

## FAMILIES

We began the Village with high hopes for our work with families. They had been strong advocates for the creation of the Village. We included them in our advisory board. They were included in our outcome study. We held several “open house” nights for families emphasizing Social Security and employment. I began doing family psychoeducation classes on medications and mental illnesses. But our programming never grew much beyond that.

Part of what happened was that things went well. We developed good relationships with many of our members’ families. We proved we could be counted on in times of crisis without having to resort to hospitalizations. We could be reached by phone and even made home visits. They no longer lived in as much fear. We took over a great deal of their burden and helped many of their adult children establish homes of their own. Many families went on with their lives. Before I quit bragging, let me add that our most rewarding accomplishment was also the one that took us most by surprise; about half of our members reconnected with long lost family members, parents, brothers, sisters, even kids, after they began to recover and to be proud of themselves.

Part of what happened was demographics. Most adults living in California left their families behind somewhere with worse weather and less beaches. This includes people with mental illnesses. Unlike the nation as a whole, where the majority of people with schizophrenia live with their families, the Village never had more than about 15% of our members living with their families. As we began focusing on homeless and jail diversion members the number of families dropped even more and the percentage of truly abusive destructive families climbed. Transitional Age Youth mainly come out of foster care. Many of them have less family than I had imagined possible. Over the years, there have simply been less and less families around to work with.

That’s not the whole story though. Over the years we’ve had some memorable conflicts with families. Usually we’ve conflicted with frightened families who had been through a lot and wanted safety and protection for themselves and their family member, even if that meant locking them up. Our approach, emphasizing empowerment and learning from mistakes, while aggressively keeping people in the community, was sometimes hard for them to swallow. Sometimes the families withdrew from the conflict, leaving their adult child with us. Sometimes they withdrew with their adult child. And sometimes, after long battles we grew to appreciate each other as recovery emerged. As the Village became more famous, families brought their adult children who they felt had been inadequately treated everywhere else, from far away to be helped at the Village. Needless to say, those scenarios rarely had happy endings.

These conflicts generated the core innovative concept of this next paper; that our program should strive to be surrogate peers instead of surrogate families. I first presented this at the annual meeting of the International Association of Psychosocial Rehabilitation Agencies (Now USPRA) in Detroit.

## Friends with Families

(1997)

Traditionally within the medical model of treatment for people with serious psychiatric illnesses, the relationship between professionals and family members has been poor. One of the problems has been that professionals tend to criticize and judge families who may already be feeling guilty or responsible for their family member's illness. Professionals have forwarded increasingly politically correct, but still blaming, viewpoints of parents from schizophrenic mothers to high expressed-emotion families.

Another problem comes from the nature of the medical model treatment contract: Patients and their families give control to professionals, becoming dependent upon them, in return for our promise to take responsibility for taking care of them. Since we can't actually dispense many cures, frustration, blaming and defensiveness erupts on all sides. From the families' point of view, professionals come crashing down from our pedestals when we're unable to cure their loved ones, exposing our arrogance, inattention, "not caring as much as a parent would", etc. From the professionals' point of view, more often than allies, families are described as intrusive, interfering, sabotaging, infuriating, sending mixed messages, blaming, passive aggressive, etc.

As things deteriorate, we may prescribe family psychoeducation in bad faith so families will stop ignorantly undermining our treatments. They may gratefully accept, so they can learn enough to replace our ignorant, ineffective treatments. Armed conflict, burnout, and more blaming too often are the result.

As illnesses go on, many families and professionals have moved beyond this contract to a more equal, human collaboration. Usually we can find an abundance of shared goals to work on together. Families often have extensive knowledge about their one situation, whereas, professionals usually have broad knowledge about a great many similar situations. If competition can be avoided, we can complement each other. Having a knowledgeable and compassionate professional share a family's life can often be helpful.

Even still, professionals are usually able to perceive a number of pathological things about any family. Bolstered by the belief that improving these family traits will lead to increased maturity and independence for our patients, we are often tempted to try to work on improving these, rather than sharing or empathizing. In fact, improving family pathology is not the normal path to independence. Most of us achieve

substantial independence without ever improving our families. That's one of the reasons why we tend to regress around our families, whoever we are. Families usually don't really change to promote and accommodate our adulthood. But we grow up anyway.

If family therapy isn't the best way to help people grow up, what is? Developmentally, most of the people we work with had their maturation disrupted in adolescence, probably because that's when their illnesses or substance abuse began to seriously interfere. Normally, this is not a stage where parents are the main force behind their children's maturation, so there's no point "fixing" parents or becoming surrogate parents. Adolescents typically distance themselves from their parents becoming blaming, belittling, even becoming overtly hostile to them. Their main emotional investments are in peer groups which may be either very constructive, like a college dorm study group, or very destructive, like a violent gang. Lifelong friendships often emerge. A new self identity, set of values, and roles for adulthood are developed within this peer group with often only minimal influence from parents. Even in adulthood, after relationships with parents may have improved, friends remain crucial.

People with serious mental illness usually lose their adolescent peer group and find themselves unable to develop with just their family's help or on their own. What they need to develop and mature may not be replacement parents, but instead replacement peers and friendships.

Within a psychosocial rehabilitation philosophy it is possible for us to become a replacement peer group. We blur boundaries between staff and people with illnesses so we can be peers. A visitor to our program often can't tell who are the staff and who are the people we're working with. We try to relate, not as professionals to patients, but instead as adults to adults, as concerned and hopefully helpful friends. "Bull sessions" are more useful than psychotherapy in this context. We do a lot of self disclosure. We also developed a clear set of group values, which as with all peer groups may or may not be the same as our parents' values. Our value system includes self-determination and expression, sobriety, overcoming illnesses instead of dwelling on them, a work ethic and identity, material success, social responsibility, and intimacy. At its best this can lead to developing mature adults with lifelong friendships with us.

If the Village is acting as replacement peers instead of a replacement family, the relationship between staff and families changes dramatically. No longer are we competing for the same role, or even collaboration together on it. (For better or worse, there are usually very few other peers to compete with and many of them can be

incorporated on our group.) Families should have the same uneasy feelings dealing with us as they did when their “normal” adolescent children get in a packed car to go to a party, or rock concert, or an incredibly stupid mountain climbing trip. If we get to this point, we’re all relating to a person instead of an illness. Families get to be normal “screwed-up” parents and the Village gets to be normal “screwed up” friends instead of competing caretakers. Then the patients get to be normal “screwed up” adolescents or adults instead of chronic mentally ill patients. Then they have a chance to mature, develop, and grow.

The developmental process is extremely difficult and stressful for parents in “normal” circumstances and becomes more so with the added burden of serious mental illness. Professionals can potentially assist with this burden. We can assist with improving relationships between patients and their family members to facilitate openness, intimacy, and naturally respectful negotiations. Instead of doing this in a formal therapy setting, we are more likely to approach this as a friend of the patient we’re working with. We’d pressure them to increase contact (e.g. “Send your mother a birthday card, meathead!”), we’d share our own experiences, we’d go along to help “break the ice”, etc. Ultimately, we may succeed at this, not because of our knowledge of family pathology, but because we actually are being caring friends.

We can also switch roles (or different team members can have different roles) and become an alternate peer group and friends for parents. Many of our staff are parents, and a few even have seriously disabled children. We can also assist families in forming their own peer groups like AMI. Once again, our boundaries are intentionally blurred so that this peer group can contain both staff and families we’re working with. Once again, we’re may succeed not because of our knowledge of developmental psychology or mental illnesses, but because we are actually being caring friends and fellow parents.

I feel so much older than I did when I wrote that paper almost a decade ago. I can no longer be a peer to our young adult members. I have to leave that to younger staff. I’m simply too old. Somehow my small children have grown up and are in college. I don’t know when all this happened.

What I expected to happen as I got older was that I would start identifying more with our members’ parents and become more supportive to them. While it is true that I probably treat parents better now that I’ve been one for so long myself, I ended up connecting not so much with our members’ parents as much as with our members who are parents.

It turns out that the majority of our members are parents, but that's not obvious because so many of them are separated from their children and never got to raise them. Those separations don't cause most of them to stop feeling like parents. It just means most of them are heartbroken parents. They have this painful black hole in their heart that overflows with tears and it never goes away or even gets much better no matter how many years it's been. As the years have gone on I've focused more and more on that heartbreak.

There's a lot left to learn about families and recovery.