzpatrick, A. (1999) GROW Ireland Questionnaire to Members. GROW, Kilkenny.
- Dunne, E.A. & Meehan, T. (2003) Personal growth and community development through leadership: evaluation of a training programme for members developed by GROW (Ireland). GROW in Ireland.
- Elliott, J. (2005) *Using Narrative in Social Research: Qualitative and Quantitative Approaches*, Sage, Los Angeles.
- Emanuel, E.J. & Grady, C. (2006) Four Paradigms of Clinical Research and Research Oversight. *Cambridge Quarterly of Health Care Ethics*, 16, 82-96.
- Evans, D. (2003) Hierarchy of evidence: a framework for ranking evidence evaluating healthcare interventions. *Journal of Clinical Nursing*, 12, 77-84.
- Eve Limited (2008) *Our Personal Stories of Recovery*, Eve Ltd, Dublin.
- Farragher, B., Carey, T. & Owens, J. (1996) Long-term follow-up of rehabilitated patients with chronic psychiatric illness in Ireland. *Psychiatric services*, 47, 1120 - 1122.



- Feldman, M.D., Franks, P., Epstein, R.M., Franz, C.E. & Kravitz, R.L. (2006) Do patient requests for antidepressants enhance or hinder physicians' evaluation of depression? A randomized controlled trial. *Med Care*, 44(12), 1107 -13.
- Fetterman, D.M. (1989) *Ethnography: Step by Step*, Sage, Newbury Park CA.
- Finn, L. (2001) Mutual Help Groups and Psychological Well-being: A Study of GROW, A Community Mental Health Organisation. Unpublished PhD Thesis, Department of Psychology, Curtin University, Perth.
- Finn, L.D., Bishop, B.J. & Sparrow, N. (2009) Capturing Dynamic Processes of Change in GROW Mutual Help Groups for Mental Health. *American Journal of Community Psychology*, 44, 300 -315.
- Fisher, D. (2008) *A New Vision of Recovery*, National Empowerment Center, Boston.
- Flanagan, B. (2011) The Spiritual Classics and Mental Health: Julian of Norwich. Paper presented at *Mental Health Practical Theology and Spirituality Conference*, All Hallows College, Dublin (10<sup>th</sup> June 2011)
- Flick, U. (2009) *An Introduction to Qualitative Research*, Sage, London.
- Forster, E.M. (1963 [1927]) *Aspects of the novel*, Penguin, Harmondsworth.
- Foudraine, J. (1974) *Not Made of Wood: A Psychiatrist discovers his own profession*, Quartet Books, London.
- Frank, A.W. (1992) The pedagogy of suffering. *Theory and Practice*, 2(4), 467 - 487.
- Frank, A.W. (1995) *The Wounded Storyteller: Body, Illness and Ethics*, University of Chicago Press, Chicago.
- Frank, A.W. (2000a) All the Things Which Do Not Fit: Baudrillard and Medical Consumerism. *Families, Systems and Health*, 18(2), 205-216.
- Frank, A.W. (2000b) The Standpoint of Storyteller. *Qualitative Health Research*, 10(3), 354-365.
- Frank, A.W. (2002) Why study people's stories? The dialogical ethics of narrative analysis. *International journal of qualitative methods*, 1(1), 109-117.
- Frank, A.W. (2004) *The renewal of generosity: Illness medicine and how to live*, University of Chicago press, Chicago.
- Freeman, M. (2003) Identity and difference in narrative inquiry: a commentary on the articles by Erica Burma, Michelle Crossley, Ian Parker and Shelley Slater. *Narrative Inquiry*, 13(2), 331 - 346.
- Fricker, M. (2006) Powerlessness and social interpretation. *Episteme*, 96-108.
- Gaffney, M. (2011) *Flourishing: How to achieve a deeper sense of well-being, meaning and purpose - even when facing adversity*, Penguin Ireland, Dublin.
- Glaser, B.G. & Strauss, A.L. (1967) *The Discovery of Grounded Theory Strategies for Qualitative Research.*, Aldine De Gruyter, New York.
- Glasser, W. (2003) *Warning: Psychiatry Can Be Hazardous To Your Mental Health*, Harper Collins, New York.
- Goffman, I. (1990) *The Presentation of Self in Everyday Life*, Penguin, London.
- Gosden, R. (2001) *Punishing the Patient: How Psychiatrists Misunderstand and Mistreat Schizophrenia*, Scribe Publications, Victoria.
- Government of Ireland (2001) Mental Health Act. Government of Ireland, Stationery Office, Dublin.
- GROW (2001) *Program of Growth to Maturity*, GROW, Sydney.
- GROW (2003) *Personal Growth and Community Building through Leadership: Part One*, GROW, Kilkenny.
- GROW (Undated) *GROW Program Training Manual*, GROW Publications, Sydney.
- GROW (2011) Personal Communication (e-mail circular January 21<sup>st</sup> 2011)

- GROW in Ireland (1994) *GROW in Ireland: A Celebration and a Vision of Innovations in Community Mental Health*, GROW in Ireland, Kilkenny.
- GROW in Ireland (1996) *Soul Survivors Volume One: Twenty Two People Tell How They Overcame Mental Illness and Breakdown in Ireland*, GROW Publishing, Kilkenny
- GROW in Ireland & HSE National Office for Suicide Prevention (2010) *You Can Do It But You Can't Do It Alone: Young Adult Personal Stories of Recovery Towards Mental Health* National Office for Suicide Prevention, Dublin.
- GROW International (1979) *GROW Comes of Age: A Celebration and a Vision*, GROW International, Sydney.
- GROW International (1995) *Introduction to GROW: Enabling versus disabling help in the care of the mentally ill*, GROW International, ACT.
- GROW International (1997) *Summary Introduction to GROW: World Community Mental Health Movement*, GROW, ACT.
- Gubrium, J.F. & Holstein, J.A. (2003) *Postmodern interviewing*, Sage, London, Los Angeles, New Delhi.
- Gubrium, J.F. & Holstein, J.A. (2009) *Analysing narrative reality*, Sage, Los Angeles, London, New Delhi, Singapore.
- Hamilton, C. (2008) *Buddhism*, Red and Black Books, St Petersburg, Florida.
- Hanninen, V. (2004) A model of narrative circulation. *Narrative Inquiry*, 14(1), 69 - 85.
- Harding, C.M., Brooks, G.W., Ashikaga, T.V., Strauss, A.L. & Breier, A. (1987) The Vermont Longitudinal study of Persons with Severe Mental Illness. 1: Methodology, Study Sample and Overall Status 32 Years Later. *American Journal of Psychiatry*, 144(6), 718 - 726.
- Health, D.o. (2001) *The Journey to Recovery: The Government's Vision for Mental Health Care*. Department of Health, London.
- Healthcare Commission (United Kingdom) 2007 *Inpatient Survey 2007* Norfolk and Norwich University Hospital NHS Trust. Picker Institute Europe
- Healy, D. (2004) *Let Them Eat Prozac*, New York University Press, New York.
- Henry, J. & Dunne, E.A. (2003) *GROW Ireland Questionnaire to Members: Report of Results*. UCC, Cork.
- Higgins, A. (2008) *A Recovery Approach within the Irish Mental Health Services: A Framework for Development*. Mental Health Commission, Dublin.
- Higgins, A., Creaner, M., Alexander, J., Maguire, G., Rani, S., McCann, E., O'Neill, O., Watts, M., Garland, M. (2010) *Current Education/Training Available for Professionals Working in Mental Health in Ireland: A Scoping Study*. Mental Health Commission, Dublin.
- Hoff, P. (2008) Kraepelin and degeneration theory. *European archives of psychiatry and clinical neuroscience*, 258(2), 12-17.
- Hoffman, L. (1984) *A Co-Evolutionary Framework for Systemic Family Therapy* (Unpublished Paper)
- Holloway, I. & Freshwater, D. (2007) *Narrative Research in Nursing*, Blackwall Publishing, London.
- Holmes, D., Murray, S., Perron, A. & Rail, G. (2006) Deconstructing the evidence-based discourse in health sciences: truth, power and fascism. *International Journal of Evidence Based Healthcare*, 4, 180 -186.
- Holstein, J.A. & Gubrium, J.F. (2003) *Inside Interviewing: New Lenses, New Concerns* Sage Thousand Oaks London.
- Hresko, T. (2006) In the Cellars of the Hollow Men: Use of Solitary Confinement in U.S. Prisons and its Implications under International Laws Against Torture. *International Law Review*, XVIII (Spring ), 1.

- Huang, H.Y.L., P.C. (2009) EEG dynamics of experienced Zen meditation practitioners probed by complexity index and spectral measure. *Journal of Medical Engineering and Technology*, 33(4), 314-321.
- Hudson-Jones, A. (2005) The cautionary tale of psychiatrist Henry Aloysius Cotton. *The Lancet*, 366(9483), 361-362.
- Humphreys, K. & Rappaport, J. (1993) From the community mental health movement to the war on drugs. A study in the definition of social problems. *Journal of American Psychology*, 48(8), 892-901.
- Humphreys, T. (1996) *The Power of Negative Thinking*, Gill and Macmillan, Dublin.
- Hurault, B. (ed.) (1999) *Christian Community Bible*, Claretian Publications, Quezon City, Philippines
- Huxley, P. & Thornicroft, G. (2001) Social inclusion, social quality and mental illness. *British Journal of Psychiatry*, 5(3), 41 - 53
- Hyde, L. (1998) *Trickster makes this world: Mischief, myth and art*, Canongate Books, Edinburgh.
- Hynes, G. (2010) Dying to Breathe: A Conversation at the Crossroads of Respiratory and Palliative Nursing Care - An Action Research Project. Unpublished PhD Thesis, School of Nursing and Midwifery, Trinity College, Dublin.
- Hyypä, M.T. & Mäki, J. (2003) Social participation and health in a community rich in stock of social capital. *Health Education Research: Theory and Practice*, 18(6), 770 - 779.
- Irish Critical Voices Network (2011). Online Communication Board. Website address <http://www.criticalvoicesnetwork.com/forum.html#/>. Accessed April 2011
- Irish Critical Voices Network (2012) Personal e-mail January 2012.
- Johnson, R.B. & Onwuegbuzie, A.J. (2004) Mixed Methods Research: A Research Paradigm Whose Time Has Come. *Educational Researcher*, 33(7), 14 -26.
- Johnstone, L. (2000) *Users and Abusers of Psychiatry*, Routledge, New York.
- Jung, C.G. (1936) *Collected Works*, Bollingen Foundation, New York.
- Jung, C.G. (1965) *Memories, Dreams and Reflections*, Random House, New York.
- Kartalova-O'Doherty, Y. & Tedstone Doherty, D. (2010) Recovering from mental health problems: Perceived positive and negative effects of medication on reconnecting with life. *International Journal of Social Psychiatry*, 57(6), 610 - 618.
- Katz, A.H. (1981) Self-help and mutual aid: an emerging social movement? *Annual review of sociology*, 7, 129-155.
- Katz, A.H. & Bender, E. (1976) *The strength in us: self help groups in the modern world*, Franklin-Watts, New York.
- Kaufman, W. (2000) *Basic Writings of Nietzsche*, Modern Library, New York.
- Kendall-Tackett, K.A., Williams, L.M. & Finkelhor, D. (1993) Impact of Sexual Abuse on Children: A Review and Synthesis of Recent Empirical Studies. *Psychological Bulletin*, 112(1), 164 -180.
- Kennedy, M. (1989) Psychiatric Hospitalisation of GROWers. In *Biennial Conference on Community Research and Action*. East Lansing Michigan, pp. 1-12.
- Kennedy, M. (1995) Becoming a GROWer: world view transformation among committed members of a mutual help group. Unpublished PhD Thesis, Department of Psychology, University of Champaign, Champaign.
- Keogh, B. (2011) Personal e-mail April 2011.
- Keogh, C.B. (1979) How it all started in a nutshell. In *GROW comes of age: a celebration and a vision*. GROW International, Sydney.

- Kercheval, B.L. (2005) Women's experiences at GROW: 'There's an opportunity there to grow way beyond what you thought you could...'. Unpublished Masters Thesis, Department of Psychology, University of Victoria, Victoria.
- Kerney, B. (2008) The Theology of Friendship. Unpublished PhD Thesis, Department of Theology, Durham University, Durham.
- Kipling, R. (1899) *From Sea to Sea: Letters of Travel*, Doubleday and McClure, New York.
- Kleinman, A. (1988) *The illness narratives: Suffering, healing, and the human condition* Basic Books, Chicago.
- Kloos, B. (1999) Cultivating Identity; Meaning making in the context of residential treatment settings for persons with histories of psychological disorders. Unpublished PhD Thesis, Department of Psychology, University of Illinois, Urbana Champaign, pp. 420.
- Koenig, H.G. (2008) Religion and Mental Health: what should psychiatrists do? *The Psychiatrist*, 32, 201 -203.
- Konstan, D. (1997) *Friendship in the classical world*, Cambridge University Press, London.
- Kuhn, T.S. (1962) *The structure of scientific revolutions*, University of Chicago Press, Chicago.
- Kvale, S. & Brinkmann, S. (2009) *Interviews: Learning the Craft of Qualitative Research Interviewing*, Sage, London.
- Labov, W. & Waletzky, J. (1967) Oral versions of personal experience. In *Essays on the verbal and visual arts* (Helm, J. ed.) University of Washington Press, Seattle, pp. 12 -44.
- Laing, R.D. (1966) *The Self and Others*, Tavistock Publications, London.
- Lather, P. (1986) Research as praxis *Harvard Educational Review*, 56, 257-277.
- Launer, J. (1998) Narrative and mental health in primary care. In *Narrative Based Medicine: Dialogue and Discourse in Clinical Practice*, (Greenhalgh, T. & Hurvitz., B. ed.) BMJ Books, London.
- Lavoie, M., De Koninck, T. & Blondeau, D. (2006) The nature of care in the light of Emmanuel Levinas. *Nursing philosophy*, 7, 225 - 234.
- Lehmann, P. (2002) *Coming off Psychiatric Drugs: Successful Withdrawal from Neuroleptics, Antidepressants, Lithium, Carbamazepine and Tranquillisers*, Peter Lehmann Publishing, Berlin.
- Levin, A. (2001) Conference Focuses on Mental Illness Stigma. *Psychiatric News* 9(May 4), 8.
- Levinas, E. (1969) *Totality and Infinity: an essay on exteriority*, Duquesne university press, Pittsburgh.
- Lincoln, Y. & Guba, E. (2000) Paradigmatic Controversies, Contradictions and Emerging Confluences. In *Handbook of Qualitative Research* (Denzin, N. and Lincoln, Y. eds). Sage Publications Inc, Thousand Oaks, California, pp. 189 -200.
- Lincoln, Y.S. & Guba, E.G. (1985) *Naturalistic Inquiry*, Sage, Newbury Park, California.
- Lundstrom, M. (1996) What is synchronicity? "A wink from the cosmos". *Intuition Magazine*, May, 176 -180.
- Lynch, T. (2001) *Beyond Prozac: Healing Mental Suffering Without Drugs*, Mercier Press, Dublin.
- MacGabhann, L., Lakeman, R., McGowan, P., Parkinson, M., Redmond, M., Sibitz, I., Stevenson, C. & Walsh, J. (2010) Hear my voice: the experience of discrimination of people with mental health problems in Ireland. Amnesty International Ireland.

- Marx, K. & Engels, F. (1848) *The Communist Manifesto*. The Communist League, London.
- Maton, K.I. & Salem, D.A. (1995) Organisational characteristics of empowering community settings: a multiple case study approach. *American Journal of Community Psychology*, 23(5), 631-656.
- Maturana, H.R. & Varela, F.J. (1992) *The Tree of Knowledge: The biological roots of human understanding*, Random House, Boston.
- Maxwell, J.A. (1996) *Qualitative Research Design: an interactive approach.*, Sage, Thousand Oaks.
- McCrum, B.W. & MacFlynn, G. (1990) Psychiatric rehabilitation – does it work? A three year retrospective study. *The Ulster Medical Journal*, 59(2), 168 -173.
- McFague, S. (1993) *The body of God: an ecological theology*, Fortress Press, Minneapolis.
- Mental Health Act (2001) *Mental Health Act 2001*. Government of Ireland, The Stationery Office, Dublin.
- Mental Health Commission New Zealand (2001) *Recovery Competencies for Mental Health Workers*. Mental Health Commission New Zealand, New Zealand.
- Merriam, S.B. (1998) *Qualitative Research and Case Study Applications in Education. Revised and Expanded from "Case Study Research in Education"*. Jossey-Bass Publishers, San Francisco.
- Mental Health Commission (2005) *A vision for a recovery model in Irish mental health services*. Mental Health Commission, Dublin.
- Mental Health Commission (2008) *A Framework for Development of A Recovery Approach Within the Irish Mental Health Services*. Mental Health Commission, Dublin.
- Mishler, E.G. (1986) *Research interviewing: context and narrative*, Harvard University Press, Cambridge MA.
- Moncrieff, J. (2007) *The Myth of the Chemical Cure: A Critique of Psychiatric Drug Treatment* Palgrave MacMillan.
- Morris, J. (2005) *Citizenship and disabled People*. Disability Resource Centre, UK.
- Mosher, L.R., Menn, A. & Matthews, S.M. (1975) Soteria: Evaluation of a Home-Based Treatment for Schizophrenia. *American Journal of Orthopsychiatry*, 45(3), 455 - 467.
- Nagle, E. (1959) Methodological issues in psychoanalytic theory In *Psychoanalysis, scientific method and philosophy* (Hook, S. ed. New York University Press, New York.
- National Disability Authority (2002) *Public Attitudes to Disability in the Republic of Ireland*. National Disability Authority, Dublin.
- National Disability Authority (2007) *Public Attitudes to Disability in Ireland*. National Disability Authority, Dublin.
- Newberg, A.B. & Iverson, J. (2003) The neural basis of the complex mental task of meditation: neurotransmitter and neurochemical considerations. *Medical Hypotheses*, 61(2), 282 - 291.
- National Institute of Mental Health Regier, D. (1988) The NIMH depression Awareness recognition and treatment program *Journal of Psychiatry*, 145, 1351-57.
- O'Donnell, A., Watson, E., Morris, E. & Watts, M. (2008) *A Survey of GROW membership in Ireland*. GROW in Ireland, Kilkenny.
- O'Shea, E. & Kennelly, B. (2008) *The Economics of Mental Health Care in Ireland*. Mental Health Commission, Dublin.

- O'Sullivan, M. (2011) Incest and Spiritual Journey. Paper presented at *Mental Health, Practical Theology and Spirituality Conference*, All Hallows College, Dublin (10<sup>th</sup> June 2011)
- Ogawa, R.T. (2005) Leadership as a social construct: The expression of human agency within organisational constraint, in *The sage handbook of educational leadership: Advances in theory research and practice*. (English, F. W. ed.) Sage, Thousand Oaks CA, pp. 89-108.
- Øktedalen, O.S., Haugen, A.H., Opstad, P.K. (2001) The influence of physical and mental training on plasma beta-endorphin level and pain perception after intensive physical exercise. *Stress and Health*, 17(2), 121 - 127.
- Patel, V. & Kleinman, A. (2003) Poverty and common mental disorders in developing countries. *Bulletin of the World Health Organisation*, 81(8), 609 - 615.
- Patent, A.M. (1995) *You Can Have it All: A Simple Guide to a Joyful and Abundant Life*, Pocket Books, New York.
- Penuel, W. & Wertsch, J. (1995) Vygotsky and identity formation: A sociocultural approach. *Educational Psychologist*, 30, 83 - 92.
- Perry, H.S. (1982) *Psychiatrist of America*, Harvard University Press, Massachusetts and London.
- Pert, C.B. (1998) *Molecules of Emotion*, Simon & Schuster, London.
- Pfeiffer, M.B. (2007) *Crazy in America: The hidden tragedy of our criminalised mentally ill*, Carroll and Graf, New York.
- Plummer, K. (1995) *Telling sexual stories: power, change and social worlds*, Routledge, London.
- Polkinghorne, D.E. (1989) Phenomenological research methods. Existential-phenomenological perspectives in psychology: Exploring the breadth of human experience. In *Existential-phenomenological perspectives in psychology: Exploring the breadth of human experience* (Valle, R. S. & Halling, S. ed.) Plenum Press, New York, pp. ( 41-60).
- Post, S.G. (2008) The Joy of Giving: Why altruism and generosity make us healthier and happier – and how we can all give more. *Psychology Today*, 3(September), 43 - 44.
- President's New Freedom Commission on Mental Health (2003) *Achieving the Promise: Transforming Mental Health Care in America*. Rockville, MD: DHHS.
- Price, R.H. (1979) *Abnormal Behaviour Perspectives in Conflict Second Edition*, Holt, Rinehart and Winston, Inc, USA.
- Putman, R. (2000) *Bowling Alone: The Collapse and Revival of American Community*, Simon and Schuster, New York.
- Ralph, O.R. & Corrigan, P.W. (2007) *Recovery in Mental Illness: Broadening Our Understanding of Wellness*, American Psychological Association, Washington DC.
- Rappaport, J. (1981) In praise of paradox: a social policy of empowerment over prevention. *American Journal of Community Psychology*, 9(1), 1-25.
- Rappaport, J. (1987) Terms of empowerment/exemplars of prevention: toward a theory for community psychology. *American Journal of Community Psychology*, 15(2), 121-48.
- Rappaport, J. (1988) The evaluation of GROW in the USA and its significance for community mental health. GROW, Chicago.
- Rappaport, J. (1995) Empowerment Meets Narrative: Listening to Stories and Creating Settings. *American Journal of Community Psychology*, 23(5), 795-807.

- Rappaport, J. (1998) The Art of Social Change: Community Narratives as Resources for Individual and Collective Identity. In *Addressing Community Problems: Psychological Research and Intervention* (Arriaga, A. B. & Oskamp, S. ed.) Sage, Thousand Oaks California.
- Rappaport, J. (2000) Community Narratives: Tales of Terror and joy. *American Journal of Community Psychology*, 28(1), 1-24.
- Rappaport, J. (2005) Community Psychology is (Thank God) More Than Science. *American Journal of Community Psychology*, 35(3/4), 231 - 238.
- Rappaport, J. (2008) Introduction of Kenneth I. Maton on his receipt of the 2006 SCRA Award for Distinguished Contributions to Theory and Research. *American Journal of Community Psychology*, 41(1-2), 1-3.
- Rappaport, J.S., Toro, P.A., McFadden, L., Reischl, T.M., Roberts, L.J., Salem, D.A., Stein, C.C., Zimmerman, M.A. (1985) Collaborative Research with a Mutual Help Organisation. *Social Policy*, (Winter), 12-24.
- Reason, P. (2003) Pragmatist Philosophy and Action Research Readings and Conversation with Richard Rorty. *Action Research*, 1(1), 103 -123.
- Redfield Jamison, K. (1997) *An Unquiet Mind: A Memoir of Moods and Madness*, Mackays of Chatham, Chatham, Kent.
- Reischl, T.M., Toro, P.A., Zimmerman, M.A., Rappaport, J., Seidman, E., Luke, D.A., Roberts, L.J. (1988) Professionals in mutual help groups: impact on social climate and members' behaviour. *Journal of Consulting Clinical Psychology* 56(4), 631-632.
- Repetti, R.I., Taylor, S.E. & Seeman, T.E. (2002) Risky families: Family social environments and the mental and physical health of offspring. *Psychological Bulletin*, 128 (2 Mar), 330 -368.
- Ricoeur, P. (1984) *Time and Narrative Vols 1 - 3* University of Chicago Press, Chicago.
- Riessman, C.K. (2003) *Narrative Analysis*, Sage, Newbury Park CA.
- Riessman, C.K. (2008) *Narrative Methods for the Human Sciences*, Sage, Boston.
- Riessman, F. (1965) The Helper Therapy Principle. *Social Work*, Vol 10 (2), 27-32.
- Riessman, F. (1990) Restructuring Help: A Human Services Paradigm for the 1990s. *American Journal of Community Psychology*, 18(2), 221-227.
- Rogeness, G.A. & Badner, R.A. (1973) Teenage helper: A role in community mental health. *American Journal of Psychiatry*, 130, 933-936. .
- Rosenblatt, P.C. (2003) Interviewing at the border of fact and fiction. In *Postmodern Interviewing* (Gubrium, J. F. & Holstein, J.A. ed.) Sage, Thousand Oaks, New Delhi, London.
- Roth, E.F., Lunde, I., Boysen, G. & Genefke, I.K. (1987) Torture and its treatment. *American Journal of Public Health*, 77(11), 1404-1406. .
- Rowe, D. (2008) Ask Better Questions. *New Scientist*, (November), 18.
- Rubia, K. (2009) The neurobiology of meditation and its clinical effectiveness in psychiatric disorders. *Biological Psychology Volume 82*, , 82(1), 1 -11.
- Sacks, O. (2007) *Musicophilia: Tales of Music and the Brain*, Knopf, New York.
- Sainsbury Centre for Mental Health (2003) The economic and social costs of mental illness in England. SCMH, London.
- Saks, E.R. (2007) *The Centre Cannot Hold: My Journey Through Madness*, Hyperion, New York.
- Salem, D.A. (1984) Learning From the Failure of Deinstitutionalisation: The Mutual Help Alternative Conference Presentation Understanding Mutual Help Organisations In *92nd Annual Convention of the American Psychology Association*, Toronto.

- Salem, D.A. (1987) The Culture of Mutual Help: Characteristics of the GROW Membership. In *Community Research and Action* Columbia, SC.
- Salem, D.A., Seidman, E. & Rappaport, J. (1988) Community Treatment of the Mentally Ill: The Promise of Mutual Help Organisations. *Social Work*, September/October, 403-408.
- Sarbin, T.R. (1986) *Narrative Psychology: the Storied Nature of Human Conduct*. Praeger, New York.
- Scaff, L.A. (2000) Weber on the cultural situation of the modern age. In *The Cambridge Companion to Weber* (Turner, S. ed.) Cambridge University Press, Cambridge.
- Schank, R.C. (1990) *Tell me a story: a new look at real and artificial memory*, Scribner, New York.
- Scheff, T.J. (1984) *Being Mentally Ill: a Sociological Theory*, Aldine, Chicago.
- Schizophrenia Ireland/Lucia Foundation and the Irish Psychiatric Association (2003) *Towards Recovery: Principles of good practice in the treatment, care, rehabilitation and recovery of people with a diagnosis of schizophrenia and related mental disorders*, Schizophrenia Ireland/Lucia Foundation and the Irish Psychiatric Association, Dublin.
- Schweitzer, A. (1931 reprinted 1998) *Out of my Life and Thought*, Johns Hopkins University Press, Baltimore, Maryland.
- Scully, A.T. (1979) *Museums of Madness*, St. Martin's Press, New York.
- Seidman, E. & Rappaport, J. (1981) Development of an evaluation research grant proposal for GROW. University of Champaign.
- Seligman, M.E.P. (1972) Learned Helplessness. *Annual Review of Medicine*, 23, 407-412.
- Seligman, M.E.P. (1995) The Effectiveness of Psychotherapy. *American Psychologist*, 50(12), 965-974.
- Seligman, M.E.P. (2007) *What you can change... and what you can't. The complete guide to successful self-improvement*, Nicholas Brealey Publishing, London, Boston.
- Sennett, R. (2007) *The culture of the new capitalism*, Yale University Press, New York.
- Shannon, P.J. & Morrison, D.L. (1990) Who Goes to GROW? *Australian and New Zealand Journal of Psychiatry*, 24, 96-102.
- Shepherd, G., Boardman, J. & Burns, M. (2008) Making Recovery a Reality. Sainsbury Centre for Mental Health.
- Shields, C.M. (2007) *Bakhtin: Peter Laing Primer*, Peter Laing Publishing Inc., New York.
- SHINE (2012) Website address: [www.shineonline.ie/index.php/bi-polar](http://www.shineonline.ie/index.php/bi-polar). Accessed April 2012.
- Shorter, E. (1997) *A History of Psychiatry, From the Era of the Asylum to the Age of Prozac*. John Wiley and Sons, New York.
- Silverman, H.J. (1997) *Inscriptions: after phenomenology and structuralism*. Northwestern university press, Evanston.
- Smith, M. (1998) *Social science in question*, Thousand Oaks, Sage Publications Ltd, London, New Delhi.
- Snyder, C.R., Rand, K.L. & Sigmon, D.R. (2002) Hope theory: a member of the positive psychology family. In *Handbook of positive psychology* (Snyder, C.R., Lopez, S.J. ed.) Oxford University Press, New York, pp. 257-276.
- Spataro, J., Mullen, P.E., Burgess, P.M., Wells, D.L. & Moss, S.A. (2004) Impact of child sexual abuse on mental health. *British Journal of Psychiatry*, 184, 416-421.



- Stein, C.H. (1987) Social Networks, Social Support and Psychological Adjustment Among Participants in a Mutual Help Organisation for the Mentally Ill. In *Community Research and Action*, Columbia South Carolina.
- Stickley, T. & Wright, N. (2010) The British research evidence for recovery, papers published between 2006 and 2009 (inclusive). Part One: a review of peer-reviewed literature using a systematic approach. *Journal of Psychiatric and Mental Health Nursing*, 17(8), 674 - 682.
- Szasz, T. (1961) The Myth of Mental Illness. *American Psychologist*, 15(113 -118).
- Tappan, M.B. (2005) Subordination and the Dialogical Self: Identity Development and the Politics of 'Ideological Becoming'. *Culture and Psychology*, 11(1) 77-88.
- Thornicroft, G. (2006) *Shunned: Discrimination against people with mental illness*, Oxford University Press, Oxford.
- Tolle, E. (2005) *A New Earth: Create a Better Life*, Penguin, London.
- Toro, P.A., Rappaport, J. & Seidman, E. (1987) Social Climate of Mutual Help and Psychotherapy Groups. *Journal of Consulting and Clinical Psychology*, 55(3), 430-431.
- Trible, P. (1984) *Texts of Terror: Literary-Feminists Readings of Biblical Narratives*, Philadelphia, PA: Fortress Press
- Tuke, S. (1813 reprinted 1996) *Description of the Retreat: An Institution Near York, for Insane Persons of the Society of Friends*, Process Press, York.
- Turner-Crowson, J. & Jablensky, A. (1987) WHO Survey on Self Help Groups and Mental Disorder. WHO.
- Turner, N., Browne, S., Clarke, M., Gervin, M., Larkin, C., Waddington, J.L. & O'Callaghan, E. (2010) Employment status among those with psychosis at first presentation. *Social Psychiatry and Psychiatric Epidemiology*, 4(2), 119 -126.
- Ullmann, L.P. & Krasner, L. (1975) *A Psychological Approach to Abnormal Behaviour*, Prentice Hall, New Jersey.
- Usher, K.J. & Arthur, D. (1998) Process consent: a model for enhancing informed consent in mental health nursing. *Journal of Advanced Nursing*, 27(4), 692 - 697.
- Vygotsky, L. (1981) The instrumental method in psychology. In *The concept of psychology in Soviet psychology* (Wertsch, J. ed.) Plenum, New York.
- Weber, M. (2000 [1904] ) *The Protestant Ethic and the Spirit of Capitalism*. Routledge, London.
- Webster, L. & Mertova, P. (2007) *Using Narrative Inquiry as a Research Method: an introduction to using critical event narrative analysis in research on learning and teaching*, Routledge, Abingdon and New York.
- Weiss, M.D., Longhurst, M.D. & Mazure, C.M. (1999) Childhood sexual abuse as a risk factor for depression in women: psychosocial and neurobiological correlates. *American Journal of Psychiatry*, 156, 816 - 828.
- Weiss, R.S. (1994) *Learning from Strangers*, Free Press, New York.
- Wengraf, T. (2001) *Qualitative research interviewing*, Sage, London.
- Whitaker, R. (2002) *Mad in America: Bad Science, Bad Medicine, and the Enduring Mistreatment of the Mentally Ill*, Basic Books, New York.
- Whitaker, R. (2010) *Anatomy of an Epidemic: Magic Bullets, Psychiatric Drugs, and the Astonishing Rise of Mental Illness in America*, Random House, New York.
- Whitman, W. (1963) *Leaves of Grass*, Penguin, London.

- Whitty, P., Lydon, C., Turner, N. & O'Callaghan, E. (2006) The influence of psychosocial rehabilitation on patients with a first episode of psychosis. *International Journal of Psychosocial Rehabilitation*, 10(2), 17 -27.
- Whitwell, D. (1999) The myth of recovery from mental illness. *Psychiatric Bulletin*, 23, 621 -622.
- World Health Organisation (2002) Promoting Mental Health: Concepts, Emerging Evidence, Practice. WHO, Geneva.
- World Health Organisation (2005) Website address: [www.euro.who.int/HEN](http://www.euro.who.int/HEN). Accessed September 2010.
- Williams, C.L. & Young, J. (1989) Group Process and Social Climate of GROW, A Community Mental Health Organisation. *Australian Journal of Psychiatry*, 23(1), 117-123
- Wolpe, J. (1973) *The practice of behaviour therapy*, Pergamon, Oxford.
- Young, J. (1990) An Outcome Evaluation of GROW: A Community Mental health Movement. Unpublished PhD Thesis, Department of Psychology, University of Tasmania, Hobart.
- Zimmerman, M.A., McFadden, L., Toro, P.A., Salem, D.A., Reischl, T.M., Rappaport, J. & Seidman, E. (1985) Expansion of a Mutual Help Organisation: The Johnny Apple-seed Approach. In *Midwest Psychological Association*, Champaign.

## APPENDICES

### Appendix One: The 12 Steps of Recovery and Personal Growth

#### THE 12 STEPS OF RECOVERY AND PERSONAL GROWTH

1. We admitted we were inadequate or maladjusted to life.
2. We firmly resolved to get well and co-operated with the help that we need.
3. We surrendered to the healing power of a wise and loving God.
4. We made personal inventory and accepted ourselves.
5. We made moral inventory and cleaned out our hearts.
6. We endured until cured.
7. We took care and control of our bodies.
8. We learned to think by reason rather than by feelings and imagination.
9. We trained our wills to govern our feelings.
10. We took our responsible and caring place in society.
11. We grew daily closer to maturity.
12. **We carried GROW's hopeful healing and transforming message to others in similar need.**

## Appendix Two: The 12 Stages of Decline and Maladjustment

### THE 12 STAGES OF DECLINE AND MALADJUSTMENT

1. We gave too much importance to ourselves and our feelings.
2. **We grew inattentive to God's presence and providence and God's natural order in our lives.**
3. We let competitive motives, in our dealings with others, prevail over our common personal welfare.
4. We expressed or suppressed certain feelings against the better judgement of conscience or sound advice.
5. We began thinking in isolation for others, following feelings and imagination instead of reason.
6. We neglected the care and control of our bodies.
7. We avoided recognising our personal decline and shrank from the task of changing.
8. We systematically disguised in our imagination the real nature of our unhealthy conduct.
9. We became a prey to obsessions, delusions and hallucinations.
10. We practised irrational habits, under elated feelings of irresponsibility or despairing feelings of inability or compulsion.
11. We rejected advice and refused to co-operate with help.
12. We lost all insight into our condition.

## Appendix Three: The Group Method

### THE GROUP METHOD

#### 1. OPENING ROUTINE (5 mins)

- (i) **Half-minute's silence ...** "to collect our thoughts".
- (ii) \*The memento (*Leader to read out only*):  
"While we place ourselves in the presence of God, the Supreme Healer, for the work of this meeting, let us not think only of our own needs and troubles, but let us also invoke His guidance and help..".  
\*Alternative Memento:  
"As we come together in mutual help for the work of this meeting, let us not think only of our own needs and troubles, but let us also reach out with loving thoughts ...
  - For all Grow members here present;
  - For absent members of the group in their present needs (mention names if you wish);
  - For all our fellow sufferers, especially those in institutions and those most isolated and abandoned;
  - And for all who in any way are helping the maladjusted and promoting the work of GROW".
- (iii) Have someone read the Twelve Steps (p.5)
- (iv) The GROW Commitment (p.77) is now recited together (*Leader to read out important clarification in dark print above the Commitment*).

#### 2. GROUP INTERACTION (30 – 35 mins)

*(NOTE: When newcomers are present, a 1-2 minute explanation of what GROW is and how it came about is in order. For this, an inexperienced leader may find it helpful to refer to p.1 of the Blue Book).*

- (i) **"Any urgent or pressing problems"?**
- (ii) Open Discussion (Aim to get a healthy balance of the following ingredients of a good meeting)
  - A PERSONAL TESTIMONY of Recovery or Outstanding Growth through GROW;
  - REPORT ON PROGRESS (including follow-up on Practical Tasks set at previous meetings);
  - CURRENT PROBLEM SOLVING;
  - A PERSONAL STORY of suffering or Need that led to GROW (*if appropriate, for a relatively new member*);

## RECOMMENDATION OF PRACTICAL TASKS.

### 3. MIDDLE ROUTINE (20 – 30 mins)

- (i) Now we pass to our Affirmation of Good, (p.78) which is recommended to all Growers – irrespective of beliefs – but is still voluntary and profoundly personal and therefore needs prior reflection.
- (ii) The Act of Surrender (p.78) – Read introductory explanation above the prayer).
- (iii) Testing of Knowledge (both learning and understanding) of the Blue Book.
- (iv) Reading and Discussion of material from the GROW Program Commentary or the GROW Anthology. *(The reading is shared – a paragraph or two being read by each one in turn – and is followed by group examination and objective discussion of its contents).*

*(NOTE: The group is urged to spot and discourage any turning of the discussion back on to personal problems).*

OR; Once a month - Special Activation Project - if set last week.

*(NOTE: Newly established groups – that is, until at least six months old – need not attempt the Special Activation Project).*

### 4. RESUMED INTERACTION (25 – 30 mins)

- (i) Continue basic ingredients as in Section 2.
- (ii) Ensure some recommendation of practical tasks if really apt and previously overlooked.
- (iii) While not everyone will be included in giving a progress report or presenting a problem, nevertheless, try to include some people who have not yet spoken (for example, new members or visitor) for their comments, if they wish, emphasising that everyone is free not to speak.
- (iv) Group problems and recommended solutions referred from the Organisers' & Recorders' Meeting.

### 5. CLOSING ROUTINE (15 mins)

- (i) Ask someone to prepare refreshments (without disturbing noise or distraction).
- (ii) Call on the Group Organiser to:

- ..... nominate the Special Grower and 2 helpers for the Special Activation Project (if applicable);
  - ..... check last week's and arrange further volunteer Twelfth Step Work;
  - ..... make any necessary announcements from GROW Centre or other source.
- (iii) Call on the Recorder to obtain and to record on the Weekly Evaluation sheet, the group's assessment of the quality of it's meeting (*all members should answer the Recorder's questions*).
  - (iv) Comments (if any) from the Field Worker.
  - (v) Close with the Prayer of Maturity, (p.79) recited (*voluntarily*) while members stand and hold hands in expression of GROW friendship and group solidarity.
  - (vi) Brief pause, then (still holding hands) The GROW Aspiration (p.79).
  - (vii) ANNOUNCE: 'GROW has no fees or dues but any voluntary contribution towards necessary expenses will be welcome'.

## Appendix Four: Letter of Permission from GROW



G R O W  
World Community Mental Health Movement in Ireland

GROW in Ireland,  
National Support Office,  
6 Forrest Mews, Forrest Road, Swords, Co. Dublin.

T: 01 840 8236

F: 01 840 8244

GROW Infoline: 1890 474 474

E: [info@grow.ie](mailto:info@grow.ie)

W: [www.grow.ie](http://www.grow.ie)

**Mike Watts National Programme Co-ordinator**  
**Grow in Ireland**  
**Ormonde Home**  
**Barrack Street**  
**Kilkenny**

Dear Mike,

With reference to the letter you have received from Trinity College, I confirm that the research proposal *Making a Recovery Map: Uncovering Relationships that Lead to Mental Health*, has been approved by GROW's National Program team and has the full support of GROW's Board. We look forward to collaborating with the School of Nursing and Midwifery, Trinity College.

Yours truly,

**Ronan Browne, Chairman**

17<sup>th</sup> March 2009



## Appendix Five: Short Flyer for Prospective Participants

Title of Study: An Exploration of the Recovery Narratives of People who have Recovered from Mental Illness and Attend GROW.

Dear Fellow GROWer,

My name is Mike Watts. I am currently undertaking a PhD research project in collaboration with the Department of Nursing and Midwifery in Trinity College, Dublin. I hope to recruit a number of 'seasoned GROWers' to take part in this research. Hopefully this information leaflet will help you understand the research aims and encourage you to consider taking part.

**What is the study about?**

This study aims to explore the experiences of 30 – 40 'seasoned' GROW leaders as they made their way from mental illness to mental health.

**What will participation involve?**

If you are selected as one of the participants, you will be asked to take part in an interview about your recovery. During the interview, my role is to listen. I will ask some 'open-ended' questions, which you are free to answer however you wish. There are no right and wrong answers.

**How often and how long will I be interviewed for?**

The interview may last for two hours or more. It will be tape-recorded, as it would not be possible for me to remember or take accurate notes on everything you have to say. Hopefully one interview will be sufficient.

**Where and when will the interview take place?**

The interview will take place at a time and place convenient to you.

**Are there any consequences if I choose to be part of the study or if I want to opt out partway through?**

Participation in this study is entirely voluntary. If you do decide to take part, you are free to withdraw at any time without obligation to anyone.

**Will people know that I took part in the study?**

No one will know that you have taken part in the study unless you decide to inform them.

**Will everything I say be treated in confidence?**

During the interview, I will treat everything you say in the strictest confidence. There are, however, some circumstances where strict confidentiality cannot apply, and I would be morally and/or legally obliged to involve appropriate others. For instance, if you revealed that you were contemplating harming yourself, I would have to insist that you or I contact a family member, your GP, or a good friend. If your story revealed the current occurrence of sexual abuse of a minor, I would need to inform the person designated by GROW in your area, who would liaise with the appropriate person in your HSE. Should you tell me that you were planning to harm someone else, then I would have to inform this person also. Finally, if your story revealed serious professional misconduct while you were under treatment, the HSE's new

‘Trust in Care’ policy means I would have to advise you to contact your local patient advocate, and if you did not wish to, I would have to ask GROW’s liaison person to do so. He would not give your details in this instance.

**Will I benefit directly from the study?**

Telling your story to help others can be a crucial part of recovery and personal growth. This study also gives you an opportunity to help reshape our mental health services.

**Are there any risks?**

Research has shown that telling your story can be an empowering experience. At this stage of your involvement in GROW, you will have shared your story many times. Because of the very strict confidentiality around this study, I cannot foresee any risk to you.

**Is the study being funded?**

The study is being funded by GROW in Ireland. It has been designated as my work for the next three years.

You are under no obligation to take part in this study. Deciding not to take part will not affect your relationship with GROW in any way.

Many thanks for taking time to read this leaflet and for considering taking part in this study. If you would like more information you can contact me at 0863352368, or by email at [mikewatts@grow.ie](mailto:mikewatts@grow.ie)

Yours in friendship,

Mike Watts, M.Psych. Sc.

## Appendix Six: Article in GROWing Magazine

### Making A Recovery Map: Uncovering Relationships that Lead to Mental Health

In October last year I set out on a journey. It will take the next three years to complete. For its duration, the main thrust of my work as National Program Coordinator will be to undertake an exploration of GROW in Ireland. I will be seeking to find out how GROW helps, its effectiveness and usefulness. This is the journey I have begun and I want to try and bring you with me.

While GROW has been quite extensively researched in America, and to a lesser degree in Australia and New Zealand, relatively little has been done in Ireland. Liz Dunne, working with Niamh Fitzpatrick (1997), Trudy Meehan (2002), and Jackie Henry (2003), did some very interesting work in this area; there is, however, still a lot to be discovered and documented. Now would seem to be an excellent time for us to continue the evaluation and build on what has been written.. The Department of Health and Children and the Mental Health Commission, in all of their publications, are both calling for a ‘Recovery Based Mental Health Service’, one that makes full use of and includes the experience of people who use the services. We need to be able to articulate to people what we do, how we do it, and whether we really do help each other recover.

The first port of call on my journey was Trinity College, Dublin, where I signed up as a PhD student under the supervision of Agnes Higgins, an Associate Professor in the School of Nursing and Midwifery. She is a lovely lady. We met a few years back and she asked me if I would tell my story to student nurses. It was the start of a real friendship. When I asked her how you select a supervisor for research she said, “You must find someone who you can get on with – someone with whom you feel really at ease. Secondly, that person should be as passionate about your subject of study as you are yourself”. Agnes fitted both criteria.

The first task Agnes gave me was to “read, read, read”. And so I read, read, read a total of some fifty books and literally hundreds of research articles. My spirits would soar as I discovered some inspirational material, and then they would crash as I realised the huge complexity of the whole subject of Recovery. I was repeatedly confronted by my own vulnerability. I couldn’t remember most of what I had read. If I could, I certainly couldn’t remember where I had read it. I had to learn to start note-taking and bibliography-making, and I had to begin thinking about methods to carry out research. Words that I was unfamiliar with – hermeneutics, grounded theory, phenomenology, ethnography – rose before my eyes and winged their way out of my consciousness before I had had time to try and understand what they meant. Others flew in and hovered around menacingly. I attended lectures on qualitative methodology and was transfixed in a haze of fascination and overwhelm.

I would like to recommend some of the books. My favorite is *The Soloist* by Steve Lopez. It is the story of a friendship between a journalist and a down-and-out musician who is extremely mentally disturbed, but who has been damaged by compulsory help given to him and who is determined to go it alone. There are many others: *Users and Abusers of Psychiatry* by Lucy Johnstone; *The Centre Cannot Hold* by Ellen Sachs; *Post-Psychiatry* by Pat Bracken and Philip Thomas. Between them, they portray a fascinating and often horrifying story of the treatment and

understanding of mental illness and the different understandings there are about concepts such as Recovery, with examples of recovery by individuals and through community initiatives. Irish authors are there at the forefront: *Fools and Mad* by Joseph Robins; *Music and Madness* by Ivor Browne; *Going Mad* by Mike Corry and Aine Tubridy; *Beyond Prozac* by Terry Lynch, to mention a few. Funnily, nearly all of these authors have been friends of GROW and have spoken at at least one of our national conferences.

We talk about GROW as being a mutual help organisation. We come together in our vulnerability and in our strength, and we support each other through a maze of tasks and needs. Our journey to recovery can't be pre-planned because of the uniqueness of each one of our lives. It needs to be evolved. We find help, hope, direction, and encouragement in many places: in the group, in twelfth step work, from kindly professionals, from our families and friends, and from strangers. Well, the same principle is definitely at work in the world of research. Every month, we have what are called PhD study days. Like our own meetings, they follow a formula. They usually start with someone telling their story of research in the form of a presentation. Later, we have a 'middle routine' presentation from a professor who will talk about an aspect of the philosophy or practice of research. The first talk I attended was on Hermeneutics. It was fascinating. Hermeneutics is the study of meaning. It originated from man's attempts to understand sacred texts so that we can learn to live together and celebrate each other. Most importantly for me, these monthly days provide an opportunity for mutual help at the personal level. It is already quite easy to spot the newcomers: we tend to be very white-faced, almost ashen; we are almost universally overwhelmed, and doubting that we will ever progress. The general agreement is that this kind of study is a process of grappling on many levels. Grappling with ideas, with concepts, with difficult language and with yourself, very much at an emotional level. I think that is quite a good description of my own early days in GROW. The message is "Have faith": "You can and will do this"; "Things will begin to make sense if you keep going"; "It's almost like a miracle, but it will happen".

Anyway, enough about me. At this point in time the plan is that I continue to read, to write and to study. I also have to get ethical approval for the study and define my research methods. Hopefully, in January 2010 I will be ready to recruit 30 to 40 research collaborators. These will be people who have been in GROW for at least 3 years and who have really become involved, especially in leadership. I want to spend time with each person and talk about their own journey to recovery. I want to be able to record what helped along the way and, in particular, what were the qualities of the relationships that led to greater inner peace and strength. I want to be able to analyse our collective experience so that everyone can gain a better understanding of the process and the end points of recovery; this should be of help to professionals, people who are isolated and do not believe life is worth living, parents and siblings who are worried and frustrated beyond measure as they watch a loved one disintegrate before their eyes.

I believe it will be invaluable. Julian Rappaport, the person who has supervised lots of people doing research into GROW, describes our organisation in some very interesting ways. He says that GROW provides a community where a person can hear a very different and healing personal narrative – a story that counters not only the terribly negative feelings each one of us experiences, but also the cultural narratives which say that anyone with mental illness is different, is dangerous, is

worthless. He describes GROW as a 'gateway' or a 'mediating structure' which helps people to find niches in the community where we fit in and can begin to blossom, in much the same way that ailing plants revive if they are given the right care and conditions.

I will write more about my journey in coming issues of *GROWing*. Maybe, later on, some of you would like to join me by taking part. Maybe my journey will spur on others to do something similar. Comments on the story so far are very welcome.

Appendix Seven: Recruitment Poster


Collaborative Research

An Exploration of the Recovery Narratives of People who have Recovered from Mental Illness and Attend GROW.



McCormick. M 2000

Are you 3 or more years in GROW?  
Have you taken on leadership roles?  
Have you recovered?  
Would you share your experience and wisdom by helping with research?

Your story can help shape the future!  **GROW**

If you are considering taking part and would like more information,  
contact Mike Watts 0863352368

[mikewatts@grow.ie](mailto:mikewatts@grow.ie)

## Appendix Eight: Information Sheet for Interview Participants

### Title of Study: An Exploration of the Recovery Narratives of People who have Recovered from Mental Illness and Attend GROW.

#### What is the study about?

This study aims to explore the experience of 30 - 40 'seasoned' GROW leaders as they made their way from mental illness to mental health. This will be done by listening to stories of recovery as told through semi-structured interviews. The study seeks to discover what and who was helpful in the process of recovery and will give people the opportunity to reflectively critique their experience of the different forms of help. Importantly, the study concentrates on the recovery process, starting when you became involved in GROW, and is not about how you came to be ill.

#### What will participation involve?

If you are one of the participants, you will be asked to take part in an interview. This interview will involve you reflecting on your unique recovery journey. It will begin from the time you joined GROW and cover your experience of a variety of forms of help: Hospital, Medication, Professional Help, GROW, other friendships and community involvements, how you helped yourself and how your overall view of life has evolved while recovering. During the interview, my role is to listen. I will ask some 'open-ended' questions, which you are free to answer however you wish. There are no right and wrong answers. I am seeking to understand and record your experience, which holds its own unique validity.

#### How often and how long will I be interviewed for?

The interview may last for two hours or more. It will be held at a time and location of your own choosing. The interviews will be tape-recorded, as it would not be possible for me to remember or take accurate notes on everything you have to say. Hopefully one interview will be sufficient but I would be grateful if you would give me permission to return for subsequent discussion as the research unfolds.

#### Where and when will the interview take place?

The interview will take place at a time and place convenient to you. If you decide to take part I will ring you and arrange where and when we meet. If you incur any costs in travel, these will be reimbursed by GROW.

#### What will happen to the information once collected?

Once the interview is over, the information on the tape will be transcribed onto paper so I can read it and begin the process of looking for common themes among participants' experience. The tape recordings and any subsequent transcripts will be kept in a secure filing cabinet. Any information held on a computer will be protected by password access. The only people who will have access to the tape recordings are myself and my research supervisor and the person who transcribes them, who will assure me of confidentiality. At no stage will your name appear on the interview transcript. Each recording and transcript will be given a number for identification purposes. I am the only person who will know who the number corresponds to and I will divulge this to no one.

Are there any consequences if I choose to be part of the study or if I want to opt out partway through?

Participation in this study is entirely voluntary. If you do decide to take part, you are free to withdraw at any time without obligation to anyone. If you don't take part, then nobody except myself will know and your decision will in no way affect your relationship with GROW. If you decide to drop out of the study, you can do so by letting me know during an interview or by phone, letter or e-mail.

Will people know that I took part in the study?

No one will know that you have taken part in the study unless you decide to inform them. You are, of course, free to do this. Information that might identify you will not be used in any presentation or publication resulting from the study. In a similar study conducted in 2005 in Australia, some participants received training to present the research results to professionals. This is a possible option with this study. Should the opportunity arise and should you wish to take part, we will discuss the implications and risks of you being involved in a training programme to present the results.

Will everything I say be treated in confidence?

During the interview I will treat everything you say in the strictest confidence. There are, however, some circumstances where strict confidentiality cannot apply, and I would be morally and/or legally obliged to involve appropriate others. For instance, if you revealed that you were contemplating harming yourself, I would have to insist that you or I contact a family member, your GP or a good friend. If your story revealed the current occurrence of sexual abuse of a minor, I would need to inform the person designated by GROW in your area who would liaise with the appropriate person in your HSE. Should you tell me that you were planning to harm someone else, then I would have to inform this person also. Finally, if your story revealed serious professional misconduct while you were under treatment, the HSE's new 'Trust in Care' policy means I would have to advise you to contact your local patient advocate, and if you did not wish to, I would have to ask GROW's liaison person to do so. He would not give your details in this instance.

Will I benefit directly from the study?

Telling your story to help others is a crucial part of recovery and personal growth. This study also gives you an opportunity to help reshape our mental health services. The recently-adopted policy document '*A Vision for Change*' advocates involving service users as partners in every aspect of service development and delivery, and enhanced links between specialist services and voluntary groups. Your own unique experience of recovery and of various kinds of help will inform that process. Participants in the study will, if they so wish, be given the opportunity to learn how to present the results to professionals and policy-makers.

Are there any risks?

Research has shown that telling your story is an empowering experience. At this stage of your involvement in GROW, you will have shared your story many times. Because of the very strict confidentiality around this study, I cannot foresee any risk to you.

Is the study being funded?

The study is being funded by GROW in Ireland. It has been designated as my work for the next three years. However, any information you give me will be treated confidentially.



You are under no obligation to take part in this study. Deciding not to take part will not affect your relationship with GROW in any way.

Many thanks for taking time to read this leaflet and for considering taking part in this study.

Yours in friendship,

Mike Watts

Please feel free to contact me at 0863352368, or by e-mail – [mikewatts@grow.ie](mailto:mikewatts@grow.ie)

## Appendix Nine: Statement of Interest for Potential Interview Participants

Title of Study: An Exploration of the Recovery Narratives of People who have Recovered from Mental Illness and Attend GROW.

Please let me know if you will/will not take part in the research by filling in this page and sending it to me in the enclosed stamped self-addressed envelope, or call me on the telephone no. 086 3352368 or e-mail me at [mikewatts@grow.ie](mailto:mikewatts@grow.ie)

Name: \_\_\_\_\_

If you are interested in being involved, please complete the following details:

Address: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Phone: \_\_\_\_\_

Email: \_\_\_\_\_

Suitable day(s) for contact \_\_\_\_\_

Suitable time(s) for contact: \_\_\_\_\_

Thank you for reading this and for showing interest in this study. I will be in contact with you shortly.

If you do not wish to participate in the study but may be aware of another seasoned GROWer who may be interested, please feel free to give them this information sheet.

## Appendix Ten: Interview Guide

Title of Study: An Exploration of the Recovery Narratives of People who have Recovered from Mental Illness and Attend GROW.

### Purpose of Study:

The aim of this study is to explore the recovery stories of 30-40 seasoned GROW leaders. Each participant must have a minimum of three years' involvement in GROW, and consider he/she has recovered from a recognised form of mental illness.

### Objectives

The objectives of the study are:

- To explore the experiences of 30 – 40 seasoned GROW leaders as they recovered from mental illness.
- To explore how various types of help facilitated, impeded or aided recovery.
- To explore the role mutual relationships, such as friendship, reciprocity and leadership, play in a person's recovery.

### Central Research Question

What can the experience of seasoned members of GROW tell us about recovery from mental illness?

Areas for exploration:

- Your experience of mutual help through GROW, its program, its group method, its community and its opportunities for leadership
- Your experience of friendly help and involvement in the community
- Your own resourcefulness
- Your own beliefs about yourself, others, life and mental illness
- Your experiences of professional help from a range of mental health professionals
- Your experience of hospitalisation (if relevant)
- Your experience of use of prescribed drugs and ECT (if relevant)

## Appendix Eleven: Interview Participant Consent Form

### TITLE OF THE RESEARCH STUDY:

An Exploration of the Recovery Narratives of People who have Recovered from Mental Illness and Attend GROW.

### RESEARCHER'S CONTACT DETAILS:

Name: Mike Watts Telephone number: 086-3352368 E-mail: [mikewatts@grow.ie](mailto:mikewatts@grow.ie)

### BACKGROUND AND PROCEDURES :

At present, the Irish government is proposing a transformation of our mental health services from a medical to a recovery orientation. The process of Recovery and its outcomes remain relatively unknown. GROW, with its longstanding presence in Ireland, is in an ideal position to help. The purpose of this study is to interview 30 – 40 seasoned GROWers, people who have been in GROW for a minimum of 3 years, who have become fully involved in leadership roles and who have recovered. It will seek to find common themes and to evaluate the many different types of help available along the way. This information will inform GROW itself, the HSE and mental health professionals. It will help to clarify how mutual help works, and its significance in recovery.

### DECLARATION (Please read and sign if you agree):

- I have read the study information sheet and this consent form.
- I have had the opportunity to ask questions and all my questions have been answered to my satisfaction.
- I understand that all information collected in this study will be treated as confidential and that my identity will remain confidential.
- I freely and voluntarily agree to be part of this research study, though without prejudice to my legal and ethical rights.
- I have received a copy of this agreement and I understand that the results of this research may be published.
- I understand I may withdraw from the study at any time.

PARTICIPANT'S NAME : .....

CONTACT NUMBER: .....

PARTICIPANT'S SIGNATURE: .....

DATE: .....

### Statement of investigator's responsibility:

I have explained the nature and purpose of this study to the person named above, the procedures to be undertaken and any risks that may be involved. I have offered to answer any questions and have fully answered such questions forthcoming. I believe that the person named above understood my explanation and has freely given informed consent.

**Investigator's Signature** .....

**Date** .....

**For Investigator's Use Only**

Participant Code: -----

If you would like to receive a copy of the transcribed interview please tick the box

## Appendix Twelve: Biographical Data Form



### Biographical data form

Name of Study: An Exploration of the Recovery Narratives of People who have Recovered from Mental Illness and Attend GROW.

Many thanks for agreeing to take part in this research project. Please answer the questions listed below. There is no need to put your name on the form as it contains your coded number.

Code number: \_\_\_\_\_

1. How long have you been in GROW? No. of Years \_\_\_\_\_

2. During that time, what role have you been involved in: (please tick all that apply)

- |        |                              |                          |
|--------|------------------------------|--------------------------|
| (i)    | Leader of the weekly meeting | <input type="checkbox"/> |
| (ii)   | Group Organiser              | <input type="checkbox"/> |
| (iii)  | Group Recorder               | <input type="checkbox"/> |
| (iv)   | Group Supporter              | <input type="checkbox"/> |
| (v)    | Member of Regional Team      | <input type="checkbox"/> |
| (vi)   | Member of National Team      | <input type="checkbox"/> |
| (vii)  | Fieldworker                  | <input type="checkbox"/> |
| (viii) | Other                        | <input type="checkbox"/> |

Please specify: \_\_\_\_\_

3. Have you ever been hospitalised for mental illness? Yes  No

4. If yes, how many times? \_\_\_\_\_

5. Were you on prescribed medication? Yes  No

6. What names have been given to your mental health problem?

\_\_\_\_\_

\_\_\_\_\_

## Appendix Thirteen: Personal Testimony Guidelines

### Personal Testimony Guidelines

A personal testimony, in brief, tells the story of your decline into breakdown or what led you to GROW and, more importantly, shows how you have recovered or begun to recover. It thus shows ‘the way down’ and ‘the way up’. While describing ‘the way down’ is important in that it lets others know the kind of problems you faced, it is ‘the way up’, or your story of recovery, that is most valuable to others. The following are guidelines to help you understand some of the things to include in a personal testimony.

Who am I? A little background.

What led me to GROW?

First impressions.

How the group or specific people helped.

Practical tasks that I was given.

Steps or parts of the program that helped me.

Insights gained.

What Twelfth Step Work did for me.

Where I am at now.

What parts of the program I am using now.

## Appendix Fourteen: Sample of Initial Coding of Fran's Story.

### Thematic Analysis

#### Codes

#### Growing

#### Changing

1. Is possible
2. GROW helped
3. I did it
4. New me
5. Moving towards reason
6. Desire to tell others

#### Illness

1. The past
2. Lack of hope
3. I was told (suggests authority)
4. Labels
5. Schizophrenia, puerperal psychosis, manic depression
6. Tablets
7. Hospital

Possibly 4-6 are a sub-theme of lack of hope. Maybe lack of hope should be a theme. Maybe illness is a sub-theme of lack of hope.

#### Reflection

#### GROW

1. Direction
2. Change/transformation
  - i. self centredness
  - ii. and uselessness (feelings)
3. Usefulness
4. Reality (from feelings?)
5. Ignoring reality

#### Beginnings

Starting to study

#### Past

Study (purpose?)

#### Difficulty

Unable to study

Lack of discipline

#### Choices

Loud music

Forgetting about reality

Not studying

Avoiding tension

Joining sub culture.

Letting myself down

#### Home

#### Difficulties



Not conducive to study  
Lack of peace  
Violent outbursts  
Step-father  
Deafness  
Inability to relate  
Relationships  
Unbearable tension  
Fear

#### Choices

Hanging round coffee bars  
Staying out after school

#### Moving

After school (reason?)  
Grant (reason reward direction)  
University  
Reason

#### Difficulties

Amount of study  
Others expectations  
Didn't like being alone in flat

#### Choices

Day dreaming (lack of reality?)  
Pub  
Loud music  
Company  
People whose faces I knew but who I didn't really know

#### Friendship/relationships

Only one real relationship  
Talking  
Doing things with

#### Choices

Hitch hiking  
Looking for excitement

#### Past

Since I was 13.  
Future relationships  
Marriage

#### Choices

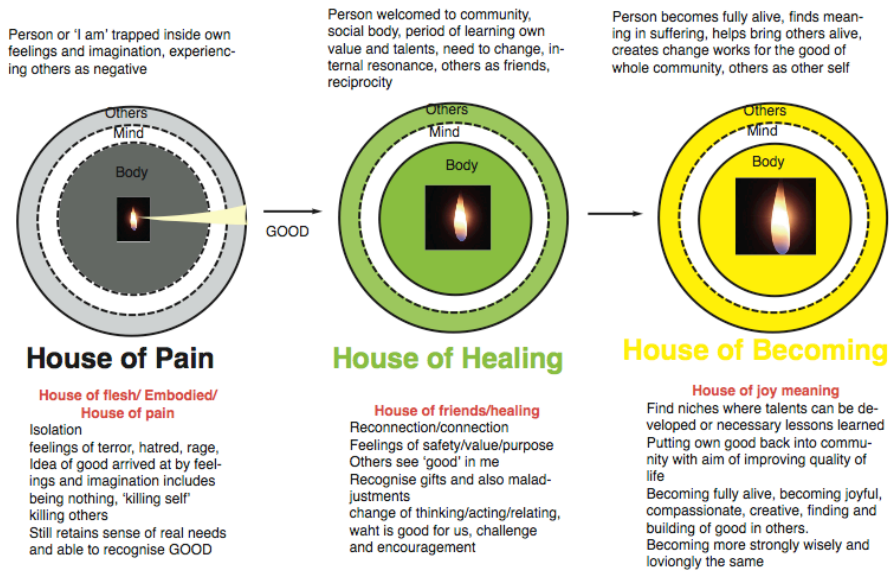
Leaving myself open to abuse (self blame?)

#### Difficulties

Abuse  
Sexual harassment  
Attempted rape

# Appendix Fifteen: Processes of Recovery/Healing or Growth

## Appendix Fifteen Processes of Recovery/Healing or Growth



## Appendix Sixteen: Stages of Recovery

Code	Name	A place of terror	A time for healing	An opportunity to become
001	Peter	<p>Very socially isolated, lost all direction in life</p> <p>My life had become so isolated I was nearly making myself kind of autistic, obsessed with knowledge and detailed information rather than people. Mood swings when you are down no goals are set when you are up you try and do ten things at once</p> <p>Self-hatred and dual personality Mr High Mr Low. Emotions all over the place. Experienced other people as being negative. No friends, not even family members. Loss of belief in God sceptical of organised religion and politics, meaningless structures that serve the organisation not the people. Very angry person ranting about the state of things</p> <p>What's the point of getting involved with other people they are just selfish.</p>	<p>Learning to connect with others, to communicate with other people, to better understand other people and to be able to express myself. GROW reversed a destructive pattern. Learning how to sleep, relating to others, making interaction with others a positive experience and be comfortable with myself. Set and achieve goals. Looking after the body, avoid alcohol, coffee, sugar; benefits of exercise. Learning control of feelings, doing the opposite to what you feel. Learning from others in group. Discovering the meaning of life. Regaining control of my life, discovering my true self, accepting my shadow. Five keys to understanding feelings. Learning to learn from highs and lows rather than being driven by them. This is GOOD.</p> <p>Sensed I needed to work on steps 8 and 9, learning to think by reason, took ten years to accept myself. Believe I am no better or worse than everyone else.</p>	<p>Started work in [mentions place of work]. Met X who did a biographical timeline and she said I seemed to have an instinct even in the middle of it all that I needed to do something. [Names workplace] was a shot in the dark. X and Y persuaded me to stay. Being able to contribute look after someone had a huge impact on my self-esteem. Went to [names different place of work]. Much less support and difficult dynamics, lot of fighting, weird chemistry and I picked up on that. Met girlfriend, but when he was a bit down she took it as rejection of her. Had two girlfriends then decided relationships too complicated but they were a positive experience... we were mutually supportive.</p>

(Different colours refer to various headings used for coding)

## Appendix Seventeen: Place of Terror Table

No	Type of feelings	Effects of feelings	Effects on thoughts	Behaviour	Relationships	Cause
01	Self hatred Highs and lows both overpowering Very angry Uselessness I went on the massive high it felt like if you keep pumping air into a tyre it explodes, that's what it felt like in my brain. All these crazy feelings and thoughts in my head.	Loss of direction My life had become so isolated Loss of self control Loss of belief in God Mood swings Loss of meaning	What's the point of getting involved with others, they are just selfish Life meaningless I am no use Antisocial delusions I am fucking useless Others think I am fucking useless I thought at the time I was permanently damaged and would be stuck in some kind of workshop Don't know who I am	Isolating myself Obsessed with knowledge and detailed information rather than people	Experienced others as being negative Psychiatrist a cold fish No friends not even close to family	Hospitalisation traumatic Often in trouble with teachers Rows with other kids No communication at home . Not able to tell anyone. Personal traits.

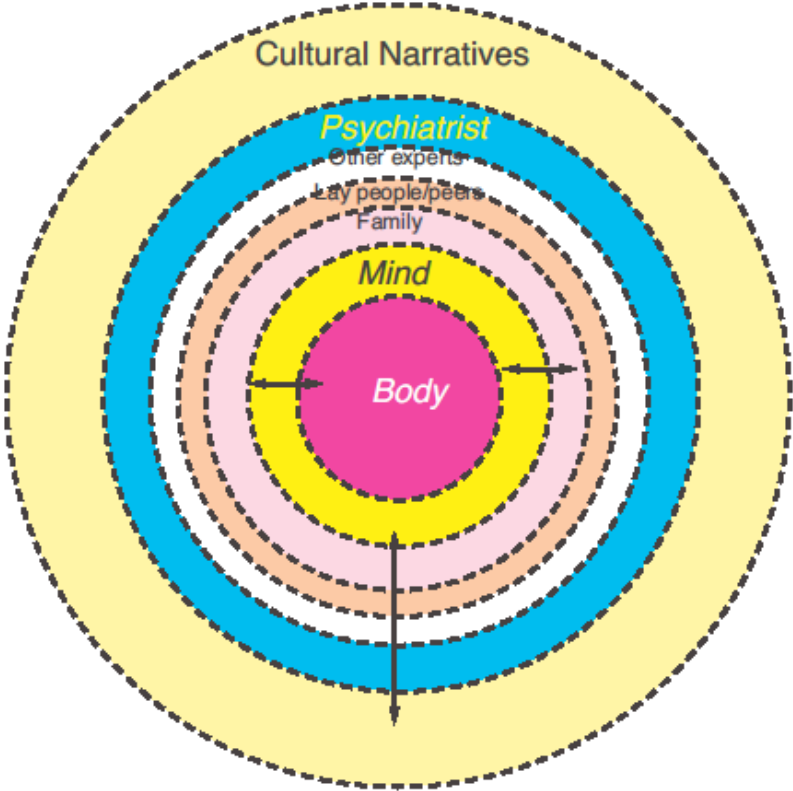
## Appendix Eighteen: Levels of Causes of Terror or Pain

No	Reported Cause	Level of being
001 Peter	Feelings. Fear, anger, resentment, despair. Exam pressure Rows with other kids Trouble with teachers Lack of friends No communication at home Seeing others as negative Personal traits Not able to tell anyone Medication Hospital traumatic Doctor a cold fish Hearing doctor on TV	Own body, emotions, instincts Cultural narrative, own beliefs connects value to achievement Peers Authoritative others Own behaviour? Others? Family Own thoughts/experiences Various traits Lack of caring others Physical Attempts at help Mental health professionals Media

No	Feeling	Behaviour
001	Self-hatred, view of others as selfish, meaninglessness, despair, suicidal, head going to burst	Isolation, growth of obsessions as substitute for relationships, interest in books, frustration, expression of anger towards others, rows, cynicism, tendency to stay in bed, taking medicine and being hospitalised.
002	Anxiety, helplessness, anger, feeling of being diseased, terror, tiredness, despair, suicidal	Tantrums, self-harm, cutting himself, fist through glass, tearing clothes, learning very little at school, dropping out of school, isolation, talking to myself, night terrors, seeking help, taking psychiatric drugs, going to hospital
003	Unconnectedness, loneliness, suicidal, terror, driven, panic	Withdrawal into self when things difficult. Isolation. Running and racing 20 hours a day. Not eating. Not sleeping. Not communicating. Plan to kill myself. Hiding problems.
004	Out of control, drowsy, meaninglessness, desire to ill, anger anger anger, hatred, resentment of parents, embarrassment, grief over miscarriages	Sit watching leaves, stop going into work, withdrawal from relationships, isolation, dreaming of revenge, dwelling in the past

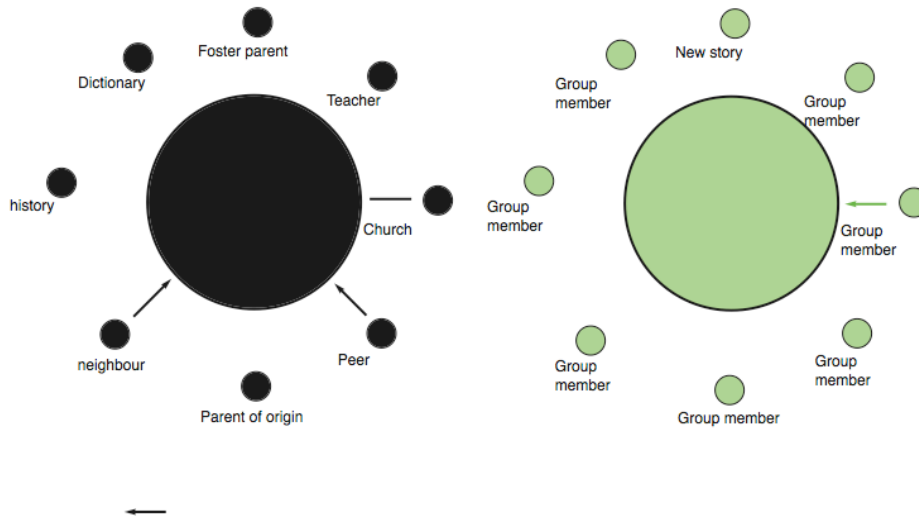
Appendix Nineteen: Mind Map for A Place of Terror

**Appendix Nineteen: Mindmap for Place of Terror**



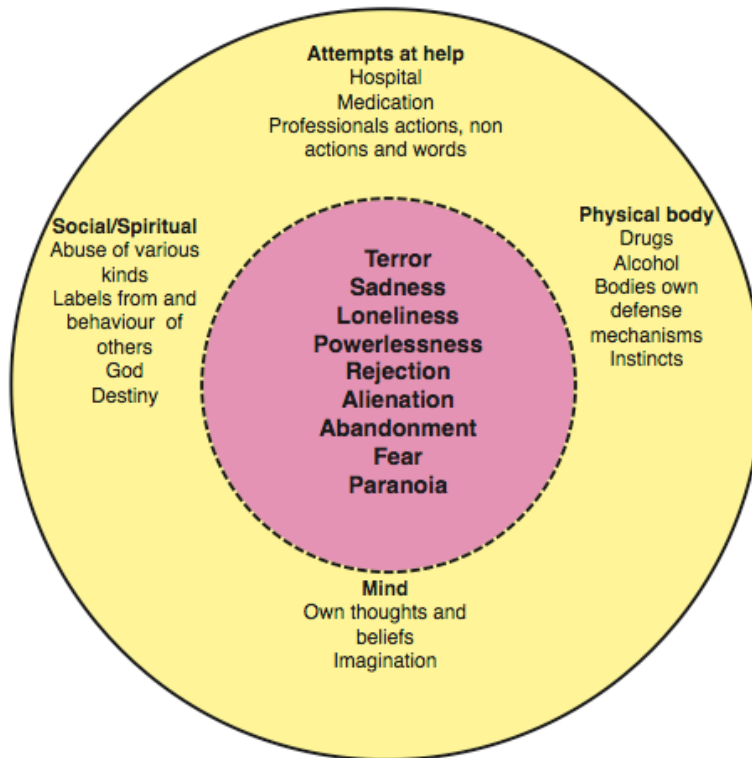
# Appendix Nineteen 'b': Frances' Transformation

Appendix Nineteen 'b' Frances transformation



Appendix **Nineteen 'c'**: Descriptions of Events Explaining Feelings of Pain and Terror

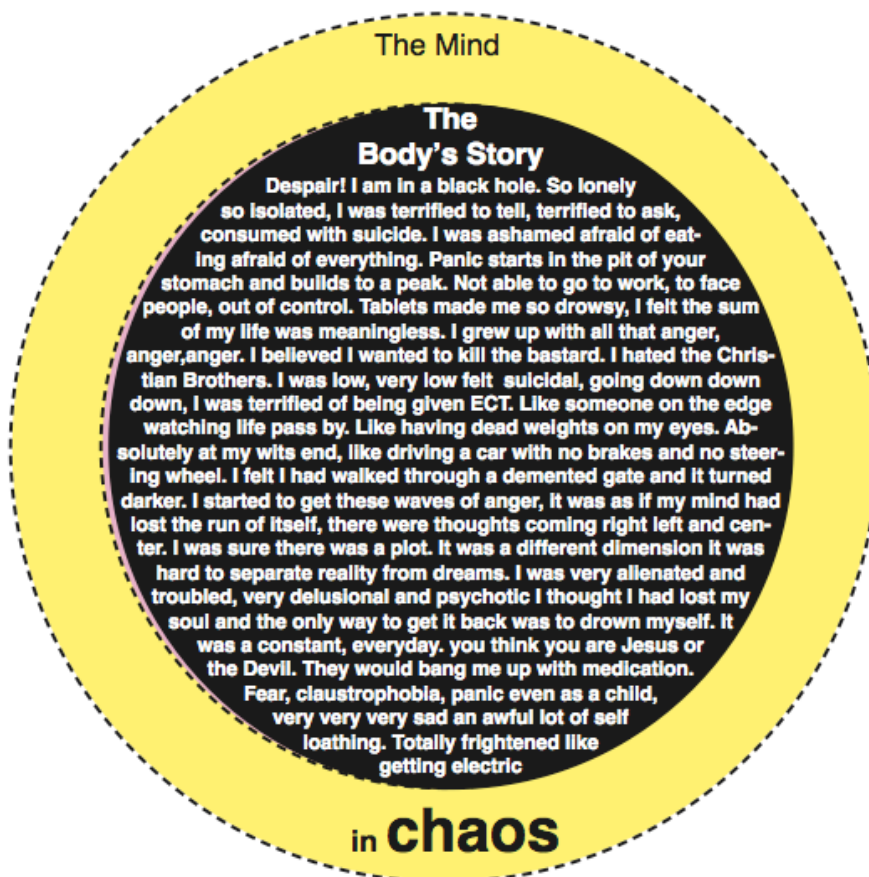
**Appendix Nineteen 'c' Descriptions of events explaining feelings of pain and terror**



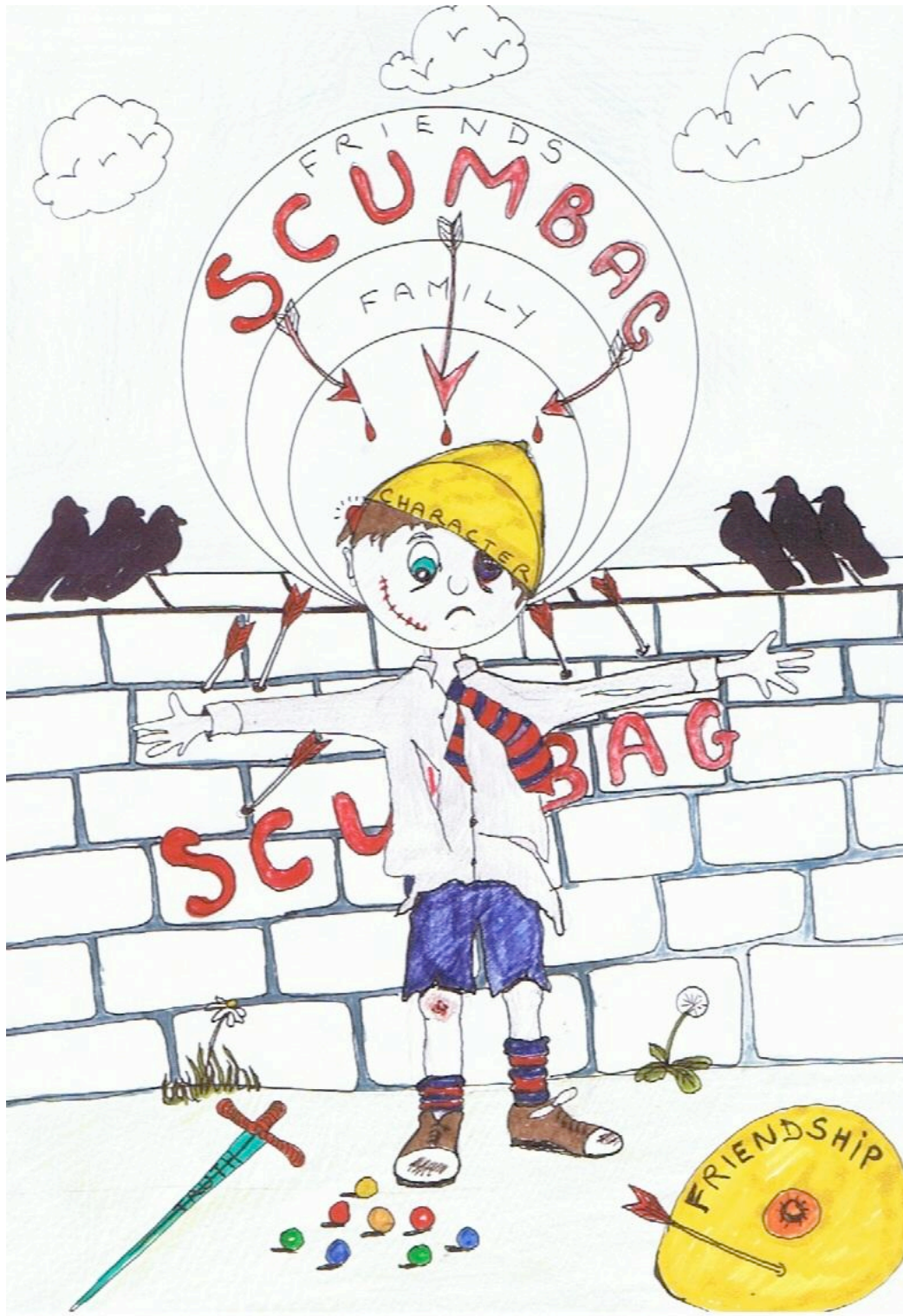


## Appendix Nineteen 'd': The Body's Chaotic Story

### Appendix Nineteen 'd' The Body's Chaotic Story



Appendix Nineteen 'e'







## Appendix Twenty: A Timeline

Nightmares/tantrums anger and fear	Isolation and beatings at home no communication
Low self esteem, feels different to others, loneliness, failure	Other kids move away
Some seed of hope and self belief	Treated harshly at school seen as backward
sense of satisfaction and belief in self	A teacher tries to help, believes in him then moves
	Decides to try and improve grades up slightly
Self hatred and self harm. Feelings of despair what am i going to do	Drops out of school coming up to exams. Noone cares
loss of hope, unemployemnt, isolation, further self harm	Admitted to hospital and heavily drugged
Total despair and then a slowly emerging decision to help himself	Rehospitalisation further loss of hope crucial story from doctor
An awkening of hope, building of some relationships	Part time work leading to regular work, learning to drive
Sense of meaning and personal value Returns to education	Visits a psychologist and meets a social-worker who encourage and explain
Begins to socialise meets future wife	Joins GROW, finds a way that helps him move on and offers leadership roles
Finds many people value his work and integrity	Becomes redundnant and starts own business, supported by group and friends
feelings of enjoyment of ordinary things, driving, nature, other people	has run own business for 5 years, married to cath

Tom's Timeline

## Appendix Twenty-One: Ethical Approval

THE UNIVERSITY OF DUBLIN SCHOOL OF MEDICINE TRINITY  
COLLEGE FACULTY OF HEALTH SCIENCES

Trinity College, Dublin 2, Ireland

Professor Dermot Kelleher, MD, FRCPI, FRCP, F Med Sci  
Tel: +353 1 896 1476 Head of School of Medicine Fax: +353 1 671 3956 Vice Provost  
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Ms Fedelma McNamara  
email: [medschadmin@tcd.ie](mailto:medschadmin@tcd.ie) School Administrator  
Mr Michael Watts,  
School of Nursing and Midwifery,  
Trinity College,  
D'Olier St.  
Dublin 2

Wednesday, 26<sup>th</sup> August, 2009

Study: An exploration of the recovery narratives of peoples who have recovered from mental illness and attend GROW

Dear Applicant (s),

Further to a meeting of the Faculty of Health Sciences Ethics Committee held in May 2009, we are pleased to inform you that the above project has been approved without further audit.

Yours sincerely

• Orla Sheils/ Chairperson *Faculty of Health Sciences Ethics Committee*

cc Dr Agnes Higgins,  
School of Nursing and Midwifery, Trinity College, D'Olier St. Dublin 2

## Appendix Twenty-Two: Limits to Confidentiality

All of the participants in this study will be seasoned GROWers. For this, you must have been involved for a minimum of 3 years and you must have successfully passed through three stages of leadership. This leadership includes practising telling your story in a variety of settings. In a way, this is like people becoming professionally qualified. Within the professions, people must spend a minimum amount of time in study of their subject and they must satisfy certain requirements and achieve certain competencies before being allowed to fulfil their professional roles. While this procedure is less formal within GROW, it does exist, and people who fulfil the criteria for participation in this study are identifiable by their example of leadership and mental health within the organisation. Because of this, I do not believe this research poses any great risk to the participants. In fact, it may present them with an opportunity to make a difference and contribute to change and improvement within the mental health services and GROW. As stated in 4.4, there are circumstances that might however create distress or inconvenience.

If, during the interview, a participant revealed that they were feeling suicidal or that they had knowledge of current sexual abuse of a minor, if they indicated that they intended harm to an other or that they had experienced professional misconduct, then I would be bound to take certain courses of action.

Suicide: If someone revealed they were suicidal I would insist that either I, or they, contact a family member, their General Practitioner (GP) or their GROW fieldworker.

Sexual abuse: I would pass this information onto the designated GROW leader, who will liaise with the HSE person in the area.

Professional misconduct: I would discuss with them whether they wished to formally report this to the local HSE or to their local Advocate. If they did, then I would contact the designated leader in GROW. If they didn't, then I would inform them that I am duty bound under the Health Service Executive (HSE) 'Trust in Care' policy to report this conduct, but that I would not give their personal details.

Harm to others: I would have to pass this information on to An Garda Síochána.

## Appendix Twenty-Three: Response of American Co-Ordinator

Dear Mike,

Thank you for bringing such a great spark into my currently dreary life! You have created a brilliant and persuasive mix of psychology, philosophy and poetry, just what the doctor ordered, a wholistic, respectful, wise and true approach to the human person. I like your presentation of the life processes of breakdown and recovery as human and ordinary, rather than hopeless and diseased. My favorite concept in your work is "re-enchantment", so lovely and so true. Also I like your description of emotions such as hope as an experience of the body; this is also an important concept.

You have proven that a dissertation can also be a work of art.

Mike, good luck with sheparding your work through the system, and let me know how it goes. I do look forward to the day when others can enjoy your creation as much as I have.

Gratefully,

Carol

## Appendix Twenty-Four: Response of National Chairperson, Who Himself Holds A PhD.

Hi Mike

I have looked at the chapters of your thesis which you sent me. Sorry it took so long but I wanted, in fairness, to take some time over it. I would summarize my comments under three headings:

1 Typos, spelling errors etc

2 Structural layout (mainly headings and standardisation of same)

3 Other comments

With respect to No 1 I have commented on these in the body of the text (I will send the marked up text as a separate email). Click the Review tab to see them.

With regard to the structural layout my comments are more in the nature of suggestions for readability. The main ones relate to Chapter 6 and I have typed up the headings (in bold in your text) with reference to the respective interviewees under the individual headings. You will note that some headings are simply the name of the interviewee, some have two headings (eg The building blocks of terror' school as a source of terror), there are two conclusions and then another heading. Chapters 7 & 8 appear OK. In chapter 9 there are 2 sequential headings viz

Becoming involved. The benefit of work.

Becoming involved in Society. Through work.

For the purpose of consistency the subsequent heading Through Education would read better as Becoming involved. Through Education which may be what you meant originally. The Becoming more mature heading is in twice, the first time with a second heading Developing the ability to cope The full circle. Are these separate headings? there are 5 more further down page 119 I am not sure if they are one very long heading or are they themes to be further expanded?

Other comments

Chapter 6 & 7 have a 2nd title/subtitle eg Welcome to the house of terror. One is in normal italics the other is in bold roman. I do not know if other chapters have one but from a "readability" point of view it is desirable to be consistent in presentation.

There is a footer on p2 repeated on pages 11,15,45,49,66,80,84 and 98! I assume Cath and Cathy are the same person. I also typed up a list of names (mainly for my own convenience) as they occur in the text for the first time. There are 27 on the list. Should it be 26?

Summary

As one of the converted I am not in a position to offer a critique of your thesis but it all seems very logical to me. I do feel that the general theme you are expounding is a very exciting one especially for those of us convinced of the Recovery model. Apart from the specific examples you quote the whole area of Talking Therapies is a very current one (I was at a talk only last Monday in John of God's on The recovery model in Mental Health care by Shane Hill). There is an old saying (I do not know it's source) "there is nothing so unstoppable as an idea whose time has come". I feel we are at a tipping point with regard to the Recovery model. I have no doubt your thesis will contribute to moving the debate along. Well done so far and best wishes for the completion.

Denis



Appendix Twenty-Five: Table Illustrating Individual Quotes Used in Findings

Pseudonym	Number of quotes used in findings	
Kate	***** ***	27
Peter	*****	18
James	*****	17
Tom	*****	14
Nan	*****	14
Richard	*****	13
Mathew	*****	13
Mags	*****	12
Jess	*****	12
Penny	*****	11
Vicky	*****	11
Claire	*****	10
David	*****	10
Pat	*****	10
Francis	*****	10
Paul	*****	9
Helen	*****	8
Cathy	*****	8
Sue	*****	7
Charlie	*****	5
Peg	*****	5
Ruth	*****	5
Gretta	****	4
Jack	***	3
Danny	***	3
Lynn	**	2

## Appendix Twenty-Six: Prayer of St Francis

Lord make me a channel of your peace.  
That where there is hatred I may bring love;  
That where there is wrong I may bring the spirit of forgiveness;  
That where there is discord I may bring harmony;  
That where there is error I may bring truth;  
That where there is doubt I may bring faith;  
That where there is despair I may bring hope;  
That where there are shadows I may bring light  
That where there is sadness I may bring joy.

Lord grant that I may seek to comfort rather than to be comforted;  
To understand rather than to be understood;  
To love than to be loved;  
For it is by self-forgetting that one finds;  
It is by forgiving that one is forgiven;  
It is by dying that one awakens to eternal life.

Amen