FOUNDATIONS:

Rebuilding After Mental Breakdown

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I declare that the thesis presented here is my original work and has not been submitted to any other institution.

…… Michael B. Roberts, Sligo, Ireland.

Dedicated to

My Wife, Jean Roberts

And

My Late Mother, Mary Roberts

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Daoine den scoth. Go raibh maith agaibh go léir

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Chapter 1 Introduction

Why Research Mental Health and Illness?

On 28th September 2001, the World Health Organisation (WHO) reported that “one in four people in the world will be affected by mental or neurological disorders at some point in their lives but nearly two thirds of people with a known mental disorder never seek help from a health professional. Stigma, discrimination and neglect prevent care and treatment from reaching them” (WHO 2001). No mention was made by WHO of the dire lack of medical and support facilities for the many people in poorer countries whose own local healers have been disenfranchised by allotropic medical forces without the substitution of an alternative regime.

According to WHO, in 20 years time, depression will be the world number one illness. Today more people suffer from mental illness than AIDS, TB and Malaria combined. The accuracy of this prediction has the full assurance of WHO a world-wide body that has assumed responsibility to report on such affairs and is mandated to find solutions.

What is the core problem here? Is mental health and its degeneration a medical or a social issue? What solution is there to bring relief from the symptoms and social outcomes of mental illness and to what extent are current world transformation forces exacerbating these issues? Is the stigma attached to mental health disorder a separate issue or a continuity of the social disorder that is mental illness?

Diagnosis Trends

Depressive disorders accounted for 31% of all admissions for HSE West; schizophrenia accounted for 19% of all; while alcoholic disorders accounted for 14% of all. All statistics are quoted from the Health Research Board web-site at www.HRB.ie.

Many organisations, mostly government organisations, giving agency to the profession of psychiatry, take the responsibility for the cure and care of people with mental health disorders. They want to help. They try to help but are they looking for solutions in the right place? On this point the Hungarian mental health rights activist, Gabor Gambos, said:

> "I remind myself that many of the mistakes in mental health care come from a helping attitude. But they want to help you without asking you, without understanding you, without involving you in your best interest" (WHO 2001).

Psychiatry takes control and, in Jackson's words, "Extinguishes the person as an individual subject through a process of iconic essentialising that transforms him or her into a mere instance of a more general case: a species, a specimen, a pathology, a class (2002: 78). Many other organisations, mostly private NGO's, believe that they have a better solution.

Why GROW?

GROW has its own unique program of recovery and growth that is radically different from the psychiatric or medical model. It is a private international organisation that does ask before helping and tries to understand and to involve its members in what is in their best interest. Its history and development is discussed in Chapter 4. GROW has celebrated 50 years of growth since it was founded in Australia in 1957. Father Con Keogh, a founding member, is still active in the organisation.

GROW is an organisation of people who have experienced disorder and inadequacy in their behaviour. This self- and mutual-help organisation has a 12-step process that brings relief from these issues. GROW is an acronym for Group Recovery Organisations of the World (Turner-Crowsen & Jablensky 1987).

GROW is a worldwide organisation but my research was set in the North-West of Ireland. For many GROW fulfils a gap in State services in an economical and effective manner. How big is this gap and how urgent is the need for this organisation?

GROW Ireland began in 1969 and has, at present, over 150 support groups throughout its six Irish regions. The Grow 12-step program of recovery and growth is based on the model developed by Alcoholics Anonymous. It has a documented set of principles and practices to support its program.

The GROW program is designed to bring those with mental disorder through a psychological, social, physical and spiritual process returning them to a state of good mental health. It sees recovery and growth as an evolutionary process that occurs at the level of the individual and the small group. It is evolution on the micro scale.

Compare and Contrast

In this research I endeavoured to compare and contrast the principle and practice of the HSE State Service and GROW in the North-West of Ireland. I excavated the layers of meaning of each view while focusing particularly on their understanding of recovery from mental disorder and how this is achieved. I looked briefly at other voluntary groups but, in general, found that they are financed by the HSE and adopt the same view as their sponsoring service.

Initially I had to understand the two vantage points or concepts in the comparison. Devereux (2000: 215) explains: “Each science has its key concept whose precise definition is the principle of that science”. While, in psychiatry, key concepts are well published and public it has elements of professionalism and privacy that make understanding of its practice more difficult. In Ireland psychiatry focuses on concepts of treatment after biological breakdown and has just begun to discuss the possibilities of prevention and recovery. In doing so it has limited the

concept of recovery to simply having the patient properly medicated and coping. Growth is not part of psychiatry's paradigm of recovery.

GROW sees 'mental breakdown' as breakthrough, as an opportunity to exploit an evolutionary process for needed personal development. GROW practice is obscured by ideas of confidentiality and privacy. GROW recognises the need for medical intervention in some cases but does not claim any expertise in this area leaving medical treatment to psychiatry. GROW provides a program, method, caring and sharing community supported by a legal framework to produce well-being. GROW sees recovery, even when defined as recovering normal life, as inadequate and sets growth to maturity as its target.

Essentially this sets the two concepts in conflict while attempting to be complementary. Psychiatry's limited concept of recovery makes attempts to compare and contrast more difficult and has pushed this research to a detailed excavation of the GROW concept of well-being.

Purpose of Research

The purpose of this thesis is to discover how the GROW process develops a healthy personal and group character in the borderland between science, the domain of logic and reason, and spirituality, the domain of inspiration and beliefs. Arthur Kleinman, a medical doctor/ psychiatrist and anthropologist, investigated the domain of psychiatry with the intention of informing psychiatric educators and clinical psychiatrists on differing international views of psychiatry. Bearing this in mind he recognises "the irreconcilably opposed schools of psychiatry - biological, psycho-logical, behavioural, social – held together the American Psychiatric Association" (1988: 148). This thesis is, to some degree, a reply to Kleinman's questions:

> "How can we elaborate a medico-religious model that can systematically compare different culturally constituted frame-

works for construing (and thereby, at least partially, socially constructing) what it is being human?
In what ways do differing cultural views of being human affect clinical and pastoral communications between the individual, society and medical and religious practitioners?
What are the culture-specific and universal characteristics of living a human life? (Kleinman, 1995: 7).

In this thesis I have sought information from members of GROW, former clients of psychiatrists in Ireland, on concepts that have enabled them to renew their humanity, to discover an individual self, and to build strong identity, “a search for self or belonging” as Jackson (2005: x) put it. This is mainly intended to inform mental health patients, the family and friends and the general public so that those with prime responsibility for recovery may continue to hold it. This would place psychiatry as servant to their patients inverting the current relationship.

Recovery and growth is achieved in GROW when earlier foundations, those before breakdown and in many cases where the concepts of psychiatry, had proved inadequate. In modern times a human being is understood in bio-psycho-social terms. In Ireland, psychiatry attempts to understand the purpose and meaning of mental breakdown, treatment and recovery from the perspective of a medical model of being human. In the North-West of Ireland, until very recently, psychiatry has taken no role in the prevention of what causes breakdown.

GROW accepts the bio-psycho-social model and attempts to understand the purpose and meaning of mental breakdown, treatment and recovery from what it calls a holistic or overall perspective. It has taken a role in prevention of mental distress by enabling the effects of breakthrough to emerge before the person hits rock-bottom.

Comparing and contrasting the two perspectives, especially around the concept of recovery and growth, produces a contested

landscape of what it is to be human, normal, ordinary and healthy. This domain is the GROW landscape that is at first imagined, then deliberately mapped, developed and manifested. The GROW program facilitates the production of a life narrative that is negotiated between spiritual and social discourse informed by values proven; in GROW terms, to be firm foundations for recovery and growth to self-fulfilment.

I researched GROW principles and practices to discover how they contribute to the development of well-being. This mainly psychological approach, a combination of in-depth analysis and synthesis, is based on the premise that mental illness is a psycho-social disorder in contest with the psychiatric view that disrupted biology is the root cause. I also investigated of other concepts of mental illness. It became clear very quickly that there were many understandings of this array of concepts. I was puzzled at this array and why there was such great difference between them. How could I gain understanding?

Jackson suggests that: “Understanding is conditional on our capacity for being open to otherness which is why good anthropology is a matter of entering the space and time of another, in difficult circumstances to achieve a changed perspective that makes a difference to the way it is possible to see, think, and act in the world (2005: 32). Good fieldwork would achieve understanding but I would have to be careful. It is not that simple. As Kleinman (1995: 142), quoting Gregory Bateson, tells us that “zoology, anthropology and psychiatry are really all one and it is perfectly natural to glide from one to the other via interest in patterns”. GROW provided a suitable site for such research.

GROW believes that it has produced tools powerful enough to achieve recovery and growth in a way that is complementary to professional psychiatric and psychological care. It accepts that professional and medical intervention can produce respite from the worst symptoms of mental illness but it is psychological, social and spiritual intercourse that makes recovery possible and ensures healthy

growth. This is what GROW strives to deliver through the caring and sharing process gleaned from the experiences of its members. Self-fulfilment emerges as a state of flow in social and personal relationships.

Meeting GROW

I first met with the membership of GROW in September 2004. I knew nothing about GROW at that time, without any preconceptions of what I would discover and saw this as a research advantage. In casual conversation I quickly discovered that ideas of spirituality were central to what GROW called their 'program and method'. In GROW the concept of spirituality is written about freely producing, what GROW terms, a holistic concept of humanity - a concept of body, mind, spirit and society. However, spirituality is spoken about less freely.

GROW views the psychiatric profession as both an ally and competitor. This produces a contested landscape where the medical model of psychiatry meets with a spiritual ideology, the territory of religious organisations. This was the borderland I was seeking, on the boundary between science and spirituality, the physical and the metaphysical. Here I hoped to find a truly holistic perspective of humanity.

My formal approach to GROW Ireland was met with an enthusiastic but considered response. The National Executive met me and agreed terms on how the research could proceed. They agreed that I could become a GROW member, to observe and participate in all GROW activities by joining a local group and regional organisation.

There are eight to ten GROW groups spread across this region, some in larger towns and some in small villages. A regional office in Letterkenny serves Sligo, Leitrim and Donegal. There are two local offices, one in Carndonagh and the other in Sligo, where fieldworkers are located. GROW facilitated me in meeting as many members and their groups in the region as I needed. This provided a good cross-section of how GROW is structured in Ireland and worldwide.

Research Location

My research is set in GROW Ireland, mainly in the North-West Region that includes Counties Sligo, Leitrim and Donegal, but also at other GROW locations throughout the island of Ireland. The North-West Region is mainly rural but includes one small city and a large number of small towns and villages. My home is in Sligo where everybody knows everybody. I was among my own people. New arrivals believe it is difficult to assimilate as the indigenous population, those with more than ten generations in residence, are slow to invite them to participate in cultural activities. I also found this to be true even for one of its returned sons. 'Ex-pats', those perceived as 'outsiders', tend to socialise together.

The social landscape is changing in the North-West of Ireland. Many people are arriving from Eastern Europe and Africa bringing new cultural perspectives with them. These new arrivals are made welcome by many but are sometimes met by a hostile reception. The new arrivals pose a threat and opportunity at the same time.

Some of the indigenous population who are different are regarded in much the same way. Traditionally these indigenous 'outsiders' were incarcerated in the local mental hospital, jail or other institution.

The work of A Jamie Saris in the 1990s gives insight to this situation. His work on the history of mental health practice and use of mapped and measured space to organise an ordered way of living suggests a psychiatric profession that grew from the ideas of colonial power but was modified by local perspectives of time and space. Littlewood suggests such a connection in saying that the logic of capitalist colonialism could equate nature with culture that could be accumulated and commoditised (Littlewood et al, 2000: 3). Foucault (1967: 45) points to this connection also when discussing The Gilbert Act of 1703 in England that gave parishes the right to set up places of confinement for the sick, the indigent and the insane. At that time there

was little distinction made between “the sick, criminal or insane who was admitted to hospital” (ibid: 65).

In the nineteenth and twentieth centuries many people were sent to the local mental hospital by a health care system that had no geriatric care facilities or room for the indigent and economically disadvantaged. As a result, the numbers of residents in mental hospitals marked the North-West of Ireland as the region most densely populated with psychiatric patients in the world.

In more recent times, the mental hospital serving the North-West of Ireland has been reduced in size and is now partly converted to a system of community care. A smaller psychiatric unit was set up in the local general hospital. The original psychiatric hospital, a large cut-stone building, has been converted into an upmarket hotel and leisure complex supplying the wants or needs of the economically advantaged in the community. This ironic transition in the use of the building, from those disadvantaged and disabled to those advantaged and enabled, marks a turning point in the culture of the region. The North-West of Ireland has become affluent.

But what has happened to those who need care for their mental health? Who or what is filling the gap left by the contraction of the health services provided, traditionally, by the state? Where have all the so-called ‘mad people’ gone in the North-West of Ireland?

Methodology

My intention in this thesis was to compare and contrast the GROW concept of mental breakthrough with the mental breakdown concept found in psychiatry. Initially I had to understand the two vantage points in the comparison. These two concepts determine how recovery and growth to maturity is understood in each discipline. To do this I had to understand, in each case, who or what is breaking or fragmenting and what might result from this process.

I looked for a method to achieve this. I adopted Devereux's (2000) advice: "One should start by simply describing a society in its own terms". With this in mind I carried out a pilot study to find out what were the words and language of those who inhabited the landscape of mental health and illness. The results formed the topics employed in interviews carried out during fieldwork and are listed in the appendix to this thesis. The interviews informed me and formed my thinking.

Perti Pelto advised, when preparing for interviews: "The phrasing of questions is problematic. Work with the aid of an insider to get good phrasing. Open ended questions enable the informant to shape the answer to what is important to them. A mix of open and closed questions can be most effective. Be careful with the use of ambiguous language or words. Use them judiciously". (Pelto et al, 1978: 77) These statements of advice formed the backbone of the design of the fieldwork.

The resulting mix of formal and structured questioning and informal discussion, intended to comply with the Pelto advice, formed and informed my research. I also learned, at first hand, GROW principles and practice in preparation for fieldwork with GROW members.

While the view of psychiatry is well published and public it has elements of professionalism and privacy that make clear understanding more difficult. Psychiatry concentrates on ideas of treatment after biological breakdown and has just begun to discuss the possibility of recovery. It has limited the concept of recovery to simply having the patient being manageable. It does not expect more from any individual after breakdown has occurred.

Psychiatry professes the bio-psycho-social model of being human with a heavy emphasis on the biological element, almost to the exclusion of the psycho-social elements. Never-the-less, mental illness originating in biological disorder is less than five percent of all cases.

The profession of psychiatry seems ambivalent on the causes of mental illness. Quoting from a teaching text book of psychiatry:

> "Psychiatric disorders are sometimes divided into organic brain disorders, physical pathology which affects the brain and functional mental illnesses, attributed to some kind of psychological stress, although in many cases it would be more honest to say that their cause is not known." (Barraclough 1996:4).

A local psychiatrist, Dr John, became a key informant in this research. I interviewed him and ten other professionals who work in the mental health area. These interviews were formal and constructed interviews based on a set of topics that arose from informal discussions with people in distress. Each interview lasted about one hour and the topics, given in the appendix 2 and 3, were for discussion rather than for question and answer.

Contact with a psychiatric hospital in the region, both formal and informal, made it clear that research inside its walls would not be considered. It became very clear, very early, that psychiatry adopts the medical or biological models and is intolerant of any other view and that research in this area was proper to medical doctors only. Breakdown is a medical problem treatable only with medications. Recovery for psychiatry is defined by a patient taking regular medication and conforming to local ideas of normality.

The GROW vantage point is somewhat obscured by ideas of confidentiality and privacy. GROW concentrates on breakthrough as an opportunity to achieve recovery and growth. What psychiatry has traditionally seen as a biological event that must be reversed GROW sees as a process of evolution to be exploited. Essentially this sets them in conflict while attempting to be complementary.

GROW has a more balanced view of the same bio-psycho-social model. It recognises the need for medical intervention in many cases

but does not claim any expertise in this area leaving treatment to psychiatry. GROW sees recovery, even when defined as recovering to normal life, as inadequate and sets growth to maturity as its target. Paul, a seasoned GROW member became a key informant. I had met him at various GROW meetings at local and regional level before asking him to contribute at interview. Topics covered are listed in Appendix 1. I total I interviewed twelve seasoned GROW members for over an hour each. I also interviewed fieldworkers, administration staff and management representatives using the topics listed in the appendix 1.

My interview schedule also included psychiatrists, psychologists, mental health nurses and therapists and a general practitioner. My intention was to discover their understanding of the major issues in mental health and illness: what caused breakdown and if and how recovery and growth could be achieved after breakdown. I found many areas among them where the language of mental health and illness differed greatly, in words and in meaning.

All interviews were carried out in a private place. Confidentiality was assured even though the interviews were recorded electronically. All names of people and places were changed to enable each person to speak freely. The interviews were transcribed immediately and then deleted from the electronic record. The transcribed texts will be deleted when this thesis is finished.

Concepts of Identity and Self

At this early point, I should explain my understanding of the major referential terms of identity and self considered disordered or diseased by mental illness? Irving Goffman's (1961, 1963, 1967, 1969) understandings of identity and self clearly delineate the complexity of the matter and these and ideas of concepts are considered in detail in the literature review in Chapter 2 of this thesis. Generally, for Goffman, identity resides in the ego or external landscape of the person while self resides in an internal landscape.

Goffman's social anthropological modelling, seminal work in this field, includes medical, social and psychological ideas and how these models interact reflexively. He did not include metaphysical aspects that have since become relevant to anthropology and essential to understanding GROW principles and practice. Also, he did not consider the prospect or recovery or growth.

The medical model includes biological, neurological and endocrine-ological aspects. Defective genes, disrupted biology or 'nerves' are at the roots of mental disorder. Medication and a directed program of behaviour modification form the cure.

The psychological model includes events in the history of an individual and his or her local society. This model, developed originally by Sigmund Freud, deals mainly with the operation of the mind. In Foucault's terms, "he (Freud) restored, in medical thought, the possibility of a dialogue with unreason". This is seen by many, such as Thomas Szasz (1974) and repeated by him at the 'Health4Life' conference at DCU in September 2007, as a separate process from that of brain pathology as constructed by the professions of medicine and psychiatry in particular.

The social model includes individual operations and social interactions of people, beneficial or otherwise. It is central to the concept of growth to full potential and is closely allied with the psychological model.

The spiritual model, of central importance for many in GROW, is constructed mainly by religious organisations. It includes forces in operation beyond scientific models. These metaphysical forces are usually attributed to a 'higher realm' that cannot be accessed directly through a scientific approach.

Carl Jung was the first to enter the spiritual field. Later authors, such as Grof (1985, 1988, 1989, 1990, 2000) and Assigioli (1989), also profess this model. This spiritual model, however, is absent from Goffman's social anthropological model.

Earlier research had shown that although ideas of spirituality are central to the curing and caring process of many patients, the vocabulary of spirituality was very limited. In Christian Ireland, spirituality is not articulated even as death approaches (Roberts, 2004). This research, sited in hospice care, sought a holistic concept of self and identity but this did not emerge. It needed a new site where spirituality would be articulated. GROW appeared to provide such a site. The area of spiritually, considered by some as too personal and private to research, is central to GROW ideas of humanity.

Such private and personal moral and ethical matters must be approached with great respect. I was concerned about the moral and ethical issues that arise in working with people who are considered in recovery from mental anguish. Some of the experiences in the field, at group meetings and at interviews, had much in common with the Freudian, Jungian and Kleinian approaches to therapy. Could my participant-observation fieldwork or interviewing technique either damage or inhibit the recovery process of my informants?

Being accepted and monitored by the National Executive of GROW Ireland put my mind more at ease on this matter. The Executive agreed to act as ethical supervisor in this research. In practice such monitoring was not evident and no ethical problems arose. The Ethical Guidelines of the Anthropological Association of Ireland informed my general approach.

Synopsis of Research

The pattern of this thesis emerged as my research progressed. When I started working in the field, the people I met saw GROW as a complement to State services, a type of follow-up service that the State did not and possibly could not provide. GROW was free of the State service adult-to-child relationship and allowed each individual to bloom outdoors under the more benign influence of a peer-to-peer relationship.

As the research progressed, I heard more critical comments about GROW, that it was as dominant as any State service, having joined with the State service. Some GROW members felt a sense of resistance seeing GROW as an extension of State service. These members felt that they could not bloom indoors and eventually they would have to leave GROW. This dichotomy became a central and structuring feature.

Chapter One introduces the research project by giving an overview of how this research was conceived, produced and developed at sites of co-operation and conflict in the transitional landscape of GROW. This landscape is populated by people in recovery and growth, buildings in transition, concepts and rituals in development and power in flux and flow.

Chapter Two is a review of the theoretical literature of the discovery of self and the construction of identity as they reflect the ritual process of recovery from mental breakdown and breakthrough. Mattingly and Garro and Kirmayer's interpretations of the use of narrative offer insight to the process of analysis and synthesis of self and identity. Saris gives insight to how the physical environment was used in the North-West region of Ireland to predispose the patients of mental hospitals to change from disorder to an ordered way of living. Edith and Victor Turner's research of ritual performance helps in understanding GROW practice. Van Gennep's rites of passage illuminate the transition from good mental health, through breakdown to recovery and reincorporation in everyday society. Foucault's understandings of power relationships give insight into the forces driving the recovery process.

Turner's and Csikszentmahali's concepts of flow and liminoid states in healthy growing help the understanding of the concept of good mental health after recovery. These concepts combine to form a single lens to interpret the principles and practices of GROW in later chapters.

Van Gennep's over-arching theory of rites of passage is illuminated at specific points along the way by the other theoretical perspectives.

Chapter Three reviews the competing understandings of disorder and inadequacy in the North-West of Ireland. It includes an overview of the dominant local understanding of mental health and illnesses and the forces attempting to resist and change that concept. It includes a review of how GROW finds a balance between using, complementing and resisting the dominant local concept while reviewing the other alternative and complementary treatments available. Competing and resisting forces are viewed from the powerful perspectives of Foucault and Szasz.

Chapter Four reviews the development of GROW locally, nationally and internationally and the key people who influenced its construction. This process makes manifest an inherent and powerful example of Foucault's 'strategy, program and technology of power' and how they have determined the trajectory of GROW. It includes a review of key settings where GROW group meetings take place, interpreted through the ideas developed by Saris (1990: 40) recognising "the embedded-ness of narrative within institutional frameworks". This same embedded-ness is found in GROW narratives, story and personal testimony of life experience shared with others with a similar life experience.

Chapter Five researches the concepts embedded in the theories and tenets found in GROW, particularly in the contents of The Blue Book, the handbook of every GROW member. This powerful program contains the wisdom distilled from the experience of recovery and growth of many seasoned GROW members over the past 50 years. It is used to construct GROW identity in Goffman's and in Saris's terms.

Chapter Six reviews the discovery of self and the construction of identity through the production of narrative embedded in performance of GROW ritual. It interprets GROW narrative from Mattingly and Garro's (2000) and Kirmayer's (2000) perspectives.

Chapter Seven offers interpretation of performance of GROW ritual, in Turners' terms, in which GROW enacts healing in a process of integration of identity and reincorporation of self. It interprets the technology of The Group Method used to regulate power, in Foucault's terms, at GROW group meetings. It reviews the concept of recovery as the final stage of a rite of passage, from breakdown to treatment in psychiatric terms, and from breakthrough to recovery in GROW terms.

Concepts of recovery are interpreted from the perspective of Van Gennep (1960) and of Turner (1957, 1969, 1974, 1982, 1992). Growth is interpreted by Turner (1982) and Csikszentmihalyi (1990 and 1993) as a concept of flow, of living a life of ease in internal personal and external social relationships.

Chapter 8 compares and collates the work of the earlier chapters. It maps and interprets the landscape of GROW identity and self and how they are constituted.

The Appendices contains the lists of topics used for discussion at the interviews that form part of this research.

Chapter 2 Literature Review

To begin this research I conducted a pilot study to enable me to appreciate what issues most concerned members of GROW and psychiatry. Ideas of meanness, selfishness, devaluation of self, identity crisis and the power of State agencies featured strongly in discussions with people who had experienced breakdown and treatment in psychiatric care.

Later, when people related what had changed for them since joining GROW, ideas of self importance and worth, friendship, narrative construction, ritual performance, rite of passage and power to make change dominated. GROW's holistic landscape, its economy of power, its language, its spiritual, social, mental and physical environment and the landscapes of self and identity came into view. This harks back to the classical period when, according to Foucault (1967: 159): "Long cures for madness were elaborated whose aim was not so much to care for the soul as to cure the entire individual, his nervous fibre as well as the course of his imagination".

The landscape features congealed to form the lens to observe GROW, participate in its operations and to appreciate and discover the hermeneutic inherent in GROW. To find and explain this hermeneutic I reviewed the literature already available from key informant researchers in the areas that emerged as critical elements.

Irving Goffman's concepts of identity and self became obvious early on. Kirmeyer's contribution to understanding narrative helps to explain how GROW uses narrative. Foucault's views on power and resistance strategies provide major insights to the construction of the truth of mental health and madness, truth arrived at "in the form of a slow pedagogy" for GROW, and for psychiatry "of an authoritarian invasion" (Foucault, 1967: 187).

Edith and Victor Turner's research on ritual practices help to explain the operations of GROW while Victor Turner's and Arnold Van

Gennep's revealing research on rite-of-passage help to provide an understanding for the purpose of breakdown and recovery from it in GROW terms. Ideas of growth are illuminated by the research of Mihalyi Csikszent-mihalyi and the ubiquitous Victor Turner. Modern authors: Dawkins, Humphreys, Allchin and Lane elaborate ideas of godliness so inherent in all that GROW does. This chapter explores and explains this networked and competing array of powers and performances and reviews the embedded theoretical concepts.

But, what is breakdown? What is the context of the understanding of what is in motion when mental health and illness, treatment, recovery and growth are raised for discussion? Even within psychiatry, the profession that presumes to care for and cure those afflicted, this is not agreed. Psychiatry in the USA tends to include all aspects of the bio-psycho-social model, according to Kleinman (1988: 148) while in Ireland the medical or biological model only pertains.

Understanding Breakdown

Psychiatry has its own language. P. J. Meehan, an Irish psychiatrist, describes mental breakdown in terms of "disorders of functioning of the personality, disturbances in thinking, feeling, and behaviour" (O'Sullivan, 1986: 11). Recovery is implied in terms of re-ordering the functioning of personality, resetting thinking, feeling and behavioural processes. Meehan does not clarify what criteria are set for this to be achieved.

Roberto Asagioli, an Italian psychiatrist, has his own definition of mental breakdown:

> "He [the patient] struggles to re-establish ordinary life. He feels distracted, with a sense of moral crisis and feelings of guilt. He feels discouraged and often suicidal in response to a feeling of increasing impotence and hopelessness, of breakdown and disintegration, nervous tension and insomnia and psychosomatic

> disturbances. Inner conflicts can now lead to resolution if handled properly, enabling integration at a higher level" (Grof, 1989: 32).

Asagioli also offers a framework for recovery and growth:

> "The physical, emotional and mental problems arising on the way to Self-realisation are temporary reactions, by-products of an organic process of inner growth and regeneration, and a good investment. This vision gives inspiration, comfort, strength and courage, and helps to maintain focus on recovery. Self-realisation is characterised by joy, serenity, and inner security, a sense of calm power, clear understanding, and radiant love. It is a realisation of essential Being, of communion and identification with the Universal Life" (ibid: 47).

He neatly combines the physical, mental, social and spiritual aspects of humanity in a holistic manner. But how does an anthropologist understand 'breakdown', 'recovery' and 'growth' processes? In other words, what do people do to achieve them?

Goffman on Identity and Self

Irving Goffman, a renowned sociologist with anthropological leanings, made a major study of the concepts of self and identity. It is also interesting to note that Goffman did this early work at the same time as GROW began to develop. He produced his work at a time that was not as gender-conscious as today and generally he referred to his informants as he or him, seldom using 'she' or 'her' in his fieldwork. I have avoided this gendered presentation since my fieldwork included interviews and experiences with men and women in equal numbers. However, I have quoted Goffman verbatim.

Goffman viewed breakdown in terms of a loss of identity and of the sense of self, and recovery in terms of their reconstruction. For

Goffman, identity and self are roles we play in everyday life that are evoked by local, social and environmental forces. In his later work, Presentation of Self in Everyday Life (1990), he quotes Robert Ezra Park who suggests that:

> "Everyone is always and everywhere, more or less consciously, playing a role. It is in these roles we know each other; and that we know ourselves" (Goffman, 1990: 30).

Breakdown then, is when we perform a role which is not reflective of the real person but is nevertheless sincerely played. "At one extreme, one finds that the performer can be fully taken in by his own act." (ibid: 28). It also occurs, presumably, when an inappropriate role is enacted in a given setting. Goffman sees these roles as fronts or masks donned to suit the scenery.

> "Since fronts tend to be selected, not created" (ibid: 38), "the audience often assume that the character projected before them is all there is to the individual who acts out the projection for them. The performer has as many different social selves as there are distinct groups of persons about whose opinion he cares" (ibid: 57).

Masks are icons of the person.

For Goffman, a mental hospital is "a social establishment, a place surrounded by fixed barriers of perception in which a particular kind of activity regularly takes place" (ibid: 231). A social establishment contributes to, and may even determine, the role played or the mask worn.

In Goffman's later work, Asylums (1961), he treats the asylum as a social establishment, a major and defining influence in the life of the person with mental health problems who spends time there. This

complies with Saris' (1990) understanding of how a building or a social concept serves to 'set up' a role or performance and the narrative embedded in it.

"The category 'mental patient', understood in the sociological sense, becomes significant as it alters his social fate and becomes fundamental only when the person is put through the process of hospitalisation" (Goffman, 1961: 128). Entry to an asylum starts a new career that calls for new and defining roles.

> "Entry to mental hospital typically begins with the experience of abandonment, disloyalty and embitterment. These mark the beginnings of his moral career" (ibid: 133).

These new roles are choreographed by powerful forces that dominate the asylum. Key informants in this research perceive that psychiatrists are the choreographers who write the script to be followed.

In asylum a person's life changes trajectory. Control is lost and the person careers as a mere planet into a new orbit around a central star, the psychiatrist. This can diminish personal worth in a way that is extremely difficult to recover. "The events recorded in case histories are just the sort that a layman would consider scandalous, defamatory and discrediting" (ibid: 158).

Others now control the orbit of the patient and usurp responsibility for recovery. What occurs in asylum imprints a stigma that can last for life. The social scar will remain in scripted history until death and, as Saris suggests, on to future generations.

> "When an individual co-operatively contributes required activity to an organisation and under required conditions, he is transformed into a co-operator; he becomes the 'normal,' 'programmed' or 'built-in' member" (ibid: 188).

He or she is normalised into the masks and roles of a mental patient. He becomes a masked and 'marked man'. She becomes a 'fallen woman'.

Stigmatising is essential in the eyes of the asylum establishment. "Ward staff members are felt to have the right to know those aspects of past conduct which, embedded in the reputation he (the patient or client) develops, purportedly make it possible to manage him with greater benefit to himself and less risk to others" (ibid: 158). The person is reduced to a case history, a psychiatric pre-scripted patient.

The rest of that person's life will be dominated, trammelled and bounded by the information or history given in the case history file. Those who will have access to it hold the power of proscription to decide how they will respond to what it contains. The case file is the visible mark of stigma. Stigma is prescribed. This focuses, as Jackson (2005: 1) proposes: "on the relationship between events and what we make of them and the way in which these discursive responses become conditions of the possibility of future events".

Goffman, in his book Stigma (1990), made a major contribution to our understanding of the effects of a stigmatising process. "The Greeks originated the term stigma to refer to bodily marks designed to expose something unusual and unacceptable about the moral status of the signifier" (Goffman, 1990: 11). For those branded with stigma the choice of masks or roles becomes limited. The community responds in a variety of ways to this stigma but, in general, "we exercise varieties of discrimination, through which we effectively reduce his life chances" (ibid: 15).

For Goffman "there are three types of stigma: (1) abominations of the body, (2) blemishes of character and (3) tribal stigma" (ibid. 14). Mental illness is mainly in the second category but has aspects of the other two categories. Uncontrolled reactions or unacceptable behaviour register the 'abominations of the body'. Residency in asylum registers as a 'tribal stigma' especially if the burn marks on the wrists

produced by ECT remains visible. These group or 'tribal markings' serve to differentiate the patient from the general public, even if they are covered and the patient has recovered full health. They remain significant as they can be uncovered at any time.

Goffman suggests "that a discrepancy may exist between an individual's virtual and actual identity. This discrepancy, when known about or apparent, spoils his social identity; it has the effect of cutting him off from society and from himself so that he stands a discredited person facing an un-accepting world" (ibid: 31) and an un-accepting self. As Wittgenstein proposes, "without such a sharing I will become incommunicable to myself" (Das, 1998: 16). Identity discrepancy leads not just to feelings of isolation and abandonment but will cause or exacerbate their actual occurrence. A feeling of being unwanted or abandoned separates the individual from the crowd and from a reasoning self.

Lacking the salutary feedback of daily social intercourse with others, the isolated person can become suspicious, depressed, hostile, anxious and bewildered with feelings of uncertainty of status. Stigma may induce cowering or hostile bravado and these can provoke in others a set of troublesome reciprocations. The reactions to stigma may reinforce stigma.

The older idea of malingering arises where the person uses a stigmatised identity as a means of avoiding responsibilities.

> "The stigmatised individual is likely to use his stigma for 'secondary gains.' He may also see the trials he has suffered as a blessing in disguise especially because of what it is that suffering can teach one about life and people" (Goffman, 1990: 21).

Stigma may even produce the idea of a 'chosen people', a people set apart for special attention and hardship, a people destined for

sainthood with much in common with those who portray the Christian crucifixion ‘stigmata’. Stigma becomes the mark of saintliness.

The question now arises of who is real, the ‘ordinary’ person before breakdown or the ‘saint’ after it? Is the original identity retained in deep memory awaiting recovery or is it destroyed and replaced by a new, socially unacceptable or sanctified identity? In either case, the original person, the set of masks and roles worn habitually before mental breakdown, is gone, and must be mourned (Saunders, 1978, and Roberts, 2004). Mourning is a rite of passage from a state of denial to a state of acceptance of life as it is.

Stigma can be a source of great stress and trauma, bringing bereavement feelings of denial, anger, bargaining and depression and if persisted with, acceptance of the reality of what the stigma signifies. Until then containment in asylum is a stigmatised state that establishes Van Gennep’s (1960, 1908) isolation phase. ‘Treatment’ is the only way out but what kind of treatment will achieve release from stigma?

Treatment, in the broad sense, marks the transitional phase between social isolation and reintegration. Family, friends, society at large and professional carers, and those whom Goffman terms wise people can populate this transitional landscape. ‘Wise’ people usually empathise with the experience of the stigmatised. Empathy can be achieved through spending time with stigmatised people and by reading their literature. I learned to empathise with GROW members and began to see them as friends with a particular set of difficulties and in this sense I became a wise person in Goffman’s terms.

Stigmatised people tend to avoid or mislead others who are not so wise or caring. They can display dis-identifiers when stigma is not immediately evident. “The decoding capacity of the audience must be specified before one can speak of degree of visibility” (ibid. 68) and dis-identifiers can vary greatly from time to time and environment to environment. Some signs of stigma are fugitive. According to Goffman, “slips”, such as the ticks or twitches of Tourette’s syndrome, “are

temporary changes of appearances that can discredit tacit claims to worth" (ibid: 61).

Flashes of what appears as undue anger can mark some who have been stigmatised with mental illness. The anger reflects a past event that the current event is a reminder of. Such unaccountable anger can produce a stereotype of being mentally ill.

For Goffman, "stigma is an off-shoot of stereotyping, broad categories of strangers, which decrease as they become friends or intimates" (Goffman, 1990: 69). The art of 'profiling', the production of conduct or characters can also apply here. 'Profiling' is a public display to achieve a false form of acceptance. In private it does not work. "In small and long-standing social circles, each member comes to be known as a 'unique' person to the others" (ibid: 73). "Facial features or voice, or what is at the core of his being will produce a specific identity" (ibid: 74). In GROW a story or personal testimony suffices.

Passing can be considered in an array of opportunities that present themselves such as moving to a new environment with little or no chance of discovery. Passing leads to re-incorporation into a new community with a new name and a selected biography, one designed to suit the new social environment. It makes daily life easier but does not confront the difficulties that brought disorder in the first place. In this way it is a space of internal disorder and external order. This is what constitutes 'dis-ease', where self and identity are in conflict.

"Where a different-ness is relatively unapparent, the individual must learn that in fact he can trust himself to secrecy" (ibid: 101). There are places where trust is more difficult. "It is easier to achieve trust in safe or civil places among his own kind", such as a support group, "and in involuntary grouping or back [porch] places, such as in a public bar" (ibid: 102). In seeking such a support group one may find a group that accepts disorder but does not attempt to rectify it. Passing may in fact exacerbate the dis-ease which continues on a destructive trajectory.

When a person attempts to pass, to act out a place-appropriate role, what soon transpires is:

> "unanticipated needs to disclose discrediting information about himself. He also suffers from 'in-deeper-ism', a pressure to elaborate a lie further and further to prevent a given disclosure. His adaptive techniques can themselves give rise to hurt feelings and misunderstandings on the part of others" (Goffman, 1990: 105).

The others may feel used and abused when they offer friendship and companionship and are misled in return.

Passing presents a learning experience that allows insight to what others 'really think' of persons of this kind. This produces "a social tension that needs resolution leading to a show-down" or being "confronted with his having been false. This resolution can even be formally instituted as in mental health hearings" (ibid: 106) to produce a cathartic cure.

People can break through to a more personal plane. "Even with stigma being very evident, some 'wise' people have the required empathy to get past it and meet the 'real' person. Familiarity does not necessarily reduce contempt" (ibid: 75). Contempt can increase if the people concerned are not wise enough to deal with the encounter. Becoming a friend does not happen without major effort beyond the range of mere talk.

"After a period of treatment in mental hospital it is easier to disguise the fact than if current treatment is ongoing", (Goffman, 1990: 97). The skeleton is safely in the closet. A conflict can arise between the need to accept the stigmatising fact and to be open about it. The skeleton in the closet is you. Stigma produces many strategies of concealment, from name-changing to cause confusion, to drug abuse to obliterate the offending stigmatised role, to the production of a cover, a

whole series of roles, each appropriate to the location and environment of performance.

This occurs regularly in GROW where members chose to attend a support group in a neighbouring town rather than in their home town, or take on a new job without disclosure of past experiences. Goffman suggests that a “change of job, once the rehab worker is eliminated” or “substituting a lesser stigma” (Goffman, 1990: 116) is often used. Many GROW members know this. GROW membership is easier to explain than being an ex-patient of a mental hospital. Being a GROW member can be a cover story.

GROW uses first names only, detaching personal history until a GROW narrative, a selected commentary, emerges. “Using an alias detaches him from personal identity” (ibid: 130). Other good ploys are to “tell a small group all” such as a GROW support group, and “tell the rest nothing at all” (ibid: 117), and “keeping a physical distance” (ibid: 122). This limits the chance of being stigmatised.

Erikson described ego or felt identity as the subjective sense of a personal situation and continuity and character obtained through social experiences. Goffman quotes Erikson: “Ego is a subjective and reflexive matter that must be felt by the person in question” (Goffman, 1990: 129). The impression we make on others creates our identity. This may reflect or disguise the inner self or a sense of ambivalence on the part of the stigmatised person.

Ambivalence towards stigma is common on the part of the stigmatised.

> “Oscillations of identification and association exhibited in regard to his fellow-stigmatised, those who are stratified by the degree to which their stigma is apparent and obtrusive. He can then take up in regard to those who are more evidently stigmatised than himself the attitudes the ‘normals’ take to him and here oscillation of identification is most sharply marked” (Goffman, 1990: 130).

Stigma produces an array of attitudes that can formulate into a strategy. It can also produce an array of emotional problems. "Social and psychological identification with these offenders holds him to what repels him, transforming repulsion into shame and finally into something he is ashamed of" (ibid: 131). Repulsion is transformed into shame when the stigmatised person is not 'wise' enough to deal well with it. "He can neither embrace his group nor let it go. Ambivalence is most obvious in 'nearing', that is, in the individual's coming close to an undesirable instance of his own kind while 'with' a normal" (ibid: 132).

Diminishment, a feeling of being devalued, along with shame, and being shameful, is accomplished by the inner self leaking into the external identity, becoming displayed to some degree. The sad and bad experiences that constructed the inner persona become displayed. This agrees with Wittgenstein's proposal that "inner states are in need of outward criteria" (Das, 1998: 16) simple because they were created in response to the outer criteria.

How can such feelings of diminishment, shame and being shameful be avoided? According to Goffman, "a desirable pattern of revealing and concealing" is made available by some psychiatrists. The person is encouraged "to believe enough in the medical, not moral, nature of his past failings to reveal himself" (Goffman, 1990: 133). This strategy relieves feelings of guilt and shame as biological illness is outside the control of the person. From this point of view, mental illness is a medical problem that merits a medical code of treatment: the psychiatric code. The skeleton can come out of the closet without shame.

To fail to adhere to the prescribed local code of conduct is to be, in the eyes of the local community, a self-deluded and misguided person. To adhere to the code is to be real and worthy, qualities that combine to produce authenticity. Awareness of the need to behave properly is strengthened by feelings of authenticity.

This is the psychiatric model at its worst. Stigma becomes institutionalised. Cure is covered by a medicated version of reality. It is 'passing' under a guise of illness. If handled badly it can be a denial of reality, a compliance and collusion leading to a continuance of disorder. For Goffman, "it is a case of conformance, not compliance" (Goffman, 1990: 153). Although behaviour is now acceptable, it is simply another form of 'passing'. In this way "identity norms breed deviations as well as conformance" (ibid. 154). This emphasises the view that "normal and the stigmatised are not persons but rather two perspectives generated in social situations" (ibid. 163), roles that each person performs. This is true in all communities but is easier to manage in smaller communities.

Can conflict remove stigma? Goffman thinks not. "Militancy to remove stigma may serve to reinforce it" (ibid.139). Being diplomatic and persuasive is a more productive strategy. "The stigmatised person helps normals to be comfortable in his company" (ibid: 144). The person becomes acceptable in community by conforming to its norms and this is easier in small peer groups.

Larger communities need policing on a daily basis, with the police, be they civil, psychiatric or otherwise, taking responsibility to maintain conformity and even collusion, while compliance is left to the individual. In this, psychiatry has a history of producing conformity and collusion. Only with the help of 'wise' people is a healthy compliance produced.

'Passing' can lead to narrative disruptions that must be addressed at some stage if acceptance is to be achieved.

> "Biographical discontinuity is bridged by affording accurate and adequate information about his past to those in his present, and by those in his past bringing their biographies of him up-to-date through news and gossip about him" (Goffman, 1990: 99).

A person can have a number of identities, each depending on the impression made on other people. "We assume that an individual can have only one biography. We assume an 'informational connected-ness', depending on the kind of facts and the relatedness of any pair of them gives to identity" (ibid: 81). We assume that what we see is what we get. If a person performs a role well deception of self and others is always possible.

"There are distinctions between social identity, the role repertoire or profiles made permissible by age, economic class, education or social past, and personal identity representation and misrepresentation" (ibid. 82). The right to reticence is earned only by having nothing to hide. It is necessary for each person to have "a memory, an accurate and ready accounting in his own mind regarding the facts of his present and past which he might owe to others" (ibid. 83). In GROW this is having a personal testimony.

Your name and past history are not private properties. They are opening gambits in the display of personal or community identity.

> "Aspects of social identity may be used to construct personal identity. Stigma, and the effort to conceal it, becomes 'fixed' as part of personal identity" (ibid. 84).

Concealing stigmatising information from potential friends undermines relationships, both current and future. This can explain a willingness to reveal ourselves, either anonymously or to a closed circle of friends, to make a public appearance before a small private audience, such as a GROW group. The assumption is that private disclosures are confidential and will not be made available to the general public. It is part of the 'coming-out' process, of revelation of self. We begin to tell our story.

Personal and social identity is divided into levels of people who know or do not know identity at different levels. "The burden is greatest

for those who are most fearful of exposure and its possible consequences" (ibid: 85). Acquaintances or friends formed in compromising situations can be perceived as a threat.

This places the person at the centre of an array of people with different levels of knowing. They not only know 'of' or 'about' him, they know him personally. "Cognitive recognition is simply an act of perception, while social cognition is one individual's part in a communications ceremony" (Goffman, 1990: 87). Some kind of single biography will be maintained "in spite of the multiplicity of selves that role and audience segregation allows" (ibid. 92). It is the construction, maintenance and development of this biography or personal story that marks the journey to social and personal acceptability and good health.

Acceptance is the hallmark of recovery but it does not come easily. "The central feature of the stigmatised individual's situation in life can be called acceptance" (Goffman, 1990: 19). Accordingly, shame and a sense of being victimised become central possibilities arising from the individual's perception of his or her own attributes as being defiling and devaluing things to possess.

The stigmatised person will find that there are sympathetic others who are ready to adopt his or her standpoint in the world and to share with him or her the feeling that he or she is human and essentially normal in spite of appearances and in spite of self-doubts. Those who "share the experience of his stigma, a circle of lament to which he can withdraw for moral support and for the comfort of feeling at home, at ease, accepted as a person who is really like any other normal person" (ibid. 32). He

"can use his disadvantage as a basis for organising life, but must resign himself to a half-world to do so. He may have to develop his sad tale accounting for his possession of the stigma" (ibid. 33).

On the other hand,

> “he may find that the tales of his fellow sufferers bore him, and the whole matter of focusing on atrocity tales, on group superiority, on trickster stories is one of the penalties for having one” (ibid. 36).

According to Goffman a stigmatised group will produce a publication to stabilise their sense of being a group. “Often those with a particular stigma will sponsor a publication of some kind stabilising for the reader his sense of the realness of his group and his attachment to it” (1990: 37). An intellectually worked-up version of their point of view is thus available to most stigmatised persons.

> “Here the ideology of the members is formulated – their complaints, their aspirations, their politics. Success stories are cited, tales of assimilation, atrocity tales are recorded, historic and recent, and exemplary moral tales are provided in biographical and autobiographical form illustrating a desirable code of conduct for the stigmatised” (ibid. 38).

GROW has such data in its collection of published works: in **GROWing**, its quarterly journal, in Soul Survivors, its anthology of personal testimony and in its Blue Book, an account of its principles and practices.

Some members may devote their lives to this publishing work or may devote their lives to the executive work of GROW. By becoming professional representatives they effectively leave the group, ceasing to be representative of it. In becoming professionals they become wise people, empathetic with but not included in the community of the disordered anymore. They may speak for the disordered but “without the stigma whose special situation has made them intimately privy to the secret life of the stigmatised individual and sympathetic with it” (ibid. 43).

Family, and other relatives, is another branch of the wise. According to Goffman, “the tendency for the stigma to spread from the stigmatised person to his close connections provides a reason why such close relations tend either to be avoided or to be terminated” (ibid. 44).

There is also the stigma-phobic response of the stigmatised to the ‘normal’, a pre-emption of a hostile response. The ‘wise’ can be uncomfortable company for both ‘normal’ and those with stigma as they can confront everyone else with too much morality. Apparent or real self-elevation is a common refutation of the wise.

People who have a particular stigma tend to have a similar moral career. That is both cause and effect of treatment in a mental hospital. It is also the result of living with normal people.

> “The stigmatised person learns and incorporates the stand-point of the normal, acquiring the identity beliefs of the wider society and a general idea of what it would be like to possess a particular stigma. The timing and interplay of these two phases form the foundations for later development”, (ibid. 45).

Understanding the implications of social difference begins: the gap between what is acceptable and what is not. This is learned in a GROW group from those who have learned it elsewhere at an earlier time.

At this point, moral career options arise. “First is to develop a personal history for those with inborn stigma” (Goffman, 1990: 45). In this case stigma is assigned without any personal input. However others may contribute to its arrival. “This will be influenced greatly by the capacity of a family (or group) to constitute a protective capsule by means of information control” (ibid. 46). Isolation begins even as a child. Family cannot accept the child’s difference. They assign stigma and its foundations are set.

This is further complicated by finding another community, such as in a mental hospital, where acceptance can involve making stigma central but in a negative way. "Where the stigmatisation is associated with being institutionalised what he learns about stigma will be transmitted during long periods of contact with those being transformed into fellow sufferers" (ibid 50). In such institutions stigma is learned from day-to-day experience in the hands of professionals and imposed by other stigmatised people.

Segregation may induce the person to find another strategy to deal with the stigma. This may include seeking "another community that makes loyalty and income claims, defining the person as someone who should take pride in his disability and not seek to get well" (Goffman, 1990: 52). In this alternative community it is acceptable to be mentally ill and to limit efforts to get well as a resistance strategy. This strategy is designed to confound the stigmatising effect imposed by time spent in mental hospitals.

Hospitalisation can be a defining moment for the person. "The isolating and incapacitating experience, such as hospitalisation, which later becomes seen as the turning point when the person was able to think through his problem, learn about himself, sort out his situation, and arrive at a new understanding of what is important and worth seeking in life" (Goffman, 1990: 54). Goffman assumes that the released patient will be able to rationalise the experience of being hospitalised in a way that is valuable and helpful. The experience of isolation, treatment, and recovery may or may not provide a narrative that he and others use to define him. If not, treatment continues. If a narrative is created, a new sense of self and identity can evolve. Goffman's biography becomes narrative construction.

Kirmayer on Narrative Construction

Laurence J. Kirmayer (2000) illustrates how narrative can be used and abused. For Kirmeyer, the narrative of a healthy person must

involve elements of true authorship and veracity of the factual information presented. For those who have been stigmatised, this can be a great problem. 'How far out can I come?' could summarise the problems involved. Pressure is on the emerging person to reduce narrative to a given formula, one that will satisfy the intended audience but is removed from the reality of life experience. "Where narratives are most coherent, they may be formulaic and distant from sufferer's experience" (Kirmeyer. 2000: 153). The personal story of a real life is not so coherent.

Personal narrative is usually developed long after the disordering experience has passed and new challenges in the present may determine what version of the personal history is narrated. "Narrative represents an end point, a revisioned account of the self as victim, survivor, and author of its own heroic journey" (ibid. 154).

This corresponds to the GROW formula for narrative production. Pressure to "weave the narrative strands of self into a tapestry, a seamless whole or at least a cognitively and socially workable and rhetorically powerful account" (ibid. 154) may alter the content and trajectory of the narrative. The act of writing narrative can alter it. "Narrative conventions serve to stabilise and authorise stories through direct effects on remembering and through effects on social acceptance" (ibid. 154).

But at least the narrative account will have a coherence that others can follow. "Fractures of narrative may also reflect the inchoate nature of illness" (ibid. 171). The many and different accounts of a personal story may appear fragmented in the ears of a discerning audience. "Identity can become fragmented through ruptures in the narrative that impair the sense of continuity of self" (ibid. 54) and these breaks in narrative must be bridged on the road to recovery.

"Narratives are important for codifying, representing and remembering experience" (Kirmeyer, 2000: 155). The structure of narrative with beginning, middle and end of a story, gives a coherent

structure to an otherwise discontinuous history of stigma, passing and acceptance. The language used to tell the story negotiates the vantage point from which it is told when "the patient and healer try to influence each other" (ibid. 155). Kirmeyer quotes Perelman (1982): "Much argument and effort to influence others rests on the poetic and evocative use of language" (ibid. 156).

Once authorised and accepted, a coherent story can be retold and so it persists. The person becomes stabilised. It displaces the broken narrative of the broken person. It displaces at a social level where "the conflicting interests of doctor and patient play at cross purposes and tears apart the fragile world of shared experience" (ibid. 169) that reflects "the voice of the body, the voice of the medical authority and the muffled voices of the family with overarching narratives that are invested with moral significance and unquestioned truth" (ibid. 170).

Privacy, immediacy and implacability vie with Saris's (1990) idea of technical knowledge, codified norms and institutional procedures. Private and professional perspectives of self and identity are set in the time and space of each cultural setting and in the over-arching culture. Time and space are used to structure narrative as travel along a trajectory, a strand, thread, line of thought or across a plot of landscape.

> "Story is narrative with linear progression. Plot has looping back in time and so violates the ordinary, unidirectional flow of time through foreshadowing, flashbacks, and other structural innovations that create new levels of meaning by relating past, present and future in spatially ordered ways" (ibid. 171).

Plot, a story with a message, reproduces and reinforces a fractured past. Story is corrective "adding teleological structure usually given as human goals and intentions where narrative is driven forward by causality" (Kirmayer, 2000: 172).

Cause and effect help to give logic and coherence even where they are only imagined and cannot be proven.

> “In mythological narrative, the causality is that of the irreducible agency of the actors: they have power and autonomy, while in ideological narrative, the actors are merely exemplars of laws or processes of action, relationship and transformation, whether these be political, sociological or physical: they have power but no autonomy” (ibid. 172).

Jackson sees narration as where “one reclaims a sense of agency, recovers some sense of purpose, and comes to feel that the events that overwhelmed one from without may be brought within one’s grasp” (2002: 36).

Power, although it may have the appearance of autonomy, in this sense, can be analysed as dependency, either overt or hidden. Exemplars are merely symbolic of what should be or, perhaps could be, and represent total independence. Myth may reflect real life more closely than ideology and explain it better.

> “Religious, scientific, and psychiatric explanations fall into each category. Psychiatric diagnosis and therapeutic interpretation involves efforts to turn the patient’s mythical narrative to ideological narrative: (1) to give coherence, (2) to give clinical control over interpretation and continuance, and (3) to reinforce the reality of the ideology from which it draws its structure [and epistemologies]. This is helpful to the patient if the cognitive and social coherence of the ideology is superior to that of the mythology - if the patient can invest in it” (ibid. 173).

Socially acceptable narrative offers an already organised belief system or epistemology for those who are mentally disordered where no

other narrative is available. If the patient resists this construction, the psychiatrist is weakened.

> "The refusal to accept the psychiatrist's narrative is countered by pathologising the patient's failure to accept treatment as a weakness in the psychology of the patient to accept the truth. Coherence adds power to the scientific narrative when it conforms to the overarching myth. Other clinical narratives are true because of their evocative poetic metaphor" (Kirmayer, 2000: 174).

Truth then simply complies with the prevailing myth that informs the perspective of the local culture. "Narrative accounts of suffering and healing can be understood as locally produced and contested essays of meaning that require shifts in the conceptual models and relative social positions of actors to pursue" (ibid. 175).

Under what circumstances does one person's coherence become powerful enough to become another's belief? Is coherence alone enough to counter the idea of fragmentation or breakdown, enough to enable or allow a shift from the concept of breakdown to the concept of breakthrough? Where does such a powerful impulse come from to enable this shift? Kirmeyer does not attempt to answer these questions. For him, coherence itself is powerful enough to evoke change of perspective and to shift myth. But what do others say?

Foucault on Power, Madness and Truth

Theoretical considerations of social power relationships must begin with Michel Foucault, an eminent French philosopher. He attempted to show that the basic ideas which people normally take to be permanent truths about human nature and society change in the course of history. His studies challenged the influence of German political philosopher Karl Marx and Austrian psychoanalyst Sigmund

Freud. Foucault offered new concepts that questioned people's assumptions about prisons, the police, insurance, care of mentally ill people, gay rights and welfare.

German philosophers Frederick Nietzsche and Martin Heidegger were among the influences on Foucault's thought. Nietzsche maintained that human behavior is motivated by a will to attain power and that traditional values had lost their influence over society. Heidegger criticized what he called “our current technological understanding of being.” Foucault's thought explored the shifting patterns of power within a society and the ways in which power is acquired. His seminal work shaped ideas of power that still give perspective to anthropology today.

My schoolroom ideas of power came from the perspective of science. For science, power is the ‘ability to do work, when a load is moved through a distance in overcoming a resistance’. Later life experience illustrated how power becomes operational in settings I could not have envisaged then. I had no other perspective. Foucault offered me a new perspective.

Foucault’s early work was carried out in asylums and led to a publication titled *Madness and Civilization*. It was produced in French in 1961 and in English in 1967, coinciding with Goffman’s work and when GROW was forming. All reflected the thinking of the time. This was also the period when Carl Roger’s work on person-centred psychotherapy reached its full flowering (Rogers, 1967). Concepts of identity and self and how they are constructed were to the fore in France, America and Australia at the same time.

It was also the period when civil rights protests occurred all over the world. This may have been because of the number of displaced, disordered and devalued people produced by World War Two. The rise in the worldwide rate of clinical depression forecast by Amnesty International (2003) brings these issues to the fore again now. This may

be because people have been devalued through the process of industrialisation and globalisation.

Foucault's work shows that civilization has always had a place for victims in its social order. War had produced a new group and Foucault investigated how they were treated. His initial observation suggests that they had learned to be poor, delinquent and mad. "Learning becomes madness through the very excess of false learning" (Foucault, 1965: 25). For Foucault, learned values and beliefs become the foundation of behaviour. It is not pathological, genetic nor particularly cultural, but something pedagogically universal. It begins in the external and experiential world of identity and leaks inwards to invade the self.

From the sacking of Troy to the wars of the twentieth century, all cultures have taught displaced people how to be disordered and deranged. It raises the question of whether this group of 'mad' people are deluded or not or whether the rest are just too insensitive, too protected or too isolated to recognise our own disordered reality? Foucault had his own answer. "Madness deals not so much with truth and the world as with man and whatever truth about himself he is able to perceive" (ibid. 27). Truth then is a matter of perception in a world of experience.

Poverty was rampant early in the twentieth century and this gave rise to Foucault's 'poor vagabonds and criminals'. But, why was madness associated with such reactive behaviour? Again Foucault answers:

> "The moment when madness was perceived on the social horizon of poverty, of incapacity for work, of inability to integrate with the group and all the ethical values linked to labour, ultimately determined the experience of madness and inflected its course" (Foucault,1967: 64).

And the inflection went down the social scale changing victims to perpetrators who must be handled like any other criminal. This false labelling happened because the value system of the industrial world saw disordered persons as deficient units of production, a type of defective automaton. This limited and unhealthy view grew from perceptions of experience. Foucault put it another way: “To respect madness is to recognise this lower limit of human truth” (ibid. 81).

This half truth of the everyday world was not sufficient to explain madness to him. He borrowed an earlier idea from Bossier, another Frenchman, from his Nosologie Méthodique, published in 1772. “The distraction of our mind is the result of our blind surrender to our desires, our incapacity to control or moderate our passions”, (ibid. 85). According to this concept, madness begins in the self and leaks outwards contradicting Foucault’s own construction (see p 46).

In either case, madness was considered a form of contamination that must be eradicated, eliminated, purged and washed clean. The treatment concocted to eliminate madness was founded on this misconception, according to Foucault. The “ebullition [the boiling up] of false ideas, therapeutics attached to the identical operation of purification” (Foucault, 1967: 162) was based on ways to wash the person clean. This was evident in England since the 1500s, where, at the Bethlehem Hospital (Bedlam) purification or internal cleaning, and washing or external cleaning were practiced. Along with various forms of containment, cleansing methods were employed to treat mad people. The way to produce a new person was through “immersion – rites of purity and rebirth” (ibid. 166). Mad people were captured and power hosed back to health.

Behavioural restraint, linked to curtailment of the thinking-to-acting process, was used to limit the mad and the bad in the patient, a “regulation of movement: fixity of body parts, fixity in ideas, with exercise as the antidote” (ibid: 172/3). Ideas of containment and controlled action were expected to correct out-of-control behaviour. “Ideas of purity of

body and mind became connected" (ibid. 176). If mistreating the body could injure the mind, perhaps suitably treating the body could cure the mind.

Recovery became possible as a matter of "transformation of qualities" which, in the view of the day, would lead to "the restitution of truth" (Foucault, 1967: 197). Jamie Saris (2000) research illustrated how architecture had been perceived in the 1800s as an antidote using mapped and controlled physical space to map and control the mind.

A major change occurred with The Council of Europe's treaties in the 1950's, part of the European Convention on Human Rights and Fundamental Freedoms (Amnesty 2003: 11). Power moved away from psychiatry's will to constrain and back to society's will to freedom up-holding the rights of its citizens. Foucault discussed many of these issues in a series of interviews and writings. Before his death in 19894 he was interviewed by a group of scholars and the results, edited by Lawrence D. Kritzman (1988) were published.

As early as 1961 Foucault had suggested that containment of the insane in institutions enabled society to distinguish between truth and madness and the normal and the marginal. He saw that medicine had limited benefits and that if "psychiatrists possessed the authority to cure it was derived in large measure from performative acts whose power was less a question of knowledge than of moral authority" (Kritzman 1988: xxi). This was more than a 'post-enlightenment' model. It reflects Vitebsky's (2001) perception of power among the Sora, where 'spirits' are at work. In France a spirit of freedom was rising after World War Two.

Foucault invented the term "specific intellectual: one who no longer speaks as master of truth and justice and is content to discover the truth of power and privileges" (ibid. xiv), reflecting the personal enhancement and enchantment of the professional individual. Through this construction the professionals become shamanic practitioners. Medicine is simply a symbol of power when privilege usurps the power

of justice by claiming the magical knowledge of curing. Foucault portrays this as “a relationship of forms of rationality and effects of knowledge” (ibid. 30) and not as he believed it should be, “the relation of self to self, of telling the truth” (ibid. 32).

Foucault went further in his essay, “Critical Theory / Intellectual History”. He quoted Lacan: “Psychoanalysis can teach you that you are looking for a master” (Kritzman, 1988: 20). Instead of attempting self-mastery we attempt identity-mastery by an outside agent. This essentially imperialist stance is, according to Foucault, no longer acceptable or tenable. In his essay An Aesthetics of Existence he forecasts the death of morality as an external force. “Morality, as obedience to a code of rules, is now disappearing, has already disappeared [leading to] the search for aesthetics of existence” (ibid. 49). For Foucault, worth is replaced by appearance. This idea also promotes consideration of the concept of merging the internal self with external identity or, alternatively, of the displacement of self by identity.

This is a major change from a moral stance common in Europe, including the North-West of Ireland, where guidance of conscience is central to Christian pastoral teachings.

Being guided was a state of being and you were fatally lost if you tried to escape it. The change from a moral stance forged a link between total obedience, knowledge of oneself and confession to someone else. According to Foucault this will

> “lead to the death of the individual, a death of self to self, and acceptance of it as good. This is not done for the sake of society but for the sake of self, to gain eternal life” (ibid. 70), concluding that “the way to heavenly bliss is through conformity here on earth” (ibid. 75). Accordingly “The ideal was a sort of total purification” (Foucault, 1967: 162).

In this perception, the social struggle leads to the spiritual reward.

Foucault also proposes that

> "before 1960 power was defined as repression, what prohibits, what prevents people from doing something" (Kritzman, 1988: 102), and this was demonstrated by "a whole technique of human dressage, by location, confinement, surveillance, the perpetual supervision of behaviour and tasks, a whole technique of management reflecting the way in which procedures for training and exercising power over individuals could be extended, generalised and improved" (ibid. 105).

Power became institutionalised as part of the process of civilisation. This was made necessary in the cultural view of the West before 1960 by the tightly packed nature of civilisation, of crowded cities.

"Science [also] had become institutionalised as power through a university system and through its own constricting apparatus of laboratories and experiments," (ibid. 107). Psychiatric medicine, as the science of madness, had also become institutionalised, presumably through its educational and training system and through its own constricting technology of psychiatric care hospitals.

A new form of power had arrived based on concepts of the mad and the bad, the sick and the healthy, the citizen and the State, and the profession of curing and caring to declare ideas of "moral insanity, instinctive insanity and degeneration" (ibid. 142).

Foucault took this hermeneutic approach further. Much of this work relates to medical and psychiatric matters where, in his view, the power of knowledge derives from scientific discourse. Foucault proposes that power becomes operational in three ways:

(1) "Through programs of power that define forms of knowledge
and discourse about objects of knowledge that are intervened

in and made functional.

(2) Through technologies of power, techniques and practices for the disciplining, surveillance, administration and shaping of human individuals designed to implement that knowledge.

(3) Strategies of power, agencies to do in practice the exercising of power and its operationalized programmes and technologies, which includes strategies of resistance." (Foucault, 1972: 251/2).

Power has been demonstrated in many different ways. Public torture and execution became unacceptable in the industrial culture of the nineteenth and twentieth centuries. New forces were afoot, the forces of social discourse. Sigmund Freud began his work at this time. "Psycho-analysis was established in opposition to a psychiatry of degeneracy, eugenics and heredity" (Freud, 1920: 60). Although Freud attempted to undermine psychiatry with psychoanalysis, medicine at the heart of psychiatry was still unchallenged. "Medicine certainly has a much more solid scientific armature than psychiatry" (Foucault, 1972: 109). Psychoanalysis attempted a cathartic shift in the state of mind of the mentally disordered person but it did not succeed quickly enough nor well enough to be a substitute for medication.

For Foucault "ideas of truth [are] central to psychoanalysis" (Foucault, 1967: 27). But Freud's analysis of personal history could not undo the traumatic event, no matter how hard it tried. Foucault believed he knew what was missing. "The event is what always escapes our rational grasp, the domain of absolute contingency" (Foucault, 1972: 113). Some more powerful action was required.

Foucault believed that Freud's psychoanalysis could be enhanced to deal with events. A performance was essential. "There are actually a whole order of levels of different types of events differing in amplitude, chronological breadth and the capacity to produce effects".

This, he believed, could be achieved by “recourse to analysis in terms of genealogy of relations of force, strategic developments and tactics with relations of power, not relations of meaning” (Foucault, 1972: 114).

The power of discourse can not match the power of experience to affect a cathartic shift. A genealogy is required that gives insight to the event. “One has to get rid of the subject to arrive at an analysis which can account for the constitution of the subject within a historical framework” (ibid. 114). The individual must become lost in membership, as in GROW.

This genealogy is “a form of history which can account for the constitution of [different] knowledges, discourses, domains of objects etc. without having to make reference to a subject” (ibid. 117). Genealogy “needs to be considered as a productive network that runs through the whole social body” (ibid. 119). In my opinion, the GROW Group Method achieves such a productive social network with the power to move along the cultural track and to change tracks when necessary.

According to Foucault, Marx talked about ideology while Freud talked about repression and between them they formed a discourse of power. “In reality this discourse serves to make possible a whole series of tactical and positive interventions of surveillance, circulation, control, at least liable to be interpreted as such” (Foucault, 1972: 120).

“Sovereign law and prohibition formed a system of representation of power. Discipline, and later, education” brought “with it the professional army, the police and the administrative bureaucracy” (ibid. 121) and on its back came psychiatry. But what sort of truth did this produce?

> “In societies like ours, the political economy of truth is characterised by five important traits:

1. Truth is centred on the form of scientific discourse and the institutions which produce it;
2. It is subject to constant economic and political incitement;

3. It is the object, under diverse forms, of immense diffusion and consumption;
4. It is produced and transmitted under the control, dominant if not exclusive, of a few great political and economic apparatuses;
5. It is the issue of a whole political debate and social confrontation" (Foucault, 1972: 131).

This suggests that truth is local and moral, forged on an anvil of discipline that must be understood as "the ensemble of rules according to which the true and false are separated and specific effects of power attached to the true. It is a battle for the status of truth and the economic and political role it plays", (ibid. 132). Truth then is a process of production and not a product.

Truth is invested in method and "understood as a system of ordered procedures for the production, regulation, distribution, circulation and operations of statements" (ibid. 133). Truth controls the production of narrative. It is also reflexive in responding to what it asserts. "Truth is linked in a circular relation with systems of power which produce and sustain it, and to effects of power which it induces and extend it" (ibid. 133). If your truth asserts that I am ill it can demand then that I am treated as such in line with what declared me ill.

My research suggests that the GROW Group Method permits a truth to form. Clearly psychiatry has its own professional process of producing truth.

> "The problem is not to changing people's consciousness but the political, economic, institutional *régime* of the production of truth. It is a matter of detaching the power of truth from the forms of hegemony; social, economic, and cultural; within which it operates at the present time" (ibid. 133).

Since psychiatry joined forces with law it has become even more powerful and dangerous as explored below. The fusion of psychiatry and law unleashed tremendous power. "Law, as a real mode of action, was the principle mode of representation of power" (Foucault, 1972: 141). Law is a technology of power invented and used by those with the means to implement it. Law and psychiatry, when fused, have the means of producing a truth that corresponds to an agenda of control and repression of rogue or dangerous elements in the population. Law gave psychiatry the right to incarcerate people against their will. Psychiatry gave law a rationale for disorder. When combined they threaten overwhelming public authority.

The constant monitoring performed by the two fused forces constitutes an irresistible force. In Foucault's view "it's a machine in which everyone is caught" (ibid: 156), that produces a "new distribution of power known as discipline" (ibid. 158). Civilization and culture are constructed through this new discipline. Tactics are invented and organised from starting points of local conditions and particular needs and made to suit prevailing opinion. "Opinion was like a spontaneous re-actualisation of the social contract", (Foucault, 1972: 161).

The practice of medicine is a social contract. The doctor and patient must agree to work together.

> "Medicine did not begin as a private practice that has recently been overwhelmed by public practice. Nor did it begin as public practice that is now being overwhelmed by private practice. Nor is it a magico-religious practice that has been laicised", (ibid. 166).

Foucault concluded that "the centres of initiative, organisation and control for this politics were not located only in the apparatuses of the State" but that "charitable, religious and philanthropic associations also played a great part" (ibid. 167).

This constitutes another anvil for the production of truth in medical politics today between the public service of the State and the private practice of medical experts, and how both are organised to serve the needs of mentally disordered people.

Where does power lie in the service of the mentally disordered people? According to Foucault; “In reality power means relations, a more or less organised, hierarchical, co-ordinated cluster of relations” (Foucault, 1972: 198). But who is at the apex of this hierarchy? If we interpret the State as the agent of civil law then psychiatry and State have already fused to form the apex. Since psychiatry and law fused power relations have changed. “From a given moment people no longer have rights, and power is constituted” (ibid. 199).

For psychiatry, “practices of internment which occupied precisely the heart of the ‘medico-legal’ domain” became possible “except for the fact that they were neither medical nor legal” (ibid. 204). Psychiatry, by virtue of its expertise, had made itself autonomous. The problem is at the heart of psychiatry, in its values and beliefs, and where it combined with law. It separated itself from the disciplines of caring and curing, becoming a discipline of containment and control, making “madness - a redoubtable danger precisely” because “only a doctor can spot it, and thus madness becomes an object for the doctor, whose right of intervention is grounded by the same token” (ibid. 205).

It was the fusion of disciplines, philosophically and structurally, that produced a new social power. A new discourse had formed about this axis:

> “The question of madness could have been made to operate in terms of discourses of truth, that is to say, discourses having the status of truth and function as true discourses. In the West, that means scientific discourse” (Foucault, 1972: 210).

At the same time we find fusing with yet another discipline, the discipline of religion and its ritual practices. Religion, meaning 'to tie back' or restrain, has much in common with law and psychiatry. Church and State fused in an alliance of disciplines of the body, mind, spirit and the social. Although disciplines had fused at the pragmatic or ritual level they are still separated at the ideological level.

> "In the eighteenth century, where the direction of conscience and the confessional have lost the essential force of their role, one finds brutal medical techniques emerging, which consists in simply demanding that the subject tells his or her story, or narrate it in writing. Confession is the operation of all those procedures by which the subject is incited to produce a discourse of truth which is capable of having effects on the subject himself" (ibid. 215).

I should note here that GROW is founded in the fused logic of philosophy and theology with its major founding member having a PhD in each discipline. GROW founding fathers provided its foundation stone, hewn from their experience with power.

Chains of Discipline

This linked chain of discipline from Church to State to Legal and Psychiatric activities is truly binding. "One finds this formidable mechanism emerging, the machinery of the confession, within which in fact psycho-analysis and Freud figures as episodes" (Foucault, 1972: 211) suggesting that psychoanalysis is just new wine in old bottles. The couch, and in the case of GROW the group, has simply replaced the confessional box.

Clinical psychology and psychoanalysis are not easily available through the psychiatric service. In many cases members of these professions do not sit on the multi-disciplinary acute care teams, their

functions seen as inappropriate until cure has been achieved through a medical approach. In one case, a patient was in psychiatric care for more than 30 years with seeing another professional who did not accept the medical model.

Through psychoanalysis, the true person is released based on the idea that the truth makes you free. But “one of the fundamental points of the Christian method of direction of conscience is that the subject does not know the truth” (ibid. 216). The priest does. In psychoanalysis a new expert performer arises, the clinical psychologist who makes a prognosis and the psychotherapist who analyses the perceived cause behind the prognosis. In the USA psychiatry includes the disciplines of psychology and psychotherapy while in Ireland it does not. In either case the psychology performs ritual in a very different way; the way of structured discourse; what Foucault (1967: 183) called “reason’s debate with itself”; preferred to that of medical diagnosis and treatment. The form of ritual has changed but ritual remains central.

Foucault’s work started a review of power at work on society. John Gledhill reviewed the work of those who succeeded Foucault and concluded that,

> “power has two modes of operation.
> (1) Authority or legitimate power and,
> (2) Coercion or abuse of legitimate power” (Gledhill, 1994: 13, 30).

Gledhill quotes Keesing: “subaltern subcultures are shaped to some extent by the structures created by the dominant strata to implement their hegemony” (ibid: 149/50). He believes this is crucial for the analysis of a resistance struggle in general and occurs in three forms.

First is the production of a counter-identity that may express antagonism but not undermine the power structures of the elite. GROW

operates in this way. It opposes without attacking the medical perspective, seeking to overwhelm by absorption, with friendship as the action mode.

Second is the self-conscious act of outright rebellion that may have unintentional system-conserving qualities. Strong assertion tends to produce a back-lash. GROW uses a reconciling approach that is consistent with its principles in its dealings with other organisations.

Third is the reaction of the dominant group to the self-conscious or less radical forms of resistance. This may be so repressive as to strengthen the structures and practices of domination that it resists. GROW must balance its resistance with co-operation.

Gledhill makes a clear distinction between resistance that is merely concerned with improving the terms of oppression and that which strives to implant a new socio-political order (Gledhill, 1994: 93). He explores how discourses construct human subjects in a capillary model of power, working at the micro- and macro-level.

Power displays itself in many political forms, in the macro-world of the State and the corporate world of industry. On the micro-scale, smaller groups can produce power but only in proportion to their size. Moral power is a matter of numbers and not a matter of being right or wrong. Organisation is imperative to enable power to become operational. GROW organisational structure, group method, legal framework and caring and sharing principles give it the power to produce change in the lives of its members. This power is expressed in the form of friendship, a binding power, an antidote for fragmentation.

Vitebsky (2001: 22) offers a much different description of power from his work with Shamans. “The Sora people describe the impulse of spirits as a force, power or energy (*renabti*). Like the Latin origin of the word power and potential, *renabti* is derived from the verb ‘to be able’. When Shamans negotiate with this power, it enables them to make things happen, as in the engineering definition.

"Shamanic power depends on keeping control over the trance state that form of possession where the spirits are in control" (ibid: p119). This power is used in the political sense and allocated to chiefs but is mainly confined to individual and community matters of health and well-being. Can GROW evoke this spirit?

A task of this thesis is to find authority and coercive programs, technologies and strategies in the narrative and ritual of GROW seasoned members when they produce the power to create identity and explain self through narrative and ritual. Narrative produces identity and a sense of self but it is ritual, "the domain of absolute contingency" (ibid. 113) that empowers it enough to produce change in life-style.

Edith and Victor Turner on Ritual Experience

Edith Turner proclaimed that "ritual is a stylized or formalized activity that has efficacy in its very form" (Turner, 1992: 163). Michael Payne defined ritual as the "repeated sequences of standardized symbolic acts in which humans seek outcomes mediated by supernatural forces" (Payne, 2000: 469). Fusing the major elements of these two definitions suggests that ritual must have formalised and choreographed activities that are performed repeatedly with the intention and effect of bringing healing through forces beyond current scientific practice. Power is again captured by group organisation.

Edith Turner, in her own book, Experiencing Ritual, quotes Levi-Stauss: "ritual has narrative whose form takes precedence over the content". In her own words she says that "we are dealing with issues beyond language, where the process is the language" (Turner, 1992: 13). In ritual we move from verbal expression to action itself. Although ritual is beyond verbal language, it does have its own narrative.

For Edith Turner, in ritual, "story enters the inner world of mind, bridging the gap between reality and the imagined" (ibid. 14). This dichotomy, of using external action to depict internal process, is an

enigma, a mystery, a conundrum, moving beyond the pragmatism of science into the realm of Vitebsky (2001).

Turner considers the practice of psychology as having a structural world view, “different from ritual which is a process” (ibid. 15). For Turner “mental and social structures have crystallisation points” that are evoked by the structure and content of a ritual where “focusing on a given issue is for something to happen, something to find, a coming to birth of an independent being” (ibid. 72).

Ritual narrative construction becomes a birthing out of the milieu of conscious and subconscious memory, a process of making manifest an image where work is done by ritual action itself, resulting in re-ordered effects. For Turner, “ritual concerns revealing, speaking private matters in public, and bringing hidden grudges to light” (Turner, 1992: 73). Inner demons are drawn out and revealed for what they are.

In this worldview, “sickness in the patient [is] a sign of something rotten in the corporate body, a socio-revelation of grudges, matters that are deep and personal” (ibid. 90) where “words are the revelation of individual psyches” (ibid. 89). Besides words, “perception in ritual is an end in itself” in which “it is necessary to undergo the experience to understand it, to become one’s own informant, to overcome one’s own amnesia” (ibid. 161).

Edith Turner learned this worldview from the *Ndembu*, a rural community in Africa. They had their own local science but held a wider perspective, one that included a metaphysical element. The *Ndembu* taught Turner that

> “Science deals only with what one man can demonstrate to another. The facts of consciousness cannot be used in scientific method” (Turner, 1992: 160).

To achieve this viewpoint Turner had to change from being an observer to become a participant acting within the ritual. “I was doing

anthropology as an observer but for a time joined in" to experience "the impelling process which leads the participant from ritual frigidity to the orgasm of experience" enjoying Levy-Bruhl's "mystical participation" (ibid. 163). I endeavoured to achieve this experience at GROW meetings.

For Turner, ritual is performance.

> "A verbal description is but a shadow of the reality. The cure demonstrates coherence of the psychic universe, itself a projection of the social universe" (ibid. 165).

Turner described how, among the Ndembu, "all join together to form a power circle by holding hands, incorporating the patient into it, and the group sing a power song" (ibid. 134) echoing activity in GROW groups. Actions of singing and circling do more than mere words to achieve the objective of the ritual.

> "We may be talking of a world of religion, … not as morals, not as mental prayer, but in the form of ritual objects effective in their own right, a matter of spirits, and people with knowledge of them operating in a ritual process that can actually be sensed" (ibid. 180).

GROW too can claim this. GROW ritual is felt in the body as described in Chapter Seven.

For the Ndembu, "The doctor is often helped by a tutelary spirit, and confession is often encouraged to clear the air so that a healing can take place" (ibid. 181). GROW tutelage appears in GROW leadership and it arrives as a caring and sharing spirit. GROW narrative clears the air and empowers ritual healing.

Much of what Edith Turner wrote was based on fieldwork among the Ndembu done with her husband, Victor Turner. In the introduction to

his book, The Ritual Process, he discussed the “the connections between culture, cognition, and perception as these are revealed in symbolic forms” (Turner, 1989: v). He explains how these can produce states of mind beyond the perspective of logical or everyday reality.

Victor Turner explored and explained the trance state or mystical space produced by ritual enactment. He used the term liminality to name such transient mind states that occur as the participants change their value and belief systems as a result of being involved in ritual practice. In this mind state, Turner found “a blend of lowliness and sacredness, homogeneity and comradeship” among the ritual participants that “presented [them] with moments in and out of time” (ibid. 96). Time stands still and vantage points shift. The power to change is unleashed, set free to operate in a world of physical and social pain.

Participation is essential to bring social cohesion and relief through inclusion in a set of social acts. In this mind state, personal story is “stripped bare, going to the foundations, to the roots of being” to where “behaviour is normally passive or humble” (ibid. 95). Truth, the wisdom of true value, is found here. Passive humility is at the root of being, a foundation stone. “The wisdom that is imparted in sacred liminality is not just an aggregation of words and sentences; it has ontological value, it re-fashions the very being of the neophyte” (ibid. 103) enabling the person to become alive at another, enhanced level in “finding acceptance of pain and suffering” (ibid. 104). This allows the participant to live in the continuous present in which “transition has become a permanent condition” (ibid. 107). Time stands still but reality shifts continuously.

A communal feeling of well-being and of being present in the moment exists here. Turner called this interpersonal feeling *communitas* “that is rooted in the now, while structure is rooted in the past and extends into the future through language, law, and custom” (ibid. 113). This disruption of proprioception, the sense of where we are

in space and time, helps to free the participant from the encumbrances of culture. Life can now be experienced in the sacred space and moment produced by ritual.

"Communitas is a relationship between concrete, historical, and idiosyncratic individuals" (Turner. 1989: 131), a series of one-on-one couplings. This relationship can seldom be maintained for long. It occurs in a variety of forms. "Existential or spontaneous communitas occurs in a fleeting moment" (ibid. 131). "Normative communitas" is where the existential declines to enduring laws." We become "stuck", frozen in time and space and "in our cultural perspectives" (ibid. 131), an apt description of psychiatric depression.

"Ideological communitas is a utopian model matching the internal experience with the internal existential experience" (Turner, 1989: 132). In this mind state people become isolated and disconnected from everyday reality but united in a feeling of ideal community.

According to Turner, "structure is pragmatic" constructing a tangible and pragmatic world, whereas "communitas tends towards imagery and the philosophical which is contextual with meaningful actions" (ibid. 133). Structure is full of objective difficulties: responsibilities, compromises and sacrifices for the group. According to Turner, it is "wisdom to find the appropriate relationship between communitas and structure under the given circumstance of time and place" (ibid. 139).

Communitas is about a mystery of human isolation: vertical isolation of man from God; and horizontal isolation of man from man. This matches the GROW concept of 'spirituality', the relationships of 'God to man' and 'man to man' (GROW, 2001: 70). For Turner, "ritual seeks to bridge this conceptual distance" (Turner, 1989:170), the spiritual gap, as GROW conceives it. But what God or god is on the other side of the bridge?

Victor Turner published 'From Ritual to Theatre: the seriousness of human play', an essay that illustrated his matured understanding of

ritual. "I came to see performances of ritual as distinct phases in the social processes whereby groups became adjusted to internal changes" and "adapted to their external environment" (Turner, 1982: 21). He articulated the concept of the liminal or the transitional stage between two states, into a concept of liminoid, the state of continuous change.

Much of the change wrought through ritual involves elements of incorporation into a new life, rectifying old injuries and misperceptions, and initiating acceptance of self within a local moral society. As Turner says, "Incorporation includes symbolic phenomena and actions, which represent the return of the subjects to the new, relatively stable, well-defined position in society or enhanced status, a stage further" (ibid. 28) in achieving ordered living.

People live disordered and painful lives for many reasons. But does such pain and suffering achieve anything worthwhile? Turner believes that such disorder occurs "either because we have had an overdose of order or because we have something to learn through being disorderly" (ibid. 29). "Communal participation, obligation, the passage of the whole society through crisis, collective and individual, directly or by proxy, are the hallmarks of 'the work of the gods' and sacred human work" (ibid. 30). Society and individuals have work to do to enable evolution to occur, physically, mentally, spiritually and socially. Ritual can produce power and give it direction. But how is it produced and is power of a single type or does it have many forms?

The Power of Ritual

For Asa Boholm, power resides in religious ideology, in an unseen higher source. For him "Political ritual lies on the interface between religion and politics with politics drawing its legitimacy from religious order, moral order deriving from some unseen higher form of controlling and structuring power" (1996: 5). Ritual then, narrates ethical concepts of religious significance with "a wide-spread assumption that ritual reveals truth and meaning that are eternal" (ibid. 189). He

associates power with truth and meaning. My research suggests that this coincides with GROW principles and practice.

For Elizabeth Tomkin and David Bryan, political ritual is a vehicle of subtle change that, through observation and mental rehearsal, brings change to the observer. "Change comes by observing variations within a fixed arrangement, learning subtlety through observation, a form of mental rehearsal that confirms individuality within a fixed social order and sets the seeds of the possibility of change" (Tomkin and Bryan,1966: 14). Again, this resonates with what GROW achieves through its ritual of Group Method.

David Kertzer explored ideas of Ritual, Politics and Power in order to understand how the seemingly irrational behaviour of political ritual can produce the individual and social power to create a cultural order. For Kertzer: "order is largely provided by the symbol system we learn as members of our culture, a system that allows for both social creativity and individual idiosyncrasy" (Kertzer. 1988: 4). The symbolic system acts as a foundation to build truth on and symbols are learned through the repeated performance of rites.

> "Ritual is repetitive and, therefore, often redundant, but these very factors serve as important means of channelling emotion, guiding cognition and organising social groups. Through ritual, beliefs about the universe come to be acquired, reinforced and eventually changed" (ibid. 9).

GROW produces ritual performance in all its meetings with the clear realisation that this will bring order and adequacy in varying degrees to participants and observers alike. How does ritual do this?

Kertzer recognises three ritual properties. The first is condensation of meaning, the way in which individual symbols represent and unify a rich diversity of meanings and manifest them in a physical form. The second is multi-vocality, the variety of different meanings

attached to the same symbol and, third, ambiguity, suggests that “the symbol has no single precise meaning” (ibid. 11). Although people, GROW members included, condense meaning by acting out principled activities to draw power from ritual, individual interpretation makes meaning what people want it to be. Personal interpretation of GROW ritual gives ambiguity and multi-vocality.

Ritual must either produce power or tap into a source of power and not simply reflect it. “Ritual is used to constitute power, not just reflect power that already exists” (ibid. 25). GROW program and method seeks to constitute power that has qualities attached, ideas of value and propriety. GROW principles reflect such qualities.

Symbols represent qualities. Change occurs when two symbolic systems collide and fuse, with ritual releasing power to make the change. GROW seeks to produce a ‘Christian’ culture. The power to change is generated by fusion of symbolic systems, philosophical systems and organisations. GROW has fused philosophy and theology and the symbolic actions of friendship to produce the power to change lifestyle.

Ritual produces change at a foundational level within the psyche. “People can communicate their inner mental states only through the use of symbols. Social solidarity is seen as a requirement of society, and ritual an indispensable element in the creation of that solidarity produced by people acting together, not by people thinking together” (ibid. 76). Narrative is not substantial enough to achieve change and must be supplemented by symbolic actions. Change must be visible to be believed.

Cognition of a set of foundational values produces solidarity. “Cognitive constructs, an integrated body of symbols that structure experience, are similar to what anthropologists mean by culture” (ibid. 80). Behavioural change produces a new culture. But if interpretation of ritual is an individualistic process how can solidarity, a construct of society, be produced?

> “The information we take in through our senses is processed through pre-existing systems of schematised and abstracted knowledge. Our perceptions are the product of the schemas we have. These schemas define certain expectations about events and experiences and suggest appropriate responses to them” (ibid. 80).

According to Kettzer, a foundational schema exists and filters out all ideas in conflict with it. An atheistic schema will filter out allusion to spirituality or God while a theologian will filter out allusion to godless evolution. The truth of each schema determines what is acceptable.

Susan Fiske and Donald Kinder explained that schemas “direct attention to relevant information, guide its interpretation and evaluation, provide inferences when information is missing or ambiguous, and facilitate retention” (Fiske and Kinder, 1981: 173). A schema is foundational but it is not passive. It produces what stands above it. In this context I propose that GROW principles inform and form GROW practice.

But schemas are not autonomous. They too can be formed, curtailed or altered.

> “Carried to an extreme the emotional state may operate with an over-riding cognitive division of people into just two categories: those ‘with me’ and those ‘against me’. In this case schemas are nullified. So, how can they be invoked or brought into operation? Does ritual have a special power to breakthrough the emotional barriers?” (ibid: 81).

Fiske and Kinder believe so.

> “People pay more attention to concrete cases than to abstract data. As in ritual, mass demonstration has greater impact than a speech”, (ibid. 82).

GROW shares this belief. In ritual size or numbers count. Ritual gives primacy to experience. GROW ritual portrays this.

> “Statements made in generic form have stronger impact than statements with qualifications. The power of ritual lies in its lack of caveat”. (ibid: 83).

Rituals speak to the point through action. “Their potency depends on the power of the ritual to place the individual in a receptive frame of mind” (ibid. 99) and to obliterate the rest of reality. This is attributed to how ritual expresses powerful concepts of dependence, inclusiveness, and ideas of incorporation.

Ritual action creates emotions but it also curtails the type of emotion portrayed. Negative emotions are excluded in a ritual of inclusion.

> “Successful ritual creates an emotional state that makes the message incontestable because it is framed as inherent in the way things are. It presents a picture of the world so emotionally compelling that it is beyond debate” (ibid. 101).

Cognition is gained through performance. People cannot perform ritual without outside help.

> “They are not ritually self-sufficient. They need the services of an outsider, a specialist or a stranger, someone who is unknown, [or] someone with a reputation”, (ibid. 115).

This outsider may arrive as a neophyte or beginner or in spirit only, perhaps as the author of great philosophical works, to enhance the power of local operators. By performing ritual together, people assure themselves they have control of performance and are in sympathy with life. In this way, power to live well is authorised and constituted.

Constituted Power

"The use of a Constitution as a holy book, beyond human meddling, is indeed just one manifestation of this mystifying effort to place adjudication beyond human will" (Fiske and Kinder, 1981: 133). A constitution is sacrosanct. "Judgement is depersonalised" (ibid. 133) and replaced by faith in GROW rite and the Blue Book which is such a constitution. "Without faith there is no rite", (ibid. 178).

Faith may come from the group performing ritual. A holy book is a collection of judgments produced in the depersonalised and sacred space of ritual. The GROW Blue Book is such a holy book. "Rituals bestow a sacred aura, a charisma", (ibid. 183), producing a sacred space. Ritual is holy work.

Being a member of any group, especially a GROW group, has other benefits. "Collectivity created through rituals and symbols not only provides people with an identity different from that encouraged by the elite, [the professionals] but also serves as a means to recruit others" (ibid. 181). According to Fiske and Kinder, a sense of community comes from "allegiances from symbolically nourished conceptions of the order of the universe" (ibid.182).

The inclusiveness generated by GROW group ritual nourishes the conception of order and adequacy in each member and in the organisation as a whole. Arnold Van Gennep's (1960) rites of passage from the isolation of mental disorder, through the liminal period of treatment, to the inclusiveness of incorporation, make sense of the experience and worth of madness. The two Turners elaborated Van Gennep's understandings of rite in the last quarter of the 20th century.

Van Gennep's Rites Of Passage

Van Gennep's (1960) rites-of-passage research produced the term that has been referred almost exclusively to cathartic life-crisis but his early usage applied to procedural forms of passage. This overarching pattern aptly describes the process of breakdown, treatment and recovery; or breakthrough, treatment and recovery and growth.

He identified three phases. The first phase of separation or isolation is where the participant is removed or excluded from his habitual social position or status. The second is one of transition where the ritual subject passes through a period of ambiguity. The third is one of incorporation. This final phase displays the symbolic phenomena and actions that represent the development of a new, relatively stable, well-defined position within community.

Van Gennep applied rites in this sense to social groups but, I contend, they may also apply to individuals. For GROW individual members and groups passage represents being well again and on the path to personal growth.

The dominant element of any ritual must relate to the prime purpose of the phase in question. All rite-of-passage ceremonies are ritual that changes the quality of time and space, and includes symbolic behaviour of reversal or inversion of things, relationships and processes.

After incorporation the participant can develop a higher life form filled with the expertise that produces wisdom and knowledge, and feelings of completion and satisfaction and feelings of flow. Flow arrives in the form of effortless social and personal progress. Healthy growth has returned. This brings us again to Victor Turner's seminal work of being in a state of flow.

Turner and Csikszentmihalyi on Flow

Flow, according to Turner, has six elements or qualities. First is "the experience of merging action and awareness" (Turner, 1982: 56) in a reflex of cognition. Second, "consciousness must be narrowed,

intensified, beamed in on a limited focus of attention" (ibid: 56) on what is sought. Third, "Reality is simplified to the point that is understandable, definable, and manageable" (ibid: 57). Loss of ego is necessary if sufficient humility is to be achieved to enable the individual to examine personal disorder and inadequacy. Fourth, the person in flow "matches the demands of the situation" (ibid: 57) and feels good about it and is fully displayed when, for example, it culminates in a GROW personal testimony of well-being. Fifth, "flow usually contains coherent, non-contradictory demands for action, and provides clear, unambiguous feedback to the person's actions" (ibid: 58) as occurs in GROW group meetings. Sixth and finally, "flow is autotelic. It has no goals or rewards outside itself. To flow is to be happy" (ibid: 58).

A GROW member seeks happiness as a state of growth. When an individual or society achieves flow, it has achieved what Maslow (1954) called, being fully actualised, in a state of perfect being.

This concept of flow was developed further by Csikszentmihalyi (1990, 1993). He endeavours to explain flow and optimal experience. He defined flow as the "positive aspects of human experience: joy; creativity; the process of total involvement with life" (Csikszentmihalyi, 1990: ix). For him a happy state of flow does not just happen. It must be worked for and maintained privately by each person and starts with that person achieving control over the contents of consciousness. This is most likely to occur

> "when a person's body or mind is stretched to its limits in a voluntary effort to accomplish something difficult and worthwhile. Optimal experience is something we can make happen [and] it adds up to a sense of mastery, a sense of participation in determining the content of life" (ibid. 3, 4).

According to Csikszentmihalyi “The concept of flow has been found useful by psychologists who study happiness, life satisfaction, and intrinsic motivation; by sociologists who see in it the opposite of anomie and alienation; by anthropologists who are interested in the phenomenon of collective effervescence and rituals” (ibid: 5). With this in mind, flow is a useful concept to interpret what GROW offers it members. GROW attempts to bring order, value and meaning to life after mental breakdown by re-interpreting it as mental breakthrough, a way forward.

For Csikszentmihalyi, “Creating meaning involves bringing order to the contents of the mind by integrating one’s actions into a unified flow experience” (ibid. 216) and this is the essential step in bringing order to a lived life. If what Csikszentmihalyi says is correct, we can examine GROW and we will find a “Detached reflection upon experience, a realistic weighing of options and their consequences” (ibid. 226).

In his later work, The Evolving Self, published in 1993, Csikszent-mihalyi states clearly that achieving a personality in flow depends on two propositions: In the first, an external condition, the person must have concrete goals and manageable rules. This makes it possible to adjust opportunities for action to suit personal capacities and must receive clear feedback on how well he is doing. Distractions must be screened out to allow full concentration.

In the second proposition, an internal set of conditions must also be achieved. The ability to match skills to opportunities must be developed by setting manageable goals. A skill at reading feedback, easy concentration and losing his or her sense of identity are essential. “The timing and interplay of these two phases form the foundations for later development” (ibid. 45).

For GROW living a Christian lifestyle constitutes discovery of self and the construction of true identity. Living in Christian flow achieves ‘a heaven on earth’. Death, the final ritual and rite-of-passage brings

heavenly bliss with God, in GROW terms. But God is on the other side of a bridge between life and death. For Turner, “ritual seeks to bridge this conceptual distance” (ibid.170), the spiritual gap, as GROW conceives it. But what God or god is on the other side of the bridge?

Understanding Godliness

In the course of conversations and discussions with many people in GROW, and with professional mental health workers, the terms ‘God’ or ‘the gods’ were used frequently. Sometimes they appeared interchangeable and at others, distinctly different. The term God appears frequently in GROW literature but the form that God takes is left mute.

For GROW, “belief in God is the positive answer to the ultimate question concerning life as a whole: In the Reality, greater than man which energises the universe, is there knowledge, love and provision for us persons?” (GROW, 2001: 71). For GROW, the atheist says no, the agnostic says it never can be known, and the doubter says ‘I don’t know what to believe” (ibid: 71).

Richard Dawkins (2006), a professed atheist, and John Humphreys (2007), a failed atheist, a doubter in GROW terms, offer some insights to the complex of meanings attached to these terms as used every day. It is helpful to distinguish the different meanings here for later reference.

Richard Dawkins (2006) proposes a spectrum of meanings for the concept of GOD. For Dawkins,

> “A theist believes in a supernatural intelligence who, in addition to his main work of creating the universe in the first place, is still around to oversee and influence the subsequent fate of his initial creation. He answers prayers; forgives or punishes sins; intervenes in the world by performing miracles; frets about good

> and bad deeds and knows when we do them (or even think of doing them)" (Dawkins, 2006: 39).

For Dawkins, the theist God is male and has purpose. He believes in

> "a supernatural intelligence but one whose activities were confined to setting up the laws that govern the universe in the first place. The deist God is some kind of cosmic intelligence" (ibid: 39).

Dawkins's deist God has lost gender and becomes a depersonalised 'big bang' or beginning phenomenon of the celestial environment.

"Pantheists don't believe in a supernatural God at all but use the word God as a non-supernatural synonym for Nature, or the Universe, or the lawfulness that governs its workings" (ibid: 40). God has become, for Dawkins, a nice idea, a concept for a force that has no substance.

Agnosticism, for Dawkins is in two forms:

> "Temporary Agnosticism in Practice" (TAP) for people who don't know because they don't have or don't understand the evidence. The second form, "Permanent Agnosticism in Principle" (PAP) is for people who cannot even begin to imagine such a phenomenon. The question exists on a different plane, or in a different dimension, beyond the zone where evidence can reach" (ibid: 70).

Evidence, a scientific term of the physical world, is too limited to reach the metaphysical dimension.

Although Dawkins is a self-confessed atheist he does not offer a concise definition of atheism but he offers two possible forms for consideration. A "De facto atheist: I cannot know for certain but think God is very improbable, and I live my life on the assumption that he is

not there" (ibid. 73). God regains gender but loses credibility. The probability of God is very low but short of zero. On the other hand, "a 'strong atheist' is someone who says: I know there is no God with the same conviction as Jung knows there is one" (ibid. 73).

For Dawkins, this stance takes strength and looks for scientific evidence of God and, on finding none to his satisfaction, dismisses the notion of God putting him in his TAP category: 'I can't find the evidence' group.

When I asked about the role of the concept of God in the treatment of mental disorder I was referred to the writings of Dermot Lane (1990) and Cannon A. M Allchin (1997) by a chaplain in an acute care mental hospital, who had been informed by their work. The chaplain understood God as a vital aspect of what it is to be human but could not see a role for this in any treatment process. In general theologians start from the premise that God is and all philosophy must work from there. Lane and Allchin see God in everything. Dawkins believes there is no God. Humphreys is unsure. For GROW members, God is an essential element of their understanding of life and death, mental health and well-being and ideas of breakthrough, recovery and growth.

This chapter has explored theoretical concepts of identity, self, narrative, power, ritual, rites of passage and flow and related them to the GROW experience. The following chapters will research how these concepts apply to the details of GROW as the only organisation in the mental health area that holds recovery and growth as possible and explores its principles and practices and how members of GROW discover self and construct identity as they transform from disordered to ordered ways of living.

Chapter 3 Biology, Biography or By-Product?

During fieldwork I was surprised at the spectrum of ideas used to explain mental health and illness. Biology explained the Irish psychiatrist's opinion, with a few notable exceptions, while personal biography explained the psychologist's opinion. Disorder and inadequacy was explained as a by-product of stress, bad diet and a toxic environment by those who had experienced poor mental health. The thema, in Fiske and Kinder's (1981) terms, adopted by a given community, whether professional or otherwise, determined the approach adopted to achieve recovery and to allocate responsibility to regain good mental health. Thema is formational.

The fieldwork took place in the community of a GROW region in the North-West of Ireland starting in 2004 and finishing in 2007. This once-rural setting, with a sprinkling of large towns, is rapidly changing from a mainly Roman Catholic, agrarian and relatively poor economy to a post-Christian, industrial and relatively strong economy.

Change has come, bringing new patterns of living but at a price. Suicide rates increased by 50 percent in the 1990's while, in young men between 18 and 25 years old, the rate is up by 70 percent. The physical, mental, spiritual and social health of the population has deteriorated to the point where drugs-related crime, alcohol-related road deaths, suicide, divorce-related social disorder and new family patterns are daily news items. Social disorder is increasing with a corresponding increase in mental disorder. But what are mental health problems and do they relate to social order? How is mental health and illness understood, treated and achieved? This chapter attempts to explore a spectrum of views found in the North-West of Ireland and on the wider scale of mental health and illness and the different views of how breakdown, disorder and inadequacy occurs.

The wide variety of paradigms, biology, biography or by-product, of the cause of mental health offered by many organisations is

underpinned by their understanding of what it is to be human and normal. For Ireland, as for Europe and the USA, these views were first documented in the late nineteenth and early twentieth centuries by Moritz Romberg (1846) in Germany and Henry Maudsley (d. 1918) in England (Alexander and Selesnick, 1966). This began a scientific approach to the subject that both complemented and resisted the prevailing, and in many cases, more religious views.

Variations of the findings were matters of degree and focus, rather than of substance. Many people still do not accept the idea of recovery, believing that once a mental breakdown occurs it persists for a lifetime and, according to research done in the North-West region of Ireland by Saris (2000, 1998, 1995), perhaps on into following generations. In the first decade of the twenty first century the recovery model has been proposed by accepting what is considered normal or average social behaviour as the objective of treatment. However, it appears to exclude the possibility of personal growth.

Yet others, such as GROW, adopt and promote a recovery model believing that growth to self-actualisation, in Maslow's (1954) terms, is not only possible after mental breakdown but may require a breakdown experience to achieve it. GROW interprets the experience as mental breakthrough to a healthier way of living. These cultural views are explored next to help determine whether GROW reflects an alternative and resistance movement to the dominant view in the local community or is complementary to it

On the International Level

Much of what is local is strongly influenced by the powerful forces of globalisation. On the global scale, there is "a growing acceptance of the bio-psycho-social model of health care and of the importance of psycho-social and psycho-pharmacological interventions by medical practitioners and managers in health care systems" (Milgrom & Burrows, 2001: 1). This extension of the medical model assumes that all illness

originates in the body and in the case of mental illness in the brain. As modern, allopathic medicine becomes accepted internationally, the biological cause of mental disorder follows with it. Medicine is applied to the brain as it had been applied to other parts of the body.

Medicines developed from herbal and other plant materials were used to treat infections and contagions. Some medications were found to have calming effects on the body and these, mostly morphine derivatives, were applied in cases of disturbed behaviour. They are intended to control and pacify the patient but some have side effects that offset their benefits.

More recently, man-made pharmaceutical products have been introduced. Along with this, genetic engineering, the alteration of the construction of the human genome, is attempting to cure or prevent diseases. Genetic research attempts to find a cause and cure for schizophrenia considered by many professionals as genetic in origin.

Many problems arise because of environmental factors, a lack of a particular chemical in food or a lack of protein can manifest with many of the same symptoms as mental illness. This is particularly the case in countries with poor nutritional systems. It is also true in the North-West of Ireland. The human endocrine system produces a variety of hormones that are essential to the adequate and ordered operation of the body and disruption of this system can also be interpreted as mental illness.

This medical model has been adopted worldwide by psychiatry and many problems have arisen as a result. Advocates for those in psychiatric care have called for change. The call has been so powerful that it is now reflected in United Nations (UN) and World Health Organisation (WHO) documents that inform policy at national level in member countries. Kleinman worries that abuse may arise from “therapeutic bias and remunerative preferences” where professional standards are lax (1988: 93).

Advocate organisations accept the need for a more holistic approach but some, like GROW, contend that the proposed changes are too limited as they do not provide for local constructions of what it means to be a human being. Global meanings appear to diminish humanity.

Human Rights

The UN Principles for the Protection of Persons with Mental Illnesses and for the Improvement of Mental Health Care (the MI Principles), a charter on the rights of those in mental institutions, was adopted in 1991. The Council of Europe's treaties in the 1950s, the European Convention on Human Rights and Fundamental Freedoms, also apply. These principles apply to all people whether ill or not.

Due to their physical or mental limitations, persons with age-related disabilities, physical, intellectual, or sensory impairment, severe or chronic medical conditions, or mental disorder, are recognised as being frequently more at risk of having their rights violated and denied than other sections of the population.

International human rights in this area derive from the UN Universal Declaration of Human Rights, the International Covenant on Civil and Political Rights, UN Rights of the Child, and the International Covenant on Economic, Social, and Cultural Rights. The WHO, a UN body, determines what MI Principle 1 calls "the best available mental healthcare." MI Principle 7.1 states that "every patient shall have the right to be treated and cared for, as far as possible in the community in which he or she lives."

It will be obvious to any critical reader that the laws enacted by these worldwide organisations reflect an unkind world, to say the least, where the weaker sections of community were being treated badly. Law tends to derive from the situation on the ground. Even in democratic countries, ruled by their citizens, the weak are at risk. Laws are intended to limit or to correct this bad situation. However, laws are of

little use unless they are implemented, used for their intended purpose, to protect the weak and to prevent further maltreatment of those who are, in fact, in need of community support.

In attempting to comply with these international principles, freeing institutionalised people became a worldwide policy in the 1980s. The results were of mixed benefit in many countries. Services as they had been for generations disappeared. Ex-patients were left to their own devices with many dying by suicide, others going to prison or sleeping rough in the streets and rubbish tips of towns and cities all over the world.

Those attended to were treated as a burden on society with very little thought for their needs: medical, psychological, spiritual or societal. No provision was made for alternative accommodation on leaving acute care hospitalisation. Some received 'charity' from religious and voluntary groups. Some, the lucky ones, went back home but struggled to make any kind of fulfilled and productive life. They often lacked the basics: food, a place to sleep, friendly company and any kind of privacy. It took many years before alternative arrangements were put in place for some. The rest are still waiting.

Psychiatric patients usually have poorer physical health and a higher mortality rate than the rest of the population. Death by suicide in this section of society is not the subject of any formal audit but is of major concern, especially in the North-West of Ireland. The hard facts of their plight are virtually unavailable.

In institutions still operating, there is a shortage of written admission and discharge policy and frequent use of inexperienced staff. As a result 53 percent of those admitted are without full assessment. In addition, 29 percent are self or relative-referrals, with 48 percent of all admissions occurring outside office hours when expert staff members are not available. Involuntary admissions are excessively high despite MI Principle 15(1) stating that "Every effort shall be made to avoid involuntary admission and must be reviewed after 21 days".

MI Principle 12(1) confers the right to be informed and to adequate explanations to all patients. MI Principle 12(2) requires that "a patient's nominated personal representative must be informed if the patient cannot understand his rights". MI Principle 21 confers the right to make a complaint through specified procedures but there is no statutory follow-up procedure to process a complaint at present. Over 18 percent of those under the age of 16 years experience mental health problems. The UN Convention on the Rights of the Child requires that "children and juvenile offenders should not be placed in adult psychiatric facilities". Services to children and adolescents remain patchy at best.

According to the WHO Chief Medical Officer, in the second Annual Report, September 2001 and quoted in Amnesty (2003: 35), "there is little research in this area to the extent of the shortfall in services". Many private and approved treatment centres are still not subject to monitoring by State services even though MI Principle 9(2) requires that: "The treatment and care of every patient shall be based on an individually prescribed plan, discussed with the patient, reviewed regularly, and revised as necessary." This prescription is not in operation in Ireland at present.

MI Principle 11 stipulates that treatment will be freely given and only with informed consent. Informed in this case means "with a written diagnostic assessment and treatment plan, giving purpose, method and duration, expected benefit, alternative modes of treatment, and the possible pain and side effects of proposed treatment". In Ireland, at present, this prescription is still the subject of negotiations between patient interest groups, including GROW, and State representatives and representatives of professional psychiatry.

WHO (2001) report calls for "a trusting physician/patient relationship, that the patient be informed on the treatment program, that it is a negotiated plan with family and friends in support of the treatment, a simplification of treatment regime, a reduction of adverse consequences, and that a history of such treatment be maintained"

(Amnesty, 2003: 32). This too is still under negotiation nearly eight years later.

It is obvious from the preceding statements that mental health promotion is an increasingly prominent feature of government policy internationally. Furthermore, there are an increasing number of international and national reports and numerous strategies dedicated solely to the area of mental health promotion, acknowledging the importance of positive mental health to the overall health and economies of communities.

The WHO, the World Federation for Mental Health and the World Psychiatric Association are playing key roles in defining and increasing the value placed on mental health. The World Bank Report (Murray & Lopez 1996) draws attention to the rise in the rate of suicide and depression as the major health problems for the twenty first century. A number of World Health Reports (2001 and 2002) advocate a comprehensive public health prevention strategy to ensure access to appropriate and cost-effective services. All are good strategies but what actions are evident?

Let us look at the more regional level, especially as it relates to the site of this research. The European Network on Mental Health Policy, established in 1995, Key Concepts for European Mental Health Promotion in 1997, and the EC Mental Indicators Project 1999 aim to strengthen mental health policy and practice European-wide. Implementing the Mental Health Promotion Action (IMHPA) is a European Commission-funded project which commenced in 2003 and is composed of three strands.

The first proposes to review policy across all European states. The second seeks the development of a European database of effective mental health promotion programs. The third will produce a training manual for use in the prevention of depression in all primary care settings. But what is happening on the ground at the national and regional levels.

Trends at the Irish National Level

The Mental Health Act, reflecting many of the requirements of international law, was passed in 2001 by the Oireachtas, Dáil Eireann and Séanad Eireann, but was not signed into law by the then Minister for Health. In any case, it fell short of that promised by the earlier White and Green papers of discussion stages. The Oireachtas did set up a Mental Health Commission, chaired by Dr John Owen, to review standards and practices, particularly around the treatment for those involuntarily retained in institutional care. This is a greatly under-resourced sector with its budget reduced by 25% between 1994 and 2001. It is still archaic in its operations with little evidence of new principles or practice. According to Mary Raftery in *The Irish Times*, 26th June 2005:

> "The 1945 Mental Treatment Act is still in law and it confers on GPs and psychiatrist's enormous powers to incarcerate people indefinitely, remove their civil rights, and treat them forcibly with injection, surgery and ECT without their consent.
> The European Court of Human Rights forced the Irish Government to admit the absence of independent review and safeguards in the psychiatric committal process and stressed that this is in breach of the Convention on Human Rights."

The Mental Health Act, 2001 was intended to change all that. It remained unsigned until 2007. Why? The psychiatric professions opposed it. They refused to participate in any independent tribunal system which, in fact, could not function without them.

The National Health Strategy, Quality and Fairness Report (2001) states that: "programs to promote positive attitude to mental health will be introduced" and that "suicide prevention programs will be intensified", recommending that service users have direct involvement at all levels of

the program and in service planning. These provisions are still not in operation.

The Report of the National Task Force on Suicide (1998) includes similar policy statements, seeing prevention of suicide best addressed as part of a broader approach to mental and emotional health. These recommendations have not yet been put into operation.

Statistics for admissions in Ireland show a rise from year to year. This information must be tempered by the changes occurring in diagnostic procedures both internationally, nationally and regionally. The Diagnostic and Statistical Manual used by psychiatry, its official diagnostic criteria, was updated from DSM III, produced in 1980, to DSM IV in 1994 and is again under review. National statistics show that there were 20,752 admissions to Irish psychiatric units and hospitals in 2008, a rate of 489.5 per 100,000 of population. The number of first admissions increased from 5,853 in 2007 to 6,194 in 2008 (+6%). However, 70 percent of these were re-admissions.

There were an equal proportion of male and female admissions. The 45–54 year age group had the highest rate of all admissions, at 768.5 per 100,000 of total population while the 20–24 year age group had the highest rate of admissions, at 212.9 per 100,000.

Single persons accounted for over half of all (54.5%) admissions. Divorced persons had the highest rate of all (695.4) while married persons had the lowest, at 363.8 for all admissions per 100,000

Depressive disorders accounted for 30%; schizophrenia accounted for 19% while alcoholic disorders accounted for 12% of first admissions.

Eight per cent of all admissions were non-voluntary. This is a reduction of one percentage point for all admissions since 2007. There were 4,726 admissions for HSE West in 2007, a rate of 466.2 per 100,000. This was the second-lowest rate of all admissions among all HSE areas.

Males accounted for 52% of all admissions, a rate of 479.7. The 35–44-year age group had the highest rate of all admissions in HSE West. The 45–54-year age group had 704.5, while the 25–34-year age group had 630.8. The under 18-year age group had the lowest rate of admission, at 24.2. The 18–19-year age group had 244.7, the 20–24-year age group, 211.4, and the 25–34-year age group192.6. The under 18-year age group had the lowest rate of first admission, at 16.3, the highest rate for this age group among all HSE areas.

Single persons accounted for 57% of all admissions; married persons accounted for 26%; widowed persons accounted for 5%; and divorced persons accounted for 2%. Divorced persons had the highest rate of all 622.3 in HSE West. Married persons had the lowest rate of all 316.2.

39% of returns for HSE West did not specify an occupation, making assignment to a socio-economic group impossible.

De-institutionalisation of mental health services began in Ireland in the 1980s. In 1958 the institutional population was 21,075. By 2002 it had dropped to 4,500, brought about by the death of many long-stay patients and the introduction of community care. Admissions to psychiatric hospitals have not significantly changed in 20 years.

This is caused by a lack of community-based services and a shortage of acute care beds. “Admissions in Ireland are at 75 per 100,000 while at 49 in Wales and England, and at 26 in Italy” according to the WHO 2001 annual report on best practice in planning and delivery of health care service. Amnesty (2003: 19) provides similar figures.

To improve this situation, these international bodies called for the following terms as community care essentials: “The State must set up a program of prevention and early diagnosis, the setting up of assessment, diagnostic and treatment centres, an updating of in-patient care services including the shut-down of some eighteenth century facilities.” Along with this there must be “the provision of day-care centres throughout the State, the provision of out-patient care in

conjunction with day-care, the provision of community-based residences, and rehabilitation and training centres." Of course, "these facilities must be staffed by competent people" (WHO, 2001).

This course of action is still at the implementation stage and a long way from completion. What is available is still a nine to five service that shuts down for the weekend.

According to the Irish Psychiatry on-line web page:

> "The training plans of Health Boards should not supersede the well- being of patients. There is an over-reliance on medications and a full range of therapies: psychotherapy; psychosocial rehabilitation; and vocational rehabilitation employment should be made available. The effects of shame are often worse than the symptoms (of disorder) and secrecy acts as an obstacle to the presentation and treatment of mental illness at all stages."

The difference between secrecy and privacy are not explored on the site.

The opinion of the Irish College of Psychiatrists, commenting on Mental Health Act 2001 and reported by Amnesty (2003: 33), states

> "There are pressures on Registrars to use newest medications with lack of guidance causing undue side effects, the dangers of poly-pharmacy and attendant dangers of over-dosage and drug interaction. There is confusion between side effects and therapeutic efficacy. There is a need for government standards and guidelines. The vast majority of patients are legally incompetent, with no capacity for informed consent, with 30 percent to 50 percent on psychotropic medication given without consent.
>
> Best practice is given through interdisciplinary teams. The current regime is an out-of-date service requiring radical change.

> Gross expenditure for psychiatric care has reduced by 20.7 percent since 1976. The total mental health expenditure in 1994 of 9.4 percent of total health budget has been reduced to 7.2 percent in 2001. This is partly explained by better efficiency in the move to community based care."

Although some large-scale acute care psychiatric hospitals have been closed the institution of psychiatry has not changed radically if we consider it in Saris's (1990: 42) terms of "bundles of technologies, narrative styles, modes of discourse, and, erasures and silences". The architecture has changed but the approach and attitude has not. The schema of Irish psychiatry is not changed. De-institutionalisation has not yet happened.

Although multi-disciplinary teams are called for by the Irish College of Psychiatrists, psychologists and chaplains are excluded from such teams in many acute care facilities regulated by psychiatrists. All team members must adopt the psychiatric and medical model. It will take time for this to change.

According to Amnesty 2003, "low levels of research lead to uninformed policy making and this, in turn, leads to ill-informed practices". GROW, with Professor Rappaport in Illinois, USA, has researched this area and has made the results available in Ireland. Therefore, it is not necessarily a lack of knowledge that is the problem. Other issues arise.

Some private groups, STEER and Advocate for example, propose to offer an advocate service to patients and their families in cases where they are not empowered to deal well with their situation. So far, this service is not yet generally available but many in GROW feel that this is essential.

Also, it is not clear if the psychiatry, psychology and psychotherapy professionals will co-operate with such an advocacy service. One STEER official feared that they "might be told to go away"

by the professionals when they attempt to provide their service. It is unclear what redress is available if this happens. Other voluntary bodies have been active in the field for many years. Without them the current bad state of services would be much worse. How can Irish society improve mental health care in WHO terms?

Recent Developments at the Irish National Level

Tim O'Malley, the Minister of State at the Department of Health & Children with special responsibility for mental health, issued in November 2006, *A Vision For Change*, a report by an expert group on mental health policy. According to O'Malley "The emphasis is firmly on recovery and on facilitating active partnerships between service users, carers and mental health professionals" (Department for Health and Children, 2006: 4). This policy framework allows for many concepts of mental health including "ideas of subjective well-being, personal autonomy and the ability to realise one's potential in life."

This policy includes the awareness that "mental health is broader than the absence of mental disorders, that poor mental health affects our ability to cope with and manage our lives, particularly during personal change and through key life events, and decreases our ability to participate fully in life" (ibid. 16).

The report accepts the bio-psycho-social model while recognising that, to date, there has been too much emphasis on the biological or medical element of the model and not enough on the psychosocial. The 'psycho' element refers to a psychological element only. The report recognises the need to revise the language used to describe mental health because it has stigmatised those with mental disorder.

To affect a change of attitude *A Vision for Change*

> "details a series of actions for developing a comprehensive person-centred model of mental health service provision. Extensive consultations with service users, families and service

> providers informed this policy" deciding that "services should be person-centred adapted to each individual's needs and potential and that services should be delivered by skilled professionals working together in community-based multidisciplinary teams (Department for Health and Children, 2006: 5).

The report proposes a holistic view of mental health and recommends "an integrated approach, addressing biological, psychological and social factors through a person-centred care plan" (ibid: 8) agreed with service users and their families. It appears to contradict itself by asking the specialist services to "assume responsibility for self-governance and to be accountable to their stakeholders, especially service users, their families and carers" (ibid: 8). If the teams are self-governing how can the service users call them to account? No mechanism is indicated or prescribed.

Some care teams will be "organised on a population age basis while the rest are geographically set with 250,000 to 400,000 people in each catchment area using current social and demographic boundaries" (ibid: 8). This system will be applied equitably across all service-user groups and teams will share expertise. State services will seek to provide for all scientific and cultural views and treatments. This openness is essential as so many non-national cultural groups now reside within the State.

The closure and sale of existing mental hospitals is intended to raise sufficient monies to cover the cost of implementing this new policy which includes a home-based and an assertive outreach element. Information about services available will be made available locally and all services will be researched on an ongoing basis to monitor the efficiency and efficacy of treatment. No detail of how this will be done is included and no management objectives are set. Without set objectives, effective monitoring is not possible.

Planning and funding of education and training for mental health professional staff is centralised in structures that will be, but not yet, established by the Health Services Executive (HSE). Capital and non-capital investment will be implemented over the next seven to ten years in parallel with the re-organisation of mental health services. The future looks bright in a bio-psycho-social sense.

At North-West of Ireland Level

The Mental Health Promotion Strategy and Action Plan 2005-2010, was issued by the then North-West Health Service in November 2004. It bears a strong resemblance to the report A Vision for Change published at national level two years later. This locally-produced regional plan describes normal behaviour or mental health as:

> "… more than the absence of mental ill-health. It is the emotional and spiritual resilience, which enables us to enjoy life and to survive pain, disappointment and sadness. It is a positive sense of well-being and an underlying belief in our own and others' dignity and worth" stating that: "mental health is about;
> (1) Feelings, thoughts and beliefs – how we deal with our world.
> (2) Emotional skills – how we deal with other people.
> (3) Basic needs being met – where we live and what our lives are like" (North Western Health, 2004: 8).

From these statements we could assume that mental disorder arises when any or all of these factors are not sufficiently satisfied. But this is not necessarily so. Other factors are involved.

> "Mental health is influenced by many factors including genetic inheritance, childhood experiences, life events, individual ability to cope, levels of social support, economic factors, religious

beliefs and access to appropriate healthcare. Gender can also impact on vulnerability to mental health problems.
All forms of discrimination, from racism to homophobia to sectarianism, can cause mental health problems. In some cases mental health service users may experience further discrimination due to their mental illness" (ibid: 8).

It would appear that this statement leaves every aspect of life open to examination, diagnosis, treatment and prognosis. This is confirmed by the principle of mental health promotion which states:

"Mental health is concerned with achieving positive mental health and quality of life at population level. Mental health promotion targets the whole population. It is an enabling process done by, with and for people" (ibid: 8).

What is proposed is for the good of all. "Mental health promotion activity relates to individuals and small groups, local communities and organisations, to reduce the structural barriers to health and to reduce health inequalities that are the result of social and economic factors rather than individual behaviour" (ibid: 9).

Prevention envisaged as "interventions that occur before the initial onset of the disorder" (ibid: 10) is viewed as the way forward. These initiatives are classified as: "universal, provided to whole populations; selective, targeting those population groups at increased risk of developing a disorder; and indicated, targeting people showing signs and symptoms of a disorder" (ibid: 10).

In this report suicide is considered an extreme form of disorder. Suicide prevention is aimed at the three classified levels. At the Universal level the plan proposes to enhance protective factors such as the quality of relationships and coping skills. Selective and indicated levels will have prevention measures such as having well-managed and

responsive health and social services to recognise early behavioural signs and social markers, and to make early interventions.

Much of the content of the North-West report is taken from GROW's home country program, the Australian National Mental Health Strategy completed in 2000 and this reference is acknowledged.

The evidence of the impact of risk and protective factors is considered greatest in the case of children's disorder, notably in areas of warm, affectionate parenting and strong family attachment, or the lack of it. Economic disadvantage is considered to have a substantial negative impact on mental health through poor nutrition and housing. Unemployment is known to produce five times the risk of mental health problems. Physical and social isolation are recognised as major risk factors, bringing difficulty of access to services.

The strategy of the plan includes the promotion of self-esteem, self-efficacy, stress and anger management and relaxation techniques. Building social supports through self- and mutual-help groups and networks to include organisations like GROW is mentioned but is not developed. In summary, effective mental health promotion interventions are those that are comprehensive and address multiple risk and protective factors throughout the life cycle.

Although spirituality is mentioned (ibid: 8) it is not developed as a tactical part of any strategy. Body or brain, mind or psychology, social or community, are considered the essential elements. Achievement of normality is not underpinned by any specific ethical or moral philosophy but by a philosophy of the pragmatic, of what is acceptable. This begins to have resonance with the lowest common denominator rather than any lofty ideal.

The underlying principle of the Mental Health Promotion Strategy and Action Plan 2005-2010 is that mental health is a positive concept and an integral part of overall health. The document quotes from a Helsinki- based report produced in 2000 which states that the burden of

mental health problems and disorders are increasing with eight out of ten physical diseases having related mental health elements.

The Helsinki document forecasts that, by 2020, depression will be the second greatest problem in countries worldwide, including Ireland. This, plus the fact that suicide among young men is also increasing sharply, has focused attention on mental health promotion. The next generation is seen at high risk of mental disorder and associated physical illness particularly infectious, respiratory, and cardio-vascular disease and trauma, diabetes and hepatitis C, and with parenting problems making a significant impact. The Helsinki document highlights the need to have mental health promotion, prevention and treatment closely integrated with all public health strategies.

The strategy developed in the North-West of Ireland, Mental Health Promotion Strategy and Action Plan, 2005-2010, suggests the need for a globalisation of the promotion of good mental health and of the prevention of disorders. The North-West plan takes a biological and biographical perspective on psychological problems, seeing childhood issues and lack of parenting skills as key factors. It places the major burden of action on mental health professionals. The plan assumes that professional understanding is capable of dealing with all cultures and all conditions.

At the same time it sees prevention and cure requiring biological or medical and psycho-therapeutic treatments with the causes of mental illnesses deeply embedded in biological and genetic, or socio-cultural and economic factors. Although the great majority of the mental disorders are psychosocial in origin, psychiatric medication is considered the key treatment. When less invasive strategies fail, compulsory hospitalisation is not only permissible but is seen as a necessity.

The underlying assumption is based on the belief that the practice of mental health care must operate as a wing of government. This is so, even where existing democratic regimes have invariably

failed in the past and required the corrective legislation of international bodies. At this time it is not clear if this specifically regional plan will be superseded by the national one, A Vision for Change Plan, 2006. However, when speaking with professional and voluntary carers, and to many service users, it is not clear which plan is current in the North-West.

My discussion of the national and regional strategic plans leads to the question: how does the practice of psychiatry fit into this picture?

A View of Psychiatry

Psychiatry is the branch of medical science that provides bio-psycho-social services, sedation and, when all else fails, hospitalisation. It attempts to deal with the diagnosis, treatment and prevention of mental and emotional illness. "It was Henry Maudsley (d. 1918) who first believed that insanity is fundamentally a bodily disease, maintaining that character is determined primarily by the structure of the brain" (Alexander & Selesnick 1966: 201).

This premise proposes that it is the pattern of nerve connections, the synaptic structure within the brain which determines how we interpret and respond to the world. It does not, however, explain what determines or permits a particular pattern of connections to occur either of a biological, neurological, psychological, social or some other influence.

Most psychiatrists believe that mental disorder results from biological or brain-related lesions or defects. Disordered brain structures, in turn, produce disordered behavioural patterns. How the manifestations of these defects are interpreted depends on the cultural setting in which they occur. They are made manifest in locally-unacceptable social behavioural patterns that can be recognised by psychiatrists as markers or symptoms of mental disorder. Suicide is considered the most profound manifestation of mental disorder.

To ensure that all possibilities of physical illness are eliminated before mental illness is diagnosed those who enter the psychiatric profession must first qualify as medical doctors. At present in Ireland, referrals to psychiatrists can come only from general practitioners. Basic education and training in psychiatry is provided through a professional organisation, The Royal Institute of Psychiatry, based in London, England, as there is not a college of psychiatry in Ireland. The Irish College of Psychiatry is an administrative office for the London-based organisation.

Psychiatric classification systems include categorical, dimensional, and multi-axial types. Categorical typing is hierarchical in form so that each case can have only one diagnosis and is considered most suitable for clinical settings. Organic psychosis takes precedence over functional psychosis, which takes precedence over neurosis. Biology is of prime importance. This typing does not allow for co-morbidity, where there is more than one type of psychosis with the same patient.

The main classification systems used in the North-West of Ireland are the International Classification of Disease (ICD), a WHO system, and Diagnosis and Statistical Manual (DSM), a USA system and these are summarized below.

"ICD-10: World Health Organisation 1992, 10th edition

This is a descriptive classification with main headings as follows:

F00-F09 Organic, including symptomatic mental disorders.

F10-F19 Mental and behavioural disorders due to psychoactive substance use.

F20-F29 Schizophrenia, schizotypal and delusional disorders.

F30-F39 Mood (affective) disorders.

F40-F48 Neurotic, stress-related and somatoform disorders.

F50-F59 Behavioural syndromes associated with physiological disturbances and physical factors.

F60-F69 Disorders of adult personality and behaviour.
F70-F79 Mental retardation.
F80-F89 Disorders of psychological development.
F90-F98 Behavioural and emotional disorders with on-set usually occurring in childhood or adolescence.
F99 Unspecified mental disorder" (Barraclough & Gill, 1996: 6).

Diagnostic guidelines are given for each condition. Some behavioural patterns are classified in sections of the ICD, for example suicide, self-inflicted injury, and poisoning in F50-F59. This system is most used to date in the North-West but, with so many psychiatrists now being trained in the USA and returning home to Ireland the DSM- IV is used.

The Diagnostic and Statistical Manual of Mental Disorders, 4th edition (DSM-IV) is a five-axis system. The strength of this system is that each syndrome is defined by a set of practical criteria that must be considered against a background of personality and intellectual features.

"DSM-IV: American Psychiatric Association 1994
Axis I: Clinical syndromes.
Axis II: Developmental disorders and personality disorders.
Axis III: Physical disorders and conditions.
Axis IV: Severity of psychological stressors
Axis V: Global assessment of functioning." (Barraclough & Gill 1996: 8).

Both psychiatric models include the use of psychological treatments but only to account for cultural, social or economic factors that may enhance or deplete a person's ability. Mental illness, for psychiatry, is essentially a biological problem. Environmental factors, such as contaminated water supplies, poor farm land or poor

infrastructure are seen as political or economic issues outside the realm of psychiatry or medicine.

Psychiatry excludes concepts of spirituality even where it is the basis of a local religion. Generally, religious practice is considered a symptom of mental disorder where the practice becomes more pronounced during the period of decline or after breakdown, where a person in distress seeks support in delusion.

Psychiatry proposes that spirituality and religions derive from personal or community suffering and need. An atheist is considered to be a person who refuses to construct such a crutch. Being spiritual or religious is simply an expression of how people cope with pain and suffering.

Dr. John is a clinical psychiatrist working the North-West of Ireland. I met him at a conference in Sligo on suicide. He is a self-confessed atheist. For him belief or faith in God is a culturally acceptable illusion. Religion is seen as an acceptable local or regional construction and helpful in dealing with stress and fear in the individual or society. “A lack of spiritual appreciation does not make people any more vulnerable to breakdown than those with a firm belief in a god or God” according to Dr. John. He believes that having a concept of a god is neither innate nor necessary to good mental health. Nor is the lack of it a symptom of good or bad health but it does exclude the support that such a construction allows. He spoke from his own professional approach to religion or spirituality during our interview.

> “In my practice I try to avoid such areas. I detach myself. I adopt the medical model, offering help where I can see them [patients] getting some benefit from what I do. I will discuss spirituality or religion but I try to keep my role separate from that of the chaplain. I see undue time or importance given to prayer only in terms of change in behaviour from pre-morbid behaviour.”

Dr John, as a psychiatrist, is open to input from psychologists and sees good in religious concepts. He is a pragmatic man.

> "There is a need for some social glue. Without it there is a higher rate of social and psychological disruption. Religion is a value system, and a forum for knowing what is right and wrong, a useful set of reference points. Religion can supply this social glue. In my practice the issue of spirituality has not been of concern."

If Dr John avoids the topic of religion it is unlikely to arise.

Dr Jonathan Zuess found a high rate of atheism among psychiatrists. "It is interesting to note", said Zuess, "that over 50% of psychiatrists and psychologists are self-declared atheists in contrast to the figure for the whole population which is 1 to 5 %" (Zeuss, 1999: 44).

A Critical Review of the Dominant Psychiatric Paradigm

Dr Thomas Szasz, a psychiatrist and academic, renowned in the field of mental health, asked the question: "Should there be different strands of psychiatry for each religious denomination and other morally or ethically-based groups?" (Szasz, 1974: 15). He recognised that local constructions of mental health must be respected or else some international consensus must be derived. This consensus would have to be broad enough to encompass all local perceptions, and yet narrow enough to be usable in the daily work of professional carers.

Szasz views psychiatry sceptically, seeing it as a form of social engineering. He believes that the health values espoused by psychiatry have tended to replace moral and political values. Just as in democracy, in psychiatry there lurks the danger of tyranny by the majority. He warns the public, proposing that for the intelligent layman, organised psychiatry poses a grave threat. The term mental health, for

Szasz, is a “vague, almost meaningless term. Probably it is only a new name for an age-old longing or need for personal and social security” (Szasz, 1974: xvii).

For Szasz, many contemporary psychiatrists are “physicians who hold the view that some neurological defect will be found to explain all disorders of thinking and behaviour, which implies that people’s troubles cannot be caused by conflicting personal needs, opinions, social aspirations, values and so forth” (ibid: 11). This psychiatric view releases mental illness from any social and, particularly, moral or ethical context in which it occurs even if it results from misuse of drugs or alcohol.

For Szasz, those who regard mental illness as disease of the brain would be better, for the sake of clarity, to say just that and nothing else. In this view, behaviour may be disordered but the cause is biological. This, however, does not deter psychiatrists from making a diagnosis in terms of deviation from a social norm. “Whatever this norm may be, in whatever cultural setting, it must be stated in terms of psycho-social, ethical and legal concepts, yet, for psychiatry, the remedy is sought in terms of medical measures that are free from ethical value” (Ibid: 14).

This position is criminal as Szasz sees it.

> “When scientific judgement becomes a basis for social action we are confronted with an act of discrimination. This is true of racism, anti-Semitism, homophobia and many more stigmatised issues. While we consider physical illness as something that happens to us, mental illness is something that we do or feel, or think. This creates the situation in which it is claimed that psycho-social, ethical, and/or legal deviations can be corrected by medical action. But is this rational?” (ibid: 16) he asks.

Szasz believes the term, mental illness, is a metaphor which psychiatry has mistaken for a fact. This, for him, explains why "many historical figures, from Jesus to Castro, and from Job to Hitler, have been diagnosed as suffering from this or that psychiatric malady" (ibid: 17). For Szasz:

> "Mental illness is a convenient term of derogation, denigration, or thinly veiled attack, has thus become part of everyday life. Instead of science there is advertising. Instead of diagnosis there is name-calling" (ibid: 20).

Szasz, speaking about ICD and DSM IV classifications, said

> "This outmoded nosology is chaotic and eclectic, a mix of physical, psychological and social illnesses. Spiritual areas are ignored" (ibid: 23 -25).

These systems treat the mental hospital patient, not as a person, but as the occupant of a status, isolating and depriving him or her of any right of contract. In this light, the claim that mental institutions are essentially medical hospitals must be rejected as false.

> "This type of social control is a threat to a free society, because it is based on mysticism and deceit, not on rational thought and honesty. The practice of hospital psychiatry is a positivistic legal attitude which equates legality with morality" (ibid: 70 – 87).

The conception of a mental illness as something similar to a bodily disease serves to obscure the many significant ethical, legal, and socio-economic aspects of forced mental hospitalisation. "The relationship between physicians and patients in psychiatric hospitals is often a struggle between adversaries" (ibid: 181). Szasz believes that

psychiatry has acquired social prestige and power through an essentially misleading association with the practice of medicine by using pharmaceutical treatments.

Thomas Szasz conducted his research and developed his sceptical views in 1974. What does he think today? He confirmed his early view when I asked him this question at the Health4Life Conference in Dublin City University in September 2007. Has there been a radical change in thinking by those in psychiatry? Apparently, not in Ireland! The view expressed by practicing psychiatrists at the same conference confirmed the conventional psychiatric paradigm. For them mental disorder is an illness that needs medication

Besides this, a text book used in training psychiatrists today is Hughes' Outline of Modern Psychiatry, 1996, 4th edition. Quoting directly from the introductory pages we find: "Psychiatry is a branch of medicine which deals with mental, emotional and behavioural disorders".

The most rigorous type of classification is one based on cause, for example, a single gene defect such as Huntington's disease or an infection such as neuro-syphilis. However, for psychiatric disorders, this is inapplicable and official psychiatric classification systems largely consist of descriptive accounts of clinical syndromes each with their characteristic symptoms, signs and natural history.

> "Psychiatric disorders are sometimes divided into organic brain disorders, physical pathology which affects the brain, and functional mental illnesses, attributed to some kind of psychological stress, although in many cases it would be more honest to say that their cause is not known" (Barraclough & Gill 1996: 3-4).

Psychiatry recognises the limitations of its paradigm but, so far, in Ireland, it has taken a hard line and has failed to amend it.

Szasz took a hard line, in 1974 and today, in reviewing psychiatry. His hard and negative view of psychiatry persists also in the minds of many ex-patients, their family members, and many in the caring professions.

In the interview with Dr John, a practising clinical psychiatrist, he apologised for the sad state of affairs of psychiatry in Ireland today. This is a source of embarrassment to him but he hopes for change and points to the work of the Mental Health Commission, a body set up by government to implement the new mental health strategy A Vision For Change (Stationery Office, 2006) as a source of his hope. What changes can he hope for?

Dr John, in practice for ten years and currently working in the North-West, is open to change but not to ideas of spirituality. For him "Spirituality is spoken about at many conferences in America and at The Royal College of Psychiatry in London but it has not gained the same momentum as, say, Cognitive Behavioural Therapy or Psychotherapy." Spirituality in the religious sense, a concept that is fundamental to GROW philosophy, is excluded. Spirituality does not have a medical or curing or healing facility for Dr John.

Alternative Psychiatric Views

Not all psychiatrists agree with Dr John. For Stan Grof, a psychiatrist by profession and a colleague of Csikszentmihalyi, some breakdowns are not psychiatric disorder but a spiritual emergence with a positive potential. This sets him close to GROW principles. Grof argues that "many conditions are found to have organic bases such as: infections, tumours, vitamin deficiencies, and vascular and degenerative diseases of the brain" (Grof, 1989: introduction: p xii), but insists that the great majority of mental disorder has no biological or neurological basis. Grof is uncomfortable with the current practice of psychiatry because "the same remedies are applied when no organic basis is found, making no distinction between psychosis and mysticism" (Grof, 2000: x).

Grof believes that, “Freud, Charcot, Bernheim, and Liébault formed the roots of psychology, psychiatry and psychotherapy around the holotropic experiences of their clients, Miss Anna O, in particular” (Grof, 2000: 13). He became familiar with what he terms ‘holotropic states’ researching effects of LSD and non-ordinary states of mind related by indigenous people in the Americas.

This is consistent with the findings of my own research into the use of alternative and complementary treatments in the North-West of Ireland (Roberts: 2002). Many people have turned to complementary treatment to find a spiritual experience, a contact with the mystical, elated feelings of completion and their concept of a creator of the world.

Holotropic states can be induced chemically, evoked through the experience of rhythmically exciting percussion instruments, evoked or induced through the experience of extreme pain produced artificially or through traumatic life experiences such as birthing. Grof’s wife had such an experience during childbirth (Grof, 2000: 2). During altered states of mind “We can reach profound psychological insights concerning our personal history, unconscious dynamics, emotional difficulties, interpersonal problems and the nature of the Cosmos beyond our cultural frames” (Grof, 2000: 3). Holotropic states occur in the liminal stage of rites of passage (Van Gennep 1960) and engage what anthropologists John Harner (1980) and Victor Turner (1969, 1992) calls the primal mind.

In the 1950’s Grof espoused a movement to develop humanistic psychology and experiential therapies where direct expressions of emotions are achieved, headed by Abraham Maslow (1954) and later by Carl Rogers (1967). Well known among such therapies is Fritz Perls’s Gestalt therapy. Grof developed what he called ‘Condensed Experiences’ (COEX) consisting of emotionally charged memories that resemble each other in quality and physical sensations with a common denominator (ibid: 22) that set expectations for later life similar to the schema concept proposed by Fiske and Kinder (1981: 173).

He developed a form of treatment based on breathing exercises, loud music and drumming. Such groups, trained by Grof, operate in the North-West of Ireland today, helping people that have had received no remedy in psychiatry. Some psychiatrists referred their patient to Grof's groups, but asked that the referral remain secret.

Grof understands disordered states as part of a human process of separation and individuation. He proposes that the early traumas affect the very foundations, the schema of identity. He views the difference between mystical experiences and psychoses as one of attitude and interpretation. For him, successful completion and integration of a psycho-spiritual crisis can move the individual to a higher level of consciousness evolution. In this he approaches the GROW holistic understanding of mental disorder. If psychiatry does not open to these other views Grof believes it will become redundant.

The View of Psychology

Psychology, the science of mind, gives precedence to the effects of traumatic events in the life of the person. Discussions between the psychologist and client serve to expose the traumatic event and to relieve its emotional power. Freud suggested that "neurotic disturbances can be conquered only by recognising their origin through self-revelation" (Alexander & Selesnick, 1966: 84). His method is a philosophical process set in a narrative context with understanding as the agent of efficacy. "Psychology has its roots in philosophy, religion and literature" (Milgrom & Burrows: 2001: 2). This places psychology in contest if not in conflict with the medical and psychiatric model and explains why psychologists are excluded from multi-disciplinary teams in many Irish acute care centres.

Freud's psychological model formed in the cultural setting of Nietzsche's Europe where God was proclaimed dead. In fact spirituality was then and still is considered a symptom of psychological disorder.

Carl Jung disagreed with Freud and wrote voluminously on the relationships between psychotherapy and religious belief. For him both were essential parts of the human model. Carl Rogers, an eminent psychologist in the USA in the 1950s, did not agree with Freud either. For Rogers the innate drive in all people towards self-fulfilment was an essential element (Rogers, 1980: 119). He saw human beings as autotelic or self-actualising, moving towards the realisation of innate human potential of capability (ibid. 191). He considered a scientific approach as unable to enter the sphere of therapy and inappropriate to the study of psychology (ibid: 212/3) and "the only learning that significantly influences behaviour is self-discovered, self-appropriated learning" (ibid: 276).

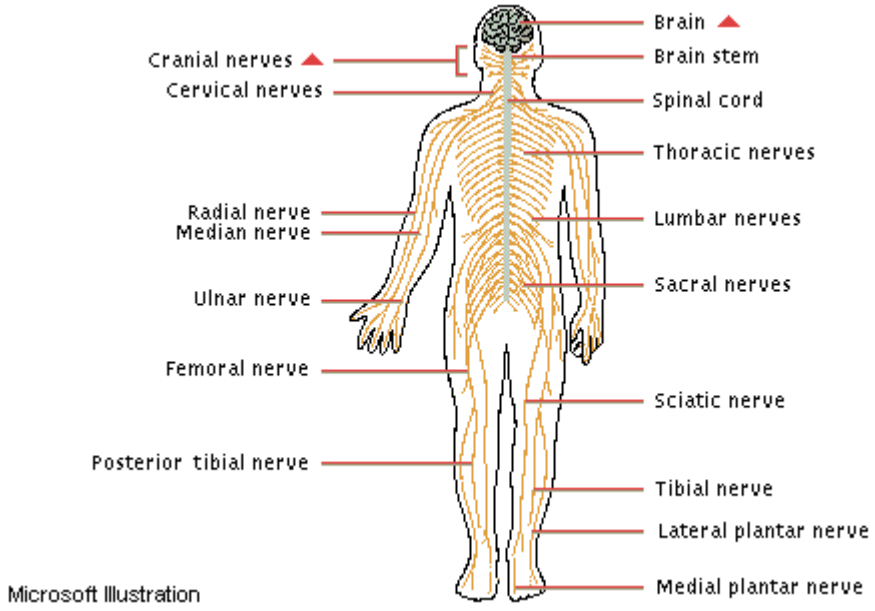
Melanie Klein saw disordered relationships as the root of all psychological and psychiatric problems. She developed group therapy as a forum for analysis and synthesis. For her dealing with an individual was inappropriate and even a cause of further trauma.

Edward Boyne reviewed the psychological approaches available in Ireland. What he makes clear is that psychology is not an integrated field of knowledge. In the North-West region, when psychotherapy is sought what is offered depends on what is available. The Cognitive Behavioural Therapy (CBT) available through HSE services uses talk-therapies to bring resolution by achieving an understanding of reality. CBT analyses disordered behaviour and proposes a more productive strategy. Currently CBT is available only for a minority with psychological problems.

The View of Nervous System

Neurology studies the brain and the nervous system. Human neurology integrates the senses and coordinates the motor system. If the nervous system is damaged it will distort perceptions, thinking and reasoning processes and the ability to respond to them appropriately.

This causes difficulty when a child is diagnosed with Autism and the psychiatrist prescribes medications to treat the nervous system.

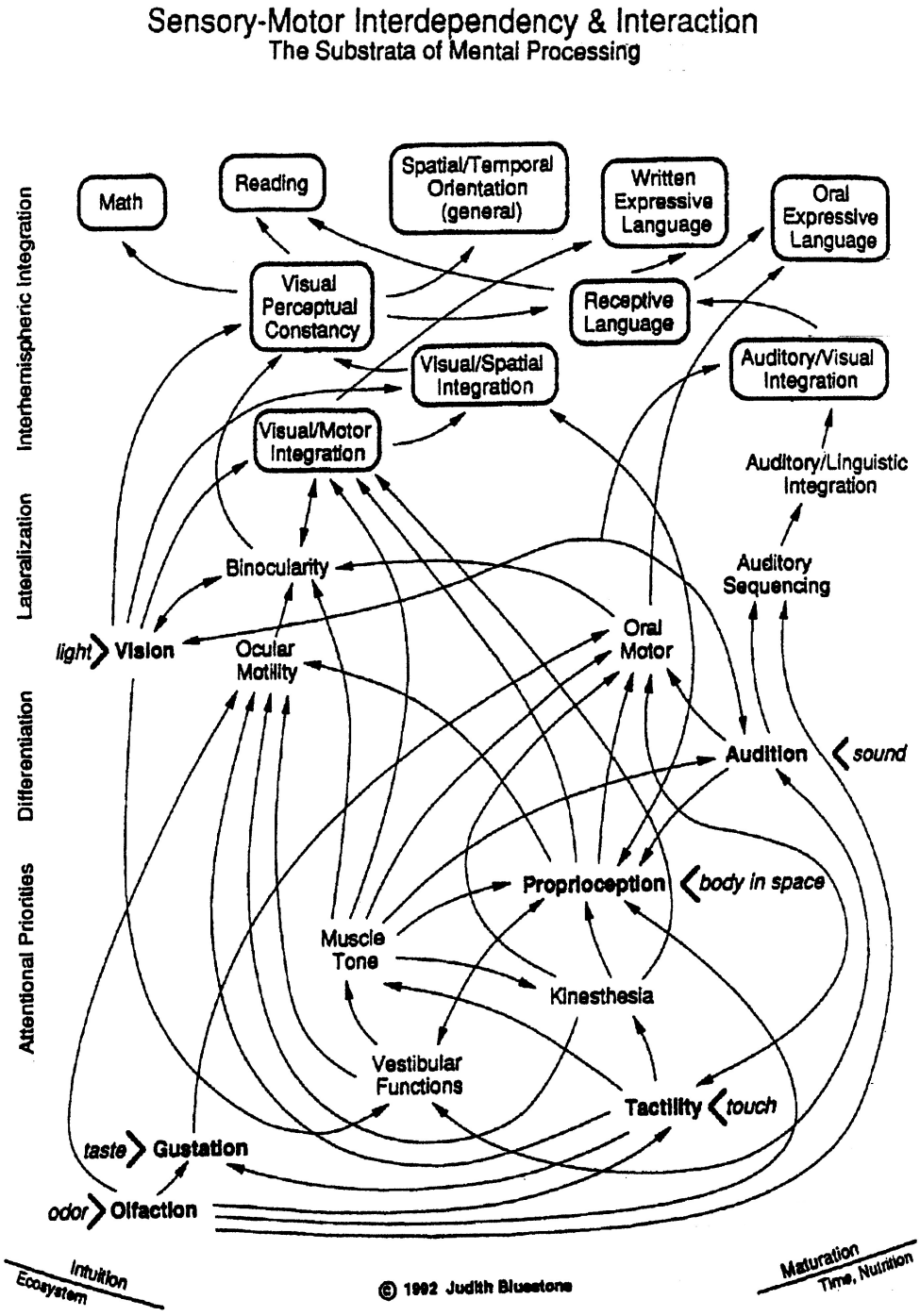


Autism is a major concern for those treated by psychiatrists, psychologists and speech and language therapists and report little progress. Ritalin is prescribed by psychiatrists but the side effects of this drug: slurred speech and Tourette's syndrome of ticks; have discouraged its use.

Judith Bluestone, born in Seattle, USA, had a complex of neurological disorders and was, eventually, diagnosed with Autism. Psychiatry could not help her. Autism reveals itself in a spectrum of disorders that manifest with three classic symptoms: impaired social interaction; difficulty with verbal and non-verbal communications; and severely limited activities and interests and is commonly assumed to be a mental disorder (Bluestone, 2004: 1).

Bluestone advocates a total load theory for Autism, "a theory of multiple assaults on the whole bodily system such as traumatic birth, health problems in the mother, yeast infection and food additive

damage, and sensitivities to chemicals, dyes in clothing, perfumes, and prescribed medications" (ibid: 2).



Printed here with permission from the HANDLE® Institute

This complex subject requires a systems approach as these factors are nested and bundled together and symbolised in the chart reproduced on Page 107 with permission from Judith Bluestone at the HANDLE© Institute.

For Bluestone the body-mind-spirit system does not process information on one- way streets but in interactive loops that can be disrupted (Bluestone 2004: 4). For her, psychological stress, poor basic nutritional levels for children fail to support basic body-brain functions on a cellular level and toxins in food and water cause many of the serious health problems (ibid: 15).

Her father, a chemical researcher, was contaminated while developing insecticides and pesticides such as Agent Orange recently recognised as neuro-toxic and banned by a treaty among 127 countries. His toxic condition disrupted his child's neurological system even before she was conceived. For her, it was a system that produced toxic materials that could not distinguish between family and adversary that was flawed.

As she grew up, her family and community reacted to her in a way that taught her how to live in a pattern of disordered responses. Her father could not fathom his daughter's problems and she seemed totally unreasonable and unreasoning. Judith could not explain in his language what her difficulty was and he could not interpret her rebellious behaviour (ibid: 4). When Bluestone attended a psychiatrist she discovered that they too could not communicate. The psychiatrist used words whereas Bluestone used disordered behaviour to express a disordered life experience (ibid: 11).

Bluestone developed an organisation called HANDLE®, an acronym for a Holistic Approach to Neuro-Development and Learning Efficiency, an approach that has brought relief to thousands on all continents. She developed this form of healing while learning to deal with her own behavioural disorders. She, like GROW members, took full responsibility for her own personal development.

Concluding Comments

In reviewing the strategy proposed by carers in State and private services what becomes clear immediately is the spectrum of causes of what is called mental disorder. It has multiple roots. This makes diagnosis and treatment extremely difficult especially if there are multiple or escalating causes. Also, it is difficult to discern if one trauma has caused another, as Paul's narrative suggests where sexual abuse produced social insecurity.

If, as Foucault, (1972: 120) says, power is generated through the discourse developed between madness and sanity is true, conventional psychiatry can be seen to dominate this discourse, structure it, control it and set it in a frame that places psychiatry and psychiatrists at its head. The input of other practitioners and voluntary organisations serve as a resistance movement only. Ideas of spirituality are at the nexus of this conflicted landscape that locates an individual in a relationship between self, identity and community.

When this research began I saw GROW as a suitable location to investigate how well-being is understood. Adopting the recovery and growth model makes GROW representative of a major movement that is resistant to the medical model of well-being. The principles and practice of GROW provide insight to this movement.

When considering the contents of the next chapters it is important to remember GROW members are in recovery from mental disorder and stigma. The cultural setting in the North-West reflects the disordered approach to treatment that Dr John apologised for. The Irish government and HSE plan*, A Vision for Change,* is, as yet, an aspiration only.

Chapter 4 GROW History and Development

This chapter reviews the history of GROW and what influenced its development. The founding fathers and their schema, particularly Fr Con Keogh who is still active in GROW more than 50 years later, were people who had experienced a spectrum of mental health experiences. The stigma attached to the experience made it extremely difficult for them to re-enter their local community. To avoid total isolation a group formed an organisation based on the Alcoholics Anonymous 12-step model. The need for this organisation enabled it to spread to other continents and countries. GROW is an acronym for Group Recovery Organisations of the World (Turner-Crowsen & Jablensky, 1987). It was founded is Hurstville, a suburb of Sydney, in Australia 26th April 1957 and has, since then, spread world wide.

Con Keogh, a Jesuit priest, led the first meeting. He experienced difficulties after 11 years of intensive study and work in stressful and controversial social issues. After acute psychiatric care, Keogh attempted to re-enter the everyday world. He found that stigma attached to treatment in mental hospital made re-incorporation extremely difficult. Former friends and companions did not know how to treat him. They avoided him. Although he did not have an alcohol problem, he and others like him, were welcomed into the local branch of another stigmatised group, Alcoholics Anonymous. His new friends later became his associates in setting up GROW with more focus on the needs of those with mental disorder. They adopted and adapted the Alcoholics Anonymous 12-step program and developed a practical method of recovery. 50 years later, this program has proven its worth.

Today GROW is open to everybody. No fees or dues are charged. The organisation provides members with a Program of Recovery and Growth, a uniquely structured meeting Group Method, a caring and sharing community and an organisational and legal structure to regulate and standardise its activities locally, nationally and inter-

nationally. Keogh's organisation was initially called RECOVERY. In 1974, just 17 years later, its members changed the name to GROW for two main reasons.

Firstly, the name RECOVERY appears to accept recovering as a best possible outcome. Although still limiting it is more positive than the professional understanding of mental breakdown with chronic fragmentation of the self. GROW believes break-down can, more productively, be interpreted as a break-through that suggests a collapse of a limiting and failed paradigm. It allows for the emergence of a more productive paradigm and fulfils Van Gennep's rites-of-passage concept.

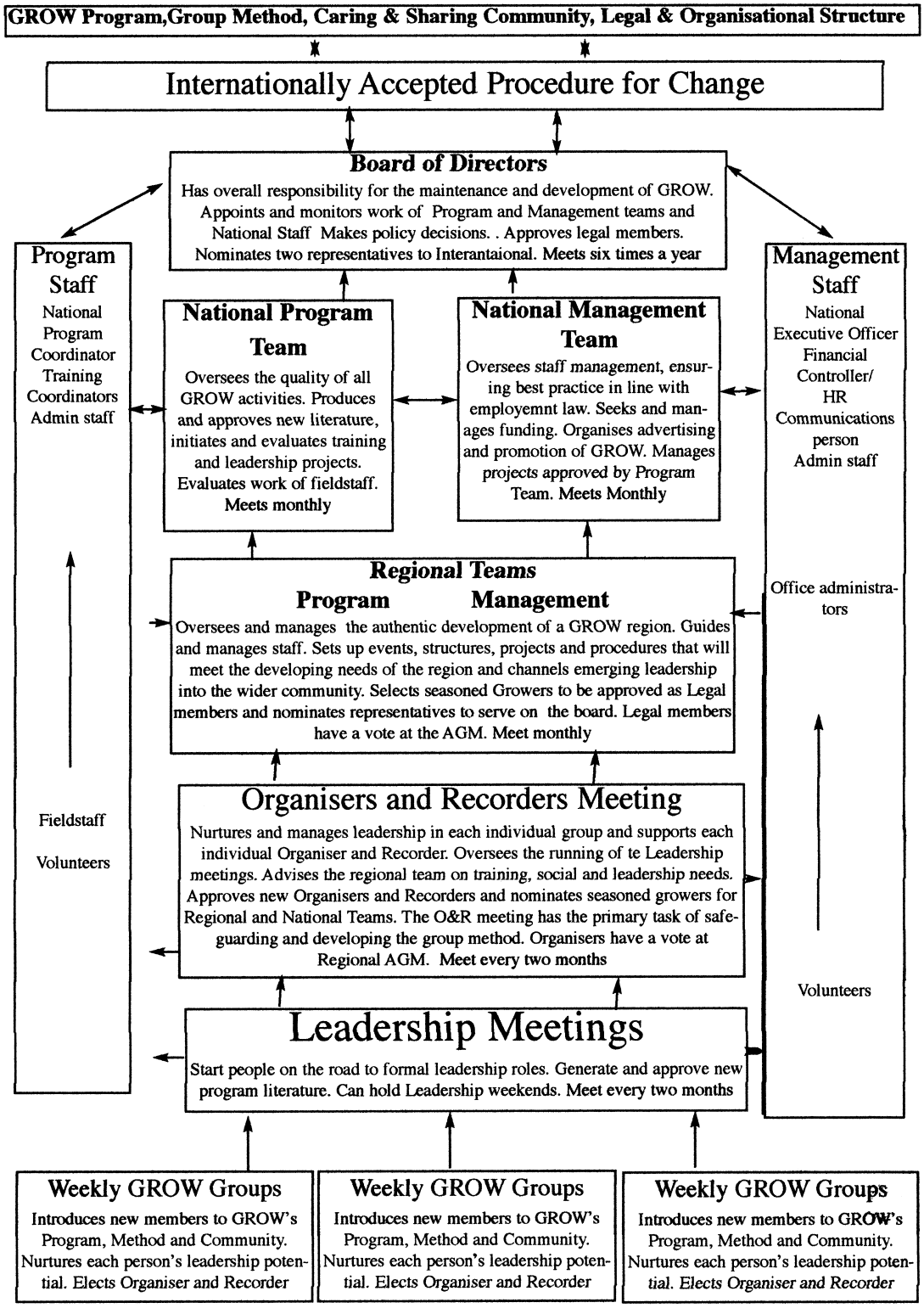
Secondly, on expanding into the USA, Keogh's RECOVERY found another organisation using the same name, aims and objectives. Changing to GROW avoided confusion between the two organisations. But the objectives of GROW did not change. "GROW is a uniquely structured community mental-health movement" (GROW, 2001: 1).

GROW is different from professional and other voluntary groups who consider mutual help as inappropriate if not dangerous according to Rappaport (1988). GROW believes that continued professional involvement after a period of acute care in hospital, if not balanced by social and community involvement and good peer-to-peer relationships, it has a disempowering effect on the patient (Rappaport, 1991) caused by the continuance of a professional / patient relationship.

International and National Structures

At present, in 2008, GROW operates in Australia, the Continental USA, Hawaii, Canada, New Zealand, England, Mauritius and Ireland. There are over 700 groups world-wide. All groups use the same principles and practices and organisational structure. The international organisation structure was under review at the time of writing. However, the proposed structure is shown below.

An Organisational Structure for GROW



Supplied by GROW Ireland

GROW Ireland documentation, such as the Memorandum and Articles of Association, prescribe co-operation between all national bodies with each reporting to the international body. In practice, each national organisation operates independently while holding to requirements set by GROW in Australia.

GROW international structures have been vague in policy documents and in practice. A meeting between the Irish National Executive and the Australian International Executive took place in Ireland in 2007 and discussed how this could be improved. So far, information on these deliberations is not available. In their day-to-day activities each National Executive operates alone. They stay affiliated with GROW International provided they continue to use GROW formulations but methods of monitoring are unclear.

A document titled *Internationally Accepted Procedure for Change* that proposes a method of developing GROW principles, practice or structure, is also currently under review but it was not available when a copy was requested. There is some ambiguity about how the organisation should and can develop. The proposed structure emphasises the national level. Internationally the organisation appears to be less than fully functional. This review process will continue as long as GROW continues to grow.

GROW in Ireland

GROW began operations in Ireland in 1969. At present there are more than 140 groups in operation. Father Séan O'Hanlon, a founding member in Ireland, had been a Roman Catholic missionary working in Rabaul, the capital of Papua New Guinea. While there, O'Hanlon met Dr Albert Lacey, a co-founder of GROW in Australia, who was there to help launch a GROW group. O'Hanlon collapsed in 1969, his health ravaged from living in a tropical climate for 21 years. His mental and physical condition was shattered. He was struggling with cancer. As

well as helping to set up GROW in Rabaul, he attended GROW group meetings for his own benefit.

When his health improved, he returned to Ireland where, along with Father Brian Dunleavy, he started GROW groups in Cork, Limerick and Dublin. O'Hanlon remained involved until his death in 1971 (GROW, 1994). The Irish organisation grew organically, starting new groups wherever there was a need and a few willing people. Groups gathered into a national executive and finally regions formed. GROW in Ireland has remained in contact with, and was supported by, the Australian organisation that, to date, has operated as the international co-ordinator of GROW operations. In more recent years the need for more formal arrangements has been recognised.

National and regional structures evolved as membership grew. Registration as a charitable organisation became a legal requirement as GROW depended on charitable contributions. GROW Ireland is now a tax-free registered charity (Reg. No. CHY 9319). It is legally constituted to enable it to work effectively with Government departments, the Health Service Executive and other legal entities and organisations.

A Charter Agreement between GROW International and GROW Ireland was co-signed on 10th August 1992 by the directors of each organisation. This agreement binds GROW Ireland to abide by the GROW formulae, to protect the interests of GROW International and to be subject to it. It entitles GROW Ireland to full access and full use of the GROW documentation and staff while developing the organisation in Ireland.

The agreement limits GROW Ireland to the island of Ireland. It is difficult for GROW Ireland to operate within Northern Ireland. GROW has not flourished in the United Kingdom because it has not received the same endorsement from the British National Health System (NHS) as it has from the Health Services Executive (HSE) in Ireland. As a result, GROW has not flourished in Northern Ireland.

GROW Ireland has a Board of Directors, its Executive. This Board produces audited accounts every year and holds an Annual General Meeting (AGM). It operates in line with Articles of Association, bylaws, and Charter Agreement. The Bylaws relate mainly to the composition of various teams and their responsibilities, and define the organisation of GROW.

The Board of Directors is elected by legal members of GROW (not to be confused with members of GROW groups) at their AGM. Some legal members are elected for life although the outgoing Executive elects the majority for a period of two years. All legal members have more than three years of active membership. Employees of GROW are not eligible to serve on the Executive. The Board meets five to six times each year and is concerned mainly with policy matters.

The day-to-day management of the organisation is delegated to the National Management Team (NMT), a sub-committee of the Executive, and consists of seven ordinary GROW members. It meets every four to six weeks. Its task is to manage the day-to-day business of GROW on behalf of the Executive Board. It is responsible for financial matters including negotiations with the HSE and other bodies that contribute to the financial well-being of GROW.

The NMT communication staff produce **GROWing,** a quarterly A4 sized journal, and other literature and books. Fieldworkers, regional and national administrators, public relations and other office staff are employed by the NMT.

The NMT is responsible for the production and delivery of training materials used at national and regional events. A major current task is the production and implementation of the Personal Growth and Community Building through Leadership: A Distance Learning Course. Part 1 is already operational throughout the country and part 2 is in preparation.

Partnership is innate in GROW. Partner organisations that affiliate to GROW can contribute to their common fund of knowledge and experience, but all changes or improvements to GROW formulae must be sanctioned by GROW International. Any partner's agreement can be terminated either voluntarily or through enforcement by GROW if the agreement is not honoured in full. The laws of the Australian Capital Territory prevail if any legal dispute arises. Legality and control concepts, along with partnership, are fundamental to GROW.

The document incorporating GROW Ireland as a legal entity was completed on 6th January 1989 under the Companies Act of 1963 (GROW, 1989). In GROW established legal and business practices are accepted fully. The organisation is named GROW (Ireland) but is referred to as GROW in general usage. Legality and the requirements of good governance form the organisational foundations of GROW. GROW is ordered in its operations.

The task of GROW is to promote the personal growth of people who are inadequate or maladjusted to life and to work for the prevention and rehabilitation of people abusing alcohol or drugs. This includes the fields of prevention and rehabilitation in community mental health. To achieve this GROW Ireland establishes and co-ordinates GROW groups throughout Ireland. It supports research and investigation into these and related matters.

GROW may use any and every legal method to develop as a national organisation. It can co-operate with statutory, professional and voluntary organisations, public authorities, and individuals with the same objective. GROW has the authority to carry out these objectives and to acquire property in the pursuit of its objectives.

Regardless of whom its partners are, GROW must hold full responsibility for all GROW properties and monies. It can procure funding and accept gifts. If the organisation is dissolved at any stage in the future, all monies and properties must revert to GROW International.

Audited accounts must be prepared annually for the Revenue Commissioners.

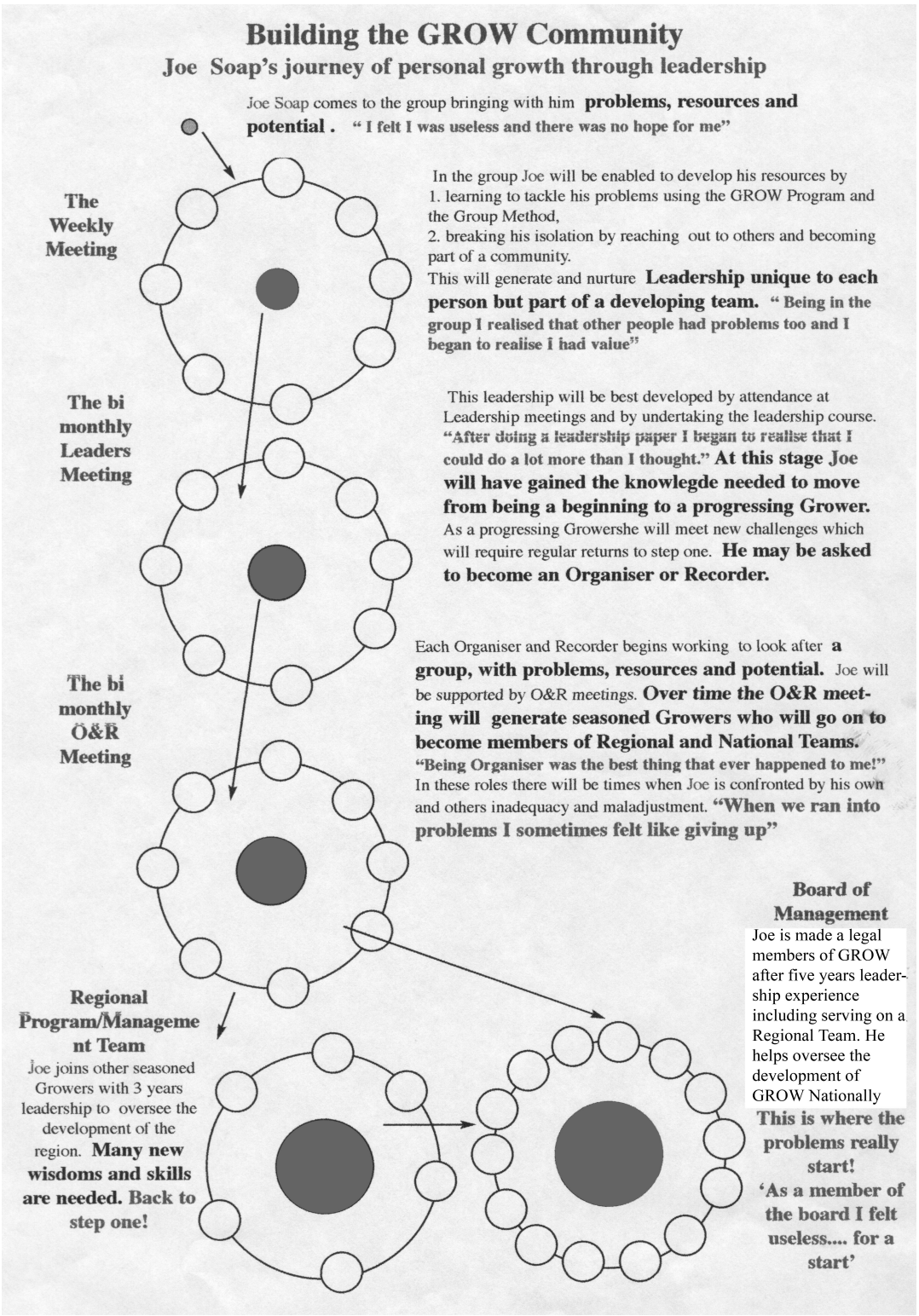
GROW must achieve solvency while operating in the best interests of GROW employees and its officers. It must act prudently in GROW's financial interests and pay all fees due to GROW International. In GROW's legal and business structure, shrewd judgement and judicious practice is compulsory. Discipline is central to all its operations.

In its operations, GROW is as bureaucratic as any other charitable organisation. It is tightly bound by civil and case law in all proceedings and must keep records of all its transactions.

Executive and Regional Activities in Ireland

The National Executive consists of a chairperson, vice-chairperson, treasurer, two appointees of GROW International, and will have between five and twelve members in total of which two-thirds must be GROW members. All are eligible for re-election. The Executive can co-opt members. The normal legal preclusions apply to appointment to the Executive.

The GROW Executive Board is a cohort of select individuals regulated by common and case law, and moral and ethical principles. At this level, the needs and rights of the group are primary while those of the individual take a secondary position. This mixture of GROW members and non-members is in overall control of the organisation, while employed staff (non-members) provide support to the executive. Decisions are group events making GROW a social group of participating individuals. In all GROW events the group is primary. This is depicted below.



Supplied by GROW Ireland

The map below shows some but not all GROW Regional Team locations in Ireland. An up-to-date regional location map of GROW offices is not yet available as it is under review. Currently there are eight Regional Program Teams reporting to the executive board. These teams are responsible for all regional activities, the development and expansion of each group and for the expansion of the number of groups in the region. In principle this gives the team total control of its region. Such a regime provides flexibility in GROW operations and gives full responsibility for all operations to the Regional Team.

There are fifteen groups in the region with new groups forming and dissolving all the time. Driving through the region takes four hours. It employs two part-time fieldworkers, each working 30 hours per week and a full-time administrator in the Letterkenny office. This region has been operating for almost 21 years. It has two fieldworker offices, one in Sligo City and one in Carndonagh in north Donegal. These locations are determined by the home location of the fieldworkers.

Although the administrator works alone there is regular contact between this office and members of the regional team and the two fieldworkers. Along with salary, fieldworkers and administrators are reimbursed for business expenses by the HSE. There is a need for another fieldworker but budget limitations set by the HSE may delay this appointment.

I was part of a sub-committee of the regional team that produced a plan which identified the need for a total of 30 groups in the region. Even without a time frame, the scale of the work to fulfil this plan was daunting for most members of the regional team and the fieldworkers were particularly challenged by it.

There are seven other regional offices throughout the Republic of Ireland. This research concentrates on GROW in Ireland with most fieldwork done in the North-West Region. I met with members of these other teams on many occasions and interviewed key people with years

of experience of GROW development. All were very helpful and discussed major GROW issues at length.

Map Supplied by GROW Ireland

The West Region covers counties Galway, Mayo and Roscommon and has an office in Castlebar. The North-East Region, covering counties Louth, Monaghan, Meath and Cavan, is based in Drogheda. The Eastern Region, covering counties Dublin, Wicklow and Kildare, is based in Dublin. The Midland Region covers counties Laois, Offaly, Longford and Westmeath and is based in Tullamore. The Mid-West Region, covering counties Limerick, Clare and Tipperary, is based in Limerick. The South-East Region, covering counties Kilkenny, Waterford, Wexford and Carlow, is based in Kilkenny City. GROW is divided into manageable parts all operating in accordance with GROW principles and practice.

There is a group forming in Northern Ireland. It is based in Belfast and it liaises with the organisation in the Republic. It cannot sustain a regional organisation. Monies cannot be seconded from the Republic as any HSE funding must be spent in the local jurisdiction.

Regional Team Structure and Duties

Each Regional Team consists of a chairperson, vice-chairperson, treasurer, secretary, and four other non-assigned members. Three core members of the Regional Team can be appointed by the National Program Team who, in turn, appoints the balance of the team or the balance can be selected at an annual Regional Conference. All but two must be seasoned GROW members, those with more than three years membership. A maximum of one staff member may be a voting member of the team.

The Regional Team must select and appoint a chairperson who calls regional meetings every four to six weeks and prepares an agenda for each meeting. Three members form a quorum. Minutes of regional meetings must be kept and a copy sent to the Executive Board.

The Regional Team is, in effect, a sub-committee of the National Management and Program Teams, committed to upholding GROW standards. In principle the Regional Team is the main planning and

advisory body for regional activities such as leadership cultivation, training, educational, social and recreational events, community weekends and GROW's seminars. It decides when to open or close local groups including all special groups and it ratifies staff appointments and monitors the conduct of group Organisers and Recorders and staff at regional offices.

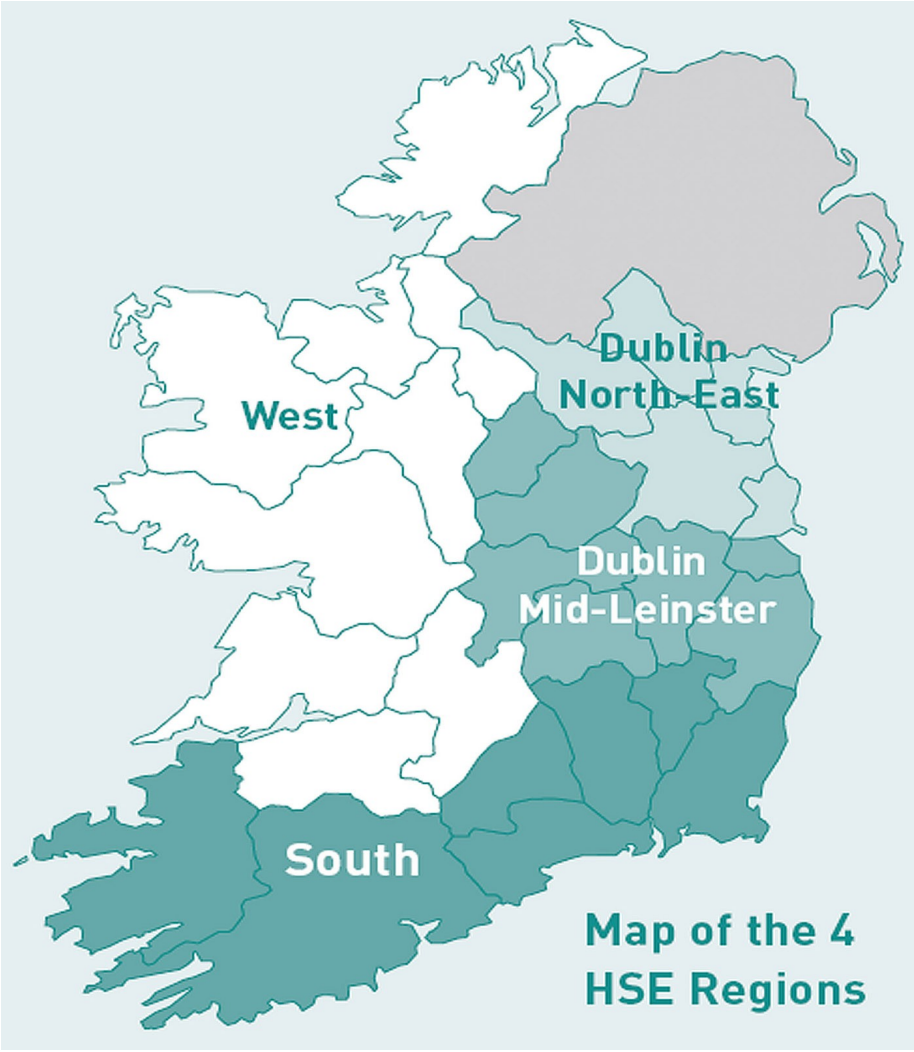
Other duties include the education of community and professional carers in GROW-related matters. This includes public relations and publicity, financial management, reporting of GROW activities in the region, regional budgets and fund-raising, and all other regional affairs. The regional team also gives advice, guidance, and direction to administration staff and fieldworkers working in the region.

In practice the fieldworkers and administration staff report, in an informal manner, to the National Management and Program Team. Their duties are detailed in the GROW Regional Team Handbook (GROW, 2003: 5) produced by the national team. Although at the regional level the main role of the fieldworker and administrative staff is in assisting, advising and facilitating the work of the Regional Team, in practice the reverse is true.

These staff report to the Regional Team only in the sense that they submit a written report at each regional meeting. In my experience, members of the Regional Team do not feel empowered to question what the fieldworkers do or direct them in their work. Any attempt to manage the fieldworkers is met with resistance and claims about their lack of facilities and time. In my opinion, at the regional level, GROW is struggling to grow. This appears the case for all regions.

As the HSE structure evolves there is pressure on GROW's structure to match the HSE regions, shown below, to avoid a lack of administrative synchrony. In this way, the organisation of the HSE may determine GROW's future organisational structure. This is symbolic of fears expressed by GROW members where the HSE is perceived to determine what GROW can do.

At present, the GROW North-West region is understaffed and developed to half its potential. If it is to fulfil its regional plan, it needs another fieldworker but without funding, HSE or otherwise, this will not be possible. Those in need of support will continue with State services only.



Map supplied by HSE

At the time of writing, GROW membership had grown to over 145 groups in Ireland. Since 1969 the organisation has provided support for more than 55,000 people contending with various forms of disorder. A

GROW group is the essential and primary element of the entire GROW structure. Its operation is at the core to the whole GROW structure and is shown at the bottom of the structural diagram shown above.

Each group has its own identity consisting of a name, location, meeting time and discrete membership. For economic reasons most groups meet at a location managed by the HSE or owned by a church body, mainly a Catholic parish or religious order.

Each new member attends for three meetings before being accepted as a group member. The GROW Program of Growth to Maturity, (GROW, 2001) can then be bought and taken away. This A6-sized book has a copy inserted of The Group Method, a light, folded card of the same size. It is an agenda for all group meetings with references to the Program, the Blue Book, for readings used during group meetings. These documents are reviewed in detail in chapter 5.

It can take five years for a group to settle down, by which time the incidence of new members joining lessens. If the numbers extend to more than 12 attending on a regular basis, the formation of a new group can be considered. At each meeting, members of the group sit around a table facing each other. Where people sit depends on simple things like where the heater is, where the window is, where people of the same sex sit or where the fieldworker sits. Later, as the group becomes established, people habitually sit near a member they know and like.

The fieldworker acts initially to ensure that GROW principles and practices are adhered to. This is achieved by example, by organising and leading initial meetings and later, by assisting a group member to do so. Gradually, the fieldworker withdraws, allowing a group member to become a permanent organiser who operates, supervised by the rest of the group, to regulate group operations.

The group also nominate a member as recorder to check the quality of each meeting by recording the comments of the group on major aspects of the meeting. This comment sheet is sent to GROW

headquarters by the fieldworker but, during my fieldwork, no reply or comment was ever forthcoming.

Organisers and recorders have a regional meeting each month. This monthly meeting follows The Group Method agenda but deals with issues of concern at group level throughout the region. It is intended as a group exercise of peers where the more experienced members help to develop the expertise of those new to their post. It has a social aspect to it as it allows members who have known each other for a long time to meet and discuss issues of common interest. In my opinion, such meetings function as a form of leadership development meetings.

All members and groups belong to a "family of friendship", to quote Father Stan Mellet, National Chairperson, from the GROW annual report 2004. This family has a board of directors and patrons, and includes the 'Friends of GROW', a group of people with an established public profile, who are dedicated to raising funds to cover GROW's operating costs.

GROW has a program of radio advertising, a computer website, a phone helpline, and has just completed a rebranding program to show a strong and vibrant image of GROW to the Irish public. GROW has 20 field-workers, some part-time, some full-time, covering all eight GROW regions.

At present GROW Ireland is implementing a five-year plan. Its intention was to expand with a target of 400 good-quality groups by the end of 2007 although this did not happen; at the end of 2007 less than 150 groups were in operation. The budgets set by HSE did not allow for the recruitment of the fieldworker cohort needed.

Growing Leadership

Training of leaders, along with good literature, is considered an essential element in the development plan. Immediately after her 2006 appointment, the National Training Co-ordinator assessed the training needs of GROW in Ireland and produced a comprehensive training

program to respond to these needs. The leadership correspondence course (GROW 2005) was developed to fulfil the needs identified. The course attempts to train members in leadership skills, getting them ready for more responsible positions inside and outside GROW.

The course is administered through the fieldworkers with a number of seasoned GROW members mentoring the trainees. This course is proving reasonably popular and beneficial but ostensibly, it has not produced the cohort of leaders needed. Group peer-to-peer interpersonal activity has been replaced by individuated adult-to-child schooling. The group ethos, at the heart of GROW principles, has been replaced. The lack of peer-to-peer relationship of the leadership meeting diminishes the 'learning-by-example' approach at the heart of GROW development and this explains why leadership development, especially of potential field-workers, has faltered in Ireland and why non-members must be employed to fulfil the needs of the developing organisation.

The correspondence course helps the participants to understand GROW principle and practice and encourages them to progress to leadership positions in their own group and region. Some people who start the leadership training course do not finish it because, based on my observations, they do not like the teacher / student approach it adopts.

Leadership meetings, as such, developed in the early days of GROW, have virtually ceased. That form of development, where members met to discuss GROW principles and practice, has been replaced by a correspondence course. Personal development in GROW requires much more than what a training program can provide. Training of this type conflicts with the concept of self and mutual support.

Leadership meetings developed at the same time as The Program of Growth to Maturity (GROW, 200). In the beginning, the group meeting and the leadership meeting happened in the same week. The group meeting, (as is still the case) dealt with the individual

member's personal problems, and their solutions. Leadership meetings, as explained by seasoned members, dealt with developing an understanding of GROW principles and practice, the skill factors needed by group organisers and recorders, and discussed any questions arising from the Method and Program.

This, in time, produced a substantial body of wisdom: text about good practice and explanatory notes. The material produced was first published in 1957 as the Program of Growth to Maturity and The Group Method. Later, in 1964, GROW published its explanatory text under the title Readings for Recovery, best known to GROW members as The Red Book. Readings for Mental Health, best known to GROW members as The Yellow Book, containing more explanatory and exploratory text was published in 1975.

These books were used in developing Leadership Course Part 1 (GROW, 2005). However, subsequently solitary training exercises have replaced a discussion-based development system. Reading, thinking and writing, solitary activities, have replaced the group activities of discussion and debate.

GROW Training Programs

As discussed above, a correspondence course has replaced leadership meetings. The leadership course, Personal Growth and Community Building Through Leadership: A Distance Learning Course, Part 1 (Grow, 2005), explains what GROW leadership is and how it should work. It is comprised of five modules and each module has clearly defined aims and objectives. Questions for self-assessment are included in each module, the answers to which are generally contained in the body of text of each module.

Exercises are included to link each principle of leadership to a personal experience. The modules are studied alone by each participant. Although a workshop was held to provide a forum for

discussion about the difficulties in doing the course, it did not provide for interactive leadership work.

Module 1 of the leadership course introduces GROW leadership as a responsibility for personal development that brings loving affirmation and wholesome discipline, while encouraging ideas of personal value and growth towards maturity.

Module 2 deals with Leadership by example that inspires observers and listeners to examine their own lives and identify troubled episodes.

Module 3 deals with leadership through helping others. It encourages GROW members to hold strong ideas about confidentiality.

Module 4 serves to clarify the role of the person leading a group meeting. Specific examples of how this is done are included, providing the participant the opportunity of showing their knowledge of these skills.

Module 5 deals with the Leadership Meeting and with the connection between public speaking and personal growth.

Part Two of the leadership correspondence course is currently under development but it will include eight more modules that deal with the role of the group organiser, the recorder, the operation of organisers & recorders meeting, the role of fieldworker, the role of the Regional Program Team, and the role of the National Teams. It promotes GROW as an international movement and as a link with other agencies in the national and local community.

This course is intended for those who wish to take on greater leadership roles. The metaphor of the sailor's voyage through stormy seas is used to illustrate all kinds of GROW leadership on 'the voyage of life'. Leadership training is developed around the core literature developed by GROW, which is reviewed in Chapter 5.

A Regional Manual was developed to assist seasoned GROW members to operate and develop a GROW region. This gives details of the structure and operations and the duties of each office holder at

regional level. Again it is presumed that knowledge gained through training will produce the skills and courage needed by those who take on leadership roles. So far, in my view, this has not happened.

One member said that she has been on her regional team for 15 years and could not step down as nobody was available and willing to take over the role. In her case, three people carried on the regional team work when at least eight are recommended. This is true for other regions also.

The Fieldworker Conundrum

In Ireland some regions have employed fieldworkers who are not seasoned members. The seasoned GROW members I spoke to are unhappy about this but they have no alternative to supply the needs of the developing organisation. This issue was addressed at the National Forum in March 2006 in a set of papers titled: What is the difference between a fieldworker who has progressed through GROW and a fieldworker who has been employed directly from outside GROW?

Although a source of concern, no other way is available if GROW is to endeavour to meet its target of 400 groups countrywide. But the main concern of seasoned members is that recruitment of fieldworkers from outside GROW represents missed opportunities for seasoned members to become fieldworkers, and highlights the shortage of GROW leadership. As GROW is enlarged, the rate of growth is outstripping its ability to produce seasoned members with the skills and experience to fulfil its needs. How can healthy growth be achieved?

How can an ethical GROW approach that brings healing through friendship be accomplished? Can training produce personal development? Is the experience of mental disorder a more powerful motive to develop friendship or can people with good hearts and intentions have the same level of motivation? This conundrum looms large in GROW at present. There is no ready answer.

Fieldworker training continues to be refined. When a new fieldworker or administrator is appointed their duties are clarified through training. Established fieldworkers meet eight times a year for ongoing training. These meetings concentrate on individual work in each region and attempt to develop expertise related to the work of GROW. Fieldworker training, according to some seasoned GROW members, promotes the replacement of the function of the Regional Team by the fieldworker, inverting the working relationship between them.

Administrative staff members carry out routine duties given by the regional team in line with a job description that includes mainly secretarial and accounts duties within the region. In practice, the administrators work closely with the fieldworkers. The role of the regional team appears to be usurped by the fieldworkers.

A major question arose for discussion at the National Forum 2006: “Can a Regional Team start a new GROW group without input from a fieldworker?” The answer, theoretically, is yes but in practice this does not happen anymore. For many years, before fieldworkers were employed the regional teams had done so but now believe that it is not within their remit. Many seasoned GROW members believe that the fieldworkers are now a controlling and managing force in GROW.

It is part of the GROW development plan to have special groups available for those with special needs. This includes people who have been sexually abused, those who have experienced incarceration in the State jail system, and those at risk of suicide. Examples of such special groups are the Ceart group in Kilkenny for people with physical difficulties, and another, in St Loman’s Psychiatric Unit in Mullingar, for those with acute mental disorders.

In St Loman’s, the professionals employed at the hospital form part of the group. They have adopted the GROW approach to recovery and growth. The longer-term plan is to expand this initiative and to deliver training to staff in other institutions to enable them to organise special groups throughout the country. HSE staff are now applying

GROW Method and Program in St Loman's. Can they supply the caring and sharing community essential to success in GROW terms, and if so, how can this be achieved? GROW is changing internally. What is happening externally?

GROW's Public Image in Ireland

At a recent GROW forum, a lighted candle was used to symbolise a 'light in the darkness' of depression, copying 'the light in the window', an old Irish symbol of hospitality offered to a passing stranger. This symbolic gesture was very well received by all in attendance and it led to the formation of a Branding Committee which set out to build a contemporary image of GROW. This new brand would help to build a brand new image of GROW members and help reduce the negative stigma associated with acute care in mental hospital. The brand would replace stigma and highlight GROW services in Ireland.

Uniformity of design of letterheads, documentation and information literature incorporated the fuchsia blossom, a flower long associated with GROW will strengthen the brand image. Nobody remembers where the Fuchsia symbol came from originally, but all agree that it looks good and is appropriate to GROW. The response by the membership of GROW was very favourable, seeing the fuchsia blossom as a beautiful symbol of their organisation. A good symbol is usable even if it has no overt meaning. Beauty is its prime feature. In this way the beauty of the fuchsia replaces the ugliness of stigma.

The Irish GROW website became operational on December 16th 2004 at www.grow.ie It aims to increase brand awareness. It includes a list of suggestions as a Guide to Mental Health, a list of GROW Publications, contact details for Friends of GROW, a list of current news and GROW events, and a section where donations can be contributed.

The GROW Infoline, a lo-call number, 1890-474-474, can be accessed from anywhere in the State. It promotes the aims and objectives of GROW, gives general information to callers about GROW,

and specific information of GROW services, and where they can be found. It attempts to raise the public awareness of mental health and what GROW can contribute to it. The Infoline has been available since November 2004.

GROW News is a quarterly newsletter with a broad appeal, first produced in spring of 2005. The newsletter includes contributions from GROW members and from those outside GROW whose own work complements the work of GROW. GROW News is on public sale as well as to the membership of GROW. It is targeted at the adult education market where self- and mutual-help ideas are used to promote good mental health.

Typically it reviews GROW progress, includes a personal testimony of GROW members and up-dates the news of mental health issues in Ireland. It fits well with Goffman's prescription for "a publication of some kind stabilising for the reader his sense of the realness of his group and his attachment to it" (Goffman, 1990: 37).

GROW News is a new initiative but already fears are expressed by some seasoned members about cost factors and its viability in the long term. However, other seasoned members are very optimistic about its future. All new ventures bring such fears inside and outside GROW.

National and regional GROW weekends attract hundreds of GROW members each year. Involvement is recommended in these training and socialising weekends as GROW sees them as being of key importance on the road to recovery. These weekends have been so popular that now, with membership growing to an all-time high, it is becoming a problem to find a suitable venue that is big enough while being affordable.

With over 145 groups in existence, the total attendance rises above 200 very quickly. The search is now on for a larger venue, which must have a large communal space or theatre and gardens or a beach for long walks. Walking and talking are major factors of GROW weekends. Space is a limiting factor.

Costs must remain low to make the weekend affordable by the membership. Typically, GROW members are people of moderate means. Their life problems preclude high-income work and most live on Social Welfare allowances. Money is a limiting factor.

In 2007, the membership was divided into two geographical groupings as a single venue proved impossible to find. This, although not ideal, may become a permanent arrangement. This suggests that a national organisation may not be ideal. Optimum size is determined by the nature of the task and the limiting factors and not on artificial political factors. This position must be addressed as the organisation grows.

GROW Finances

Although GROW has the 'Friends of GROW' as a fundraising committee, State bodies subsidise up to 90 percent of GROW's annual running costs. This is a form of recognition of the very positive and essential role that GROW can play. With this said, according to one seasoned GROW member, "Subsidy of GROW activities began before there were any real economic pressures to do so. Community Psychiatry was becoming current as a term if not yet as a practice on the ground" (GROW, 1994: 33). In this way GROW identity has been changed.

Dr Julian Rappaport (1990) in the State of Illinois, USA, investigated and demonstrated the great economic and social values that GROW can contribute through its activities. Rappaport and his team consider such activities to be essential to the well-being and progress of those in recovery and growth. After the State-sponsored professionals have concluded with their input, GROW provides the psycho-social and spiritual inputs that Rappaport and GROW consider essential for recovery and growth.

As GROW in Ireland is developing quickly the need for fundraising is ever greater. How can it fund its expanding needs? The National Executive intention is to encourage and enable local volunteers to work along with GROW administrative staff and for local seasoned

GROW members to work along with the fieldworkers. The funding for this must be raised either locally, through Friends of GROW, or from the HSE, and probably all three will need to contribute. GROW is a victim of its increasing success.

A large number of people contribute to GROW finances. This includes many individuals, State and private organisations. This is having another impact on GROW as it opens the organisation to the gaze of a significant audience outside its membership. A benefit of this greater scrutiny can help to deplete the power of negative stigma if stigma derives through ignorance of the facts. Getting to know more about disorder can help to replace negative stigma with a positive one, permitting Goffman's "secondary gains" (1990: 21) to become a primary consideration. As stigma is caused by isolation and ignorance its depletion is achieved by community living and knowledge.

The HSE subsidy to GROW amounted to €1,017,726 in 2004, plus grants of more than €100,000 towards the upkeep of buildings and equipment. To appreciate the true value of this subsidy, it is best to view it as an investment in the light of the following cost factors. The average subsidy for each GROW member each year is €982. The average cost of hospital care for a patient per year is €155,125. GROW can therefore save the State in the order of €154,000 each year for each patient that does not return to acute care. These figures were supplied by the HSE in 2004.

In 2006, the total allocation of funds to the HSE from State finances was €12.3 billion. Of this approximately 6.6 percent, over €820 million was allocated to mental health services. From this amount, grants to outside bodies like GROW of approximately €115 million are allocated. (See www.hse.ie/finance). GROW receives less than 1 percent of available funding.

Other voluntary organisations, heavily funded by the HSE, are operating in the North-West region. Virtually all of these adopt the psychiatric model of mental disorder and act as supports to this concept.

Although they try to be helpful they illustrate what Gabon says, they do so without asking. In GROW opinion this directive support undermines the power of the person in difficulty. One GROW member, a lapsed member of more than one of them, told me: “All they do is ensure that you keep taking your medications and their other activities simply keep you off the streets”.

The EU Program For Peace and Reconciliation is supporting a two-year program to develop GROW services in two border counties, Cavan and Monaghan. Sponsorship from BUPA, a health insurance company, funded the production of the GROW website, Infoline, and the new logo/ fuchsia symbol design. A variety of other sources, private and public, contributed another €50,000 in 2004. GROW has recruited a full-time staff member for fundraising activities but this person must also manage GROW’s human resources. This dual role is not necessarily incongruous as most of GROW expenditure is on staff salaries and expenses.

Regional team members, countrywide, believe that the heavy burden of human resource work tends to keep the staff member very busy leaving very little time for fundraising. Funding has become virtually centralised because of this. The regional teams collected between €3,000 and €20,000 each in 2006. The variation is mainly determined by the population density in the region with most success in and near large cities where efforts and populations are more concentrated. The variation also reflects the opportunity available to members at regional level to participate in public activities.

Every region now has part-time administrative staff and their training program seeks to ensure maintenance of a GROW ethos. A draft outline of a new handbook for GROW employees was made available in March 2006. It does not include job descriptions for GROW members and non-GROW people who take on voluntary roles and responsibilities. The Company Handbook details the legislative requirement of GROW as an employer. It was on trial for 2007 before

being finally accepted into operation. This reflects GROW moving to the more business-like approach needed as staff numbers increase. The Handbook outlines the full-time management requirements to satisfy the operational needs of the organisation, and the legal and auditing criteria of those who provide subsidy and funding to GROW. As I have indicated earlier, GROW is becoming business-like in all its operations.

The Establishment of GROW

GROW is represented at board level on the Mental Health Commission, a government body set up to review all aspects of mental health. It is also represented on The Expert Group commissioned by government to develop a mental health policy. GROW and the HSE are promoting GROW services in areas where no other professional services exist in Ireland, especially in the North-West Region.

GROW is changing to enable this to happen. Seasoned GROW members worry that their original ethos of voluntary self-and mutual-help is being eroded and replaced by a business or professional ethos under the authorship of the HSE. This concern is most acute in the placement of fieldworkers who are not GROW members and with the replacement of experience-based discussions by training-based activities. The question then arises: As GROW practice changes are GROW principles changing also? The next chapter reviews GROW principles, its theories and tenets.

Chapter 5 Excavating GROW Theories and Tenets

GROW, an international self- and mutual-help organisation, celebrated 50 years of service in 2007. In that time it has accumulated the knowledge and experience of its 55,000 members, emic views in Kenneth Pike's (1967) sense of the term, of the participant who learns at first hand what it means to be declared mentally disordered and stigmatised. More particularly, GROW has produced theories and tenets of its understanding of mental health terms such as 'breakdown', 'recovery', 'growth', 'normal' and 'ordinary'. This wisdom, generated at GROW leadership meetings of people who have lived outside the normal social environment, is contained is the small collection of books reviewed in this chapter. They reflect Socratic wisdom of knowing ourselves that Malinowski (1922: 518) proposes cannot possibly be reached "if we never leave the narrow confinement of the customs, beliefs and prejudices into which every man is born" (Jackson, 2005: ix).

I attempted to gain a vantage point of this wisdom literature in action by joining a GROW group. This achievement of wisdom through unpacking and repacking the meaning of its words and language is core to how the GROW program brings healing. The process of gaining wisdom sets the pattern for recovery and growth. In examining this process its pattern will also be exposed.

The Blue Book

This body of wisdom is encapsulated in a book of 81 lightly packed A6 pages, titled The Program of Growth to Maturity and commonly known as The Blue Book, reflecting the colour of its sky-blue cover. This small book was first published in 1957 and revised 15 times since. The 2001 edition is reviewed here. It was produced at early Leadership meetings and collated and written later.

GROW, in The Blue Book, defines mental health as "maturity" and "the vigour and peace of a person who is wholly attuned to reality"

(GROW, 2001: 6) the opposite to being “inadequate or maladjusted to life” (ibid: 3). Being normal in GROW terms means:

> “to be fundamentally sound, wholesome or conducive to growth. This is altogether different from the average, which is indeed a norm, but of immaturity or of positive decline and disintegration” (ibid: 43).

A banner headline on the front cover of The Blue Book proclaims the organisation to be: GROW: World Community Mental Health Movement.

This serves as a flag of the organisation and states its foundation stones as Character, Truth and Friendship set prominently in a circular registered ® icon. The icon shows three people in a huddle supporting each other.

The Blue Book is a handy pocket reference available to GROW members after attendance at three group meetings for the price of €3. It opens with a set of challenges: “Are you inadequate or maladjusted? Are you capable of truth? Are you prepared to be a friend?” (GROW, 2001: inside front cover). It offers a synopsis of GROW history which is read out when a new member joins a group.

The book suggests why people join GROW:

> “To learn the GROW program, to use the GROW group method, and to co-operate with competent agencies and persons for the community goals of mental health, social harmony and spiritual integrity” (ibid: 2) and as the means to respond to the challenges in a graded way.

The Blue Book is the GROW program of power defining GROW forms of knowledge and discourse. The GROW Group Method is its technology of power, the technique and practice for disciplining and

shaping GROW members to implement GROW principles. The legally constituted organisation and operational procedures of GROW form it's strategy of power, defining the agency and structure that implements the technical Method and Blue Book program.

GROW has these attributes but, in my experience, in themselves, they are not enough to reconstruct identity and a true concept of self. More is required and GROW provides it. GROW taps into a source of power through its caring and sharing community. This element of GROW friendship is explored in Chapter Seven.

GROW power does affect change but, if not implemented properly, forms of resistance can arise in response to GROW power. At national, regional and local levels, individuals and other organisations may begin to develop an opposing program and technology to undermine or overwhelm GROW if it does not modify its strategy. If modified too much, however, GROW may become ineffective and overwhelmed.

Some people have difficulty in joining GROW. Most have been stigmatised by entry to an acute care regime so that entry to another regime is daunting. GROW attempts to reduce this difficulty. New members can be escorted into their first meeting and helped to contend with any negative feelings. From there on, the program helps contend with stigma and recovery. It explains mental illness in GROW terms as "Mal-adjusted means either in the wrong or sick," and "Inadequate means either immature or insufficient on my own" (GROW, 2001: 3).

The decline to rock bottom is recognised when any perception of disorder is totally lost. For GROW this process occurs in 12 stages:

"The 12 Stages of Decline and Maladjustment:

1. We gave too much importance to ourselves and our feelings.
2. We grew inattentive to God's presence, and God's natural order, in our lives.

3. We let competitive motives in our dealings with others prevail over our common personal welfare.
4. We expressed or suppressed certain feelings against the better judgement of conscience or sound advice.
5. We began thinking in isolation from others, following feelings and imagination instead of reason.
6. We neglected the care and control of our bodies.
7. We avoided recognising our personal decline and shrank from the task of changing.
8. We systematically disguised in our imagination the real nature of our unhealthy conduct.
9. We became prey to obsessions, delusions, and hallucinations.
10. We practised irrational habits, under elated feelings of irresponsibility or despairing feelings of inability or compulsion.
11. We rejected advice and refused to co-operate with help.
12. We lost all insight into our condition" (ibid: 4).

Paul, a seasoned GROW member, describes the process to me as he remembers it:

"Decline from health, through being foolishly self-centred and driven by our inflated sense of our own value, to being lost to self happens by lack of focus on what is happening all around us. Then our imagination takes over.
It begins by letting ego to become too dominant. We become more self-centred and avoid co-operation with the people we live with. We allow our feelings to overrule our reason and good sense. Losing a co-operative approach further isolates us from our neighbours and friends. Nobody can talk to us.
We stop taking care and interest in our appearance. Washing, hair-care, wearing clean and nice clothes becomes boring and bothersome. We deny our poor performance in daily routines

and cannot face the task of trying harder. It's all too hard and boring. We fool ourselves about how disordered we are and we become obsessed with false or trivial issues. We adopt a false, compulsive or selfish value system while feeling superior to our neighbours and friends. We don't listen to good advice.
Finally we reject our friends. They become a threat, invading our comfort zone, and the comfort zone becomes smaller and smaller. The barriers go up, we cannot see over them, and that we are the problem. It's a living death. There is no way back without some kind of help.
Medicine may help if we are out of control but only as a stopgap measure. We need friends: immediate family, good neighbours, doctors, nurses, and priests. We need a community to support us to come back up. This is what GROW does."

There is an undefined intermediate and liminal mental space left between rock bottom at stage 12 of decline and step 1 of recovery that is left unexplored and undocumented by The Blue Book. As a result, it is difficult to discern the exact nature of this turning point on the journey of recovery. This suggests that recovery begins virtually unnoticed and passes through uncharted territory. People get carried along in moments of empathy by the flow of support and nurture of their friends and family.

Recovery begins with the admission by the person to themselves of being inadequate and disordered. From this point on, a journey of 12 steps proceeds towards recovery and growth.

When recovery becomes evident, it arrives in 12 steps.

"The 12 Steps of Recovery and Personal Growth:

1. We admitted we were inadequate or maladjusted to life.
2. We firmly resolved to get well and co-operated with the help we needed.

3. We surrendered to the healing power of a wise and loving God.
4. We made personal inventory and accepted ourselves.
5. We made moral inventory and cleaned out our hearts.
6. We endured until cured.
7. We took care and control of our bodies.
8. We learned to think by reason rather than by feelings and imagination.
9. We trained our wills to govern our feelings.
10. We took our responsible and caring place in society.
11. We grew daily closer to maturity.
12. We carried GROW's hopeful and healing and transforming message to others in similar need" (GROW, 2001: 5).

Paul put it well:

> "I took a long time before I could say 'yeah, I need help'. I'm screwed up. All the steps in the book are sound enough but doing them is different. It was Marie, my wife that got me going and made me stay. Toughest part for me was to stop hating the past and the people in it. I really wanted them dead. The meetings helped great. I began to calm down inside and look at the outside a bit more.
> I kept at it and began to take care of myself. It was tough to keep going but the group were very good. They 'gave out' to me, praised me for any little thing I did and gave me bits of the book to read. After a few months I was fit to live with, by me and everybody else. Marie was great. I don't know how she stuck it. Now, I can help some of the others.
> That's what GROW did for me but it couldn't have done anything if Marie didn't keep me going. The woman is a saint. I suppose I helped her be a saint", he added with a little laugh.

The objective of the 12-step program is recovery from breakdown through a holistic form of treatment that leads to personal growth to maturity defined as “the vigour and peace of a person who is wholly attuned to reality” (GROW, 2001: 6). For GROW, a mature person is one with “a true mind, a strong character and a loving heart, possessing the great habits or strengths we call the five foundations of maturity: understanding, acceptance, confidence, control and love.” (ibid: 6). The rite is complete. Passage is complete. The hero is home.

The 12-step program has an inherent pattern of recovery and growth, a rites-of-passage pattern in it: **Step 1** requires admission of a problem that must be solved. **Step 2** requires a firm resolution to find the solution by co-operating with others willing to help. **Step 3** requires a surrender to a higher power, either God or fellow-humans. This is a process of becoming knowledgeable about the exigencies of life. It requires an analysis of the past and a synthesis of a solution to make corrections to disordered lifestyle.

Step 4 requires taking an inventory of talent and accepting of personal limitations. **Step 5** requires checking up on a personal moral code and a clearing of prejudices. **Step 6** requires persistence until finished. **Step 7** requires taking care not to over-tax resources. **Step 8** requires that rational thought must persist and any temptation to intuit an answer through feelings or imagination must be avoided. This requires an acceptance of self and the beginnings of acceptance of responsibility to live with the reality of life in a positivist way.

Step 9 requires training the will to control feelings that might leak through. **Step 10** requires taking a responsible and caring stance while recovering and growing. **Step 11** requires daily effort to understand what the real problems are. **Step 12** requires that the resulting solution is made available to others in similar need. At this stage responsibility for self and others is accepted along with a resolution to bring continual change and improvement in a productive lifestyle.

What is also made clear from the 12-step program is that it is a pattern to follow to achieve understanding. Understanding, in this instance, reflects what Das (1998: 175) proposed: “There is no ‘inner state’ called understanding that has occurred. Instead there is a – licence under certain assertions that someone means such and such and that his present application accords with what was said in the past” or in GROW, what was agreed in the past.

The rest of the Blue Book articulates what acceptance and responsibility implies and how it can be achieved and the rites-of-passage completed in GROW terms. It is a route-map through the difficult territory ahead with markers at key points. These landmarks were put their by earlier voyagers.

Completing the Voyage

GROW provides the final steps of rites-of-passage to a maturity that marks the shoreline of the homeland. GROW principles illuminate the route to maturity, wisdom and a sense of personal value based on being human enough to find “my unique part in my Creator’s own saving, healing and transforming work” (GROW. 2001: 7). This requires self-activation that requires “patience and perseverance, and systematic development of personal resources” (ibid: 7). GROW believes that “mutual help, ordinariness and friendship” to be fundamental to good mental health.

These GROW principles, along with God, are the stabilizing and rehabilitating elements for those in decline. If a person fails to adhere to these principles “professional guidance, medical intervention and compulsory help” (ibid: 8) become necessary. This divergence opens an alternative medical route. Medicine becomes the last resort when the person fails to co-operate with God, self and community removing agency and obliterating mind and spirit and agency is lost. For GROW agency is comprised of mind and spirit.

Before joining GROW Paul saw his disorder and inadequacy as a punishment from God for something he had done. Seasoned GROW members consider mental illness a gift from God presenting them with a "comforting paradox, the opportunity to respond with the wisdom and energy to recover and grow" (ibid: 9) offering an opportunity for real growth. The mind is challenged to control and train the brain through good thinking and good actions giving agency to the person and a set of objective rules and regulations.

From here on GROW strives to retain agency but under the control of GROW principles. This requires objective thinking, social interaction with like-minded people and plain speaking about what is important in life in GROW terms.

Questions of self-worth, vital needs, and the changes needed to gain maturity, how to understand physical and mental feelings, are elaborated (ibid: 13). Practice overcomes disordered thinking in a form of continuous Pavlovian conditioning process. The Program offers God, or god, as bedrock, a foundation that will not fail. It discusses what it means to be a whole person with an emphasis on wholesome relationships and the concept of belief in God (ibid: 22).

However, GROW welcomes non-believers to be fully active in their group. For non-believers care for others becomes an alternative to being God centred. Even so, I did not meet any non-believers during fieldwork. To the question, if it was possible to recover and grow without being God centred, Patrick, with over 20 years membership said: "You can recover but you cannot grow to your full potential." Patrick believes in God and sees Jesus Christ as a role model for all. "He really showed us how to live", he said. Having a belief in God is essential to good mental health

For GROW, caring is belief expressed in action. Each person is encouraged to live by whatever spiritual or ethical code they have and, if an atheist, to their humanist or moral code. In all cases a code is needed to develop co-operation to direct the loving relationship of

friends. Love and friendship are proposed as fundamental to co-operation and companionship. GROW defines "friendship" as "a love of intimate sharing between mature equals" (ibid: 35).

For GROW love operates in two major forms: "Effective love in deeds, while affective love is the expression of one's feelings" (GROW. 2001: 34). Love is an acknowledgement of feelings and an expression of them. GROW counters maladjustment with positive action and a resolve to decentralize and use resources for the good of all. When persisted with recovery leads to growth of a new way of life, a born-again experience.

The third part of The Blue Book applies to seasoned GROW members, case-hardened campaigners who are re-born to a normal way of life. GROW proposes its own definition for 'normal':

> "By normal in GROW we mean fundamentally sound, wholesome or conducive to growth. This is altogether different from the average, which is indeed a norm, but of immaturity or of positive decline and disintegration" (ibid: 43).

Accepting all that nature has given as good is essential for GROW members. This includes a "willing adjustment to life's built-in limitations and difficulties," and a "reckoning with real and positive evils" (ibid: 56). Evil, in GROW terms, is defined as "handicaps, sickness, death, conflicts, separations and betrayals, things which are a hindrance and a scandal to love" (ibid: 56). Confidence is essential as a mode of operation especially when combined with control, which is "regulated spontaneity" (ibid: 58).

Ignorance is seen as a root cause of ill-health (ibid: 44) indicating that education and training are the antidote. However care that the person in trauma retain agency is also essential. "The expert should be on tap, not on top" (ibid: 52). For GROW, knowledge acquired "through experience, reason and testimony or authority" (ibid: 49) illuminates the

way. GROW seeks a happy mean in all its dealings, favouring acting rather than reacting, rivalling evil instead of merely opposing it. Living a good life and opposing evil, in all its disordered forms, is essential.

To live a good GROW life members must question their personal worth, issues of security and loving harmony, and the concept of hope (GROW. 2001: 47). The answers to these questions give each person direction to the correct way forward. Building understanding of self-worth raises hope for a happy future. Understanding is achieved through having knowledge and a pure heart.

In GROW feelings relate to being neither over- or under-controlled. Pleasure and suffering are mentioned specifically and elaborated on (ibid: 57-60). Elaboration: analysis and restructuring while balancing needs and wants of the individual and community are key concerns. For GROW, "Love" (GROW, 2001: 62), is the balancing factor and core to all its activities. It separates love from its lusty context in calling for sexual maturity "the capacity for profound and loving but non-sexual friendship" (ibid: 65) that, when fully bloomed for GROW, is an experience among equals.

For GROW the most dreaded part of life is not death but "social separation, bereavement, abandonment, or betrayal by dearest loved ones, disgrace, war - what are these if not social death. Spiritual dying is guilt, hurting those we love most and desertion of ideals" (ibid: 68). "No one gets out of this world alive" summarises the GROW approach to life and death.

Spirituality, in GROW, has a narrative of love and relationship and acknowledges two types: "horizontal spirituality based on belief in persons and vertical spirituality based on belief in God" (ibid: 70). God is defined as "One Supreme Personal Being who knows and cares and powerfully provides for us" (ibid: 72), a theistic concept in Dawkins, (2006) terms. An outside resource is essential to achieve relationships.

Finally, for GROW, all things social, personal, natural and supernatural, must be in balance to achieve good health (GROW, 2001:

76). This array of concepts combines the individual, community and cosmos into an intelligent and holistic belief system, a system to trust. (ibid: 76) as a concluding and coherent statement to seasoned members.

The Program of Growth to Maturity also provides readings that form an integral part of GROW group meetings. These readings remind members of confidentiality, good intention, truth, striving, maturity and good leadership (ibid: 77). They affirm belief in the possibility of recovery, forgiveness, hope and friendship (ibid: 78). All things can come to those who hold these concepts close to their heart.

Surrender to A Higher Power, acceptance, trust, peace and friendship among equals is aspired to (ibid: 79).

These readings compose a protocol intended to give structure, order and repeatability to every group meeting. Other written materials are available for educational purposes which, in general, are written by the founding members of GROW to record what became illuminated and evident to them during their leadership development meetings. This wisdom was written as recently as 2005 although the earliest book was written in Ireland in the late 1960s. Work done by the early members of GROW now illuminate the way for later members who need only to follow the code. Recovery and growth have been patterned.

Innate Patterns

What is evident from this analysis of GROW wisdom is a pattern of in-depth analysis of the issues that produce renewal after mental trauma. Renewal involves a process that is particulated, each particle is then parsed and analysed and, finally, articulated in fine detail. This analysis and synthesis was first produced at early GROW leadership meetings that considered what happened at GROW weekly meetings. This exposed a pattern that reflects the internal unpacking of deep-seated tensions and traumas, accepting them for what they are and then placing them where they belong in the past.

Language is used as the vehicle to carry the process. In this process we find a pattern where words and their meanings are detached from the baggage of misuse to achieve clear understanding. This understanding reflects the root idea that informs it: to stand under and look up at what is in question; to examine and consider in fine detail. Understanding brings with it an acceptance of the fact that the event or series of events did occur, are real and must be contended with.

With acceptance there develops the sense of responsibility to take the actions required to make changes that will prevent such trauma reoccurring and to reform the life style that produced it. In this way to inform is to instigate reform. Success in achieving positive change brings the confidence to undertake further change. Understanding the problem leads to undertaking its cure.

Such undertakings put the person taking the action in control of the process. Control brings order to the disordered in areas of thought, word and deed. Controlled and positive actions are a good description of good mental health, good lifestyle and growth to maturity. The pattern of the process is implanted in the mind, articulated in language and translated into the actions of the GROW member who, if persisted with, is healed by the process.

The process and pattern is well illustrated in later GROW literature in a series of books that grew out of early GROW leadership meetings. O'Brien, (1969), Keogh, (1995 and 2001) and Waters (2005) have taken key elements and words that the process has uncovered and concepts that have been high-lighted to parse and analyse and reconstitute these concepts in even greater detail. "Recovery is the revival and reintegration of a human person" (Keogh, 1995: Introduction).

These contributions illustrate the microscopic work required to achieve understanding showing that it is the process of unpacking and repacking inherent meaning, the excavation of truths that achieves

understanding. This is a voyage of discovery that aptly demonstrates the rites-of-passage theme intrinsic to it.

For Keogh, the philosopher and theologian: “Ultimate values and [ideas of] acceptance are involved, profound motivation and purpose: in short, the things that generally come under the heading of spiritual or religious realities” (ibid: 1.9). Keogh offers five foundational personal attitudes for success and in doing so uncovers a pattern:

> “Understanding to grasp the difference between theoretical demonstration and real certainty, acceptance of a willingness to respond to life as it presents itself, confidence in someone else’s better judgement to guide you, control enough to be objective and careful, and enough love to live generously” (Keogh, 1995: 8.20).

Ann Waters, a seasoned GROW member, produced a book also based on discussions at GROW Leadership meetings, particularly in Hawaii and in Ireland. In the book, Waters selects key GROW topics: Understanding, Acceptance, Confidence, Control, and Love, and elaborates on how GROW understands them. She has added Love, a vital part that animates the process but is not visible in the pattern. For Waters, honesty and truth are at the heart of an understanding that produces change and brings recovery. For her, understanding is a key to acceptance. This psychological pattern provides for the elision of disorder back into order.

Changing lifestyle first requires acceptance of the current state of being and this is very difficult. In GROW a change in life-style arrives in twelve steps, starting at ignorance of the need to change. It progresses to denial of the need to change, to acknowledgement of what friends say, to admittance and recognition of what is wrong with the current state of affairs, and to acceptance of the need and responsibility to make change happen. This parallels the trajectory suggested by Kubler-Ross (1970) of ‘denial’, ‘anger’, ‘bargaining’, ‘depression’ and then

‘acceptance’ of life and death. For Waters, when acceptance is achieved change can begin. Acceptance marks maturity. “Being mature means habitually taking responsibility” (Waters, 2005: 83).

If we consider the 12-step process in this light it becomes clear that achieving knowledge follows a parallel course to Waters voyage to GROW acceptance. The voyage follows a pattern from unawareness in Step 1 through denial, acknowledgement and admittance before acceptance in Step 4 is achieved. Unawareness is overcome through the experience of rites-of-passage.

Most people feel that the inverse is true, that they will be responsible when they become mature. This, for Waters, is how GROW identity is constructed. “Which identity we realize depends on how we now choose to live, the things that happen to us, and how we react to these happenings” (ibid: 83). Identity is generated through experience. Humility helps to develop the essential confidence for acceptance of life’s journey.

“Confidence is the other side of acceptance, the victorious side, which makes acceptance possible and growthful” (Waters, 2005: 91). Acceptance and confidence are reflexive. Life demands heroism from most people. Acceptance and confidence form along the way of the hero.

Waters does not suggest that life can be controlled completely but that risk of disorder can be greatly reduced. To avoid the risk of mental disorder, it is necessary for people to know and understand that they are smart enough, strong enough and likeable enough to perform well at work and play.

Love, according to Waters, always produces a better response. “Love is the consistent, active care for the whole welfare of another human being as equally important as my own”, (Waters, 2005: 177). For Waters and GROW, love is a practical rule of living that enables a community to function in an ordered way.

Love is an attitude of mind. “Genuine loving is a habit” (ibid: 183). Waters and GROW recognise love as a commandment that is common to all the major religions and one that everybody is capable of living up to. Love in this sense is a spiritual gift. “The truly spiritual person becomes more whole, more effective, yet less egocentric (ibid: 217). For Waters, spirituality gives body and mind true meaning and is at the core of a healthy being brought about by an evolutionary process.

Evolution of thinking promotes an evolution of speaking and behaviour, changing the way of being in the world, responding to the changed psychological environment. One concept elides into another to form a web or network of thoughts. This web resembles the web of connections among organisations as described above. A personal web can reinforce an organisational web if their core concept is compatible. Otherwise the webs will conflict and resist each other.

Chapter 6 Excavating GROW Narrative

Paul's GROW story is one of abuse and depression that began when his uncle sexually abused him. It is representitive of the many narratives I heard at GROW meetings and those recorded in GROW anthologies (GROW 1996, 2003). His private personal testimony began when he met his wife whose love and support made the difference between, in his own words, " living a full life and a living a prolonged death." His GROW personal testimony began when he joined GROW and eclipsed his earlier GROW story diminishing it to make room for recorded progress.

Paul is a soft spoken man with a talent for writing, a philosophical type who thinks about what he does. He has received great benefit from his GROW experience and he recognises this fully. Never the less, he is one of a small minority in GROW who is critical of some aspects of GROW and has worked hard to bring change to these aspects.

Paul leads an examined life, in Plato's terms, but also a planned and well-executed life. I was glad when Paul agreed to participate in this research. I have already quoted Paul's understanding of aspects of GROW principles in Chapter 5. His great progress along with his philosophical outlook helped me to select him as a key informant. His narrative was already published and so confidentiality was not an issue.

I first heard Paul's GROW narrative at a local group meeting. It was a powerful and rather awesome experience. It shifted my perspective on the world of mental health and illness. Paul's narrative inspired me. The published version is included in this chapter.

Paul's GROW Narrative

It was a dark, wet November night when I heard Paul speak about his life at a group meeting. The Kilbride group met at the usual time and place with eight people present. The hard chairs, small table

and dim light gave a feeling of sparseness to the big room. Paul proposed to give his personal testimony during a period of group interaction. He smiled at me when he did this. I appreciated his gesture, seeing it as a form of acceptance of me, a visitor to the group. I had met Paul at earlier meetings and we had enjoyed each other's company at regional training days and events. He knew of my research and welcomed it. Liz, as meeting leader, gave assent to Paul's proposal. The rest of the group shuffled their feet and bowed their heads slightly looking at their feet.

The meeting quietened. Paul sat up a little straighter, like a man getting ready to do something that demanded his full attention. He spoke in a low, soft, rather pensive voice and looked straight ahead not making eye contact with the rest of us as though looking at each other would reveal or expose something embarrassing. We listened silently and with great respect. The group was totally integrated and yet totally isolated from each other at the same time. I felt that something special was about to happen.

It seemed a long time before Paul spoke. When he did, he spoke slowly, powerfully and clearly and with great personal dignity. He seemed to leave the room, leave our company, and go to a far country. He invited us to go with him but we could only observe. We could not participate. He cleared his throat and began.

> "My little ray of sunshine, my mother called me in 1969, a sunny year that was clouded by the violence and financial insecurity caused by her alcoholic husband. I grew up in a home dominated by a kindly but alcoholic father. The family moved back from England to live on the west coast of Ireland. Eventually my father and mother split up leaving the family fatherless and penniless. My mother couldn't take any more. He moved back to Birmingham to work, and we stayed in our little cottage. Later he moved to Brighton to work and we saw less of him. He sent money home regularly, each month at first.

Later, the flow of money from England faltered and became unreliable. Alcohol was a more vital need for Daddy, more than his family could be. I missed my daddy and I loved him. My daddy was my hero and I longed for him to come home. I was six years old. I knew nothing of the dark details and Mother kept it that way. My childhood memories of south Mayo are precious: a river of trout and salmon; railway tracks; Muckross Castle; and visiting Daddy where he worked in Brighton in England with its funfair and on to Cornwall's beaches. Then all changed again, prompted by lack-of-money problems.

My mother sold off our little house and we moved to her childhood home in north Mayo. We moved to the small farm of my grand-mother with one uncle and two aunties still at home. The house was overcrowded. This made life difficult for all for many reasons. My mother's parents had discouraged her from marrying my father when she introduced him to the family. He had signs of alcoholism even then. Now alcoholism was in full bloom with disastrous effect.

When she arrived back on the doorstep with her three small children, looking for support, she did not get a good reception. Granny sat us around the range after we arrived and spoke, with a sharp tongue, of how Daddy broke a chair on Mammy's head and had blackened my aunt's eye. More was said, too much for the ears of a six year old. For 20 years my nightmares recurred of a Demon Daddy breaking up our little home and attacking our family.

Working with my uncle on the farm was a miserable experience. We were very crowded in that small house and the land was poor and unproductive. It was hard work for all just to survive. Uncle Bill roared and shouted verbal abuse and, at night, if visitors called in, my brother and I gave up our bed to share his where he did what I knew to be wrong and touched a part of me I knew to

be private. For subsequent years I suffered diarrhoea and occasionally soiled my desk in school. The resulting taunting and humiliation were as excruciating as the pain in my gut. I hurt all over, in every part of me.

A new village, a new school, a new kid: quiet and shy. The boys reckoned I had a big head, so they banged it off the wall. And to end my tale of woe, to help me get by, I developed a habit: I began to fantasise, dreaming of killing myself. Twenty years later the habit died. Thank God it died alone and I survived.

At the foot of the corkscrew hill, a boyhood wonderland, there were honey bees, hazel branches, baler twine, bows and arrows. We were commandos, knights, cowboys, eating chocolate-covered bars. My brother and I with our friend Padraig, all in one tar barrel, rolling down the steepest hill in the valley. Great! Next house up, a blue-eyed, blonde-haired girl. She was beautiful. I loved her. She brought joy to my heart. Better again!

After months that seemed like years, we left the farm and my life improved in many ways. I was reunited with my father in Cluain Muire, thanks to Sister Consilio. Every holiday was spent in Athy visiting Daddy. We moved to live in Galway and I kept an interest in my studies.

My father came and lived with us for five years. He was bossy and domineering and he dictated to us. I was in secondary school. I was working for peace in the family at the cost of my own self-expression, but I was glad to arrange for a solicitor to work out a formal separation for my mother before I started college. It was a great relief to all of us when he finally went back to England and left us alone. We needed that. We couldn't take anymore.

I enjoyed the first two years of college, with old school friends sharing my lectures. When the old friends moved, I was not able to make new friends. I was an outsider, a real loner. I felt

depressed and suicidal. I longed for a girlfriend but was too shy. University offered expert guidance for most sports and I was shown how to find the ‘unequal roots of a quasi-linear differential equation’ but nobody would show me how to reach out. There was no GROW, no Aware, and so, needlessly, I missed out on happiness.

I qualified as a civil engineer and left for London to seek employment, as was expected of so many of my generation. Lacking my “three vital needs: to be somebody, to be at home, and to be going somewhere” (GROW, 2001: 13). I was ‘a nobody’, away from home, lost and indifferent to where I was going.

I returned to Dublin and met my father after four years. He had found sobriety through Alcoholic’s Anonymous and he was on the kind of spiritual journey that I hungered for. I was going down while he was coming back up. It took a little while longer for me to stop going down, some time before I hit rock bottom.

I returned to Galway and, unknowingly, I began to experience my first mental elation in the form of religiosity. My mood rose to severe mania, peeking in my believing that my little sister to be possessed by Satan. This was the start, the turning point; my life would never be the same again. I was ‘put away’. I had hit rock bottom.

There I lay, almost unconscious, a psychiatric patient in the county mental hospital. Labelled and stigmatised, I felt worthless. The nurses were happy, ordinary people, worthy and useful. I was among schizoids, maniacs and druggies, Alzheimer’s patients, retards and knights of the road, the living dead. I was a zombie who would never get to go to work, fall in love or have a home and a family. I spent the following six years going in and out of that hospital.

I had learned the names of many saints I had never heard of before: St Mary's, St Teresa's, St Brigid's. From St Brigid's I went to a halfway house where a special bus took me to the community workshop. To gain independence, I moved to a bedsit in Dublin. I paid my bills, collected my dole, saw my doctor and became domestically self-sufficient. Life was very dull for a while but I survived. Thoughts of suicide went away.

In the crowds of College Green I bumped into an old school friend, an artist and skilled womaniser. He led me on a course of socialising. I learned well and soon met my soul mate, a young Enniscrone woman of seasoned wisdom and maturity. Nora believed in me in a way that nobody else did. Love stayed and Nora made it clear that she would too.

There were more hospitalisations, but with a difference. As with all services, professional and otherwise, there is the average, the excellent, and there are shysters. Where I lacked the strength and the will, Nora had the courage to challenge and confront the medical staff when it was more convenient for them to let me fall through the system once more. She pressed them for more than just medication. More was necessary. Nora made sure I got it. She was my advocate before they were available from elsewhere. She saved my life.

Finding GROW was a god-send. During my first stay in hospital I had the good fortune of meeting a patient whose interests were in understanding, acceptance, confidence, control, and love. He was a member of GROW. GROW had helped him. Most people are interested in getting rich, their garden, a sport, a promotion or doing exams. GROW is different. GROW is interested in you and helping you to become interested in helping yourself.

I joined the Mayo GROW group and it was great to meet others with an interest in real stuff, in growing to maturity. For two hours every week, I experienced a level of friendship and

communications I could not find anywhere else. I had found a new home.

A big problem for me was feeling useless and worthless. My education in the principles of physics was of no benefit here. GROW first principles of personal value were a must for me. It is something I work on regularly because the world is often ready to tell me the lie that I am useless. I use 'Desiderata' to remind me that I am a 'Child of the Universe'. Now my only dreams are of life and joy.

Like a caution sign on the road, I use step 1 of decline to check if I'm giving too much importance to myself and my feelings. If so, I practise to Decentralise, the Sixth Rule of Objective Thinking. I have a little technique to get myself out of my head. I begin to describe my surroundings to myself and often notice how blind I have been. I have a decentralisation team: my two and five year-old daughters.

GROW belief in God 'who improves as we mature' has helped me have a new perspective on my old worn-out beliefs. I look forward to when we have grown enough to see 'the One Supreme Being who knows and cares and powerfully provides for us' (in GROW, 2001: 72). Christy Moore, the folk singer, sang that 'the ordinary is nothing special, nothing grand'. For me, this is not true at all. My mania was fuelled by unrealistic goals. I had no interest in the ordinary. I know now that there is no petal without a stem or a root. The beautiful and extraordinary grow out of the plain and ordinary.

Sometimes when I find life is getting on top of me, and I've meditated for a while, I take on a practical task to get me back to it, to keep peace in my soul. I remember what peace there is in silence, stillness and solitude. By being still and knowing that all is well, harmony, tranquility and serenity return and I leave, knowing that there is nothing I shall want.

Uncle Bill is where I still hurt today. I have the option to take legal redress but I am reluctant to do so. It sounds too much like revenge to me. I don't want revenge. I'm doing well now and I don't know what he was dealing with in his life at that time. God only knows his story. My daddy is dead now and so are my feelings about him".

Paul stopped talking, looking pensive and a little sad. Nobody else spoke, continuing to look at their feet, at the floor, at anything but at each other. After a short while Liz shuffled her feet and mumbled something and then continued the meeting by inviting everyone present to make comment on what they had just heard. Mary made some comment in a very soft voice but it was inaudible. Paul looked around at the faces of all present and everyone lifted their head to nod at him.

"You are a great man," commented Jim. "That was a powerful story. It must have been very hard for you". No one else made or felt that they could make any further comment. Paul had spoken as if to himself but all present were riveted to all he said. He had narrated in a few minutes what had taken 20 years to live out. He had been selective in what he said, relating only the vital parts, disregarding any repetition, and emphasising the recovery and growth phases. This is typical of all GROW story and personal testimony.

Concepts of social and personal worth and spirituality were clearly evident in Paul's narrative. Any biochemical or pathological evidence had to be a consequence rather than a cause but this did not convince Paul of its relevance. He abhorred the idea of medication as a cure. The rip had occurred in the fabric of his personal, social and spiritual relationships, and that was where repair had been required. For Paul, medications could not do that. For him medication, at best, is simply a treatment in preparation for the real cure. At worst it delays curing and healing. He succeeded in mending his ripped self,

abandoning what could not be mended and built a person with the help of his family and GROW.

Paul repeated his personal testimony again some months later at a regional training weekend. This time there were almost 100 people in the audience, most if not all listening, had something equally powerful and awesome to offer. Again the GROW narrative saddened me and gladdened me, but most of all it inspired me. It made me draw my breath. It raised my spirit, touched me and made me feel blessed for the life I have had. It was largely an emotional experience for me. I felt proud to know Paul and to have him among my friends. Knowing his struggle to overcome trauma made any personal struggle seem more manageable.

I heard another GROW personal testimony at a National Forum weekend in an audience of nearly 400 GROW members and 50 others. Like Paul's narrative it spanned 25 years and still continues to grow.

Paul agreed with GROW to have his personal testimony published in a local newspaper. His total emergence symbolised his total acceptance of his experiences and their consequences. Each time I heard Paul's narrative it, and he, seemed to have grown some more. It included more of his progress and less of his traumatic youth. That is the nature of his recovery and growth pattern. His past recedes while his present and future expand. GROW narrative never stops growing.

Turning Points

Much of what Paul presented as his narrative was structured around the turning points of his life. They marked the rites of passage that began with conception, leading to birth, and to the point when he was first molested by his Uncle Bill. There were other, more minor points, such as leaving his home in England, but the major points had much more emotional impact on him. Becoming isolated in college is a typical turning point. Life changed radically, for better or worse at these times. Being abused by Uncle Bill was for worse. This was countered

by finding Nora. Meeting and marrying his beloved Nora was for the better. Telling his story marked Paul, changed him and his identity. What had been private and secret became public. As Jackson (2005: 1) explains: “The telling of stories enable people to transmute experiences felt to be theirs alone into forms that can be circulated and shared. Paul structured his story around bad turns and his personal testimony around good turns.

Rock bottom is a final turning point, the point of engagement with and yet one of departure from a disordered life towards a life of order and fulfilment. Rock bottom arrived for Paul when he contemplated suicide. He needed help to survive this state of mind. GROW’s 12-step program is designed to bring this transformation. Progress in this process is mapped in the production of GROW narrative. Narrative growth is symbolic of personal change.

Narrating, expressing life experience as words, happens slowly and gradually in the week-to-week work of each GROW meeting. Once in verbal or written form it becomes malleable. It can be changed, controlled and curtailed. Writing it down is embedded in the 12-step program. GROW story is a synopsis of the 12 Stages of Decline and Maladjustment while GROW personal testimony is a synopsis of the 12 Steps of Recovery and Personal Growth. Paul had spent a long time writing his narrative with the help of GROW.

Writing story and personal testimony helps each GROW member to face the truth or reality of life. Constructing and narrating stories, with the support and encouragement of other GROW members enables each member to first acknowledge and then admit the essential facts of their life and finally to accept the responsibility to change or as Jackson puts it: “The onus is always on us to accept responsibility for what we are made, even if it is only to assume this responsibility” (2005: 2).

GROW story includes the traumatic turns that brought them to GROW, the events that disordered their thinking and left them

disordered, “maladjusted and inadequate”. Story confirms the behaviour patterns of life before recovery began.

GROW story is embedded in Step 1: “We admitted we were inadequate and maladjusted”. In this way it indicates that rise from rock bottom has happened, that the stages of decline and maladjustment are over, and that recovery and growth has begun. Story, in GROW terms, can be told once only. In telling it a space is created to conceive testimony.

A new person is born from this conception. Mental conception, especially when accomplished in strongly suportive emotional settings, opens the liminal space to bear recovery and growth. GROW group meetings and regional training days provide such emotional settings. Story is personal and unique but has a lot in common with all GROW stories.

The first telling of story brings prior life to the light of day, expressing it like canker from a wound, relieving emotional downward pressure and cleansing the site. New growth is now both possible and probable. Any later edition of story will be different from the first edition told. It has moved on, developed, changed shape, reconstructed and rehabilitated in the process.

Story tends to grow in the telling. When told again it uses different words to suit the mood of the storyteller and a different audience in another setting and time. The later versions of GROW story mark micro-steps towards recovery and growth. The story eventually developes, if persisted with, into personal testimony to narrate future possibilities, and is prescriptive and descriptive of a present and future life.

Personal testimony relates to step 4: “We made personal inventory and accepted ourselves”, and to step 5: “We made moral inventory and cleaned out our hearts” (GROW, 2001: 5). It grows in an organic way, like a baby. Its birthing is eased by guidelines developed by GROW

over 50 years of narrative reproduction. Later it grows with guidance from parental seasoned GROW group members.

Constructing a Future

Guidelines for writing a GROW narrative are available to members when they feel ready to take on the task. It can take up to 13 meetings and longer even when they are encouraged by their group to do so. The group helps conceive the idea of GROW narrative. During this gestation period GROW story forms gradually until it emerges. Personal testimony begins to develop as story nears full gestation. The icon of acute care, the psychiatrists case file, now has a rival icon. Personal testimony, the icon of the reconstructed self, takes on a life of its own. On its arrival, negative stigma begins to shift, to become less of a burden, fading like a mothers birthing stretchmarks. A new positive stigma is prescribed and imprinted. The marked body of a new self materialises.

GROW personal testimony is made to order. The group organiser offers established GROW guidelines for use in producing narrative, invites a developing member on a voyage of self-discovery, of a version of truth that is acceptable to the storyteller and the listening audience. It leaves room for omission where the facts are too painful, too shameful and damaging to current identity if repeated. The guidelines ask a set of questions, each question leading to the next, organising a trajectory and direction that is fruitful and constructive.

Question 1 asks, “Who am I ?” offering advice based on the successful completion of the task by others. The guidelines suggests inclusion of a little background of childhood, school, work and family circumstance. This defines, with a minimum of data, the person in terms of origins and early history. It challenges the writer to face the facts of their early life with its good and bad memories. The selection made favours a particular line of thought and diminishes the rest, “starving out

unhealthy thoughts" (GROW, 2001: 29), thoughts and facts that are unnecessary to the central theme or causes of embarrassment or shame. The guidelines advises reducing difficulties to a minimum while stating them plainly.

This history describes the trauma that led to disorder and confusion and sets a context for what comes next. The facts selected include the time and place and context of the first insult, the frequency of insults, the major sites of experience, and the people who were essential characters in what defines the trauma. This process plots the trajectory to rock bottom: to the foundation stone or launching pad of the discovered self.

Question 2 asks the reasons for joining GROW as an invitation to the site of disorder and yet confined to a fraction of the full life experience. Memory is curtailed, inhibiting false memory and limiting the expression of emotional turmoil that accompanied it, and is reduced by becoming merely a small step in a much longer and more powerful process of recovery and growth. Jackson puts it another way. It is "how the meaning we give to events eclipse and compromise our memory of them, so that while we go beyond the past in our new imaginings, rationalisations and narrations, engrained habits of thought and actions persist, effectively binding us to the past" (2005: 2).

The group acts as a governor of emotional reactions by creating and demonstrating considered and friendly responses to the narrative of the exigencies of life. The group serves to change Garro's "episodic memory", memory within a personal frame, to "semantic memory", knowledge validated in a community (Mattingly & Garro, 2000: 72). The group has learned from being in disorder, and by answering the 'why me?' question for themselves. They empathise with the narrator and set a safe cultural frame for storytelling. Garro explains that such "remembering is reflexive and generative within the framework of possibilities afforded by culture" (ibid: 73).

Being meaningfully connected and linking a remembered past with a plausible interpretation helps an ordered frame of reference to form. Those in the group who are at a low point can be strong in empathy, while those who are feeling strong and clear-minded can offer sound advice based on their experience of working with the Program. They offer new knowledge and insight into how to find a way forward. Development within the GROW group brings "new knowledge, playing a constructive role in the reorganisation and interpretation of past experience" (ibid: 74).

Question 3 asks about the support of the GROW group and seeks to affirm that the advice and encouragement offered by the seasoned members of the group is acknowledged and appreciated as beneficial. It also demonstrates for new members how they too can be helped by the practical tasks given by the group. Practical tasks relates to the difficulty the person is contending with. There is a balance of personal advice which might include 'get some exercise'; and 'spend time or share a meal with your family'. Social advice includes 'go to the theatre with friends'; and community issues include 'spend some time involved with other voluntary support groups'.

Spiritual or religious areas are not included in the GROW guidelines, illustrating how GROW , in practice, is non-denominational whereas, in The Group Method and Program, many spiritual topics and religious exercises are provided.

Question 4 asks about the steps or parts of the programme that helped most and in what way they had helped. GROW members enter the program when at a low ebb in their life. They may not be ready to acknowledge that support is needed. They may even deny, or simply not know or be able to appreciate that they need support. At best, they may recognise the GROW group as a safe place to be for a while. This, very often, is sufficient to retain many in membership.

Question 5 asks about the insights gained since joining GROW. Semantic memory recalls a reality set in a broad perspective. Group discussion among trustworthy friends gives a better chance of achieving genuine memories and true beliefs based on reality instead of on individual and dangerous delusions. It is the quality of discussion that informs the memory produced and distinguishes belief from delusion. GROW wisdom texts provide the materials for discussion. Besides clear memory and beliefs, something else is discerned and interpreted from observation of group activities and is communicated at the subliminal level to provide self and mutual support.

Question 6 asks how 12th Step work contributed to recovery and growth. This work of meeting and helping other members outside the weekly GROW meeting helps to decentralise members from themselves, directing attention and concern towards others who need support in carrying out their GROW-designated tasks. Phonecalls to a friend in distress, giving time and attention to another's concern, affirms the giver's and receiver's worth and value as members of a friendship group. Receiving time and caring from others contribute to feelings of self worth.

Question 7 asks 'Where am I now?': defining the present is a vital step in setting out how to deal with reality. The listening group affirm this authorised point of progress; its actuality and intention are witnessed and supported by a promise of friendship and advice on the journey ahead. This exercise informs the author and the audience as to how much improvement has been achieved to date from a disordered and maladjusted past, engendering hope and expanding the foundation of the future.

Discussion on which parts of the program are in current use clarifies further the 'where am I now' question. Confirming the current step in the program draws attention to the fact that, although good progress has been achieved, there is much yet to be done. This

approach measures the progress achieved to date and to be achieved, setting a target and a trajectory for future achievements.

The Program has no finishing point. It is always in progress. One seasoned member proposed that, although step 12 is achieved in some areas, there is always some area of life where more work is needed. “Perfection is aspired to but is not achievable in life” she said.

Writing GROW narrative is not an easy task for any GROW member. Speaking it or reading it in public and learning it by rote is also difficult to do. It is a form of confession, to self and to others, but it is more than that. It is mainly a formal acceptance of the facts of one’s life. Acceptance is marked by the ability to tell the story and re-tell personal testimony. It is a measure of how well Step 4: ‘We made personal inventory and accepted ourselves’ is entrenched. Acceptance of inadequacy and maladjustment to life is not step 1 but step 4. GROW group work brings acceptance.

Acceptance is a complex issue, a nexus of decisions that binds the person to a new paradigm of how to live. The new paradigm may not be fully developed. In fact it is unlikely to reach a ‘floral peak’ until much later. Acceptance is a liminal state in Van Gennep’s (1960) terms, a threshold state of becoming. For Turner, (1982) it is a liminoid state, a state of continual becoming.

Once entered, development of all elements of the person becomes possible but endless. Without crossing this threshold recovery is greatly restricted if not prohibited. The threshold is the point of entry into full realisation and reification of what it is to be a human being reflecting a process of continuous change.

Crossing the Threshold

People who have had disabling difficulties that made them feel inadequate and maladjusted to life, go to their first GROW meeting in the hope of finding recovery and growth. They seek a process that State services do not and, perhaps by their nature, cannot provide.

Seeking, in itself, sets in motion what acceptance, recovery and growth are, a process of healing and growth.

The process of change requires the potential GROW member to take responsibility for its achievement and narrative construction of the past, the present and the future. He or she needs to cross the threshold, enter the process and take responsibility for self. This is an essential element of GROW narrative process.

Narrative production in GROW attempts to give the total lived experience but it always fails in its attempt. It can never complete its task, as Stan, a seasoned GROW member, says:

> "Everyone has a story and it is unique, a complex mosaic studded with people, experience and events over many years results in a personal history that is far from simple. No amount of detail or analysis can exhaust the mystery of any of us." (GROW, 1996: 17).

I prepared and gave my own testimony in December 2005. I did not produce a story at first as the difference between story and personal testimony was not clear to me. Nobody thought to explain the nuances until I began the exercise itself, despite conducting more than a year of fieldwork and attending group and multi-group meetings. I learned my own version of the rules of writing GROW narrative by listening to the personal testimony of others. I had not heard a GROW story as a separate element.

All the narratives were powerful, constructed to give power to the teller, synthesising the reborn self as it emerges through the focal or vocal point of personal testimony. Later I asked for guidance from a fieldworker and received the standard guidelines, discussed above, that GROW uses to construct a personal testimony. That list was unknown to me and others in my group until that point.

A listening audience endorses the power and legitimacy of the personal testimony and its teller, enhancing both, and making construction of the reborn-self a collaborative effort as in all storytelling. GROW not only provides a birthing space but also provides midwives to ease the situation.

The GROW group “asks questions, probes for meaning and affirms the author” (Rappaport et al, 1988). This is done in a spirit of friendship, caring and love. Story begins to emerge when a GROW member says just a few words about themselves in their group meeting. This expression is a vocal surfacing of a forgotton or buried past and leads, slowly and cautiously, to a story being told at a group meeting. Story establishes an initial form and proprioception begins to develop locating the narrator in time and space.

Many stories progress to being published. There are two published collections of GROW personal testimony (GROW, 1996 & 2003). Each narrative is a self-contained edition of a life story, a by self and about self biography with minimal emotional and rhetorical content. It is designed to have credibility through the power of precisely-selected acceptable words and phrases.

The narrative limits the otherwise limitless web of life, the all-pervasive life-story, to what has been negotiated from the total remembered. It eliminates false memories through the kind questioning of the experience by the group meeting. If the experience narrated is not credible, it cannot be included. Truth emerges exploding myth.

Narrative Deconstruction

GROW story entraps the past. Its narrative make-up performs like a shaped explosive charge designed to demolish the negative, emotion-laden construction of the past, blowing an opening to a future, making a break -through. The story clears a space for the foundation of a new life giving it a clear view. Debris, the remnant memories of an old

life, is cleared when you “dig, starve, and crowd them out” (GROW, 2001: 29).

The past is not abandoned or disowned but curtailed, controlled and fragmented. It is stored in its shrunken form, a homunculus buried in a memory tomb. This creature will never see the light of day again, belonging to and fixed in a dark past, with no way of escape, blocked by the new present that is engaged with and occupied. Breakthrough happens when the homunculus and the present self and identity have been accepted as separate.

The future is filled with positive plans and possibilities, an imagined future built on the foundations of the curtailed present and buried past. From this position of acceptance, GROW members can sail out to colonise a future with their ship’s full complement of friends. To employ the GROW sailing metaphor further, “our supporting navy” (GROW, 2005), all with the same port in mind, sail away to occupy the present and colonise the future by peaceful means. The voyage is made, making room on board for all, taking provisions for whatever each person needs to make the future peaceful, calm, enjoyable, exciting and worthwhile.

All GROW sailors are encouraged and helped to write a GROW story and, later, a personal testimony. This is their own negotiated and agreed version of their life. It is delivered, like a new-born, to a variety of audiences. This, according to GROW, is an intrinsic part of recovery and growth. At no time did I witness a member being overtly persuaded to construct narrative or to find an audience. Some were openly invited but the process of conception was suggested either privately or, as in my case, done alone. GROW narrative is conceived and constructed by the example of other group members giving theirs.

Audiences

Listening to the testimony of others subliminally imprints how testimony is understood in GROW. Members, as in my case, learn to

construct their narrative by listening to the narrative of other group members. Personal testimony is modelled, consciously and unconsciously, on this impressed format that awakens the need to express a narrative edition of life history.

The first audience for any GROW narrative is the local group where members meet each week. It takes time before any story emerges. New members are encouraged to wait before telling their story as saying too much too soon can re-awaken old demons of embarrassment, shame or guilt. These demons, like stigma, are founded in a local culture. Living with the stigma of having a mental illness promotes and reinforces such demons.

At first, a new member is encouraged to say very little or nothing about their biography. After four or more meetings the new member will contribute comment about themselves as they become more comfortable and confident in their group. This situation usually happens after the new member has offered a supportive comment to others. Listening to the narrative of others evokes expression of self-narrative. The vacant space needed for sympathetic magic to emerge arrives immediately after ritual speech actions. Ritual speech acts, or prayers, evoke more ritual talk. GROW narrative is ritual talk in a ritual setting.

Confidentiality is essential for new members as their GROW story begins to emerge. It is emphasised by reading the GROW Commitment in part 1 of each meeting. Note-taking is not allowed while others speak. Nothing is recorded except in memory. Confidentiality, not speaking outside the meeting, encourages speaking inside the meeting. Control of speech enables controlled speaking. Encouragement to speak and the opportunity to do so is an essential task of the group leader.

New members begin by telling short excerpts of their story. When the story is told often and well it develops into GROW personal testimony. Then, when the narrative is well rehearsed, it is often written

down to make a material expression replacing a verbal expression of identity as it was in the past, how it has changed and how it is now. This time-based narrative serves to encapsulate the past and set it in an negotiated context; part of a process that is changing for the better. The narrative becomes a product, an artefact, a boundary mark between the death of a past life and the birth of a new life.

For beginning GROW members, the journey from silence and isolation to fluent narrative, group listening and acceptance parallels the journey from madness to mental health. A narrative account is necessary "not so much that we need shared experience of language to be communicable to one another but that without such a sharing I will become incommunicable to myself" (Das, 1998: 187). Through vocal expression the new reflective and reflexive self is born. Active listening, to self and others, is the other half of relating GROW narrative.

GROW Narrative Performance

The act of listening recognises the worth of what is being said and of the person speaking. Active listening acknowledges and reinforces what is said by reflecting it, repeating it, asking questions about it and indicating attention to what is said by making comments such as: "yes", "aha" or "is that so". Such listening indicates the attentiveness of the audience, confirms that the person has spoken and broken a silence that may have lasted for years about people, events and occasions that may never have been spoken about before.

Active listening reinforces the worth of the speaker. Listening requires the investment of time, attention and some silence from all in attendance. It gives the speaker the centre stage position for a short period of time favouring the speaker above all those present. Favouring implies valuing or recognising the worth of the speaker. Regarding the speaker as worthy to speak and worth listening to endows them with worth that cannot be self-endowed but it begins the

process of endowment of self-worth. The silence of the audience creates the space to speak, a priviliged and sacred space.

If the speaker feels unable to continue, the audience offer supportive comments, such as, “that must have been tough,” or “it was great that you could do that,” or “if you can keep that up you will do really well,” which encourages the person to keep trying. Continuing such replies symbolises a continuous stream of concern flowing towards the narrator. This sense of flow in supportive dialogue draws in everyone in attendance to a current of care and cure of stigma and social trauma.

The tone of voice is always quiet, soft and gentle at the narrative period all group meetings. The tone, consistent with a low level of negative emotion and a high level of positive emotion, serves to calm and soften the emotional trauma of the narrative. Social trauma is often concomitant with loud and abusive tones and is counter-pointed by the tones at a GROW group meeting. Loving and caring is associated with soft and gentle tones. A touching sense of love and care is generated by the group with this type of speech act.

Body movement expends energy, the stuff of life itself. Actions of the body reflect the attitude and disposition of the actor. The actions, by group members, of touching the hand, knee, arm, shoulder or back of the speaker, in a gentle and respectful manner, common during GROW narration, suggests care and concern and a willingness to act in a beneficial way. Actions symbolise life and support its continuance. Each appropriate tactile expression proclaims care and concern bounded by the ethics of the meeting. Actions, speaking louder than words, is at the core of ritual practice. How do GROW seasoned members understand GROW actions? The following examples tell.

Joe: Gaining a Proper Context

Joe spoke about his understanding of testimony during an interview and discussion. For him, his personal testimony was a matter

of safe disclosure in seeking help and support, but he proposed that it also had a cleansing effect. It has a confessional aspect to it.

For Joe:

> "It's not essential to create a personal testimony, but when you do, it allows others to know your personal issues so that they can understand your pain and contribute better to helping you. Narrative has an element of negotiation about it. A personal story of suffering is a first draft of the testimony. It can be cleansing to speak about it but it can be very negative if it is received badly, if it appears judged. It is a tale of suffering. A personal testimony gives a more developed background and includes also the steps to overcome the problems".

Joe's GROW narrative was a matter of putting things "in a proper context," a context that relieved the negative feelings and emotions tied to the experience. When well received by a caring and sharing group it had affirmed him, made him feel worthwhile and welcome, knowing that, with all his worst faults and difficulties on display, he was accepted by his GROW community.

Evelyn: Unconscious Moulding

Evelyn, after almost 30 years in GROW, was even more detached from any narrative construction. "I haven't thought about the difference between story and testimony" she said. Any benefit gained from telling story or personal testimony, for Evelyn, had occurred unconsciously. For her, construction of GROW narrative is a form of sympathetic magic or a simple act of faith. No rationalisation was necessary. It was something evoked in the space of the silence of her group meeting and belonged to that space. Her personal testimony became for her an icon

of her life, something she negotiated a past, present and future with. It was her edition of her life story.

Lorna: Conscious Moulding

Lorna joined GROW more than 20 years ago. She was the most eloquent of all the people I interviewed in GROW. Like Paul, she was rather pensive when she spoke. This intelligent and quite philosophical woman had invested a lot of time, thought, and effort in learning GROW's Group Method and Program, probably more than any other person I had met during fieldwork. She spoke of GROW narrative as follows:

> "Testimony? The value of a personal testimony is to make your own story as a counter to expert or professional diagnosis and prognosis, and other outsiders, even family, friends, neighbour's stories. When I went to GROW at first, my husband had taken over my life and I didn't want to live. He had started to talk for me and I had to stop thinking. They had to ask him to leave the room so that I could speak for myself.
>
> As you tell your story you are making sense to yourself, something that you wouldn't normally formulate. You are making a person through a story about a person that is you. It is an act of creation. You get a way of looking at yourself that you didn't have before. You put yourself out there [stretching out her arm] and look at yourself. You have a new vantage point or perspective and you try and describe yourself. It gives you insights and it changes you as you go along. It allows you to reinvent yourself. You make up a new person and let go of the old one, the one you were hanging on to. You begin to associate with this new person that you are at the moment.
>
> Story and testimony? Separate or together? I don't have an

opinion on that. The reason you come to GROW is to put a shape on it [yourself], where you are in a place, where you want to think about things, and to put order on things. You can tell the story and then let go of it. It is too slippery to hold on to. As you grow out of depression, you begin to see bits of light and you remember some of the good times as well as the bad, and that it wasn't all black. You never see yourself as a person when you go by your feelings. You see yourself as a disaster only.
You take the story out of yourself. It's very like clay, I suppose. You have a basic block of clay and that's where you come from. That's the block of clay, and you can shape it yourself as you go along. It gives you a new beginning. It puts a mark or a full stop behind where you came from. You put yourself out on to the potter's wheel or table and make yourself."

For Lorna, GROW narrative production is a construction or forming process. It enables the mind to grasp the shape or pattern of a life that had been lost in the preoccupation with its disordered details.

Patrick: Narrative Account of Reality

Patrick is very well informed about GROW story and personal testimony. Although he seemed uncomfortable to talk about it, it was very obvious that, after more than 30 years in GROW, he too had spent considerable time and effort learning GROW. Here is what he had to say:

"It's incredibly important to give and to write a personal story and personal testimony. Retelling your story or personal testimony does sound a bit like a mantra. I can't say why, but it is really important as it is tied in with reality and depends on how you understand yourself. You may change that understanding as you go along but it gives you a reality check that you don't have unless you stop to do it. It is very much a part of the process. It's

an account of yourself. That is vital. Some groups do it very easily while others avoid it as it is too hard. It is usually done very informally at first, building up through the questions that other people will ask.

There is a lot of psychology behind story and testimony. Firstly, it helps you to get the realistic picture of yourself. It helps to sort out the past and what you need to do to forgive, to move on and what bits you need to change. When you give yourself to the group and get thanked and a round of applause and you are told that you are great for having problems. That's basically what the secret is. If you go to the psychiatrist and tell him your story, he will listen for symptoms and write them down and charge you money for doing it.

In GROW the worst thing is the big round of applause. You should see it in the mental hospitals and prisons when they get a round of applause for killing their father, or their child, and telling their story. It is liberating for other people. That's the effect on the group of listeners. Also, realizing that after telling your story you are still acceptable to the group and they can see some good in you. It is positive feedback. We are not good at praising each other, affirming each other.

Words are too crude to explain or state exactly what we mean. Language is a poor vehicle. The definition of man is that we are "words made flesh" and that we write our story with words given by our relationships with other people. The way we interpret these words: courage, endurance, wisdom, understanding, acceptance, etc., etc., they are things we aim for but never achieve. We fall unbelievably short of them. That is what the real word is. We are all words. God equals Good and Real Word equals Real World.

People are words. They have auras, if you like. If I think of somebody, I get a feeling of them as well. I feel how much I trust

them and whether I like them or not. In GROW groups, you meet people who become incredibly significant for a while because of where they are at, and you build a new person."

All seasoned GROW people interviewed had their own, if differing, ways of expressing their ideas of language or word construction. They did not need an anthropologist to do it for them. After spending months in discussions it became unclear what distinguished my interpretation from theirs and the boundary between the experience of observation and of participation. They merged. Instead of being distinct they appeared as end points of a spectrum of experiences.

Emic Participation and Etic Observation?

How can narrative be understood from these diverse views? My understanding of personal testimony allows for both participant emic and observer etic editions in Pike's (1967) terms. In GROW, the terms emic and etic take on new dimensions.

The emic view is the internal view of an individual's landscape. It is the view from the vantage point of the self, of identity negotiated between the internal personalities constructed by different life experiences. The discussion to find consensus is available only within. All outward expressions depend on the external social and physical environment that evokes an internal personality.

The etic view is from the vantage of the personality evoked in the current group environment. It views the local environment and responds appropriately. What is considered appropriate is a concensus of the group. Jackson proposes that: "This implies that understanding is a social rather than a purely intellectual activity" (2005: 31). It is a consensus or group achievement.

Discussions at regional, national and international levels add layers to the spectrum between emic and etic views. Finding concensus

or making decisions among the various levels becomes more difficult as the number of layers increase. Making the decision of what is GROW principle and practice is a major problem that must be negotiated and evolve continuously if it is to survive.

When I speak of my own experiences it is my experience-near of GROW process, an inner experience. When I read or hear the story and personal testimony of others I view them as experience-far, the view of the anthropologist and any other observer. If the anthropologist's method of working in a participant-observation mode is to be of value, it must include both views.

Experience-far is achieved through observation of others while experience-near is achieved by participation, living the experience at first hand. Both are informed and formed by knowledge and are agreed views of what is true. Participation is interpreted from an emotional and viceral experience as well as knowledge. Both the emic experience-near and the etic experience-far must be reported as such and then combined to resolve the gap or fill out the spectrum of knowledge between them.

What is true in GROW is determined by the group method, the program, the caring and sharing community involved, and the legal framework in which truth is set, the strategy, method and technologies of GROW in Foucault's terms. GROW at the international level is not consistant in these elements and so its truth, like individual personality, will vary with location and the experience of that environment.

Emic Experience-Near

Narrating my personal testimony, especially for the first time, was a very different experience from hearing the personal testimony of others. It affected me physically, psychologically, socially and spiritually. I felt a pressure in the back right-hand side of my skull and my skin felt tight over my body. I felt weightless. I read from my prepared notes

without seeing clearly what was written on the paper in front of me. My focus of attention was open or diffused. I was spaced out. I avoided direct eye contact with others in the group. Time seemed to stop. I lost all awareness of anything outside the group. My focus had turned inwards, into myself, to the space of memory of the past. It was set within the group rather than on any specific person or thing that made up the group. The silence was palpable.

My experience was holistic This experience spectrum defines for me the expression ‘a spiritual experience’. It is emic in the sense that only I could experience it, an internal experience unavailable to my surrounding audience. It had a spiritual dimension to it insofar as I felt another presence in the group, one that was not there before I began to speak. Perhaps it was a collective aspect of the group that was not evident to me before I began. Perhaps it was a personality of myself that emerged to narrate my story and personal testimony. Perhaps I had discovered my self.

This experience was emic, or insider, in every sense. No other person had that experience. It was particular to me and set at that point in time. In this way, it made me more aware of myself than would otherwise have occurred. I became closer to myself, less fragmented and more integrated. I was in the Now in Eckhardt Tolle’s (1999) terms. Only I can know what my experience was like. All else happens at a distance in time and space, outside of personal culture.

Etic Experience-Far

Listening to other members relate their narrative is to experience their history at a remove, at a distance, an etic experience. Because it happened outside myself, at best it can be listened to and witnessed only. You cannot share another person’s past experiences. It is only as an experience in listening to narrative that it can known and appreciated.

After giving personal testimony to local group audiences GROW members give it with larger audiences as witnesses at regional training meetings, national meetings and at international GROW meetings. Ultimately, for seasoned GROW members, personal testimony is related to the general public, verbally or in published form.

There may be intermediate steps in giving personal testimony to members of other voluntary organisations. This recurrent telling serves to empower personal testimony even more: the greater the audience and the more often the repetition, the more power personal testimony, and the teller, accrues. Healing condenses out of this highly-charged accumulation of power.

The process of creating a personal testimony becomes part of the process of curing for the person who testifies on his or her own behalf. The language of personal testimony is kept free of the terminology of mental health professionals, a language that limits and shapes a particular understanding.

Competing and Co-operating Paradigms

The current paradigm of psychiatry and psychology follows the scientific model described in Chapter 2. Professionals claim exclusive expertise in curing while generally neglecting the caring aspect (Roberts, 2002). This apparent lack of caring is best symbolised by the prevention of the person's own narrative emerging. Instead, psychiatry determines that medication is the way to cure, while psychology determines which psychological narrative is most appropriate for the patient to adopt.

Professionals use their own over-arching concepts of scientific method to legitimise their power to diagnose the condition of a person who seeks their help. In this way they can help the person to find a cure for their malady, but it takes more to achieve healing, the holistic recovery required before growth can commence.

I use the word holistic in its all-inclusive sense rather than in any 'new age' sense that it has gained through overuse in recent years. It takes a whole community to accept, and not stigmatise the person, and to nurture, and not isolate a person, in order for healing or recovery and growth of the full potential of the person to be realised. This is GROW pragmatic loving in its essence.

GROW narrative emerges slowly to the light of day. It emerges from the initial inner labyrinth where lifestory is stored, a story that attempts to tell all, especially the difficult events, times and locations. GROW story depletes and thereby weakens the overwhelming saga and concentrates on crucial events that define or parallel what led the person to GROW. GROW story is a reduced and selected lifestory. What it contains must be true but it need not be the full story. A limited truth is acceptable.

The full truth could be too devastating and too undermining for the teller to contemplate. This may never be told or need to be told. Attempts to tell it could be destructive in evoking the unspeakable, giving it vitality and power. Movement around the fixed point of a GROW story, in the form of slightly different versions of story, creates a motion that in time slips and flows into a personal testimony.

Metaphors of Hard Cases

GROW personal testimony is a single, strong, linear thread, a simplified edition of selected GROW truth. It leads the listener or reader to an understanding of the experience of being abused by another individual or community, bringing knowledge and understanding into the light of day. Associated feelings that can ensnare the teller in a sticky web of the past are eliminated in a GROW personal testimony which has a hardened edge, a seed case, a limit that gives personal testimony a size, shape and an agreed trajectory.

This hard edge or shell of tied-back, irrelevant threads of storylines limits GROW personal testimony to the essential and relevant facts set in terms acceptable to the teller and the listener. The shell prevents further sprouting of irrelevant threads of story that would deplete the personal testimony's vitality and alter its trajectory. The hard case cracks open at a time and place prescribed by GROW's group method, focusing it towards the light of understanding and acceptance found in the group experience.

Storylines that narrate details of feelings confuse the GROW truth narrative. They act like "Mycelium; a threadlike structure that forms the growing structure of a fungus" (Derrida, 1998: 14). These growing tendrils lead inward to dark places, to the 'skeletons in the cupboard' of the person, hidden away from the light of understanding.

Capra's 'sticky web' of story is a modern interpretation of an old metaphor of the labyrinth. These storylines form a maze of loops and deadends that create feelings of being lost, abandoned or isolated. This maze of storyline is similar to Bluestone's diagram (Page 107) of the labyrinth of the nervous system. It suggests the confusion and disorder that can derive from continuously wandering their paths.

The metaphor of the labyrinth is ancient in its origins. The oldest labyrinth I know is near my home in the Sligo landscape at the Carrowmore Heritage Site, dating back to c3,500 BC. It is a large-scale oval construction, more than one kilometre on the long axis and just less than one kilometre on the short axis. It is made up of articulated chambers and passages designed to make it difficult to find a way in or out. You can travel the perimeter or edge of the structure in a continuous loop but it takes a slight but definite change of trajectory to accomplish entry. Travelling on a curved trajectory develops a tendency to spiral inwards.

The term labyrinth is also applied to mazelike patterns on the floors of some medieval churches, intended to symbolize the tortuous ritual journey of Christian pilgrims toward salvation. These patterns also

symbolised the journey of walking inwards seeking the soul of the pilgrim. Metaphor and ritual were necessary to make the narrative available to the unlettered people of the day. They are necessary today for an relatively unlettered community of people attempting to provide a passage to recovery and growth. Ritual is the essential element to gain exit from the labyrinth although contemplation of narratives of rebirth and redemption helped to sustain the ritual.

Forming narrative involves generating words to illuminate the internal process of growing. However, narrative or metaphor alone are not powerful enough to escape the labyrinth. More powerful magic is needed to elucidate the external process of social growing. 'Talk is cheap, actions tell more' summarises the difference.

In the next hapter I will expand on GROW ritual performance, essentially a rite of incorporation, needed to re-socialise the person.

Chapter 7 GROW Ritual Performance

GROW ritual is best illustrated through local group meetings. All GROW meetings display a standardised method and practice. Out of respect for GROW confidentiality, I illustrate these common factors through a group now defunct. Names have been changed to ensure confidentiality.

All group meetings have three phases: travelling to the meeting place, the meeting proper and travelling home. The total event illustrates Van Gennep's (1960) rites of passage: isolation, transition, and incorporation but, in GROW, incorporation is the critical element. The pattern of meeting attendance reflects the continuing incorporation process.

This third phase represents a return to self and society after an episode of mental disorder. The experience of Paul and Joan, the organiser and recorder respectively, of the now defunct group in the North-West region, at their weekly meeting is typical of all group meetings. My fieldwork notes, written the next day, helped me to remember the event.

Paul and Joan had travelled a distance of 20 miles of winding, windswept and wet roads. They were weary of this weekly trek but they persisted for the sake of their own health and the good of their group. They were not keen to form a group in their home town. Distance from it gave them a sense of separation, privacy and confidentiality, and fulfilled Van Gennep's 'isolation' requirements. Their home life was thus a form of passing in Goffman's (1990: 73) sense of the word. As usual they arrived early at Arus an Brú, the meeting location.

Group Meeting at Arus an Brú in Kilbride

This small hall is on a secluded side street on the edge of a small rural town. It was very wintry, dark and bleak outside the hall in 2004. No security or cosmetic lighting relieved the gloom and there was no

shelter for those waiting outside. My first impression was one of isolation and dismay. The Brú was far from inviting. In fact its presentation, for me, was a deterrent.

Even the inside looked sparse, solid and durable but cold and uninviting. The ceiling rose to the pitched roof supported by heavy, varnished wooden beams. The small pictures in dark frames and other wall decorations were reminiscent of stained glass church windows but there were no windows in the meeting room.

The lighting level was low and poorly placed to facilitate reading small print. The floor was covered with hard-wearing carpet to silence footfalls. The tubular-steel tables and chairs were simple but functional.

It is a community hall, a meeting place for local people. During the day, the Brú functions as a walk-in centre for many people in the locality who have little or no family support and who are in the care of the local health authority.

A small kitchen is used to prepare refreshments. The Brú accommodates people for meals and provides a sitting room and serves to keep the inhabitants dry and warm, out of sight and off the streets. It is a transitory place, a liminal space.

When Liz, the GROW fieldworker, and I arrived two men and one woman were already waiting outside. Liz fumbled for the door key, stepped in and switched on the lights and then concentrated on moving the table and chairs into position in preparation for the meeting.

Eileen arrived and needed help to get up the steps and in the door. She suffers from severe arthritis and walks with great difficulty. She was well muffled up against the night chills but wore a soft smile almost all the time despite her difficulties.

Liz had decided to move the meeting place to the other end of the hall with a seat near the radiator for Eileen. Eileen smiled her appreciation as she manoeuvred into a position near the heater. Her arthritis feels better if she can keep warm and dry. She pulled off her coat, scarf and woolly hat and smiled at everybody.

Sean arrived next. His small, round eyes stared as he nodded but he said nothing when we greeted him. His body and small, bald head stayed very still but when it moved it was quick and bird-like. He sat near Liz who engaged him in small talk. I sat opposite him.

Mary arrived, a woman in her twenties and back from her skiing holiday, and sat beside Paul. Soft smiles filled her eyes and face. She spoke quietly but seemed at ease in the company even though it was only her second meeting as I discovered later. Mary arrived at the same time as Jim who sat opposite her.

Jim speaks very little and he does not smile at all. In fact no emotion shows on his face except what could pass for mild annoyance. Donal was a visitor from another local group. The agenda that night, The Group Method, was the same as for all GROW group meetings.

Paul, the group leader, sat on my right. He called the meeting to order and asked who would lead or chair the meeting. Nobody volunteered and he asked Liz to do it. Liz agreed and shuffled in her bag to find her Blue Book.

The Group Meeting Protocol

Liz took a small blue-covered book from her bag and an A5 sized card titled THE GROUP METHOD (GROW, 1982). This card gives the meeting agenda in five timed sections:

1. Opening Routine (5 mins)
2. Group Interaction (30-35 mins)
3. Middle Routine (20-30 mins)
4. Resumed Interaction (25-30 mins)
5. Closing Routine (15 mins)

The meeting attempted to follow this agenda precisely. However, GROW method is more to do with the style of the meeting, in my opinion, by incorporating ‘a caring and sharing’ style. This mix of

precision and flexibility demonstrates the GROW approach, a combination of reason and logic with inspiration and intuition, a holistic approach.

Liz began the meeting. She did not introduce me to the group and I felt uncomfortable about this. I suspected that she wanted to handle my presence in her own way.

The Opening Routine

All present observed the obligatory half minute of silence. Liz read The Memento, the opening prayer, placing the Kilbride group in "the presence of God, the Supreme Healer". Everybody opened their Blue Book at page 5 and Paul read aloud the first of the 12 Steps of Recovery and Personal Growth. Each member present read the other 'Steps' in rotation.

The GROW commitment on page 77 of The Blue Book was read by Paul alone, reminding all present of the need for confidentiality, good intention, truth, and the need to strive for maturity and responsible leadership. Everyone stood up and held hands, forming a circle of friends, and recited: "In GROW we believe in one another, we love one another, and we trust one another". All sat down again. This concluded Part One.

Group Interaction

Part Two began and, as there were no urgent problems, the group moved on to open discussion of their issues for that week. Paul asked Sean to give his testimony but Sean mumbled something about "what's the point. It's still the same, no change".

"Maybe you could do it anyway," said Paul. Sean just looked him in the eye while shaking his head.

Paul decided to give his personal testimony, a practised narrative of his recovery from breakdown. As related in Chapter 6, his story was one of abuse and depression, loneliness and isolation until he met

someone whose support, in his own words “made the difference between living a fulfilled life and suffering a living death”. He spoke slowly and quietly, quite poetically and with great dignity for over ten minutes, telling of his difficult and disturbed childhood, periods of childish delight, his abusive uncle and the resulting depression. The group was silent all the way through.

Paul’s potted personal history, told with great emotional restraint, brought a change of mood replacing casual interaction to gut-wrenching empathy and a heightened but positive emotional response from all present. We were in an altered state of mind when he finished speaking. Something had changed. My sense of time and space had shifted with Paul’s narrative taking me to another place. I felt different. Paul had touched a chord in all of us. As Jackson explains: “This demands that one finds something in one’s own experience that is analogous to or approximates the experiences of the other and thereby bridge the gap between the two” (2005: 31).

After Paul’s testimony the meeting moved on to the second phase of the Groups Interaction. Liz invited everyone present to report on their progress with the self-allotted practical tasks of the previous week. All had done well except Sean. He was struggling to keep up with the ordinary, everyday routines that most people take for granted. His clothes, although clean, were disordered, too thin, dishevelled and inadequate for the wintry weather. His sparse outward appearance reflected his inner landscape. The everyday was too difficult for Sean. He could not tolerate the “possibilities of recovery through a descent into the ordinariness of everyday life through which alone the words that have been exiled may be brought back” (Das, 1998: 183), or recovered.

Paul asked Sean to give his report. Sean said nothing. Sean was pressed a little more than the others. At an earlier meeting they had suggested to Sean that he should ask his doctor to review his long term medications. Sean was annoyed now because he had received a blank “no” to his request from his doctor leaving him feeling unheard and ill-

considered. His doctor had put him in a certain category and that label was permanent, or so he felt. He resented this.

Those of us listening felt his frustration. This was what he had expected from the professionals. He was not disappointed. Sean would need great support and encouragement before he would ask again for a medical review. He had completed his practical exercise to walk tall and breathe deeply many times during the week but it was apparent that he was disheartened. Paul continued to talk to Sean but Sean could not open up.

Joan, on the other hand, was feeling giddy and laughed aloud as she gave her progress update. She had promised to get to bed early each night during the week and to get up in time to see her husband out to work each morning and she had done so. She was delighted with her success and received compliments from her group. A short applause recognised her efforts.

Paul read a section from 'The Yellow Book' about the value of a person - the 99.9 percent value that remains even if the rest is disordered, unproductive or uncomfortable through illness, old age or youth. Paul seemed to target Sean with much of the discourse of the meeting. He appeared to have made Sean a special project.

Current problems of each group member were discussed. Paul was feeling faint and light-headed recently. Mary was feeling very tired continually. Eileen was having a lot of pain from her arthritis. Jim mumbled something about walking a lot and getting lots of fresh air. He knew that this was good for him but he struggled to do it. It took all of his willpower to keep it up. He said something about not going to work because it was boring. He was tired of it. Sean made no comment.

Paul called on Liz to report on her practical tasks which included working hard to be sociable. Jim seemed exasperated when asked how his walking regime was progressing. It was wearing out his patience and footwear. He said nothing. Eileen pulled out a partly-knitted pink scarf and showed it to the group. Everybody was full of praise for the

craft work. Each person was listened to and praised even when progress was meagre. Nobody argued with or criticised the others. All were listened to and given encouraging and helpful comments.

The Middle Routine

Part Three began when all read aloud the Affirmation of Good: "that the bad in us can be remedied and that the good can grow" and The Act of Surrender: "to abandon myself entirely to your wise and powerful love" from the Blue Book (GROW, 2001: 78). What followed was a discussion on quotes from the same book designed to give familiarity with it to all GROW members. Paul read a loose-leafed text about friendship and everybody listened and commented on it except Sean.

With no Special Activation Project to discuss, a process of highlighting the achievements of a member, the Middle Routine concluded.

Resumed Interaction

Part Four is a continuation of Part Two essentially. "Anybody else?" said Paul, looking around the table. His glance finally landed on me. He smiled. I felt a personal friendship beginning to blossom. I agreed to give a testimony after looking at Liz for approval. She grinned but said nothing. All eyes turned to me, a full recognition of my presence, and a good start. This was a chance for the group to get to know me a little and that would help me to integrate with them. This was a political ploy on my part but I tried to play the part properly.

My GROW narrative was light-weight when compared to Paul's gruelling narrative but it was treated politely and respectfully. I told of a difficulty in early life that had altered the trajectory of my life and how I had recovered from it. I finished by saying that I was attending the meeting as part of my studies on how people handle trauma in life. Sean and Jim looked uncomfortable.

Everybody thanked me and seemed prepared to wait for a full story to develop and become a GROW testimony. I felt that I had set a process of self-expectation in motion. I was left wondering where this would take me. Already my perspective was changing. It was hard to believe that this pleasant group of people could ever be seen as unwelcome in their community.

A brief plan developed around 12th stepping. Each member made a promise to contact another member outside the meeting setting. For the next week, I promised to phone Joan on Friday afternoon for a conversation. Joan agreed to meet with Eileen for a coffee on the Saturday afternoon. Jim and Sean agreed to go for a walk by the river on Sunday morning after mass. Paul agreed to phone me on Saturday. Mary agreed to phone Liz to encourage her to prepare for her party. Cheal's (1988) "general reciprocity", a phenomenon he found in the West of Ireland, where a favour is repaid to a third party, came to mind. All had reciprocated in the previous week. This brought a good-humoured end to Part Four.

Closing Routine

Part Five began when Liz, the meeting leader, stood up to prepare refreshments. This happened as she appeared to confuse her role as fieldworker, meeting member and meeting leader. She went into the kitchen. In doing this she disrupted the meeting. The momentum faltered and the group began to fragment. Jim and Sean shuffled their feet and looked at each other, gathering the courage to go. The circle was broken.

Joan, acting as recorder, completed a questionnaire on the quality of the meeting asking those present to comment. Responses were sparse. She called the roll of those present. Liz came back and put refreshments on the table. Sean, Jim and Eileen, now anxious to leave, said they would have nothing to drink. Mary had water. I asked for tea.

Joan asked Liz how to record my presence. “Michael is a community observer” said Liz ignoring my role as researcher.

“What’s a community observer?” asked Jim. “I thought he said he was some kind of student.” His voice was rather stern.

“Oh, they are just someone from the community who comes in to learn how we do things,” replied Liz. “They can come for three meetings if they are a doctor or something like that, and want to know what goes on at our meetings,” Liz explained.

“I see,” said Jim. He and Sean began to move towards the door.

“Wait for the closing prayer” suggested Liz. “Only take a moment”.

Jim and Sean remained standing. Joan continued questioning the group about the meeting. Everybody was meant to participate. Jim remained aloof, cold, disconnected, isolated. The others were putting on coats and scarves, getting ready to leave.

“Do you have far to go,” I asked Jim in a friendly tone.

“About eight miles up on the mountain road to Coolera” Jim replied.

“That is my mother’s country,” I added, “in Scarden”.

“What’s the family name?” he asked, looking decidedly surprised.

“The mother’s family name was McDermot but my grandfather was known as John the Manse. I am related to all McDermots.”

“McDermot! That’s my name, from the same townland,” gasped the astonished Jim.

He was stammering now, quite shaken by this turn of events. Now I was not a nosey official from far away at a private meeting of local people. Scarden was too small for us not to be related, members of an extended family, closer to each other than the others in the group. Both of us displayed our surprise and curiosity.

Jim stared hard at me like an archaeologist looking at pottery shards. This was no longer a matter of research for me or annoyance for him. It had become a matter of personal concern. I wanted to know more about Jim and his extended family.

Liz, re-entering the meeting as leader, called for quiet and participation in the recording of the meeting. Jim sat down and waited to say the final Prayer for Maturity. All stood, held hands and recited:

> "True, Strong and Loving God,
> Teach me to see things as they really are,
> To accept myself and to trust fearlessly in Your care,
> To govern myself, and to find my peace in doing Your will,
> And, living or dying, to give myself back to You and to my fellow man (GROW, 2001: 79).

The meeting closed when Paul announced, "GROW has no fees or dues, but any voluntary contribution towards necessary expenses will be welcomed". Everybody laughed at this announcement. Most put small change into a box produced by Liz. I wondered what was amusing but the laugh did return us to the profane world. The sacred space was finally dispelled when money was jangled in the box.

"Jim. Will you have a cup," said Liz.

"No thanks. I want to get on home now," he said over his shoulder.

He left quickly with Sean close on his heels, but not before he flashed a smile at me. The group seemed very surprised at this turn of events. Nobody present had seen Jim smile before. We made polite conversation about Jim's smile as we munched biscuits and drank.

We all returned home in our respective ways. "See you next week" echoed around the front door as I helped Eileen down the steps and Liz closed the door behind us.

This ended my first Kilbride group meeting. It left me with a lot to think about, to understand, to accept and to interpret. I had found new friends and a possible cousin.

Paul and Joan stood and talked in the cold night air. I was surprised that they had not hurried away immediately as the journey home would give them a lot of time to talk. They were still in discussion as Liz and I drove away. Somehow, although it was still cold and wintry, the scene did not look so bleak. Something special had happened. It was as if the world had changed and this was a happier place. Ritual had done its magic or, in GROW terms, 'God's grace had been gifted to the group'. Das (1998: 187) calls this "a transformation from social exchange to communal trance", where the world shifts in response to group intention.

The pattern that emerged from the meeting reflected the incorporation process: Quietness and thoughtful preparation; entering the sacred space of personal sharing and introspection; quiet and thoughtful rest; entering the sacred space again; quiet introspection at the end and emergence from the sacred space of the meeting and reincorporation to the everyday. Das (1998: 183) proposes that "everydayness is then in the nature of a return - one that is recovered in the face of madness". Incorporation, then, is return to the "paramount reality' of the everyday" (ibid. 183) that determines what being sane or mentally healthy is. Each GROW meeting achieved a deeper level of incorporation for those in attendance.

Levels of Incorporation

I attended many group meetings throughout the region and all followed the same ritual formulation. This included the organiser and recorder meetings and regional team meetings. Each level of GROW organisation represents a further level of incorporation into the world organisation. The higher the level in the organisational structure, the

deeper the level of understanding of GROW principles, the greater the level of incorporation achieved. But there is a problem.

No leadership meetings occurred. The need for such meetings, to raise topics for discussion to develop leadership, was spoken about often but they did not occur. Discussion is the essence of negotiations, the method of attaining the understanding and to develop leaders. Leading a discussion to a conclusion exemplifies the art of leadership. Not having leadership meetings limits discussion, true understanding and acceptance and limits the depth of incorporation.

In the opinion of some GROW members like Paul, the lack of leadership meetings appears to ignore and devalue the input of current group members while 'deifying' the founding members. This happens through training current members in the results of early GROW leadership meetings instead of generating new and local wisdom and leadership. Arguably, training sessions, learning through listening, has replaced leadership meetings, learning through doing, and thwarts leadership development.

Training can inform the members but it does not involve them in the process of developing the GROW wisdom. Nor does it eliminate resistance or dissension when the language of GROW becomes dated in the eyes of members like Paul. The continued use of the 'crude language of the 1950s', Paul's expression for the language in The Blue Book, is a good example of the type of issues in need of review through discussion at leadership meetings.

GROW local group meetings concentrate on each individual to help them to grow. This is where action and narrative merge. Narrative strings connect at points of common or like occurrences to produce social networks that support the narrators as they become friends. The ritual performance of friendship creates validation, displays wisdom, and promotes growth.

Understanding Grow Ritual Performance

Group meetings add practical and performance elements to GROW narrative but The Group Method produces characteristics of Bauman's (1977) performance that narrative alone cannot provide. The group meeting is a behavioural episode set on a stage constructed to display GROW caring and sharing. Bauman's five critical measures apply. The group meeting is bounded in time with a fixed starting time and a fixed period of two hours to complete the performance. This timed performance is true for GROW group, organiser and recorder and regional meetings.

Each participating GROW member is aware that there is a behavioural requirement to perform as a caring and sharing community. Without this the Group Method and Program of Growth to Maturity have a different meaning. They can be perceived as a form of autocracy. This well-meaning autocracy led to an occasion where a dishevelled and disordered elderly woman could not get a cup of tea because it would have disrupted the meeting schedule. Some flexibility is essential.

The meeting has symbolic components of how GROW members make friendship manifest, acting in ways that philosophy, language and wisdom cannot. The ritual transmits important aspects from a local group level right through to the international organisation. At all levels, GROW performance of The Group Method complies with Bauman's performance requirements.

Institution or Incorporation?

The Group Method is outlined clearly on a small card. In practice, there must be flexibility in how it is adhered to, especially for new groups. Operational flexibility is inherent in group performance.

The rigidity of the script is clear and the stage-setting is typically institutional but GROW members use friendship to create the flexibility required to avoid institutionalism. Incorporation is achieved by

developing new actions in the individual body and group to produce and consolidate ordered and adequate behaviour.

Features of institutional power are displayed at the location where GROW meetings occur. Most meetings take place in buildings owned by religious communities or at Health Services Executive (HSE) facilities. The design of these buildings has the same power to alter narrative and ritual as Saris allocates to the landscape of mental hospitals. For Saris, landscape has "agency, meaning and power in the production of stories" (1990: 42).

Even when designed and built in more recent years, establishment buildings retain the ethos of the colonial period when State institutions first appeared. Arús an Brú at Kilbride is typical of these facilities where buildings help to colonise the mind of the occupant. The occupant becomes occupied.

From this perspective, GROW is an association within an institutional landscape, so embedded that, when combined with GROW principles and practice, the combination serves to reproduce membership characteristics. Saris put it well:

> "This way of conceptualising institutions gives us an appreciation of such organisations that goes beyond the idea that the main function of an institution is to control its inmates and to reproduce itself (Goffman 1961) or to Douglas' notion that the main function of an institution is to name (Douglas 1987)" (ibid: 40).

In this way, GROW narrative is diverted towards the principles of the influential institution in which it is embedded. As Saris perceives:

> "Institutions as helping to constitute stories as well as being sites of narrative productions. The problem of institution necessarily bears on our thinking about the relationship between texts,

narratives, practices, and discourses with assumptions that both constitute and constrain the production of knowledge" (ibid: 40).

An institution can help or hinder incorporation by diverting ritual into a limiting and debilitating channel or into a channel to freedom and friendship. It is an embedded body of principles, practice and a physical structure. As Saris puts it:

> "By institution I do not mean a particular building or even a self-evident social network, but rather, following from the Latin root of the word 'institute', *instituere*, 'to set up', I mean a structure (physical or conceptual or both) that 'sets up' discourse and practice. I am defining institutions then as bundles of technologies, narrative styles, modes of discourse, and, erasures and silences" (ibid:40).

GROW then can be viewed as an embedded organisation within an establishment institution in the same way as a personality or self is embedded within the multifaceted identity of an individual.

Ritual Formulation

At the Kilbride Group meeting, the full ritual was adhered to and all required elements were included. This ritual of raising concerns, discussing them, suggesting and accepting tasks to bring healing when encapsulated in prayer, in conjunction with uniform acts of kindness, made a potent and well-packaged event.

The pattern of: prayer to a 'Higher Power'; of accepting responsibility; of facing problems; and of striving to heal and help others to do the same is at the core of GROW ritual. Power is released in the breach as well as in the observance of protocol, as in Jim's case. The resulting effect fulfils Turner's definition of "communitas, a blend of

lowliness and sacredness, homogeneity and comradeship, presented in moments in and out of time" (Turner, 1989: 96).

Participating in and observing ritual brings feelings of involvement and power to promote feelings of well-being. Change arrives in the flexible moment and space between rigidly formulated parts of the ritual by infusing it with the 'caring and sharing' community attitude. The power of ritual formulation and the social environment evokes change even if the physical environment, as in the case of Kilbride, deters it. Intentionality is the primary element.

If Liz, the leader for the meeting, had imposed the strict rule of no loose or irrelevant talk, my conversation with Jim would have been prevented. If she had adhered rigidly to ritual protocol and had asked somebody else to prepare the refreshments, my interaction with Jim could not have occurred and the more intimate feeling of relationship would not have occurred to change Jim's attitude.

The power to change came from feelings of kinship, friendship, and commonality. The group intention to heal trauma enabled healing. In the moment of awe when Jim smiled for the first time, the trajectory of Jim's recovery turned upwards. The everyday opened and ritual magic entered.

Confidentiality, a key concept in GROW ritual, is referred to in the statement of the GROW commitment: "I will respect the confidential nature of what is disclosed at GROW meetings". It is inherent in the closing statement: "In GROW, we believe in one another, we love one another and we trust one another" (GROW, 2001: 77).

Jim seemed uncomfortable with my presence as a community observer or researcher but changed his opinion radically when he discerned a highly-probable blood relationship. Confidentiality was maintained but secrecy was abandoned. Jim changed his trajectory, shifting towards the moment when personal testimony became possible for him. Ideas of stigma, disclosure and revelation were altered radically.

For Jim, I was now an insider, more in than anybody else in the group. Groups have layers of inside-ness. A spectrum of relationship was revealed ranging from stranger to acquaintance, to neighbour, to friend, to kinship.

Now, for Jim, I merited a smile, something no one else had merited. In minutes Jim had leaped the barriers of isolation and made contact with me, a member of his extended family. Jim's wall of isolation had developed a rupture that in time could lead, hopefully, to its total collapse. Breakdown could now become breakthrough. Such meetings are very productive and life-changing as Rappaport's (1988) GROW psychology research had reported and as I had witnessed and experienced. Living a happy and productive life is at stake. GROW meetings are high stakes rituals.

Orientation Meetings in a Mental Hospital

What of the world of professional care, of psychiatry and psychology, outside GROW? Is life as ordered and adequate and a curing and caring experience? I attended GROW orientation meetings in acute mental hospitals intended to recruit new members for GROW. They were designed to inform residents about GROW and how GROW can help them. In my experience these meetings were neither productive nor edifying. Some times they were extremely disappointing. The patients were neither informed nor did they recruit many members.

Hospital staff did not respect what GROW was offering. It was not the case that staff members were too busy to attend and find out. In fact they appeared to wander about without anything in particular to do. They looked bored and grumpy. Even during a meeting nurses often barged in to bring out a patient to another event. GROW meetings were not a high priority for them.

Patients who were feeling better and getting ready to go home hovered near the reception area looking distinctly unhappy. On one

occasion a young man said: “Get me out of here. I hate it here. I want to go home now”. He wept as he pleaded for help.

Some senior staff generally displayed a very aloof air. They hardly spoke to me and when they did it was in a brusque manner. This situation was not the case for Community Care Centres (CCC). At the Shellhouse Community Centre, when I visited with a GROW fieldworker, the environment was different. We were expected and welcomed, and treated with polite respect and good manners by a nurse who knew we were coming. The nurse attended the meeting and encouraged GROW membership for those going home. We were welcomed with no signs of resistance.

GROW as a Movement

GROW is an international group of local groups. It is a social organisation based on mutual affection, common interests, equal status and shared purpose. All members have a common adversary that serves to bind them together. They must contend with, in their terms, many challenges including an overwhelming and hegemonic psychiatric service.

In this way, as Dorothy Hammond puts it, GROW “subsumes age, sex, occupational or other differentiations that otherwise might be considered important, and membership results simply from an act of joining” (Hammond, 1972:1). GROW fashions a leading tip of change. “Associations are the growing tip of a society,” in Hammond’s view, having friendly “integration as their latent function” (ibid: 19). She saw “friendship, a field less worked in by anthropologists, as the simplest form of all associations” (ibid: 5).

GROW is an association resisting an institutional frame. It does this by incorporating practices in the body of its members and its membership which is at variance with the State institutional regime. At the same time, it is complementary with the religious institutional

framework set by its founders and is essentially Christian and humanist in its principles and practice.

GROW is a circle of friends that forms a wormhole to another reality. This circle is the GROW symbol of strength, togetherness, unity, society, a way in and out, a way through. Membership is both open and inclusive, and closed and exclusive. It is open to all who can accept that they need help while it is closed to all who cannot. Membership requires and develops a breakthrough.

Acceptance of the frailty of the human condition is the password to entry. GROW faces inwards at its group meetings for the benefit of members while facing and going outwards for acceptance of and from the public. This fixed and focused rhythm, turning inwards from society and outwards to society, is symbolic of "the systolic and diastolic breathing or pumping of heart-blood [that] helps those who are desperate for breakthrough" (Turner: 1992: 164).

Periods of concentration on life-changing possibilities enables crystallisation of a new personality to emerge from the chaos of the old and complex life story. Ritual acts produce "a birthing out of the milieu of conscious and subconscious memory" (ibid: 72). As already indicated, GROW narrative is embedded in its ritual behaviour, in its friendship network.

Finally, the group method structures the operation of a caring and sharing community which is achieved through integration or acceptance into the GROW community and finally into society. Ritual incorporation programs behaviour into the body of the individual as it accepts and integrates the individual into the body of membership.

Incorporation and integration are complete when individual internal flow and group social flow are achieved. GROW has finished its work for that individual. However, GROW will not have completed its task until it has achieved this outcome on the world scale.

In GROW, flow and growth are synonymous. Growth is achieved in moments of shifted or spiritual experience that combine the human

and the superhuman or supra human. Lorna, a seasoned GROW member, expressed this concept very well.

> "There is a flush of magical power when you do it. You have done all the preparations, like the swan, and now you can fly and like for the swan, the wind does most of the work. As the song says 'you are the wind beneath my wings'. You let go and let God and you take off. There are very few things now that I am adamant about but I go a way that I am happy with myself. I haven't got all the answers but I have enough to live my life well."

This is what GROW is designed to achieve. The formula also fulfils security and safety requirements that serve to preserve GROW from being usurped or abused by related, supporting or competing regimes.

The legalistic structure of the group method also serves to protect GROW internal operations from being disordered or inadequate. Its many feedback loops and inbuilt checks and balances are intended to maintain GROW operations in accordance with its principles. This is essential if GROW is not to mutate into some other form of organisation that is more in line with local, cultural and post-Christian concepts.

GROW provides the ritual setting and method to prevent this mutation from occurring. In GROW, "ritual offers a way to unite a particular image of the universe with a strong emotional attachment to that image" (Kertzer: 1988: 40), in this case the image of a theist God of love. For this reason GROW principles and practice must be consistent.

The formal and legal structure of the organisational activities forms a backbone to uphold the program. Other factors including the caring and sharing community put meat on the bones. Ritual has its own inherent, sacrosanct mechanisms.

The opening routine enables clearance of everyday profane concerns from the frame of reference. This brings total focus to the

event. Praying the Memento places the group in the presence of its theist God. Alternatively, if preferred, a common and supporting frame of mind creates the sacred space of an uninvolved deist God.

A community circle, a potent symbol, has the power to create a sense of collectivity that provides a renewed sense of identity. "This collectivity, created through ritual and symbols, not only provides people with an identity different from that encouraged by the elite", the professional carers in this case, "but also serves as a means to recruit others" (Kertzer, 1988: 181).

The ritual produced by the GROW group method counteracts the ritual of a consulting room where people are examined, diagnosed, prescribed and given a prognosis, a lifelong narrative. As Kertzer says: "One of the most common uses of ritual is to socialise new members to the value and expectations that make up its culture" (ibid: 29).

Kertzer suggests three properties of ritual. Condensation is, in Kertzer's view, "the way in which individual symbols represent and unify a rich diversity of meanings, and manifest in a physical form" (Kertzer, 1988: 11). It is available in the method, the program, the circle-of-friends seating arrangement and the group focus of attention on each individual in turn.

Multi-vocality, the "variety of different meanings attached to the same symbol" (ibid: 11), is available in the differing understandings of narrative discussed in the previous chapter. For some, like Jim, the method is confining and cumbersome, for others, like Paul, it is what keeps the group operating in a civilised and Christian manner, while for Liz it is a symbol of confidentiality.

Ambiguity, a symbol that has "no single precise meaning" (ibid: 11), is shown in the threat to confidentiality of speaking to strangers and hoping for privacy. All three factors are inherent in GROW ritual.

Foolishness or Wisdom

Leadership and training meetings attempt to increase knowledge and understanding of all GROW wisdom. This are considered essential if recovery and growth are aspired to. This approach recognises the ability of the individual to deal with difficulties and indicates that social interaction and education contribute to well-being. Wisdom, through insight, arrives through GROW ritual.

This compares well with recent WHO (2003) recommendations at an international level and discussed above. It suggests that individual's can live a productive and meaningful life despite vulnerabilities that may persist, equipped with the necessary self-understanding and resources to minimise relapse. It encourages psychiatrists to make better attempts to inform and involve their patients, patient's family and advocates in producing a suitable and agreed care plan. Amnesty International quotes MI Principle 12(1) of the WHO report to say that all patients have "the right to be informed and to explanations" when in mental health care (Amnesty International: Ireland Section. 2003: 27).

New GROW members who do not understand GROW principles can, through observation of GROW ritual develop fundamental concepts of what well-being is. They can then use this schema to "direct attention to relevant information, guide its interpretation and evaluation, provide inferences when information is missing or ambiguous, and facilitate retention" (Fiske & Kinder, 1981: 173). This serves to produce GROW truth. Like the pilgrims walking the labyrinth in churches in the medieval period, this schematic foundation can be used to create a belief system.

Whether this belief system is, in essence, religious or community-based depends on the constitution of the group and its fundamental schema or image that inform its ritual actions. GROW constitution is both religious and humanist, allowing for believers and non-believers in a spiritual realm, making it a holistic belief system. In GROW ritual members love God or neighbour or both and each is beneficial. Invoking the goodness and guidance of God or community brings faith in

God or fellowmen to bear on the ritual. “Without faith there is no rite” (Struve, 1968: 763).

The Ritual Circle

Reading the 12 Steps of Recovery and Personal Growth reminds all present what they are there for. This ritual repetition of fundamental beliefs “structures our experiences, guides our perceptions and channels our interpretations of those perceptions” (Kertzer, 1988: 84). Repeated recitation of the GROW commitment re-establishes the binding forces at work in the group: confidentiality, good leadership, truth, the willingness to engage with disorder and maladjustment, and the will to operate within GROW principles and practice to hold the group together.

The circle of friends formed when all hold hands, symbolises the binding forces in operation when combined with mutual belief, love and trust creates a cultural milieu that leaks out from the meeting group to bind the members into the local community. A ritual meeting sets the behavioural standard. “Ritual crosses the boundary between the sacred and the profane. At the outset ritual shifts the setting, objects, acts and participants to the sacred” (Payne, 2000: 469).

The circle of friends marks the boundary of sacred space, a circle that has, temporarily, symbolically and actually, turned its back on the outside world of chaos to create an inner ordered world. In this space, the world of the everyday is not abandoned but is ignored for two hours, a fixed period of liminality in Turner’s (1969: 95) terms. This creates a safe place to expose and explore otherwise taboo subjects.

The level of eye contact within the group is a barometer of the level of this concern or friendliness. It is lowest as a story or personal testimony is told, when all eyes are averted. Members look into the middle distance, avoiding direct fusion of the gaze of narrator and audience members. Peripheral vision suffices.

Paul told me how much he disliked the gaze of the professional psychiatrist who, on many occasions, had sat in front of him, staring into his face and eyes, trying to hold him like a rabbit in the headlights of a car. The psychiatrist assumed the power of a deep intrusion. He was not invited or given permission by Paul.

Friends do not take such liberties. They do not usurp the power of the disordered individual and do not impose eye contact upon them. In GROW ritual, friends look away, respecting the deep level of exposure of identity. It takes time, trust, care and concern and, ultimately, an invitation to make eye contact, to enter the gaze of the member. This negotiation takes place at a subliminal level. The circular shape to the group facilitates it, making a common middle distance point of contact between the feet of the group. The middle-distance, the liminal space, is the social space where GROW group members meet.

GROW attempts to integrate GROW members into the local group through the rite constituted by inclusive loving and caring actions. Turner has a similar concept for the performance of acts of incorporation. “Incorporation includes symbolic phenomena and actions, which represent the return of the subjects to the new, relatively stable, well-defined position in society or enhanced status, a stage further” (Turner, 1982: 28). Such friendly actions affirm group membership.

Testing of knowledge at the group meeting reinforces the concepts being considered. Repetition of speech and bodily actions is the key to bringing order to mental process. Repetition, a Pavlovian process to some degree, creates and strengthens a foundation or schema on which to build other concepts and actions. Ritual contains elements of sympathetic, contagious and homeopathic magic. Sympathetic magic is invoked by ritual acts themselves. Contagious magic occurs in the presence of such acts. Small acts, the essence of homeopathic magic, enable greater acts of a similar nature. All common acts contribute to a common alignment of will.

Victor Turner wrote: “Ritual is a process and not a custom” (Turner, 1992: 15). This idea can be applied to the internal changes within a GROW member and group. “I came to see performances of ritual, a rite that changes the quality of time, as distinct phases in the social processes whereby groups became adjusted to internal changes” (ibid: 20).

Ritual repetition is cyclical and ongoing. It takes effect at the level of the psyche to produce Turner’s “liminoid state” (1982: 32), a state of incorporated liminality. “Liminality is frequently likened to death or being in the womb” (ibid, 1982: 95). This enables growth to begin and continue to a new lifestyle or way of being extending “communitas, a blend of lowliness and sacredness, homogeneity and comradeship - presented with moments in and out of time” (Turner, 1989: 96).

Rites of Passage

The change from isolation resulting from a fragmented foundation, through the liminality of mental disorder, to GROW foundations formed through ritual, has all the elements of Van Gennep’s rites of passage. This evolution occurs because religious or magical powers intrude. He makes a sharp distinction between religion and magic. His insight came from a tradition of positivism, the insistence that general laws of social process should be derived from empirical observation rather than from metaphysical speculation.

Turner’s concept of rites of passage does need a spiritual element. For him, “we may be talking of a world of religion, not as morals, not as mental prayer, but in the form of ritual objects effective in their own right, a matter of spirits and people with knowledge of them operating in a ritual process that can actually be sensed” (Turner, 1992: 180).

Whereas the source of power may be debated, the effect can not. Ritual produces change. For Van Gennep, “the examination of any life-crisis ceremony will quickly establish the validity of the three-fold

classification of separation, transition and incorporation." In GROW, incorporation is the dominant element.

GROW Rites of Passage

The rite begins with attendance at the first meeting. The dominant element of any ritual act must relate to the prime purpose of the rite in question. In GROW rite, incorporation dominates.

The meeting begins with the group isolating itself from the outside world. A silent moment, clearing the mind to enter Turner's "communitas" that "is rooted in the now" (Turner, 1969: 113), initiates the Opening Routine. Praying the 'Memento' calls in Boholm's 'Higher Source', tapping into a power to change and heal. The meeting opens, prays, remembers the process of recovery, renews commitment to confidentiality and good intent, and to GROW truth. All strive to believe in mutual love and trust.

Tolle puts it another way: "An intelligence much greater than the mind is now in charge, and so a different quality of consciousness will flow" (Tolle, 1999: 149). Ritual opening actions exclude the profane world but incorporate the group into a unity of purpose.

The Group Interaction phase is divided into clearing any urgent problems, giving and listening to GROW narrative, discussing personal problems and progress, and deciding on acts of recovery to consolidate the group. It moves the group into a space of reflection on disturbed being, of intentionality and initiates a liminal space where "communitas tends towards imagery and the philosophical" (Turner, 1969: 33). The friendship network is reinforced

In the Middle Routine, the group prays again, asks forgiveness and remembers hope and enduring friendships. It surrenders to God's will and then, through reading and discussion, brings in GROW wisdom and an experience of knowing. Wisdom is sought in imagined and remembered settings of space and time. This complies with Turner's proposal that "wisdom that is imparted in sacred liminality is not just an

aggregation of words and sentences; it has ontological value, it refashions the very being" (Turner, 1969: 103).

The group continues to reflect, to humble itself, to inform itself, and further involve a metaphysical element to create a deeper liminal space. The ritual attempts to achieve healing through "acts of a special kind derived from a particular frame of mind" (Van Gennep, 1960: 1). Friendship sets that frame of mind with small acts of kindness.

The Resumed Interaction phase repeats a clearing of the mind of any urgent problems, includes powerful GROW narrative, discusses personal problems and progress and decides on acts of friendship. In this way it enters a world of disorder, a chaotic space, and attempts to put order on it. It attempts to bring understanding and acceptance to construct a sacred time and place, an ordered world. This is the essential character of incorporation.

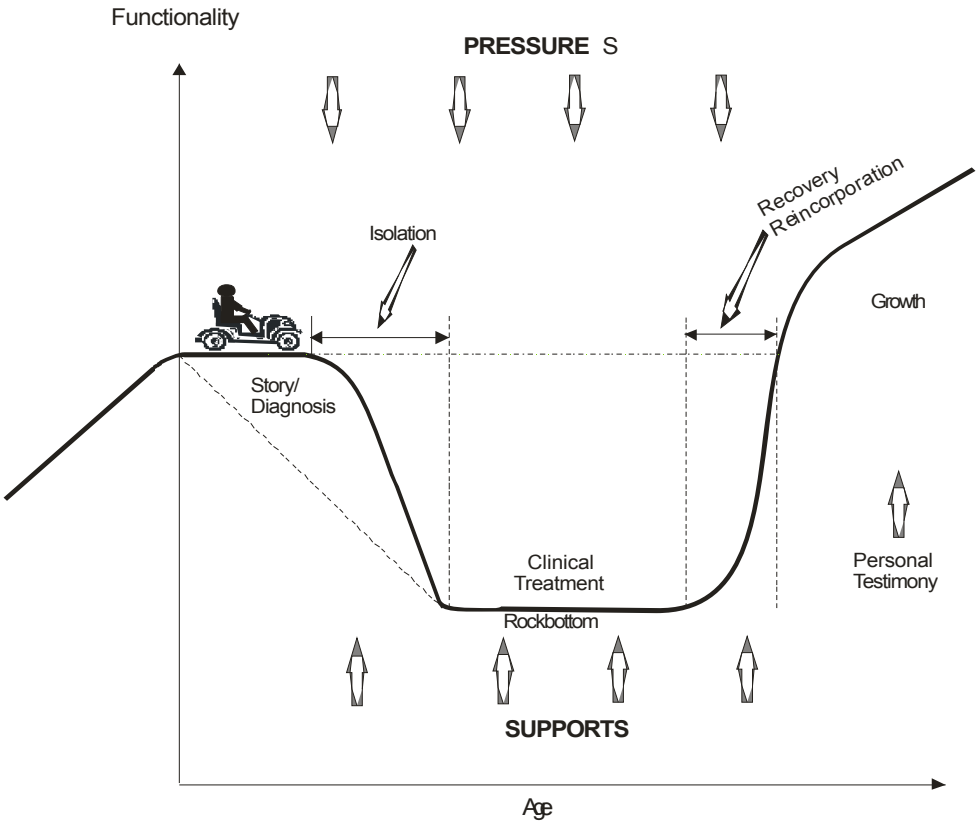
The Closing Routine checks progress, records the quality of group performance, listens to an outside influence, strives for maturity, asks for insight, self-acceptance and trust and offers itself back to the Higher Power. Finally, the routine includes hope that GROW friendship will bring healing, making self, the group and the world whole and integrated, re-incorporated. The group returns to Turner's "structured world rooted in the past and extends into the future through language, law and custom" (Turner, 1969: 113) with an increased commitment to GROW wisdom, order and adequacy. Mentioning fees and dues confirms the return to the everyday.

The diagram on Page 222 portrays the cycle of decline, the abyss of rock bottom, the journey to self-acceptance and on to recovery and self-fulfilling growth. The idea of growth or development suggests a fourth phase after Van Gennep's triumvirate.

Supports can derive from schemas of a theist God or pantheist god or any concept of a helpful God. In GROW, life grows ever-closer to alignment of wills between the individual, the community and God's will, whether theist or pan-theist. GROW ritual strengthens these

schemas in the manner to Grof's (2000: 22) "Condensed Experiences" (COEX), where an experience reinforces a later similar one.

On the other hand, despair is produced in the same manner when self and society fail the person and there is no concept of a supporting god. Repetitive negative experiences serve to undermine the sense of worth of the person. In this mental space and time suicide may seem the only way to escape the distressing total environment.



Author's conception

Time shifts regularly in the GROW ritual. Linear time, which creates ideas of unending stress, is transmuted to cyclical time associated with seasonal variations and natural change. The ritual prescribes circular time through its repetition of active ritual elements.

GROW ritual shifts time from an unending linear progression to cyclical weekly seasons, which relates to Turner's (1982) concept of the liminoid space of continual and directed change. In this way, "transition has become a permanent condition" (Turner, 1969: 107).

The prospect of change makes room for hope and makes further attempts at living seem natural, disempowering the idea of failure and enhancing and empowering the idea of making progress slowly and naturally. Progress of this type becomes an evolution of the person and the community, an apparently natural evolutionary process of incorporation and integration.

GROW ritual incorporation acts as an antidote for what Guy Debord called the "everyday" that incurs:

> "an avowed incapability of living. Everyday life is a colonised sector and is naturally the domain of ignorance. Everyday life is thus private life, the realm of separation and spectacle, the sphere of the specialists, resignation and failure, of personal disarmament and of an avowed incapability of living" (Debord, 1961: 3).

Incorporation, going forward, is an unconscious antidote born of GROW ritual that produces rebirth to a new way of life. Quoting Arendt, Jackson suggests that "In replacing the notion of reversal with renewal Arendt places her emphasis on the perennial possibility of rebirth freeing ourselves from the past" (2005: 47).

GROW ritual acts to "reveal values at their deepest level and is the key to understanding of human societies" (Turner, 1969: 6). To reveal in this way is equivalent to rebirth. Rebirth of a new self is reified at first in thought, then in narrative and, even if not recognised, in actions through performance of GROW ritual. Ritual actions predispose witnesses to actions in the everyday world that are both sympathetic

and contagious. “Sympathetic acts are based on the belief in reciprocal actions” between group members, while “contagious acts are based on the belief that natural or acquired characteristics are material and transmissible” (Van Gennep, 1960: 4).

Witnessing acts of friendship and trust raises the expectation that society and God will act in this way making anticipation of good in the world appear possible and believable. Jackson (2005: xxii) sees the possibility of rebirth in group activity. Quoting Arendt (1958: 176-177), he recounts that the “possibility of second birth - may be stimulated by the presence of others whose company we may wish to join – we respond by beginning something new on our own initiative”.

The closing stage of the Group method: taking refreshments; praying for maturity; standing and holding hands; confirms incorporation as the major theme.

> “The rite of eating and drinking together is clearly a rite of incorporation, of physical union, a sacrament of communion. So is holding hands, putting feet together [under a table], or pronouncing an oath” (Van Gennep, 1960: 29).

Uncharted Space

There is a space left undocumented by GROW, a space of awe between rock bottom (stage 12 of decline), and admitting that there is a problem (step 1 of recovery). It is similar to Turner’s “fleeting moment” of “existential or spontaneous communitas (Turner, 1989: 132). As a result, it is difficult to discern the exact nature of the turning point on the journey of recovery, but it suggests that recovery begins virtually unnoticed and passes through moments of empathy in uncharted territory. Turner explains such moments as “a mystery of human distance. Spontaneous communitas is magical and rich in pleasurable effects” (ibid: 139).

People are carried along by the flow of being supported and nurtured by their GROW friends. This is a liminal flow experience. It is liminal insofar that it is transitional, and flow meaning that it does not require effort. Flow occurs spontaneously and without overt guidance. Any covert guidance is contagious or sympathetic, acquired by being in the presence of friends.

When recovery becomes evident, it arrives with GROW in 12 steps to map its trajectory. When recovery is secured, growth becomes possible. Growth occurs when well-practised recovery moves into flow mode in the sense used by Turner (1982) and Csikszentzmihalyi (1990, 1993). This is an effortless state of being where life is an exercise conducted with patience and great expertise, as demonstrated by Paul's performance.

This type of performance also corresponds with GROW concepts of growth to maturity "the vigour and peace of a person who is wholly attuned to reality" (GROW, 2001: 6). Ritual brings internal incorporation and external integration to its participants and observers. It fills the spectrum between the emic and etic experience.

Other voluntary organisations are operating in the North-West region. Virtually all of these adopt the psychiatric model of mental disorder and act as supports to this concept. As one GROW member, a lapsed member of more than one of these organisations told me: "All they do is ensure that you keep taking your medications and their other activities simply keep you off the streets". They do not have a formulation of how they support recovery, no principles and practice that single them out from each other. Generally they offer basic art, talk or occupational therapies but do not expect or promote any 'false hopes' of recovery or growth. Most function as safe places for those released from acute care out of the gaze of the general public. Others support family members by providing respite from the burden of caring for patients at home.

Chapter 8 Finding Foundations

"The unexamined life is not worth living." Plato.

This work set out to discover what resilient foundation could be found that would withstand the exigencies of life. To find this I explored the landscape of self and identity of two groups that purport to know and promote a way of developing a healthy lifestyle: GROW and the psychiatric service in the north-west of Ireland. I analysed and compared the foundational concepts held by these two groups. This proved problematic as GROW and psychiatry does not have a common schema on what they were dealing with.

I learned that GROW does not consider mental disorder and inadequacy to be an illness but a social and spiritual condition, unsuited to treatment with medications. Psychiatry offers medical treatment only and has, until recently, not considered a role in prevention and recovery. Each uses their resources to bring resolution to individual and group trauma. While they appeared to work with each other they appear to fundamentally disagree with what the condition of 'madness' is. Each begins with a different understanding of what it is to be a being human.

GROW understands that being human as a creature in a process of evolution in a community set with a physical environment. For GROW, the individual and community have a task to complete and a place to go. Community disorder causes disorder in the individual along with disorder or inadequacy in the physical environment develops further disorder in the individual and community. The task for individual and community is to overcome disorder by providing adequate resources to support the healing process.

Psychiatry understands being human as a creature in a physical environment. The individual considered mentally ill is a member of a category with no place to go. Weakness in brain biology is expressed in disorder and inadequacy in their performance of living. This can be

corrected only by suitable application of natural or artificial pharmaceutical medications. Only people with the specific expert knowledge can select and administer these products. A cultural setting determines the mode of expression of illness but has no impact on it. Behaviour results from biology but does not impact on it. Prolonged biological illness derives from genetic deformation which occurs by chance. Being human derives from a lucky biological process.

Other interpretations of being human, whether based on spiritual, psychological, biological or neurological schema, appear as variations of these two versions. Variation in the construction of these any of these constituent elements, or combinations of then, can produce illness or disorder. All disorders in these elements need attention to achieve a productive and happy lifestyle.

GROW acknowledges that psychical elements can cause disorder but it is spiritual, psychological and social factors that contribute to recovery and growth. This suggests that physical defects derive from disorder or inadequacy in the system of provision of necessary resource brought about by defective ways of thinking, talking or doing used to construct lifestyle foundations.

As Foucault suggests that what is considered a suitable lifestyle will change with time. It will also change from one cultural setting to another and the concept that lifestyle is based on is learned in the same time frame and cultural setting. For him, we become mad through false learning (1965: 25) and e learn our foundational concepts from our local environment.

The Need for Foundation

We all need foundations. Without them we are rudderless, without concepts that give directions on how to proceed. Enlightened thoughts, words and deeds, derived from the collective experience, give the wisdom give to produce foundation and direction. Without these a lifestyle will crumble under stress or fail from being too weak to survive

the ordinary exigencies of life. Stress is generated in the social, cultural, spiritual and physical environment when conflicting concepts cannot be resolved, resulting in a fragmented thinking. New thinking is required. This takes time, research, learning and acceptance. GROW members have learned this the hard way over fifty years.

The psychological journey from the failed paradigm, through the learning phase to the new and, hopefully, a more robust paradigm fulfils what Arnold Van Gennep called “rites-of-passage”. This provides the overarching theoretical frame of this thesis. All other theoretical inputs serve to explain events and experiences that occur along the journey.

The responsibility to make positive change, confidence to keep trying for change and to control of the process to achieve well-being evolve from this sense of acceptance. Change arrives but how does it happen? Jackson proposes that it arrives between “the ‘margins of freedom’ wherein new possibilities are envisioned and struggles take place over the sense of the social world, its meanings and orientation, its present and its future” (2000: 234- 235). GROW margins are set between the limitations and permissions it proposes. Freedom allows change to occur, driven by the power of the encounter. Where has power come from?

Foucault (1972: 55) suggests that power is a “phenomenon of the social body, not of a consensus but of the materiality of power, operating on the very bodies of individuals”. Power comes directly from the people who make up any group. GROW extracts people power through their 12-step program to produce their truth. For psychiatry, power comes from the consensus of scientists, a group of the type Foucault (1972: 126) “would call the ‘specific’ intellectual’ that bestows power on its adherents. Truth, what people extract as true and choose to believe, makes power available.

For GROW, power gives direction to the GROW voyager to arrive at maturity. For GROW, God is the source of human power or ‘god’ is simply the expression used by GROW for its source of inspiration. In

either case, humanity, for GROW, is close to the original meaning of 'human': a 'child of God'. God is outside the bounds of the medical or scientific paradigm.

Current psychiatric practice does not allow for recovery and growth. According to its medical model, following a stable course of medical treatment constitutes a limited form of 'recovery'. Psychiatry in the North-West of Ireland, informed by biological and chemical research, takes what it considers a scientific view. However, psychotropic drugs are administered in a heuristic manner without prior knowledge of the outcome. In this way psychiatry is not scientific. Psychiatry, with its scientific view, leaves no room for will-power or self-motivation to influence the outcome.

Information attained forms the law or concept the receiver lives by setting patterns of thought that produce analogous forms of actions. In this way information or truth forms the receiver. However, analysis alone does not develop information powerful enough to bring change in behaviour. The synthesis of a better lifestyle is based on information derived from observation and participation. Only case-hardened facts can produce foundational beliefs and bring the will to change. Ritual provides such concrete ideas.

For Van Gennep (1960: ix), the change resulting from human group interaction or experience is a form of sympathetic magic or a form of spiritual power. In GROW spiritual power derives from the Christian theist God in the form of friendship or from community magic in the form of consensus among non-believers.

For GROW, morals derived from inter-human experience are local and limited while ethics, based on their experience of God in the form of friendship, are universal. Ethics provides the power to overcome traumas and enable catastrophes to become tolerable. For GROW catastrophe is necessary for people lacking awareness or in denial. They disrupt inappropriate concepts and make way for new knowledge that derives from high-quality social interactions. Such experiences

produce new patterns of thinking, new concatenations of concepts in the mind and produce new strings of synapses in the brain. Such implants bring new ways of being.

They also bring balance to brain chemistry and a cascading flow of power to promote actions that medications alone can not do. This reverses what Foucault proposed: “Learning becomes madness through the very excess of false learning” (Foucault, 1965: 25) and proposes that ‘Learning becomes saneness through the very excess of true learning’. For Foucault, learned values and beliefs become the foundation of behaviour. It is not pathological, genetic nor particularly cultural but something pedagogically universal. It begins in the external and experiential world of identity and leaks inwards to invade the self.

GROW pattern of development comes in two strands of thinking. The first is comprised of unawareness or denial, acknowledgement, admittance and acceptance. The second is comprised of understanding, acceptance, confidence, control, and love. The two minor strands combine to give unawareness or denial, acknowledgement, admittance and acceptance confidence, control, and love. They indicate that understanding is achieved through moving from unawareness or denial to admittance in a series of ritual contemplations guided by people with good experience of the process. In doing so, it releases enough power to allow for evolution to a higher performance to occur. It makes clear that acceptance is not just a concept that facilitates but is a state of mind, a way of mature being.

Ritual behaviour communicates foundational concepts that enable what were once reactions to become considered responses. When the two strands intersect in acceptance they enable the person to have confidence and take responsibility and control of their life. The individual strands are elaborated in personal narrative and contain strings of concepts that meet at points of common experience and cross over where empathy bridges the gap. This web of concepts acts to

catch those in free fall, determine where rock bottom is and finally serve as a foundation to rebuild a new life on.

Foundations are webs of concepts that are strong enough to support a new lifestyle and provide the building blocks of evolutionary growth. It was formed in group activity resembling what Foucault called the 'universal intellectual' concept where one gets "rid of the subject to arrive at an analysis which can account for the constitution of the subject within a historical framework" (1972: 117). This is how GROW produced a body of philosophy, the Blue Book, independent of any one story or testimony.

The Pattern of Evolution

The evolution from beginning GROW member to board of management member symbolises transfiguration, a process of personal incorporation and social integration. Incorporation relates to internal patterning of the mind with its various personalities developed through experience. Integration relates to external organisational form. Wholeness is produced through the intuitive learning of ritual and the logical learning of narrative.

The pattern inherent in GROW principles and practice offers an engineered landscape for the minds of GROW members to copy, an internal schema that does for the mind what Saris (2000) proposes for asylum architecture in the North-West of Ireland. It shapes the mind. Moral and ethical strands of progress are wrapped around each other, like strands of DNA, touching at the turning points in life. This process of incorporation is essentially organic in its nature. Private incorporation and public integration satisfy the requirements of the third stage rites of passage.

This sympathetic and contagious growth pattern shows a chained set of Grof's (1988) condensed experiences, in this case, of a caring and sharing community. Like the synaptic structure of the brain, the internal layers of personalities become case-hardened through continual

repeated performance, producing a robust human being who is resistant to the traumas of life producing and reinforcing holistic idea of humanity. Psychiatry, with its ritual use of medications, can bring a person experiencing a full blown psychosis to a rested state where GROW can begin its work. The gap between rock bottom at stage 12 of decline and admittance at step 1 of recovery may be bridged by the magic of medications.

Psychiatrists prescribe medicines for categories of people with mental disorder. But, as Goffman suggests, the medical model can offer a desirable pattern of revealing and concealing mental disorder. Its inherent problem is that it simultaneously produces isolation of the individual and conformance with societal norms without any acceptance or compliance. This suggests that the medical model is close to Munchausen's hypochondria syndrome in providing relief from the personal responsibility to recover and grow.

Insider or Outsider

An empathetic audience can have a limited internal view of a parallel landscape, the scope of which is determined by similar personal life experience. The internal landscape, even when incorporated, is coherent but isolated. The narrating participant and any current observer cannot re-enter as a participant in a narrative of the past. The concept of emic and etic experience, first coined by linguistic anthropologist Kenneth Pike (1954), explains this phenomenon.

For Pike, these neologisms suggest that two polar perspectives can be employed in the study of a cultural system. He defines the emic perspective as focussed on the intrinsic cultural distinctions that are meaningful to members of a given society who are the sole judges of its validity.

It also describes the individual GROW member's perspective of their own internal landscape. Two people cannot have the same emic perspective as their individual schema, based on their individual

condensed life experiences, will be different. The question then arises: To what extent can an observer give reliable insight and information? The event can happen only once. Any later attempt at replication must, by its very nature, be distorted. Although a group may have a consensus it will be interpreted differently through the lens of personal experience. It is emic only at the time of the event. Later views are essentially etic, the view of the outsider with less power and emotional impact.

The knowledge and practice of psychiatry is essentially etic originating in a singular medical model and has remained faithful to it. It is confined to a biological perspective based on Newtonian physics. It misses the subtly of quantum physics.

Understanding Recovery

Recovery is a process, a state of becoming, not a state of being. Recovery becomes growth when a person moves forward to develop their abilities to full potential, towards Maslow's (1954) "self-actualisation". However, the concept of recovery limits potential progress. The concept of growth to self-actualisation is a higher ideal.

Friendship changes people from being problems to being resources. GROW is a complementary therapy whose contribution begins where current psychiatric services finish. It brings an epi-genetic and epi-biological power to bear on the situation that changes the dynamics of the phenomenon. It is a therapy that is alternative and a complement to the psychiatric model for those who can avail of it. This epi-phenomenon is what GROW calls the spiritual dimension.

For GROW, Turner (1982) and Bluestone (2004), disordered and inadequate behaviour has an internal logic of its own and is not a pointless phenomenon. Disordered behaviour is a symptom of distress or illness. There is no point in treating symptoms. The underlying trauma that produced disorder must be dealt with. For GROW disordered behaviour symbolises that breakthrough has occurred providing an opportunity for evolutionary growth.

If biological disorder arises from drug or alcohol abuse, and if genetic disorder, deriving from prolonged exposure to a toxic environment, either nutritional or social, then these contribute less than ten percent of hospital admissions. If it is necessary to take care of those affected in terms of what caused the disorder in the first place then a combination of drugs and social environment is necessary. This would require the decontamination of those with nutritional, alcohol or drug problems, the removal of the toxic social situations that introduced the toxic substances and social rehabilitation and supply of a better way of living. This would situate the person back in society without stigma and isolation.

Stigma

Stigma is a self-assigned and accepted as appropriate when self, as an icon of power, is overwhelmed. It is assigned by others who assume the power to appropriate the overwhelmed self to produce social identity. Assigning stigma isolates the individual and contributes to personal downward social and psychological pressures. It has fear of living and dying as its basis. It is counter-acted by a public declaration, in a supportive social environment, of the trauma that brought the disorder.

Publishing GROW narrative anthologies constitutes a stigma reduction campaign by making narrative public, declaring narrative and those effected by it acceptable for public consumption. Stigma is a by-product of the concept of hierarchy in a society. In a society of equals, stigma cannot exist. Stigma, like moral elevation, is a matter of degree and is concomitant with the hierarchical structure of society. Narrative and ritual offer feedback mechanisms to correct deviations from acceptable behavioural norms. Failure to respond to such feedback raises Szasz's (1961, 1964) idea of malingering.

The disorder and inadequacy encountered by those in GROW has the concept of chaos and not random behaviour at its heart. Chaos

has an inherent tendency to produce pattern, a fundamental rhythm absent in random behaviour. GROW disorder is chaotic, a temporary state that has a fractal resolution embedded. Mental illness, the psychiatric concept, has randomness inherent in it.

Friendship is the Lorenzian (1967) “strange attractor” that draws chaotic disorder into patterns of acceptable and orderly behaviour. It is the key factor that makes order inevitable. For GROW, God is present in the form of the friendship and is the ‘strange attractor’ bringing order.

Selfishness is the “strange attractor” that produces stigma in a *locale* isolated from the world community that lacks suitable feedback mechanisms. A universal discipline is required to prevent isolation and self interest.

Mental health cannot be the subject of a single discipline or schema. It has been confined to the process of the mind. To diagnose, treat and heal disorder and to prevent it requires a multi-disciplinary approach, inclusive of every sub-discipline of humanity and facilitate cultural differences. If any aspect of humanity is neglected it will bring inadequacy and disorder in understanding the person, group or situation. The culturally bounded medical model is less potent for this reason.

In Ireland at present ideas of humanity are changing. The spiritual aspect, a central to its construction in earlier times, has been relegated to a minor role if not negated totally. Mental capability is enhanced through the benefits of education but, in an overarching way, the consuming body has become the primary element. This has ensued through over emphasis of bodily needs and wants in a material culture. The body has consumed the human being.

With the spiritual element diminished or negated humanist values, in the narrow sense, value the body and mind as mechanisms of production. Such use is sanctioned, in modern automated agriculture and industry, by a social construction of people with little inherent worth. People are rendered expendable and vulnerable.

All aspects of humanity encountered in GROW compile to give a holistic view with spirit predominating. This complex of relationships forms a nested complex of elements to form an anthropological whole.

GROW knowledge, like any other holistic set of principles and practice, provides a firm foundation and a suitable model to achieve healthy and self-fulfilling people and community and provides an appropriate means of resolving cultural differences. For those who become distressed healing will derive from the acceptance of a new cultural context for the causes of trauma.

Final Comments

This study was designed to explore the role that GROW plays in modern Ireland in supporting individuals recovering from mental disorder. In particular I sought to compare GROW principles and practices of GROW with those of psychiatry and its substrates. To set the context for the study an extensive review of relevant literature was undertaken. What emerged shows that for GROW, people can recover and thrive while for psychiatry, once breakdown occurs, recovery, if at all possible, can be achieved in limited terms only.

While reviewing GROW literature I was given a privileged opportunity to get an inside view of GROW principles and practices. What is most impressive about GROW is the way the organisation enables members to help themselves and to remove the stigma. It helps rebuild the self-esteem in people with mental disorder. What is unique about GROW is the alternative holistic process it offers to replace the medical model that is so often shown to be de-humanising.

A Final Word

The privileged opportunity I was given to see GROW from the inside allowed me to build the kind of relationships needed to effectively carry out this study. I am indebted to GROW as an organisation for providing me with this opportunity.

Bibliography

Aeschylus, 1953 (c. 500 BC) *Oresteia:* The Eumenides. Chicago: The University of Chicago Press.

Allchin, A. M, 1997 God's Presence Makes the World. London: Darton, Longman and Todd.

Amnesty International: Ireland Section. 2003 Mental Illness: The Neglected Quarter. Summary Report.

Anthony, W. 1990 *Recovery*: The Guiding Vision of Mental Health Services in the 1990s. Reprinted from *Psychological Rehabilitation Journal*, 1993, 16(4), 11-23.

Appell, G. N. 1978 Ethical Dilemmas In Anthropological Inquiry: A Case Book. Colorado: Crossroads Press.

Assagioli, R. 1989 Self-Realization and Psychological Disturbances in *Spiritual Emergency*, Editors S and C. Grof. New York: Jeremy P. Tarcher / Putnam.

Atkinson, P. 1983 The reproduction of the professional community, in R. Dingwall and P. Lewis (editors) *The Sociology of the Professions*. London: Macmillan.

Ayto, J. 1994 Dictionary Of Word Origins. Columbia Marketing.

Barlow, D. H & L. F. Bufka 1997 Microsoft® Encarta® 98 Encyclopedia. © Microsoft Corporation.

Barraclough, J. & D. Gill 1996 Hughes' Outline of Modern Psychiatry. Fourth Edition. New York: John Wiley and Sons.

Bateson, G. 1979 Mind and Nature: A Necessary Unity. New York: E. P. Dutton.

Bateson, G. 1987 Steps To An Ecology of Mind. London: Jason Aronson Inc.

Bateson, C. D., P. Shroenrader and L. Ventis 1993 Religion and the Individual. Oxford: Oxford University Press.

Bauman, R. 1977 Verbal Art As Performance. Illinois: Waveland Press.

Berger, P. L. 1963 Invitation to Sociology: A Human Perspective. New York: Anchor Books.

Bergin, D., J. Rice, D. McGarry, J. Phelan and A. Walsh 2003 Soul Survivors. Volume 2. Kilkenny: GROW Ireland.

Bhaskar, R. 1979 The Possibility of Naturalism. Brighton: The Harvester Press Ltd.

Bhaskar, R. 1989 Reclaiming Reality. London: Verso.

Biddulph, S. 1994 Manhood. London: Vermillion.

Bluestone, J. 2004 The Fabric Of Autism. Seattle: The Handle Institute.

Bohm, D. 1980 Wholeness and the Implicate Order. London, Routledge.

Boholm, A. 1996 Political Ritual. IASSA , Sweden: Gothenburg Press.

Boshear, W. C. and K. G. Albrecht 1977 Understanding People: Models and Concepts. California: University Associates Inc.

Bossard, J. and E. Boll 1950 Rituals in Family Living. Philadelphia: University of Pennsylvania Press.

Bourdieu, P. 1998 Practical Reason. Oxford: Polity Press.

Boyne, E. 1998 *Psychotherapy In Ireland*. The Columba Press.

Brosnan, L. 2006 Partnerships in Mental Health (Parts 1 & 2). An Exploratory Survey. Ireland: Western Alliance for Mental Health.

Burns,T. 1992 Erving Goffman. London, Routledge.

Byrd, R. C. 1988 Positive therapeutic effects of intercessory prayer in a coronary care unit population. Southern Medical Journal, 81(7), 826-9.

Cannon, W. B. 1942 Voodoo Death. American Anthropologist Association, n.s., XLIV.

Capra, F. 1996 The Web Of Life: A New Scientific Understanding Of Living Things. New York: Doubleday.

Cassirer, E. 1946 The Myth of the State. New Haven: Yale University Press

Cheal, D. 1988 The Gift Economy. London, Routledge.

Cohen, D. *1997* A critique of the use of neuroleptic drugs in psychiatry. In S. Fisher and R. P. Greenberg (editors.) *From Placebo to Panacea.* New York: Wiley.

Crowley, F. 2003 Mental Illness: The Neglected Quarter. Dublin: Amnesty International: Irish Section.

Csikszentmihalyi, M. 1990 Flow: The Psychology Of Optimal Experience. New York: Harper & Row Publishers, Inc.

Csikszentmihalyi, M. 1993 The Evolving Self. New York: HarperCollins Publishers Inc.

Curle, A. 1972 Mystics And Militants: A Study of Awareness, Identity, and Social Action. New York: Tavistock Publications Ltd.

Dawkins, R. 2006 The GOD Delusion. London, Transworld Publishers.

D'Aquila, E. and A. Newberg 1999 The Mystical Mind: Probing The Biology Of Religious Experience. Minneapolis: Fortress Press.

Das, V. 1998 Wittgenstein And Anthropology. Annual Review Anthropology. 27:171.95.

De Chardin, T. 2001 The Divine Millieu. New York: Perennial.

De Chardin, T. 2002 The Phenomenon Of Man. New York: Perennial.

Derrida, J. 1998 Resistances to Psychoanalysis. California: Stanford University Press.

Department of Health and Children. 1998 Report of the National Task Force on Suicide. Dublin: Department of Health and Children.

Devereux, G. 2000 Normal and Abnormal in *Cultural Psychiatry and Medical Anthropology*. Littlewood, R. and Simon Dein. London: The Athlone Press.

Doka, K. 2002 How Could God? Loss and the Spiritual Assumptive World. in *Loss of the Assumptive World: A Theory of Traumatic Loss.* J. Kauffman (editor) 2002 London: Brunner-Routledge.

Downey, M. 1997 Understanding Christian Spirituality. New Jersey: Paulist Press.

Finn, L. 2001 Mutual help: An important gateway to well-being and mental health. New Paradigm: Australian Journal on Psychological Rehabilitation, June, pp. 13-17. Melbourne, Vic. Vicserv Inc.

Fiske, S. T. and D. R. Kinder 1981 Involvement, expertise and schema use: Evidence from political cognition. in N. Cantor and J. F. Kihlstorm (eds.), *Personality Cognition, and Social Interaction, pp 171-190.* Hillsdale, New Jersey: Erlbaum.

Flanagan, O. 1996 Self Expressions: Mind, Morals, And The Meaning Of Life. New York: Oxford University Press.

Fontana, D. 2003 Psychology, Religion, and Spirituality. London: BPS Blackwell.

Foucault, M. 1967 Madness and Civilisation. New York: Randon House.

Foucault, M. 1972 Power and Knowledge. London: Penguin.

Foucault, M. 1981 The History of Sexuality. Harmondsworth: Penguin.

Foucault, M. 1988 Technologies of the self, in L. Martin (ed) Technologies of the Self. London: Tavistock.

Foucault, M. 1988 Politics, Philosophy, Culture. London, Routledge.

Franz, G. and S. T Selesnick 1966 The History Of Psychiatry. New York: Harper & Row.

Freud, S. 1920 A General Introduction to Psychoanalysis. New York: Bonni and Liveright.

Freud, S. 1927 Future of an Illusion. in vol. 21 of the Collected Works. London: Hogarth Press.

Garro, L. C. 2000 Cultural Knowledge as Cultural Resource in Illness Narratives. In *Narrative and the Cultural Construction of Illness and Healing.* C. Mattingly and Linda C. Garro. Berkeley: University of California Press.

Geertz, C 1980 Negara: The Theatre State in Nineteenth-Century Bali. Princeton: Princeton University Press.

Gledhill, J. 1994 Power and Its Perspectives. London: Pluto Press.

Goffman, E. 1961 Encounters: Two Studies in the Sociology of Interaction. Indianapolis: Bob-Merrill.

Goffman, E. 1961 Asylums. Harmondsworth: Penguin.

Goffman, E. 1967 Interaction Ritual. New York: Pantheon Books.

Goffman, E. 1969 *Strategic Interaction*. Philadelphia: The University of Pennsylvania Press.

Goffman, E. 1990 Stigma. Hammondsworth: Penguin Books.

Goffman, E. 1990 Presentation of Self in Everyday Life. Hammondsworth: Penguin Books.

Good, B. J. 1994 Medicine, rationality and experience. Cambridge: Cambridge University Press.

Goswami, A. 1993 The Self-Aware Universe: How Consciousness Creates the Material World. New York. Tarcher / Putnam.

Gould, A. 1981 The salaried middle class in the corporist welfare state. In Policy and Politics, *9(4), 401-8*.

Greenfield, S. 1999 Soul, Brain and Mind in *From Soul To Self.* James C. Crabbe (Ed.). New York and London, Routledge.

Greenspan, S. 2001 The Affect Diathesis Hypothesis: The Role Of Emotions In The Core Deficit In Autism and in the Development Of Intelligence And Social Skills. *The Journal Of Developmental And Learning Disorders, Special Edition 2001, 3 (1), 1-45*.

Gribben, J. 1991 In Search of Schroedinger's Cat: Quantum Physics and Reality. London: Black Swan.

Grof, S. 2000 Psychology Of The Future. Albany: State University Of New York Press.

Grof, S. and Grof, Christina. 1990. The Stormy Search For The Self. G. P. New York: Putnam Publishers.

Grof, Stanislav and C. Grof 1989 Spiritual Emergency. New York: G. P. Putnam Publishers.

Grof, S. 1988 The Adventure Of Self-Discovery. Albany: State University Of New York.

Grof, S. 1985 Beyond The Brain. Albany: State University Of New York.

GROW. 1982 *The* Group Method. Sydney, Australia.

GROW. 1985 Charter Agreement Between GROW International And GROW Ireland.

GROW. 1989 Memorandum And Articles Of Association Of GROW Ireland.

GROW. 1994 GROW in Ireland. Published for Irish Silver Jubilee

GROW. 1996 Soul Survivors, Volume 1. GROW Ireland.

GROW. 2003 *Soul Survivors. Volume 2*. GROW Ireland.

GROW. *2004* Annual Report.

GROW. 2001 The Program Of Growth To Maturity.

GROW. 2003 Regional Team Handbook.

GROW. 2005 Personal Growth and Community Building Through Leadership: A Distance Learning Course, Part 1.

Gutherie, G. M. 1973 Culture And Mental Disorder. An Addison-Wesley Module in *Anthropology No. 39.*

Hammond, D. 1972 Associations. An Addison-Wesley Module in *Anthropology No. 14.*

Hyman, R. 1996 Evaluation of a program on anomalous mental Phenomena. *Journal of Scientific Exploration*. *10. 31-58.*

Illich, I. 1977a Limits to Medicine. Harmondsworth. Penguin.

IMHC Core Group, 2008 A Vision for Change Monitoring Group: Second Report on Implimentation. Stationary Office.

Jackson, M. 1998 Minima Ethnographica, Chicago: The University of Chicago Press.

Jackson, M. 2005 Existential Anthropology. Oxford, New York: Berghahn Books.

Jackson, M. 2002 The Politics Of Storytelling. Copenhagen: Museum Tusculanum Press.

Kahn, J. 1971 Human Growth. 2nd Edition. Oxford: Pergamon Press.

Kauffman, J. 2002 Safety and the Assumptive World. In *Loss of the Assumptive World: A Theory of Traumatic Loss.* London, Brunner-Routledge.

Kauffman, J. (ed.) 2002 Loss of the Assumptive World: A Theory of Traumatic Loss. London, Brunner-Routledge.

Keogh, C. 1995 Readings For Recovery. Marricksville, N. S, W: Southwood Press.

Kerr, Fergus. 1991. Getting The Subject Back Into The World: Heidegger's Version in *Human Beings: Philosophy, Royal Institute Of Philosophy Supplement: 29.* D. Cockburn (editor), Cambridge, USA and Australia: Press Syndicate Of The University Of Cambridge.

Kertzer, D. I. 1988 Ritual, Politics And Power. New Haven, CT: Yale University Press.

Kirmeyer, L. J. 2000 Broken Narratives. *In Narrative and the Cultural Construction of Illness and Healing.* C. Mattingly, And L. C. Garro Berkeley: University of California Press.

Kirschenbaum, H. and , V. L. Henderson 1990 The Carl Rogers Reader. London: Constable.

Klass, M. 1995 Ordered Universes: Approaches To The Anthropology Of Religion. Boulder, CO: Westview Press.

Kleinman, A. 1988 The Illness Narratives: Suffering, healing, and the Human Condition. New York: Basic Books.

Kleinman, A. 1988 Rethinking Psychiatry: From Cultural Category to Personal Experience. New York: The Free Press.

Kleinman, A. 1995 Writing At The Margin. Berkeley: University of California Press.

Koenig, H. G., M. E. McCullagh and D. B. Larson 2001 Handbook of Religious Health. New York: Oxford University Press.

Kornfield, J. 2002 A Path With Heart: The Classic Guide Through The Perils And Promises Of Spiritual Life. London: Rider.

Kritzman, L. D. 1988 Politics, Philosophy, and Culture: Interviews and others writings, *1977 – 1984*. London: Routledge.

Kubler-Ross, E. 1970 On Death and Dying. London: Tavistock Publications.

Lane, D. A. 1990 Christ at the Centre. Dublin: Veritas Publications.

Latour, B. 1987 Science in Action: How to Follow Scientists and Engineers Through Society. Cambridge MA: Harvard University Press.

Levinson, H. N. 1986 Phobia Free: A Medical Breakthrough Linking 90% Of All Phobias And Panic Attacks To A Hidden Physical Problem. New York: M J F Books.

Levi-Strauss, C. 1962 The Savage Mind. London: Weidenfield and Nicholson.

Levi-Strauss, C. 1963 Structural Anthropology. Vol. 1. Hammondsworth: Penguin Books.

Lew, M. *1993 Victims No Longer.* London: Mandarin Paperbacks.

Littlewood, R and S. Dein 2000 Cultural Psychiatry and Medical Anthropology. London: The Athlone Press.

Lupton, D. 1998 The Emotional Self: A Sociological Exploration. London: Sage.

Lorenz, E. N. 1967 The Nature and Theory of the General Circulation of Atmosphere. World Meteorological Organisation. No. 218.

Lukoff, F., F. Lu and R. Turner 1992 Toward's a More Culturally Sensitive DSM-VI: Psychoreligious and Psychospiritual Problems. In *Journal of Nervous and Mental Diseases 180 (1992):673-82.*

Manning, P. 1992 Erving Goffman and Modern Sociology. Cambridge, London: Polity Press.

Malinowski, B. 1945 Magic, Science and Religion. Glencoe: Free Press

Malinowski, B. 1960. A Scientific Theory of Culture and Other Essays. New York: Oxford University Press.

Marshall, R. 1990 The Genetics of Schizophrenia: axiom or Hypothesis? In *Reconstructing Schizophrenia.* R. P. Bentall (editor) London: Routledge.

Maslow, A. 1971 The Farther Reaches Of Human Nature. New York: Penguin.

Maslow, A. 1968 Towards A Psychology Of Being. 3rd Ed. New York: John Wiley and Sons, Inc.

Maslow, A. 1954 Motivation And Personality. 3rd Ed. New York: HarpurCollins.

Mattingly, C. and Linda C. Garro 2000 Narrative and the Cultural Construction of Illness and Healing. Berkeley: University of California Press.

Meyendorff, J. 1997 Microsoft® Encarta® 98 Encyclopedia. © Microsoft Corporation.

McGrath, A. E. 1999 Christian Spirituality: An Introduction. Malden, MA: Blackwell.

McTaggart, L. 2003 The Field. London: HarperCollins.

Milgram, J. and G. D. Burrows (editors.) 2001. Psychology And Psychiatry: Integrating Medical Practice. New York: John Wiley and Sons Ltd.

Moody, R. 1983 Life After Death. New York. Bantam.

Morris, C. W. 1956. Varieties of Human Values. Chicago: University of Chiago Press.

Murphy, G. 1947 Personality: A Biosocial Approach to Origins and Structure. New York: Harper & Row.

Murray, C. J. L. and A. D. Lopez 1996 The Global Burden of Disease. Geneva: WHO.

Department of Health and Children, 2001 National Health Strategy, Fairness, and Fairness. Dublin: Stationery Office.

Department of Health and Children. 2005 Reach Out: National Strategy for Action on Suicide Prevention. Dublin: Health Services Executive.

Newberg, A., E d'Aquila and V. Rause 2001. Why God Won't Go Away. New York: Ballintine Books.

Nichols, A. 2003 A Spirituality For The Twenty-First Century. Huntingdon, Indiana:Our Sunday Publishing Division, Our Sunday Visitor, Inc.

North Western Health Board, 2004 Mental Health Promotion Strategy and Action Plan 2005-2010. Sligo*:* Health Promotion Unit.

Nussbaum, M. 1990 Love's Knowledge. New York: Oxford University Press.

O'Brien, L. 1969 The Friendly Way To Mental Health. Kilkenny, Ireland: GROW Ireland,

O'Callaghan, G. 2003 *A Day Called Hope.* Hodder and Stoughton.

O'Donohue, J. 1997 Anam Cara: Spiritual Wisdom from the Celtic World. London: Bantam Press.

O'Donohue, J. 1997 Eternal Echoes: Exploring Our Hunger To Belong. London: Bantam Press.

Oppenheimer, M. 1975 The proletarianisation of the professional. In *Sociological Review Monograph, 20*.

O'Sullivan, K. (ed.) 1986 All In The Mind: Approaches To Mental Health. Dublin: Gill and Macmillan.

Parker, I., E. Georgaca., D. Harper., T. Mc Laughlin and M. Stowel-Smith 1995 Deconstructing Psychopathology. London: Sage.

Parsons, A. 1969 Belief, Magic, and Anomie: Essays in Psychosocial Anthropology. New York : The Free Press.

Payne, M. 2000 A Dictionary Of Cultural And Critical Theory. London: Blackwell Publishers.

Pelto, P. and G. Pelto 1984 Tools of Research. In *Anthropological Research.* 2d Edition. Cambridge: Cambridge University Press.

Piaget, J. 1960 Language and Thought of the Child. Cleveland: World Publishing.

Pike, K. L. 1967 A Stereoscopic Window on the World in Language. In *Relation to a Unified Theory of Structure of Human Behaviour. 2nd ed.* The Hague: Mouton.

Pilgram, D. and A. Rogers *1993* A Sociology Of Mental Health And Illness. Maidenhead: Open University Press.

Preble, R. C. (editor) 1962 Britanica World Language edition of The Shorter Oxford English Dictionary. Vol. 1. London: Clarendon Press.

Pribham, K. H. (ed.) 1993 Rethinking Neural Networks: Quantum Fields And Biological Data. In *Proceedings of the First Appalachian Conference on Behavioural Neurodynamics.* Hillsdale, N. J: Lawrence Elbraum.

Radin, D. 1997 The Conscious Universe. San Francisco: Harper Edge.

Raftery, M. 2005 Irish Times 26th June.

Ramon, S. 1986 The category of psychopathy: its professional and social context in Britain. In P. Miller and N. Rose (eds.) *The Power of Psychiatry.* Cambridge: Polity Press.

Rank, O. 1971 The double: a psychoanalytic study. Chapel Hill: University of North Carolina.

Rappaport, J. and E. Seidman 1881 The Development of an Evaluation Research Grant Proposal for GROW.

Rappaport, J. and E. Seidman 1987 Overview of GROW Research Project.

Rappaport, J. and E. Seidman 1985 Preliminary and Interim Reports on the Status of Self-help and Serious Psychopathology.

Rappaport. J. 1988 The Evaluation of GROW in the U. S. A. and its Significance for Community Mental Health.

Rappaport, J., M. Reischl and A. Zimmerman 1988 Mutual Help Mechanisms in the Empowerment of Former Mental Patients. In *The Strengths and Perspective in Social Work. S*aleebey. D. (editor).*Practice: Power in the People*. White Plains, New York: Longmans.

Rappaport. J, 1990. GROW is Results! –not just Good Intentions. Annexure 8.

Ricoeur, P. 1992 Oneself as Another. Chicago and London: The University Of Chicago Press.

Rivers, W.H.R. 1988 Medicine, Magic and Religion. London and New York, Routledge.

Roberts, M. B. 2002 Power to Heal. NUI-Maynooth Library.

Roberts, M. B. 2004 Detaching and Departing Concepts: Anthropology of Dying In Hospice Care. NUI-Maynooth Library.

Rogers, C. 1967 On Becoming a Person. London: Constable.

Rogers. C. 1980 A Way Of Being. Boston: Houghton Mifflin Company.

Rogers, C. and B. Stevens 1982 Person to Person. Pocket Books.

Róheim, G. 1950 Psychoanalysis and Anthropology: Culture, Personality and the Unconscious. New York: International University Press.

Romanucci-Ross, L., D. E. Moerman and L.R. Tancredi 1997 The Anthropology Of Medicine: From Culture To Method. (3rd Ed.) Westport, CT: Bergin and Garvey.

Rose, N. 1990 Governing the Soul. London, Routledge.

Rothman, D. 1983 Social Control: the uses and abuses of the concept in the history of incarceration. In S. Cohen and A. Scull (eds.) *Social Control and the State.* Oxford: Basil Blackwell.

Rynkiewich, M. J. and , J. P. Spradley 1981 Ethics And Anthropology: Dilemmas. In *Fieldwork. Florida:* Robert E. Krieger Publishing Company, Inc.

Salger. M., L. Mc Fadden and J. Rappaport *1991* Mental Health Professional's View of Professional Support and Mutual Help Groups.

Saris, A J. 1994 The Return of the Repressed: Bringing Culture Back to Psychiatry. In *Culture, Medicine and Psychiatry 18: 115-133. 1994.*

Saris, A J. 1995 Telling Stories: Life Histories, Illness Narratives, and Institutional Landscapes. In *Culture, Medicine and Psychiatry. 19: 39-72, 1995.*

Saris, A J. 1995 Mad Kings, Proper Houses, and an Asylum *in Rural Ireland. American Anthropologist.*

Saris, A. J. 2000 Producing Persons and Developing Institutions in Rural Ireland. In *American Ethnologist 26 (3): 690-710.* American Anthropological Association.

Saunders, C. 1978 Management of Terminal Illness. London: David Clarke Publishers.

Scheper- Hughes, N. and M. Lock 1987 The mindful body: a prolegomenon to future work in medical anthropology. *Medical Anthropology Quarterly, 1: 6-41.*

Scull, A. 1979 Museums of Madness. Harmondsworth: Penguin.

Seymour, W. 1998 Remaking The Body. London, Routledge.

Shore, B. 1990 Human ambivalence and the structuring of moral values. *Ethos*: 18 (2): 165-179.

Spindler, G. D. 1978 The Making Of Psychological Anthropology. Berkeley: University Of California Press.

Steadmen, H. J., E. P. Mulvey and J. Monaghan J. 1998 Violence by people discharged from psychiatric inpatient facilities and by others in the same neighbour-hoods. *Archive of General Psychiatry,* 55: 393-401.

Steinglass, P. 1987 The Alcoholic Family. New York: Basic books.

Stocking, G. W. 1983 Observers Observed: Essays On Ethno-graphic Fieldwork. Madison: The University Of Wisconson Press.

Struve, N. 1968 Pseudo-religious rites in the USSR. In Donald R. Cutle, (ed.) *The Religious Situation.* 1968 pp 757-64. Boston: Beacon.

Schwab, J. 1989 Psychosomatics: *The Journal of Consultation and Liaison Psychiatry. 30: 245-254.*

Department for Health and Children 2006 A Vision For Change. Dublin: Stationery Office.

Szasz, T. S. 1961 The uses of naming and the origin of the myth of mental illness. *American Psychologist. 16: 59-65.*

Szasz, T. S. 1974 Law, Liberty And Psychiatry: An Inquiry into the Social Uses Of Mental Health Practices. London: Routledge and Kegan Paul.

Szent-Gyoergyi, A. 1974 Drive In Living Matter To Perfect Itself. *Synthesis, Spring 1974: pp 12-24.*

Taussig, Michael. 2000 Vicerality, Faith, and Scepticism: Another Theory of Magic. In *In Near Ruins*: Mimesis and Alterity. N. B. Dirks (Editor) 1993 London: Routledge.

Thompson, L. 1969 The Secret of Culture. New York: Random House.

Tolle, E. 1999 The Power of Now. Britain: Hodder and Stoughton.

Tomkin, E. and D. Bryan 1996 Political Ritual. IASSA , Sweden: Gothenburg Press.

Turner-Crowson, J. and A. Jablensky *1987* WHO Survey on Self Help Groups and Mental Disorder

Turner, E. 1992 Experiencing Ritual. Philadelphia: University of Pennsylvania.

Turner, V. 1957 Schism and Continuity in an African Society. Manchester: Manchester University Press.

Turner, V. 1969 The Ritual Process. London, Routledge & Keegan Paul.

Turner, V. 1974 Dramas, Fields and Metaphors. Ithaca: Cornell University Press)

Turner, V. 1982 From Ritual to theatre: the seriousness of human Play. In Liminal to Liminoid in Play, Flow and Ritual. New York City: Performing Arts Journal Publications:

U. S. Department of Education 1986 What Works About Teaching and Learning. Washington DC.

Van Gennep, A. 1960 The Rites Of Passage. Chicago: The University of Chicago Press.

Vitebsky, P. 2001 *The Shaman*. London: Duncan Baird.

Ware, K. 1999 The Soul in Greek Christianity. In *From Soul To Self.* Crabbe, M. J. C. (ed.) New York and London, Routledge.

Waters, A. 2005 Growing To Maturity. Kilkenny: Grow (Ireland) Ltd.

Watts, M., J. Rice and P. Purcell (eds.) 1996 Soul Survivors. Vol 1. Kilkenny: GROW (Ireland).

Whorf, B. L. 1956 *Language,* Thought, and Reality: Selected Writings of Benjamin Lee Whorf. Massachusetts: The M.I.T. Press.

Wikan, U. 2000 Life in One's Lap. in *Narrative and the Cultural Construction of Illness and Healing.* C. Mattingly and L.C. Garro (Editors) University of California Press.

Wilber, K. 1993 The Spectrum of Consciousness. Illinois: Quest

Wilber, K. 1996 *A Brief History Of Everything*. Dublin: Gill and Macmillan.

World Health Organisation. 2001 The World Health Report. Mental Health: New Understandings. Geneva: WHO.

World Health Report. *2002 Prevention and Promotion in Mental Health. In Mental Health: Evidence and Research.* Department of Mental Health and Substance Dependence. Geneva: WHO.

www.grow.ie

www.HRB.ie

www.irishpsychiatry.com/public.html#2

www.mhcirl.ie Mental Health Commission web-site.

Zuess, J. 1999. The Wisdom of Depression. Newleaf: Dublin: Gill and Macmillan.

Appendix 1

Topics for Discussion with GROW members.

(a) How long have you been in GROW?

(b) Did you do the Leadership Program?

12 steps (on page 5 of The Blue Book).

1 Do the 12 steps follow in the sequence of the book or in what way do they have an order for you?

2 Is step 1 a good starting point for you? How can GROW help Those who cannot take Step 1, that is about 30 to 40 % of those who come to GROW for help but do not stay?

3 What is your understanding of God in step 3?

4 How do we accept ourselves as in step 4?

5 How do we know when we reason instead of working with our feelings and imagination as in step 8?

6 How do we train our will as in step 9?

7 How do you understand being responsible and caring in step 10?

The Group Method.

8 How important is it to write a personal testimony in section 2?

9 How far can we go in personal problem solving in section 2?

10 In the act of surrender what do we mean by the word surrender (page 78?

11 Why do we learn The Blue Book off by heart? (Is this a form of programming?)

12 How important is it to have refreshments at the end of the meeting? (instead of being in the middle for example).

13 Why should all in attendance reply to the Recorders questions when filling in the Recorder's sheet?

14 How has GROW helped you? Would you change anything about the Group Method or the 12 Steps to Recovery and Growth?

General Topics.

15 How necessary is it for GROW to remain independent of the HSE?

16 How politically active should GROW become and how strong can GROW become politically?

17 Can people who do not have a faith in God get well?

18 What services can GROW not provide for its members? What is the limit of support that can go?

19 Suggestions of other items I should be paying attention to.

20 Any books or articles that you would recommend.

Appendix 2

Topics for discussion with General Practitioners.

1. How long have you worked as a GP?
2. Why did you prefer GP to more specialist work?
3. How much do mental health problems arise in your work?
4. How do you recognise and treat them?
5. In which cases would you call in a psychologist or psychiatrist?
6. What are the main causes of mental illness?
7. What are the chances of full recovery from mental breakdown?
8. How often would you get involved in committing somebody?
9. How do you feel about that?
10. Did psychology and psychiatry feature in you medical education?
11. In what way do you understand the word – holistic?
12. Do religious or spiritual issues arise in the course of your work?
13. Do you do continuing education programs in these areas?
14. Is this an area of work that would attract you to specialise in?
15. Is the role of GP: a profession, a vocation, a job, or work?
16. What is the main personal characteristic that makes a good GP's?
17. What support groups do you recommend to your patients?
18. What reference book mental health do you recommend for GPs?

Appendix 3

Topics for discussion With Mental Health Professionals.

1.0 Endogenous and reactive conditions: Are there any others general kinds of mental illnesses?

2.0 Where does “learned behaviour” fit in with these?

3.0 Where does Autism fit in?

4.0 Can people recover permanently and totally from any or all of these?

5.0 Where or what are the boundaries between medicine, neurology, psychiatry, psychology, psychotherapy and chaplaincy?

6.0 Does each have a distinct purpose or how do they relate to each other?

7.0 Does the “Multi-disciplinary Team” approach to mental ill-health care work?

8.0 What is your view of: (i) spirituality? – (ii) religions?

9.0 What is the difference between a “belief” and a “delusion”?

10.0 Should there be different strands of psychiatry for each religious denomination or other morally or ethically based group?

11.0 How does spirit or soul influence the mind?

12.0 Do you have a topology of body, mind and soul?

13.0 How do you distinguish between body, mind and behaviour or how are they related to each other?

14.0 Why has the 1998 / 2001 Act, referring to acute care admissions, not been ratified?

15.0 How should ideas of law and of mental ill-health be decoupled?