Abstract
This paper presents initial findings of a new model of care that encourages the rehabilitation of relationships between carers, families and consumers of mental health services. Many models of care have been implemented to enable service providers to achieve better outcomes for the consumer.

However, many carers continue to feel pathologised by the system that cares for their family member. Improving health outcomes and services for carers needs to be as important as improving health outcomes and services for consumers.

This paper presents a new model which is based on research conducted in the trauma and family therapy fields over the past decade.

This model allows service providers to improve their services to carers by reconsidering the impact and possibilities of maximizing the health outcomes for the carer and the consumer who experiences mental illness.

Specifically, this model uses a triadic/systems approach which gives the carer and consumer an effective means of reformulating their relationships. Subtleties in the treatment provided to consumers of mental health services and the service provided to their carers are contrasted and highlighted.

Initial support has emerged into the improved emotional health and relationships for the carer and consumer following the implementation of this model. While a stable definition of this new model continues to evolve, the core theoretical tenets underpinning this approach have remained central to the model for over 10 years.

The new model has provided an approach that enables carers and consumers to effectively restructure, and manage, both crisis and remission periods of the mental illness, resulting in better health outcomes for both.

This paper presents the model, discusses the theoretical tenets, presents data from carers and consumers of mental health services, and case exemplars of the approach. Limitations of the approach are considered along with future recommendations for research.

Introduction
When caring for someone with a mental illness the expressed emotions during the crisis and remission phases of the consumer’s illness may impede effective relationship interaction. Mastering relationship interactions during crisis and remission across many levels of family and environment interconnection is essential for carers, because, the consumer is often reliant on the support provided by their carer/family (Carers Vignette 1, see Attachment A). The impact on a psychological level can be devastating for everyone involved with the mental illness, including the consumer (Karp 2001; Young 1997).
Many carers report the impact of a consumer’s mental illness as similar to walking into a room where the consumer has the flu and is spreading the virus; such is the parallel and infective nature of emotion (Karp 2001): “You cannot help but catch the emotion and absorb the impact” (carer comment). In circumstances where the interactions are relationships and very often, highly emotionally charged because of mental illness, escape from the impacts of expressed emotion during interactions is virtually impossible.

Carers report that while they may come to accept the consumer’s mental illness, and may even adapt to the loss of their former expectations about the consumer; this does not help them deal with the feelings that arise with the ongoing uncertainty surrounding the consumer’s mental illness. The basis of expressed emotions that the carer/families and the consumer use during interactions may appear different, and consequently may be inadvertently overlooked when mental health services are focused on the consumer. For instance consumers are welcomed into care; carer/families feel they are not. Consumers have their emotional turmoil validated; carer/families feel they do not (Young 1997; Ozgul 2003).

Research identifies that significant trauma and attachment crisis involving loss, separation and grief, influence continual realignment and restructuring of relationships in these types of caring roles (Karp 2001; Ozgul 2003; Young 1997). The subtleties concerning this emotional turmoil “on another day” could easily be reversed. The paradox being that the consumer could be the carer, or the carer the consumer. Such fine distinctions require therapists and mental health systems involved in care to distinguish and monitor a variety of impacts on all relationship interactions surrounding both parties.

Grant, Ramcharan et al. (2007) identified that self agency and resilience were linked in the caring role, and related to: (a) The environment level which includes mental health services and individual therapists, (b) the individual level (themselves) and (c) family level of relationship interactions. Carer/families report that, feedback from each of these levels often means that they feel resilient and effective, or marginalised and useless in their caring roles (Rickwood 2005: Karp 2001).

Resilience is identified as a multi dimensional, constantly morphing component of an individual’s ability to cope during adversity. Resilience or lack thereof, arises from the self image that emerges from the interpersonal processes occurring during and after the stress experience (Grant, Ramcharan et al. 2007; Rutter 1999; Aranda and Milne 2000).

In times of crisis, carer/families know that the consumer with mental health issues is in a state of turmoil. Carer/families do not interact with consumers at this time to create further turmoil, or improve their own self image. Rather they attempt to provide support wherever possible and need guidance in how to step in or out of such situations.

Ten years ago, I became a carer/parent of a daughter with mental illness; very quickly I found my usual resilience was morphing. I became aware of significant changes in my self talk, self esteem, self awareness and self effectiveness following the first crisis and that first interaction as a carer with the psychiatric unit. The emotions needed to be processed and new meaning about my life and my family life needed to emerge.

From my knowledge and experience as a therapist, I knew I was in the triangle dynamic (Guerin, Fogarty et al., 1996) coupled with my own intra-psychic triad (Ross, 1989) with boundaries diffuse (Minuchin 1977) and apparently invalidation (Linehan 1993) for my daughter, had occurred. This was a surprise and shock to me that such issues had arisen without my attention or notice.

Consequently, early in the carer/family journey I developed two visual paper metaphors (maps) for personal use. Triadic and triangle models used to address trauma and relationship interactions provided source material. Thus research and argument of Bowlby (1969), Ross (1989), Minuchin (1977), Linehan (1993), Guerin, Fogarty et al. (1996), formed the basis of the maps, and service model used in this study.
History and Development of Maintenance of Resilience Maps (MOR Maps)

For me the maps needed to represent, attachment separation and loss, trauma, grief, validation and family interaction. The “Maintenance of Resilience Maps” MOR Maps as I called them helped me maintain resilience. The MOR Maps appeared to improve communications as we interacted and managed the two-way and often unreasonable expressed emotion that arose during crisis and remission phases of her mental illness.

Each component of the MOR Map (Attachment B) was related to evidenced based theory. The MOR Map put everything that was in flux in me and which needed to be managed onto one page. The MOR Map enabled me to reference and process grief appropriately in the current context and in the long term, and I revitalised my self talk, whilst maintaining balance, self awareness, self effectiveness and self esteem.

The MOR Family Map, (Attachment C), is an extension of the MOR Map and features the same components with the variations identifying emotional movement in the family and the resulting dynamic.

This MOR Map shows the values of the family group similarly represented as family/group communications, family/group awareness, family/group effectiveness, and family/group. This map led to maintaining and (for some) creating clear yet permeable boundaries in the family relationships.

Use with Carers

This visual metaphor was then used, under supervision, once before commencing data collection.

The carer responded well to the intervention and reported feeling more resilient and capable during her interactions with the consumer and the mental health professionals.

This first carer reported that using the map tool aided her self management. I subsequently changed the way I practiced therapy and developed a model for future therapy that mirrored the MOR Maps.

History and Development of the MOR Model

Using the theoretical arguments and these experiences the rationale and flow chart shown in Figure 1, was developed. The literature review also revealed that triadic models were used successfully in therapy however using both models in conjunction had not been approached. No evidence was found concerning the use of triadic approaches to aid carer/families and consumers relationship interactions.

The current research asks two questions: (a) Will a model that respects the feedback, emotional parallels and paradoxical nature of caring for someone with a mental illness be useful in therapy? (b) Will this intervention result in better outcomes for carers and consumers and increase resilience? This pilot study is based the MOR Maps which are used in conjunction with the MOR Service Model (Figure 2), case management flow charts and therapy.
Figure 1. The Relationship of Feedback to Resilience.
The Service Model.
The MOR Service Model reflects the MOR Maps and the triadic arguments raised in the research. Arguably, services to consumers and carers based on a model that is consistent with therapy by taking into account the triadic intra (internal) psychological functioning and the external triangular dynamics should be beneficial, despite its simplicity.

**Figure 2  Carer is automatically triangulated by the intervention of the therapist.**

Unfortunately, the therapeutic demands on clinicians and services not to be triangulated may leave the carer/family with the perception they are somehow responsible (the perpetrator) of the consumer’s illness, with the potential for undermining their self esteem and self image (Ross 1989; Guerin, Fogarty et al 1996).

This study attempts to highlight the way interaction and interconnectivity can be (a) pictorially represented and (b) used as part of a triadic therapeutic approach for helping carer/families, consumers and mental health practitioners achieve improvements in carer/family resilience as the individuals and systems undergo constant change.

In this study mastering interactions links the therapeutic intervention with the service model. This qualitative study aims to assess data related to the ongoing positive feedback from carers and consumers regarding the MOR Maps developed in 1998.

Secondly to begin the discourse that generates new directions in evidence based practice, connected with using the MOR Maps in therapy for both carer/families and consumers.

**Method**

**Participants**

Using purposive sampling 53 participants were drawn from 10 years of case records. Twenty carers (15 female, 5 male), twenty two consumers (13 females, 9 males) who had carers, and two families (Family 1: 5 members including one consumer, Family 2: 6 members including two consumers). Only participants who had given prior consent to collect and use case data for research purposes we
selected, and all individual participants were referred by their general practitioner for depression and or anxiety.

**Procedure**

Using, Figure 2, to guide the intervention of the MOR Maps, each participant was exposed to the intervention (Attachment D).

The intervention of the Maintenance of Resilience Map, (MOR Map) as detailed in (Attachment B) and the (MOR) Family Map (Attachment C) was completed and then applied throughout subsequent therapy to guide other interventions.

The procedure Attachment D, was repeated with each individual in each family group, and then with each family as a group.

The intervention of both the MOR Map occurred in third session of individual therapy and the MOR Family Map introduced in the first session of the family sessions.

**Results**

Case Data collected pre and post the intervention, was organized and is reported using the parallel illustrative method for qualitative data analysis.

Attachment E provides the list of common statements drawn from participants records made prior to the intervention.

Attachment F shows the types of statements drawn from the participant’s records following the intervention.

Statements prior to the intervention by carers/families are very similar, while statements following the intervention are very individual and unique to each carer/family.

**External Validation**

All participants (100%) reported appreciation for the intervention of maps, and that drawing their own maps was effective.

Participants reported gaining wisdom, to make personal changes. All participants endorsed the use of the MOR Maps and directly attributed their use to the changes in the way they interacted with one another.

All participants reported that as a result of using the maps, they considered they were managing multiple and varied external feedback better, having established workable boundaries.

Carers reported, dealing with mental health professionals and the service system, which remained focused on the consumer, had become easier. Each participant reported feeling validated within and from the external environment.

**Internal Validation**

All carer/family participants (33%) reported that emotional extremes levelled to more reasonable reactions with greater sense of satisfaction and connectedness. Carers reported that dealing with distressing emotions remained difficult, but that their grief had reduced. Carer participants reported feeling centred having made new meaning and feeling that they could continue to make new meaning.

Participants reported feeling more resilient and able to step in and step out appropriately without feeling marginalised during crisis. Carers also reported having developed balanced self talk, self
awareness, self effectiveness and self esteem. In both cases with the family clients, only two complete family sessions were required for the changes in family function to commence working.

**Consumers**

Consumers who used the MOR Maps made the same comments of external and internal feedback and observations of their own self talk, self esteem, self awareness, and self effectiveness and improved communications.

The tenacity of consumer’s mental illness seemed to result in longer time in therapy and slower or much slower response to the MOR Maps. Four consumers from the original group still attend therapy and use the MOR Maps.

**Closure and Follow up**

The intervention of both MOR Maps resulted in fewer sessions than usually expected, (by the therapist) for 45% of participants. These participants reported feeling better and not requiring further therapy. This occurred between 2–4 weeks after the initial intervention. Follow up a 3 and 6 month intervals revealed ongoing use of MOR Maps and ongoing capacity to maintain resilience, for 75% of carers.

**Discussion**

This pilot study aimed to identify reported positive outcomes for carers and consumers associated with a new direction in both therapy practice and intervention. Because of the way the MOR Maps were developed and used in therapy, the therapy always remained evidence based.

With the model for service and the intervention thematically and theoretically consistent therapeutic interventions were consistent and transparent to all involved in managing and caring for a consumer with mental illness.

This approach to therapy and the intervention together helped carer/families overcome numerous issues associated with the paradoxical bind carer/families and consumers find themselves in during times of crisis and remission.
Figure 3 shows how the MOR Maps intervention, influenced each participant's sense of balance and centeredness.

Carer/families had been validated both internally and externally, as well as validating the experience of the consumer, which for many carers is the primary focus of their caring.

It may be argued that the MOR Map and the MOR Family Map are just another therapeutic intervention and this is undoubtedly true, however the carers and consumers themselves endorse that this intervention provides the sense of coherence, interaction and interconnectivity they seek.

More importantly, carers confirm that this intervention does not leave them feeling pathologised but useful and with some means of managing their own resilience under adversity.

**Figure 3 Building of Resilience using MOR Maps**
One of the most essential components within the maps is the change in communication developed using validation of loss and grief. Although, the map only provided a representation of what needed to occur, the therapy provided the support and education around this self/other communication strategy and better outcomes for carers were marked.

In specific, the map supported the carer/family or consumer in out of session circumstances. The action on the part of the therapist (external interaction) coupled with the establishment of a balanced validation (intra action) was effective in addressing the difficult/paradoxical emotions often disenfranchised for the carer, and showed the importance of a changed approach.

The findings of this study support Grant Ramcharan et al (2007); that resilience is multi dimensional and multi level working through the interconnections of systems.

In addition, common statements prior to the intervention indicate the common experience in external settings and the unique statements made post the intervention suggest that the making of new meaning (a unique personal perception) was also developed.

Based on theoretical approaches the MOR Model and the MOR Maps indicate that in a general sense (at least) it is possible and efficacious to encapsulate the totality of the carers experience, whilst being transparent with carers when they arrive in the clinical setting.

As such “Lines of Battle” as one carer put it can be eliminated by the intervention of the MOR Maps within the focus of external/internal validation and support.

**Conclusion**

Arising from this study there are many implications for service providers and the future of evidence based practice into the mastering of interactions for all involved in the consumers mental health journey.

Nonetheless there are limitations in this research. The limited number of participants and the private practice setting limits the potential for a large scale investigation and likewise any generalizations to a broader population of carers.

No control groups were used to ascertain if the intervention was as effective as stated. Finally, the intervention of the MOR Maps at this time relies heavily on the therapist’s judgement and skills to utilize the intervention; however up-skilling the services and the therapists would not be an onerous task.

Future research can begin to formulate evidence through rigorous testing of some of the aspects of the map. Likewise research into the effectiveness of the model at the level of family and mental health service intervention is essential. Despite any limitations in this study the effectiveness of considering and taking a new direction with a combined focus on the impacts for all shows potential.

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Carer’s Vignette 1.

Susie eagerly awaited the return of her husband to the family; he had been in the hospital for six weeks following the crisis and was admitted following a suicide attempt. Susie felt that she had come to terms with the reasons why Derek had attempted suicide and was extremely pleased that he had not completed. Nevertheless, Susie was experiencing feelings of anger toward him that she found she could not avoid, and she was worried that these feelings or any other issues that came up at home would trigger more suicidal ideations. Although Susie had been assured by the staff and doctors at the hospital that he was now past the crisis and was dealing well with his depression, Susie remained very distressed and concerned for his safety and mental health because not only was Derek experiencing depression but was also diagnosed with bi polar personality disorder. The family structure was the same but now the family functioning and life were very different. Susie struggled to figure what mattered and what didn’t matter.

Susie just couldn’t tell the difference between when he did not need her help and when he did need her to step in and help. So Susie focussed all her energies on finding out what would make things right. For several months things went very well, but eventually old patterns returned to family functioning and Derek also stopped taking his medication. When Susie became aware of this she became quite controlling and closely watched the amount of medication he was taking on a daily basis. After some more months passed with family functioning getting worse Derek was again admitted to the hospital for a shorter stay and Susie was referred for carer counselling. Susie’s distress and apparent control over Derek centred on the fact that everything had changed and she needed to get things to the way they were before his illness and suicide attempt. Susie believed that getting back to the old ways was necessary and not that difficult to do, if only Derek would do what he had been advised. For Susie, it seemed quite simple. Susie was also surprised that he had become sick again because she was sure that he had been cured (“the medication does this, doesn’t it”?). Susie worked for many weeks in counselling to become adjusted to her new life. As Susie spoke about her experience she reflected that much of what she learned in counselling was
Attachment B

The Maintenance of Resilience Map (MOR Map).

Based on Ross, Linehan, Minuchin, Doka, Hippe,

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Circle of Feedback

Representation of Emotional Self

EED – Experience of Emotional Distress
RED – Reactions to Emotional Distress
ResED – Attempt to Repair Emotional Distress

Movement of Emotion

Individuals in Current Context

All Past Experience and Influence on Thoughts, Feelings and Actions, Self Talk

All Life Experiences

Unprocessed Grief

Self Esteem

Self Aware

Self Effective

Representation of Relationship of Internalised Components of Self

Self Critic – Invalidating Self Talk

Self Friend – Validating Self Talk of Feedback
Attachment C

The Maintenance of Resilience Family Map (MOR Family Map)

Based on Ross, Linehan, Minuchin, Doka, Hippe,
Vignette 1 – Returning to our initial Vignette the intervention commenced at the 3rd session. I introduced Susie to the MOR Map. This was done by giving her a pen and paper and asking her to draw the feedback circle, next she drew arrows pointing into the circle to represent the other people in her life that influenced her thoughts, feelings and actions. Then she was asked to draw in one large arrow to represent life (that being the uncontrollable events that come upon all individuals) and another large arrow that represents all her past experiences, learning and self talk. Next Susie was asked to draw a triangle in the centre of the circle and label the triangle with her Experiencing of Emotional Distress, Reacting to Emotional Distress and attempts to Repair Emotional Distress. Each of these terms were explained to Susie as she completed each point of the triangle. Next I asked Susie to add the arrows of emotional movement. Susie and I stopped here to bring all Map components so far identified together. Then the circle representing grief was placed into the centre of the triangle followed by the 3 intersecting circles of self awareness, self effectiveness and self esteem. Finally, the images related to self talk were represented using stick figures. Susie was introduced to new communication strategies that involved validation at this point. Susie was given opportunity throughout her construction of this map to reflect on the map and her insights as she drew it up. At the conclusion of the session Susie was given a copy of the MOR Map as represented in Figure 1 to take home with her. The next session, the same procedure was used to help Susie complete the MOR Family Map this time considering the way each person experiencing their own internal experiences might react when interacting at the level of family or the environment. The maps were used in subsequent therapy interventions to guide the management of (individual or family) expressed emotion, reactions and responses to expressed emotion. The MOR Maps were also used to identify grief, validate experiencing and emotions related to context and to aide in building a better self image through self awareness, self effectiveness, and self esteem. This process usually takes between 20 – 30 minutes at most.
Attachment E
Prior to the Intervention with MOR Maps

Feedback - External
Everyone keeps telling me that I can step back now.
I keep hearing that it is my fault.
The nursing staff just stand in their little glass cage protected from the world while I wait endlessly for their assistance.
She can just be as rude as she likes and no one cares if I'm crying
They keep pressuring me to take him home, but I'm not ready yet.
They keep telling me I've got depression, one even told me I had the mental illness not him.
Like, they are interested, they walk straight past me (sarcastic).
They took so much family history I'm sure they are assessing me for being mad too.

Self Talk - Internal Feedback
It's like I've got this voice inside my head saying you're a failure.
Why me, Why our family?
If I step back or give up on them and they suicide its my fault.
These emotions are just silly, you aren't the one with the problem, just get on with it and do everything like you always do.
Its worse for them than it is for me so I'm fine.

Attachment, separation and Loss (Grief)
I cry constantly.
I can't believe he would do this to us.
Where did it all go wrong?
I thought everything was alright.
I've got so much anger and I can't understand why.
I don't know how I feel most of the time.
No one in the family seems happy anymore?
Everything's changed how do I cope now?

Self Awareness
I know that there has been trauma for her, but what about me.
I don't understand how we got here.
Why am I experiencing such intense emotions, after all I'm not feeling depressed.
I can't say yes all the time surely?
Well I was depressed once so it has to be my fault.
She had trauma and I couldn't protect her.
Those other therapist who told me nothing was wrong were so off base in their assessments.

Self Effectiveness
I'm not interested in talking to anyone.
I spend all my time at the unit I haven't even had time to dress properly today. I am constantly worrying and on edge, waiting for the next crisis.
Doing anything for myself means that I am selfish, I've been accused of this so.

Self Esteem
I feel useless and ineffective.
No one is interested in what I have to say.
It feels like I'm being blamed
They tell their story, and I look like a bad parent.

Coherence
I'm just supposed to stay laughing and keep it all together, doesn't matter if I'm shattered inside.
I can't live with myself like this.
Nothing seems to fit anymore.

<table>
<thead>
<tr>
<th>Centredness</th>
</tr>
</thead>
<tbody>
<tr>
<td>Everything is messed up and confused.</td>
</tr>
<tr>
<td>I don't know where I am or where I am going</td>
</tr>
<tr>
<td>I feel so empty on the inside, sometimes I feel physically ill.</td>
</tr>
<tr>
<td>My head just feels like a spinning top</td>
</tr>
<tr>
<td>Blow up? I embarrassed myself on the unit, I couldn't keep it together.</td>
</tr>
</tbody>
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<table>
<thead>
<tr>
<th>Resilience</th>
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<tbody>
<tr>
<td>I feel like I cannot go on.</td>
</tr>
<tr>
<td>I just want to run away and forget it all the time.</td>
</tr>
<tr>
<td>I can't watch someone I love go through this again.</td>
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<tr>
<td>I don't think our relationship is going to last the distance.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Interactions</th>
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</thead>
<tbody>
<tr>
<td>I'm always yelling at people</td>
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<tr>
<td>I'm doing a thousand things but nothing is ever good enough</td>
</tr>
<tr>
<td>I am scared to ask anything and even to speak with him now.</td>
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<tr>
<td>I'm not going to that family meeting so they can just tear me to pieces while they feel sorry for him.</td>
</tr>
<tr>
<td>Let them find him cloths everything I bring in he gives to other residents.</td>
</tr>
<tr>
<td>I won't ring him again when he just hangs up in my ear.</td>
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</tbody>
</table>
Attachment F
Following the intervention with MOR Map.

Feedback - External
Even when if I hear someone say that it is my fault, I know that I cannot control everything and some things just happen.
Last week I needed assistance so I just bowled up to the little glass cage and kept knocking until I got assistance. I didn’t lose my cool and I got some information.
Well I used that validating communication, and I don’t think the doctor knew what hit him but I walked out feeling that I wasn’t an idiot just a caring parent.
I never had depression and I still don’t thanks to the MOR Map.
The other day I was asked if I would like a cup of coffee, while I waited for him to return to the unit that would never happen before. Maybe it’s the communication.
When I’m angry on leaving the unit I can just refocus and it is much better.

Self Talk – Internal Feedback
I still get this voice inside my head saying you’re a failure but I don’t let it get me down I can find many pieces of gold to disprove this thought.
If he suicides its not my fault, I will just have to work through the process using the MOR Map.
These emotions are just silly, you aren’t the one with the problem, just get on with it and do everything like you always do.

Attachment, separation and Loss (Grief)
I cry, and I validate my experience this seems more real to me than trying to pretend I am not hurt.
Nothing is ever alright only manageable.
I understand my emotions now and can control them better in highly stressful settings.
I know how I feel most of the time.
Life remains hard but we seem to be moving along and managing with the way his mental illness presents itself sometimes.
When there is an argument, I just use the triangle, step back into my centre, and try not to panic.

Self Awareness
I can see something coming and almost head it off by not reacting when she is just dumping a reaction to having been upset.
Saying Yes is good but I can just as easily say No and wear the consequences.
Well I was depressed once so it has to be my fault.
I may never be able to protect him from what life brings him.

Self Effectiveness
Our communications are fantastic now, and we just spent a week away together.
I would prefer that we never had a crisis, but when they occur I just re adjust my thinking into validation mode and I can cope better.
I don’t feel guilty for doing things for myself, I know that it’s important for me to look after me regardless of a crisis or remission phase.

Self Esteem
Everything has changed but that’s okay, I don’t feel useless anymore.
It does not matter if no one is interested in what I have to say.
Many traumas have occurred for me and my self esteem has always been low, now it is much better.
I like who I am now, and I can even help myself to feel stronger when I feel weak.

**Coherence**  
That really sick feeling has gone and during a crisis when I get it again I can manage to overcome it by validating how I feel and letting go of the feeling.  
I wouldn’t say I can always keep it all together, but that doesn’t make me even more upset now.  
I understand him better and it’s easier to give him space now.  
I just remember the triangle and it in my mind I can see where I am.  
I keep one copy with me all the time, just in case.

**Centredness**  
Since using the map everything seems so clear and I have something that helps when things get to a crisis point.  
I feel much better because I know what I want to do most times.  
I can live in my own skin more comfortably now.  
I don’t see any reason to blow up anymore.  
If, I do embarrass myself on the unit, because my emotion gets out of hand then they will just need to understand I have feelings too.

**Resilience**  
I asked her if she wanted me to call the CAT team and this time she said Yes. I was amazed.  
We had another crisis last week, this time I just stepped back, they can deal with the problem. I went to the coffee shop for an hour.  
I am validating how I feel as well now and a little cry usually helps me move on.  
Our relationship (husband and I) no longer depends on the happiness or otherwise of the children.  
I can see those things you call hooks, and I can walk right by, I’m no longer a “Kamikaze Fish”.

**Interactions**  
I seem to be talking about many things other than the crisis or mental illness now.  
I’ve stopped doing everything, and you know it seems to be working. He is trying to do some things himself.  
When I want to speak with him I use that validating style and our issues change to conversations and seem to flow better.  
I guess he has to be able to express how he feels so I just let him hang up and try not to feel too bent and twisted about it.