ABSTRACT

MAKING MEANING OUTSIDE OF THE SYSTEM:
A NARRATIVE EXPLORATION
OF RECOVERY WITHIN A PEER-RUN SETTING

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This paper presents a qualitative exploration of the personal narratives of users of a peer-run residential alternative to mainstream, psychiatric treatment for severe psychological disturbances. Given that a person’s treatment setting can often be a powerful influence on how he or she construes his or her mental illness, I attempted to highlight whether the non-pathologizing and empowering practices of the peer-run setting and its open rhetoric about mental health and illness influenced its users personal narratives. Using the method of interpretive interactionism, I explored four narratives of people using a peer-run residential program for the potential impact the setting had on the stories. The narratives were represented to reflect the tension between a dominant, medicalized master narrative and a more integrated, trauma-informed alternative master narrative. A discussion of the implications of these and other findings is provided, including suggestions for both alternative and mainstream treatment settings.
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Introduction

Over the past three decades, a growing portion of both the scholarly and popular literature has been critical of the traditional, psychiatric mental health system in America. At the extreme, some claim that our current mental health system is a dehumanizing one that violates the very human rights of its users (e.g., Breggin, 1991). These psychologists and researchers highlight the damaging narrow-mindedness supported by the medical model within our mainstream mental health system (Boyle, 2002). Critics of our current mental health system also have been instrumental in supporting alternative frameworks with which to understand and approach issues of mental health. Consequently, a growing number of alternative programs to the traditional mental health system have risen in light of these various criticisms. These non-traditional organizations, typically established through grass-roots, advocacy, and political action efforts, have provided their users with support outside of the mental health system and the institutional ideologies espoused by the mainstream.

There are numerous differences between alternative and mainstream programs for recovery from mental illness. The organization, structure, methods, and values of these two arenas are quite disparate. The different ideologies and rhetoric about mental illness and health are likely the most salient differences to consider. These programs communicate, both explicitly and implicitly, their values and worldviews to consumers/users via rules, information, principles, activities, and goals for recovery (Randall & Salem, 2005). The value systems upheld by the different programs then contribute to a powerful overarching framework around which a person shapes an understanding of his or her mental illness and the life that can be led within that context.

First-person narratives of recovery and the experience of being labeled with a psychiatric diagnosis are particularly effective in revealing a person’s unique construal of these kinds of life events. These stories highlight, in richly evocative ways, the social, emotional, psychological, spiritual, and political components of their experiences. While many of these powerfully evocative stories of personal distress and recovery exist, very little scholarly work investigates systematically the influence of the value systems of the therapeutic setting on the persons’ construction of his or her narrative. Kennedy’s (1995) study is one of the limited exceptions.

Thus, this study is an exploration of the impact of being in an alternative therapeutic setting on a person’s personal narrative of being diagnosed with a mental illness, the recovery process, and his or her future. Before going into more detail about this study, I first will outline some of the most prominent controversies about the mainstream mental health system, and then I will move on to define the alternative approach of interest for this paper: peer/mutual support programs. Next, I will introduce the mutual support program used for this study, GROW and the GROW Residential Program, and describe their inception, principles, and practices.

Controversies about mainstream psychiatric treatment

A growing number of psychologists, researchers, and even psychiatrists have contested the claim that serious mental disturbances are attributable to some kind of faulty brain chemistry or genetic predisposition (Boyle, 2002; Breggin, 1991, 2008; Breggin &
Cohen, 1999; Karon, 2001; Szasz, 1972). Presently, the bio-medical perspective has championed a stance that neurochemistry and genetics are at the root of psychiatric disorders, and most professional mental health providers operate under this biologically based perspective, also referred to as the medical model. However, when we attend only to what the medical model would deem as dysfunctional, sick, or disordered, we ignore the emotional, traumatic, familial, environmental, social, political, and spiritual aspects of human mental health (Adame, 2007; Holma & Aaltonen, 1995). Because the medical model views pathology as a cluster of symptoms arising from neurochemical imbalances, treatment comes in the form of one or more (usually more) psychopharmaceuticals or medical interventions (e.g., electric shock) that are supposed to bring the person’s brain chemistry back into “balance,” thus alleviating the distressing symptoms. For the more seriously disturbed, this treatment and stabilization process happens behind the locked doors of a hospital or ward. The patient must follow the orders of the psychiatrist and the residential authority of the ward staff and technicians. Again, this strict adherence to a medically oriented stance about mental illness and how best to treat it leaves behind other important factors in the implication and healing of mental distress.

Furthermore, the medical authority and power, as well as the politics involved in who defines the nature of psychopathology, serve to cut off at the knees anyone that speaks in contrast to the pervasive medically oriented perspective. This is not surprising, especially when one considers that psychiatrists’ very livelihood depends greatly on the public perception that mental illness is caused by some form of biologically-based abnormality and treatable through medical interventions. Without the public perception that a faulty brain causes mental illness, and that, consequently, a pill can reverse that damage, the field of psychiatry as it is today would cease to be. Not only would psychiatrists be in trouble, so would the multi-billion dollar companies that create, market, and sell psychopharmaceuticals.

Not surprisingly, hospitalization and drug treatment for mental illness are the first lines of treatment for many people. Despite the pervasiveness of treatment based on the medical model, a growing literature explains the negative effects of hospitalization for mental illness (e.g., Breggin, 1991; MindFreedom, 2008; Mosher, 1995; Szasz, 1972, 1994, among others), and some, even within the field of psychiatry call the public psychiatric system an “unresponsive… mental health ‘non-system’” (Talbott, 2004, p. 1136). Critics of psychiatry accuse the profession and its institutional settings of being coercive (Barker, 2000; Szasz, 2000), authoritarian (Mosher, 1995), and stigmatizing (Rosenhan, 1973). In addition, the critics have been very concerned about the harmful side effects of antipsychotic drugs and other physical treatments (e.g., electroconvulsive therapy). These side effects include severe neuro-muscular problems, drug-induced toxic psychosis, mania, delirium, hypertension, amnesia, weight-gain, flattened affect, tardive dyskinesia, and even death. A growing body of literature has been published over the past two decades that thoroughly examines and criticizes traditional psychiatric institutions, interventions, and treatments for mental illness (Breggin, 1991, 2008; Breggin & Cohen, 1999; Johnstone, 2000; MindFreedom, 2008).

The most prominent studies and accounts of going through these therapeutic settings are those that highlight the negative experiences associated with psychiatric hospitalization. Patients in traditional psychiatric wards most commonly are inactive and isolated. Many patients are usually found staring silently at walls, talking to themselves, or
engaging in mindless activities just to pass the time (Ittelson, Proshansky, & Rivlin, 1970; Radcliffe & Smith, 2005, in Yawar, 2008; Vincent, 2008). Unfortunately, the hospital staff views these behaviors as being symptomatic of the patients’ diagnosis, despite the fact that affect flattening drugs and a depressing environment are conducive to such behaviors.

Nora Vincent (2008) is an immersion journalist who entered herself in three different kinds of treatment programs for mental illness. She describes her struggles to be seen as “well” after being admitted into a mainstream inpatient facility in her book entitled *Voluntary Madness*. She writes about the cold, uncomfortable, and dirty ward she was locked in and the incredible boredom she experienced throughout the day. She describes the way the patients talked to themselves constantly or made up stories about things happening on the ward. She makes clear to her readers that, when examined closely and empathically, the bizarre behaviors of her fellow patients were reasonable. She herself even adopted talking to herself just to stave off loneliness and boredom. This, of course, did not aid in her efforts to be discharged, because staff and doctors chalked it up to her mental illness. In a somewhat ironic turn of events, upon leaving the ward, Vincent found herself feeling even worse than before she was hospitalized, ushering the onset of a severe depression she had not dealt with in years. A project that began in a voluntary manner quickly switched following her stay on the ward into an involuntary search for healing.

Although dated, Rosenhan’s (1973) landmark study again highlights the problem of virtually all of the patients’ behaviors being construed as abnormal once they become locked in an inpatient ward. Rosenhan (1973) instructed 12 pseudo-patients to gain entrance into a psychiatric ward by claiming they heard voices. After admission, they were to behave “normally.” Unfortunately, staff always saw every single pseudo-patient as fulfilling the characteristics of their diagnostic label of either schizophrenia or manic-depressive disorder. Interestingly, a number of real patients saw these pseudo-patients differently, and voiced their suspicions saying, “You’re not crazy. You’re a journalist… You’re checking up on the hospital” (Rosenhan, 1973, p. 252). Rosenhan’s study and Vincent’s personal account certainly imply that diagnostic labels often obstruct the ability for people to form views about a person as doing or being anything that would negate the label they carry. Our mental health system survives on psychiatrists’ and psychologists’ abilities to label their patients, and the dehumanizing effect of such a practice seems to be an inherent flaw.

The evidence suggesting that mainstream, psychiatric treatment for psychological suffering is damaging and dehumanizing to its users is mounting. As these studies and accounts suggest, being diagnosed, institutionalized, and treated with pharmaceuticals for mental illness is potentially very damaging to the very person we attempt to heal. Our single-minded reliance on the medical model for understanding mental illness closes doors to new paths to healing, and, in doing so, narrows our vision of what it looks like to recover. For some, this current mainstream mental health system simply does not work or they refuse its damaging services, and a growing body of people has established and promoted alternative avenues for recovery that exist outside our pervasive, professionally oriented, and medically minded system.
Defining consumer-operated and peer/mutual support programs

Consumer-operated services began as outgrowths of the consumer/survivor/ex-patient (c/s/x) movement, a system of grassroots advocacy and political action groups that worked to create viable alternatives to the mainstream mental health system (Chamberlin, 2004). A consumer-operated group functions solely by the efforts of the group’s members. The model of peer, rather than professional, support dominates the group’s functioning, and, as such, a non-hierarchical structure defines these services. Consumer-operated services have a variety of manifestations, and services that qualify as consumer-operated include, but not limited to, support groups, drop-in centers, advocacy programs, residential programs, and warm lines.

Whereas the majority of mainstream mental health services adopt a professionally-guided system of functioning and a biologically-based ideology, consumer-operated programs allow every member to take on a leadership role and develop his or her own unique perspective on mental illness and recovery. A common misconception of consumer-operated groups is that they espouse a strict anti-psychiatry value system. The reality is that consumer-operated group members hold a wide array of opinions and beliefs about the profession of psychiatry, psychiatric treatment, and the medical model. Chamberlin (2004) notes that, while these groups are not characteristically anti-psychiatry as a whole, even those members that do follow mainstream psychiatric theories tend to remain “critical of many features of the mental health system, particularly the lack of respect people encounter within the system and the inability of people to get many of their self-defined needs met” (p. 284).

One of the most unique qualities of consumer-operated and peer run programs is that they exist in large part outside of the mainstream mental health system, without affiliations to professional programs. Because they operate outside of the mainstream, alternative programs like these can be run however they choose. Regardless of how each individual peer run program manifests itself, the peer support model is based on the notion that developing deep interpersonal relationships and sharing experiential knowledge builds the trust and mutual understanding of oneself and others necessary for healing (Chamberlin, 2004). It is through the process of building relationships among equals, sharing personal stories with one another, and cultivating each individual’s unique healing process that people recover, not through powerful authorities demanding a particular sort of treatment program be followed. Their separation from mainstream, professionally run programs and their unique structure and process of peer support sets these alternatives apart from our mainstream model of treatment of mental illness.

Consumer-operated services come in a variety of forms, and range from self-help groups that lend support, acceptance, and understanding to their members, to domestic settings that focus on treating severely disturbed adults in a non-coercive, unrestricted, and largely non-medicated manner (Warner, 1995). Only a handful of domestic, or residential, programs that function in a consumer-operated manner exist today in America. Given that these programs operate outside of mainstream mental health, and thus do not often benefit from government funding, they tend to close after a relatively short period of time despite their effectiveness.

Loren Mosher’s residential program called Soteria House, established in 1971 and located near San Francisco, still stands as one of the most researched and replicated non-
mainstream, mutually-supportive alternative programs for recovery from severe mental illness, despite the fact that it closed in the 1980’s (Bola & Mosher, 2002, 2003; Mosher, 1974, 1995, 1999; Mosher & Hendrix, 2004). Soteria House was a small home, housing 20 people at a time, and run by non-professionals and peers. Soteria valued “the healing potential of human relationship,” and drew heavily on the works of Henry Stack Sullivan and Frieda Fromm-Reichmann, both of whom viewed psychosis as a response to life crises, not as biological and life-long diseases (Mosher & Hendrix, 2004, p.1). Soteria House was modeled after its East London parent residence, Kingsley Hall, where R.D. Laing assisted people through psychosis in a non-judgmental, non-coercive, and supportive manner (see Barnes & Berke, 1971)

What made Soteria House special, besides its unique treatment approach, was that Mosher established it with the intention of researching it to answer the question: Could people newly diagnosed with schizophrenia, and thus deemed so hopeless as to require intense medication and hospitalization, be successfully treated in an intimate, home-like setting without medications? Subsequently, Mosher led the Soteria Research Project, an effort that sought to compare his residential treatment community with mainstream hospital treatment for individuals with schizophrenia. Bola and Mosher (2003) reported that people that had gone through Soteria House did significantly better than their hospital counterparts, particularly in the areas of psychopathology, work, and social functioning, even when measured two years after leaving the program.

Other “home-like” treatment programs exist, but most are not in America. They can be found in Germany, Austria, Finland, Norway, and other Scandinavian countries. The Hotel Magnus Stenbock of Sweden is a good example such a program (see Jesperson, 2007). In the United States, the east coast, in particular, is our nation’s enclave of residential, non-mainstream treatment programs. For instance, the Crisis Hostel, located in Tompkins County, New York, was a place where people could go to avoid hospitalization (Dumont & Jones, 2007). It was consumer-run, voluntary, and intimate – about five people at a time could stay there for approximately two weeks. It, too, was based on the notion that healing could come from the simple support offered by peers that had similar experiences. Like most of these programs, it was also forced to close in 1996 because of the termination of federal grant monies.

The Windhorse Project, established in 1981 and still operating today, is located in Denver, Colorado (Herrick, DiGiacomo, & Welsch, 2007). This program, much like the others, is based on mutual learning and healing, where power hierarchies are minimized and everyone contributes to the daily functioning of the residence. People live in their own apartments with a trained housemate that provides continued support even when the person is at “home.” Treatment consists of establishing healthy relationships with team leaders and other residents, maintaining a daily schedule of activities, and practicing mindfulness. Over the years, the Windhorse Project has extended its services into homes and communities with its clinical teams. One other example of a non-mainstream, residential treatment program is GROW Residential, located in Kankakee, Illinois.

GROW

GROW began in 1957 in Sydney, Australia as a grassroots effort by a number of former psychiatric consumers to discuss their experiences and hardships associated with
being diagnosed with a psychiatric disorder. Many of these people had attended and reaped the benefits of Alcoholic Anonymous (AA) meetings, despite the fact that many of the attendees were not alcoholics. Eventually, these former patients developed their own groups that met regularly in an atmosphere of mutual help and discovery, much like their AA counterpart, but for the express purposes of dealing with mental illness.

These member-run groups spread across Australia and made it to the United States by way of Hawaii in 1978. Illinois was the first continental state to have GROW groups, and today there are groups that meet in many northeastern states as well. Growers, the name for members of the program, represent a wide range of problems from substance abuse, depression, and anxiety to loneliness, grief, or stress. Many have been hospitalized for psychiatric reasons and some are taking psychiatric medication. GROW is dedicated to providing services to anyone, especially people that do not feel that they get the help they need from mainstream avenues of mental health care.

GROW’s main channel of communication of its ideology and program structure comes from an array of literature for its members. Most of these readings articulate the program’s philosophy, goals, and teachings. Growers often come to rely on these booklets, manuals, and books for reassurance and comfort, for many of these readings offer quick and helpful insights and reminders about the GROW way of approaching recovery. Older, more experienced Growers are encouraged to share the GROW beliefs and principles with newer members. Part of becoming a Grower is coming to integrate the GROW worldview into one’s own worldview. The unique component of GROW is that the Grower is free to integrate this information to any degree and in any way they desire, so long as it assists in their recovery process.

The Blue Book (GROW, 1999), for example, certainly the most extensively read and utilized piece of literature in GROW, succinctly answers the question, “What is GROW” on its first page (emphasis in original):

GROW is a uniquely structured community mental health movement. It began in Sydney, Australia, in April 1957, and has since spread to six other countries – New Zealand, Ireland, the U.S.A., England, Canada, and Mauritius. GROW’s Program of Personal Growth, Group Method and Caring and Sharing Community have all been developed from the findings of former mental sufferers in the course of rebuilding their lives after mental breakdown. Their groups were, in fact, first known as Recovery Groups. This name was subsequently changed to GROW in order to meet the increasing demand for the groups’ services in prevention as well as in rehabilitation, and even more broadly for a popular school of life and leadership for mental health.

GROW is anonymous, non-denominational and open to all. Its groups are run by their own members, sometimes with the friendly co-operation of a doctor, social worker, minister of religion or any mature member of the community. GROW groups vary in size from 3 to 15 members. Meetings are held weekly, last 2 hours, and are followed by refreshments. **No membership fees or dues are charged. However, offerings at the end of group meetings are usual, but strictly voluntary. No introductions are needed. Just come along.**
The influences of AA on GROW do not end with their “self-help” similarities. GROW also follows a 12-step program, calling it “The Twelve Steps of Recovery and Personal Growth” (GROW, 1999, p. 5). The first step states, “We admitted we were inadequate or maladjusted to life,” and the last step says, “We carried GROW’s hopeful, healing, and transforming message to others in similar need” (GROW, 1999, p. 5). Growers often recite these, and other statements from the Blue Book, from memory. Staff and fellow Growers encourage members to know these sentiments from the literature and be able to say them aloud or in their heads to assist them in their healing process (Kennedy, 1995, p. 40).

GROW works by way of the peer-support or mutual-help paradigm. As one GROW brochure states, “GROW members share their own experiences and coping strategies in order to help one another. Members don’t just benefit from one another’s experience, but through the mutual self-disclosures build trust in one another. These supportive friendships become part of our ongoing network of resources” (GROW, 1982).

In fact, the “helper principle” (GROW, 1999, p. 44) is prominent in GROW and states that, “If you need help, help others. And to help others best, let them help you.” Essentially, the theory behind such a principle is that one gains a sense of empowerment and purpose from helping others along. People tend to feel that their troubles are normalized and destigmatized when they hear others’ testimonies. This provides some relief from the overwhelm associated with serious distress and allows for the development of a new perspective on one’s own struggles. The GROW group meetings, which are the crux of the program’s work, involve reading and meditating on readings from the literature and sharing personal experiences with others in the group.

The group meetings that gather across the world are not the only way that people can use the GROW program. The GROW Residential Center, located in Kankakee, Illinois, was established in July 1989 to provide 24-hour, intensive support for people that require a more structured living and learning environment during their recovery. The Residential Center uses the typical GROW fundamentals but extends them over the course of long-term, constant care for a small number of people that live together under the same roof. The large house can accommodate about 10 people comfortably and although the doors are unlocked and Growers are generally free to do as they please, their time is structured and the rules that govern the house are strictly mandated by GROW staff members.

The Residential program is based on a four-step developmental process and is based on a user-run format. This means that current or past Growers lead the majority of the decisions and activities. For instance, existing Growers in the house meet with and interview potential newcomers. Upon entry, each Grower in the house begins to progress through the four stages of development. Oftentimes, you will hear Growers referring to the Stage they are in (e.g., Stage 2). With each passing stage, the Growers gain new responsibilities and leadership opportunities within the house. Passage to a higher stage comes when a resident has shown significant movement and maturity through the program, in relationship with other Growers and staff, and in their daily behaviors. For example, Stage 1 is for those recent members to the GROW Residence, and is characterized by relatively little household responsibilities and tends to involve simply watching and learning from others. When a person has made improvements, both behaviorally and psychologically/emotionally, they can apply to progress to Stage 2 where they can take on...
more responsibilities and have more freedom (e.g., going outside without a chaperone). Stages 3 and 4 are also marked by continued progress through the program as well as the indication that the person can accept new freedoms and new responsibilities. In Stage 4, the Grower lives in an off-site apartment and begins to take on all the responsibilities of living alone again.

Part of what distinguishes the GROW Residential Program from other residential and in-patient programs, besides its user-run format, is that every day is very highly structured and scheduled. There is very little time to be sedentary. Also, the setting is comfortable and welcoming. Meetings take place in a living room filled with comfortable furniture. Bedrooms are filled with personal items and comfortable beds and furniture. Most residents described the Center as “home-like” and the people within it “family.”

Impact of treatment setting on meaning-making

Randall and Salem (2005) express the thrust of the argument underpinning my choice to focus on treatment environment in this study. Overall, they articulate the ways that treatment settings can powerfully influence their consumers’ beliefs about what mental illness is and how to recover from profound psychological problems. They argue that “the setting (i.e., programs, organizations, services, or groups) in which [patients] receive treatment, information, and support for living with their illness have a powerful effect on their understanding of mental illness and their beliefs about recovery” (Randall & Salem, 2005, p. 174). Put another way, the model of recovery espoused by one’s treatment program or setting can be adopted into it’s user’s own personal construction of mental illness and recovery in a manner that overshadows the person’s own, unique construal process about his or her struggles or avenues toward healing.

Saris (1995) provides another interesting perspective on the impact of structures (whether they are physical, conceptual, or both) on discourse, and, specifically, on narrative development. Saris contends that narratives are not just stories of personal experiences, but instead are “deeply embedded within various institutional structures that influence its production as a story” (p. 39). More importantly, Saris emphasizes that we should consider the part institutions play on narrative development, particularly in terms of what the institution affords and what it erases or “silences” in the narrative. From this view, narratives need to be understood within the context of the narrator’s “institutional topography” (p. 67).

This is not surprising, given that narrative psychology, as well as all forms of constructivism, tells us that humans derive meaning from the world via a constant interaction between the social milieu in which they are located and their own unique construal process (Brown, 2000; Gergen, 1991; Kelly, 1955). Elucidating the institutional influences on narrative development is especially important in the context of treatment environments for mental illness. Given both Randall and Salem’s (2005) and Saris’ (1995) propositions, I expected that differences in the values espoused by different treatment institutions (i.e., mainstream and alternative) would be present in the narratives of people from one or another setting.

Further, upon entering into the discourse of the mental health system (usually at the time of diagnosis), people begin a process of overhauling their personal narrative to fit a new, profound component of themselves (Goffman, 1961; Randall & Salem, 2005). Given
that a part of being human and functioning in the chaos of the world is the need to impose “an order and regularity” on the experiences we have (Frank, 1973, p. 27 in Kennedy, 1995), this need to make sense of experiences becomes even more striking when given a psychiatric label and gaining entrance into a treatment facility. How are you to understand yourself in the midst of your psychological distress? What does your label mean? How does this affect you?

Goffman (1961) stresses the impact of “total institution” on a person’s development of a sense of self, highlighting the sequence of events surrounding admission onto the ward and the social world of the institution as being strong influences on self construction. Prior to diagnosis, most people have developed no meaningful framework with which to understand their psychological problems (Randall & Salem, 2005). The experiences associated with becoming a psychiatric patient and the life-altering implications of diagnosis almost always, Goffman claims, causes a dissolution and re-evaluation of a person’s already held worldviews and sense of self (1961). A person’s first encounter with the mental health institution becomes one of transition and a time to start developing of a network of attitudes, assumptions, and beliefs with which to understand his or her life. As Goffman points out, the newly diagnosed begin to take on “new fundamental facts” (p. 131) about himself or herself that must ultimately be integrated in such a way so as to be “meaningful, reasonable, and normal” (p. x).

Randall and Salem (2005) remind us that treatment options for the psychiatrically diagnosed tend to be narrow, and, as such, the “frameworks of recovery tend to be quite limited” (p. 174). Professionally-run, psychiatrically-oriented treatment programs are typically the first form of mental health care these people experience. Patients are immediately inundated with the institutional ideologies associated with the organization they are in. As I previously explained, traditional, psychiatric approaches are based on the medical model where mental illness is like any other disease and treated like any other malady, with medication and other medical interventions and recovery is viewed as a static goal of symptom reduction. Furthermore, the users of this kind of system are viewed as “sick,” and as such are not granted responsibilities or the freedom to actively engage in their own recovery process. The hierarchical structure of hospital wards and inpatient programs casts the diagnosed as a pure recipient of treatment orders made by an authoritative doctor. The net result is that consumers of this system are provided with a very constricted framework for understanding and dealing with psychological distress.

On the other hand, the egalitarian and empowering ethos of treatment settings like GROW serves to communicate messages of hope and strength to its users. After time, Growers “begin to adopt the GROW worldview” for themselves by going through the GROW program, reading GROW literature, and sharing GROW principles with others in a mutually engaging manner (Kennedy, 1995, p. 1). Kennedy’s (1995) study of GROW groups in Illinois suggests that Growers experience a number of worldview-changing epiphanies, allowing them to see their lives as hopeful and meaningful. Kennedy found that Growers came to the program looking for a way to heal their psychological pain, but, in working the GROW program, “they unwittingly embarked on a journey of worldview change” (1995, p. 178). Clearly, those that carry psychiatric diagnoses are provided a much more open and accepting rhetoric with which to adopt into their own meaning-making system, and being given the opportunity to personally make meaning out of life, as I will explain later in this paper, is an imperative component of the recovery process.
Narrative research

Given that my main interest is the meaning-making of people involved in an alternative treatment program for mental illness, engaging each person’s narrative is one way of gaining access into this highly subjective process. Narratives provide a unique perspective on a single individual’s experiences as the person sees it, thus illuminating the meaning-making that went into his or her construal of the event. However, psychology only recently has taken a “narrativist turn” (Kreiswirth, 2000, p. 295) and begun to understand that personal narratives reveal the ways people construct meaning from experiences in the context of their social surroundings. Narrative psychology posits that the dynamic interaction of self and social environment, via a constantly evolving dialogical loop, creates meaning for the person. The conceptualization and organization of personal experiences stems from this interaction (Neimeyer, 2000).

Many theoretical schools are interested in the influence of social surroundings and culture on how people make meaning of experiences and, as such, develop a construction of self. For example, the social constructionists perceive of a “socially embedded view of the self,” (Gergen, 1991, p. 9) in which the infusion of culture into our self-understanding impacts our conceptualization of self in a way that makes the construction of self impossible in the absence of social context. Feminists argue that behavior or experience has meaning insofar as it is constructed with sensitivity to “the politics of the culture in which it is viewed” (Brown, 2000, p. 290). George Kelly, a founder of clinical constructivism and creator of Personal Construct Psychology, posited that only through the co-construction of reality, which occurs within society through interactions with others, do we define and elaborate ourselves (Bannister, 1985; Kelly, 1955). All of these theoretical approaches posit that social factors are central in understanding how a person construes the world, and, as such, strict attention to those factors is a necessary component in being able to truly understand how a person creates knowledge and a worldview.

Sarbin (1986) emphasizes the centrality of the narrative perspective in understanding the human experience, calling this standpoint the “root metaphor” for psychology. Sarbin states, “human beings think, perceive, imagine, and make moral choices according to narrative structures” (1986, p. 8). Narratives are an organizing mechanism, allowing us to grasp the disparate parts of our experiences and join them into a meaningful whole. Jerome Bruner (2004) also writes of the importance of the narrative mode of thought, claiming that the mind’s central purpose is “world-making” (p. 691). He suggests that creating an autobiography is a cognitive feat wrought with interpretation and reflexivity on the part of the narrator, echoing the notion that the creation of a narrative is a dialogical process between self and environment. The very framework by which we come to understand the world, the human condition, and ourselves is created and reflected by the narratives. Further, a person’s narrative is highly impacted by the social context and culture of the setting in which the narrative formation takes place. The influence of setting on the elements of a person’s narrative is of prime interest in this study.

The narrative approach is an apt one when interested in the experiences of those within a treatment program for psychological distress. Boevink (2007) writes that creating and sharing narratives, a practice that is quite common within user-run communities, assists in the process of recovery itself. Narrative creation helps the person define a sense of self after the common experience of feeling depersonalized by his or her label. The act
of sharing narratives with others also is therapeutic, for it allows the voices and the experiential knowledge of the often unheard and disenfranchised to come to the fore. Further, because narratives are already being created and shared within many alternative settings, requesting that they share with me their stories is an appropriate task to ask of the members of this kind of setting. In sum, it seems clear that the first-hand narrative is not only a rich and evocative avenue for academic exploration, but it is also a therapeutic endeavor that assists in the healing process.

*My story*

I would be remiss if I did not include my *own* narrative within this exploration of others’ narratives. By taking a reflexive stance in this project, I hold myself responsible for the thoughts, biases, transferences, emotions, and motivations behind this research. Further, how could a reader evaluate or critically examine this interpretive work without being granted the opportunity to know its creator? It is with that in mind that I give you my story in an attempt to help you, the reader, understand who I am, why I chose this project, how I felt and still feel about it, and where I want this work to take me.

I imagine that this project really began when I was about 20 years old, or about four or five years ago. I was pursuing a pre-med track in college, green with envy because I simply could not master organic chemistry no matter how many hours I studied those carbon rings. Being the type-A student I was, I noticed a free block of time in my schedule, and I thought I could handle another three credit hours. It was time to revisit psychology, I figured. Psychology was always fun. Easy. Nothing like chemistry. So, I enrolled in a course on psychopathology, unprepared to hear about the myth of mental illness, the social construction of pathology, the dehumanizing effects of diagnosis, the unreliability of the *DSM*, and other unorthodox notions. The budding doctor inside of me fumed. The scientist within me was offended. This was not what I signed up for.

Turned out, it was exactly what I needed. The romantic inside me, the person that lived off of literature, exploring the spiritual, and had a heart that opened wide for suffering people, was touched. I found myself navigating to the MindFreedom website – a task our professor had encouraged us to do one weekend – over and over. I latched onto the stories, awful and ugly as they were, about people being hurt by the system of mental “health” in our country. The corruption within our mental health system became clear to me, and the politics of psychiatry felt unethical and offensive. I started noticing the ways quantitative research on the effects of diagnosis and treatment for mental illness never quite captured the experience behind these occurrences. This information constantly fell flat. But stories were rich, evocative, and meaningful. The stories called me to action.

A few years later, I decided to parlay these new interests into a doctoral clinical psychology program under the supervision of a scholar and clinician with similar interests as mine. Currently, my research focuses on qualitative, post-modern approaches to understanding alternatives to mainstream investigation of mental illness with a particular focus in alternatives to mainstream, psychiatric treatment. This Thesis was born out of a desire to publicize the issue of the damage of mainstream, in-patient, psychiatric treatment on consumers as well as highlight the utility and efficacy of alternative treatment approaches. I hope that readers will understand that even the most troubled people, when
given freedom and power, can help themselves heal and can lead others on a journey toward recovery that looks nothing like what is popular and pervasive in our nation today.

Method

Interpretive Interactionism

Interpretive interactionism (Denzin, 2001) is both a method and an approach to understanding the lived experiences of individuals through the thick description and experientially accurate analysis of self-stories participants generate. This approach examines “how problematic, turning-point experiences are organized, perceived, constructed, and given meaning by interacting individuals” (p. 71). More specifically, the focus of interpretive interactionism is the “biographically meaningful moments in subjects’ lives,” termed “epiphanies” within the methodology (Denzin, 2001, p. 58; p. 34). As such, the subject matter of my project is the biographical experience of ordinary men and women and their extraordinary and unique life events, particularly in relation to having extreme experiences and seeking treatment in a nontraditional therapeutic environment. These significant moments not only have the ability to reveal a person’s character, but they are often interpreted as being life-changing for those that experience them. Because interpretive researchers seek the self-stories that relate to life events that have “deep-level effects in persons’ life,” (p. 62) I pursued these significant instances in my participants’ narratives during the interview process as well as payed close attention to these epiphanies during the analysis phase.

The interpretive researcher seeks out participants that have experienced the kinds of life events that are of interest to the research question. The method is particularly applicable when the researchers want to explore “the relationships between personal troubles… and the public policies and public institutions that have been created to address those troubles” (p. 2). It moves from the personal to the public, honoring the notion that, in order to correctly understand the experiences and perspectives of people utilizing the services of public programs, we must attend to their own voices as they tell their own stories. The interpretive researcher thus is concerned with gathering first-person narratives as they relate to personal troubles and public services established to address those problems. As the nature of this project is the impact of therapeutic setting on the formation of personal narrative, interpretive interactionism is an appropriate approach to investigate such an interaction.

While interpretive interactionism specifically asks the researcher to focus on the epiphanies in a person’s narrative, I also was interested in listening for the ways in which these epiphanies were related to the ideologies espoused by their previous therapeutic environments (typically locked psych wards within a hospital) and the GROW environment. During the interview process, I focused on the important moments in the stories I received and listened with an ear for the ways in which the overarching ideologies of a person’s therapeutic environment was adopted into their narrative. How were the different explanatory frameworks of mainstream and alternative mental health programs employed in the stories I heard? Did they exist harmoniously within the narrative or were they at odds? These kinds of questions guided my interview process.
Recruitment procedure and participants

I gathered participants that were currently utilizing the services of GROW Residential. I came across GROW Residential during an Internet search for residential, consumer-operated programs in the Ohio, Indiana, and Illinois area. After a number of phone calls with various directors of the program, I scheduled a visit to the GROW Residential home. During this visit, I explained, in broad terms, the nature of my proposed thesis and received verbal confirmation from many of the Growers that they would be very happy to be involved in the study.

I recruited the first four people that volunteered to participate after meeting me, learning about the project, and discussing any questions with the staff members and me. Dan, a white male from the Chicago area, was 39 years old at the time of the interviews. I also recruited Seth, a 22-year-old white male from Illinois, and Jackie, 18 years old and also from a small city in Illinois. Melinda, a 51-year-old white female from a small city in Illinois, and I only met twice during this project. She elected to leave the program shortly after our second interview. With the exception of Melinda, I met three times with these adults for this project.

Interview process

During the first meeting I explained who I was, the nature of the study, and conducted a semi-structured interview. After I introduced myself, I presented the participant with an informed consent form (See Appendix A). I then explained to my participants the goal of generating a narrative of extreme experiences. I described this narrative-generating process as one in which open-ended questions guide an informal conversation between the participant and myself with the end goal of gaining an understanding of the subject’s unique experiences and understanding about his or her recovery process. The first interviews lasted between 25 minutes and just over an hour.

I interviewed each of my participants individually, behind the closed doors of the living room on the first floor of the GROW Residential home. I felt that containing our discussions to the very environment in which they were recovering would add to the experiential quality of the interviews and would allow me the opportunity to see first-hand where many of their experiences actually occurred. I requested that our meetings be private and in quiet, although the nature of the house often superceded my appeals and minor interruptions occurred. Despite the phone ringing a few times or another Grower entering the room to retrieve a book, our meetings were free from distractions.

I waited two days before returning to GROW to conduct my second set of interviews. I had instructed each participant to be aware of and write down any new information or added details they thought of during the interim between the first and second meeting. During this second meeting, I gave my participant the opportunity to add any additional information to the narrative, ask questions about the research process, and finalized plans to contact each other again after the narrative had been analyzed. I allowed each participant to continue talking with me until we both reached a consensus about ending our interview. This set of interviews lasted between 30 and 60 minutes. After we closed, I informed them about the representation process, and we made plans to meet again after each of them had the opportunity to read my interpretation of their story.
With each participant, I received permission to record all of our conversations before the start of our first meeting together (See Appendix B). Upon agreement, the sessions were recorded via handheld digital recorder, in order for me to be able to recall and use the participants’ own words in the representation of the narratives. Once the interview process was completed and the narrative co-created, I transcribed, analyzed, and textually represented each narrative. The transcriptions allowed me to read the interviews, use the text in my finalized document, make notes on them, and physically view the conversations, rather than just listen to them. After I analyzed the transcriptions, I explored different writing styles with which to represent the narratives textually to readers. After I represented the narrative in written form, the participant was given the opportunity to read my textual representation of his or her narrative before our third meeting together. I mailed each participant his or her story as I represented it, and at that point, I set up another day to visit GROW and speak with each person individually.

Within interpretive interactionism, narratives are collected through semi-structured interviews that use open-ended questions to gather information about specific points of interest to the researcher. The underlying task for the researcher is fairly simple and involves listening to the stories people tell and bolstering these narratives with interactional and conversational interviewing. In keeping with these provisions, I devised a set of interview questions that were targeted at specific points of interest that I wanted to explore with my participants. I created questions that were flexible enough to be reworded or reordered depending on how the interview progressed (See Appendix C). The questions I posed to my participants focused on 1) what my participants’ experiences were as they decided to enter a therapeutic environment, 2) how each participant understood the nature his or her struggles, both prior to and after entering a therapeutic setting, 3) what each participant experienced within the therapeutic environment, 4) how each participant defined recovery and pictured his or her future after recovery. I structured the interviews in a way that allowed for these points of interest to be addressed while maintaining the interactional, conversational tone promoted by interpretive interactionism. At times, this meant deviating from the prescribed wording of the questions or wording the questions somewhat differently, clarifying the questions for the participant, or asking questions out of order.

Storage of research materials

After each interview, I stored the digital recordings in a locked lab space on a password-protected computer. Each file was labeled with a pseudonym and locked. Any ancillary materials, like notes and signed consent forms, also were locked in a filing cabinet in this lab space. The written transcripts of the interviews were similarly stored and saved.

Analysis of narratives

Denzin (2001) outlines six general steps to interpretation within this method. I will explain them here in terms of how my research study relates to each step. First, the researcher must frame the research question. In the above section, I have posed four broadly constructed questions, or points of interest, to address in my research study. These
points of interest are the framework that guided the interviews as well as the analyses. The second step, deconstructing and critically analyzing previously held ideas about the phenomenon, was addressed in the selective literature review about narratives, the construction of the self, and therapeutic environments. In my presentation of how I position myself as the researcher in this study, I also explored my own preconceived ideas, beliefs, and knowledge about therapeutic environments and extreme experiences.

I completed the third step of capturing the phenomenon when I performed the interviews with my participants. I was constantly attempting to locate the epiphanies in my participants’ stories during the interview process. A number of the interview questions I created probed the participant for the epiphanies or turning-points in their life story. For example, I asked each participant, “Could you describe any turning points in your life that led you seek help/treatment?” and “Could you describe any significant moments in your life story that changed your self-identity?” Furthermore, during the interview process, I listened carefully for other instances of significant moments that my participants mentioned. I attempted to draw out as much detail about those events during our conversation together by asking clarifying questions to better understand that moment and highlight it within the story.

Bracketing the phenomenon is the fourth step, and it involves critically examining the phenomenon, or “taking it out of the world where it occurs” (Denzin, 2001, p. 75). “Bracketing” means setting aside one’s own prior ideas and attempting to understand the phenomenon, as it is, on its own, and this step was accomplished after the transcription and analysis phase. The narratives were compared with one another, with particular attention paid to how GROW effected the construction of the narratives. I tried to extract common themes among the narratives as well as attend to similarities and differences in style and storylines. I completed the fifth step, entitled constructing the phenomenon, when I represented the narratives, based on the information gleaned during the bracketing phase, in written form within the results section. I will explain below how I represented the narratives.

The sixth and final step of contextualizing the phenomenon involves interpreting the themes that were uncovered during steps four and five and imbuing them with meaning by putting them back into the world. My main goal in this step was to uncover how the participants experienced being in and going through GROW. I chose to use evocative texts and include my own personal reflections on the stories to make the narratives come to life on the page. In the discussion section, I will go into more detail about my choices in the representation phase. I also described how the information presented by the narratives – as well as their experiential qualities – connect back into the broader context of what the literature suggests about being in and going through an alternative therapeutic environment. I recognized new issues that arose out of the project and delineated their implications. I felt it was also important to include a reflexive portion of the discussion section. I attempted to follow Denzin’s methodology during my analyses and re-presentations of the narratives, and although I did not always comment on this process within this written project, the method always guided my work.
Textual presentation of the narratives

Not only does the interpretive researcher gather first-hand stories of meaningful life experiences, but he or she also recognizes that these data are “existentially experienced, interactional texts” (Denzin, 2001, p. 39). The method is rooted in the feminist critique of positivism and understands “that every interactional text is unique and shaped by the individuals that create it” (p. 40). Interpretive interactionism thus represents a hermeneutic approach to gathering information as it situates both the researcher and the subject in the center of the research process. It recognizes that the self-story generated by the interview process is a one-of-a-kind result of the interaction between the participant and the researcher. The subject that tells the story is clearly at the heart of the story, but the researcher is also an active participant in the creation of the story. This hermeneutic circle also has implications for the way the researcher chooses to represent the personal narratives the participants generate during the interview process.

Representing the narratives gathered using interpretive interactionism is a task in connecting the experience of the participant to the representational mode of the researcher. The stories should be re-told in a way that honors the interaction between participant and researcher and should show rather than tell. As such, Denzin cherishes the notion of having the researcher reshape the narrative gathered from the interview into a performance text. Performance texts “are storied retellings” that provide information “via evocation rather than explanation or analysis” (Denzin, 2001, p. 16). What makes the performance text attractive is that its endpoint is not factual information. Rather, performance texts allow the reader (or performer of the text) to “relive experience” through the perspective of the storyteller and enables the reader to feel his way into the experience of the participant. It complicates and deepens rather than simplifies the issues raised in the text, and, because it evokes issues that are being experienced, it is always incomplete.

Because performative writing is not a formal style, the writer is free to explore writing styles that allow the text to evoke the feelings and the experiences of the participants. In performative writing, where the task is to show rather than tell, the writer is free to mix genres and utilize non-prosaic mediums to express the story. Employing non-prose allows the writer to explore the ways creative literary devices provide for experiential readings of the text. Thus, poetry, stream of consciousness, and dialogue may be used in this methodology. The writer is free to mix these writing styles and experiment their presentation so that the reader is able to feel their way into the experience being described in the text.

Adame and Knudson’s (2007) study is a good example of this type of approach to representing narratives. In this study, the primary researcher chose to represent her discussions about constructions of recovery by psychiatric survivors in a text that is both poetic and dialogical. The reader was able to experience both the researcher’s and the participant’s perspectives through the ongoing dialogue present in the representation of the narratives. This writing style also respects that both parties were active agents creating the narrative during the research process. Adame and Knudson (2007) elected to present the narratives in stanza form, allowing the words to read like a poem. This poetry-like style promoted a more experiential, performance-oriented reading of the narratives. I used this study as a guide, and structured the narratives my participants and I co-created in a similar manner.
The work of Carolyn Ellis (1997) also guided me during the process of representing the narratives I collected. Ellis writes what can be called creative ethnography, autoethnography, or, more descriptively, “evocative ethnography” (Ellis, 1997, p. 119). Whatever the name, this kind of writing style allows the author develop texts that depict the interaction between the writer and the subject she is writing about, and it centers on how an author or researcher can write in a way that evokes the emotions, feelings, and experiences of the story. Specifically, the task for the creative or evocative ethnographer is to connect the lived experience of the storyteller to the representational mode of the researcher. By writing autoethnographically and evocatively, the author invites the reader to participate in the emotional process of the story, to “think and feel with the story” (Ellis, 2000) rather than simply read and digest facts. No matter the literary tools the author decides to employ, the author should privilege creating a text that elicits felt emotions and experiences within the reader over one that provokes cognitive contemplation.

Evocative ethnography requires that the author find ways to employ literary techniques and writing genres in a manner that, when read, allows the reader to feel immersed in the story. Ellis (2000) achieves this immersion in the felt experience of the story by combining writing styles in unique and unexpected ways. By disrupting the natural progression of the text with other literary devices, like poetry or stream-of-consciousness, the reader is invited to set aside the author’s authoritarian voice and inspect the text for him or herself. The interacting writing genres invite the reader to participate in the emotional process of the story (Ellis, 1997).

For example, Ellis (2000) peppers her own self-story about how she evolved into an autoethnographer with asides from the imaginary “voices” of a chorus of grey-bearded sociologists – set off from the normal text of the document in italics and smaller font size – that question her ideas, mock what she had previously written, and argue with her about her rhetoric. Her own inner voice, also recognizable by its font size and shape, interrupts the text to air concerns about the message she is sending her readers and the way in which her story could potentially be flawed. This multivoiced, dialogic approach to writing the story beckons the reader to delve into the text and read it as one would a novel, experiencing what the storyteller is experiencing - rather than dryly ingesting the information as one would a textbook.

Another prime example of mixing writing styles toward the aim of creating a performance text is Hoogen’s (2006) thesis about women’s narratives of depression. Hoogen allowed each woman’s experience to dictate to her what writing style to employ so that she could show, rather than tell, the story. For example, one woman’s narrative of being medically treated for her depression, expressed with “almost numbed remove,” (p. 23) was textually represented by a third-person recapitulation of her experiences that allowed the reader to feel the distance and numbness the woman was experiencing in her story. The narrative of another woman, inhibited about her story yet yearning to be heard, was presented as a series of the woman’s journal entries, almost like letters to Hoogen, that communicate her experiences. Hoogen’s choice to present this participant’s story as a set of secretive journal entries invites the reader to experience the repressed, shy nature of the woman as she struggles with depression. The texts that were created in this thesis urge the reader to dive into the experiences of the women, and mixing writing styles allowed the feelings and experiences of the women to come alive.
The textual representation of each of my participant’s narrative emerged after I considered what writing style best evoked, rather than simply represented, the experiences of my participant. The above examples were guideposts as I experimented with different forms of writing. The crucial criterion was that, upon reading (or performing) the story I created, the reader feels immersed in the experience of the participant. To that end, and with the exception of Melinda’s story, I used only words that came directly from the transcripts of interviews. Given the thinness of Melinda’s interviews, I elected to create a third-person narrative based on her own words. Doing this allowed me to flesh out scenes and events that she was too distressed to talk about in detail. Also, because I allowed my participants to read and provide feedback on my first draft of the re-presentation of their narrative, some participants wanted me to change my representation style in my original draft. I accommodated this kind of feedback and changed the narratives to fit the participant’s wishes.

Evaluating the interpretive materials

The goal of interpretive interactionism is the location of meaning in individuals’ experiences. This approach posits that meaning is established through the interaction of people wherein the co-creation of a story between researcher and participant draws out the participant’s personally important events and experiences. Further, “These interpretations are reflected against the person’s on-going self-definitions” (Denzin, 2001, p. 80) and thus creates an experientially accurate depiction of the powerful moments in a person’s history. Because interpretive interactionism contends that meaning is emotional, experiential, and biographical, locating meaning involves uncovering how an individual emotionally and biographically fits an experience within his or her “emerging, unfolding” (p. 80) definition of self. By creating self-stories that highlight the important events and experiences within a person’s life, we can better ascertain the meaningful parts in a person’s life. Furthermore, by creating texts that evoke meaningful experiences, readers and performers of the texts are better able to learn via experience, rather than dry, cognitive ingestion, about the powerful moments in people’s lives.

How exactly one evaluates interpretive texts is an important question to consider in the interpretive process. How do we know if the interpretive researcher has accomplished what he or she sets out to do, namely to ascertain and interpret the meaning in a person’s life and represent it in a way that is experientially evocative and emotionally accurate? This issue is a particularly salient and problematic one for the qualitative researcher using experimental, performance texts. The mere idea of providing criteria for the evaluation of such unconventional research materials may “only conventionalize the new writing” and highlight the ways in which it has already become unadventurous and normal (Denzin, 2003, p. 246). Clough (2000; as cited in Denzin, 2003) makes this issue clear and immediate by claming that to set criteria for judging experimental writing, one may forget that “experimental writing was strongly linked to political connections over questions of knowledge,” (p. 246) and would thus serve to negate the political statement that experimental writing in qualitative research sets out to make. All too often, Denzin (2003) cautions, criteria serve as “policing” (p. 246) devices that sometimes divert our awareness away from the creative work that performance texts allow for.
In order balance the need to avoid feeling “policed” while creating my performance texts and the need to outline, for practical purposes, the ways in which performance materials are judged, I will outline briefly the various qualities that qualitative researchers and ethnographers provide in regard to what makes good or bad experimental, performance research texts. In its “final” form, my text likely will include many of the qualities these researchers and scholars champion in good research texts. Furthermore, as Denzin (2003) aptly reminds us, there is no single standard against which these types of texts may be measured. There are usually only multiple standards that are constantly changing. Those that read and judge my work will likely have different viewpoints and varying conceptions about what makes a successful performance text, and to that end, I will attempt to outline the criteria that I would like to attain in my work.

The evocative ethnographer Carolyn Ellis has developed a set of criteria that emphasizes the literary aesthetic of a text. According to Ellis (2000; as cited in Denzin, 2003), good texts are detailed, nuanced, and evocative. They show rather than tell. In terms of aesthetics, they should have a strong plot, build up dramatic tension, be “lifelike” (p. 254), and vividly depict smells, sounds, and sights. In general, Ellis wants to read a story that “is worth fighting for” (p. 254) and one where the reader is fully immersed. Those that judge texts from the feminist and communitarian perspective pay close attention to ethics, politics, and power (Denzin, 2003). Accordingly, from this viewpoint, performance texts ought to attempt to dissolve “the usual differences between ethics, politics, and power” (p. 247), and, in doing so, disrupt the public sphere. Creating these disruptions highlights the often taken for granted aspects of everyday life that are often laden with ethical problems, power inequalities, and the politics of experience that shape life. Finally, these texts should be an avenue through which dialogue about the issues presented in the text may emerge. These texts should not be a way to close off a subject from the public forum of discussion; rather they should introduce into this dialogue the voices of the voiceless by using their own words, telling their stories, and sharing their personal and unique conceptions of the matter at hand.

These qualities have much in common with the criteria that Denzin (2001) lists for the evaluation of interpretive materials in his text *Interpretive Interactionism*. Because Denzin’s (2001) approach and method is what I will be utilizing in my study, I will list each criterion he provides and explain each briefly explain each detail. Denzin (2001) asks readers to evaluate interpretive materials based on eight criteria. Assessing interpretive materials requires readers to evaluate the materials both holistically and microscopically because at times the criteria concern details about the materials and other times, they are about the overall presentation of materials.

Starting broadly, the first criterion asks whether the materials illuminate and enliven the phenomenon of interest. This can only happen when the materials are written using the voices of ordinary people in the context of lived experience. Secondly, and again, quite generally, the reader must decide whether the materials are thickly contextualized. In other words, are the interpretations built upon richly described events and experiences that create a distinct context around which to understand the materials? Has the researcher used the words of the participants and attempted to speak from the participants’ point of view? These are all questions to ask when evaluating the text for the second criterion.
The third criterion asks whether the interpretive materials are historical and relational. That is, do they exist within the lived history of the individual and do they include the individual’s relevant social relationships? Fourth, and in some ways very related to the third criterion, do the materials make clear both the process and interaction involved in creating the story? The presentation of interpretive work must make clear to the reader the process involved in creating the stories as well as the interaction between participant and researcher during the interviews. This is the hallmark of good interpretive work.

The fifth criterion concerns the extent to which the researcher has included any and all relevant information needed for understanding and interpretation of the research materials. Denzin (2001) calls this “engulfment” (p. 82) because the implication is that the interpretive framework expands and deepens to fit all the information relevant to the story. Sixth, the researcher must include previously held knowledge, beliefs, and thoughts about the topic of interest, both in the professional literature and in him or herself. This aids in the creation of richer interpretations and also accounts for the researcher’s inherent biases and may indicate how these views shape what she sees, hears, and writes.

The seventh criterion asks whether the interpretive materials lead to a coherent understanding of the phenomenon of interest. As previously mentioned, the foundation for the cohesion of interpretive materials is that they are thickly described, relational, historical, and interactional. The eighth and final criterion is related to the notion that “All interpretations are unfinished, provisional, and incomplete” (Denzin, 1984, p. 9). To meet this criterion, the interpretations made always must occur within the hermeneutic circle. Each time the researcher returns to the materials, new and changing interpretations may and should arise. In this way, interpretations are never complete nor are final. That being said, incomplete and unfinished interpretations always convey meaning. This meaning is subject to change with each new reading or performance of the interpreted materials. Overall, the researcher should never assume that he or she would find the answer to the questions asked, and the finalized research document should convey the notion that the ideas presented in the study are always subject to change with each and every reading.

Denzin (2003) has mentioned elsewhere that he views a performance text as an allegory or a parable – “a means of experience” (p. 253) – that is a pathway leading the reader to a greater understanding about himself via the text’s inherent reflexive quality. These works are constantly created with a critical eye cast on how truth is being created, “asking always who stands to benefit by a particular version of the truth” (p. 253). Ultimately, performance texts should empower the oppressed and facilitate changes in the public establishments of everyday life that too often fades into the background.

While all of these criteria are relevant to the materials created by the qualitative researcher, there is still no prescribed recipe that guides the evaluation of materials produced during the interpretive research process. I trust that my committee will grapple with the issues and ideas raised by other researchers about what constitutes a good performance text. Indeed, I will strive to create a final document that achieves the qualities defined by Denzin, Clough, Ellis, and others while not viewing these criteria as strict borders that stifle my creativity during this research process.
Results

In this section, I attempted to re-present the narratives that were co-created during the interview process in a manner that reflected the degree of tension between the medicalized master narrative and a more open, coherent, integrative, and trauma-focused narrative within my participants’ stories. At times, I discovered this tension in an experiential manner, as was the case in Melinda’s story. At other times, the tension between guiding narratives was evident in the content of the story, as in Jackie’s and Seth’s narratives. My goal was to re-present the Grower’s narratives in such a way so as to make these tensions overt.

I also presented the narratives in a manner that reflected the recovery process at GROW. It was clear that part of the recovery process at GROW was the transformation of one’s narrative from a highly disjointed one of competing master narratives to a more unified personal narrative that was indicative of a unique blending of master narratives. This process of narrative transformation is mirrored in the order with which the narratives are presented. By this, I mean that the narratives move from most tension-filled to the least.

Lastly, I chose different modes of textual presentation for each narrative based both on the degree of tension evidenced in the stories and based on the feedback I received from each individual participant during our last interview session. The third-person, authorial stance of Melinda’s story communicates the almost numbed distancing she felt from her own life and story. Jackie’s story is ordered in such a way so as to highlight the tension felt between the traumas in her life and the happy face she puts on for the world. Seth’s story, one that I had intended to present as a series of poems or songs, ended up appearing as an interview transcript based on some of the feedback I received from him. Finally, Dan’s story weaves poetry with prose in order to communicate to readers the emotion-filled yet flowing integration of his story.

Melinda Silently Speaks

An episode

What was supposed to be a warm, welcoming homecoming for her ailing mother by her children swiftly turned into a yelling match. A drunken brother being belligerent, a frail mother, and a family room of screaming voices made Melinda flee the scene. She ran to her car, begging for her husband to “Hurry up! Come on!” She watched her two young nieces, hair tied back in pigtails, summer sun glinting off their dimpled cheeks, laughing at her as she sat, meek and childlike, in her husband’s car, trembling. Didn’t one of them just pull a knife on me? The pulsing of her heart felt to Melinda as though the kids could see it through her sweat-dampened shirt. The god-awful feeling of yet another spell, laced with the overwhelming fear that her family’s screaming would bring on her mother’s second heart attack in two weeks was written on the lines on her face. She rubbed her bulging belly, feeling the baby softly stir, hoping for some comfort from the tiny, perfect little thing inside of her.

Her mother had just told her, in between deep, difficult breaths, that she had to do something. “I can’t handle your Daddy anymore,” she admitted. “He’s stressing me out,
your father.” Melinda did not know why she was telling her this - why her mother depended on her for help. Even after watching her mother nearly die from a heart attack and then get brought back to life by the doctors, Melinda could not understand this sudden appeal for help. This was all very hard for her to handle.

The whole family, the brothers and sisters, all gathered together on that hot, summer afternoon. Melinda was days away from giving birth to her second child and the heat was unbearable. Their mother had just come home from the hospital a week prior. Upon arriving home, Melinda supported her mother’s feeble figure as she ambled into the living room and settled into a chair. *Everybody, just be quiet,* Melinda thought to herself, knowing deep down that her family’s way of doing things could easily set Mother into another spell. *Please,* she pleaded to herself.

Moments later, her youngest brother busted into the room, carrying a can of beer in one hand, stumbling ever so slightly as he wandered around the living room. *Oh God,* and Melinda’s hands began to shake. *He’s drunk.* The nieces and nephews look on and the family friends that have paid a visit watch curiously at the event unfolded. He waved his hands about and started yelling about something. Who knows, really, what it was about? And, like usual, the whole family started yelling and screaming right back. They never did learn how to deal with stress. Everybody was going crazy, going berserk. Melinda’s hands shook even more and she could feel the ever-so-familiar feeling of her heart racing inside her chest. The dizzying palpitations, the light-headedness that follows. *Oh my God,* Melinda thought. *I’m going to have another panic attack!*

*All in the family*

Panic attacks. That’s how it all started. Panic attacks are why she had spent countless visits hospitalized for days on end. Though she never left feeling any better than when she arrived, she continued to go back, hoping that maybe this time, it would work. After spending nearly 40 years adjusting, readjusting, going on and getting off the meds and never finding the one or the combination of pills that worked for her, she still dreamed of, one day, finding the meds that would take her depression and panic away. The paralyzing panic was the cause of more ambulance rides than she and her husband could afford, forcing them into court for not making payments. Panic attacks and suicidal thoughts. That’s it. She wonders frequently what it would be like to *not* have the depression weighing her body down all the time. What would a normal life look like?

After all, she contends, this seems runs in the family. The depression, anxiety, and post-partum depression seem to be just gifts her gene pool left her. Let’s see… Her niece, Lacey, over in California, the one getting married on her birthday, just started to have panic attacks, too. She’s been in the hospital a lot, thinking she’s having heart attacks. Melinda’s daughter, Jamie, has always had problems. She spaced out a lot in grade school and never got along with her friends well. Perhaps that was ADD. That’s what her husband thought. Melinda often noticed herself forgetting what she was saying mid-sentence, wandering off in her mind to who knows where. What else… Melinda’s sister suffered with post-partum depression after having her babies, too. And the brothers and sisters, well, they all had their issues. Alcoholism, depression, anxiety, and just plain problems. It was all in the family. Inherited issues.
For Melinda, she had a very hard time in grade school, much like her daughter would some 30-odd years later. Melinda had a hard time concentrating on her homework when her drunken father would come home after school, hollering at her mother, poking her on the chest when she was asleep so he could argue with her. He was emotionally abusive and an alcoholic, as were her older brothers. Her drunken brother coming home trying to break up the fight between her parents never helped either. It added to the craziness. Yes, it made for a crazy household. By first grade, she was depressed. The nuns would gently tap her on the shoulder as she rested her head on her lunchbox and glumly fingered the peanut-butter-and-jelly sandwich her mother made her. Come on, you’ve got to eat something, they would say. But she couldn’t. Looking back on it as an adult, she knew she had a bad childhood.

By 13 or 14, the doctors had put young Melinda on Valium and Melinda put herself on a steady dose of alcohol. She dropped out of high school during her first or second year there – drugs, partying. She was the only one of the 5 siblings not to graduate from high school. That stung. Her mom cried when Melinda told her she was going to quit school. She didn’t want to upset her mom like that, but she felt the pressure of school becoming too much to handle. By age 20, she had met a man, got pregnant by him, and her mom, Catholic through and through, wanted her married. So she did. The day before the wedding, she miscarried. What should I do, she often thought. Should I stay with him? She already had a hard time trusting men. He was controlling, and although Melinda recognized that quality in him, she could do nothing to stop him. It took seven more hard years of marriage to that man before she had a baby. And the joy of holding that warm bundle of baby boy in her arms was quickly wrenched away by a soul-shaking bout with post-partum depression. She loved her baby, but always felt the experience of mothering being dampened by her battles with panic, depression, and anxiety.

Her husband was a very controlling person. Pushing her to do this, to do that – all while she was feeling depressed and overwhelmed with new baby Jeremy. That stress just pushed her over the edge. And then that one time with the knife. That time… she ended up in the hospital with baby Jeremy. She was washing a sharp knife. She started panicking. The depression! She didn’t even know what happened. She didn’t even know how to remember it.

Five years later, Melinda gave birth to a baby girl. Again, the maternal bliss of having a new baby was ripped way by the post-partum depression. Again, the one little thing that could bring her happiness – and maybe respite from the depression and panic – only brought on more suffering through the post-partum depression. This child ended up having quite a temper problem. Melinda chalked it up to her being picked on at school. Jamie learned how to be a you-ain’t-gonna-treat-me-this-way kind of girl, and this tough little girl turned in to a controlling, temperamental woman that bossed her husband-to-be around. This way of being that her daughter had adopted, this attitude and swagger, it remind her all too much of something familiar. Remember – she told herself – we decided that Jamie was doing better.

Then there was that one night. That one night in 2000. Jeremy was 15. Jamie, who never really attached that well to anyone, was close to her big brother and they decided to take a trip to Oklahoma. Their father, some friends, and the kids piled into a car to make the trek down south. Jeremy was behind the wheel, getting some good practice driving on the highways and at night.

It took a hold of her.
It tore her up.

*Constant conflict and relapse*

In the end, the doctors never could find a medication that would take away these memories, the panic associated with them, and the combination of anxiety and depression that always followed Melinda like a storm cloud. The medications could never take away what, for Melinda, was something many of her family members suffered from – an inherited set of symptoms. She was straight depressed. Hopeless. Depressed. Always had been. Sometimes it got so bad she figured that ending it all would be just as good as sticking around. Her son was gone, her husband a source of unbearable anxiety, and her daughter slowly spinning off into a life that Melinda was afraid would look a lot like her own. And the constant depression. Nothing helped.

Melinda’s stays in the hospital, usually only four or five days at a time, were awful. She would refuse the nauseating food they tried to give her and only drank a few Ensures a day to stay fed. She would obediently take the meds they gave her, slipping off into a place where everything felt like nothing at all, until she was declared “stabilized.” In truth, she never felt any better when she walked out of the heavy, locked hospital doors. She told them, I miss my family, and thankfully, she was released. Then, it was back home. Almost as soon as she returned home, the panic and suicidal thoughts would return.

She found GROW a few years after Jeremy’s death. Melinda had been in the hospital in 2004 after a particularly bad spell of panic and bout with suicidal feelings. Things were not going well. Even though the hospital stays were old hat at that point, she knew she could not work through her issues in a place like that. She heard about GROW, and it sounded appealing. It would be a safe and supportive environment with people always around, not like her home where she was often left alone. If she panicked at GROW, someone would be there to support her through it. No more ambulance rides, either, Melinda thought, making GROW sound even more attractive. Her first stay at GROW was, well, fine. Better than the hospitals, that’s for sure. Melinda, quiet and unassuming, felt cared for, safe, and protected in that house in Kankakee. For perhaps the first time n her life, she felt the warmth of friendship. Of safety and community. She felt wanted. She read her Blue and Brown Books, attended GROW group, and dedicated herself to the program. She also continued to diligently take her meds. GROW worked, and six months later, Melinda went home feeling better than when she came. And the food, Melinda remembered, was great.

Things had been going well, for the most part, when Melinda found out that Jamie was pregnant. She was pregnant by a man that made Melinda nervous. He just sat there, staring at her, not saying anything. He made her feel stupid, just looking at her like that. She felt like her teenage self being teased by her brothers when she was around him. There was just something about him, something eerie and unpleasant that caused her pulse to quicken and her nights to become sleepless. But what really plagued her was the thought of Why did Jamie pick *him*? In the deepest recesses of her mind, Melinda couldn’t shake
the sense that Jamie would end up repeating her mistakes: A shot-gun marriage to a man that she shouldn’t be with, a relationship defined by who controls whom, and a whole life of promise left behind in the dust of wifedom, depression, and regret.

A sense of growing dread, fear, and panic slowly mushroomed like an ominous cloud inside of her. Another desperate call to her husband, another expensive ambulance ride, another hospital stay - this time 10 days, one of her longest yet. When it was time to leave, Melinda decided to head back to GROW. Why? She knew, deeply, that she could not go home until she was better. She also knew that she had tried getting better in the hospital, but that option never seemed to work. Her daughter was encouraging her to do this – to take the time to get better. And on some level, she felt her husband’s support, too.

Reflections

This is the point in the story when I come in. Melinda had been in GROW for the second time, about three months in, when we sat down together to talk. I hardly noticed her when I was spending time in the house. She seemed to camouflage herself into the background, quietly evaporating into the setting so as not to disturb the present events. She made little noise as she engaged in daily activities of eating meals, cleaning up, and even playing a board game with the other Growers. Frankly, I was a bit surprised that Melinda agreed to talk to me. But talk she did through the darkness of depression, and I was touched by her effort. After I left my first interview with Melinda, I drove back to Chicago in the March rain, talking into my voice recorder in attempts to parse things out.

Here is what surfaced for me. It arose more as feelings than thoughts for me, and the more I allowed those feelings to percolate, some important themes emerged. I felt tense. There was a nervous energy in my belly and my hands were sweaty on the steering wheel. I examined that feeling, thinking that perhaps it was all just a sympathetic nervous system response from the excitement of the interviewing process, but came to recognize it as a response to Melinda’s story in particular. She spoke in quiet, terse, and tense snippets that were barely audible. I had to draw her out a bit, even self-disclosing about my own struggles with panic attacks in order to talk with her. In the wake of the interview with Melinda, I had picked up the tension left by the silence that existed all around and within her. For every word she spoke, I felt a thousand other words go unspoken, existing only as tense pulls from the pit of her being to say more, say it all. Perhaps these words were so deep inside of her that she did not even hear them herself. Perhaps she did not want to hear them. Who knows what the implications of that would have been if she decided to let them out?

As I moved past the nonspecific feeling of tension and the vacuum-like silence of Melinda’s story, I attempted to pinpoint the source of the empty space to which I so deeply reacted. First, and quite importantly, Melinda was in a self-defined state of depression at the time of the interview. I am sure this contributed to some (or possibly most of) of her choked-back quietness. Beyond her depression, I also noticed that there were quite clearly two larger narratives pushing against each other in her personal story. A medicalized narrative and an alternative/trauma narrative were warring against one another in her story. This was the tension I was feeling.

When approached with an eye toward the ways in which two very different meta-narratives were espoused by her two different treatment settings, one can envision how the
medicalized narrative, probably the one championed by those in the hospital all those times she was admitted, was a hand around her throat, choking back any contradicting plotlines or conclusions to the story. Every time she told me about an event in her life that was traumatic or psychologically damaging, she stopped, and told me, in a somewhat off-the-cuff manner, that whatever the side effects of those events were, they were normal for her because they run in her family. In essence, her story was one of, “Well, I was very traumatized and troubled as a child and young woman, but my depression and anxiety are to be expected because it runs in my family… and I was symptomatic because the drugs just never quite worked for me.” The biologically-based reasons for her psychological problems trumped any other explanation, despite the constant, quick appearances of alternative clues in her story. As soon as the story turned to one about trauma and emotional turmoil, she swiftly silenced it with stories of a broken brain, doomed genes, and failed meds.

And I could not blame her for the silence. For allowing those unspoken words and unfelt emotions to live somewhere far inside of her in an unreachable place. As I considered the idea that it is logical to rely on the much less threatening biologically-based narrative than the frightening trauma narrative to define one’s own story, the tension I first felt around Melinda’s story turned to fear. She was terrified to set aside the comfortable, acceptable medicalized narrative and give airtime to the far more disorienting, painful trauma narrative. The trauma narrative, the one that GROW probably spent a lot of time trying to help Melinda talk about, told of a life left unlived, stolen in some ways, by a marriage she did not want, a child buried in the ground, and another child about to embark on her own life of Melinda-like mistakes.

When viewed from the vantage point of threat and fear, Melinda’s silent story is full of noise. It tells of a story that most likely lives quite loudly inside of her, clamoring to be set free, to be recognized. But at what cost? If she let the trauma narrative out, would that mean potentially facing her haunted, abused past? Telling herself and her family that they all treated her so badly that she could not even think of them as family anymore? Would that mean telling her daughter not to screw up her life like she did? And facing her own demons about maybe being a bad mother for allowing her daughter to follow in her own, messed up footsteps? And telling herself that her husband is, deep down, unsupportive and uncaring? Would it mean finally telling herself that no amount of drugs will fix the events that unfolded in her past and the ones still happening in the present? Would it mean tearing apart her fragile life and starting over again? Probably.

Melinda’s story is one of a silent shout. I will never really know how she is doing or what she is doing. She left GROW a few weeks after our interviews, so I never had the chance to follow up with her about anything. Even though I have a pretty good cognitive understanding of Melinda and her story, what lingers most powerfully for me about her still exists as feelings. I worry about Melinda. I continue to feel the tightness in my chest, the tension, when I remember her. I think about her often and hope she is well. Mostly, I hope she knows that people understand and respect her silence. I also hope she knows the power of her own story.
Rachel: Could describe some of the experiences that led up to you being involved with GROW?

Seth: I don’t remember much, until I’m 10 years old, because I was, how do I say this? A lot of my childhood wasn’t nice. I had a bad childhood. My grandpa died when I was 10 years old. And, after that, shortly after that, I was raped by a guy. And then my best friend died. All at once.

I was sexually molested, by my mom’s boyfriend’s cousin. He was sent to jail for a year. I was sent to the hospital. They had to put stitches in me, and I was flirting with the nurses. They were letting me color and stuff. I knew what was happening, but he tried to persuade me not to tell anybody. And the way he did that, was he made hot chocolate for me. But, it was just too much, and I had to tell my mom. She told her boyfriend, and he beat him with a bat. Gave him black eyes. And for some reason, he came to the hospital with us. But I think he discarded some evidence when he was there. It was my bloody underwear. Nobody could find it. After that, he was taken to jail. I still won’t forgive that person. I actually planned it out… How to kill him. But I’m not even going to try.

Next, my grandfather died. And then my best friend died. He drowned in the river. He was swimming, and he got caught in a hole. I couldn’t believe it for a while. But eventually, I accepted it. I don’t know if I cried or not… It takes a lot to get me to cry.

What else? Well, my mom wasn’t around a lot, because she had me when she was 15 and she passed me off to my Grandma a lot. She even had to drop out of high school just to support me. So, my grandma was taking care of me, and then my mom had two more boys.

That’s probably why I partied so much when I was younger. It’s pretty much like… abusing drugs. Abusing marijuana and alcohol. At the same time. And I was doing it every single day. It started when I was about 12 or 13. I used to drink vodka like water. Just chug it. And the older I got, I just started drinking beer more. And I’d start drinking until I puked. And eventually, I found I didn’t want to drink anymore. I was smoking so much weed that I didn’t feel anything and I’d just… It’s a lot of the reason I smoked weed, was because a lot of problems in my life.

I didn’t really want to deal with them. Just like family conflicts, responsibility… I started smoking cigarettes because I felt kind of guilty that my grandpa died. I mean, we were going to see him right before he died. And when we left, he died. So, I mean, on the way there, all the way, I was crying. I thought my grandpa was going to die before I got to the hospital, and then I got there and I saw him with all the tubes and stuff and I just felt helpless. Like I couldn’t do anything about it. And I think that gave me a little guilt. I was very close to him. Even though I was close to him, I didn’t know him that well. Never got to know him that well. And he was smoking and drinking while he was on the respirator. That’s what drove him to the hospital. And that’s really what killed him.

I really regret not getting to know my dad. He’d come for me every, like, once a year on the holidays. And that’s when he wanted to see me because he worked all the time. It’s not his fault he was not able to see me. And mostly he said he works too much. He couldn’t come. I wish I could have just had a relationship with him. I mean, we’re just like friends. We’re not like son and father. That really hurt me. It made me feel like I
wasn’t important. Like I wasn’t worth it. Like I didn’t matter. And there were days he
didn’t come. And it really made me mad. And I’d cry sometimes… I would cry every
time he didn’t come to get me. I loved my dad so much. And I was… I was just… I see
my mom, why can’t I see my dad? I think things would have been different for me if I had
a relationship with him. I mean, he doesn’t even know how to be a father. But if he did,
he could have taught me a lot of things that he didn’t. I missed out on that. I just felt like
he lied to me.

Rachel: How did you end up at the mental health center?

Seth: I was delusional. I thought I was Jesus. I looked like Jesus! I had hair down to
here, and a beard and the whole thing! I thought I was performing miracles and I was just
waving my hands around… Like magical stuff with my hands or something like that. It
happened before my eyes. I remember the day before I started that I had something else I
thought I was. I thought I was an Indian warrior, and I stayed up all night at my friend’s
house, swinging weapons. Practicing. And the next day, I thought I was Jesus for some
reason. I ran all the way to school. I got there before the bus did.

That was when I was a second-year junior. Somehow I graduated. I was going to
school, and I was smoking weed and taking tests, and I still graduated. It’s like, why did I
do that? I mean, maybe I was trying to challenge myself. I don’t know. But it was kind of
easy. If it wasn’t easy, I was just talking too much. Making a ruckus.

I don’t know! When I was delusional, it was like my eyes were tricking me! But I
don’t know one thing. My mom told me something. “Someday, she said, “You’ll be
something great.” And I took that really too far, and it went to my head. I was just using
pot as a recreational drug, but it gives you a different perspective on life. And I think I was
just too far into the fantasy world. My reality was definitely off. But… I didn’t really
know that at the time.

I was also kind of paranoid. I just didn’t know what to do. You know how Jesus
got killed by everybody? I thought the whole world was after me. I felt the whole weight
of the world on my shoulders. I kind of think somebody calls me Jesus sometimes. I try to
stay away. I try to avoid that. I used to think the TV was talking to me, and I saw all kinds
of stuff on it.

But I don’t really know what led to these events.

It was either… It was either marijuana or alcohol. And if it wasn’t alcohol and
marijuana, I was just down and depressed all the time. I was depressed for about three
months one time when I was 17. Then, I went to the nursing home when I was 18.
Montrose Park. After the delusions. And I stayed there for three and a half years. But
before I went to the nursing home, I went to Fairlawn Park Mental Health Center when I
was delusional and thought I was Jesus.

When I went to the hospital, they didn’t want to deal with me. They just put me in
a room. I waited there for hours. Finally, someone came to ship me to Montrose Park. It
was weird. I mean, when I went to St. Augustine’s to get transferred to the hospital, I was
in a holding room for like hours on end. Because, they didn’t know what I was going to
do. And they didn’t want to know. And when they opened the door, they just put me on a
bed, put me on an ambulance, and I didn’t know where I was going. I was watching. I
knew I was on the highway, because I saw the highway signs. They had me strapped
down.
I think I felt like I was Jesus for a couple of days when I got there. But after that... kinda, it slipped my mind or something. I don’t know. They gave me, I don’t know what kind of medicine they gave me. I think they gave me the wrong medicine sometimes. It might have been just a suspicion that I was, you know, just weird. A suspicion. I mean, I don’t think they took enough time to look at what they were giving us. We were just filling up the beds. Really. I mean, they had people coming in and doing groups with us, but the regular nurses and staff, they really didn’t care. They had this one lady come in to give us something to do. We could have got our GED’s in there. But I already had my diploma, but I still went back there and did some math and stuff. Just to keep my mind busy so I wouldn’t feel at home in the place. It’s not a place to feel at home. I mean, if you want to stay there, I feel sorry for you. You know? It’s really nasty there. It’s like... the food is nasty. The label affected me. Really. For a long time. It just made me feel like a statistic. And... like I was weird. Like I was just an outcast from the whole society. I was... I mean, my diagnosis is schizophrenia with active psychosis, and I just figured out what psychosis meant not too long ago! I knew what schizophrenia meant, but, well, I think it’s true. Because, I do have depression sometimes. But, it kind of makes me realize why they give me medicine for bipolar disorder. My depression.

But, I don’t really understand what they meant by I’m schizophrenic. Because I was only hearing voices for a little amount of time. Delusions? Yeah. Hallucinations? Not much. I just think – I just think it’s like, just something for me to watch out for. I know it happened before, so, in case something goes wrong, you know, I have a recurrence or relapse. And the funny thing is, when I did drugs, it didn’t really – drive me to relapsing mentally. It’s like it’s just all in my head. Pretty much. To start talking to myself sometimes. Just to hear myself talk or just to break the silence. Because the deafening silence... I don’t like it at all. Unless it’s a peaceful silence. I guess. Only sometimes do I get peaceful silence.

It’s just opened my eyes to what I’m like and what I need to work on and stuff like that. Well, it took me a while to realize what I needed to change. Because I was in denial for a while. But, it’s a process. Accepting something and admitting it to yourself. It really is.

My parents, they were worried about me, but they knew I’d be alright. I mean, they missed me a lot. They got to see me a couple of times. It was hard. Well, one of the times I saw them, I wasn’t even adequate to pay attention. I was just messed up on medicine. And it wasn’t evened out yet. I was kind of worried about the other people next to me in the visit. I was kind of conscious of them more than my own grandma. And I had to realize that they’re in there, too. So, it doesn’t matter.

I stayed there three and a half months. Then I went to the nursing home. I was there three and a half years. You can do pretty much whatever you want to in the nursing home as long as you don’t leave without... I mean, you have to be on a certain stage to leave with someone or by yourself. And they had the doors locked the whole time. You can sleep anytime. You don’t have to eat if you don’t want to. I’d stay up a lot of the nights. Just because. Why go to sleep? I have nothing to look forward to. I was really depressed.
And my psychiatrist... he thought of himself as a dictator. I think it’s a conspiracy. I mean, he calls up his nurses and recites these numbers. And every number means something. You know? I just think that dude is way too abusive. He abuses his power and treats people... Well, he didn’t get to know them, so he treated them like crap, really! He didn’t really listen to you unless you had something to say to him. He put me on all kinds of different medications. I believe part of that medication made me worse. I took Risperdal for a while. That gave me bad hallucinations. I was so incoherent on that medicine. I couldn’t even play video games. I couldn’t concentrate enough. It was frustrating, because I know what was happening, but nobody else seemed to. That’s why I stopped taking my medications sometimes. It just wasn’t good. He told me that I would have to take medicine for the rest of my life. He explained it in a way that it’s something that you can’t change. You have to live with it for the rest of your life. You can’t do anything about it, besides stay away from drugs. Take your medications. That was very... It hurt my spirit. It was bad for my personal value and my self-esteem.

Until I came to GROW, I was a label. I thought that I was a category. And that was it. I was just a type of person. A number. It’s just like an excuse, you know? Them saying my problems were because I had this. And I think people push us to the side because they think we’re crazy. They think they’re better than us because we are mentally ill. And that’s not right at all.

Anyway, I was kind of smoking in the nursing home. They didn’t know about it. The first time I did, they did know about it. The next time, they didn’t. They let me out, and I was pretty much already starting. I kind of lied to my grandma. I told her I would, like, be... better. You know? Be good when I came home. And I just, as soon as I got home, I just went out and bought some weed. I missed my partying days.

And then I started partying too much. Like every single day. If I wasn’t smoking weed, I was drinking. If I wasn’t drinking, I was smoking weed. Or both.

You know, I had something to do about being in the nursing home, so I made a plan to get out. And that helped me a lot. The planning. Like knowing what I need to do and doing it. A sense of awareness. I was able to take myself out. I just needed a place to go and had to tell them where I was going.

Rachel: What made you change you mind and decide to come to GROW?
Seth: How I came to GROW was like... I was in the hospital and my grandma said I couldn’t come home. They were scared of me, because I was yelling at them. My attitude was out of control because my emotions were all jumbled up. I mean, I would never - I would never lay a hand on any of my family. They were just scared of me. They were just terrified of my temper. So I really didn’t have a place to go.

I got this idea that I was going to go to California. I met these people called, they said they were in the Rainbow Family. So, I went and hung out with them one night, and then I came home and told my family I was going to California. So I came home the next night and I told them, “I’m leaving tomorrow and I’m staying here tonight.”

And, I put a cup of noodles in the microwave and it started on fire. And luckily I caught it before it got too out of control. But I opened the microwave and a big plume of smoke came out. And I inhaled a lot of it. And I went back in my room and I was I was attempting to go for a knife because I didn’t want that stuff in my system. I was trying to
flush it out right away. I was just going to cut. I was going to cut myself and drain my wrists. I was going to cut my wrist and get the bad blood out.

But that don’t work.

It just made sense to me for some reason. And then my brother called 9-1-1 on me. I was in my boxers. Luckily, they let me put some clothes on before I went to the hospital. They thought I was a danger. They didn’t really do anything about the smoke inhalation.

I was there like a week. At that point, I thought I was going home. At that point, I was like, “Oh my gosh! My hope is gone! I have no place to go! I might as well just stay here.” And I didn’t want to go to GROW. I was too bullheaded to think about it at that time. And Anne, a woman from GROW, came in and talked to me. Changed my mind. She told me it’s like a voluntary thing. You don’t have to do it. You can if you want to. That made me feel a lot better.

But I still was feeling that I needed… I didn’t want to be in a big community. And, so, it was either nursing home or GROW. I figured, the nursing home was a way bigger community than GROW. And I picked this.

I called Anne. She said, “I’ll see what we can do.” And Dr. Brandon, my psychiatrist, helped a lot too I think. I talked to Donna, the social worker there. She said “I think that they have found a spot for you in a couple days.” And I said, “Wow!” because a lot of people don’t get in here. I was just relieved that I had a place to stay. I wasn’t really worried about the rehab or anything.

When I first came here I was really – I didn’t really like the structure at all. I just wasn’t used to it. I resented it a little bit. I would rebel. I’d say off the wall things. Get really angry. I mean, I’d go outside without anybody else. They’d just tell me I’m not supposed to do that, and then they would come out with me. One of the things I really didn’t like was people telling me what to do and stuff. I don’t like answering to people. But I had to realize that I’m a person, too. They are people. And you gotta’ answer to somebody all your life. So… might as well start now.

It was a big switch for me, especially because my grandma wasn’t that strict at all. I would do stuff when I wanted to and when I wanted to be nice. I really didn’t have structure. And, I’m kind of a perfectionist sometimes, so I have had to learn to just settle for what happens. Like, they change things a lot here, like the staff schedule. All kinds of stuff. I used to be susceptible to getting angry about it. I just accept it now and know I can’t do anything about it. So… might as well just roll with the punches. I could snap off easily, but… I don’t let it out so easily, but I don’t keep it in either. I try to express my feelings without being overly enraged. I think about things before I say them now.

I mean, when I first came here, I thought… I kind of thought it was a cult. They were all saying things in a circle. I actually asked them if this was a cult! But they said, “No, it’s just our routine.” It’s basically like a prayer. I eventually got used to it… I didn’t really like it here at first.

After being here for the little time I’ve been, I do feel a lot better about myself. Made me care about what I want to do. Instead of partying every day and just throwing my life away. I think it’s the sense of accomplishment from doing something good. And actually trying to make yourself better. In so many different ways. And knowing that you can you can get better. Even though you have a disorder… mental illness. And someday you can eventually… probably… get off your meds.
What else? The food is definitely better than the nursing home or hospital! The people are a lot more coherent. People in the nursing home... some of them were kind of loopy. They don’t know what they’re talking about. The residents... they’re just so far gone. They need the care for the rest of their lives. I really had to get out of there. I mean, we did have some good stuff in there. But a lot of it was just down time.

At GROW, well they actually took the time to figure out all these little things in life. And they put it in this book. So I mean it’s like, you can, you can learn a lot about life here. It’s like hands on. It’s visual. I mean, that’s a different method. It’s more... Well, in a regular rehab place, it’s more like... Let me see... Impersonal. They don’t really get to know you that well. But they do try to help you. Here it’s more personal. We get to know the staff. We get to know everybody in here. We actually know each other. In the little time you go to rehab - a couple months – you’re not going to know much about each other. There’s a big barrier. I think there’s a lot less of that here. I think it’s better. If you get to know someone, you’ll know how they act. You’ll know how to help them.

Now, I don’t see myself as just a label and just a person with mental illness. Now, it’s just a problem. You’re not a label, you’re a person. I feel accepted here. We don’t address our diagnoses. They’re not really relevant... just because everybody has problems. We all have different problems. Just because it’s our diagnosis, doesn’t mean that we... Anything can happen in life! Somebody can blame it on anything. Everybody has problems. It was a relief to come here and take away the label. I was in denial for a long time. I wasn’t ready to think about the past, all the years of abuse. Physical, mental, Sexual. Drug abuse. It was all packaged up. So, when I came here, they said, “You possibly might be able to get off your medication and recover from mental illness.” And that was something new!

I know people are here to support me when I have my downfalls. I just hope they know that I’m here for them. The people here, they might not be ready to let people help them. I don’t like asking for help when I need help. But I know I have to. That’s one of the things I’ve got to work on. It’s not like I’m shy or scared to ask. I just don’t want to. I’m independent.

Rachel: How do you see yourself now? How have things changed for you?
Seth: I don’t think I’m different. I think I’m changing. And I think my thinking is a lot more healthy. I think I’m a little more open-minded than I was. It’s kind of like, when I have to do something that I don’t want to do, I just go against my feelings without thinking about it. Just do it. So, I won’t be mad because I did it. You know? I figured that out a little while ago here. It’s not really a big deal. You know? I’m used to the structure a little bit more. If you just do what you need to do, it won’t really bother you. If you try to go out of structure, it will.

So, I don’t really notice turning points. What I do notice is when I change. Afterwards. I act a lot more responsible than I used to. I do what’s asked of me without questioning. Before, I’d question or protest. Now, I just know I have to do it.

This place builds character. It builds a lot of trust. Builds a lot of friendships. It’s good. It feels good. I mean, I’ve always had friends... most of them not worth being friends with though. They don’t have enough to offer to be a friend. It’s a one-sided relationship. It’s a good thing to have friends that are mutually engaging friendships.
GROW gave me a home. They gave me… it even feels like a home a little bit. They gave me a sense of security. I feel like I’m loved here. It’s good to know that I have somebody other than family that supports me that I live with. That I can call on. Trust with anything, tell them anything. And, a lot of my hobbies are also helpful, like playing the guitar, writing songs, writing poems, drawing pictures.

Rachel: What do you think you’re recovering from here?

Seth: Immaturity. Emotional immaturity. But… it wasn’t always that for me. I don’t think in the past I was really working on that. I mean, I didn’t really know how, because I grew up emotionally immature. I think our whole family did. But, I think I’m rehabbing out of drugs, too.

I just don’t think I want to do them anymore. It’s just like something that pops up. You know? It’s there. It’s a luxury drug. I don’t want to do it. The way I had it, I could have had it any way, anytime. I could have had it going to my friend’s house. I could have bought it. I could… everywhere I went it was there.

It’s always going to be there.

And I’m a very spontaneous person. Like, right now, I’d love to be out there skating somewhere. I used to skate up and down this street all the time. All the time. Skating is a big part of who I am.

But, recovery means I can have a fulfilling life. I can go out and do what I want. You know? So I just… I just want to have a normal life. And hopefully fulfill my dreams.

I want to be a musician. And I want to design things. I want to draw. Do something with art. Maybe even cartooning someday. I would hope to be married with kids. Making money. I just want to make enough money to support my family. Be a good dad. I think a lot of people have told me I’m good with kids. So I know I’d probably be a good dad. I want to be mature enough to support a family. Be a good father. Teach them the values of life.

It’s always been my dream.

But some days, I miss people. I miss my friends. I miss my family.

I can’t talk to a lot of people anymore, because they are set into a lifestyle that is drug-related and it’s always going to be that way. I kind of get mad at myself when I get stuck in that again. Every time. I relapsed a lot of times.

I know what it is. I know what it does. I know I don’t want it. It’s just a way out. And it’s not really the way out. It’s temporary. I think I’ve thought too much about having fun and meeting different people. You know, those experiences I’ve already had. I wanted them. I just know I gotta do some work. I grew up deprived of emotional maturity. So I figure I better change that myself.

I don’t know if my problems could ever be gone. I mean, from all the abuse and my childhood trauma. All that. I don’t think it’ll be gone. I think it’ll be something to live with. Maybe so unnoticed that it seems like it’s gone. But I don’t think it’ll be gone. I do have disturbing thoughts. Everybody does. I mean, I’ve heard voices before, but I don’t anymore. I know I’m not Jesus. I know it’s not real. It’s just a sense. A falseness.

But, I do feel like I’m improving. Making progress. I think I’m doing really good, actually. From what my peers tell me, I’m doing really good compared to some people that have been in here. The other night, I let out some feelings and I just explained why I was mad, and they told me I had improved a lot. In the past, I would have just snapped off. Just yelled at everybody. But, I stayed calm, collected. I do my personal
responsibilities, take care of myself better. I’m helping people. I’m asking for help even though I don’t want to. I’m pushing myself. I believe that it’s all character building. My thinking has changed. Instead of thinking about what I want, I think about how other people would feel and what they would want. I look at the whole perspective now. It’s different. But it’s good. And, I think we’re getting to know each other better here. Have compassion for people. Knowing what they went through, you realize that some things are similar, and that you have more things in common. It gives you trust.

But it’s not really going as fast as I want it to go, because I kind of don’t want to be here. I want to have my own place and be doing my own thing. You give up your freedom for a little while. I still get frustrated sometimes, because I feel like I’m wasting away. When I went to the nursing home, I was there for 3 and a half years, and I felt like my life was going nowhere. I was the least productive I could be. Now, I’m sort of feeling the same way again, but not exactly. I’m not unproductive. I’m just working on myself.

I’m just anxious to start my life. I feel like I’ve been held back for too long. But, one of the wisdoms they have here is, “It doesn’t take a day to get mentally sick. So, it’s not going to take you a day to get cured.” But, I’m not sure if I’m going to stay here the whole time. I just… I feel like I’m growing in maturity, but I don’t know if I can stand being here for 3 years. But, I’m also worried because there’s always going to be marijuana out there in the world. I just hope it isn’t as available to me as it was the last time. It was ridiculous how available it was.

And I get stir crazy. I’m not used to being in the house all the time. I am a skater. I have a rebellious attitude.

So, basically, I’m a survivor. I can pretty much withstand what I have to. A lot of things I don’t know how to deal with, I’ll learn how to. The things that I do know how to deal with, I’ll learn how to cope with them better.

I’m a lot different, in terms of responsibility. Before, I didn’t carry it out. I didn’t have the motivation. I didn’t really want to do it. I guess I didn’t have exactly what I needed. And because my grandma raised me. She didn’t really give me too much strictness. She was really lenient with me. Maybe because of all the resistance I gave her. She didn’t want to put forth the extra effort to try to get me to take on my responsibility.

Well, I take on my responsibility now. I like to do what I’m supposed to do. What I have to do. And even if I don’t want to do it, I have to make myself do it. I really like the way I’m learning how to get over the… avoid disturbing feelings that I have, resisting against what I need to do. I feel a lot better about myself. I take care of myself a lot better than I used to. My confidence has grown. I’ve learned that everyday we grow closer to maturity. That’s what they say in the program.

But, like I said, I really don’t recognize turning points. I do notice a change afterwards. I can’t really pinpoint it. Like, maybe… evolving. In a mind-state. You know, we learn something every day. And we change from it.

Reflections: War Wounds

Seth and I came up with the nickname The Rebel during our follow-up meeting in June. I made the comment to him that when I read his transcripts, what stuck out for me was his penchant for rebelling. He was a skater at heart, desperate, in some ways, to get
out of GROW and get back on the street where he could be free. He played his guitar a little too loudly, went outside without permission, and did not buy into the whole GROW program at first. The way I saw it, he only ended up at GROW because he felt it would be better than the nursing home. That’s it.

When I made these comments to Seth, he laughed and nodded his head, making his newly shorn blonde hair bounce. He looked healthier than he did when I met him for the first round of interviews some three months earlier. He looked happier. “Yeah, I am a rebel,” he chuckled, smiling. So, that was it. He had been dubbed The Rebel. He enjoyed taking on this persona. It suited his 21 year-old, skater boy personality.

While Seth enjoyed the mystique behind being The Rebel, this character resonated with me for a different reason. It helped me understand how Seth was making his way through the GROW program and through recovery. It was a story about fighting against a system that was finally helping him, reluctantly admitting it was helpful, and then aching to get out as soon as possible. Seth was softening slowly but still clung tightly to his ultimate goal of getting the heck out of there.

When I first sat down to interview Seth, his urge to leave GROW and his skepticism kind of got to me. I could not understand why someone would ever question such a wonderful program. How could he not see how much better GROW was compared to the locked hospital ward or the boring nursing home? At first, I interpreted this as perhaps being an artifact of his youth or his (self-proclaimed) immaturity. When I considered it further, another interpretation arose.

Sure, Seth was young and probably immature. He had no problem admitting his lack of maturity, in fact, it was easy to blame his struggles on that cause alone. But there was something else operating beneath his Rebel façade. I had heard something similar in Melinda’s story, actually, so it was not so foreign to me. If I listened closer to Seth, past his immaturity and wishes for a skateboard and an open road, I could hear the clashing of two stories. But unlike Melinda, whose inner battle was being fought between two worldviews of mental illness, Seth’s war was one of an Old Self up against a New Self.

I envisioned two identical Seth’s with swords brandished, circling each other, blades striking and crashing together now and again. One Seth had long, scraggly hair and ripped clothes on, somewhat like the way he looked when I met him the first time in March. His opponent, the second Seth, had on clean clothes and wore his hair shorter, out of his eyes, a replica of the young man I met in June. Mostly, they just glared at each other as they engaged in a neatly executed dance of a battle perfected over time. But in an instant, no telling when, really, one of the Seth’s would lash out and bring his sword down in the direction of his enemy.

Both Seth’s had sustained injuries. I could see gashes taken from arms and the neck. Dried blood was splattered on jeans and the tops of shoes. War wounds. They were both tired. They sometimes stumbled or misstepped, but they never stopped pacing around each other. Both Seth’s were eagerly fighting for dominion over the territory of his life, neither one willing or ready to give up. Or die.

I am not sure how it would end, really. Would the Old Seth just die? Would he give up after a long, hard battle? Or would they both put down their weapons and walk away? I do not know. What I do know is that Seth’s story tells of a young man getting better yet wanting the recovery process to go faster. His old life, his old friends, his old
habits called to him from somewhere deep within, pestering him to get out of GROW. Be
done already. In these moments, I could imagine the Old Seth taking a swing at the New
Seth. Sometimes the blade cut through the skin, sometimes it missed. His story was also
one of the New Seth fighting back, stronger than ever, and making progress. A new life, a
new support system was now energizing him to make it. To get well.

It seemed to me that Seth, as I experienced him in June, was certainly a stronger,
more mature, happier version of himself. On the one hand, it was evident that he was
appreciating the process of recovery as much as he could. On the other hand, it was clear
that his youth and spontaneity, his Old Self, urged him to leave GROW. What stays with
me now, thinking back on my time with Seth, is the valor with which he fights for his
wellness. What I did not see at first glance were Seth’s war wounds, the injuries sustained
during his struggle to recover. I somehow missed the terribly exhausting conflict going on
inside of him. I feel bad that I did not see that in Seth at first. I saw only what most people
saw in him, his youth, immaturity, and impatience. My interpretation was off.

My hope for Seth is that both sides of his story, the old and the new, learn how to
coexist. I genuinely hope that Seth manages to find a way for his old self, the daredevil
and rock star, to merge peacefully with his new self, the mature and thoughtful. Maybe
then he can have a rest, put down his sword, and enjoy the life he worked tirelessly to
rebuild. Maybe then we will have to think up a new nickname for The Rebel.

Jackie’s Story

Preface: Laying the cards on the table

Let me be honest here. When it came time for me to put my fingers down on the
keyboard and start re-presenting Jackie’s interviews, I balked. In fact, I think I convinced
myself that I had “unintentionally” saved her interviews for last. Really, I was just
stalling. I was not simply procrastinating or putting the work off for some other day. No, I
felt dumbfounded and nervous about diving into a set of interviews that I thought
somehow did not make sense. Whereas with my other participants – whose interviews and
stories begged for a certain form of representation - Jackie’s story puzzled me. A form of
representation did not jump out at me. A coherent message was not immediately evident.
In fact, it was not evident even after days of sitting at my desk, staring at her interviews,
fingers a million miles away from typing out something meaningful. I was, to put it
technically, stumped.

Allow me to explain. I met Jackie during my second visit to GROW, the visit in
which I conducted my first set of interviews. I had expected to see only
the people that I
had met during my first visit to the house some five months earlier. So, when I walked in
the door in March for my interviews, I saw Jackie and thought something that was not all
that unusual in a place like GROW. Is she a resident, or a staff member? I did not
remember her from my last visit, so I figured she could have been a staff member I did not
meet in October. In any event, she was busily darting in and out of the kitchen, blonde
ponytail bouncing with each boisterous step she took. Her smile was so bright! I
remember that smile. Well, she looks happy, I thought. “Hi!” she burst forth. “I’m
Jackie!” Of course, a hug followed. I get a lot of hugs when I’m at GROW.
Soon enough, I learned that Jackie, the youngest resident in the house at that time, had only been there for seven weeks. She was 18. She had been doing very poorly after another stay on the ward after another suicide attempt. Really? I wondered quietly to myself. She seems happier than I am!

And that was it. That was the sticking point. Only seven weeks in and I would never have imagined that Jackie, of all people, was getting intensive treatment after trying to kill herself. After sitting down and talking with her for about two hours, that sentiment remained.

Is this just too good to be true?
That question haunted me for months. Each time I tried to let her story sink in, I had that thought. How could she be doing SO well in so little time? I mean, I knew GROW worked, but that quickly?

Okay.
I am just going to lay all the cards on the table.
Oh, boy. Here it goes.
Here is what happened next. I fought it. I had to find a way to not think of Jackie as someone that was “faking good.”

God, I cannot believe I just used the term “faking good” in regard to one of my beloved participants.

I wrestled with clashing notions about what it means to be “researcher” and “participant” and the role of honesty and truth (whatever “truth” is, anyway) in the process of gathering information as interacting individuals, not as actors in an academic endeavor. Should I be suspicious of Jackie? Or just credulous? Was I being too cerebral? Was I looking for “truth” even though I do not believe in such a concept?

I needed help. So, in June, after months of sitting on her interview, “saving” it for last, I said to myself, “How do I write this up in a way that is honest but open?” I knew, above all else, I had to be honest. I knew I had to let my readers and my participant know my thoughts and my feelings. I had to maintain the dialogical and reciprocal nature of the project. Even though it makes me nervous...

I decided to call a friend. A trusted peer that I knew would be able to help me come to grips with Jackie’s story and make peace with my overall interpretation of her story as appearing more positive than I felt possible, and thus, somewhat off. I gave my friend the blow-by-blow of Jackie’s story, reading some of the transcript for her, and providing her with my impressions of Jackie when I sat in the interviews with her. We went back and forth. Maybe journal entries would be an effective way of showing what could be her internal thoughts that were not spoken during the interviews. Maybe I should include my own reflexive notes throughout the story, allowing the reader to grasp my struggles as the story progressed. None of this felt right. It did not feel like Jackie.

“Some of what she says is just so matter of fact,” I say, hesitantly. “And… she’s just so young.”

“She is young,” my friend validated.

“And, well, she sounds awfully mature for someone so young and someone that has gone through so much. The way she talked to me was as if she had her story already written. She knew what she was going to say even before I asked the questions. She’s really comfortable with her story.”

Huh. Just the facts. That sounded right. Just the facts would be the best way to show readers Jackie’s very well put together story. It was a story that I certainly did not interfere with as she was telling it, so why impose myself in it during the representation phase? As for my uncertainties about it, whatever might be underneath her story that I did not get, I figured I would never get. I never asked and she never offered that information. Staying with what happened in the interaction between Jackie and I was the most honest representation of her story.

“You’ve got to find a way to be honest with yourself and your readers, though,” my friend cautioned me. “You can’t pretend you weren’t confused or suspicious.”

“Yeah. I know,” I said, already drafting this preface in my head.

So, it is time to finally start typing Jackie’s story.

Jackie gets lifted up from beneath the rocks

Ok. I’m going to try to start from the beginning so I don’t get confused.

I was born in Atlanta, Georgia, but I moved here to Illinois when I was a young child. I’ve been living in Mayfield Park. When I was younger, about five or six years old, my biological mom and dad left. My dad left because he was very abusive to my mother before she left. My mom left when I was about six and dropped me off at my grandparents’ house and said she had to go find herself. I remember her leaving but I don’t remember my dad. I just remember my mom.

So, my grandparents adopted us, I think at age seven. My two biological sisters were adopted also. I also have an adoptive sister that we adopted about three years ago. She was one of my friends and her dad gave us permission to take guardianship because he felt like he couldn’t take care of her anymore. Anyway, my grandparents adopted us. So, now I call them Mom and Dad. We’re pretty close as a family. As we grew up, we kind of parted. We kind of became a little bit more… not as close as we were. I think I was pushing them away. Truly. Because I didn’t want to get hurt… like I did before. With my parents.

So, when I was 12, I started going to the Junior High. I had a best friend that we never went a weekend without seeing each other. We never went a night without calling each other. And she died unexpectedly. No one knew why or how she died. So, I felt like I was left alone a little bit… That’s when my depression really sank in. I was depressed as a child just because I felt it was my fault that my parents left. Like, if I was never born, then they wouldn’t have left my sisters.

But, my friend died. Whew… She was a piece to my puzzle. She really was. And I lost her. So, that’s when my depression really sank in. That’s the first time I tried to kill myself. It was at school. I was… just about 13 at the time. And I tried to kill myself at school by cutting my wrist. And, well, they sent me to Brookville (that’s a hospital) for the first time. At the time, the doctor put me on a lot of different drugs to help with the depression and stuff, but I felt like the medicine was living my life for me. Really. Because… I didn’t feel like myself.

So, I got out of there, and I continued taking my medicine, thinking I was going to be able to move on. Then, when I was 14, I started high school. My freshman year was
probably one of the most difficult, because you’re new and it’s not that great. But I had a
friend, a guy friend that grew up with me ever since we were in kindergarten. He was
really trustworthy and he was a really… a good person. I noticed during freshman year
that he took special interest in me. And I thought, ok, you know, I think that’s pretty
normal.

Well, one day I was in the girl’s bathroom, and I was washing my hands. And all
of a sudden I hear the door close, and I looked and he was in the girl’s bathroom. I thought
maybe it was a joke or something like that. And I asked him, “What are you doing?” And
he looked very angry, and he pushed me against the radiator in the bathroom and into a
stall. And… he raped me. I don’t know… I couldn’t breathe. I felt I couldn’t move or
fight back. I felt paralyzed.

But when he was done, I was able to go – I was crying, and I tried to go down to
the office and tell them what happened, but I was really scared, so I only told them that he
touched me. I was really scared and I didn’t want… I was just really scared. I was a
freshman in high school. I didn’t know these people in the office. So, I went down there
and told them that, but they just had me write down a statement. They called my Mom and
Dad and I went home. They didn’t call an ambulance. They didn’t tell me to go to the
hospital or anything. I felt like they didn’t care, like it was a normal thing to them.

Almost.

I’ve been home schooled since freshman year… half of freshman year. I tried to go
back junior year… and it didn’t work. I left. Then I tried to go back senior year, thinking,
you know, senior year will be ok. It’s the time of your life! Or whatever. As they say.
But it didn’t work out. I found out that the guy that raped me was in my class. And in my
lunch. I just dreaded going to class and to lunch. He’d stare at me and he’d circle the
table… glare at me and stuff like that. The reason he didn’t get into trouble is because I
told them that he only touched me. Being scared of everything that would happen if… if I
were to say the whole truth.

We went to court, actually. I had a restraining order on him, so he couldn’t be in
school. He couldn’t go anywhere near my house. At the next hearing, he was allowed to
fight the restraining order. We both had to give our testimonies, and the judge said that
there’s just not enough evidence. Our stories didn’t match up. I told them everything up
until the rape. I told them everything. I told them about the touching and all that, but I
never told them about the rape. I was so scared. So this guy, he fought the restraining
order and the judge said there’s not enough evidence to continue the restraining order.

I only admitted my rape about a year ago. I kept it inside until I was 17. It tore me
up. It really did. I finally told my counselor, and it felt almost like a relief. It was like
there was this weight lifted off my shoulders. I mean, it was very painful, but it was still a
relief. Really.

Anyway, after that, I went to a residential place in Indiana for four months because
of depression, suicidal thoughts, and aggression. I was upset and angry with myself and I
hated everyone. I felt like it was my fault, like if I hadn’t become so close with the guy, it
wouldn’t have happened. Anyway, I felt like the residential place was almost like the
hospital. They stabilize you as long as you’re there and they expect you to go out and be
better. And the psychiatrist there was… he was not a nice guy. He was pretty mean. He
made comments about you and how you need to just move on and stuff like that.
So I was done… I got done with that program. Well, my insurance ran out, so they brought me home. My parents brought me home. After that, I was just very upset and very angry all the time. My moods were all over the place. I was up one day, down one day. And I was labeled Bipolar. So, they put me on different drugs, like Zoloft. (Now I’m on Prozac for depression.) They put me on a whole bunch of different drugs, just to try it out, but now I’m set on Prozac and some other mood stabilizers to have me evenly… like… figure out my issues and stuff like that. But, back then, when I had that first doctor, he put me on so much of it. Too much.

Anyway, I came home from the residential place and I tried to kill myself… three more times. Since the residential place, I thought that nothing could get better. I thought that this was the worst it could get. That’s how I felt. I was always depressed. I was always down. I didn’t want to get up. I didn’t want to do anything! So, I tried to cut myself again, which… didn’t work for some reason. I used glass, but it didn’t work. I mean, I was cut, but it didn’t work like I was trying to get it to work. Something was holding me back, even though I fought it. (Maybe it was God?)

So… I tried to OD… on some sleeping pills I had. And so I was taken to the emergency room. I was pretty unconscious, and then when I woke up, they were giving me charcoal. They said, “You can either drink it or we can put a tube up your nose” or however they do that. And, so… I just drank it. After that, I was at St. Luke’s, another hospital around my hometown. They transferred me to Brookville again because my psychiatrist was there. For the third or fourth time, I’m not sure, I went back to Brookville. This was the last time before I came to GROW.

At the hospital, we had groups. We had groups on different issues in different people’s lives. They didn’t try to… I mean… there was more than just me there, so they didn’t try to just focus on me. When we did do individual therapy, you do that with your psychiatrist. They figure out what’s going on, they try to change any meds if the need to change them. Increase. Decrease. Just try to figure stuff out. Try to figure out what’s making you feel this way. And I was told I had a chemical imbalance, and that I didn’t have enough endorphins or that they were, like, going against me instead of for me? Something like that. I’m not really sure what that’s about. But I wasn’t labeled as a person. I was labeled as a… label. I was labeled as Bipolar, Major Depressive. They were just kind of… I had a number, label, and they just treated me and let me go, pretty much. That made me feel really bad. I felt like I wasn’t worth much.

I think I thought of myself as a disaster. That’s kind of why I had suicidal thoughts. I thought of myself as not worthy enough to be on this earth. I think the different places I went to, like the hospital and the residential place, I felt like they failed. They made me feel like… either I didn’t put enough effort into it or I wasn’t worth enough to get help from those places.

My parents were also pretty much fed up with me trying to kill myself because my parents felt that that’s the coward’s way out. And, I think my parents were scared at the same time, not knowing what was going to happen. So, they refused to get me from the hospital. I was 18. They said I could go anywhere I wanted, and the hospital gave me a choice of the Salvation Army, which is kind of like a homeless place, GROW, or a nursing home. And someone told me a nursing home is just a dead end. And I knew I wouldn’t survive in the Salvation Army because… you just sleep there and they’ll get you up at a certain time and you have to leave for the whole day and then you come back to sleep. It’s
not like you can stay there all day. I didn’t… I felt like I couldn’t make it there because there’s not therapy there. It’s just all on your own.

But, needless to say, I chose GROW. I got released from the hospital a day before I got here. And I was very skeptical and very iffy about coming to GROW. I didn’t know what it was, really. I had no idea. I thought maybe it was just another residential place that was just going to get you stabilized and throw you out there again. The people at GROW described it, you know, but I was so close-minded at that point that I just thought that it was not going to work.

So, the night before coming to GROW, I was contemplating suicide. Again. I was like, “I don’t want to go to GROW, I don’t want to go to the Salvation Army, and I don’t want to go to the nursing home.” But, I was able to tell myself, let’s just try it out. So, I chose GROW, and I had an interview at the hospital with the coordinator here and it was really good. She told me the basic stuff. I told her my story. I was crying and I told her that I just have to get my mental health back. I can’t… can’t live like this anymore. And she asked me a couple of questions, like, “Is this just trying to get out of your house? Just trying to get away from your parents?” Just asking. Then I said, “No, this is trying to… get me to be a whole person again.”

And not even three hours later, she called back and said I was accepted. It felt really good. But… I was still skeptical. I was. And, at first, my parents weren’t very supportive of this place. They thought it was me trying to escape the problem instead of trying to work it out at home. They knew about GROW. They had a friend that used to work here. But they didn’t… they just weren’t supportive of me coming here. But now, as they’ve seen me grow in many aspects of my life, they’re very grateful to GROW.

So, I got here the next day and I had my bags packed and I came in. My dad brought me. (My family is going to visit tomorrow, actually. They’ve been very supportive… after the fact. I haven’t really seen my sisters or anything since I came.) At first, I was really homesick… the first few weeks. Very homesick. I wanted to go home. And a lot of people do. A lot of people, sometimes, if things get rough, they pack their bags and want to go home. And then they figure it out, you know? This is a once in a lifetime thing. You can’t just leave. It is a small piece of your life that will change your life forever. So, sticking to it, I will never regret coming to GROW.

But, it was very, very, very nerve-wracking the first time coming here. Truly. I didn’t know anyone. Just very nerve-wracking. But over the first few days, I got adjusted. I was talking and… I don’t think I admitted to them about the rape until two weeks in. It was an issue, and I needed to bring it up so that the group could help me figure out different ways besides just medicine to cope with it. Because one of the wisdoms we learn from the Blue Book is that you get exactly out of this program what you put into it. And we have a 12-step program here and it really works. And we have a little Blue Book. It works really well, too. It almost has all the answers… The book I was looking for my whole life. And it probably doesn’t have all the answers, but for most situations, it’s there. There’s different steps you can use, just different things like that. I’m still getting used to the Blue Book, so that I can memorize and just try to apply it daily.

I mean, looking back, I see… someone that was… at rock bottom. Someone that was at the bottom of the barrel… that was lifted up. I came here with very low self-esteem, and it was actually in the Blue Book that I learned about personal value. They accepted me for who I was. Personal Value – it’s in the Blue Book. And you have to
study it and give an understanding and just read it over and over again. It makes you realize that no matter how bad your physical, mental, social, or spiritual condition; you’re still a human person loved by God and a connecting link between persons. You have your unique place and unique part in God’s work. I really believe that. It helps me along. It makes me feel really good. It makes me feel like I have purpose. I usually read Personal Value every night before I go to bed. Sometimes if I get upset I’ll go and get the Blue Book. I usually carry it in my back pocket, but I haven’t been doing it for a couple days. I just forgot, I think. But I usually keep it in my back pocket.

I’d definitely say that GROW is very different than the other places I’ve been. It’s... more structured. It’s more personal. It’s more... it’s a close-knit community. It’s more... almost like a family. Seriously! So, on Monday mornings, we have what’s known as a GROW group. You bring up a problem. You bring how you’re feeling. And the group gives you feedback. How can you make this better? How can you cope without totally losing it? They give you what’s known as a practical task. It’s something out of the Blue Book that you can work on during the week or during however long you need to work on that issue. They do this because they don’t want you to just go into your shell and just never work anything out. That’s not healthy and that’s not going to get you anywhere.

It’s really fun when we do things together, as a family. As a household. On Tuesdays, we go to the library at night. And Wednesday nights we have a family game night. Thursday at 3 we have bowling and we cheer each other on. Friday night we have free night. Saturday we have an outing in the community. Oh, and Monday night we have a family meeting. And on Saturday nights we have family meeting. Sundays are really laid back. On the weekends, you get up at 8:30. You get a nice hour and a half extra to sleep! We go out to eat on Sundays to some really nice restaurants. I mean, in the other places I’ve been, you wouldn’t even be going out... anywhere. We’re very active here. You’re always doing something. It’s not like you can sit and dwell. And some people do dwell and you just got to motivate others, like, “Alright! Come on! Let’s go!”

I’ve always been one to help others, really. But, when I first heard about this principle of mutual help: The more I am maladjusted, the more I need help, yet to grow out of maladjustment, I need to become concerned for and to be helping others... to help others and to help yourself help others and let them help you, it made sense. It’s more like a two way street and a friendship. You know? They’ll help you and you’ll help them and you’ll grow stronger together. Mental health can’t be taught; it has to be learned together.

Right now, I’m on the kitchen team, so I do chores in the kitchen. I do prep for the kitchen. I do lunch for the kitchen. I’ve noticed that my cooking is getting better. And before I was on the kitchen team, I was on the housekeeping team. I kept up the house. I think it was hard for me to want to do these chores, sometimes. I didn’t have a lot of confidence in myself. So, I felt like maybe I’d do something wrong and then somebody would be upset with me. Something like that. But... I’ve been better. I mean, it’s getting better.

Basically, it’s just real acceptance here. You feel comfortable bringing up things in your past that you need to work on. Issues in the daily life, and stuff like that, because you know you’ll get support from everybody else. Everyone has a different perspective on different things. So, you get so many different perspectives and you just take them all into account and you sort through what you need to sort through. And I’m not going to say that every day is perfect. Because it’s not. Some days you wake up and you don’t want to do a
thing here. Some days you have bad days because there’s so many different personalities here. And it’s because there are so many different personalities! It stirs things up so that you can work on what’s bothering you.

It has made me a more open person. It has. I came in with an open-mind, and then it kind of closed up the first few days. They would check on me, and say, “Hey, Jackie, are you ok?” Or, “What’s going on? How are you feeling?” Not too pushy. Then, I noticed how everyone was accepting of everyone else and how everyone cared and loved everybody else, so, that just opened my mind back again. I mean, surprisingly, I never admitted the rape to my mom until I got here. And it made me feel really good and really confident to have them say, “It’s alright. It’s alright. We can move through this. We can. We can get stronger.”

My attitude towards life changed when I got here, pretty much. I see that my life has greatly improved with GROW, and I can see that my growth isn’t over. I’m still kind of transforming. At the same time, I’ve just seen a drastic improvement, because, before, I thought, “I’m a disaster!” This whole life that I’ve led is a disaster. And now I see that things happen for a reason and we have purpose. We’re put here for a reason, with these people… for a reason. We were put here together as residents and staff all at the same time, because God knew we were going to learn from each other. He knew that we had different personalities, but that at the end of the day, we would all love each other. And we would all care. And we would all be there and accept each other. It feels like this is where I’m supposed to be. Really. It feels like I’m finally going to be able to get help and become whole again.

And, you know, there’s still something about a chemical imbalance. But, I know that in time, or as GROW would put it, the goal of treatment is the end of treatment…. Meaning that we can wean off our medications and know how to live daily without a dependency on a medication. I’m not saying that if you don’t need a medicine you just don’t take it. They search into things here. Like, are you always depressed? Then maybe you do need a little bit of medicine to just boost you up a little bit, and then you can work through it. Maybe later on down the line, you can know how to make yourself happy. Know how to become happier in your daily life. So, they will take you off your medicines. Of course, they’ll want you to be off medicines. They don’t want you to depend on that. But, some people like to wean off of medicines here to just to see how it goes. You don’t want to be out in the community and wean off your medications and… just… lose it.

I think recovery… I think recovery, for me, would be being in daily situations, being out there in the community, working. Recovery would be knowing how to deal with issues without becoming suicidal, without becoming angry. I mean, people can become angry or upset, but without taking it to the extreme. I think that when you hear testimonies of others… We have a couple people here that actually went through the program and now they’re staff or volunteers. And they’ll give you their testimony and you’ll say, “Wow! Look at how they’ve recovered from all the crap they’ve been through! From all that stuff!” And they really move. They really expanded their horizon. They really just… it blows me away how some people can go from dirt bottom to way up there and just helping others. They’ve become so helpful and so relaxed about their testimonies, like, “This is what I’ve been through, this is how I got over it, and you can, too. I have faith in you.” It gives me hope! It gives me hope that there is a tomorrow. That I will get better, no matter what.
I don’t think you’re ever done with your issues. But, I think you learn here how to cope better with them. I deal with my issues differently and I think about them differently. When I used to think about them, I used to think this is the worst thing! Nobody knows why or how I feel. But now I know people do know how I feel. People here accept you for who you are, and they teach you how to cope with different situations. They teach you different ways to relate to each other. Different ways to… to just become closer as a community and a family. I think that… everyone here understands me.

In terms of my future, I will walk around as a person, not a label. My future is definitely different than what I saw for it before I was here. I didn’t have a future. That’s why I tried to kill myself. I just felt… that nothing can get worse… nothing can get better. I have no future and I’m not needed in this world. But GROW has given me hope for a future. And strength… confidence. Acceptance. Love. You grow every day. You learn something new every day, and you grow every day. And I want to give back what was given to me. I’ve always wanted to be a pediatric nurse. But, now I’m thinking that I want to be maybe a part-time nurse and a part-time social worker. Part-time staff here, even. Let people know that everybody has a chance.

To close, I have to say that in the past, I just felt like my world was crumbling and I had nowhere to go. Then I would be under all the rocks after the world crumbled, and I wouldn’t be important. I wouldn’t have a purpose in life. But our three vital needs, as we would say in the program, is to be someone, to be going somewhere, and to be at home. I feel all three of those things now. To be someone is to be unique. Like an individual. Worth. So, to be going somewhere is like purpose and progress. And, to be at home is loving and harmony. Just be at home with yourself. I’ll probably always have to work on these things, but they’ll be there in my future. And I will always be eternally grateful for the GROW program and the people in it.

Postscript: Mea Culpa

Approximately two weeks after finishing a draft of her narrative representation, I sat down with Jackie to talk about it. We hugged again in the dining room of the GROW house when I greeted her, and I noticed she was quieter than last time we met. More pensive.

“Six months,” she told me when I asked her how long she has been at the house.
“How are you doing?” I asked.
“Good,” she offered, with a slight shrug of the shoulders.

We sat back down on the couch in the living room, I turned on the recorder, and we went over her reflections and feelings about the way I wrote her story. Jackie began flipping through the document, and she showed me that she had gone through, page by page, and written in neat, little handwriting in the margins comments, questions, and additional sentences to be tacked on to certain paragraphs. I had come prepared to guide her through this process of discussing the narrative, but Jackie took the reins. She was in control. Prepared. It was then I realized that Jackie was thorough. Honest. She did not hold back. I was concerned that my participants would not tell me what they wanted or needed to see in my representations of their narratives, but Jackie was up front with me. She even called me out on some grammar and spelling errors that had slipped by me when I sent her the story.
Oh, boy, I thought. I totally read her the wrong way! Here she was, being completely honest with me and I had doubted her. So, I swallowed deeply, feeling my heart flutter quickly underneath my skin, and fessed up.

“Jackie, I got the sense, months after we talked, that you’re so young but you’re so mature… and when I think about all that’s happened to you and how young you were when… you first attempted suicide, and it sounds so different than the person that I saw in you which was just this very happy, bubbly person. And it just, for me, I was like, ‘I can’t imagine Jackie being that way.’ Do you know what I mean?”

“Mhm,” she nodded, waiting for me to ask a question.

“What do you think I was feeling when I thought that?”

Jackie calmly explained to me that, quite simply, GROW had already had a huge impact on her life and the way she viewed her future. She explained to me that the amount of effort she put into the program was immediately and equally exchanged for positive growth and development. Her mindset and attitude, not only her behaviors, changed drastically. It was a hard process, but it happened. Not only that, but Jackie told me that she was “pretty good” at talking to people. She had learned, long ago, to put on two faces, one happy and put together, and another that was a disaster. The “disaster” face only really came out in really bad situations. And never in public. And probably not with me, I thought.

It was then that I think I got it. As she explained this to me, I watched, in my mind’s eye, Jackie making it through each day, putting a smile on her face despite the anger, disgust, guilt, and fear she felt on the inside. I imagined her feeling the pain beneath the smile and pulling out her ragged copy of the Blue Book and reading Personal Value one more time, even though she had it memorized. I saw her in the groups she attended, listening carefully, taking notes, and talking openly. Whatever hidden parts I thought were underpinning her story evaporated, and in their place I simply felt Jackie’s struggle to be well. For her, the happy side of things was finally starting to overshadow the disastrous, perhaps, and I had been too cynical, too analytical and academic, to notice it.

So, Jackie, I am sorry it took hearing you explain it, yet again, for me to finally listen and stop doubting. I am so happy for your success. Thank you for your lessons.

Dan

The Start, Spirals:

I’ll try to make it short, but start early. I’m from Chicago. My father died when I was a little kid. My mother died when I was in my early 20’s. When I was a kid, I knew that there was something completely different about me that I couldn’t figure out. I was just emotional. I was always up and down throughout the week. It’s hard to say. But it was kind of like I just felt like other people had all the answers to everything and I didn’t. Like a book with all the answers that I didn’t have. I just couldn’t figure it out. That’s how I felt when I was a kid. Everybody else knew how to deal with things and I would always be letting things get blown out of proportion or getting into trouble.

And I was sexually abused from when I was 8 to 11 years old.
All I could ever think about were those incidents.
I started smoking pot when I was 13. And, when I got high for the first time, it was like the answers to my prayers. I didn’t have to think about anything anymore. So, at 13 I was hooked on marijuana. When I got up into high school, all I did was party. I skipped school a lot – for three months at a time – just out partying with friends instead of going to school. When my mom found out about it, I said that, “Oh, it was just one time,” and I convinced her it was something I didn’t like and I wasn’t going to do anymore. But she didn’t know why I liked it. She didn’t know about the abuse. I never told her. I kept that to myself. Nobody knew about it.

So, the drugs started to affect my school as much as my behavior. One night I threw a huge party while my parents were out of town, and I destroyed my step-dad’s car. I didn’t know how to drive and I ended up blowing his engine. When they came back, they found out about it, my mother and step-father threw me out of the house. I was 16. I stayed at a friend’s house for a few months and then came back. They told me to come back, and the day I went back they put me on a plane to Omaha, Nebraska for a boy’s program out there for rehabilitation. It was a good place, but I continued smoking.

*I was addicted to the high.
It was a big escape.
‘Cause anytime I wasn’t high I’d have nightmares
And I’d have racing thoughts and images in front of my mind
That I just wanted to push away.
And I did.
The pot did that.
I can say it did something good.
And that was it.*

I ended up getting kicked out of the Omaha Home for Boys when I turned 18 because I had been caught a number of times smoking. It’s the reason I got sent there and the reason I got kicked out.

*They put me on a bus with $25 back to Chicago.
My parents wouldn’t have anything to do with me.
They just said
“You know, you’re 18.
You made your bed.
Lay in it.”*

I ended up having to stay at a friend’s house and get a small job and then start living on my own. It was very hard. Very hard. For many years. But I did it. I couldn’t afford the pot so I was constantly thinking about the stuff. I could never get this abuse out of my head and I always had extreme anger for the person that did it. But, also, my emotions started getting even more radical. The only way I can say it is that I had these extreme ups and these extreme downs. I mean, when it was going good, it was really good. But when it went bad, it was really bad. And I would fall into these depressions,
but, the funny thing is, is the work that I did get in ended up being relatively good work. And it’s the one thing that I’ve done in my life that’s good. Is that career.

_And so_
_I began to live one life at work_
_And I’d go home and live another life._

When I came home, everything was a disaster. I did it for 20 years. 20 years like that. What happened between, say, when I was 18 and when I was 30 was like really just…

_Get up_
_Go to work_
_Come home_
_Eat_
_Sleep_
_Get up_
_Go to work_
_Come home._
_Over_
_And over_
_And over._

And still with severe depression. It’s just one of the things that I was able to do was turn it off, hide it, when I got to work. But, it came back on whenever I came back home. I didn’t know what it was though. Between my 20’s and my 30’s I would never go to a doctor and tell them what was going on with me because I was embarrassed. I didn’t want somebody to say, “Ok, you know what? You’re just crazy. And we’re just going to have to put you away and that’s going to be the end of it.” That was what my fear was. That I was losing my mind and everybody else around me was just going on with their lives. I didn’t want them to find out. It could just be a figment of my imagination. In my 30’s, things started going south. Around 34, I started missing work.

_I would be so depressed that I would sleep all day._
_They could be ringing the phone all day long_
_And I wouldn’t wake up._
_I was just in this depressed stupor._

I’d come up with all these excuses. I’d say that I was stuck in a snowstorm and I couldn’t get back and I couldn’t call anybody. I’d say any lie that I could to make it sound reasonable as to why I’d miss work. And they started getting suspicious. They appreciated the work that I did do so well that they ended up making excuses for me! But, say, the fifth or sixth time that I missed going into work, I got so worried that I was going to be fired that I just quit my job. It was a $60,000 a year job that I just said, “To hell with it.” And I just kept spiraling down. The depression got really bad. After three or four months, I tried to pull myself up out of it. And I found another job. Never had a hard time
finding a job. For even more money. So things were going better for me. Then, within six months, I started falling into that trap again.

Where I was getting depressed.
Come home
And sleep.
Over sleeping.
Waking up late and not wanting to go to work.
Making excuses to this new place.
And it happened again!
I woke up one day and I was late for work and I just said,
“You know what?
I know they’re going to fire me today.
And I don’t want to get fired.”
So I just quit!
I did it again!
I just couldn’t deal with it anymore.

When I had my depression, I always had my work to pick me up during the day. But then, you get used to things that work and it’s not so special anymore and it’s just living another day. So, the depression would bring me down even more.

I got another job, and three months later – it was a shorter span of time each time – three months later I started falling into the exact same trap. I was getting paid even more money, and I ended up giving up that job trying to avoid being fired.

And after a few months
I got another job.
I ended up...
I ended up starting to do cocaine.
That’s when I ended up saying
“What the hell.
Maybe I need something to pick up.
To keep me going.”
I got hooked on cocaine real quick.
Real fast.
And real bad.
Over the course of another year or two
I lost
My family.
My one friend.
My work was gone.
Everything just went.
My finances went into a hole.
Everything just disappeared.
I tried to commit suicide.
I tried to overdose on drugs and pills.
Just end it all.
And I did a lot of them
Thinking there’s no way I’m not going to die doing this much.
But I woke up the next morning.
And when I woke up the next morning
I was so devastated because I had spent every dime I had.
Nobody wanted anything to do with me.
I was just a mess.

Absolutely everything I had was gone. I was kicked out of my apartment because I couldn’t pay rent. I began living in a friend’s apartment. I’d sleep on the floor in her living room. I had myself with my computer there. And that was my life. It was really bad. And I got caught up in drugs again. I just kept getting worse. Knowing that I was hooked on cocaine was the worst thing. For ten years I wouldn’t have a relationship with anybody because I didn’t want to drag them down with somebody who was addicted to pot and addicted to cocaine.

I ended up calling all these different places, trying to get into a drug rehabilitation center. It literally took me months to find a place that would let me in with no insurance, no job, no employment, no money. Nothing. I tried for months to find them and they kept saying, “You’re going to be put on a waiting list.” Until three months later, when I let them know that I had tried to kill myself.

And so I ended up calling and finally making the one plea, saying, “Look, this is the end of my rope. I feel like I’m going to kill myself today.” They said, “Alright. Come in and we’ll see what we can do.” They ended up getting me into this place called Read Mental Health Center, a state mental hospital. I checked myself in, and for a month and a half, I was there.

But that...
That place is...
It’s a mill.
People come in every day and leave every day.
All they do is just get you to say you’re not going to kill yourself
And they put you in a half way house or some shelter or something.
It’s a cycle.

You’d wake up have just some breakfast. Then you’ll have a meeting for a half hour and then exercise for 15 minutes. And then you’re on your own until noon. You can go back to bed, you can do whatever you want. There is no real structure. They have some groups that you can go to. But if you’re depressed, you usually don’t. And they don’t force you to and they don’t encourage it that much. If you go to sleep, that’s your deal. Well, I never did. I always went to the groups. I wanted to get something. Some help.

The thing is, the help there is just – there’s so little out of a whole day that’s productive. The rest of it, you’re just sleeping or playing dumb games or something like that. Their whole thing is they call those state hospitals “stabilization units.”
You go in.  
They want to stabilize you.  
Get you to say  
You won’t kill yourself.  
And then they kick you out of there  
And put you in a shelter or halfway house  
That’s going to put you right back in the same position again.  
And it did.  
It did.  
It happened to me.

When I got out of there, I got medication for the first time in my life.  Prozac and Seroquel.  At that time, having medication was a good thing for me because it helped even things out.  And I wasn’t so depressed.  The medication seemed to pick up where the drugs left off.  The medications I was on takes you from going up and down, up and down, to just being nice and even.  So, there was no withdrawal for me.  I got out of there.  I was in a better way.  I was on medication.

I lasted eight months.  
Then my doctor reduced my medications  
And then  
I relapsed.  
The dreams and thoughts of abuse returned.  
I started doing cocaine again.  
That was another spiral down.  
I hadn’t been working or anything  
But it got so bad again where I ended up trying to commit suicide again.  
The exact same way but a lot more drugs  
And a lot more pills.  
I still woke up the next day  
Like nothing ever happened.  
The weirdest thing and the most frustrating thing to wake up after that.  
You just don’t want to be here anymore.

Well, I ended up going back to Read Mental Hospital.  I signed myself into the same place again!  Back to the stabilization unit at Read.  It was the same thing.  I did the exact same thing because there was no other recourse.  You go through this thing.  There’s no other option.  It’s a half-way house, shelter, and there’s nothing else.  When I left Read, I ended up in a shelter.  Actually, I ended up living on the street myself for 2 months.  And then I said, “What the hell.”  It was winter and I was freezing, so I ended up going to the shelter.  But things kept getting worse.  This time I wasn’t doing drugs, but I got so depressed that I remember sitting at the harbor in Chicago and I was ready to jump through the ice and just…

You know.  
God.
That’s the best way to do it.
Just jump through the ice
And you can’t get back through and
It’ll be over quick.
Only...
The thought of the impact
On my little brother and sister
Stopped me.

So I went back to Read again. I checked myself into the hospital again. That was the last time. That’s when I got there I said, “You know what? I’m tired of you kicking me out of there, thinking that I’m not – there’s nothing bad going to happen to me. I keep trying to kill myself, keep getting suicidal thoughts! Nothing’s changing for the better for me. This is not working. You guys have to do something better for me or I’m going to keep coming back!”

Finally, A Glimmer of Hope:

And I ended up praying for the first time
Since I was a little kid.
Praying.
One night.
That something would come my way that would
Be better than what they were trying to push me into.
Something that would rehabilitate me
And make me...
Productive again!
I wanted to get better and go back to work!
And then
My social worker comes walking in
And she says that she pulled a scrap of paper out of the back of her desk
That has been there for years.
And she says
This is a place she doesn’t use anymore because the administration
Doesn’t let people go there anymore.
But maybe you could find some way to get yourself into it.
And it was for
The Residence Program at GROW
In Kankakee.
And it blew me away.
Because when I looked at the paperwork they gave me
It talked about
Truth
Character
And friendship.
And growth to maturity.
One of the biggest things in my life was I was living an immature life. All my decisions were awful.
And I saw their Blue Book.
And the first day I opened the Blue Book
It was like I was a kid again
But at least now I had the book of answers.
And it had all these good things in there that gave me answers for how to deal
With every situation that I had been dealing with.
I didn’t have the book
And now
Here’s my book!
This place has got to be the right place for me.
I think that there was a little gift from God there
When I got that piece of paper from my social worker.
Without that
I would never have come here.

I finally felt a glimmer of hope in my life. For the first time. After all this knowing that no matter what I did at Read, nothing was going to work. It was a glimmer of hope. And then, calling this place, and talking to them, I knew right away that I had to come. I did everything I possibly could to get into this place because I knew it was what I needed. They were taking interviews and I pleaded with them. I pleaded with them, I wrote letters to the administration of the hospital. And I ended up getting in!
It was an insane process. What they do these days with people that are mentally ill is sick. They throw them away. They just throw them away. There are a lot of good people that I have met, and one of the things about what’s happened to me is that I’ve been humbled. I’ve met people who live on the street… who are people. Who bad stuff has happened to and they can’t figure out how to get out of that circle.

But when I came to GROW, and I got accepted, and I walked in these doors, I knew. I knew this is exactly what I needed because even the staff was people that have had problems themselves in their lives. Those problems run the gamut of things that could happen to people in their lives. So, some of them have been through this program themselves and graduated. Some of them have just had problems in their life and so they can relate to you. One of their first principles in the book is personal value. It’s about that you are somebody. You’re a connecting link between persons. You have value; you have a unique place and part in God’s work. They make you feel, from the minute you walk in this door, that you matter again. And after feeling like you don’t matter out there, it’s a huge thing for somebody to walk in here and feel that. I have more family here than I ever had in my real family in my life. Everybody here accepts you for what you are. Sure, things have gone wrong in your life. But you know what? So did everybody that’s here, something went wrong in their lives! And they’re moving ahead. I mean, these people change using this program!

All the work is done by the people that are getting well here. That’s the weird thing. And the staff does a lot of work, but at the same time, they try to put it in our hands. I would never have thought of something like that – putting the mental health recovery in the hands of the people that are recovering. But it works. When I came here they called
me “high functioning.” When I came here, I couldn’t understand how I was going to put
my mental health in the hands of somebody who was even lower functioning than I am.
But it’s funny because it doesn’t take much. It takes knowing what you need to get well
and be willing to help another person. And that’s what every single person here does.

I wish I could find a way to express what this place does for you.
It’s hard
Because the words don’t always fit.
It’s just something you know.
It’s like light coming on in your life
For the first time in your life.
This place is incredible.
Walking in here, I felt weak.
I felt hopeless.
I felt useless.
I just didn’t know why I was even worth the trouble.
Right now
I see my strengths.
There are weaknesses I had when I came here
That are now strengths for me.
I feel like I’ve done a lot for the people that are here
In giving back to them.
The hope that now I’ve got the tools that I need
To go on with the rest of my life.
I’ll be able to do it without falling backwards.
That’s huge!
It’s just a whole new...
They call it a whole new self.
You’ve never really even known yourself
Until you’ve come here and rediscovered some of the stuff
That’s inside of you.
I feel nothing like I did when I walked in these doors.
Nothing like it.
And I’ll still be here a while
Because there’s still things for me to work on
At the same time
The change is dramatic.
I’ve seen that in a lot of people here.
Very dramatic change.
I’ve never seen that in mental hospitals.
I’ve seen people go in and out
In and out.
In and out.
Same people
Over and over and over again.
Their situations never change.
There’s a little of everything here at GROW. They don’t knock anything. For instance, in holistic medicine they may say that you should not take certain types of medications or see certain types of doctors, this place isn’t like that. We see psychiatrists if we want to. We have health doctors if we want to. We take medication as prescribed by our psychiatrists. And that medication helps even us out so that when we’re dealing with the hard stuff here, we don’t go into a huge depression. We can deal with it; know it for what it is, but do not fall into our old traps of ups and downs. Then what they intend to do is have you titrate off the medicines. People have done it. It works. Now you have these ways of dealing with things when they become a problem instead of allowing them to overwhelm you. So, you don’t really need the medications anymore, because now you have the life tools.

We have the GROW groups. We have one here every week. I was kind of surprised at that when I first came here, that there weren’t more. But it’s one a week and it’s for two hours. You deal with your problems and then you move on. Then you just live a normal life for the rest of the week. We go out, we go to the movies, bowling, games, go out to eat. You’re not enclosed here like a rat like you are in the mental hospital. You actually live a life together. We go everywhere together. We do things. We go to museums; we’re going down to Springfield on a trip. All kinds of stuff! The mental health rehabilitation comes in the living. Making mistakes during the day and if some of your emotions come out during the day, they use the program to help you to calm down, to help you to put things into perspective, to help you look around and say, “You know what? All this stuff is pretty good around us.” You take pride in what you’ve got, not what’s hurting you. And, it works! It’s a daily living group. All day long, without being a formal, sit-down group.

I used to live eight hours a day.
That was at work.
And that was it.
The rest of it was just... hiding.
You could call my life a hermit life.
I lived a hermit life.
I didn’t like going out
Didn’t trust anybody
Didn’t want to be with anybody.
And it isn’t going to be like that anymore.

When I first came here, I thought I would be out in a year. I was going to do everything I could to get out of here and get back to work. Well, my first three months here I made it to Stage 2. I did everything I needed to do to learn the structure, learn the program, learn the rules. When I got to Stage 2, I started dealing with some of my problems about the abuse and my father being an alcoholic, me skipping school, getting physically abused and verbally abused. All this stuff. I started dealing with all those problems and so I thought, “I’m on my way!” And then I applied for Stage 3. I was told,
“You’re not really ready yet.” I’ve never been told that. When I apply for any job, I get it. It was weird to think that I have the qualifications to have this, but they’re not going to give it to me.

I got a little frustrated. What’s going on here? Why would they want to hold me back? Well, it took a few more months to just let it sink in. It took me a few more months for things to start coming up. Problems that started coming up that I didn’t expect. One example would be dealing with some of the other people here. I got into a few situations with one resident who was always screaming and hollering. I helped her with everything I possibly could.

And then she started stabbing me in the back.
And it started bringing up feelings inside me.
She put me down and would say things about me.
And it brought up these feelings that I hadn’t had since I was a kid.
They were feelings from the verbal abuse from my older brother.
I never thought I’d have to deal with those feelings.
I just pushed them away.
Like that’s kid stuff.
Well, they hit home.
And hit hard.
And it took months for that stuff to come out of me.
And there’s more stuff that is starting to come out of me.

The feelings that are coming out of me are feelings that I didn’t expect. The thoughts that are coming out of my mind are totally different than just the abuse that I went through. The sexual abuse that I went through as a kid. There is all this other stuff that has happened in between that I tried to push away. So, they keep you here long enough so that stuff has a chance to come to the surface. They don’t try to push you out of here. If I had walked in here and they “stabilized” me like Read Mental Hospital did and sent me back out on my own and I started working again, I’d just relapse. I’d relapse. I would just spiral downwards. When I spiral down here, they’re always there to pick me up and help me work through it.

Walking in here, I felt weak. I felt hopeless. I felt useless. I just didn’t know why I was even worth the trouble. Right now, I see my strengths. There are weaknesses I had when I came here that are now strengths for me. I also feel like I’ve done a lot for the people that are here in giving back to them. I have hope now and I’ve got the tools that I need to go on to life by myself without falling backwards. They call it a whole new self. The change is dramatic.

Before and After:

I’ve been in the state mental hospital three times, and I came out of there the same way three times. Nothing like at GROW. When I walked in these doors, the main things that were going on with me were –

Loss of motivation
Lack of personal hygiene
Lack of social life
Financial irresponsibility
Paranoia – I had extreme paranoia.
I was totally delusional.
I had manic spending habits
I was a work-a-holic.
I wasn’t dependable to either my friends or family.
I talked to myself a lot.
Suicidal thoughts
Binge eating
Bursts of anger and depression.
Fatigue
Vivid memories of the sexual abuse.

When I went to the mental hospital, Read, I had every one of these symptoms. And all Read did was feed you, give you a very basic set of clothes and a very tiny little bit of structure for your day. And the people, the staff there, didn’t care about anybody. They were all angry, frustrated, annoyed at everything. They just wanted you to be quiet and just do your thing and get through the day. They don’t have any interest in forming a relationship with anybody. The amount of people that go through that place in one day is unbelievable… there’s always constant turnover.

And I was a bed. I was the-guy-in-that-room. And my name was Dan. That’s it. They diagnosed me there. But they didn’t do anything about it. They gave me medication, but they didn’t do anything to help me recover from my problem. It’s like you walk in with all these things that I just listed, they give you a medication to calm you down, but what they never do is they never taught you a way to deal with the problems that you have. Or to overcome them in a way that you can live with. It’s just a matter of, we’ll drug you up and then send you back out on the street again. I came in and out of that place three times, and every time I came out, they’d try to put you in either a half-way house or a shelter and it was the same thing every time. They didn’t do anything towards recovery. That’s the difference that I find at GROW.

All those things that I mentioned are things that I don’t have now. I have a tool to deal with it or it’s gotten to the point where I have dealt with it enough so that it doesn’t affect me anymore. My problems don’t run my life. I live a normal life around here. But what this place has that none of the others had is what really, I felt, was the most important.

A loving atmosphere.
You walk in this door and you are a person again.
You’re not just somebody that comes off the street
Or came out of a mental hospital.
You’re a person.
You’ve got problems.
They call them simple inadequacies or maladjustments.
It is not like you’re awful because this is what happened in your life.
No.
There’s something here that you couldn’t deal with
Because you didn’t have the right tools.
And so this is what you’re lacking.
But they do it
With love.
You walk in the door
And you get hugs from everybody.
You get taught personal value
That your life has meaning
That with everybody you deal with here
You are affecting their life in a good way
By helping them
And in doing so
They help you.
It’s called mutual help.
And the respect.
You get respect here.
It sounds like a trivial thing.
Like, everybody should just have their respect.
But for me
What it meant
Was that they care what I think.
They care about what I think and why I think it.
They didn’t just listen to you and say
“Yeah, yeah, yeah.
We don’t want to know about it.”
And everybody’s an individual.
Everybody’s treated as
“This is Dan.
These are his weaknesses.”
But they also want to know what your strengths are.
And what you end up doing is turning all your weaknesses into your strengths here.
They find ways to build upon them.
It’s not just stabilize you and get you out the door.
Put another person in your bed.
It’s about teaching this person what he didn’t know
Even before he got mentally ill.
Let’s teach him what he needs to know to avoid that happening again.
They do it through structured living.
They do it from the minute you wake up.
You have chores
You cook
You clean
You do everything that when you’re depressed
Just goes to the side.
Here
They focus on that.
All day long
You’re an individual
Who is here to live the program
To learn the program
And to learn to live a new life.
I think it really makes
A profound effect on your recovery
When people around you care.

It really does matter when you’ve gone 20 years of your life on your own and just don’t know what you’re doing wrong. The structured living at GROW is the best. And they have stages here where they call everybody a leader. And that kind of threw me at first, because one of the last things that I ever wanted to be in this world was a leader. Even at my work, I loved to do the work, but I never wanted to tell anybody else what to do. Well, from day one, you’re somebody who has influence in the community because we all run this place together. It just gives you a little bit more of a feeling of being a person to call yourself a leader and to train yourself to be a leader – to train yourself to do the things that you need to do to help others.

GROW has given me a sense of self-worth. Absolutely. A sense of self-worth. Hope. And not just hope, but confidence, too. Confidence. It’s brought back my spirituality, which isn’t the focus here, but there is support for it. And it is brought back big in me. Definitely hope and self-worth are the biggest. And confidence. Without those, you don’t have much! And if there was one thing that helped, it’s got to be the Blue Book. It has got to be. Because that thing, most of the time I carried that around in my pocket and if I was struggling with something, there would always be an answer in there. No matter how weird it seems at first, if you put this stuff to work, it works. It does work.

Here is a list of living habits, new living habits that they teach here. They sound basic, but when you don’t have them, and then you do, it matters.

Cooking
Cleaning
House maintenance
Gardening
Socializing with others
Community integration on the outside
Healthy eating habits
Personal hygiene
Financial responsibility
Volunteering

All that stuff. All that stuff is something that a hospital won’t give you. They won’t give you it at all. They get you stabilized, but they don’t help you recover. This place is helping me recover.
I was Dr. Jekyll and Mr. Hyde. I knew it every day. When I went to work, everything was professional. It was literally like turning out a light switch when I walked into the door at work. Nobody would ever know what I was like at home. And as soon as I would walk out that door, another switch would hit and I was on automatic. I’d drive home, if I had plans to do somewhere, I can’t tell you how many times I found myself driving straight home, forgetting I was trying to drive somewhere else. I did that so many times. I’d drive home, I’d walk in the door, work on the computer, get high, and I would go to bed. And then I would wake up and start it all over again. It just kept happening, over and over and over again. Every day. During the week, I just hid out at home. I didn’t want to go anywhere, didn’t really care to see anybody. It was a lot different. It’s kind of hard to think back now to the way it was, because it was so bad.

I didn’t have any value in myself because I knew it was all a lie. I knew everything I was doing when I got home was the real me. What was at work was just a façade that I put on that worked well for many years because I was able to maintain employment. Then it started to fall apart at the seams. I just couldn’t hold it together anymore. I started actually caring that I was living this second life and it was a miserable one. When I was younger, I thought I was slick because I was trying to hide it and I could get away with it. I didn’t want to get away with it anymore. I’d look at other people, and they had a life! You’d walk into work and people were talking about what they did during the week and you would always have to avoid their eyes or I avoided getting to know people because I didn’t want them asking me what I did on the weekends. I didn’t want them inviting me to go places on the weekend. I just wanted to stay in my own little shell, and you could tell people at work thought I was very different because I didn’t fall into their little cliques.

They say you hit bottom, but I’ve hit bottom about three or four different times before I got here. And there is no turning back for me. This place has given me a sense of myself that I will never ever forget. You could call it a turning point but it’s like a rebirth. It really is. What I am today is nothing like I have ever been in my life. What I have in my heart is a hell of a lot more than I have ever had. I have always thought of myself as a caring person, but when you realize what I did not have and what I have now, you see how much different it is. I used to say they’re giving me my life back, but I never had it. I never ever had what I know now and I never had the value in myself that I have now. To me, that’s incredible. There’s no price you can put on that.

The Future, Totally Different, Totally New:

Recovery means, for me, something different than it did at first. When I first came here, I thought I wanted to go back to the same job that I had; to the same life, but have the answers on how to deal with things. It is no longer about the money for me anymore. While the job that I had before was a great job, it was very stressful and it wasn’t rewarding at all. If I can find something that’s different, that is rewarding, and it could lie in mental health, it could lie in anything to do with helping people. The money, as long as I have enough to eat and have a roof over my head, I don’t care about the money anymore. The money never made me happy. It never did.

I don’t think anybody that comes through this program goes back to what they were, because you find things that you never knew you had here. I was the shyest person in the world when I walked in this place. And now, that has all blown out the window.
And it took time. When I first came here, the hope is what helped me talk and get involved with people. At the same time, there was that shyness that wouldn’t go away. And it took only a few months! It took a few months for 38 years of maladjustment to start fading away. That’s why they keep you here longer than most places would, because you are going to go through some hard times.

They have this part in the book that is a diagram that represents your recovery. It goes up a little bit and when it gets to the middle, it crashes down a little bit, and then it goes up more. There is that point in your recovery when you have done all the right things, but then the things that really hurt you starts affecting your recovery. The feelings start welling up inside you and you have to figure out how to deal with them. Then once you do that, you start moving up and onward and away from it all.

One of the moments where things crashed for me was about my family. When I came here, I was numbed to the whole fact that my family, every single member of my family, has turned their back on me. That started hitting me hard when I started realizing that there was some worth inside of me. I even called my father and got an extremely cold reception from him. I was just trying to do what I could to get my family back. That was a hard one. For a few months there, I was down. With that, it was a few months I was down. And then, with the next thing, it was a few weeks down. And then, the next thing, I was only a couple days down. It just gets easier to deal with.

And I still don’t have my family. I still don’t have the finances, the job, or anything like that. You know what? So what! I am going to figure out something from here. I know it will get better. I know that.

I’ve got some hopes. Finally. I’ve always been tied down by my job, and it’s always stopped me from doing the things that I wanted to do. One of them, it sounds kind of silly, but I want to move out to California and see how it is out there. I have got a friend out there, a good friend of mine. I would like to go see what it is like to live out there. I can get a job out there, do everything that I have always wanted to do, and if it doesn’t work, I can always come back. No big deal. What I don’t think I’ll ever do again is go back to Chicago. That’s the most, for me, depressing place in the entire world. And that’s where I spent most of my life. Everything that you don’t want in your life is there. So, I don’t think that I will ever go back there. That’s another reason I came here is to get away from Chicago entirely. Sever all my ties with anybody that I knew there, any situations that would cause me to slip back.

The thing is, I really want to start a GROW somewhere. Eventually.

My recovery, the whole idea of recovery, has changed. I don’t want to go back to what I was before… even without the depression. I’d like to take what I have now and put it to use somewhere. How? I don’t know how I’m going to do that yet. But, that’s my hope.

It’s a new self.
They say it’s recovery.
But how do you recover
From something you never had?
This is just totally new to me!

Reflections:
Here are some of the things I said into my voice recorder on the way home from GROW after my first interview with Dan:

My first interview with Dan I thought was so rich and so wonderful. So evocative. He speaks so affectionately about GROW and the kind of program that it is for him and what it’s been like for him there… And I get the sense that… this was really the one thing in the world he felt would work for him. And it did feel sort of miraculous the way he stumbled upon it. It almost felt like it found him. And… I think that piece of it, that, sort of miraculous finding of this Blue Book that had all the answers and I think that really relates back to his childhood of wanting to have all the answers that he never thought he could get. I think that part of the story… is one of the parts that really… highlights how important this is for him.

I must be honest here. I really enjoyed talking to Dan. Not only was he articulate, but what he had to say was exactly what I needed to hear. It might not be evident in what I am saying into my voice recorder here, but my heart is exploding with joy. Dan just told me a story that resonated so deeply with my expectations that hearing his words confirmed for me why I chose this project in the first place. On some level, I felt that I had found something. I had found a person that was living the experiences I only imagined in my mind. He was experiencing what I thought all people within the system ought to feel about alternative treatment programs. Dan was my affirmation. My confirmation. And he came into my life not a second too soon.

You see, when I began doing these interviews, I was the middle of my second year of graduate school, a time marked by the ending of a semester-long bout with depression. My doctor even told me that my trip to the hospital because of an unimaginably fast heart rate, a physical experience I went through three more times, was actually a panic attack, not supraventricular tachycardia or whatever they called it. I was not satisfied with graduate school, and the fog surrounding my academic endeavors haunted me every day. I felt lost in that haze. I felt that somehow, for the first time in my life, I was doing the wrong thing. I thought about quitting, actually. Just cut my losses before I spent even more time doing something that felt so disappointing. And even though I was on the upswing at the time of these interviews, for schoolwork and clinical work was improving, I still had the lingering feelings of utter dissatisfaction, listlessness, and dread within me. I was better, but barely.

That changed on my drive back to Chicago from Kankakee after the first set of interviews. That haze I felt hanging around me had lifted a bit. That feeling I knew so well, that feeling of being sad and disappointed with my choice to be in graduate school, was beginning to depart. At the time I attributed my mood change to an overall high from completing my first interviews as a researcher. Looking back on it, I can see that I felt better because I sensed that my work in graduate school was just confirmed in a fundamental way by what Dan told me. My crazy ideas and unconventional stance about much of the field of psychology (and psychiatry), my theories and ideas about how to get help for mental distress were all echoed through the story Dan told. That felt good. A
giant part of graduate school, my thesis, was unfolding in front of my eyes in a beautiful way.

For this, I will forever be indebted to Dan. Not only did his spirit and the power of his journey toward recovery inspire me, but also he challenged me as a researcher. I had to learn the difficult lesson of tempering my attraction to and excitement about his story with the restrained distance of an academic. I learned to ask myself uncomfortable questions like, In what ways did my connection to Dan blind me to certain interpretations of his story? Was I favoring him over my other participants? Could I be missing the impact of my other participants’ stories because I was infatuated with Dan’s? I needed to manage all of these questions while honoring the fact that, indeed, Dan’s story meant something to me. It was special. And in all honesty, this was one of the most difficult parts of the research process for me, not just academically, but emotionally. It meant coming down from the high I was finally experiencing in graduate school. It meant re-focusing and re-evaluating me as a researcher.

Despite the fact that I experienced a huge high from meeting with Dan and feeling as though the research process solidified my path as a graduate student, I ultimately decided to discontinue my graduate training after I completed this project. Odd, I know. Perhaps this was exactly the high note I needed to have before walking away from the academy for a while. Perhaps Dan and the other Growers helped me to understand that it is never too late to really explore yourself and your possibilities. Whatever the reason, and I assure you there were many, I can certainly connect what I learned from Dan and the other Growers to my decision to re-evaluate my life, career, and goals.

With that, I have a message for Dan. If you read this Dan, and I hope you do, I want to thank you for your story. My hope is that it changes others as it changed me.

Discussion

In this discussion, I first reiterate my goals for this project and the ways that they changed as the study progressed. I then outline common turning points about transitioning from mainstream to alternative treatment programs within the narratives. I next explain how narrative transformation is linked to recovery, and, more specifically, go into detail about the experiential elements associated with this transition. I also discuss the issue of the medicalized narrative serving as a subjugating force against an alternative, personally constructed and trauma-focused narrative. Throughout, I explain my rationale in representing the narratives in the Results section. I provide a number of research and treatment implications for how we, as a field, may re-construe notions of mental illness and recovery in light of these narratives. This research not only adds richness and breadth to the current literature on alternatives to mainstream avenues for recovery, but it suggests new areas of focus for those interested in people’s experiences as they progress toward recovery from severe psychological distress.

Research goals: A hermeneutically informed process

In this study, I was interested in exploring the ways that an alternative therapeutic setting’s culture and framework for conceptualizing mental illness and recovery were integrated into its consumers’ constructions of their personal struggles and outlook for the
future. I also was interested in articulating the experiences of members of an alternative, residential program for mental illness as they go through this kind of recovery process. I worked from the assumption that different treatment settings, for this study defined as either mainstream, bio-medically and psychiatrically oriented versus alternative, consumer-run programs, adhere to vastly different orientations for understanding what mental illness is and how to best recover from such distress. What I attempted to do was explore explicitly the effects of being in and being cultured into an alternative, user-run program on people’s construal of their personal struggles and on their conceptions about their future (Randall & Salem, 2005).

Furthermore, I generally followed the notion that mainstream, psychiatric inpatient settings and treatments tend to be dehumanizing, traumatizing, and ultimately not helpful to the patients in these settings (see Breggin, 1991; Goffman, 1961; Mindfreedom, 2008; Mosher, 1995; and others). Conversely, I presumed that alternatives to this type of treatment and construal of mental illness might be more empowering, humanizing, and ultimately more successful in helping people recover from serious mental illness (Chamberlin, 2004). I personally support the alternative movement, and my decision to interview people within this latter treatment setting was an intentional one. I hoped to bring awareness to the consumer-run movement and its successes through this study. I thought that by interviewing people in GROW, readers could begin to better understand that people can construe their psychological struggles in a very different manner than what is championed by the mainstream, biologically oriented framework.

As I began this research at GROW, it became clear that all of my participants had experienced the culture and practices of the mainstream, psychiatric mental health system, not just the user-run program they were currently using. In fact, I learned from the staff and the Growers that it was virtually impossible to find a person that explained his or her serious psychological struggles wholly outside of the discourse of the medical model. GROW usually comes into people’s lives after the mainstream system. This was an important discovery, and it changed the scope of the project. Another shift in the project occurred when I noticed that the narratives I was co-creating focused on recovery and the recovery process. With the exception of Melinda, who was still in the process of making meaning out of her psychological struggles, my participants told stories focused mainly on the changes that had occurred in their lives since being a part of GROW as well as their outlook for their futures.

Upon finding this out, my primary interests for the project changed. It was clear that I had to attend to how both mainstream and alternative explanatory systems were at play within my participants’ narratives. I needed to be concerned not only with the issues surrounding each person’s own ideas about his or her struggles prior to entering into GROW, but also how they began to change after being in GROW for a period of time. Given the differences in theoretical orientations of mainstream and alternative treatment settings, my hope was to elucidate what, if any, tensions existed within their narratives between mainstream, psychiatrically-oriented and more open and alternative constructions of their own mental illness and health. I also was interested in textually representing how that struggle existed in the participant’s personal narrative. Again, I must stress that these aims of the project arose out of the research process organically and were not, with the exception of the textual representation issue, goals of the study prior to beginning. I felt I had to include them in the project, as these issues were impossible to ignore.
What also became very obvious to me as the study progressed was that as I delved into and explored the turning point experiences of my participants, I found that my subjectivity could not be suppressed. I could not, it seemed, take the stories generated during the interviews out of the context in which they were created – a context that included me and my ways of knowing and interpreting. As personal construct theory (Kelly, 1955) contends, none of us can see the world except through the frame of our own construct system. So with that in mind, I made my frame of reference and my subjectivity clear to readers by including reflexive postscripts to each of the narratives.

Finally, and in the interest of staying reflexive, I must share with readers that the whole research process, for me, was a turning point in many ways. For instance, my own worldview became more complex in response to the work I was doing with my participants. I entered the research process adhering to very radical beliefs about what mental illness is and how to deal with it. I had lofty ideas about mental illness being myth, as Szasz (1972) so famously wrote. I also envisioned alternative residential programs to work best when there was no structure surrounding the day-to-day activities and the person seeking help could be there simply to “go down,” as Mary Barnes described her time in Kingsley Hall (1972). By spending time in the GROW residence and learning about the complexities of each person’s story, my rigid notions about these issues began to loosen. Inevitably, the interviews from that point forward probably progressed differently than they may have had I not been changed in this very important way. I hope that my readers understand the hermeneutic nature of this project, my part in it, and how the work continued to grow and change throughout the research process.

I continue to be changed by the stories we created in this study. In fact, as I began to put the finishing touches on this study, I decided to take some time away from academia. Working with the Growers gave me the courage to know that a fancy degree hanging on my wall does not necessarily mean that I am smarter or more capable of helping someone else. They reminded me that I have personal value as I am today and that what really matters is doing what will make me happy. And so, with that, I decided to take a leave of absence from my graduate training, and turn toward a new phase of my life – as a person, a learner, and a grower – unbridled by expectations and full of hope for what I might accomplish.

Common epiphanies

One of my primary goals in this project was to elucidate what my participants identified as turning points, or epiphanies, in their personal narratives. Upon reflecting on the narratives, I noticed a number of common moments that the participants identified as epiphanies, in the sense that these events marked important turning points in their lives, especially with regard to recovery (Denzin, 2001). I identified three moments that all of the participants recognized as turning points in their personal narrative – moments that signified a change in their life, worldview, or sense of self. These turning points were, 1) leaving mainstream mental health programs and experiencing GROW for the first time, 2) sharing a significant part of their story or struggles with the group and receiving mutual help from them, and 3) helping others recover.
Escaping the mainstream and finding GROW. The first epiphany I located in my participants’ narratives was the importance of leaving the mainstream mental health system and experiencing GROW for the first time, as each participant indicated this as a powerful and life-changing event. In fact, for Seth, the simple act of planning a way to get out of the nursing home was a meaningful, empowering event for him. Dan remembered the moment he got the paperwork about GROW, while he was still inpatient, as being a major turning point in his life. It marked a switch in his life where he knew that, finally, there was hope for him. In general, each Grower felt relieved to move away from a system of care that was not helping and was not making them happy. Although not every Grower involved in this study felt an immediate sense of relief upon walking through the doors of the GROW house, they all noted the importance and significance of experiencing the GROW program for the first time.

What is so meaningful about leaving behind traditional mental health programs? The Growers all mentioned that these kinds of treatment programs were not places you necessarily wanted to be, nor were they ultimately helpful. Dan, for instance, referred to hospital inpatient units as “revolving doors,” where people would just filter in and out without ever spending enough time there to get help. It was a constant game of stabilization, he said, and once that aim was achieved, you were back on the street without any real skills to help you along in your recovery. Usually, you relapse and end up back on the ward. And the revolving doors continue to spin.

Even the Growers that did not spend time going in and out of the hospital like Dan did, but rather spent extended periods of time in one treatment facility, reported on the meaningless they experienced day-to-day in their programs. Each of the participants noted that, although some effort was put toward helping the patients get better, the activities and programs offered simply fell short of actually being therapeutic. Seth was succinct about it, saying that the nurses “really didn’t care” about the groups they were running. Jackie reflected, with some resignation, that “They didn’t try to just focus on me” and said that she felt more like a label than a person. Each Grower attested to the lackluster groups and activities they were allowed (but not required) to attend, and no one felt that their individual needs were being met by these group therapy sessions or skill building activities. Thus, they constantly felt let down. In fact, after her four-month stay at a residential program in Indiana when she was declared stable, Jackie went home only to feel “that nothing could get better” and she tried to kill herself again. It seems that she felt worse after completing the program, not better.

Furthermore, and perhaps more disturbingly, nearly all of my participants attested to the damaging effects of institutionalization, including everything from the negative effects of psychopharmaceuticals to the dehumanizing way they were treated by staff. I will never shake out of my mind the image of Seth, strapped down and restrained while nearly blacked out from all the medications he was given and no idea where he was being taken, as he was whisked off to a residential center after a psychotic break. Or the pain on Jackie’s face when she told me how the psychiatrist at her residential program told her to just move on after she had been raped and tried to kill herself multiple times. Numerous first-person narratives as well as scholarly literature have documented the horrific emotional and physical abuse and neglect suffered by patients in mainstream institutions (Barnes & Berke, 1971; Breggin, 1991; Goffman, 1961; Szasz, 2004; Vincent, 2008). It is
not surprising, then, that all the Growers involved in this study signified escaping the mental health system as a turning point in their life story.

This, perhaps, is why first entering GROW and experiencing the GROW path to recovery was so meaningful and life changing for these people. Simply put, GROW is the antithesis of the mainstream treatment they experienced for so long. From the theory underpinning it to the activities it involves, GROW sends a message of personal value and hope to everyone that walks through the doors. Treatment is never coercive, doors are not locked, and recovery happens via peer-help, not hierarchical power structures. This format and framework seems to work and be accepted by its users (although acceptance does not always occur immediately, as I will discuss later).

If nothing else, our field should recognize how important it is for people to have other options outside of the mainstream discourse and institutions in which to find help and healing from severe mental illness. The literal act of leaving the mental health system does more than remove people from the damaging and traumatizing experiences that so often happen within mainstream institutions. It also means that the person can finally begin to re-construe his or her narrative outside of mainstream, medicalized terms, which is, as I will describe, an important step toward recovery.

The mere existence of GROW stands as a beacon of hope for those wanting to take their recovery out of the confines of the mental health system. Unfortunately, very little funding is available for places or programs like GROW, despite their successes; and these programs continue to close their doors due to lack of funds. The public, and, to a very large extent, the government, cherishes the power of the medical model and empirically validated treatments for mental illness. This makes it increasingly difficult for alternatives to mainstream treatment to stand as viable possibilities for users of the mental health system. Given these issues, programs like GROW and other consumer-operated or peer-run residential and non-residential programs may consider conducting research, much like Loren Mosher (1995, 1999) did with Soteria House, that would empirically support their effectiveness. Although Soteria House was forced to close its doors due to lack of funding, Mosher was able to empirically document the great effectiveness of non-mainstream treatment for severe mental illness. If others were to add to this literature, perhaps funding would find its way to these alternative sites.

Sharing one’s story. As the literature suggests, reconstruing one’s narrative is an important component of recovery (e.g., Holma & Aaltonen, 1995, 1998; Lysaker, Lancaster, & Lysaker, 2003). Adame (2007) discovered in her study on narratives of recovery of individuals that identified as a member of the survivor movement that there needed to be a clearing of “dialogical space” in order to make the move away from the medically-informed master narrative toward a more personally-created narrative during the reconstruction process. It seems that, from what the Growers said, both finding GROW and leaving the psychiatric system was an important step toward that end. In GROW they also get feedback from their peers about their individual progress through the program when they share personal stories with the group.

This opening of dialogical space seemed to happen during what my participants identified as a second turning point, the sharing of feelings or experiences with the group as they recited their “testimony” to the group. In GROW, group meetings are often centered on the sharing of personal testimonies, or accounts of one’s life. The Growers use
this group forum not only to share their personal testimonies, but also to provide one another with support and advice after the telling of the story. Weaver, Randall, and Salem (2005) talk specifically about the power of the community narrative that is formed through the telling and re-telling personal stories of illness and recovery with a group. In this way, group members are free to integrate their personal narrative with the community-based one (Boevink, 2007). By opening the floor for many people to share their stories and issues, the group members are exposed to a variety of ways to talk about and, thus, construe their experiences and recovery process. This is similar to what Holma and Aaltonen (1995, 1997) describe is a fundamental step toward recovery – that of being given the opportunity to “adopt multiple perspectives” on self-narrating (p. 309).

For example, Seth, the rebel-rock-star, said that when he “let out some feelings,” he got the feedback from his peers that he was really improving, and he was happy about that change in himself. Being given the space to explore his feelings in his own words, not the ideas filtered through the language and rhetoric of the formal mental health system, was a transformative moment for him. Jackie also appreciated the acceptance built into these sharing experiences with the group. Part of what made GROW a good place for her was that she knew that she could get support from everyone in the house – and not just one, but many, viewpoints on her problems. In fact, most of the people in the group, including the group leaders and staff, have experienced the same things as the person sharing his or her story. My participants all reported that when they needed help or when they were working through their “issues,” an incredibly healing part of the GROW process was sharing their problem or story to the group, having them truly empathize (because most of them have been there before themselves) and give supportive feedback.

Usually this feedback sent an I-can-do-it message to the Grower. Jackie, for instance, remarked on how relieved she was to see how many other Growers had made it through to a healthier, more recovered state. For her, hearing others talk about enduring similar problems and feeling at “rock bottom” just like she had felt, and then seeing them succeed, was a powerful counter-statement to what she had been told all her life – that her problems would never go away, that they were biological in nature, and that she would never be able to live a normal life. Jackie’s experience is clearly an instance in which the story-sharing format at GROW helps to clear the way for the Growers to confront and move past the mainstream master narrative that so powerfully defined their problems and their hopes for recovery.

This finding challenges current and mainstream views on treatment for and recovery from severe psychological distress. In particular, it shows the importance of attending to way users of mental health programs construct and then go about the process of re-constructing their narratives. Given the therapeutic nature of narrative transformation, programs for recovery from severe mental illness should find practices that open up dialogical space in which people can explore and re-construe their self-narratives. Programs can integrate into their practices peer gatherings where participants are encouraged to share and explore their personal narratives with one another. In fact, some mainstream programs have even found success in hiring peer consultants (see Mowbray et al., 1998; Paulson et al., 1999). In general, we can use the GROW program as a guidepost here, as GROW is built on the principle of sharing experiences, knowledge, and stories with one another toward the goal of inviting, rather than silencing, multiple perspectives, or multiple narratives, on mental illness and health.
Dedicating research efforts toward further understanding how, exactly, sharing stories effects change in people would also be important. At what point in the sharing process does a person experience a shift in his or her self-concept, as the Growers attested to experiencing? Also, we could explore what different mental health professionals feel are important issues to discuss and explore with their clients and how those differences may relate to outcome. Are the kinds of mental health practices that integrate the client’s thoughts and ideas about his or her struggles and recovery related to better outcome? What is the impact of immediately conveying a biomedical construal system on a person’s notions about his or her experiences? Are the effects of sharing one’s story more profound in a group or individual setting? These are just some lingering questions and practical research ideas that would be beneficial to explore in the future.

Helping others. Helping others along in their progress toward recovery was the final common turning point for my participants. The importance of helping others is not surprising, considering that the GROW program is founded on the theory of mutual help and one of the main principles of the program is the “Helper Principle” (GROW, 1999, p. 44). Part of the recovery process at GROW involves the empowering impact of helping others heal from their own psychological maladies. Research supports the notion that gaining a sense of agency is a curative component of treatment (Holma & Aaltonen, 1997). Panepinto (2004) and Adame (2007) also found that helping others was an important component in the recovery of rape victims/survivors and people that identified as members of the survivor movement respectively.

One way of viewing the importance of the Helper Principle is through Victor Frankl’s (2006/1959) contention about the vitality of finding purpose in one’s life after a trauma. He proposes that making meaning out of trauma can happen via three avenues, one of which is through a deed or some kind of work that utilizes the trauma for the betterment of others. It appears that helping others in their healing process is one of the ways that the Growers made meaning out of their trauma, or, in Frankl’s terms, “transform[ed] a personal tragedy into a triumph” (2006/1959, p. 116).

For example, consider Jackie, who talked about how important helping others had been in her recovery. She felt that not only did the emphasis on helping others fit with her personality, and that she grew even stronger as an individual as a result of the helping friendships she formed. “It’s more like a two way street and a friendship,” she said. “They’ll help you and you’ll help them and you’ll grow stronger together. Mental health can’t be taught; it has to be learned together.” (The last portion of her statement is actually a quote from the GROW literature, a sign of Jackie constructing her narrative in a GROW-inspired manner.) For Jackie, and, in fact, the rest of the Growers in this study, the practice of helping others felt more like forming friendships than it did forming strictly “helping” relationships. This may have been salient to them because the latter form of relationship had been the kind formed within the mental health system that usually ended up being dehumanizing and traumatic to them. Being able to reconstrue the role of “helper” as a peer or confidant, and not “dictator” as Seth described his psychiatrist, may increase the chances that the help is accepted, and, in turn, given back to someone else, aiding in the recovery process.

After being embedded in a system and a discourse that viewed people diagnosed with mental illness as useless, helping others also resulted in the person feeling needed.
Dan’s experience of and reaction to the mutual help principle in GROW was particularly striking to me. He was astounded that the staff put “mental health recovery in the hands of the people that are recovering.” In all his years in and out of the ward, he never once was told that he could be helped, let alone that he had the power to help others. Once he began at GROW, that changed. He said, “They make you feel, from the minute you walk in this door, that you matter again. And after feeling like you don’t matter out there, it’s a huge thing.”

Some Growers even desired to continue helping others after they graduate from the GROW residence and program. Part of recovery, for them, included becoming active within the mental health community, specifically in support of non-mainstream treatment options for other people that suffer with mental illness. In fact, both Dan and Jackie expressed the desire to work within GROW or another peer-run facility in the future. This finding reflects similar outcomes of making meaning out of traumatic events (Adame, 2007; Panepinto, 2004). It also connects to Frankl’s (2006/1959) assertion that part of making meaning out of trauma is to find work that turns a negative into a positive. For example, Dan said that his dream would be to start a GROW program somewhere. Jackie said, “I want to give back what was given to me…. I’m thinking that I want to be maybe a part-time nurse and a part-time social worker. Part-time staff here, even. Let people know that everybody has a chance.” It is clear that, for Jackie and Dan, part of what will make their stories meaningful is using it in order to help others for the better.

Growers are expected to actively contribute to the helping atmosphere of the program, not just receive help, guidance, and support from fellow Growers. Implicit in this “rule” about mutual help is that the Grower feels that he or she is valuable perhaps for the first time in a long time. These narratives show that feeling valuable is a momentous turning point in their lives. Unfortunately, the locked doors, constant blunting of affect and motivation due to medications, and rhetoric that mental illness is a life-long disease, all serve to convey a message of uselessness, hopelessness, and disempowerment to users of these programs. The issues presented in this study challenge the narrow possibilities afforded to users of institutions that subscribe largely to the medical model approach to treatment.

Given the strong relationship between recovery and feeling empowered and useful, the mental health system should strive to revise its practices in order increase the chances that its users experience empowerment rather than stigma and hopelessness. We could dedicate research efforts toward further understanding the impact of having agency in one’s own treatment. What small changes could be made on the wards that would increase patients’ sense of empowerment? How can various treatment settings attempt to integrate peer-help into their programs? What would be the most effective ways of including peer-help into a variety of treatment programs?

**Narrative transformation as recovery**

A great deal of literature describes narrative transformation as a significant component of recovery, particularly from severe mental illness (Holma & Aaltonen, 1995, 1997, 1998; Lysaker, Lancaster, & Lysaker, 2003). These authors suggest that narrative transformation happens when the story goes from an unstructured, past-oriented “pre-narrative” to a more coherent, and future-oriented narrative (Holma & Aaltonen, 1998, p.
Seikkula, Alakare, and Aaltonen (2001) also suggest that being stuck in the pre
narrative state may be because of an inability to interpret traumatic or emotionally laden
past life events. The implication is that once the person is able to confront and actively
interpret these traumatic events, narrative transformation may occur, and, thus, so may
recovery. Overall, recovery can be viewed in relation to a person finding meaning in past
events, at which time his or her narrative will shift to integrate these understandings,
resulting in a more hopeful, future-oriented, empowered, and coherent personal narrative.

The narratives the Growers in this study told seem to affirm these notions about
narrative transformation and recovery. It appeared that progress through the program, and
thus toward recovery, was correlated with a narrative that contained more personal
understanding of traumatic and painful past experiences. These narratives also were
future-oriented, rather than contained to the past. Given these issues, I intentionally
structured the results section to demarcate points of transition within the recovery process
of going from medicalized master narrative or “pre-narrative” to a more alternatively
constructed, non-medicalized, and more coherent narrative. Taken as a whole, the four
narratives seemed to reflect the development of an individual through the GROW program
and toward recovery – from 1) construing one’s mental illness and recovery in nearly all
mainstream, medicalized terms (e.g., Melinda), to 2) actively negotiating both mainstream
and a new, alternative, GROW-informed conceptualization (e.g., Seth and Jackie), to 3)
construing one’s mental illness and recovery in a unique, largely trauma-based, but
generally non-medicalized manner (e.g., Dan). The textual representation of each narrative
also illustrated the felt experience of being with each person during the interview process
as we co-created the narrative. I also attempted to textually symbolize each person’s
experiences as they began to shift their worldview. I will discuss this experiential
component of the narrative transformation later in this section.

Melinda’s story represented a construal process with the strongest connection to a
medicalized narrative. As I mentioned in my reflections of her story in the Results section,
her narrative was littered with biological constructions of her psychological distress despite
the lifetime of traumas she had endured. Although she never overtly stated that her
symptoms were the direct result of a chemical imbalance, she also never really recognized
the contribution of her traumatic past as the reason these symptoms arose in the first place.
For example, after describing her tumultuous family dynamic, her marriage to a man she
did not trust, the death of her son, and the tenuous nature of her daughter’s life, Melinda
believed her panic, depression, and anxiety was genetically inherited. The traumas simply
set off her genetically preordained problems with panic and anxiety. She told me that she
still hoped that, after 40 years of the pills not quite working for her, that her doctors would
eventually find the right mix of drugs to take away her problems. In essence, the problem
was not the trauma, but the biological disorder she suffered from that traumatic and
stressful events made worse. Her story is also one that lacks any future direction, implying
that she has not yet transitioned out of the pre-narrative state. Melinda could not envision
life beyond her current state of being. She told me she was just “straight depressed” and
that she wanted to be “normal,” whatever that meant. Before making much progress, she
left GROW to go back home, presumably to continue the life she had prior to he short stay
at the GROW residence.

I presented Seth’s narrative next, as he was in the beginning stages of moving past
medicalized language and theories to describe his struggles. Although he still could not
meaningfully explain some of his past experiences, particularly about why he thought he was Jesus or why he was delusional (“When I was delusional, it was like my eyes were tricking me!”), his narrative showed, for instance, that he was beginning to vocalize his rejection of his diagnosis and the stigma it carried. He said, “It was a relief to come here and take away the label.” Seth’s story also implicitly reflected his recognition of his abusive and trauma-filled past as contributing factors to his present psychological struggles. He said that, given the amount of trauma he had endured, he does not think that his problems will ever totally subside. Although Seth still views his mental illness as an issue he always will have to live with, a notion consistent with what the medical model espouses, it is important to recognize that he was not insinuating that the battle was against imbalanced neurochemicals but against the pain of past experiences. This, I believe, is a true sign of narrative transformation.

Jackie’s story reflected even more openness in her narrative and a more pronounced disavowal of the medicalized master narrative. At first, Jackie reported being so close-minded about her own recovery that she did not think GROW would work for her. It is possible that she absorbed some of that narrow-mindedness herself, given the amount of time she spent within the context of an institution whose beliefs about recovery are fairly narrow. After a few weeks though, Jackie said that, through learning about personal value from the Blue Book, she came to find new meaning and purpose in her life. She no longer saw herself as someone trapped beneath the rocks of her misfortune and traumatic past, but rather saw her life as full of possibilities for the future. For example, Jackie said that she now knew she wanted to go on to help others as either a nurse or on staff at GROW. The medical model still guides part of her construal of her problems (“You know, there’s still something about a chemical imbalance.”), but she does not abide by the mental health system’s rhetoric about life-long medication use for symptom reduction and maintenance. “Maybe later on down the line, you can know how to make yourself happy,” instead of rely on the pills, she said. It is clear that her narrative is in the transformation process.

Finally, Dan told a story of a very traumatic and abusive childhood, one that, in the past, he used drugs and his Jekyll and Hyde persona to avoid. In simply recognizing his problematic avoidance of past traumas, Dan tells a narrative that stands against the medicalized narrative, provided to him by the litany of psychologists and psychiatrists he saw during his inpatient stays that provided him with medications that helped him forget about the abuse. He reported that his experience at GROW was like a “light coming on” in his life for the first time in a long time. This light, his story shows us, illuminated the past traumas that were haunting him and that he so desperately tried to avoid. Dan reported that being given the time to explore and come to terms with past abuse and trauma, including experiences that he never realized he had been avoiding, had been one of the most therapeutic components of his recovery process:

The feelings that are coming out of me are feelings that I didn’t expect. The thoughts that are coming out of my mind are totally different than just the abuse went through. The sexual abuse that I went through as a kid. There is all this other stuff that has happened in between that I tried to push away. So, they [the GROW staff] keep you here long enough so that stuff has a chance to come to the surface. They don’t try to push you out of here.
Although Dan still recognizes the relative utility of psychiatry in the process of recovery, he has transformed his narrative from blaming his problems on drug abuse and viewing his recovery as a life spent adjusting his meds, to one that is making sense of past traumas and looking forward to a future filled with purpose and progress. Dan described his future as one filled with exciting new possibilities that were very different from what he wanted for himself prior to GROW. He talked about wanting to travel to California and parlaying his experiences in GROW to open a group of his own some day.

Correlating recovery with the process of narrative transformation was one of the most salient findings from this study. This phenomenon is consistent with research on recovery from severe mental illness (Holma & Aaltonen, 1995; 1997; 1998; Lysaker, Lancaster, & Lysaker, 2003; Seikkula, Alakare, & Aaltonen, 2001). It challenges prevailing notions about what is curative for people suffering from severe psychological struggles. The field of psychiatry and the medical model in general views recovery as a fixed goal of reducing symptoms rather than a process of meaning making and intrapsychic transformation. One of the major pitfalls of mainstream, medicalized mental health, as Johnstone (2000) contends, is that it does not help people make meaning out of their experiences with mental illness. I believe that these narratives echo this lament and bolster the notion that recovery should be construed in terms of people making sense of their life stories and being allowed to re-author it in a manner that is personally meaningful.

For example, instead of focusing solely on symptom reduction, psychiatrists and other mental health providers could ask people how they understand their symptoms, what it means to them, and how it affects their lives. Psychotherapists could work with clients to help them face and make sense of traumatic life events rather than spend time focused solely on symptom reduction. Furthermore, therapists could begin to view symptoms as narratives in their own right, and, as such, attend to the important information they hold. As clients attempt to make sense of out unusual and painful life experiences and symptoms, clinicians would need to be tolerant of the ambiguity of the meaning-making process and be creative with the client in thinking about how experiences can be interpreted (Karon, 2001).

The role of trauma

Another common and vitally important element in all of the narratives in this study was the role of trauma. All of the participants reported traumatic experiences and events that generally occurred during childhood and adolescence, although both Dan and Melinda reported having lived through quite traumatic experiences during adulthood, as well. Overall, each of my participants reported surviving one, if not multiple, occurrences of childhood sexual assault. They all told stories about suffering the loss or death of important people in their lives, including caregivers and best friends. Drug abuse and suicide attempts were other traumatic events most of the Growers I spoke with had in common. Dan and Melinda also talked about either experiencing or witnessing physical abuse in their lifetimes. My participants’ pasts were tremendously traumatic.

I was also struck by the degree to which the Growers downplayed past traumatic experiences, particularly during the early stages of the program. In other words, the trauma narrative that was certainly available to them to use in the construction of their own personal narrative was largely ignored. For example, before GROW, Seth envisioned his
problems as largely drug-related. He said that smoking marijuana gave him an altered, fantasy-like sense of the world, causing him to hallucinate and have delusions. In fact, even as he experienced the GROW program, Seth continued to construe some of his recovery as “rehabbing out of drugs,” and focused a lot on his anxiety about being confronted with the ability to access drugs again once he is out of the GROW house. Melinda clung fiercely to the medical and genetic explanation of her problems rather than talk about the immense traumas she had suffered in her lifetime. It was much more acceptable to her to downplay the trauma and focus on the supposed genetic problems she passively inherited.

Researchers certainly describe the role of trauma in the development of severe mental distress. In fact, Karon (2001) describes schizophrenia as “a syndrome of chronic terror and defenses against terror” (p. 17), arguing he had never known a schizophrenic whose life would not have driven him crazy, too. The works of Karon and others (e.g., Breggin, 1991; Holma & Aaltonen, 1997; Szasz, 1972) bolster the notion that, when faced with traumatic, terrifying, and emotionally laden experiences, people may develop creative ways of living despite the trauma that often appear to be abnormal or “crazy.” From this perspective, it is the incredible suffering from trauma that underlies severe mental illness, not genes, neurochemicals, or broken brains (Karon, 2001).

Despite the common factor of extreme trauma within each of the Growers’ narratives, most of them had a very difficult time recognizing and integrating the trauma into their personal narratives. Instead, they construed their issues in mostly biomedical terms. This was a fascinating discovery and has implications for how the presence of the medicalized master narrative can hamper a person’s recovery process.

Experiencing the transformation: The medicalized master narrative as a defense

As I listened to these narratives of living with and recovery from severe traumas and psychological struggles, I began to hear beyond the words my participants were saying. It began with Melinda, my first interviewee, and, as the research process continued, I began to hear and feel an unspoken message underneath the narratives. As I mentioned in the post-script to Melinda’s narrative in the Results section, what I was sensing was the tension, fear, and denial bound up in what the research, and even the Growers, suggests is a therapeutic process of narrative transformation.

The experiential difficulty associated with the narrative transformation process piqued my interest, as the literature did not predict this phenomenon. In fact, very little, if any, research speaks to the difficulty associated with this narrative negotiation (see Kennedy, 1995). Holma and Aaltonen (1998) report that sharing past experiences can be difficult for people that have experienced extreme states like hallucinations and delusions, but no one has systematically explored exactly what this “difficulty” looks like. Furthermore, no one had couched this difficulty in terms of the process of re-negotiating and re-authoring a narrative of personal experiences with severe mental illness. The question I began to wonder was, what was so painful about the process of moving from a “pre-narrative” state to a narrative that was constructed out of a meaningful interpretation of past, usually traumatic, events?

I continued to re-read the narratives in hopes of coming to some hypotheses about this question. What came to the fore was the notion that, for most of the Growers at some
point, the medicalized narrative stood as a defense against experiencing the trauma they had suffered in their lives. Experiencing tension, pain, and fear during the narrative negotiation (recovery) process made sense when viewed from this angle. These negative feelings were usually a response to the idea that the trauma would be re-experienced, or at least recognized, through the telling of it in narrative form. Put another way, it is safer and less terrifying to rely on a medicalized narrative that never requires you attend to the traumatic and horrifying experiences in your life than it is to actively turn and face the experiences in your life that haunt you.

The literature appears to support, although not predict, this idea. Seikkula, Alakare, and Aaltonen (2001) suggest that recovery through narrative transformation occurs when emotion laden or traumatic past experiences are confronted and meaningfully interpreted. After this occurs, the person is usually able to construct a more resolved narrative that is no longer stuck in the past and unable to move past the trauma. The issues arises, as Holma and Aaltonen (1997) contend, narrative transformation is hindered when “a subjugating story blocks the performance of alternative stories” that allow for reconstruction and resolution of past experiences (p. 464). In fact, Holma and Aaltonen (1995) viewed the “medical story” as exactly this subjugating story that saturates a person’s unique narrative when he or she enters into the discourse of the mental health system. When the medicalized narrative gets introduced into their frame of thinking about their lives, it collapses the person’s ability to multiply construe their narrative and keeps it in a “pre-narrative” state.

I view the discourse and rhetoric about mental illness and health provided by the GROW literature (e.g., the Blue Book) and by other Growers as exactly these “alternative stories” that can be suppressed by the more pervasive, more common, and less trauma-oriented medicalized master narrative. It seems that the medicalized discourse limited the Growers’ perspectives on past experiences (usually by eschewing them in favor of biologically-oriented explanations for distress) and on future possibilities (typically by diminishing recovery to a simple goal of stabilization and maintenance of symptom reduction through psychopharmaceuticals). In Holma and Aaltonen’s (1995) terms, I view the “medical story” as the “subjugating story” that blocks other narratives from being told. Furthermore, this medicalized master narrative provides people with a comfortable, logical, and culturally acceptable narrative with which to overshadow a narrative ripe with traumatic experiences that most people, naturally, do not want to re-experience through narration.

As a result of escaping the mental health system and spending time in the GROW program, a dialogical space opened up for the Growers to explore alternative discourses on mental illness and health. At that point, they were able to re-construe their narrative outside of psychiatry’s limiting terms. This freedom to re-construe their narratives, as my theory suggests, implied that they would finally have to turn and face their traumatic pasts. This oftentimes meant reliving the pain of those horrible experiences before being able to meaningfully interpret them into a more coherent and resolved personal narrative.

The experiential terror associated with this process was most palpable with Melinda, both as I sat with her during our interviews and when I re-read the transcripts. Her story was one of a painful push and pull between construing her problems medically and non-medically. Most of the time, in fact, she followed up a story of a traumatic past event with a comment about her genetic connection to anxiety. It was as though she could
not even let herself speak out loud the tragedies and traumas of her past, lest she have to
feel the pain associated with them again. Better to just think about the pain in terms of
imbalanced brain chemicals and faulty genes than actually consider how horrible her life
had been. I also construe her departure from the GROW program (for a second time) as
reflective of the overpowering fear she had of confronting traumatic past experiences. The
terrors of Melinda’s traumatic experiences were understandably too horrific for her to face
at that time. I can only imagine the pain that it brought her to even recall the memories she
shared with me. I also believe it finally became too threatening to be constantly asked by
her fellow Growers to talk about her traumatic life. So, she left.

Melinda’s story sends a message about the power of the medicalized narrative, its
pervasiveness, the comfort it provides people despite the damage it can ultimately cause,
and the difficulty some people may experience as they attempt to bring into their construal
processes new, non-medicalized understandings for mental illness and recovery.
Unfortunately, the mental health system is replete with both overt and covert attempts to
assist in the eschewing of the adoption of a trauma narrative into people’s narratives. The
overt pill-pushing and description of people’s serious psychological troubles as being
caused by brain chemical imbalances is one way that people learn to construe their
problems in mainly biomedical terms. Of course, there is also the constant onslaught of
advertisements from drug companies for a growing number of pills to fix any number of
mental illnesses. The covert rhetoric and subtle messages about brain chemistry and
genetic propensities toward certain “disorders” and “illnesses” provided by these drug
companies and the psychiatrists that use their products makes it hard for a person to also
adopt a view on psychological struggles as being the negative effects of tragic, traumatic
life events. In these ways, it is easy to see why Melinda and so many others find their way
to the medicalized narrative to make sense of their personal struggles. It also helps explain
why pulling that sensible and comforting narrative away from a person, which the GROW
program and other psychotherapy programs for recovery attempt to do, can be an
experientially terrifying process, and one to avoid.

The experiential avoidance of past traumas, and the associated pain experienced
upon facing these traumas, also came up in the other narratives. Dan, for instance, told of
a life spent in and out of inpatient wards after severe bouts with depression and suicide as
well as a considerable drug abuse problem. He talked about his sense of treatment and
recovery in the hospitals when he said, “The medication seemed to pick up where the
drugs left off. The medications I was on takes you from going up and down, up and down,
to just being nice and even… I was in a better way. I was on medication.” Essentially,
what the psychiatrists prescribed for Dan as treatment provided exactly the escape from his
past that his recreational drug use did. They helped him to be “nice and even” despite
feeling so much emotional and psychological pain that he was continually depressed and
suicidal. The doctor-prescribed psychopharmaceuticals just “picked up where the drugs
left off,” and sent him the message that the only way to get better and get back to normal
life was to become numb and “even” again. It was not until after a number of failed
attempts at recovery under the care of psychiatrists that Dan started to challenge the
rhetoric of the medical model as it related to his mental health. He knew that this approach
was not working for him, although he was not sure what would. At that point, he began
advocating on his own behalf for anything different than the hospitals and half-way
houses, and then, like a “gift from God,” GROW fell into his lap.
But that was only the beginning of his journey toward recovery. The GROW program not only confirmed that the medical model in general did not work for him, but, more specifically, it challenged the idea that becoming numb to his psychological and emotional pain was the path to recovery. In fact, the GROW program helped him realize just how important and difficult it would be to *not* live a life of numbness. Dan talked about it this way:

They have this part in the book that is a diagram that represents your recovery. It goes up a little bit and when it gets to the middle, it crashes down a little bit, and then it goes up more. There is that point in your recovery when you have done all the right things, but then the things that really hurt you starts affecting your recovery. The feelings start welling up inside you and you have to figure out how to deal with them. Then once you do that, you start moving up and onward and away from it all.

Dan experienced this “crash” a few times at GROW and told of the traumatic memories and difficult emotions it brought up. After the medicalized narrative stopped being the dominant one in his own story, he felt what “really hurt” him, namely the sexual abuse and other traumas. Dan’s story is a clear illustration both of the defensive power of the medical model, in that the psychopharmaceuticals allowed him to continue to ignore the past that he knew affected him, and of the pain associated with removing the blinders that this master narrative places on past traumas.

These experiential qualities associated with narrative transformation were not explicitly predicted by the literature. In fact, little, if any, of the research attempts to articulate what people experience as they negotiate a new conceptualization of themselves, their struggles, and their future when in the context of alternative treatment programs (Kennedy, 1995). My participants’ narratives indicate the felt sense of tension and difficulty people can experience when faced with such a different way of construing mental illness and recovery. The process of rethinking one’s problems and one’s life does not happen effortlessly. When given the opportunity to be creative, open, and exploratory about the roots of one’s own psychological distress, the tension can be significant.

Although researchers like Holma and Aaltonen (1995, 1997, 1998) and Lysaker, Lancaster, and Lysaker (2003) describe the therapeutic ends of narrative transformation, virtually no one has described the functional nature of staying within a “pre-narrative” state as it relates to negotiating a medicalized narrative with an open, alternative narrative informed by multiple perspectives. Although researchers describe the function of symptoms, especially hallucinations and delusions, as an escape from the pain of traumatic experiences, “leading to the construction of an alternative story and alternative identity to replace the unbearable situation” (Holma & Aaltonen, 1997, p. 465), no research systematically explores the issue that a mainstream, medicalized narrative can be used as a defense against re-experiencing past traumas by blocking the authoring of a more trauma-focused narrative. We can infer from this that it is useful to have a narrative in place that eschews the need to attend to painful experiences. In this way, perhaps, we can expect that the medicalized narrative can function as a similarly useful story to employ in order to “replace the unbearable” recognition of past experiences on the development of one’s psychological struggles, and thus, on one’s personal narrative.
Beyond framing recovery from severe mental illness as a process of narrative transformation, this study suggests that the dominant, medically-informed master narrative that gets absorbed by many users of the mental health system can assist in the person avoiding dealing with and making sense of traumatic, painful, and emotionally laden past experiences. Given that the research suggests that making meaning out of trauma and coming to terms with past experiences can be therapeutic, we must pay close attention to what structures may stand in the way of this process. We need to be alert to the use of the medicalized master narrative as a defense. Future research studies could qualitatively investigate how people may be using the mainstream medicalized narrative as a defense against the recognition of painful past traumas. We could continue to explore the experiential qualities of narrative transformation to better grasp the nuances of such a process. Does narrative transformation differ across symptom presentations? What does narrative transformation look like with children? These are questions that would be useful for our field to consider in future research.

The felt sense of dread, denial, and fear wrapped up in the recognition and processing of unwanted, traumatic experiences also speaks to the issue of how to approach this process within treatment programs. GROW’s structure and environment are all created in a way that facilitates narrative transformation and provides emotional support along the way. What could other treatment settings include in their programs that would assist in their users feeling supported and cared for as they move past the fear and denial into a transformative state? Interpersonally, it would mean that client and clinician need to form a strong therapeutic alliance based on trust and consistency. The Growers continually mentioned how important it was that they could trust and rely on their fellow Growers and the staff as they went through the hardest parts of their recovery process. As such, clinicians should be aware of the level of interpersonal connection it takes to form an environment in which transformation and the associated experiences are welcomed and attended to with care.

The Growers also appreciated the time they were allowed to spend in the residence. Unlike in hospitals and inpatient programs, the Growers were given more than enough time in GROW to settle in, feel comfortable, and get to know the other Growers and staff before moving into the hardest work of the program, that of confronting past traumas and dealing with past sorrows and pain. Without this time, the Growers were certain that they would not have established the trust with others they needed in order to feel comfortable expressing a range of emotions. Given these issues, it would behoove treatment programs to view time as an essential factor in people’s recovery process and provide them with the time they need to become comfortable. Of course, the unfortunate constraints of our current state of health insurance make “quick fixes” the gold standard. The stories in this study stand against the notion that faster is better in the treatment of severe mental illness.

Given these issues, there are some suggested implications for the role of mental health workers within these alternative settings. Although the presence and involvement on mental health workers within this kind of treatment environment is variable, this study may provide information for what and how these professionals ought to accomplish when working with users of an alternative program. First, being aware of the power the medicalized narrative has on a person’s sense of self would be paramount. Second, the mental health professional should attempt to understand the process of recovery as the person sees it, not necessarily as the overarching field of mental health sees it. This
research suggests that individuals define for themselves different views on progress and recovery. It would be wise for mental health professionals to try to work with, not against, those viewpoints. Third, an understanding of the experiential difficulties associated with working through programs like GROW would be important. Places like GROW can be very successful, but as this research indicates, a person’s progress can be peppered with periods of time where people experience a significant amount of stress, denial, fear, or dread. Lastly, mental health professionals in this setting would need to understand that their role can be limited and that the work gets done in large part between the users of the program.

The narratives in this study also point toward some suggestions for the GROW Residential program. First, and as Melinda’s story shows us, there may need to be a degree of readiness on the part of the Grower to really dig into their lives and begin to make sense of their whole life of experiences before they can really move through the program. I can only surmise that perhaps Melinda was too distressed or too uneasy about doing what the GROW program asked of her to make progress with her struggles. As a wife and mother, it may have been incredibly difficult to go through the process of letting go of some of the pain associated with her son’s death, her daughter’s issues, and the potential trouble within her marriage. The program’s efforts and successes are praiseworthy, and there is much that the mainstream mental health system can learn from it. There are some areas that the GROW Residential program

The issue of the medicalized master narrative being employed in a defensive way against the trauma and sorrow of past experiences also has implications on psychology as a field, in general. It speaks to the need for more non-biomedical forms of dialogue for mental health and illness. More than ever, we all must attend to the power behind the words we use to describe what ails us. Instead of the impact of faulty brains, we need to talk about the influences of tragic lives on psychopathology. We must be willing to recognize the negative effects of the constant barrage of advertisements by big pharmaceutical companies for this or that drug for this or that mental illness. These images and sound bytes add to the medicalized master narrative, and facilitate what Lifton (1979) calls a “psychic numbing” to the trauma, sorrow, pain, and fear that really ails us.

Our field has turned against the natural creativity within humans by providing only one dominant discourse with which to understand psychological struggles, and this deadens our abilities to look back, reflect on, and make meaning of our lives. Until the people that suffer most from the pains of their pasts are given the time and freedom they need to creatively explore their lives, they will likely continue to live in psychic numbness. Fortunately, programs like GROW and other non-mainstream settings provide the time and space where people can come and freely explore their lives without the threat of being misunderstood, locked up, physically or chemically restrained, or shocked into submission. Unlike the rhetoric espoused by the mainstream, these alternative programs call for a respect of basic human rights, especially the right to feel and be creative, that so many people are told by the medical model to ignore. They call for a more open, compassionate, patient, and mutually supportive mental health system that recognizes the healing power within everyone.
References


Appendix A
STUDY TITLE: Creating Meaning Outside the System: Exploring Narratives from Within an Alternative Mental Health Program (Working Title)
PRINCIPLE INVESTIGATOR: Rachel E. Stern
FACULTY ADVISOR: Larry Leitner, Ph.D.

The purpose of this study is to explore the personal stories of having extreme experiences from the perspective of those utilizing the services of a treatment facility.

You were asked to be involved in this study because you are currently seeking the services of an establishment designed to aid in the assistance, treatment, or recovery of mental and emotional distress. By consenting to be involved in this study, you agree to share with the researcher your experiences of being in and going through a therapeutic environment as well as other experiences of being labeled mentally ill or experiencing symptoms associated with mental illness. At no time will you be required to disclose any information you do not wish to share.

Your participation in this study is strictly voluntary and you may withdraw participation at any time before the completion of the Thesis document without penalty. Your involvement in this study or decision to withdraw from this study will not affect the services you receive from the establishment where you seek treatment.

You will engage in 3 one-to-one meetings lasting about 1 to 2 hours in length, although if necessary, this time will be extended. The first meeting will consist of engaging in an open-ended interview, and the second meeting will consist of completing any relevant interview questions, allowing you to clarify or revise any of the information gathered during the interview process, and setting up a time to complete the last meeting. The final meeting will consist of the presentation of the researcher’s work with your interview material, at which time the researcher will seek your feedback on this work.

Your confidentiality during this research process will be protected. Only the principle investigator, her research assistants, and her research advisor, Larry Leitner, PhD, will have access to the names of the participants in this study. The materials generated during the meetings will be stored in a locked cabinet in the researcher’s laboratory and only the researcher, her research assistants, and her advisor will have access to these materials. Except for the signed consent forms, any materials gathered during the research process, including tapes, digital audio files, and transcripts, that bear a participant’s name, will be replaced and coded with a pseudonym. After the research process is completed, these materials will be destroyed.

If you have any questions about the nature of this research or the research process, please contact Rachel Stern at 330-620-1043 or at sternre@muohio.edu, or her faculty advisor, Larry Leitner, at leitnelm@muohio.edu. If there are any questions or concerns about the rights of research participants, contact the Miami University Office of Research and Scholarship at 513-529-3600 or humansubjects@muohio.edu.

I have read the preceding statements and agree to participate in this study. I also verify that I am 18 years of age or older.
I also understand that the directors of GROW will have a copy of the final Thesis document, and that although the researcher will have taken steps to mask my identity, due to the nature and size of GROW, the directors may be able to identify my story.

Signature of Participant Date

Signature of Researcher Date
Appendix B

STUDY TITLE: Creating Meaning Outside the System: Exploring Narratives from Within an Alternative Mental Health Program (Working Title)

PRINCIPLE INVESTIGATOR: Rachel Stern

I give permission for the principle investigator to audio record all interview sessions. I also give my permission for the researcher to quote from the interviews in any reports from this study (including papers presented at professional conferences, articles submitted to scholarly journals, or book chapters). At any time before the completion of the Thesis document, I am allowed to withdraw this permission for any or all interviews. There is no penalty for withdrawing consent.

I consent to my interviews being recorded and quoted from as described above.

__________________________________________
Signature of Participant

__________________________________________
Signature of Researcher
Appendix C

Interview Questions

Experiences leading up to treatment environment
- Could you describe what led to your (admission to the hospital/inpatient facility, involvement with ______ group/home/center)?
- Could you describe for me what happened that finally led you to seek help/treatment for your problems?
- Did you have an idea about what was happening/wrong before seeking help?
- How did you feel about getting help with your struggles?
- Could you describe any turning points in your life that led to you to seek help/treatment?
- How old were you? Where did you live? Job? School? Relationships?
- Were you diagnosed with a mental illness?
- What did that label mean to you?
- Did receiving the label change your self-identity or how you viewed yourself?
- How did those around you (family, friends, co-workers, etc.) understand the nature of your struggles?
- Did conversations with them have anything to do with how you chose to seek help/treatment?
- What did you hope would happen to you after you chose to seek help with your struggles?

Personal theory of mental illness
- How did you understand the nature of your struggles before entering your therapeutic environment?
- What is your personal theory about mental illness or extreme experiences?
- Have books, the Internet, education, or conversations with others been helpful in forming your understanding of your struggles?
- What was your knowledge of mental illness/extreme experiences prior to you yourself seeking treatment?
- Has your understanding of the nature of your struggles changed since being involved in the therapeutic environment?

Treatment environment
- Could you describe your decision to be admitted into/become involved with the hospital/group (or describe your experience of being involuntarily admitted)?
- Was the Internet, books, or conversations with others influential on your decision about where to seek treatment?
- Could you describe some of your experiences in the hospital/being involved with the group/home/center/community?
- Could you describe a typical day for you here?
- Could you describe the method of treatment used in this environment?
- Have psychiatric medications or treatments (i.e. ECT) been helpful for your recovery? Describe…
- Has psychotherapy been helpful? Describe…
- Have any alternative treatment methods (meditating, artwork, yoga, etc.) been helpful? Describe…
- What is the community like in your therapeutic environment? Do you have friends? Do you see your family?
- Has treatment/the recovery process/healing changed your self-identity?
- Were there any significant moments or events that assisted in that change of self-identity?
- What else has changed since you’ve been here?
- What has not changed since being here?
- What has this therapeutic environment provided you that you would not have had if you didn’t enter?

**The Future and Recovery**
- What do you think has been most helpful for you in dealing with your personal struggles?
- What obstacle(s) have you overcome during your treatment/recovery process/healing?
- What do you think *could be* most helpful for you?
- Could you describe what recovery or “getting better” means for you? Can you describe how you came to this conclusion?
- Could you describe any turning point(s) or life-changing moments in your life story?
- Could you describe any significant moments in your story that changed your self-identity?
- What are your thoughts about your future? Can you project into the future and explain what life might be like?
- Is this future a different one than you imagined before seeking help here?
- What has being here given you that you would not have had if you weren’t here?
- What role to extreme experiences/mental illness have in your future?