



5-2013

Relational Identities: Reclaiming Ourselves through Recreating Each Other in Collaborative Conversations in Group Therapy Work

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Recommended Citation

Quintas, Celia and Burnett, Christopher F. (2013) "Relational Identities: Reclaiming Ourselves through Recreating Each Other in Collaborative Conversations in Group Therapy Work," *Peace and Conflict Studies*: Vol. 20 : No. 1 , Article 5.

DOI: 10.46743/1082-7307/2013.1146

Available at: <https://nsuworks.nova.edu/pcs/vol20/iss1/5>

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Relational Identities: Reclaiming Ourselves through Recreating Each Other in Collaborative Conversations in Group Therapy Work

Abstract

This project took place at an outpatient mental health setting, and offers new understandings in our pursuit for communal well-being. It documents the unique participation of group members in the co-creation of new knowledge and better understanding of human relationships using a participatory action research methodology. The article explores how improvements can take place in the lives of people diagnosed as chronically mentally ill. It demonstrates how a postmodern, collaborative approach to group therapy impacted the ways in which persons diagnosed with serious and chronic mental illness recreated their identities, thereby affecting their ways of relating to others and to themselves. It examines the social and communal components of understanding human behavior, moving away from an intrapsychic and individualistic framework. Doing so allows us to expand our awareness and utilize our humanity in the treatment of people who have been diagnosed with mental illnesses. The role and power of collaboration are illustrated by considering the unique ways group members presented their ideas and behaved with one another. Possibilities for more sustainable ways of living together and sharing meaningful moments are considered. This article can serve as an invitation for how mental health professionals can also contribute to a culture of peace.

Keywords: *group psychotherapy, mental illness, Ohana Project, participatory action research (PAR) methodology, relational identities*

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Cover Page Footnote/Acknowledgements

This paper was first presented at the Taos Institute Conference entitled "Exploring Relational Practices in Peacebuilding, Mediation and Conflict Transformation: From the Intimate to the International" held in November 2012 in San Diego, California. Peace and Conflict Studies was a co-sponsor of the conference.

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Abstract

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Introduction

There has been a long tradition and history of discontentment with traditional approaches to mental health treatments (Melucci, 1994; Orford, 2008; Revenson & Seidman, 2004; Szasz, 1974). The medical model, under the influence of psychiatry and pharmaceutical companies, has dominated the ways in which people’s emotional suffering and distress have been conceptualized. Consequently, the stigma, fear, and demoralization

associated with the diagnoses and treatment of mental illness have shaped the lens through which society sees, and therefore cares for people with psychiatric histories. People who have experienced emotional difficulties, such as loneliness or self-doubt, or who have lost the ability to make sense of shared, common habits of living, are often ostracized, medicated, and left with a severe sense of shame, failure, and guilt in addition to the side effects of the medications prescribed to them.

However, there is an alternative way to conceptualize the idea of mental illness, an approach that attempts to reshape the relationships between mental health professionals and people diagnosed with severe mental illnesses. It does so by shifting the focus away from diagnosing and treating individual, intrapsychic symptoms. Instead, this alternative moves toward seeking to create meaning out of people's experiences, amplifying their knowledge by identifying social, political, and cultural influences in their behavior. This unique approach to conceptualizing mental illness can help individuals reclaim their *personhood* and restore dignity for the people who have been considered mentally ill.

This research project describes my experience working at a small, private psychiatric hospital in an intensive outpatient program, where I facilitated group psychotherapy for people diagnosed with severe mental illnesses. Some of the group members actively experienced psychosis despite taking many medications that were dispensed daily at the assisted living facilities where they resided. Members attended the program three to four days a week to join conversations that were social invitations to gain more understanding about what was going on in their lives. The group attended to Medicare/Medicaid patients who lived off monthly disability incomes collected by the ALFs where they lived in the local community. The patients attending had been diagnosed with chronic mental illnesses through a psychosocial assessment and psychiatric evaluation taking place prior to being placed in the group. Most had been hospitalized numerous times, for long periods, in psychiatric institutions before coming to the facility, and they had all faced serious socioeconomic constraints on top of their emotional losses. They had also been prescribed multiple psychotropic medications, which at times contributed to their inability to participate in the group conversations. These medications, however, also allowed patients to live in our communities rather than be jailed in psychiatric wards.

As a therapist at this facility, the "Ohana project" was my initiative to provide group members with a sense of belonging in a safe, communal environment—a place for them to come, feel accepted and believe that their contribution in the construction of a culture of

peace will benefit all. All this became a negotiation taking place routinely from the moment they were picked up by vans at their assisted living facilities. In a previous job, I witnessed how mental health services can perpetuate feelings of inadequacy and amplify deficiency in the lives of people diagnosed with chronic mental illnesses. When I first met some of the people who later became members of the Ohana group, I witnessed their experience of feeling misplaced, and it mimicked what I had previously seen. They arrived with a diagnosis of chronic mental illness and were still sent home for not meeting the criteria for the programs in place at that time. However this time I felt able to make a change. I quickly went to the director of the program, and shared with her some of the ideas I had in order to include them in our community. Two weeks later they started attending group meetings at the outpatient program and joining the efforts of the Ohana project in our community.

I served as the facilitator of the group conversations and proposed activities for an average of 12 patients. The group was formally named *Reconnections*, but its participating members knew it as *Ohana*. Ohana means *family* in Hawaiian. Every time we had to introduce ourselves to a new group member, Eve, one of the group members, liked to add, “In Ohana, no one is forgotten and no one is left behind.” Once this posture was manifested, it continued every time we initiated a group meeting, even at times when someone was missing. Our work derived from everybody’s participation. It also relates to how one’s participation was elevated. Ideas and feelings were invited, not discounted or left behind. Each one’s contribution had the potential to bring awareness, knowledge and more understanding.

One member of the group named Eve, or the “little prince”, was elected the spokesperson of our group, despite his speech impediment. He was perceived as the one who participated most in the group conversations. He always had ideas to share and opinions to give. His odd physical features, like his deformed hands, with fingers webbed together, and a cleft palate, gave added poignancy to the beauty of his person and the creative richness of his mind. He commanded attention and his challenges sparked vivid discussions and learning moments. Rather than isolating himself because of a mental diagnosis, like he had in the past, he found space and offered stimulating starting points for many of our explorations. With us, his ideas were not confirmations of his oddness and mental illness diagnosis. Eve’s presence gave voice to many of our questions within our group. We collaborated in creating answers that were meaningful and novel. We learned to explore what led us to formulate questions, and to appreciate the notion that someone benefits not only from our answers but also our questions.

Eve initiated the way we, in the group, introduced our work together to new members and modeled the preferred language and behavior we used to talk and interact among ourselves. Because group members were highly attuned to the ways we talked and related to each other, we created an environment in which we did not reenact, through our interactions, the neglect and disrespect learned and perpetuated through past experiences. My presence in the group purposefully illustrated an active role, as I participated, facilitated, shared, interpreted, and learned like any other group member. I often reminded the group members of their expertise in life; my own expertise, combined with my clinical experience, created tasteful ingredients for the soup of knowledge we created through our conversations. The soup of knowledge was the idea that I invited them to attend to. As we conversed in group, I reminded them about their roles in our performances and actions together as we dialogued. I used to say that there was a caldron in the center of our circle that we stirred with our ideas, feelings, words, and actions, and that we were all nourished by it.

Szasz (1974) emphasized that people diagnosed with problematic behaviors do not necessarily need to present any physical pathology in order to be considered medically ill. However, they may violate social, moral, ethical, or legal norms dictated by social expectations and stipulated by dominant norms created for social conformity. In such cases, the apparent mental illness is not an illness but actually a social status. “In actual contemporary social usage, the finding of a mental illness is made by establishing a deviance in behavior from certain psychosocial, ethical, or legal norms” (Szasz, 1960, p. 115). Moreover, according to Levine, Perkins, and Perkins (2005), some forms of mental health treatment place problems exclusively within the boundaries of the individual, emphasizing blame and isolation and dismissing the social and political components of the concept of mental illness. Furthermore, Levine et al. call attention to the consequences of restricting our understanding to individualistic explanations of people’s problems. They emphasized:

Mental health professions in general and psychiatry in particular, contributed to the incidence of mental health problems by confirming and helping to enforce existing social norms. By defining mental illness in isolation from social conditions the profession distracted attention from social issues that were at the root from abnormal behavior in the first place. (Levine et al., 2005, p. 63)

The Ohana program invited people diagnosed with chronic mental illness to become more responsible, by generating an environment that allowed for the re- and co-creation of people’s

social identities. We elevated our sense of community with the purpose of bringing forth our social responsibility, emphasizing the importance of perceiving and speaking about our experiences in a relational manner, and encouraging a sense of interconnectedness among everyone. The process that takes place in the lives of people diagnosed with a severe mental illness diminishes their capacity to perceive their influence on the lives of others. If people are considered ill, their disability can invalidate them socially. They are not usually expected to experience feelings, share emotions, or manifest affection like most other people do.

In our group meetings, we made explicit the social difficulties faced by members of the group outside the group setting. We created alliances across different environmental issues affecting the lives of group members, such as housing, issues with roommates, medical visits, transportation, community resources, employment, hobbies, and others. Many of the mental health services currently offered to the community are housed in institutions or settings guided by the dominant view of psychiatry and its diagnostic and individualistic conceptualization of human behavior. According to Scheff (1966):

One frequently noted deficiency in psychiatric formulations of the problem is the failure to incorporate social processes into the dynamics of mental disorder. Although the importance of these processes is increasingly recognized by psychiatrists, the conceptual models used in formulating research questions are basically concerned with individual rather than social systems. Genetic, biochemical, and psychological investigations seek different causal agents, but utilize similar models: dynamic systems that are located within the individual. In these investigations, social processes tend to be relegated to a subsidiary role, because the model focuses attention on individual differences rather than on the social system in which the individual is involved. (p. 9)

Disease prevention efforts in our modern health system strongly rely on individual efforts for success. Revenson and Schiaffino (2000) illustrated how assumptions and causes of illnesses in our existing society focus on individuals' faults. Consequently, interventions for better health and lifestyle are based on campaigns that still target individuals rather than attending to the environmental contributions that lead to constructions of such misbehaviors; "then health interventions will be limited to persuading individuals to discontinue these behaviors, either through health education, fear appeals, or negative reinforcement" (Revenson & Schiaffino, 2000, p. 473). Revenson and Schiaffino (2000) made reference to medical

conditions such as heart disease, cancer, and stroke, for which medicine has achieved progress in treatments. Although society has not made the same progress in understanding so-called mental illnesses that has been made with other medical conditions, the same medical model continues to dominate the ways in which mental health providers address the concept of mental illness and provide services to the community. Dalton, Elias, and Wandersman (2001) emphasized,

Instead of preserving rigid lines of expertise between mental health professionals and their patients, it involves finding ways that persons with disorders may help each other, or ways that persons with disorders may be enabled to assume greater autonomy in managing their lives. (p. 9)

As a result, a change in a system entails reviewing the assumptions of the people involved, impacting social constructions, and creating changes beyond the individual.

Anderson (1997) described how the postmodern movement in the social sciences illustrates the way we are moving from a stagnant, detached, hierarchical, unidirectional, linear stance to one that is lateral, embraces togetherness, attends to the contexts of systems and multiple perspectives, promotes dialogue, and exposes our need for one another. The language of traditional and mainstream treatment neither permeated nor expressed the preferences of those with mental diagnoses for trusting relationships, respect, and their desires to share ideas, show affection and speak their minds. It mostly served to maintain what had been subtly told to them: "I see you and hear you as a mentally sick."

We cared for the ways we listened to each person's stories and interpretations, attempting not to instill shame or fear when someone's ideas and hopes were being expressed in the group. Some members of the group had difficulty putting together their thoughts and we gradually learned to wait in silence as if we could almost see the creation of a thought in someone's mind. We elevated the notion that one's contribution and participation mattered to the group. In the process, we found healing in a few minutes of silence and patience.

When I was curious about a particular topic, and I was the one inviting the group to a particular area of exploration or group dynamic, I asked them to reflect on what they thought had inspired me to make such an invitation. There was a continuous effort to make visible the knowledge we carried and the new understandings we created together. Anderson (1997) elaborated on knowledge, the individual, language, and therapy from a modern perspective, and how these forces interplay and can be interpreted differently through a postmodern view of human behavior. In the modern tradition, "knowledge is representative of an objective

world, existing independently of the mind and feelings . . . and is universal and cumulative” (Anderson, 1997, p. 30), and language is only a representation. The metaphor of the human mind as a computer-like machine (Anderson, 1997) confined within an autonomous individual and the view of the human being as an independent observer of reality richly depict us as being self-sufficient. Our role of powerful and distant authority is manifested in the way we interact with our environment, believing it to be constantly available for us to exploit, use, and dispose of. From the modernist view, relationships based on hierarchical dynamics are created and maintained to support status. Some dictate norms and right ways of being in the world, possessing social, educational, economic, and political privileges; others are subjugated and placed in a submissive position, passive followers, observers of their realities, and recipients of knowledge.

Anderson (1997) alerted us that a mental health professional, “as representative of a dominant social and cultural discourse, is the knower of the human story and what that story should be” (p. 31). The therapy process, according to Anderson, can perpetuate silence and oppression by placing the therapist in the role of *superior expert* of clients’ lives, assessing and pointing to their limitations and disconformities and rendering them mere actors of a diagnostic script. According to Anderson, “Professional and cultural labels classify and place people; they do not tell about them” (p. 33). On the other hand, the postmodernism movement offers different focuses and possibilities. As a critique, postmodernism opens space for questioning the modernist view of the world with its emphasis on universal truths. It challenges:

The scientific criterion of knowledge as objective and fixed . . . rejects the foundational dualism of modernism, an outer real world and a mental inner world, and is characterized by uncertainty, unpredictability, and the unknown.

Change is a given and is embraced. (Anderson, 1997, p. 36)

Andersen (1992) elaborated on the notion that *knowledge* was considered by Plato and his followers to be a source for explaining and predicting; creating rights, wrongs, and truths; and using either-or lenses to interpret human behavior. He proposed:

The discussion that has been introduced by postmodern philosophy . . . yields other concepts in addition to those which have dominated thought for a long while, including mythos in addition to truth, metaphor in addition to concept, figurative in addition to literal, imagination in addition to reason, rhetoric in

addition to logic, and narrative in addition to argument. (Andersen, 1992, p. 61)

McNamee (1992) elaborated on the modernist and postmodernist orientation to therapy and differentiated the unique focus of each of these traditions. In the modernist view, therapy is an opportunity for rational problem talk through various models and methods, with the intent to uncover an individual's essence—through systematic observations and comparisons—and form conclusions. “Although these therapeutic approaches vary, they all share in the focus on individual rationality, techniques of observation, and belief in progress” (McNamee, 1992, p. 191). Postmodernism, on the other hand, is marked by a focus on language and on how people interact in the process of constructing their realities. Moreover, it invites openness in the rescue of a plurality of perspectives—some which were previously silenced or ignored. This shift in traditions represents progression from the individual as the sole generator of events to a communal and relational starting point in the search for understanding of any situation, in our ways of speaking, of asking questions, of positioning ourselves before one another. Consequently an opening of a multiplicity of propositions for possible answers can become available for us as endless points of explorations. “How do particular interactive contexts privilege one form of discourse while other contexts provide opportunities for vastly different discourses? This is the postmodern question” (McNamee, 1992, p. 191).

Shotter (1993) explored four main points that illustrate the changes taking place in the humanities from a postmodern perspective and the implications those changes have for the social sciences. The author noted differences in how researchers position and present themselves and then participate within the investigatory arena. Shotter explained, “There is a movement, first from the standpoint of the detached, theory-testing onlooker, to the interested, interpretative, procedure-testing participant observer” (p. 19). The researcher attends not only to what he is able to observe and reflect on, but also to the influence of his observing process. There is “a shift from a way of knowing by ‘looking at’ to a way of knowing by being ‘in contact, or in touch with’” (p. 20). A new set of research topics is attending more to what happens between people as the locus of investigation. The study of human behavior is entering a parade of changes, “giving rise to a non-cognitive, non-systematic, rhetorical, critical, social constructionist approach to psychology” (p. 19).

Collaborative Lenses: New Practices in the ‘With-nessing’ of Group Therapy Work

The Ohana project was an illustration of how collaborative practices and the joint efforts of a group of people provide a sense of belonging and togetherness. These practices, in turn, can be quite influential in the promotion of well-being and the offering of hope for better ways of understanding the complexity of life. Moreover, the Ohana project provided evidence of improvement in the welfare of individuals who had been diagnosed with severe mental illnesses and struggled in carrying the labels and stigma associated with such diagnoses. Our conversations created an environment where symptoms and their manifestations were placed in the background of our daily routines. Group therapy sessions focused on life scenarios which became invitations to assume preferred identities in the permanent process of construction through which we interacted and contributed to each other’s lives. “There is no hidden self to be interpreted. We ‘reveal’ ourselves in every moment of interaction through the on-going narrative that we maintain with others” (Lax, 1992, p. 71). Our conversations in the group sessions were generated by events taking place in the group or in the local community, and they were brought to the group’s attention by group members. Our experiences of these events were storied in our group meetings.

According to Cecchin (1992):

The expression of our experience through these stories shapes or makes up our lives and our relationships . . . through the very process of the interpretation within the context of the stories that we enter into and that we are entered into by others. (p. 98)

The topics for our conversations in the group varied from relationships to social/self-awareness; family dynamics; feelings; social systems; social-esteem; past experiences, both good and bad; abuse; trauma; and successful stories. Any topic was welcomed. This practice, based on constructionist ideas (Anderson, 1997; Gergen, 2001, 2006; Gergen & Gergen, 2008), freed us to use group time as an endless landscape of possibilities for conversations. As we spoke together, we attended to the ways we articulated our ideas, as the “words we use—just like the names we give to each other—are used to carry out relationships. They are not pictures of the world, but practical actions in the world” (Gergen & Gergen, 2008, p. 15).

Additionally, I used to place the notes I would write down during our conversations on the center of the table inside our circle, to give the patients the opportunity to review our conversations, learn more through the comments I had written about our process in group, and verify the accuracy of their quotes in the progress notes that I would later document in

their medical charts. I also liked to read back to the group some parts of what they shared. This was another way to invite awareness by noticing group members' contributions through the hearings of their own ideas through the sounds of my voice. I often asked them to share why though I did that and what they thought was informing my action, as a way to invite more reflections, emphasize their contributions to my ways of thinking, facilitate dialogue, and invite them to interpret our conversations. We practiced transparency in our *with-nessing* of each other's contributions in group. This concept of *with-nessing* manifested itself in our experience of being with each other and, in being together; we witnessed in each moment each other's life performance and our own.

In his work on the process of constructing therapeutic possibilities, Cecchin (1992) acknowledged the contribution of therapists' hypotheses, claiming that they serve as bridges which not only inform the beginning of a conversation but also establish a connection between the realities and all the elements of the scenario that patients come from. He also referred to the importance of language and how "humans use words to caress each other" (p. 90). In this way, words and hypotheses—in spite of their content—allow people to get in touch with each other.

Patients' Voices and Language as Actions

Gergen and Gergen (2008) remind us that language exposes our performance as people in relationship with one another, reconstructing ourselves each time we meet. "In a broader sense, we may say that as we communicate with each other we construct the world in which we live" (Gergen & Gergen, 2008, p. 11). Language can create new realities and maintain old traditions. The ways in which human experiences are languaged illustrate and sustain relations of power and privilege, fashioning professions such as psychiatry and psychology, promoting certain values, favoring dominant ideologies, and guiding ways of being with each other in the world (Gergen, Hoffman, & Anderson 1996). According to Smith (2007):

Psychiatry did not rise up one day and slay the ancient voice like a mythical dragon. Rationality did not up and murder irrationality. But somewhere around the eighteenth century, the culture's way of thinking and talking about unusual experiences alters markedly. What was once revelation and inspiration becomes symptom and pathology. What was piety and poetry becomes science and sanity. In public discourse, voice-hearing becomes a force of harm and an experience to eradicate. (p. 13)

In Ohana, we were carefully vigilant of the language we used to speak with each other. Patients were invited to reflect on what practices we were promoting as we spoke and paid attention to whether our ways of relating through language were coherent with the kind of people we were continuously choosing to become.

During group conversations, I presented alternative stories as contributions to the equally valid stories the patients would tell; together, we co-created new ways of understanding and speaking about different topics. We had conversations as we increased our awareness and appreciation of each group member's ideas and points of view. In this way, a multitude of possibilities became available. Consequently, the rapid speed of thoughts and ideas, the urge to stand up and circle nervously while searching for an idea or a word, or the spontaneous generation of a seemingly off-topic question were all embraced and considered valuable contributions and bridges of connection among group members. As a result of this accepting stance, no group member's participation was lost, and any movement in the direction of expressing experience had the potential to become dialogue and an invitation for the creation of stories and learning opportunities. Group members' initiatives towards elevating their presence in the group were neither minimized nor discounted exclusively as manifestations of psychiatric symptoms.

One's words are a transparent means through which one can achieve a sensible contact with those around one. Only if we switch our metaphors, only if we begin to talk of knowledge "by being in touch" do we begin to raise the kinds of question that make contact with the issues here: to do with the rhetorical "shaping" and "moving" functions of language. (Shotter, 1993, p. 23)

The Ohana group faced difficult moments when some of the group members chose to participate and elaborate in ways that seemed senseless to the rest of the group. However, the group learned about *respectful listening* practices and understood the benefits of hearing one's own voice, feeling heard by others, and experiencing respect. Andersen (1992) took this idea further by presenting the concept of "co-presence", which refers to a person's ability to sit still, remaining respectfully and silently accessible, fully present, and celebrating just being with the other. As Andersen proposed, "Might that be the most significant of our contributions: to listen to the quietness of the troubled one's thinking?" (p. 63).

I often reminded the group about the importance of full acceptance; by doing so, I attempted to bring down any walls of shame, any possibilities of recursive behaviors for the perpetuation of previous experiences. I was alert not to feed further and maintain *the*

pervasiveness of past experiences serving solely as reminders of inadequacy and deficit, when their uniqueness and difficulties had been considered merely psychiatric symptoms. As Gergen (2001) articulated,

We may all agree that there is something unusual about an individual's behavior, but why should we suppose that the community of clinicians and psychiatrists are correct in calling it a mental illness, and that DSM categories are maps of this world? (p. 12)

This idea was simply performed in group, with the assumption that there was always something to be learned from one another. We *co-created* ideas, performing the knowledge we continuously built during our group work.

There were times that members of the group engaged in conversations I found difficult to follow, and I openly expressed this, making public my difficulties and asking if what one member was saying made sense to some of the other members. This co-elaboration of our group work process often translated into an invitation for a group member to relate and then elaborate, rescuing his or her contribution from an echo of loneliness to a call for more dialogue. According to Becvar, Canfield, and Becvar (1997), "One does not know and cannot predict which story will be meaningful to which group member" (p. 116). My transparency also became an invitation to other group members to jump in, relating to the speaker or rescuing a thought, idea, or feeling that otherwise would have been lost, its fruitfulness wasted. This communal knowledge, which we continuously recreated, became like food for each one of us. We constantly added to our *soup of knowledge*, a nickname given by the group to our conversations, in which we stirred our ideas and feelings as we interacted and created knowledge with one another.

I tried to remind the group of our social responsibility as part of the group and our need to be responsible for the progress of the group's conversations, work and growth. Social constructionists McNamee and Gergen (1999) proposed the idea of relational responsibility as a posture we take as we present ourselves when speaking. The idea in our group was that we languaged our stories through relational lenses rather than in individual terms. By conversing relationally, we framed the ways we talked with each other, attending to the vivid relationships manifesting themselves among us as we interacted in conversation. Moreover, our group process became part of a gradual invitation to influential people, whom we had internalized and embodied through our life journeys, to take part in our dialogues. Our intention was to make present in our dialogues a multiplicity of intelligibilities that we

acknowledged as contributors to the persons we were becoming. Gergen (2009) claimed that “in the process of relational flow, we generate durable meaning together in our local conditions, but in doing so we continuously innovate in ways that are sensitive to the multiplicity of relationships in which we are engaged” (p. 46). We, in Ohana, distanced ourselves from the traditional discourse of personal blame, moving instead toward a discourse in which our voices came together in our search for better ways of acting, relating, and understanding our process of being, living, and growing.

Group members were encouraged to reflect on how the group benefited if one member chose to share a particular idea or event and excluded others, prioritizing the well-being of the group and how the group members benefited from it. Many times, I invited the patients to engage in asking one another questions. When someone was sharing an event, a memory, a dream, or a wish, I asked the group to ask questions, engaging the group members to not only be attentive to the conversation taking place but also to use their intelligence and heart. The act of asking questions became a point of connection for us all, as we engaged with and became prepared for one another, making ourselves accessible and available to the group. According to Becvar et al. (1997), “Questions are used both to deconstruct stories, and to create new stories” (p. 116). Being attentive to the close relationship between the influence of questions and the openings for more conversations and the understandings they may generate allowed us to be creative and curious. Gergen and Gergen (2008) reminded us of one of the main characteristics of social constructionism, as it continuously alerts us to maintain a posture of curiosity and respect for one another. We explored how and what each one of us decided to bring to the group, based not only on our version of events or past experiences but also our cultural traditions. “Something has happened for them, but to describe it will require that it be represented from a particular cultural standpoint—in a particular language” (Gergen & Gergen, 2008, p.11). Accordingly, I invited the patients to become inquisitive in their search for better understandings of group members’ points of view and to be sensitive to whose influence we were favoring as we were choosing certain topics instead of others, attending to particular ways of behaving over others, or prompting ourselves to be present and hear others’ sharing. Patients were reminded that they were constantly exercising their right to choose in every move they made in the group, including when there were none, as there were times that some patients were tired or overly dominated by medications and were, therefore, unable to participate fully. In general, the happenings and choices taking place in the group were done mindfully. We voted to decide whether we

would let a tired group member take a nap during group time, and the group talked about whether everyone found it acceptable for someone to decide not to participate in our conversations by just saying, “pass.” Whichever way a group member chose to be in the group created a pause for reflection for the rest of the group, including my invitation to take things to a vote or other group dynamic I presented. Gergen and Gergen (2008) proposed:

We thus become curious about whose traditions in particular are honored or unquestioned, and whose voices are silent or suppressed? . . . Do we necessarily want to embrace this way of constructing the world and the future it will create for us? (p. 26)

These were questions I posed directly at times and, at other times, in more subtle ways. My intention was to elevate our level of awareness and respect for one another and to attract us to meet again the next day. We provided each other with comfort and security, and were constantly reminded of our potential to be better people. In the group, we elaborated on our ways of being, and we asked ourselves if the way we were performing our moment with one another was consistent with the people we wanted to become, as we joined together in search of more understanding and a better life, both within our group meetings and in the community.

One of the main characteristics of our conversations in group was our emphasis on “undiagnosing” as we conversed. If what patients shared was only clinical material for the purpose of fulfilling labels’ expectations and assessments, we would have lost track of what brought us together in the first place, which was our search for dignity and respect, and a sense of belonging. Furthermore, this would have maintained what was already known.

I have witnessed how diagnostic discourses are embedded in our understandings of mental health and how they dominate the ways we speak about each other’s emotional experiences and difficulties. It may facilitate communication among treatment providers and provide some sense of tangibility for persons experiencing certain manifestations. However, this poses risks, for it can lead to the creation of a wall of words and ideas, limiting more understanding, preventing meaning making, and unquestionably isolating people. Life after a formal mental health diagnosis can be storied as a mixture of guilt, fear, mystery, shame, and resentment. Revolving hospital doors become stages for choreographed dances of repeated psychiatric admissions and outpatient treatments. The psychiatric diagnosis given earlier in participants’ lives had become who they were, and the only way they had available to speak about themselves. Through a language of deficit, expressing and defining deficiencies of the

self (Gergen, 2010; Gergen, Hoffman, & Anderson, 1996), labels of mental illnesses take over one's identity and one is robbed by a system that from then on dictates who one is. This could be called a kind of identity theft. If labels of chronic mental illnesses can take away the potential of individuals to manifest and work on their beliefs, dreams, aspirations, and narrowing down life to a path of conformity to clusters of behaviors, in Ohana labels became then irrelevant, purposefully neglected, denounced, and demystified.

So we attempted to exclude practices that reduced to symptoms the richness of the diversity of the ways we manifested creativity, imagination, and the unique ways we spoke and communicated our ideas and expressed our feelings. Therefore one member's disclosure of the experience of paranoia he had in the workplace when he took medications in front of others, or the fear another one felt as he walked the streets of an unsafe neighborhood and heard the feelings of inadequacy, loneliness, and uncertainty were not simply manifestations of a symptom of schizophrenia due to one's core deficit and merely challenged as a distortion of perception but explored, interpreted and deconstructed.

These manifestations became tools for more self and social understanding of one's experience in life, due to a contextualized and meaningful group work translation of the performance of a community we are all part, a community that we contributed to create. We were attentive to denounce how language could perpetuate limits and silence through a discourse of deficit and normality, and doing it we were moving towards the *co-creation* of a culture of peace.

Researching Knowledge and Generating Understandings

The possibilities offered by participatory action research (PAR) methodology, including challenging the status quo on oppressive practices that keep marginalized groups under scrutiny and control (Chenail, St. George, & Wulff, 2007), appealed to me as a way to research this project. Moreover, its focus on attending to local knowledge, contextualizing and favoring the language and experiences of participants (Chenail, et al, 2007) met the criteria on which the Ohana project was developed. Action research methodology intensifies action and the generation of new knowledge in which the acts of performing knowledge, interacting, and participating together are indivisible in the research process (Reason & Bradbury, 2001). Action research is "only possible *with, for and by* persons and community" (Reason & Bradbury, 2001, p. 2). Elden and Levin (1991) emphasized the importance of the role played by participants in the research process as active and interacting agents, promoting

changes within their social realities. They explored how they initially used the term *collaborative action research* to refer to such methodology.

This merged well with my belief in the Ohana group project because of its collaborative tone, which weaved our work together. The ongoing process of socialization during group meetings, such as social abilities (ways of greeting each other, social manners), ways of speaking, choices about asking questions or passing, and the topics proposed for conversations were all manifestations of our emphasis on the relationships we had with each other. Group members were invited to examine their knowledge (understandings, skills, and values) and interpretive categories (the way they interpret themselves and their action in the social and material world) It is also participatory in the sense that people can do action research only “on” themselves, individually or collectively. It is not research done “on” others (Kemmis & McTaggart, 2003, p. 385).

Group members were invited to share how social, political, economic, and cultural circumstances in the larger community had affected them, and to learn with each other about their impact on people’s lives, how they had managed their lives, and possible ways of changing them. We promoted more understanding, the practice of solidarity, and the sense of social and communal responsibility. There were also old learned tendencies of isolation, fear, and shame that our work together called to change. We were encouraged to share with each other our most threatening moments, when secretive voices permeated our minds and threatening feelings became overwhelming. We were with each other and provided comfort and safety. These practices gave us emancipatory ways to relate to our memories and emotions and, therefore, to each other. The Ohana project can be an illustration of how theories of mental health can be applied and how they can challenge the dominant, traditional way in which mental health professionals have attempted to treat people diagnosed with severe mental illnesses.

This approach can offer an invitation to examine our practices and possible changes if we conduct these relationships to include working and understanding through being with each other. As articulated by Giddens (1979), “Every social actor knows a great deal about the conditions of reproduction of the society of which he or she is a member” (p. 5).

Participatory Action Research Methodology enabled me to use my own reflections as an active participant, facilitator, collaborator, and researcher of the Ohana group. In addition, it allowed me to provide the readers of my research with a better understanding of our experiences working together, the impact of Ohana on our established relationships, and the

new ways we learned to adapt in order to promote more relational possibilities and more respectful and sustainable ways of being. What would I do differently? I can say that every moment was different, and there was always something singular happening. I needed to be different and continuously rethink my choices and actions throughout this journey, finding ways to maintain that difference.

Finally, I looked at each one of the group members that participated in Ohana with the intention to learn and, ultimately, be inspired by them. Through Ohana I also recreated myself through the reclaiming of those involved in working together. I am taking these experiences with me and, moving on in life in the lessons ahead, I will recall Ohana, and the family we were in the shape of a group therapy work.

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