From being dumped by waves to finding shells on the beach: Rediscovering life after a mental health crisis in later life

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There is a myth in the mental health field that medication is the only intervention option for older patients. The patients themselves often believe this myth. Depressed and anxious older people talk of reduced contact with friends and family, withdrawing into themselves, and being judged for not shaking off the illness. Experiencing significant losses of life partners and long friendships, and trying to cope with their mental illness, they often believe that at this time in their lives they are not going to be able to make new friendships and cannot look forward to positive experiences. I wanted to challenge this myth.

Moreno talks of the curse of social death:

> *As we grow older replacements of lost members in significant roles take place with greater difficulty; similar as repairs are difficult to our physical organism in the course of aging. An individual may begin to lose in the cohesion of his social atom for various reasons: loss of affection, replacement by another individual not as well suited, and death. It is probable that the minute shocks coming from social death experiences paves the way to premature aging, old sickness and physical death. Old people should learn not to give in to this curse, they should find friends, someone to love again.*
>
> Moreno, 1947, pp. 65-67

As a group therapist I delight to offer a new way of being, developing skills and imagination; new hope for a future that is otherwise shrinking. A sense of belonging enables respect, builds self-confidence and relationships are formed. A fear I had was working with strong personalities, keeping my boundaries in the face of people with entrenched ideas about their situations and experiences.

The Staying Well Group

I was invited to create a group program for older adults who had been discharged from a psychiatric hospital. I went on to develop and run the Staying Well program for over 12 years. I present here moments from this program, showing how group work, action sociometry and simple psychodrama interventions, produced a culture of kindness and warmth, allowing for playful exploration, the discovery of new friendships and the creation of new responses with people who had felt chronically stuck. Essential to the work, was my growing confidence in the capacity for spontaneity and creativity of myself and the group members, so that we became more adventurous together.

Developing and running the Staying Well program was a new role for me. It provided me a place to continue to learn and extend my experience, and it offered me a great team of colleagues to work with. I was excited that this was a way to further use my counselling and group work skills, and to bring psychodrama more into my work.

My purpose for the group was to reduce isolation. I wanted to create a group where patients could experience being heard, their illness was acknowledged and a learning environment was created; where new skills could be developed that would support recovery.

The Staying Well group was a process group, rather than skills-based. While a gentle educational component was structured into each session, including mindfulness practise, relaxation, simple exercise routines, and education about depression, anxiety and adjusting to life after loss; the focus was on group work and relating to the interests and concerns of the group.

The group was a full-day 20-week program, with an option to repeat the program once. It was the organisation's policy to aim for nine members in each group program. This policy is financially driven. In developing this program I was aware of the need to comply with health fund criteria, organisation policy and consider requests and suggestions from psychiatrists. I thought that seven members worked best for me to facilitate monthly bus trips for outings with picnic lunch provided in an eight-seater bus that I would drive. If I commenced with seven to nine members, it was a closed group. If I commenced with fewer people, the group remained open to new members until we had a full complement of nine group members.

The group members

The group was for people over 65-years old. Referrals came from the psychiatrists connected to the inpatient mental health unit, and every person referred had an assessment to review their suitability for the group. Frequently the group was part of discharge planning, offering support and

structure for those patients still in recovery. In the beginning, 80% of my group were patients I had nursed on the hospital ward.

Most group members had functioned well during their lives, having careers and raising families prior to the intrusion of their mental illness. Some were aware that they had functioned throughout their lives with a mental illness, though it now had become debilitating. Their mental illness was exacerbated by prolonged grief or difficulty transitioning to retirement.

When they joined the group, people presented with high anxiety, low mood, isolation, and lack of motivation to self-care. They typically reported poor sleep, low or no exercise, poor appetite, and substance misuse as a way of coping. They were all mobile and independent, with many using a walker or other means to mobilise and self-care onsite.

Building connections

My focus in the early stages of the group, or when a new person joined the group, was on building connections so that fear and anxiety reduced, and people were able to effectively participate.

Doubling a new group member as she enters the room for the first time
The group of five are very warmed up to each other; they have been working together for six weeks and today a new group member Heather, joins. Heather has major depression with chronic feelings of worthlessness. During her assessment she struggled to find words to describe how she was going or what she hoped to get out of group. She had high anxiety and avoided eye contact.

It is the beginning of the group session. The regular group members, Sam, Liz, Jane, Cath and Peter, take their seats around a large table in the room. They know exactly where they like to sit and chat as they settle into the meeting space. Heather stands just inside the doorway, her body appears stiff as she makes a tentative move into the room, then hesitates. She takes a breath and observes where the chairs are. She moves hesitantly over to the far side of the table, with her head down. The director moves towards Heather and stands beside her, in the position of a double. Heather looks up at the director and they have eye contact.

Director: (doubling Heather) *Where will I sit? I don't know where to sit. Is this spot someone's seat? I don't think I will fit in here, I'm nervous.*

Heather: (her body relaxes slightly) *Is this someone else's seat?*

Director: (warmly) *Heather this is your spot. Please take this seat.*

Heather smiles slightly, making warm eye-contact with the director, then sits down. Heather took up the prompt of the double to ask if anyone was

sitting here. The doubling seemed to settle and focus her in this first challenging moment, so that she could more easily join the group.

As the group progresses, sociometry is built through simple processes that acknowledge the here and now reality of group members

I found that action assisted the flow of dialogue between group members. They could first express themselves in action, and this assisted them to share more. Continuums became a simple intervention that people could readily participate in. The director begins the session making opening comments, welcoming group members and inviting them to speak. Heather's body appears to soften more, her shoulders relax slightly now that the attention is not on her. She appears to be listening, although she does not make eye contact with group members. She becomes more fidgety and appears to pull away from the group as the last group members speak, knowing it will soon be her turn.

Heather: (eyes looking down) *I don't have anything to say.*

Director: *That's fine.*

I pause, making eye contact. I wish to convey that here is a new member of our group, anxious and worthy of equal time but unable to speak at this point. I introduce the topic of the week, anxiety, and invite the group to join in an activity that may be unfamiliar to them. I describe the purpose as getting to know something about themselves and each other, telling a story through action.

Director: *During our 20 weeks together we will learn skills to help with anxiety. To begin with today, we are going to create a scale of your experience of the impact anxiety has on you right now. Stand and place yourself on a continuum. Please use your walking frame or walking stick. At one end against the wall on the left is the point where you place yourself if you have no anxiety (0/10), in the middle is mid-range anxiety, uncomfortable but manageable (5/10), the other side of the room is very high anxiety, awful and distressing (10/10).*

Sam: *Do you mean now? I was really anxious this morning when I left home.*

Director: *Yes, Sam, let's look at what's happening to you now. And yes, our anxiety does fluctuate a lot, even in the time in this group.*

Jane: *I'm not sure, how do I know?*

Director: *Jane, connect with your body. Is your belly feeling tight? What about your chest?*

Jane: (with a giggle) *Oh love, I don't like noticing what's going on for me.* (she places herself on the continuum)

Peter moves slowly to the middle of the room along the imaginary line.

Peter: *Argh…getting out of this chair is an effort for me.*

Liz: (moves to position herself) *My anxiety is in between five and ten* (giggles)

Liz and Heather look at each other, and Heather moves to be near Liz.

Heather: (speaking abruptly) *That's me!*

Liz and Heather smile at each other.

Aware that group members are warming up through being active, I decide to keep the movement going.

Director: *We will share about what you become aware of in a moment. For now, while you are standing, we will have a new criterion: loneliness. Loneliness is often spoken of as the silent intruder of the older person. We will create a loneliness scale. Over this past week show on this scale the impact of loneliness in your life. Beginning at this point I am not lonely; this is not something that impacts my life. The other end of this line represents those who experience extreme loneliness.*

The group move quickly to places on the continuum. This is an easy criterion for them to relate to, and they do not ask for further clarification.

Director: *Look around and notice where you have placed yourself. Are you alone? Do you have one or more companions on this continuum? How was it placing your experience on a graph?*

Heather and Jane are both at the extremely lonely end of the continuum.

Jane: *I never thought I would be on my own in my old age.*

Heather: *I don't live alone. I live with others in a residential care facility, but I am lonely.*

Heather speaks fluently and clearly; this is an important statement she makes here.

Director: (to the group) *How are you going?*

Group voices: *Good.*

Director: *Those with walking frames sit if you need to.*

Everyone remains standing.

Director: *The next criteria is pain. How much is pain interrupting your everyday life?*

There is quite a bit of energy expressed, mumbling as Peter and Liz move.

Peter: *This is where I shine. Pain stops me from doing most things.*

Liz: *I don't like it.*

I notice that there is an easy movement from Sam and Heather. Each know where to go on the continuum.

Sam: *Heather, you and I are here together.*

Heather: *I'm so glad I have strong legs.*

They laugh together; I am aware that mutual tele begins to build.

Director: *The last measurement is insomnia, or poor sleep. Place yourself on the scale from no problem sleeping to poor sleep.*

Director: *Take a seat. Now we will have a time of sharing. What did you become aware of about yourself, and what impact do you think looking at your vulnerabilities may have?*

Liz: *I really liked doing that.*

Peter: *For me it was another way to tell my story. I didn't feel judged.*

Jane: *I feel sad.*

Heather's head lifts, making eye contact as some speak.

Reflections

The purpose for me as group therapist, was to give voice to the physical and mental health concerns the group members struggled with in a way that was different to just talking about them. I use the continuums to assist movement from isolation with a symptom to inclusion in the group and acceptance of one's co-morbidities. A continuum produced gives a place for a statement to be expressed with no judgements or the experience of being shut down for complaining of a symptom. Common themes are identified. The impact of continuums for the group generally is a greater life expression. The movement reduces anxiety. There is group awareness and integration of membership with all involved in the exercise.

The impact of continuums on Heather's expression assisted her to build connections. Heather was very anxious and unable to speak when she joined the group; she was able to communicate with action. Before the continuum exercise, kind eye contact or a smile from a group member was overwhelming for her. After the exercise, she moved toward eye contact

when seated with those she connected with on the continuum. Heather could now receive the warmth being offered from the group.

Group members become auxiliaries to one another

After three to four weeks, I observed kindness and warmth grow. People greeted each other upon arrival and patterns became noticeable. The new group was forming, becoming oriented to the room, to me as group leader and to each other. On reflection they were so courageous. I witnessed them as they built relationships within the group and shared their light bulb moments of understanding. As group members settled into group and with each other, they became aware that they consisted of more than their deficits or symptoms. In an environment of acceptance their strengths and values became more evident.

When I took up my leadership and invited the group to move to find a partner, I considered the less mobile members and requested they stay seated whilst the more mobile members move around. I showed them how to face the chairs. The response was a lot of talking in pairs, deeper engagement was experienced. Talking in pairs reduced anxiety for some, developing moments for self-expression and learning listening skills. A friendliness and lighter atmosphere developed in the room. These group members had a shared belief that one loses friends as they age and finding friendship only happens when young. Now they were discovering something new. They were experiencing friendship. I could see the process of healing take place in the group.

The value of the warm-up phase in a group cannot be underestimated. The time for a group member to warm-up to themselves then to the group is of profound importance to the success of the group work. A good warm-up strengthens tele and can lead to social atom repair. Max Clayton (2004) says "we're always working with the warm-up. We're not just interested, in fact we're not interested at all, in the end product. We're interested in the protagonist developing a good warm-up. And they take that warm-up with them into the world afterwards". I have learned that building tele with one another and with the therapist allows for deeper work to be explored.

At times, group members being auxiliaries to one another had an immediate positive impact

The group members are taking their seats at the beginning of the session.

Noella rushes to speak: *I was unwell when I woke up, I am not good.*

Director: *I'm really pleased you are here. What will help you to remain here with us today?*

Noella: *Sue has already helped me; she carried my cup of tea.*

Sue smiles and touches Noella's shoulder.

Noella: *Just being here with everybody helps me.*

Sue: *I'm not sure what to do when I feel unwell some group mornings, but when I come to group, I always feel better when I go home.*

Noella: *Sue, I like you sitting next to me, I'm so pleased you have recovered well from your surgery.*

Noella is doubled by Sue. There is mutual positive tele between Noella and Sue; this relationship assists Sue to be a spontaneous double.

Later in the session … Sue stands up to change position then sits again.

Cath stands and walks around. I observe her to be a bit agitated as if it was now urgent to move her body.

Cath: *I can't stand it, the back love, my bloody back!*

I validate Cath and Sue for making choices.

Director: *Cath and Sue, you both responded to pain. You both moved, stood up and shifted to ease your discomfort.*

I wanted to maximise what just occurred. I reviewed the options that I was thinking maybe Cath and Sue may have thought. (Doubling and adding some other responses that I thought might be present in the group).

Director (addressing the whole group) *As Cath and Sue sat, feeling their discomfort, thoughts probably passed in their mind. Here are some examples. Let me know if any of these thoughts ring true for you.*

I can get up and walk around to ease pain.

I think I will have to leave group and go home.

I cannot say anything, I must sit in my chair and let tears fall as I suffer in pain.

I can sit and get angry and agitated and think I can't do group. I won't come again.

Before I could add further to the options Noella spoke up, "that's me! I can't get up; I don't want to disrupt the group."

Noella then stood up. Her long-held belief was not to be a nuisance and do not disrupt; she must suffer in silence. These beliefs were getting in the way of accepting support from the group. Her option previously was not to attend group if she couldn't manage sitting through it, "I cannot be an inconvenience."

Noella became quiet and sat taking her gaze far away.

Director: *Sue and Cath, you both were auxiliaries, doubles for Noella. When you stood up responding to your back pain, this assisted Noella to stand up to ease her back pain.*

The life in the group is rich and full in this moment

Noella is beginning to experience that she has choices, and that in this group, when she makes a choice, she is encouraged and not considered 'an inconvenience'. The group had observed Noella's difficulties in walking independent of any aid. She had expressed that she could only use a walker when no one would see her, borrowing her husband's when she was at home.

In another moment in the group, I invite Peter to talk about his experience of using a walking frame, to share this with the group and as modelling for Noella. Noella came to group the following week with her own walking frame. She spoke of how when using the frame she had less pain.

Physical and other limitations can be challenged playfully through action

The focus for the session was on physical exercise. Peter, Noella and Jack made it known to me and the other group members that they don't do exercise. I invited them to come join the circle and modify the activity to their ability, with some movement. I was aware of the fear they held of creating increased pain, and a general dislike of exercise. I invited pairs to start by bouncing a ball to each other. The balls were bouncing everywhere and laughter erupted in the room. Peter, Noella and Jack were willingly involved and bouncing a ball and laughing.

As the group becomes more established deeper issues can be given attention

Max Clayton (1993, p. 87) asks two key questions that awaken me to the questions I wish to begin exploring within my group work: "Can we love ourselves to such a degree that we continue on in spite of feeling insignificant? Can we value ourselves in the midst of loneliness, aloneness and smallness?".

When I, as the group leader, can name an experience and raise a topic that may be taboo with family or friends, the group has an opportunity and a place for this. Sometimes one's shame or guilt gets in the way of talking about such topics as death, fear of the end of their life or the death of a spouse.

Generally, society makes assumptions about how people should respond after the death of a spouse and experiencing relief after a loss can been judged as wrong. One group member, Jane, had struggled with her husband having dementia and being in a care facility, and so when he died, she felt

conflicted. She is able to bring this out in the group, whereas in her family she has experienced being sharply dismissed.

Jane: *On Thursdays I can talk about anything and express my fears with no judgement. I feel guilty if I talk about my loneliness to my family.*

When group members are present in the room and experiences of life are shared, Jane becomes connected. She responds to the sensitivity given to her and she experiences positive tele flowing her way. In the group she experiences new roles and new functioning: she is welcomed as she arrives, her peers are interested in her and she feels heard. She participates in seated exercises; she is learning mindfulness, and much laughter is shared.

Life beyond the group room

> *Ultimately, the task is to make "home" a better place to go to, rather than the group the best place to stay in. Life in the social atom is often not as exciting or as close as it is in the group. The group itself becomes a major part of members' social atom — that is the ethical and therapeutic trap of most groups... This two-way stretch of warming up a group enough for cohesion and creativity, at the same time as providing a frame whereby members (and directors) do not forget what they came for has been alluded to constantly.*
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> Williams, 1991, p.177

Director: (speaking to the group) *I invite you all to think of the things you once enjoyed, and now no longer engage in this activity. Is there something you would like to get back to doing?*

Sam: *I liked going for walks along the beach. I can't do it now. I would have to drive past the cemetery where my wife is buried.* (Pauses). *I miss her so much.*

Director: *Sam choose someone to be you from the group.*

Sam: *umm.... I choose Peter.*

Director: *Now Sam, you take up the role of being your wife Betty. Peter and all of us, we are supporting Sam here as witnesses to his dilemma.*

Director: *Hi Betty, what do you think of Sam no longer driving to the beach?*

Sam as Betty: *It's stupid. Sam loves the beach. He would always talk to the fishermen, asking if the fish were biting, and if they would cook the fish up for dinner.*

Director: *Thanks Peter for assisting Sam.*

Director: *Now Sam be yourself. Sam, you have just heard from Betty about her thoughts on your beach walking. What do you make of all this?*

Sam: *She is right you know. It is a stupid thing in my head. I just thought I couldn't do things without my wife.*

The following week Sam shares with the group of his drive to the beach and enjoying a walk. Smiling as he said, "I did see a fisherman too."

A different approach to endings

After our 20 weeks, group members liked it so much that they did not want the program to end. Endings became a challenge for me as the group leader, just as they were for the group members. I questioned myself, whether I was now responsible for group members experiencing another loss; creating a place of belonging once a week, then announcing this too will end.

For the first couple of years leading the Staying Well group I had an awkwardness around endings. For some folk who chose to repeat the program, I worked with them for 40 weeks. The ending of the program still arrived unwanted. Navigating the sadness and anger from some group members about "why did the group have to end?", almost became a burden for me. I understood they had made new friendships and intimate details of their lives were shared, their question "where do we go from here?" was valid.

With the use of psychodrama techniques and sociometric connections I found new ways to end the group program. This process was life giving for me and each group member.

I now find endings easier. I am creative and spontaneous with group beginnings and endings. I can speak of what is in the room, name it and concretize it. I don't have to fix it or change it. I just bring an awareness to and acknowledge what is. By bringing a curiosity within the group about what has occurred in group from their experience of beginning the program and now the ending of the program.

Fear and anxiety are still present for some members when talking and planning toward the group ending. I can now give more time for the ending experience and hear their expression whether positive or negative of how they are going, thinking about the end of group.

When I look at my own experience of beginnings and ending with ease, I can assist the group to do the same.

In planning for the last day of the group, I request the members to bring along shells or stones that they may collect along the shoreline of the ocean or lake, or that they may have previously collected: one shell for each group member, representing their relationship with that person.

The group begins with open discussion about their fears and plans, recognising that today they are meeting here for the last time. I invite the group to give their collection one by one to the members, and as they give their gift, express what they value about the other person.

The collections vary greatly with Sam bringing very delicate little perfect shells. Peter has large shells from an around Australia trip a few years back. Liz has marked her shells with smiley faces. Rhonda begins tracing on paper her new gift shells and writing the name of the giver next to the tracing. There is much chatter, and great honouring of friendships made within the group. The group members begin talking about how precious the gifts are and the special spot they would be placed:

"I'm going to put these shells on my window sill in the kitchen."

"I have an idea to place them around pot plants on my veranda."

"These mementos are going on my desk."

This ending was different. They were concretizing their relationships, new relationships formed during the group program. Honouring moments shared. The relationships will be remembered. I became aware there was a softening in me, an easiness. I felt less anxious and had a sense that this ending experience was adequate for group members on the day.

Conclusion

Much of Moreno's work was aimed towards improving the situation of the isolated person. He highlights the value of group work; the individual has the potential to feel less isolated. Two processes happen concurrently in a group. There is the one-on-one relationship, who is sitting next to me; and at the same time each member becomes part of the whole, the group. What is learnt in the group can be taken and practiced at home.

The expectation in the health system is that group work with older people will maintain them in the community and at best reduce their admissions to hospital. Yet, the experience in the groups I run is that outcomes can be much more life giving.

One major focus of the work of the group leader is to pay attention to the transitions in the life of the group — the big step of a new member joining the group, and the difficulty of transitioning out of the group when the program is completed. Another major focus is to assist group members to become aware of old patterns, generate new possibilities, and develop new responses to changes in their lives. New roles can be experienced when fear and worry reduce. New relationships can flourish and the experience of living life in older age has value. Learning is possible within the later years or ending phase of life, debunking the idea that when you are older change does not occur with a good outcome. In the recovery phase following

a mental health crisis in later life there is an opportunity for a beginning to new roles and an ending to old ways of being.

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