CHICKENS, ROADS AND RECOVERY IN MENTAL HEALTH Part 3

BY STEVE WHITE

In bringing this series to a close I want us to consider what we know about recovery. It is about readjustment, self discovery, self renewal, and transformation. It is an often complex, non-linear process, deeply emotional, at times painful and difficult, takes time but is ultimately transcendent.

Transcendence is an interesting concept in the sense that it is often used to describe the process whereby one achieves a state of being or existence above and beyond the limits of material experience. – Of achieving enlightenment in the philosophical and spiritual sense. But how about this idea – Transcendence is the state of excelling or surpassing the usual limits, or in terms of recovery, surpassing and breaking through the limits placed on us by mental illness, and the environment in which we live.

Even though we have previously explored the idea that the recovery journey is one that does not come with maps that can guide you, I recently read that as we grow up and learn to live in the society we are raised, we are told or shown how to live our lives. These maps of how to live are shaped by many things – the rules and expectations of families, the beliefs and ideas of society that are promoted in the classrooms, in the media and in public policy. These are like accepted roads or paths that we are expected to travel, and the majority of people stick to these roads (whether they want to or not). Accompanying these maps or directions are all the ideas about the characteristics of the travelers themselves – what should they look like, what clothes do they wear, and so on. It is these 'rules' that actually determine what is normal or accepted. Recovery is moving beyond this and redrawing the map. A group of people who have been diagnosed with bipolar disorder write:

> *"Healing is a lot more than just taking drugs. It's a wide open road and it's a scary one full of big ugly cars whose passengers either sneer at you or look terrified as they blow dust in your face. It's unfamiliar territory, the straight lines and narrow shoulders, the foreboding weather, flashing billboards full of corporate drug advertisements and fast food. Are you sure you want to be on this road? Isn't there an easier way, a way where they just pick you up in a big wide van and take you to a nice clean building where everyone's on the same schedule and you never have to make any decisions because the answers have already been standardized? Maybe you should just get back to familiar territory.*
>
> *But something has to change if you're ever going to face yourself and find a way to live in this crazy world. You're on a mission to learn how to take care of yourself and figure out where you belong. And things aren't always what they seem. Be patient."*

Let's face it, the Recovery Road is not an easy journey, and there will be times when thoughts return to that familiar territory of being told what to do, having all decisions about what is best for you made by others who don't really know you, and not really having to accept any responsibility for making changes to your life. Does this strike a chord with any of you?

Many barriers and obstacles exist on the recovery journey. These are the factors that impede, delay or interfere with the process of recovery, and can be categorized in two ways – internal and external. Internal barriers are those imposed by people with mental illness upon themselves, whilst the external barriers are those imposed by society or some external force (e.g. family, friends, teachers, etc). These external barriers are the accepted roads of 'normality' and 'abnormality' that were discussed earlier in this article.

The external barriers have been discussed and researched extensively, and it has been identified that many of the barriers are attitudinal, the "beliefs and assumptions based on prejudicial or stereotypical images of people with disabilities; for example assuming that a person with physical disability who uses a wheelchair is helpless and dependent, or thinking that a person who has a speech disability is stupid or less intelligent". These attitudes are based on false assumptions or generalizations and create barriers that can be difficult to penetrate. The Like Minds/Like Mine advertisements are an example of an effort to challenge these attitudinal barriers. Chamberlain (1990) refers to the attitudes held about people with mental illness as 'mentalisms, that they are "incompetent, unable to do things for themselves, constantly in need of supervision and assistance,

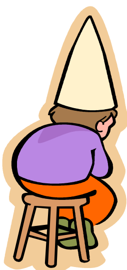
These attitudes are pervasive and run deep in our society and have far reaching impacts on the lives of people who have, or do experience mental illness.

"Social stereotyping stands as the most potent systems barrier ... for persons with psychiatric disabilities", and they are difficult to confront. Kramer and Gagne (1997:470) have identified that the most common external barriers to recovery are:

* Lack of accurate information and access to resources
* Poverty, isolation, and segregation
* Medication side effects and other chronic health conditions
* Issues to related to physical/sexual abuse and trauma
* Lack of positive role models
* Discrimination in the workplace
* Financial disincentives in government benefit programs (the US context)
* Lack of choice and of alternative services
* Absence of civil rights
* Mistreatment and abuse by providers
* Lack of involvement and participation in treatment planning and policy decisions

Whilst this is taken from research in the American context, the barriers identified are similar in Aotearoa New Zealand. Heron (2003) has considered the service user experience, and the impacts of this experience on people's lives. Her discussion on being initiated into the consumer role supports the points identified by Kramer and Gagne.

The second kind of barriers that interrupt and delay the recovery journey are "internal". Ever thought about how you get in the way of you recovery? We often internalize myths and stereotypes of people with psychiatric disabilities and become as we are portrayed, Often these are the toughest barriers, the ones that exist in our own minds, the result of negative beliefs that we have heard and learnt. "Many survivor/ex patients received strong messages from early childhood, "You'll never succeed in life", "You're not smart enough," or "Why cant you be more like your sister/ brother?" Negative feelings about our inferiority or "badness" were later confirmed by the mental health system. Many of us still hear haunting echoes from our pasts, "Work is much too stressful with your illness," "You'll always need medication and treatment," and You'll never be able to do the kind of work you used to do". Such statements, whether spoken or implied, are still pervasive and contribute to immobilizing negative images and lack of self worth".



Despite the 'power' of these barriers we know from the numerous accounts of mental health service users that one can overcome and transcend these barriers, and it seems pertinent that we end this series with looking at how we can begin to challenge and overcome the barriers and obstacles on the road of recovery.

One of the key tenets of recovery is that an individual redefines themselves in the presence of a psychiatric label. This redefinition of self, centres around a "process of rediscovering and reconstructing an enduring sense of self as an active a responsible agent …. becoming aware of a more functional sense of self and building upon it. [Research interviews] note that an enhanced sense of self provides [one] with both a refuge from their illness and a foundation upon which they may then take up the work of recovery in a more active and determined fashion"

According the research undertaken by Davidson and Strauss, this developing sense of self involves a number of steps:

1. Discovering a more active self
2. Taking stock of the self
3. Putting the self into action
4. Appealing to the self

Discovering a more active self involves the realization that we can act in our own interest. This discovery that we can do things that work may be gradual and may simply start with things that seem minimal or inconsequential to others. Things like getting out of bed on time, cooking a meal, have a regular shower, keeping appointments. The discovery that we can be in control can have a profound impact. It can be fragile and easily bruised by setbacks and negative experience. One thing that is known is that the development of this sense of self can be clear helped by the support of others who believe in you and acknowledge and support the process. Recovery needs a support environment to thrive!

Taking stock of the self involves one taking the time to identify not only their limitations and personal challenges but perhaps more importantly, identifying the personal strengths. Confidence then builds as we test and challenge these strengths and find that indeed we can overcome the barriers and obstacles. Feedback from others during this time can be very important.

Putting one's Self into action is the dynamic process that builds on the stock-take just mentioned. It

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further grounds and enhances the development of the active You, and gradually, we reclaim the living, learning and working life that may have been lost. Putting the self into action also means challenging and confronting negative personal, professional and societal values, attitudes and practices.

Lastly, the appeal to the self comes "as our level of confidence grows, [and] we begin to acknowledge more deeply the presence of the this stronger sense of self that we can call upon as needed", so that whilst negative life experiences may still happen, and vulnerabilities exist, we can be confident in the knowledge that we are empowered to overcome.

In closing I want to encourage you to believe in yourself, surround yourself with people who love you and believe in you, and take each day one step at a time, living in the moment and believing that dreams and goals are achievable.

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iii. Kramer, P. J., & Gagne, C. (1997). **Barriers to recovery and empowerment for people with psychiatric disabilities. In Spaniol, L., Gagne, C., & Koehler, M. (Eds.), *Psychological and social aspects of psychiatric disability* (467-476).** Boston, MA: Center for Psychiatric Rehabilitation.

iv. Chamberlain, J. (1990). **The Ex-patients movement: Where we've been and where we're going. *The Journal of Mind and Behaviour, 11*(3&4), 323-336.**

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vi. Noble Jr., J., & Collington, F. (1987). **Systems barriers to supported employment for persons with chronic mental illness. *Psychosocial Rehabilitation Journal, 11*(2).**

vii. Heron, M. (2003). ***The service user experience: Implications for the National Certificate in Mental Health (Mental Health Support Work)***

viii. Kramer, P. J., & Gagne, C. (1997), **Ibid.**

ix. Mental Health Commission. (1998). ***Blueprint for mental health services: How things need to be.*** Wellington: Mental Health Commission.

x. Davidson, L., & Strauss, J.S. (1992). **Sense of self in recovery from severe mental illness.*British Journal of Medical Psychology, 65,* 131-145**

xi. Spaniol, L., Koehler, M., & Hutchinson, D. (1994). **Ibid**

xii. **Ibid.**

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