

A series of thoughts on Personal Recovery

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I present a series of starting thoughts that have been developed and continue to be developed around recovery from serious mental illness. Choosing to present them in a short one or two page format gives you permission to use what you want, build upon or change the ever changing thoughts on recovery. These thoughts have been developed from my own "lived" and professional experience; from what others have told me has helped them; reading and reflecting on what others have written on the subject of recovery; and undertaking research within the area of recovery.

Mental Impotence



Definition: Systems of care and societal induced messages to a person that provides them with knowledge that claims their will, dreams, passions and memories of wellness replacing them with the internalised messages of inability, loss of hope, resulting in terminal or chronic death of the human spirit.

May be inflicted covertly or overtly but onset of symptoms may be swift. The longer one is exposed to the iatrogenic environment the harder it is to overcome.

Cure: Remove immediately from infected source and re infect with the virus of HOPE. May need to find a person or range of people to assist in this process - not necessarily professionally trained but those who believe in the ability of the person to reclaim their own lives. All people must work "as if" "the person can recover despite presenting situation and have the essential competency of 'stickability'. Must allow the person to regain the driver's seat of their lives and help them unlock themselves from the entrapment of the boot.

HELEN GLOVER uses her professional and lived experience to expand and challenge the concepts of recovery within mental health service delivery.

Helen has spoken and lectured internationally on the challenges and opportunities of the provision and development of recovery-oriented mental health services. She has worked primarily within Australia and England, with fellow professionals and those that use services and their families, to promote practices that support wellness.

She recently has worked as the Chief Executive Officer of CHANGE in Birmingham, UK. CHANGE provides residential and community crisis recovery alternatives to hospital admissions and is staffed by recovery guides who identify primarily with the lived experience of their own recovery from mental health difficulties.

In 2001 Helen was commissioned by the National Institute for Mental Health England (NIMHE) to write its discussion papers on "Developing Recovery-Orientated Services for Mental Health Services in England". She has also been a co-researcher in an Australian study Recovery from Schizophrenia from a Consumer Perspective.

On her return to Australia in 2004 she accepted a position with Queensland Health to develop and deliver a curriculum for mental health professionals on recovery-orientated practice.

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The following is an adaptation of a poem that challenges us to be “Holders of Hope”.

The Call....

Adapted by Helen Glover

A voice from on High said... **Be a holder of Hope for those who cannot Hold it themselves...**

I said,

Listen here...you are calling the wrong person. I am not that sort of mental health worker. It takes all my time to stand on my own two feet...

The Voice on High says...**You are a Holder of Hope...**

I said...

“Now, don’t get me wrong... I do all I can within reason, but I can’t afford to go overboard. I mean I have a job, a family ... I have to live in this world.

The Voice continues....**You are a Holder of Hope...**

I said...

“It’s all very well to talk about Hope but Hope is dangerous. It can get people crucified. At best it can be misunderstood. If I go around telling people that I have Hope that they can recover...I might get locked up...

The Voice being persistent said.... **You are a Holder of Hope**

I said,

“The trouble is, I am not ready. Come back in a few years when I’ve got my life sorted out. By then I should have something to offer people...

The Voice repeated... **You are a Holder of Hope**

I said,

“Hey...don’t look at me like that. You’re making it very difficult. All right I’ll spell it out. I am afraid.... I’ll let people down.... if I try to do what you want ...” a holder of hope” and fail what will you and others think of me...I am weak... I do not have the strength to do this...Look for someone else...”

As the Voice continued...**You are a Holder of Hope**

I said,

“You don’t understand what I am telling you. I’d deny and betray those you give me the responsibility to hold their hope...There would be times that I’d get it wrong...maybe very wrong”.

And what would you think of me then?”

The voice un-relentlessly just replied: **“You are a Holder of Hope”**

“Holders of Hope”

*Hope sees the invisible, Feels the intangible, But knows the possible
(Author unknown)*

Do we dare to be the “Holders of Hope” for those that cannot hold it themselves but do we have the courage to give it back to them.

Hope is not a new concept to the recovery process of mental illness, distress and despair. In fact I think professionals, academics, consumers, carers, the community and even those with little knowledge of recovery would claim that hope is an essential ingredient and without it recovery from extreme emotional distress is extremely difficult.

It is a small word yet means so much and has many different understandings especially in the field of mental health recovery. Therefore teasing it out and challenging ourselves personally and professionally to understand the impact the role of HOPE has on our practice and our lives is essential in the world of working and living from a recovery orientated base.

It only has four letters - H.O.P.E. Although it is only four letters it remains a complex concept to practice in a manner that is strengthening and not weakening. We may say “Yes I have Hope for someone” but do we?

Do we, in the things we do for people show HOPE or do we in doing something gives people messages that we do not have hope for them at all?

Do we give the very damaging and strong messages, whether consciously or subconsciously, that we believe people do not have the ability to do it for themselves?

These are big questions which our systems of care must struggle to understand and fundamentally change practices and values that enable recovery for all and not just the handful that have managed to recover in spite of these messages.

If I was to ask you how you hold HOPE, I am sure I would hear ...I listen to them.... I gave them advice.... or I found them a house to live in.... or I took them to an activity...or I encouraged them to do an activity that would give them structure for their day.... or I made them or a cup of tea. Or if I was a doctor I prescribed them some medication that may give them some relief. At times these may be part of giving HOPE and holding HOPE but given at the wrong time may be giving a person very intrinsic and extrinsic messages that you have no Hope for their recovery at all. So at some stages giving advice or making or giving a cup of tea for someone is giving HOPE. Doing it at the intuitive wrong time is telling a person “I have no Hope for you that you can do it...I will do it for you...” Getting the intuitive balance right is difficult. As a worker developing the “Intent of Hope” is probably the

most crucial competency that must be developed, supported and encouraged in recovery orientated mental health practice. That without the ‘intent of hope’, that believing things will be different even though we might not have the privilege of witnessing it, we are causing iatrogenic harm. There is no excuse for this.

Getting the balance right is the difference between mollycoddling and helping people discover life in a way that they can drive their own journey. Knowing when...`to do for someone.... or with someone... to do without us at all ...and when to kick butt...are the intuitive competencies we must all learn to struggle with and fine tune.... many times we will get it wrong, but the opportunities we can learn from risking mistakes being made are too great to ignore.

The ability to be able to do all these things is essential components of journeying with someone in their recovery. ‘Holding Hope’ is only one component of recovery orientated practice, the knowledge and manner in which we return hope to the person to hold it themselves is just as crucial.... far too often we forget to give it back. Not giving it back is also giving messages that create mental impotence.

The understanding of the term iatrogenesis is helpful here in knowing that we as mental health professionals have the power to give and destroy life. Iatrogenis, meaning medical induced or caused harm is not used in our day-to-day practice of mental health service delivery. Giving implicit and explicit messages that a person does not have the ability to reclaim their lives after being diagnosed with mental illness is contributing to the societal and system condition I have name “mental impotence” and therefore an injury. Mental Impotence, the destruction of human spirit, is probably more iatrogenic than a surgeon removing a wrong body part in a surgical procedure.

In not holding hope and giving it back we are actively contributing to this injury yet we continually hold up these practices of “care and treatment” as best practice allowing many, many people’s human spirit to perish and die. I cannot think of a worse medical inflicted injury on a person.

It is hard when people present in crisis and acutely unwell...even harder when the tools of our trade, the medications, the hospitalisations etc have little effect on their level of distress. Our limitations to understand the world of their distress leaves us with temptations to use terms such as ‘treatment resistant’, “non-compliant” or “difficult patient”. Seeing beyond the distress, illness, behaviour is very difficult, but one I believe that to be a holder of hope we must extend

ourselves to do. The basic premise of Holding Hope for someone who cannot hold it himself or herself at that moment is the knowledge and belief that they have the ability and capacity to hold it for themselves one day.

The intrinsic and explicit messages we give people when we get this balance wrong is that.” I will do that for you as I don’t believe you have the ability to do it yourself...” A simple example of intuitive balancing would be if I always took someone shopping despite their level of wellness or ability to shop by themselves. If I knew they had the ability to shop by themselves, even though being difficult for them sometimes, I would be reinforcing the message that I have no belief in their ability to ever do their shopping by themselves or have expectations of them to participate in their recovery process. I know this is extreme... but are these subconscious reasons for doing for people when they have the ability to strive and struggle to do it themselves?

In addition there are other complex reasons for doing for that surround the workers identity and purpose. It is not clear cut and needs our intuitive ability and skills as it times doing for is appropriate but when it is not it is causing spirit-breaking harm.

I would like to share with you a short story that illustrates the benefits of developing such a focus within a recovery framework. We cannot afford not to develop practices that give strong messages of Hope but they may not always come dressed as modally coddling, nice words and warm and fuzzy feelings.

To cut a much longer story short ...I was a third year social work student and had internalised my illness very well and used my illness status to unknowingly get privileges within the academic system. At the time these were subconscious to me and those that treated me...they thought they were helping me. Since being accepted into University my treating mental health professionals were fearful that any form of failure would incur a massive relapse and therefore preventing this was paramount in their minds and I had swallowed the need for this like a bitter pill and without question to the extent the most of my degree was done from hospital in the “cocoon of safety”.

Every semester the doctors would fill out a “special consideration” form that asked the University examiners to look favourably upon me. For the first two years this was signed without hesitation and I ingested the subconscious message that they too held little hope that I could not get through the rigour of the course without it.

In third year I took the form to be signed which described in full technicolour all the deficits of experiencing a serious mental illness and recommendations to the effect that I required special consideration in order to complete my studies that semester. To my utter dismay and horror the Chief

Examiner looked at me, looked at my academic record and then proceeded to tear up the special consideration form. Standing there shocked I exclaimed "that I had rights I was mentally ill and he could not do this and I would fight this to the highest!!!" He replied," that if I could give him evidence of needing special consideration he would be happy to reconsider". With an extremely high grade point average I had no such evidence.

As I stood there scared without the confirmation and security of special consideration. He said,' that if he signed that piece of paper he would be giving me a very strong message that I can't cut it and struggle with the course like every other student and he was not prepared to take that opportunity away from me". Although I left his office very angry, upset and scared I learnt my first valuable lesson that holding hope is not always feel warm and fuzzy and giving into the wishes asked of you may be sewing the seeds of harm. As a worker it asks you to take a very strong stance against the war of mental impotence. This conversation was a turning point in my recovery journey and with it came a knowledge that Holding Hope comes sometimes dressed in kicking someone's butt and not always in holding his or her hand.

As workers, consumers and carers we must all learn to work and live with the “as if”. I believe the iatrogenic spirit breaking and creation of mental impotence starts when people loose the belief that there will be difference and therefore work or behave according to what is currently before them. There is so much literature, research and the mere presence of people in recovery to prove that this is not true. I re- stress again that it is not just those that “have it in them” that will recover ...if we are going to be a holder of hope until someone can hold it themselves then we have no option but to work with and relate to everyone from the very first moment of contact that we believe recovery is a reality regardless of the current distress and despair people find themselves in.

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