# MAKING A DIFFERENCE

by

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The articles in Self and Society recently (Aug/Sept) about those "denied access to the pathways of privilege" ("The self-awareness movement - a critique" by Chris Scott, Vol.XIV No.4) were of great interest and I would like to report what it's like delivering psychotherapy to a group from the lower end of the social scale, the working class and poor of the Rhondda Valley. For twelve months I worked in a local authority mental health centre run by the social services in South Wales. I hope to indicate how difficult it is to see, from such a position, that: "The fact that (counselling) is not politics is simply a fact, not a drawback or a condemnation". (The self-awareness movement - a rebuttal" by John Rowan, same issue).

**The Mental Health Centre**

The building we used for the Centre was once a library and later offices, although it looked like a commodious double-fronted Victorian house. It stood in its own grounds, about half way up the valley between small terraced houses.

At the head of the staff team was a clinical psychologist, referred to variously as the officer-in-charge, the project leader or the manager, depending on the orientation of the speaker.

The other member of staff with qualifications in the work we were doing was a social worker from the mental health district team, attached to the centre part-time. I was one of the three day care workers. We were qualified in child-care, teaching drama and stone-masonry! We had a part-time clerk-typist and were assisted by three sessional (part-time) craft workers and four part-time volunteers. This meant that the day-care workers and the project leader were the only full-time staff, which made communication, planning and just knowing who was where when quite complicated, especially as it was the full-time staff who undertook home visits to clients and ran the one-day-a-week satellite centre. So we could be expected to be out of the building on average one and a half days a week.

To further complicate matters about 200 clients attended the centre on a day basis, coming in for perhaps half a day or up to five days a week. We had 40 places per day allocated to us and required a

waiting list. Just the logistics of such an arrangement justified the leader's office door sign: "Come in and join me - I'm having a crisis".

**The Clients**

Our clients all lived in the area but they came to us via a variety of routes. Most were referred by statutory agencies, the hospitals, GPs, health visitors, our own department. Some came to us of their own volition, often recommended or brought along by friends, sometimes just turning up on the doorstep to ask: "Can you help me?" This constantly surprised us: we knew we were known locally as "The Funny Farm on the hill" and people had to be desperate to come in the face of such stigma. Indeed, some refused to come because of it.

Those who did come presented all sorts of problems and histories, from chronically psychotic illnesses through to marital upsets and bereavements. One person's constellation of problems might include being the child of a broken home, being the victim of child abuse, failure at school, difficult family relationships, unemployment, bad housing, epilepsy, agoraphobia, anxiety and depression. Another person might have enjoyed an ordinary life up until a complete schizophrenic break-down or until unemployment left them incapable of ordinary every-day functioning.

Women outnumbered men amongst the clients, and ages went from eighteen to middle sixties and seventies. Many had lived in the area all their lives, although some were from other parts of the country, or had lived away for some part of their life. All were living on low incomes, a tiny minority having been in the professions but reduced by their illness.

**The Work**

To respond to such a clientele we worked with as much flexibility as possible. We provided group sessions and individual therapy, counselling and social work support to about thirty "key" clients each within what was known as "the therapeutic community" or "milieu therapy system". Group therapy ran according to a programme which changed, introducing new groups and moving clients about between groups, every four months. The aim was to have a client attend for no more than one programme, but this was seldom achieved. We had to accept that some had be realistically viewed as permanent clients, but I shall return to this later.

Group activities reflected both the needs of the clients and the skills and styles of the staff members. There were various discussion groups, drama, music, craft, social and domestic skills, keep-fit, health and relaxation training on offer. A maintenance group was run for people with low intelligence or impaired mental functions due to chronic conditions, such as dementia.

The project leader ran a day-long psycho-drama group once a week, assisted by a day care worker. The social worker ran an alcohol education group along social

learning theory lines, while two day care workers used the same principles for the agoraphobic group. These two groups spawned informal self-help sub-groups, whereas the anorexic group was designed for self-help from the outset. The parents' group was decidedly humanistic in its methods.

As the same clients would experience more than one group within the one programme, they were in a position both to take advantage of the various therapeutic approaches and to be confused by them.

**Group Membership**

Clients were selected for groups by the project leader and allocated attendance days to fit the programme. Few, if any, of our clients were in employment and they were therefore available throughout the week. The practice of selecting clients for groups, especially amongst the long-term attenders, tended to create problems of resistance and low levels of motivation. Occasionally a group leader was confronted with a client saying: "I don't know what I'm doing in this group - I don't belong here". In the parents' group they were encouraged to discuss this fully and supported in going to the project-leader for an explanation, but it was a difficult issue to deal with for the (subordinate) group facilitator.

To counter the detrimental effects of the selection procedure however, it was true to say that some clients would not otherwise have gone to any groups, sometimes because the very nature of their illness or problem left them apathetic.

Furthermore, for many of the clients, being selected for "treatment" carried with it a peculiar kind of kudos. People could be overheard boasting of how many groups they attended, and with this attitude prevailing few voted with their feet, staying away on the specified days. In fact, attendance at the centre was such a highly valued prize that on occasion it was used as a bargaining device in contract-making. For instance, a dangerously over-weight comfort-eating woman was offered an extra day's attendance if she could lose 'x' number of pounds in 'y' number of weeks.

**A Place to Be**

Many of our clients lived alone in poverty, in sub-standard housing. We kept the Centre warm, offered meals at reduced costs. provided comfort and friendship, outings and even paid their fares to and from the centre. For emotionally insecure people there was always the opportunity to gain attention, support and sympathy, if not from the staff, then from each other. The rewards for fitting the label mentally ill, for "suffering with nerves", far outweighed the staff's ability to encourage them towards coping and health, but could we have arranged things differently in an humane welfare state?

Was there a way of diminishing the disparity between what was on offer in the Centre and "out there" in the bleak world of South Wales? It's a nasty fact of life that the way we run our society, someone has to be at the bottom of the heap. Our clients

were. Inside the Centre they had a caring, cheap and cosy environment. They attained some level of self-respect within its boundaries, and were treated by a group of professionals with respect, courtesy and care. Outside they were nobodies, with little prospects of ever becoming somebodies.

The staff knew we were being managed by the clients. They weren't confused by the variety of therapeutic approaches; they played us at our own game, moving from group to group, responding to treatment sufficiently well to keep us happy, but never quite well enough to be discharged from the Centre. We couldn't blame them, no matter how frustrated it made us. After all, their desire to remain told us that we'd succeeded in making the Centre an attractive place to be. They allowed themselves to be selected for groups time after time. It was just a price they paid for being amongst those denied the pathways of privilege". They were not self-determined, but given their social circumstances they were determined to cope their own way, to remain in the client role, stigma, labels and all, because it was better than being without a role in the greater society.

John Rowan said it's simply a fact that counselling isn't politics. I don't believe that Our best efforts served to maintain the status quo, we inadvertently entrenched people in their low status and as local authority servants it wasn't our business to whip up political action among our clients. I don't think John Rowan believes it either, given the fact that his writings, and that article in particular, always address the politics of change. As one of my clients told me: "If I changed my ways, no one would notice ? It wouldn't make any difference to the world".