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Weathering a violent storm together – witnessing and co-constructing meaning in collaborative engagement with those experiencing psychosis-related challenges

Lizette Nolte

Abstract

The experience of psychosis can sweep into a life like a violent storm. In this paper I firstly attempt to fully imagine the experience of such a storm by drawing on first person accounts and then consider the clinical encounter between mental health practitioners and those who find themselves amidst this storm. I reflect on ways we can better support meaning-making of, and purposefully living with, these potentially intensely distressing and disturbing experiences. Drawing on Narrative and collaborative practices, I consider grounding the embodied experiences related to psychosis, honouring the stories of severe and enduring mental health problems and the life experiences that lead to them, accompanying people in their meaning-making of these experiences and joining in the fight against stigma. In particular, the importance of walking alongside those in the throes of the storm and bearing witness to their suffering is highlighted. Finally, the implications for the training of mental health professionals are considered.

Keywords

Psychosis; Mental 'illness'; Clinical encounter; Witnessing; Meaning-making; Narrative; Collaborative practice; Mental health practitioner training

"And are we not of interest to each other?"

Elizabeth Alexander, Ars Poetica Nr. 100: I Believe, "Crave Radiance": 185

The violent storm[1] of psychosis

This paper considers the clinical encounter between mental health practitioners and those who find themselves amidst the violent storm of psychosis-related psychological distress. Despite many people living meaningful and fulfilling lives around and despite severe psychosis-related distress, it can be devastating in its impact on a person's life, sense of self and place in society.

By fully imagining the experience of psychosis, we as practitioners can consider what might be of most use in people's contact with us at times of such intense distress. This allows for a re-imaging of the therapeutic encounter, away from what Jurecic (2012: 6) calls the "loss of intimacy" between persons experiencing distress and practitioners and towards a more humane 'withness' (Hoffman, 2007). First-person narratives are drawn on to take us closer to these experiences, allowing us as practitioners to reflect on useful ways to respond.

Providing embodied grounding

The way psychosis-related experiences are described by those in the throes of such experiences is often intensely visceral. Gareth[2] describes it such: *"Everything feels… magnified… it's also tremendously physical, it's like a… it's not a tirade, it's beyond a*

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[1] The metaphor of 'a violent storm' and other conceptualizations of the experiences of psychosis described in this paper are taken from interviews from a recent study into the experiences of parenting and psychosis. For a full description of the study, see Nolte and Wren, 2016. All information has been anonymized to protect the identities of those who shared their stories.

[2] Pseudonyms are used throughout to protect confidentiality

tirade, it's a typhoon… yes, it's a violent storm…" Psychosis can relentlessly take hold of a person's mind, undermining reason and choice, as Carla explains, "*it was just extraordinary, because I was hearing this voice and it was telling me to do all these things and… it seemed so real, you know. And I was doing it [what the voices were telling me to do] as well…"*

Such strange, extra-ordinary experiences can feel emotionally *"frightening… a nightmare"* (Faith), leading to an intense sense of fragility. However, at these times of great personal vulnerability people find others often responding to them as dangerous, fear-provoking or eccentric, as Grace powerfully describes: *"I was shouting to people 'why won't you help me', 'why won't you help me' and… I remember a woman on a bike and she was actually kicking out at me and saying 'get away from me'."* It can therefore be that when a person is feeling personally most vulnerable, they can also be left feeling most alone.

Such experiences of rejection can lead to people feeling cautious about beginning to talk about their most challenging psychosis-related experiences – to express intense raw emotions and to speak of personal suffering can feel perilous when one already feels vulnerable and exposed. Furthermore, the experience of trying to tell of such powerful and disturbing experiences can feel potentially overwhelming and destabilising. Thus, it becomes especially important that practitioners are able to create a containing space for such conversations to take place, a space where the person can experience themselves as grounded as they start to speak of their experiences. Interpersonal warmth and calmness, an attunement to the person's expressions and a valuing of the conversation can go a long way towards creating such a space.

Honouring stories of suffering

Beyond these intense embodied experiences of psychosis, people can find that once a period of mental distress had been experienced, their sense of self and their lives are altered irrevocably and they can find themselves living with what Penn (2001: 37) has called a future that it "wounded". The unpredictability of psychosis can make life perpetually uncertain. *"I think it steals up on you and… then you're in it and you don't realise you're in it until you're in it",* Karen says. Dreams for the future can be lost as plans repeatedly come to nothing and the rhythm of life is continually interrupted. At times, for some, hope can be lost. "*I don't know, I don't know, I don't know, I don't know, believe me, I don't know... I'm lost, I'm lost…"* expresses Lamine.

Making sense of such troubling experiences is challenging, as much can feel confusing, indescribable or even unacceptable. These experiences of extreme psychological distress can be seen as lying on the fringes of conceptualization and conversation. Thus, people can learn to censor their narratives and remain silent, or feel silenced about, what they are going through. Faith says *"the memories are all there – you can still remember it, but you do not want to talk about it. I remember everything, (but) I am not comfortable talking about it."* Safe spaces are needed where such broken stories can be heard and where the silencing of stigma and the silences that come from confusion and fragmentation can be countered.

As mental health practitioners we therefore need to create such safe conversational spaces where stories of psychological distress, no matter how frightening, disturbing or fragmented, can be told and respectfully heard; where we can provide what

Weingarten (2004) refers to as accompaniment, a form of compassionate witnessing of these stories. Weingarten (2004: 152) highlights the meaningful experience for any of us at times of illness and distress when we enter into a relationship with a clinician and we experience a matching and reflecting of our own “internal, perhaps even unarticulated, explanatory model” for what is the matter and what can be done about it. She describes how this matching, this deep experience of being understood, allows one to settle in to do the work that will bring relief and also to make sense of oneself within the context of the illness or distress.

Thus, the nature of the therapeutic relationships that we facilitate with those who consult with us becomes highly significant. In this regard, I particularly appreciate Ness, Borg, Semb and Karlsson’s (2014: 3/8) description of this relationship as a process of “walking alongside” someone - listening generously to the person, taking the person seriously, seeing their experiences as meaningful and showing respect for their choices, preferences, hopes and concerns. This represents a focus on people’s everyday lives, activities and relationships, including their developing relationship with us within the therapy context, and on their personal descriptions of their troubles. The work that narrating their experiences in this way can do for people as they respond to their challenging circumstances, is potentially highly significant. It may allow someone to more easily come to terms with forming a new relationship with their body and their mind; it may help them feel more able to face the challenges they are living with; and it may allow them to more readily make changes that will support their well-being.

Katz and Shotter (1996: 919) describe the meeting between a practitioner and someone in distress who consults with them as a “delicate negotiation” between two worlds. During this delicate negotiation people do not only describe their pain, but also share their vitality, their values and attitudes and those aspects of themselves that can move towards health, inviting new possibilities of meaning and action. These authors warn that clinical training often involves being socialised into narrow cultures of professionalism, inviting clinicians to leave behind other aspects of themselves and responding to others in predetermined, limited and non-creative ways. Instead, they encourage us as practitioners to position ourselves to be “open to being 'arrested', or 'moved'” (Katz and Shotter, 1996: 919) by what those who consult with us say and do, allowing us to come closer to understanding their experiences of suffering. This not only validates their understandings as response-worthy, acknowledging the uniqueness of their lives and experiences of their difficulties, but also opens up the potential for new meanings to unfold.

Finally, human possibility can be brought into view and hope can be cultivated. Weingarten argues for fostering a “reasonable hope” (Weingarten, 2010: 8) as a significant part of moving to wellness; that is, a hope that focuses on what is within reach, while acknowledging the uncertainty and unpredictability of what is to come. Thus, through listening generously, bearing witness to people’s struggles and honouring stories of suffering, but also of strength, new therapeutic possibilities can emerge.

Accompanying people in their meaning-making

A particular challenge faced by those who experience psychosis-related distress, especially within the context of past experiences of trauma, is that their experiences can at times feel beyond narration. At such times the story cannot be told; people can become overwhelmed by their experiences and the narrative fragments and breaks. Here, as Gareth becomes increasingly distressed, his narrative loses coherence: *"I also think… I never really understood it all whether, I never understood particularly the full account of her, of how I'm, but I never (inaudible-upset)… Um-um... Yeah yeah... I just felt the most outrageous indignation, because they… and it's partly that they're just not fast enough on their feet, which I (quiet and inaudible) or… if I ask a question, wait for the answer… in that state it was like being tortured …"*

The most troubling and disturbing aspects of mental distress can thus often remain outside of conceptualization and conversation. At such times accompanying people in their meaning-making becomes significant. Rather than privileging abstract factual explanations (e.g. psychiatric diagnosis), we as mental health practitioners can become deeply interested in people's personal idiosyncratic understandings of their difficulties (Denborough, 2005). A stance of openness, curiosity, 'not-knowing' and collaboration as developed within postmodern family therapy approaches (Anderson and Goolishian, 1992) and narrative and collaborative approaches (Strong, 2000; White, 2007; White and Epston, 1990) can open up new relational possibilities and create contexts for personal meaning-making and identity construction.

The late Michael White and David Epston developed Narrative Therapy from the position that the problem is the problem, the person is not the problem. Thus, they suggested working towards externalising the difficulties, that is separating the problem from the person and allowing the person to chose a name for the problem that is meaningful to them. From this externalised position we as practitioners can then richly engage with the person’s own constructions of those difficulties, fully explore their narratives of the influence of the problems on their lives, while also deeply engaging with the solutions people have already discovered in dealing with their difficulties (White, 1987; White and Epston, 1990).

In a conversation with someone like Gareth above, describing his experiences as like a ‘violent storm’, we as therapists could for example become interested in what the violent storm looks and feels like and we could aim to fully understand when and how it sweeps into his life and which areas of his life are most affected by the storm. However, from this Narrative therapy position (White, 1987) we would also be deeply interested in Gareth’s responses to the storm. We would want to understand how he has learned to prepare himself when he feels the storm building. We would want to know whether there are ways he has learned to minimise the impact of the storm on different areas of his life and how he sustains himself through a storm; and we might also be particularly interested in whether there are any parts of his self or life that the storm has not been able to touch. As therapists this allows us to position ourselves alongside someone like Gareth and align ourselves with his values and his hopes and dreams for his life. Thus, restricting narratives of living can be re-authored and narratives of preferred ways of living more richly developed.

Similarly, collaborative approaches as described by Anderson and Goolishian (1992), Hoffman (2007), Strong (2000) and others, drawing on the view that narratives of distress are socially constructed, emphasise the clinical encounter as a space where meanings are negotiated; where existing meanings can be deconstructed and new meanings can emerge. These authors encourage practitioners to remain very close to a person’s experiences, while also creating a context of openness to new possibilities. This again positions us as therapists alongside the person experiencing difficulties. Rather than ascribing general depersonalised medical explanations (of e.g. ‘schizophrenia’ or ‘bipolar disorder’) we can remain interested in the unique personal explanations of the particular person we are in conversation with.

Furthermore, narrative and collaborative approaches allow the person and practitioner to consider the implications of any such ascribed explanations for psychosis-related distress. This allows the therapist and client to return the normalizing gaze (White, 2002) and positions us in relation to any specific explanatory framework. We could ask whether a particular framework ‘fits’ and feels helpful to the person in making sense of their experiences or whether there are other ways of understanding that better capture their lived experience. From this position, as therapists we can then begin to look for new avenues opened up by alternative constructions of the difficulties.

This also enables an engagement with and elaboration of a person’s preferred identity. For example, where Grace above describes feeling baffled about no one responding to her call for help, we as therapists may become interested in what this tells us about what Grace might do if she was to find herself in a similar position with someone else asking her for help. We might then wonder with Grace about what values might underpin what she would do and how this speaks to what Grace stands for as a person; that is, we are situating the person in the landscape of identity (White, 2007) where their sense of self is actively linked to their values and their actions.

Again, such narrating can potentially do highly significant work. It can “reclaim patients’ voices from the biomedical narratives imposed upon them by modern medicine” (Jurecic, 2012: 3). Massfeller and Strong (2012: 196) refer to this as “conversational agency” to emphasise the client’s participation in therapeutic dialogues and shared meaning-making. In particular, it invites people into a consideration of the implications of their difficulties for their sense of self. This process can involve both storying one’s experiences and one’s (preferred) self and a process of ‘calibration’ in response to living with the new self and others’ reactions to self. Through accompanying people in this way in their meaning-making a coherent and personally meaningful understanding of their difficulties can be co-constructed and a sense of the continuity of self can be restored (Denborough, 2005).

Joining in the fight against stigma

Finally, these experiences do not occur in a vacuum, but rather it sits within the milieu of current dominant social discourses within Western cultures where moments of sadness, distress and human struggle have become problematised (May, 2007) and a moral obligation to be happy is implied (Midlands Psychology Group, 2007). Experiencing psychological distress thus becomes a moral failure and stigmatising perceptions are often internalised. Mualla says *“I started to criticise myself… if there’s something that I didn’t do… like stupid or silly.”*

Many de-humanizing, shaming and stigmatizing experiences can accompany the experience of psychosis and people carrying labels of being psychiatrically ‘ill’ are still often construed as incompetent, irresponsible, unpredictable, frightening, dangerous and in need of social control within our society. These constructions can be internalised and it can be difficult for people to distinguish between themselves and their experiences of psychosis. As Gareth describes, “*I suppose I just feel whatever me is and whatever it is, we are inseparable.”*

Thus, people can feel their known selves are lost. “*I used to be good, I used to be alright, I used to be (a) happy man. I used to be successful and happy. Yes, normal, normal”,* says Lamine. Instead, people can draw negative identity conclusions, which can be compounded by painful relational experiences. Lamine continues, “*You know how they say (to me) these bad things happens to you because God hates me, that’s why. My God hates me.”* Such negative identity conclusions can have highly significant implications for people’s sense of self and for their lives. Stigma thus contributes to both the sense of a ‘contaminated’ or broken self for those with mental health problems and to rendering people silent. Thus, the social practices of pathologising lives has been described as “one of the great marginalisations of contemporary culture” (White, 1995: 113).

Given the implications of stigma for people’s lives and identities, it needs to be constantly considered when working to understand talk with a person with mental health problems and we can support people in examining such stigmatizing practices in society. We as practitioners can clearly communicate that experiencing pain in life is not pathological. As Focht-Birkerts and Beardslee (2000) argue, it is the lack of adequate emotional attunement and responsiveness to painful emotional experiences that renders them unendurable and thus, a source of trauma and damaging distress. Furthermore, pathways to resilience occur not where all conditions leading to wellness are favourable, but rather where contexts of tenderness, connection, kindness and even humour can hold painful experiences and conversations. Thus, as practitioners we can actively counter stigmatising and identity-limiting stances when in conversation with those who consult with us. Furthermore, we can consider moving beyond the therapy room to join those experiencing mental health concerns, advocates and campaigners in robustly battling the limiting discourses of stigma in our society.

In summary, within the current mental health environment we as practitioners are repeatedly confronted with the discrepancy between the complexities of difficulties and challenges we encounter when clients consult us, and the requirement to provide time-limited, standardized, one-size-fits-all packages of care. Within this structure, 'neutrality' and 'objectivity' often are valued and mental health practitioners are encouraged to authoritatively correct or interpret people's experiences, meanings and descriptions (Strong, 2000). Instead, a case is made here for "[profoundly] re-humanising (our) practices" (Weingarten, in conversation with Denborough, 2005: 74), practices that restore dignity and compassion; practices fully committed to understanding the experiences of the person whose suffering is being witnessed; practices where we allow ourselves to be arrested and moved by what we witness. In this way we can fully engage with the complexity of experience shared with us as response-worthy, allowing for subtlety and nuance, for ambivalence and contradiction, with respect and humanity. Furthermore, let us not only share in people's worlds of pain or suffering, but let our conversations also reveal vitality, human dignity, hope and paths to healing (Katz and Shotter, 1996).

The self of the practitioner

Therapy is a sacred space where stories of suffering and hope are entrusted to a therapist. Thus, every interaction is an opportunity to play our part in a transformation towards "cultures of compassion" (Denborough, 2005: 76). Therapy is also a domain where meanings are deconstructed and reconstructed. Weingarten (1999) highlights that we as therapists should hold ourselves profoundly accountable for the meaning-negotiation process we engage in with clients. Therefore, training of mental health practitioners should foster a "high moral awareness" (Malterud and Thesen, 2008: 92) of discursive processes within the clinical encounter, bring an awareness of power differences and facilitate understanding of the implications of the discursive choices we make and the discourses we privilege in our conversations with clients.

Furthermore, therapy, when it confronts us with the often frightening and disturbing experiences related to psychosis, can unsettle practitioners or let us lose our footing. Allowing ourselves to come into close contact with the fragmented, troubling or challenging experiences of those in extreme psychological distress can be overwhelming at times. One can find oneself overcome by emotions, feel frightened, hopeless or powerless to help. At these times we might be tempted to create distance from these experiences and those telling us about them. Therefore, we need ways ourselves to remain grounded and sustain ourselves while we do this work (deep breathing, talking with a colleague, quiet space, time to reflect). Without these we may struggle to remain fully present in conversations with those describing intense distress (May, 2007).

Thus, in arguing for a more humane approach to our clinical work, the argument is not only for the wellbeing of clients, but also for the wellbeing of therapists. In a challenging discussion of therapist burnout Reynolds (2011: 31) refers to “the discrepancy between what feels respectful, humane, [and] generative, and contexts which call on us to violate the very beliefs and ethics that brought us to therapy and counselling work” in the first place. Training could foster a strong, embodied and mindful awareness of these beliefs and ethics that can cultivate “an aliveness… and a genuine connectedness with others…” (Reynolds, 2011: 32) and thus sustain us in our work.

Conclusion

In conclusion, the clinical encounter provides a space where the visceral experience of psychosis can be grounded, where the suffering of those who experience psychosis can be witnessed, where people can be accompanied in the process of finding a way to narrate their experiences and make sense of who they are in relation to these experiences, and where hope can be fostered. For this to be the case, we need to radically re-humanise our services.

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