Narrative practice and Intentional Peer Support:

A conversation between Hamilton Kennedy and Shery Mead

Hamilton Kennedy is a mad person who currently works as a consumer academic in the Centre for Psychiatric Nursing at the University of Melbourne. They completed their Master of Narrative Therapy in 2018, during which they worked on exploring notions of failure and the intersections of narrative therapy and intentional peer support. Hamilton can be contacted via email: hamilton.kennedy@unimelb.edu.au

Shery Mead is the past director of three New Hampshire peer support programs, including the world's first peer-run crisis alternative. She has done extensive speaking and training, nationally and internationally, on the topics of alternative approaches to crisis, trauma-informed peer services, systems change, and the development and implementation of peer operated services. Shery's intentional peer support model has now been adopted by several US states as 'best practice'. This trauma-informed approach sees connections and relationship as the core of healing and growth. Her publications include academic articles and training manuals. Shery's current interests include: developing a theory and practice base for peer operated programs, de-pathologising the effects of trauma and abuse, and finding research and evaluation models that accurately reflect the work of peer programs. Shery can be contacted via email: sherymead@gmail.com

Abstract

Hamilton and Shery Mead spoke with each other over the course of 2019. They had been united through their connection to intentional peer support (IPS), of which Shery is the founder and Hamilton a practitioner. Narrative therapy and IPS have both proposed meaningful alternatives to clinical ways of work with people. More recently, Hamilton has attempted to use both of these skills together. You can read about this more in the accompanying article, 'Narrative practice and peer support' (Kennedy, 2019).

Key words: IPS, mental health, narrative therapy, intentional peer support, mental illness

Hamilton: From the banner on the IPS website and throughout many of your writings, the idea of 'social change' is evident. Could you tell me more about what you wanted with this social change?

Shery: I have always thought that IPS had the ability to change conversations and therefore relational dynamics. When another person changes the way that they know and see, it has an impact on all their other important relationships. I've heard people say, 'I find myself doing IPS with my mother' or my neighbour or my kids. That has the potential to affect their other relationships and so on. Selfishly, I had hoped this would eventually have an impact on my neighbours, so rather than wanting to send me to a hospital when I told them I was feeling suicidal, they might ask me what that meant for me and what had been going on.

Hamilton: I too have felt that desire for others to relate to me differently, as well as a desire for others to relate to each other differently. I am particularly interested in the ways that IPS and narrative therapy can create more equal relationships between people. Is this what you intended? And if so, where did this come from?

Shery: First of all, you need to know that I am no expert in narrative practice. I always liked the idea of externalising the 'problem', but particularly felt drawn to Johnella Bird's ideas about relational externalising. I guess I was interested less in individual narratives and more in what can come out of an intentional dialogue.

Hamilton: So, what is intentional dialogue as opposed to unintentional dialogue?

Shery: My hope is that when we practice being both vulnerable and strong, we stand to gain new ways of knowing and new ways of making sense of our experiences. This grew out of my frustration around 'illness narratives' and consequently 'illness dialogues'. Historically, peer support has been about people coming together around shared experiences. The problem with that is that we often come into it with a set of assumptions about what that experience is and what it means (both to us and to other people). If we use that set of assumptions as our starting place then we get into problem-solving based on a clinical paradigm rather than challenging each other's meaning constructs.

Hamilton: I particularly like the ideas in IPS about exploring the 'untold story'. It is a key part of creating a new dialogue. When we come to understand how someone else has created their knowing, we come into the relationship with a sense of presence rather than an opinion about what they should do. Is this equality in relationship?

Shery: I'm not sure I would describe it as equality, rather that people practice not knowing and an awareness of power, and then use the conversation to go beyond the current dynamics. Let's see if I can come up with an example.

Equality: Peter and Paul are doing peer support together. They both experience what they've come to understand as depression, and so their conversation centres around problem-solving depression based on their current understandings.

Practicing mutual vulnerability: Peter and Paul come together knowing that they have very different histories but also an awareness that they've both been labelled with depression. So they might talk a little about how they've learnt to call it depression and what that means to each of them. They will bring a willingness to challenge each other while at the same time respecting each other's worldview. Out of this (hopefully) comes the possibility of new interpretations.

Hamilton: It is really interesting to see how you have differentiated between an equal working relationship and mutual vulnerability. I also thought it was very apt that you described the process of peer support as being both 'vulnerable and strong'. Are these ideas that could be learnt and implemented by narrative practitioners?

Shery: I do think there's a difference between IPS and therapy. I also think that being authentic pushes us towards uncomfortable edges, and one of those edges is sharing hard

stuff with people you work with. It might not be personal information but perhaps sharing some challenging feelings with the person. I think narrative practitioners, more so than other therapists, practice mutuality and vulnerability, but I'd be surprised if they talked about their own experiences with being in mental hospitals and turning into 'mental patients'. But this is stuff I don't know about narrative practice; I might be quite wrong.

I remember having a conversation with Michael White about boundaries. Michael came to Maine many years ago to help start a peer respite program. I was the consultant/trainer for the project. Michael and I worked together to develop a vision for the program. I had read just about everything he'd written up to that point, as well as some of the deconstructionist literature, anthropology literature and systems literature. Also lots of the feminist literature, which is where I started reading Johnella Bird. I didn't work with Michael extensively, but in this particular conversation he said that he thought in terms of personal limits rather than firm boundaries. I assumed that meant that each practitioner would decide what their own limitations were. Is that the case?

Hamilton: Yes, I believe that is what was intended about personal boundaries and limits: workers are ultimately the ones who should decide what they are and aren't comfortable with sharing.

I don't believe that narrative practitioners are known for sharing their own difficult experiences, but I am hoping that there is room for practitioners to respond authentically. Not matching experiences with people, but authentically honouring the feelings that they may have in the work.

I feel as though my experiences of peer support give me a lot of transferable skills and knowledge. For example, listening to and honouring people's stories of hardship and success.

Can you tell me a story about one of your success/hardships with IPS?

Shery: One story I'd like to share is from the very early days of respite. We had started a crisis respite program and were looking at how to set up rules and boundaries since we collectively decided that we didn't like them being stated arbitrarily, but rather wanted them to be negotiated. On this occasion there was one respite guest and one worker. The respite guest had stated firmly that he wanted to go out to a bar that evening but didn't want to go alone. So he talked the worker into going with him. They both drank plenty, but the respite worker was in worse shape than the guest and lost the key to the building. The guest ended up breaking into the building, causing much commotion. After talking about it, we agreed that respite workers probably shouldn't go out drinking when they were working. I honestly don't remember what happened next, but it certainly provided lots to pull apart in co-reflection.

Hamilton: Wow. I think many of us have experienced the difficulties of working with rules and boundaries. What do you think others could learn from IPS about boundaries and rules in their working relationships?

Shery: Negotiating boundaries is one way to avoid 'othering' people. It's more honest and forces the clinician to sit with their discomfort about sharing personal information. When a clinician says, 'we don't share personal experiences here, it's a policy', they're hiding behind their power and can set up an assumption-based relationship. By that I mean a relationship in which assumptions are the starting point and then never get talked about. A person might assume that the therapist thinks they're going to call them relentlessly, or that they must be bad or untrustworthy.

And, while I think sharing personal information is an important part of building relationships, I also think that sharing should be done very intentionally, when there is connection and trust (this is as true in peer support as it is in clinical practice). I do think that what is taught generally about boundaries in clinical programs takes people away from building real relationships. If negotiating boundaries is practiced

(with a lot of co-reflection), I think power dynamics can be made clearer and this can lead to both people growing and changing.

Hamilton: Are there any questions you would like to pose to narrative practitioners or peer-support workers out there? Anything you might like them to reflect on or ask themselves about their work?

Shery: How do you personally combine IPS and narrative practice. Can you tell me a story about that?

Hamilton: *The Charter of Storytelling Rights* (Denborough, 2015) tells me 'No-one is a passive recipient of trauma. People always respond. People always protest injustice'. I suspect many others like me knew this already. People who are diagnosed with a mental illness are overwhelmingly people who have experienced trauma or hardship. Yet many of our accounts of it, including mine, can recount a kind of passivity and don't acknowledge what we did throughout and afterwards in defiance.

An example of this was a young man's experience of 'the bullies'. He recounted experiences that were upsetting for us both. It evoked some of the memories and feelings associated with past events. My knowledge of trauma-informed practice means that I don't want to retraumatise people when talking with them. However, my understanding of double-listening and the associated double-story development meant we were able to avoid this. After this person had disclosed a story of hardship, I recounted a similar experience I once had. I was intentional in disclosing that I (and we) did not passively experience this, and then shared some of the ways in which I had resisted. I chose to do this to develop solidarity through shared lived experience. When done with thoughtfulness and appropriate timing, sharing a personal experience can make the sharing of unique outcomes possible. Such is the nature of a peer relationship. It was through this personal disclosure that we were then able to explore the ways in which he too resisted. One of the ways this boy resisted was through the creation of music, which served to reflect but also resist difficult experiences he had had.

I have found that the solidarity and understanding that comes with a peer relationship allows for a kind of rapport that other practitioners cannot achieve. Once this relationship is established then we can do extraordinary things.

Shery: I agree that that kind of sharing can lead to a deeper, more developed relationship. I was interested to hear about the double-listening and the double-story development. Can you explain what these are?

Hamilton: Double-listening and double-story development were a bit confusing to me when I was first learning about them. For me, double-listening is listening for all that is said (and unsaid) in ways that allow us to counter dominant ideas. For example, there have been times when I believed I was evil and a bad person. If someone were to hear this narrative, they might listen deeply about this but also listen for things that are counter this, like me doing things for others or being kind.

Dominant narratives, such as the idea of the traumatised person or the mentally ill person, are difficult to counter, but when we listen carefully to what people say we can come to hear that all of us have an incredible diversity of experience. For example, I mentioned a boy who had been bullied. I knew that the bullying was not all that had happened in the boy's life. Double-listening is hearing and caring about the traumatic experience while simultaneously being open to the idea that there are other important stories that may be hidden. I knew that the boy would have resisted the bullying somehow. When we double-listen for these moments of resistance, we can begin to develop double-storied accounts of existence.

Double-story development can help us to explore other preferred stories. We are not just mental or traumatised or any one thing, we are all a polyphony of stories.

Shery: I wonder if double-listening is like listening for the untold story, as we do in IPS, except

you're listening for the preferred story? Can you tell me any stories about conflicts you've had with people and how you resolved them? I still find conflict really challenging!

Hamilton: I have had to grapple with conflict ranging from differences of opinion to physical threats. It hasn't always gone well, and at times I have let worry dictate my behaviour, leading me to act authoritatively or to swiftly exit the scenario. I have also found that my positioning as a peer provides me with a significant protective factor against conflict. This is because I am rarely infringing on people's human rights. This is not to suggest there has never been relational conflict, or that I never let people down. I have. A way of attempting to repair relationships has been doing what people in traditional health services do not: that is accepting responsibility and apologising. I can ground my apology by relating a feeling that I might have if I were in a similar position: 'I am sorry for... I know that if this happened to me, I would be furious'. Although this is quite simple, it is more than many health practitioners in Australia would usually do.

Another example of conflict involves me speaking honestly about what I believe without discounting what others are saying. People have mistakenly identified me as being a secret agent, a person in disguise, an angel, or a long-lost family member. Often this has meant people are quite angry with me. When people have become angry with me because they mistakenly believe I am a member of their family, I have said to them, 'I am not your father, but is there something you would like him to hear?'

Shery: I always like the quote about conflict that's something like: 'It's about supporting your own truth while at the same time supporting the truth of the other'. I think I got that from a professor I had in graduate school named Barnett Pearce, who wrote a book called *Moral Conflict* (Pearce & Littlejohn, 1997), which I highly recommend.

I'd just like to say that it's been fun going back and forth with you, Hamilton. It's really pushed me to stay involved and curious. Thank you so much for suggesting this!

Hamilton: I have appreciated the opportunity to stay connected with IPS. It reminds me to always keep going back to ideas and theory that sustain me. I hope that IPS and narrative practice can continue to learn from each other and work together.

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